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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

CURRENT PERSPECTIVES ON THE GESTALT
OF NURSING CURRICULA

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Natural and Health Sciences
School of Nursing
Nursing Education

May 2019

This Dissertation by: Brandi Lynne Venvertloh

Entitled: *Current Perspectives on the Gestalt of Nursing Curricula*

has been approved as meeting the requirements for the Degree of Doctor of Philosophy in College of Natural and Health Sciences in School of Nursing, Program of Nursing Education

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ABSTRACT

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This research study aimed to investigate the current gestalt of the Bachelor of Science in Nursing (BSN) curricula in the United States. Presently there is an emphasis in nursing education on the practice–education gap in order to ensure new graduate Registered Nurses are adequately prepared for entry into practice in a dynamic and complex healthcare environment. There has also been movement in nursing education to remove nursing theory from BSN curriculum guiding frameworks and replace them with essential educational standards. The purpose of this qualitative phenomenological research study was to explore the lived experiences and perspectives of faculty curriculum leaders and administrative program directors as they implement, develop, and/or revise a BSN curriculum. Ten nurse educators and/or administrators from across the United States participated in in-depth, semi-structured interviews that were guided by open-ended questions, recorded, and then transcribed verbatim. Data analysis and coding using qualitative data analysis software resulted in seven themes: (a) graduates readiness for practice and awareness of practice–education gap, (b) clinical placements impact nursing curriculum, (c) faculty influences on nursing curriculum, (d) students’ characteristics that influence nursing curriculum, (e) curriculum revision, (f) nursing essential educational standards predominantly guide and influence BSN curriculum, and (g) nursing theory. Findings

from this research study reveal the greatest influences and motivations for the BSN curriculum and the current issues for the BSN curriculum. This research study confirms that the practice environment greatly influences program outcomes and availability and usage of resources in nursing programs. Faculty, students' characteristics, and clinical education play a larger role in the BSN curriculum than originally hypothesized. Therefore, issues in these areas are also issues for the BSN curriculum. This study also found that nursing theory is being taught and used less as a theoretical curricular framework in the BSN curriculum as well. Essential educational standards heavily guide and influence the BSN curriculum to a point where they may be replacing theoretical frameworks within the curriculum. Implications for nursing education include transformation of clinical education to mimic the changes in the healthcare environment, faculty development and mentorship for novice nurses on their role within the BSN curriculum, and guidance and support on how to teach and include nursing theory within the BSN curriculum. Recommendations for future research include a comprehensive investigation nationwide on the preparedness of and employer satisfaction with new graduate RNs, further studies on the faculty's perceptions of nursing students with disabilities, and higher levels of research and evidence to evaluate the implementation of the concept-based learning curriculum.

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From the start of my Ph.D. program, I recited the phrase, “just keep swimming.” I kept this phrase in front of me, literally as a sign in my office as I was elbow deep in assignments during the coursework period and when I was staring blankly at my computer screen while writing my proposal. The phrase reminded me that this endeavor was a journey to a specific destination, a temporary experience. Although it was painful and pushed me beyond all limits, I had to keep moving each day, week, month, and year. I am so grateful that I had this opportunity to deeply grow as a professional nurse educator. This has forever changed how I approach every aspect of my life from teaching, nursing, and parenting.

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CHAPTER I

INTRODUCTION

Leaders in nursing and nursing education recognize that nurse educators can no longer prepare nurses to practice in today's complex workplace using the same methods as decades prior (Benner, Sutphen, Leonard, & Day, 2010). Aside from that, nursing education is confronted with looming nursing and faculty shortages (Benner et al., 2010), an increase focus on evidence-based quality and safety-related competencies (Institute of Medicine [IOM], 2003), near-future goals to increase the percentage of Registered Nurses (RN) who hold a Bachelor of Science in Nursing (BSN) by the year 2020 (IOM, 2010), and an over-stuffed nursing curriculum (Giddens & Brady, 2007; Ironside, 2004; Ruchala, 2015). These topics generally dominate the discussions and strategies within nursing education. Each of these either direct or not connect to the nursing curricula, whether by the faculty who are in charge of the curriculum, what is most important to include as content, or how the curriculum is organized to ensure seamless transition post-degree.

These transformative times for nursing practice and education are reflected in the literature through expert commentary, research, position statements, and experiential case discussions. Nursing and healthcare organizations such as the IOM, American Association of Colleges of Nursing (AACN), and National League for Nursing (NLN) often produce publications through various outlets on salient topics that incite discussion and possible revision at the curricular level (Giddens et al.,

2008). In fact, in most literature today, the introduction to most articles on the topic of nursing education, especially on the topic of nursing curricula, begins with a brief synopsis or relates back to one or more of the above topics.

Ultimately, nursing faculty is responsible for the revision and overhaul of the nursing curriculum to keep pace with all the rapid changes in nursing practice (Yancey, 2015). Together with nursing education leaders, they must address a widening practice–education gap in nursing to bring nursing education closer to the realities of nursing practice. There is already support and leadership within nursing organizations, such as the AACN (2008) statement that demonstrates a focus on “the knowledge, skills, and attitudes needed by nurses to practice effectively within this complex and changing environment” (pp. 6-7).

With much emphasis on the practice–education gap, it is clear that nursing theory is seldom on the forefront of discussion on nursing curriculum. The use of nursing theory was once a staple component to the curriculum (Berbiglia, 2011). In recent years, the use of nursing theory in nursing curriculum has been on a steady decline (McEwen & Brown, 2002). It is unclear how much of a decline has occurred or if there is a concern it will become extinct within the nursing curriculum.

However, the use of nursing theory in the nursing curriculum does not have to be an either/or situation with the emphasis on the practice–education gap. As Yancey (2015) stated, “a wise leader in nursing education will seek ways to meet the demands of accreditation and healthcare without sacrificing the nursing science foundation” (p. 275). This statement is important because nursing theory does have significant ties to the generation of new knowledge for the nursing discipline. Therefore, it is a worthy endeavor to explore whether nursing theory is truly on a permanent descent from

nursing curricula today. This researcher explored the current gestalt of nursing curricula using qualitative research methods to explore the phenomenon and reviewed recent literature that focused on the curriculum and what has been added, removed, revised, and why.

Background of the Study

Before the current gestalt of nursing curricula may be explored, salient background information will be shared. The background of this research study identified and clarified definitions; elements of an educational curriculum; and pertinent historical information specific to nursing education, the nursing curriculum, and nursing theory. This background on the nursing curricula aims to provide essential context for not only the research study, but also for the subsequent review of the literature on the topic.

Definitions of Curriculum

The curriculum could be considered the heart and soul of the nursing program. Keating (2015) defined a curriculum as a “formal plan of study that provides the philosophical underpinnings, goals, and guidelines for delivery of a specific educational program” (p. 1). Iwasiw and Goldenberg (2015) used a practical definition of curriculum in that it is a “program of studies with specified courses, leading to an academic certificate, diploma, or degree” (p. 4). Both definitions are accurate in their description of the curriculum; however, they differ in their perspectives, perhaps one speaks more to the soul and the other to the heart of the program.

Nursing faculty often turn to professional organizations for definitions within nursing education. The NLN is a respected organization that provides guidance and

resources for faculty at the course, program, and administrative levels in nursing education. The NLN's (2004) definition of curriculum stated:

The curriculum is flexible and reflects current societal and health care trends and issues, research findings and innovative practices, as well as local and global perspectives.

The curriculum provides experiential cultural learning activities that enhance students' abilities to think critically, reflect thoughtfully, and provide culturally-sensitive, evidence-based nursing care to diverse populations.

The curriculum emphasizes students' values development, socialization to the new role, commitment to lifelong learning, and creativity.

The curriculum provides learning experiences that prepare graduates to assume roles that are essential to quality nursing practice, including but not limited to roles of care provider, patient advocate, teacher, communicator, change agent, care coordinator, user of information technology, collaborator, and decision maker.

The curriculum provides learning experiences that support evidence-based practice, multidisciplinary approaches to care, student achievement of clinical competence, and, as appropriate, expertise in a specialty role.

The curriculum is evidence-based. (Curriculum section, para. 1)

Historical Overview on Nursing Curriculum

There has been a drastic evolution of the nursing curriculum. Prior to the 20th century there was essentially no formal or academically-based curriculum in place. Nurses were trained using an apprentice model where, "learning was achieved by doing" (Faison, n.d., p. 3). By the 20th century, nursing curricula were still primarily built upon skill achievement (Faison, n.d.). The early baccalaureate programs converted nursing curricula to a more academic program of study, which is more similar to the curricula of today.

The Tyler model for curriculum development became the most widely utilized curriculum structure in nursing curricula. Tyler's model includes four basic steps: determine the school's purposes (objectives), identify educational experiences related to purpose, organize the experiences, and evaluate the purposes (Darrin, 2014). These

simplistic steps remain relevant and foundational today, even amongst drastic changes to the curricula. At one point in time, the Tyler model was the only acceptable model for nursing accreditation agencies (Bevis, 1989).

The behaviorist model or behaviorism influence on nursing curriculum gained momentum in the mid-20th century. Behaviorism refers to similar terms such as: “neobehaviorism, stimulus-response, connectionism, associationism, and operant condition” (Bevis, 1989, p. 26). Practically speaking, the behaviorist model refers to the abundance of behavioral objectives at the curriculum and course level.

The behaviorist movement was fueled by nurse educators seeking advanced degrees in other disciplines such as education, sociology, and anthropology because there were no opportunities within nursing to do so. These other disciplines’ body of knowledge was already immersed in the behaviorist model (Bevis, 1989). Both the Tyler and behaviorist models dominated nursing curriculum through much of the rest of the 20th century. Three variations within these models are the simple-to-complex, medical model, and the nursing process, which were also prevalent in this time period (McEwen & Brown, 2002).

There was a slight shift in thinking in the late 20th and early 21st centuries. As the world began thinking more globally, nursing and nursing education followed suit. There emerged a community-based model for nursing education with an emphasis on health and wellness (Stanley & Dougherty, 2010). Jacobs and Koehn (2004) defined the community-based model as “one that responds to the needs of the community, provides care wherever the client is, and partners with community agencies” (p. 31).

Stanley and Dougherty (2010) listed a few new content areas introduced into nursing curricula in the early 21st century: genetics, bioterrorism, mass casualty

response, cultural competence, health policy, and leadership (NLN, 2005; Tanner, 2006). This brief list provides an example of how nursing education has interests in adopting new topics; yet it is unclear how these new topics have impacted the nursing curriculum. However, a more complete list and descriptions of current (early 21st century) curriculum designs and additives will be discussed in more detail in Chapter II.

Components of the Curriculum

Most nursing curricula include key components such as the mission, vision, conceptual framework, theoretical framework, and lastly the course and/or program content. The mission, vision, and both frameworks are meant to reflect the educational institution's salient ideals and values. The chosen essential educational standards (Giddens et al., 2008; Jacobs & Koehn, 2004; Koestler, 2015; Mailloux, 2011; Schug, 2012) and the National Council Licensure Examination (NCLEX) (Lane & Mitchell, 2015; Mailloux, 2011) often heavily influence the content that is built within a nursing curriculum. However, the course content and progression may be in that order because of the chosen framework, theory, and also accreditation and/or state board recommendations.

Mission, vision, philosophy. Most nursing curricula have a mission, vision, and philosophy unique to the program's set of values and affiliations. For instance, if a program is affiliated with a religious organization, then the mission, vision, and philosophy may also reflect those particular values specific to the religious affiliation. It is ideal for programs to be regularly reviewed and the mission, vision, and philosophy revised as needed. It is not uncommon to see the values and priorities shift

over time and so the mission, vision, and philosophy may shift to remain congruent as well (Caputi, 2010).

Conceptual framework. Faculty will typically select a unique conceptual framework composed of important concepts related to the program's values and priorities. Bevis (1989) defined a conceptual framework as "an interrelated system of premises that provide the guidelines or ground rules for making all curricular decisions—objectives, content, implementation, and evaluation" (p. 26). This may become a program-specific curriculum framework in which the faculty defines the concepts and creates a model (Caputi, 2010). It is possible for the conceptual framework to be created with values and concepts that do not pertain to one particular nursing theory. Therefore, the faculty may decide to create an eclectic framework, one that draws from a variety of inspirations in order to capture the essence of the college, program, and student learning experience (McEwen & Brown, 2002). The popularity of conceptual frameworks, especially those based on theoretical foundations, was at its peak in the 1970s due to accreditation requirements (Berbiglia, 2011). The popularity has since waned, and there is no longer such a requirement in accreditation standards (Yancey, 2015).

Theoretical framework. The terms theoretical and conceptual framework are often confused and even used interchangeably within the literature. It is important to establish distinguishing characteristics of the two terms. The terms overlap because technically the theoretical framework is considered a more specific type of conceptual framework. The conceptual framework is a more generic, overarching term. The theoretical framework is typically based from a specific theory. A program may choose to align with a specific nursing or non-nursing theory to become the

curriculum framework. As the review of the literature is discussed, specific examples of nursing theoretical frameworks in curriculum (frameworks) will be highlighted.

Whether a program aligns with a specific theory or designs an eclectic or unique curriculum framework depends on preference of the faculty in the nursing program. However, it is still important for the program to include a framework that provides “conceptualization and articulation of concepts, facts, propositions, postulates, theories, phenomena, and variables relevant to a specific nursing educational system” (Bevis, 1989, p. 26). This provides necessary structure to the curriculum, similar to that of a foundation in building a new house.

Curricular Outcomes and Content

There are a number of possible outcomes to measure from the nursing curriculum. Many of the outcomes of the curriculum reflect current nursing practice with the educational institution’s philosophical ideals (Caputi, 2010) and congruency amongst essential educational standards (Holaday, 2010). However, the most common curricular outcomes are NCLEX-RN pass rates (Caputi, 2010; Jacobs & Koehn, 2004; Koestler, 2015; Landry et al., 2011), student/program satisfaction (Caputi, 2010; Patterson, Crager, Farmer, Epps, & Schuessler, 2016), graduation/completion rates (Caputi, 2010; Giddens & Morton, 2010), and job placement and employer satisfaction (Caputi, 2010). Other curricula may utilize test scores from standardized testing to evaluate a specific topic such as critical thinking as another possible outcome to the nursing curriculum (Patterson et al., 2016).

Aside from the academic outcomes of the curriculum, it is imperative to consider nursing practice-driven outcomes. The curriculum is ultimately responsible for generating a graduate prepared to enter professional nursing practice as a generalist

staff nurse (Caputi, 2010), which includes adequate competence in nursing (Theander et al., 2016). The curriculum committee may use faculty, alumni, and employer surveys to measure practice-specific outcomes of the curriculum (Bowen, Lyons, & Young, 2000; Giddens & Morton, 2010; Utley-Smith, 2004).

The majority of the curriculum outcomes will also influence what type of content is placed in the BSN nursing curriculum. Ervin (2015) classified baccalaureate nursing content into five categories: (a) knowledge from the physical and biological sciences; (b) communication skills; (c) the major in nursing; (d) knowledge from social science, sociology, social anthropology, and psychology; and (e) general education. However, a substantial amount of BSN curricular content is inspired from essential education standards (Giddens et al., 2008; Jacobs & Koehn, 2004; Koestler, 2015; Mailloux, 2011; Schug, 2012), nursing licensure examination content (Landry et al., 2011), nursing practice, and other miscellaneous influences.

Essential educational standards. Essential educational standards, regardless of the accreditation agency, play an integral role in nursing curriculum content. Typically the standards set forth by accreditation agencies are meant to serve as a curricular content framework for BSN programs (AACN, 2008; NLN, 2004). Therefore, it is beneficial for the background of this research study to provide a description of the various types of accreditation agencies and essential educational standards utilized in nursing education today. Pertinent literature tied to the essential educational standards or accreditation agencies in nursing education will be discussed in the literature review on nursing curriculum.

The first known accreditation, at the nursing curricular level, occurred in the late 1800s (Ruchala, 2015). The names of the accrediting agencies have changed some

over the years. It can be a challenge to keep up with which agency is favored in nursing education at a given time, unless it is an area of expertise. Presently there are two primary accreditation agencies in practice in nursing education: the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Collegiate Nursing Education (CCNE) (Ruchala, 2015). The NLN also has another accreditation agency that was recently developed in 2016, entitled the NLN Commission for Nursing Education Accreditation (NLN, 2016). For the purpose of this research study, the discussion, background, and literature review will focus on the ACEN and CCNE accreditation agencies, because they are more consistent with the timeframes and contexts discussed in the literature.

The agency formerly known as the NLN Accrediting Commission is now the ACEN and is recognized by the Department of Education as a wholly owned subsidiary corporation of the NLN (Accreditation Commission for Education in Nursing, 2017). The ACEN can accredit nursing programs at various levels including practical, diploma, associate, baccalaureate, master's, post-master's certificate, and clinical doctorate (Ruchala, 2015). The ACEN standards were recently updated and released in 2017, with previous standards published in 2013. These standards include topics such as mission and administrative capacity, faculty and staff, students, curriculum, resources, and outcomes (ACEN, 2017).

The CCNE is the AACN organization's accreditation agency, developed in 1998 (Ruchala, 2015). *The Essentials of Baccalaureate Education for Professional Nursing Practice* is a standard framework and a set of expected outcomes used by most nursing curricula in the United States. The AACN is the most prevalently used accrediting body in the United States and, therefore, although the standards are not

required for all programs, the majority of programs use The Essentials as a guide for the curriculum. The Essentials were created with the intention to address core content and knowledge specified in the IOM publications. There are a total of nine essential statements that are to be integrated into nursing curricula (AACN, 2008).

National Council Licensure Examination. The NCLEX-RN is the essential first step into entry into registered nursing practice in the United States (National Council of State Boards of Nursing, 2016). The exam is also used to ensure that nurse graduates are able to demonstrate basic knowledge competencies to be prepared to become a generalist staff nurse in nursing practice. According to the National Council of State Boards of Nursing (2016), the NCLEX-RN Test Plan “provides a concise summary of the content and scope of the licensure examination” (p. 3). Content on the NCLEX-RN is broken down into eight categories: management of care, safety and infection control, health promotion and maintenance, psychosocial integrity, basic care and comfort, pharmacological and parenteral therapies, reduction of risk potential, and physiological adaptation (National Council of State Boards of Nursing, 2016). Nursing faculty integrate the National Council of State Boards of Nursing NCLEX-RN Test Plan to ensure all pertinent test plan content is dispersed in the curriculum as a resource for teaching and learning strategies in the classroom and even in the development of NCLEX-RN style test questions for their courses.

Practice-ready graduates. An important task in nursing education is the preparation of nursing graduates for the nursing practice in a complex healthcare environment. The ultimate goal of each nursing graduate is to be competent to practice at the bedside by the time they graduate from a nursing program (Benner et al., 2010). The curriculum is the primary tool used to achieve practice-ready graduates. Mailloux

(2011) stated that, “a well-developed curriculum promotes critical thinking, addresses competencies of the profession, and builds from simple to complex” (p. 385). Further, the NLN (2004) also stated “the curriculum provides learning experiences that support evidence-based practice, multidisciplinary approaches to care, student achievement of clinical competence, and as appropriate, expertise in a specialty role” (para. 5). Further implication of how the practice environment informs and motivates curriculum revision is discussed later in the literature review.

Prerequisites in the Bachelor of Science in Nursing curriculum. Individual education institutions have the right to choose unique prerequisites to the BSN program that align with their mission, vision, and philosophy. Prerequisites are an integral part of the overall BSN curriculum and degree. However, if the goal is seamless transition either between programs (if a student transfers) and post-graduation (in future degree programs), then uniqueness can present a dilemma (Giddens & Meyer, 2016). The IOM’s call for more BSN prepared nurses in the workforce has spurred more dialogue and change related to prerequisites requirements (Giddens & Meyer, 2016; Gorski, Farmer, Sroczynski, Close, & Wortock, 2015), enrollment, and progression of students through a BSN curriculum (Giddens & Meyer, 2016), because the aim is to reduce barriers for those who will need to seek the BSN in the future in order to increase the numbers of BSN prepared nurses.

Curriculum Committee and Leaders

Patterson et al. (2016) asserted faculty own the curriculum. Additionally, Kupperschmidt and Burns (1997) stated, “nursing curricula can be viewed as an extension of the faculty’s psychological self, collectively and individually” (p. 90).

However, typically there is a larger, more diverse curriculum committee with members that may include faculty, students, academic administrators, and other stakeholders (alumnus, healthcare/academic partners, college support staff) connected to the program(s) of study (Iwasiw & Goldenberg, 2015). In times of revision and/or development, additional members may be called upon to join the committee and share expertise on a temporary basis (Elliott, Rees, Shackell, & Walker, 2017).

The curriculum committee often has a leader to guide the general business, facilitate times of revision, and oversee the continuous evaluation plans. The leader may be a part of the faculty and/or hold an administrative position in the program. Regardless, the curriculum leader must possess expertise in the area of nursing education and the curriculum processes. It is also essential that the curriculum leader be “thoroughly immersed in the literature, practice, and governance of nursing education in order to bring essential ideas to the group and have credibility with members” (Iwasiw & Goldenberg, 2015, p. 103). The curricular leader is an important role for consideration when exploring the nursing curriculum because although they do not make all decisions for the curriculum, they may have influence on the direction of the curriculum. The curricular leader will likely have salient historical and current perspectives on the curriculum, which will be valuable in an examination of the current gestalt of curricula as a whole.

Nursing Theory

Conceptually, nursing theories began broadly and as years went on became more narrowed in focus. Much of the modern theoretical work in nursing began in the middle of the 20th century when nurse theorists focused their efforts on designing grand theories or creating theory-like structures. Many of these grand theories or

conceptual/theoretical frameworks were criticized for being created to impose on practice instead of developing from nursing practice itself. The middle range theories came along in the 1970s and 1980s. These theories narrowed their focus to specific phenomena but were not designed to describe the overall nursing practice (Chinn & Kramer, 2015). More recent advancements in nursing theory have been in nursing practice theory (Parker, 2006). Nursing practice theory is the narrowest focus among nursing theoretical work and speaks to the discipline's latest interest in evidence-based or evidence-informed practice (Chinn & Kramer, 2015).

Since nursing is still a relatively new profession, theory continues to be an underdeveloped aspect of the discipline, especially in comparison with other disciplines. Many scholars in yesteryears tried to borrow theories and such from other disciplines (Chinn & Kramer, 2015). Unfortunately that strategy was typically unsuccessful because it did not illuminate nursing's unique knowledge, skills, and experiences. However, there have been some successes and accomplishments along the way in regard to nursing theory. The accomplishments in nursing theory have been in several evolving nursing theories (grand, middle range, and practice) that have continued to flourish despite the lack of consistency in the use of theory in practice, research, and education in nursing.

The underlying rationale for a need for theory in nursing reverts back to the very foundation of nursing: nursing is a unique discipline. "The goal of the discipline is to expand knowledge about human experiences through creative conceptualization and research. The knowledge base of the discipline is the scientific guide to living the art of nursing" (Parse, 2015, p. 264). It is unique in that it has both practice/practical elements, which encompasses the "important, even intimate, interaction between

practitioners and those served by the practice” (Dahnke & Dreher, 2016, p. 82).

According to Butts, Rich, and Fawcett (2012), “having a distinct body of knowledge with a scientific foundation gives nursing the solidarity and power necessary to determine the unique internal goods of its practice” (p. 154). Further, “one of the internal goods of nursing is evidence derived from theory development and research” (Butts et al., 2012, p. 154).

Science is another element to the equation because the profession requires sincere intellect and a thirst for lifelong learning, not just doing, but also the “knowing how” (Dahnke & Dreher, 2016, p. 82). Dahnke and Dreher (2016) acknowledged how important it is for nursing to determine the type of knowledge generation, in both practice and science, necessary to advance nursing as a discipline. The authors stated, “however, none of this can take place without some adherence to the principles of philosophy of science as an underpinning for all knowledge construction—whether practice oriented or theoretical” (p. 19). Ideals such as these support the argument for nursing theory in nursing. Dahnke and Dreher went on to describe several salient ideas for the science of philosophy for the practice discipline of nursing: science, empirical data, models, concepts, frameworks, and theories and paradigms, paradigm shifts, and nurses engaging in clinical reasoning.

In nursing it is ideal for theory, practice, and research to work in a constant motion to inform one another in perfect balance. The nursing praxis, as Chinn and Kramer (2015) referred to it as, is steeped in the classic patterns of knowing: empirics, personal, emancipatory, ethical, and aesthetic. Nursing praxis is when all these patterns of knowledge come together to act beyond typical practice, but actually being engaged in the situation and processes in each moment in time (Chinn & Kramer,

2015). In an expert commentary article with the renowned author, Jacqueline Fawcett, the article emphasized the importance of using empirical methods in practice, research, and any other practice activities (Butts et al., 2012). They further expressed how nursing theories should guide all activities within nursing as a means to provide, “a rationale for what nurses do and why they do what they do. If nurses want to claim the rights and privileges of disciplinary status, they must acknowledge the already existing nursing knowledge and demonstrate how it guides practical activities” (Butts et al., 2012, p. 152).

Problem Statement

In recent years greater emphasis has been placed on the practice–education gap in nursing education, which was necessary to address the complex and ever-changing healthcare environment. However, with the focus in nursing curriculum on quality and safety competencies, coupled with an over-stuffed nursing curriculum, there may have been a shift in focus away from nursing theory. Together, these trends may indicate a weakened presence of a nursing theoretical foundation at the curricular level in nursing education with unknown consequences. Therefore, the aim of this research study was to better understand BSN curricula from the faculty curriculum leader and administrative program director perspectives, the greatest influences and/or motivators for curriculum revision in their program, and where or how does nursing theory guide BSN curricula.

The research questions:

- Q1 What experiences do curricular and/or administrative leaders have about the needs for educating nurses for the future?
- Q2 What perspectives do Bachelor of Science in Nursing faculty curriculum leaders and/or administrative program directors have

regarding the importance of nursing theory and its incorporation in their respective curriculum?

- Q3 What is the current gestalt of developing or revising nursing curriculum in Bachelor of Science in Nursing programs?

Overview of the Methodology

This research study used a qualitative, phenomenological methodology to answer the research questions posed. The aim of this research was to explore the current gestalt of nursing curriculum from the curriculum leaders' perspective. This use of a phenomenological qualitative research methodology is appropriate to answer exploratory research questions. The researcher interviewed (via telephone or videoconference) faculty curriculum leaders and/or administrative program directors to collect data. The researcher interpreted the findings from data collection into themes and eventually formulated into a cohesive narrative the current gestalt of BSN curriculum.

Delimitations of the Study

The scope of this study is narrowed to focus on faculty curriculum leaders and/or administrative program directors with a self-disclosed level of expertise on their perspective BSN curriculum. This study did not include participation of faculty or administrative personnel who participate in a totally shared faculty curriculum leader, one without an individual leader.

CHAPTER II

REVIEW OF THE LITERATURE

A literature review on the topic of nursing curriculum brings forth three main subcategories: curriculum revision, curriculum development and design, and curriculum evaluation. The aim of this research study was to explore Bachelor of Science in Nursing (BSN) curricula from the faculty curriculum leader and administrative program director perspectives. This research study also explored what influences and/or motivators lead to curriculum revisions in curricula and where or how does nursing theory guide BSN curricula. There is a lack of literature on the topic of curriculum leaders' perspectives in nursing curriculum and indicates a possible need for such research to provide more insight and context. Therefore, this review of the literature explores and analyzes the types of publications that are available within some of these relevant subcategories. This review and analysis of the literature supports the need for more research.

Curriculum Revision

In the review of literature on the topic of nursing curriculum, curriculum revision is the most prevalent subcategory available. This may be in part because most all aspects of the curriculum somehow connect to or overlap with curriculum revision. For instance, the curriculum design and development section of the literature review contains several examples of the integration of a new curriculum, which is similar to a report on curriculum revision. Additionally, much of the curriculum evaluation

literature is an evaluation of a curriculum that is often times new, which also relates back to revisions. Each aspect of curriculum revision is discussed throughout the literature review and provides a foundation of knowledge and context of the nursing education environment for the researcher prior to data collection with faculty and administrative curriculum leaders. In the primary section on curriculum revision, the discussion will focus on highlighting the literature specific to the motives for revision and actual revision processes.

Motives for Revision

Change is inevitable and is inspired for a variety of reasons, no matter the topic or discipline in discussion. For nursing education, in particular in recent years, there are several documented reasons why nurse educators revise, revamp, or even add to their nursing curriculum. This research study explored the current gestalt, which included conversations about the motivations for revision and influences on the participant's curriculum. Based on this review of the literature, the motivations for individual, regional, and national levels of revision are both internally and/or externally driven. This discussion will focus on the content saturation crisis in nursing education, influence of professional nursing organizations, and individual curricular outcomes as the primary motives for nursing curricular revision.

Content saturation is likely one of the greatest challenges posed to faculty in the maintenance of nursing curriculum. Many agree that the over-stuffed nursing curriculum is driving individual curricular change in nursing education (Elliott et al., 2017; Fater, 2013; Herinckx, Munkvold, Winter, & Tanner, 2014; Landen, Evans-Prior, Dakin, & Liesveld, 2017; Patterson et al., 2016; Ruchala, 2015; Stanley & Dougherty, 2010). A common practice amongst faculty is to include everything in the

curriculum (Giddens, 2010). Then, as content keeps coming to the forefront, it becomes a challenge to decide which content should come out of the courses/curriculum (Ironsides, 2004).

It is important to understand that the content saturation crisis is not at the fault of one individual (Giddens & Brady, 2007). This issue is beyond the individual nurse educator and even reaches into some of the essential educational standards set forth by professional nursing organizations. Tanner (1998) has widely remarked that the expectations set forth in *The Essentials* is actually a more appropriate blueprint for a 20-year-plus curriculum as opposed to the typical four-year time frame. If the gold set of standards, as *The Essentials* are often referred to, also struggle with too much content, it is no wonder that individual nurse educators do as well. Again, the dilemma is in the decision about what core knowledge content should stay and what should come out (Giddens et al., 2008). The literature is beginning to reveal why and how nurse educators are choosing new paths to avoid content saturation in the nursing curricula.

One path in the literature is concept-based learning and curriculum. Giddens et al. (2008) cited content saturation as a driving force for making the curricular changes to concept-based learning. This may be in part because of a shift from the industrial age to the information age, changes in healthcare delivery, teacher-centered pedagogy, content repetition, and the academic–practice gap (Giddens & Brady, 2007). Some believe that conceptual learning is more student-centered in opposition to the instructor-centered approaches that are more content-heavy (Giddens & Morton, 2010). Giddens et al. discussed some of the benefits of the conceptual approach is that it addresses the content saturation concerns by de-emphasizing some content to better

manage content overload. Another benefit is that it can foster students' critical thinking and bring down boundaries within patient populations found in the traditional teaching and curricular styles (Giddens et al., 2008).

Professional Nursing Organizations

Although the Institute of Medicine (IOM) is not strictly a nursing organization, it continues to motivate change across the board in nursing education. Two IOM seminal reports have motivated significant change on individual, regional, and national levels of nursing curricula. The IOM 2003 report, *Health Professions Education: A Bridge to Quality*, listed priorities for quality and safety in nursing that have left a lasting impact on nursing education. The IOM 2010 report, *The Future of Nursing: Focus on Education*, set a high standard for the advancement of nursing education in the United States. The goal set forth by this report is for 80% of nurses in practice to have a BSN by the year 2020. This goal is a definite motivator for change within nursing curriculum to create a more seamless transition for Associate Degree in Nursing (ADN) and diploma graduates to matriculate into BSN programs (Knowlton & Angel, 2017; Landen et al., 2017; Munkvold, Tanner, & Herinckx, 2012; Tse et al., 2014).

Recommendations set forth by the IOM continue to flow throughout nursing education and motivate change on multiple levels. The IOM (2003) communicated a vision that stated, "all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (p. 3). These IOM competencies can directly motivate change and curriculum design in individual nursing programs (Morris & Hancock, 2013). The exact IOM vision is reinforced

within the American Association of Colleges of Nursing ([AACN], 2008), The Essentials, document. The AACN, The Essentials, can influence AACN accredited schools to motivate change with their nursing program and/or curriculum (Jacobs & Koehn, 2004; Koestler, 2015; Mailloux, 2011) and research (Price, Buch, & Hagerty, 2015).

The IOM vision is considered to be the inspiration for the six quality and safety education for nurses (QSEN) competencies (Barnsteiner et al., 2013). The six competencies of QSEN include safety, patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, and informatics (Disch, Barnsteiner, & McGuinn, 2013). The QSEN movement started with funding from the Robert Wood Johnson Foundation in 2005. Since then, nursing education at multiple levels has slowly integrated the six competencies in curriculum, including courses, objectives, and content nationwide (Disch et al., 2013).

There has been a nationwide institute use to educate nurse educators about QSEN. The support and sponsorship from the Robert Wood Johnson Foundation assisted in the development of an online webpage with educational tools to assist with integration and implementation (Barnsteiner et al., 2013). This support has allowed nurse educators across the country the opportunity to integrate QSEN at the course, clinical, and curricular levels (Fater, 2013; Lane & Mitchell, 2015; Mailloux, 2011). Barnsteiner et al. (2013) found that there is an increase in the number of programs integrating QSEN within the United States. It is likely these numbers have only continued to grow.

Giddens et al. (2008) not only acknowledged The Essentials document as a motivator for curricular change, but also credit the National League of Nursing's

(NLN) influential publications for promoting change in nursing education and nursing curriculum. The NLN often publishes position statements on salient topics in nursing education to provide expertise and guidance in complicated circumstances. One such position statement, *Transforming Nursing Education*, was published at a time when curriculum change was on the forefront of all nurse educators' priorities (NLN, 2005). The NLN accreditation standards are also used as a solid framework for nursing curriculum and a reliable foundation for curriculum evaluation practices (Schug, 2012).

Improvement of Curricular Outcomes

Both the external motivating factors, such as professional nursing organizations and individual nursing programs, work towards one important, common goal in nursing: for graduate nurses to be safe generalist practitioners. The profession uses the National Council Licensure Examination for Registered Nurses (NLCEX-RN) to ensure safe practice. By state law, this exam must be successfully passed prior to receiving a license to practice. Some nursing programs utilize the NCLEX-RN Test Plan as a guide for content within their nursing curriculum (Lane & Mitchell, 2015; Mailloux, 2011). Others may experience a decline in their nursing program's NCLEX-RN pass rate that triggers curricular revision (Carr, 2011; Davis, 2011; Koestler, 2015). This may prompt a reexamination of their curriculum and explore new knowledge or strategies to integrate in order to improve that particular curricular outcome.

For some, curriculum outcomes are not a problem, and they decide to move forward with curricular revision in hopes to elevate an already successful program

(Elliott et al., 2017; Thomas & Carroll, 2006). Elliott et al. (2017) described their nursing program prior to a major curricular revision as being successful with high NCLEX-RN pass rates and positive graduate outcomes. However, in spite of this success, their curriculum development team recognized their curriculum was too focused on the acute care setting, content overloaded, and poorly integrated. This resulted in the “silo” effect and ultimately became a workload no longer manageable by nursing students (Elliott et al., 2017). Similarly, Thomas and Carroll (2006) decided to move to a community-based nursing curriculum: “we were ready to take a good, even great, product [nursing curriculum], and improve it in response to changes around us. We were ready to challenge our goals, our mission and vision, and the processes that support them” (p. 286). They made the decision to revise their curriculum because changes within nursing practice such as the shift of nursing care from acute care facilities to the community settings. They also recognized that professional organizations such as the NLN and American Nurses Association are emphasizing health promotion and disease/illness prevention (Thomas & Carroll, 2006).

Another curricular outcome that can motivate change in the nursing curriculum lies in how important it is to have graduates who are ready for nursing practice. Some will use various methods to collect data from key curriculum stakeholders such as hospital, nursing, and home healthcare administrators (Utley-Smith, 2004). Another example used a survey of recent graduates to assess what characteristics of new graduates are necessary upon entry into the workforce (Bowen et al., 2000). Both methods can highlight the essential competencies that are most valued in that

particular market. Nurse educators can then adjust the curriculum to ensure these competencies are priorities throughout a nursing program.

Revision Process

The nursing curriculum literature contains several publications on the topic of revision and change processes and even some how-to-guides. Those in nursing education acknowledge the constant push for revision and what a challenge it can be for nurse educators, especially for faculty, to let go of what used to be in the curriculum and move forward with something new (Kupperschmidt & Burns, 1997). The literature offers resources for organization during a revision process as well as pearls of wisdom to consider.

Giddens et al. (2008) summarized and discussed key points in a typical revision process. Their curriculum revision process included the integration of a concept-based curriculum, major changes in clinical education, and a new and innovative, web-based teaching platform. The authors described their use of a curriculum revision task force that was tasked to lead, oversee, and guide the revision process from start to finish. This revision process took over 18 months to complete. It is common in nursing curriculum revision for change to occur slowly over time. Some advice shared in this article was to resist the urge to make any other changes too quickly or too closely to this major revision (Giddens et al., 2008). Other changes may interfere with evaluation and outcome tracking processes.

Some institutions elect to revise their curriculum by starting over. One example of a total curricular revision is reported by Elliott et al. (2017). They described how their curriculum design team essentially built their nursing curriculum from the ground up, because they started with drilling down to the roots of their

purpose and goals in nursing education. This resulted in totally redefining their philosophical underpinnings and graduate outcomes to develop a unique curriculum model. As the curriculum design team outlined the revision process, they recounted how they reviewed other curriculum models for inspiration in the development of their unique model (Elliott et al., 2017). During such extensive change, such as the one mentioned previously, some educational institutions will pause other college meetings or extracurricular activities in order to focus on the revision (Mailloux, 2011).

Organization During Curriculum Revision

No matter the change to the nursing curriculum, staying organized throughout planning, implementation, assessment, and even evaluation is essential. Fortunately there are examples in the literature for nurse educators to use as guides. Mailloux (2011) described how they used the AACN The Essentials standards as a guide to curriculum revision. Content mapping was chosen as a method to guide the revision process. Content mapping is a process where faculty maps out the curriculum from start to finish, listing out the content covered in each course. Then the faculty compares the content covered to The Essentials to ensure that all pieces of the standards are covered and that there is not too much repetition.

Another example of using a structured method to organize content during a curriculum revision is on the subject of concept-based learning. This is not surprising since the task of completely reorganizing the content in curriculum is intimidating. One early adopter of concept-based curriculum identified a challenge during the implementation of concept-based curriculum is in the organization of all the concepts to ensure content ends up in the proper place. The authors offered a solution to this

problem in the use of a conceptual grid. The grid was used to organize content, ensure proper sequencing, and determine workload of faculty (Patterson et al., 2016).

Pearls of Wisdom for Curriculum Revision

Some of the literature on the topic of curriculum revision use case examples as a platform for nurse educators to share their experience with others. The aspect of the curriculum literature is not entirely research driven; however, many of the pearls of wisdom shared from the experiences are still valuable to other nurse educators, especially as they entertain the notion of revising a nursing curriculum. For instance, Mailloux (2011) offered two pieces of advice during the curriculum revision based on their experience: Ensure to use faculty and student feedback throughout the process, and ensure there is a plan for evaluation prior to and during the implementation process.

Lane and Mitchell (2015) described an innovative approach to curriculum revision. The authors described how they use a two-day retreat in order to address and jumpstart their curriculum revision process. During this retreat faculty and staff mapped out the BSN curriculum, identified any content gaps, leveled out content, and identified how simulation might be able to integrate both didactic and clinical concepts.

On a much larger scale, multiple nursing programs underwent curriculum revision together as they adopted QSEN into their nursing curricula. Nursing faculty from across the United States attended the AACN and Robert Wood Johnson Foundation Faculty Development Institute (Barnsteiner et al., 2013). This institute supported faculty with knowledge, resources, and guidance on how to integrate QSEN

into their respective nursing curricula. This example described how proper support, education, and resources may make a difference in curriculum revision, especially during a larger scale implementation process.

Some publications describe best practices in curriculum change and instruction on the process itself to provide a framework for change. Hull, St. Romain, Alexander, Schaffer, and Jones (2001) listed the six C's of successful curriculum development or revision: "commitment, compatibility, communication, contribution, consensus, credit" (p. 280). It is hopeful that the use of some of these best practices allows the process to be more team-oriented and streamlined to confirm an end date for completion. During development or revision, leaders should effectively communicate with all those involved to decrease fears or threats to their integrity (Neufeld, 1983). The revision process may go smoother with fears put aside in order to focus on the end goals.

Kupperschmidt and Burns (1997) encouraged faculty to change their mindset on curriculum revision from being a change to being a transition. The authors asserted that the transition terminology better prepares faculty for the process of "restructuring and redefining" as opposed to an abrupt change or doing away with the old (Kupperschmidt & Burns, 1997, p. 90). The authors went on to describe some typical feelings amongst faculty as an old curriculum is phased out: "anger, grief, denial, bargaining, situational depression, fear, threatened sense of mastery, frustration, resistance, resentment, distrust" (Kupperschmidt & Burns, 1997, p. 91). There also may be responses to a new curriculum, such as:

anxiety, impatience, anticipation, insatiable need for information, demand for communication, insecurity, risk averse, feeling overwhelmed, isolated,

ambivalent, fear of failure, losing position, excessive work load, not meeting promotion and tenure criteria. (Kupperschmidt & Burns, 1997, p. 91)

This review of the literature on curriculum revision highlights the motivations for curricular revision as well as the types of resources and publications available for nurse educators to review as they embark on curricular revision. The key gap discovered in this section of the literature review is found in the motivations for curriculum revision. Overwhelmingly, nurse educators are striving to meet essential education standards set forth by professional (nursing) organizations. Yet, Yancey (2015) identified that many of the essential education standards set forth by these professional (nursing) organizations focus on the practice–education gap in nursing education and less inclusion of theoretical underpinnings. This research study explored the perceptions of curriculum leaders regarding the incorporation of nursing theory into their curriculum in consideration of these current motivations for change and influences on their curriculum.

Several of the examples of motivators for change and influences on the BSN curriculum also intersect with multiple other areas of the nursing curriculum literature. In fact, some of the lines are a little blurred between curriculum revision and complete development. This comes to light as the common and current curriculum designs are discussed within the curriculum development and design section of this literature review.

Curriculum Development and Design

This research study explored the current gestalt of the nursing curriculum. During data collection, the curriculum leaders were asked to share information about their curriculum design. The most prevalent curriculum designs identified in the

nursing education literature include concept based learning, QSEN, consortium models, and miscellaneous other mentionable designs. This literature review will discuss pertinent and recent literature about each of these curriculum designs. It is important to determine whether the current gestalt of nursing curricula in this research study is consistent with these most prevalent curriculum designs identified in the literature.

Multiple factors have played a role in the current state of nursing curriculum development and design in the United States. Again, several of the motivators of curricular change and revision are also responsible for the types of curriculum designs that are most prevalent in nursing education practice and literature. However, before the most prevalent curriculum designs can be discussed, it is important to also analyze a phenomenon that has occurred in both nursing education practice and literature regarding nursing theory in the nursing curriculum.

Decline in Nursing Theory in Nursing Curricula

The use of nursing theory as a curriculum framework in nursing education is in a state of decline (Karnick, 2013). Fewer and fewer nursing programs utilize theory as a basis for their curriculum framework, with some intentionally removing nursing theory all together (Lowry & Aylward, 2015; McEwen & Brown, 2002). In part, this may have occurred over time, likely due to the fact that nursing essential education standards no longer require a formal curriculum framework (Berbiglia, 2011; Yancey, 2015). Lastly, upon review of faculty resources on nursing curriculum, there is a decline in nursing theory discussion and content.

Berbiglia (2011) reported that programs using Orem's self-care deficit nursing theory as a curriculum conceptual framework decreased from 21 down to seven over the last two decades. At one point in the late 1980s, it was estimated that more than 100,000 students had graduated from a school using Roy's adaptation model (Senesac & Roy, 2015). Unfortunately it is difficult to identify a current estimate on the number of students graduating from a curricula based on the Roy model because recent literature does not address this.

Nevertheless, nursing theory is not dead in nursing curriculum. There are still some examples of uses of nursing theory within nursing curricula. In fact, Berbiglia (2011) highlighted the benefits of using nursing theories as conceptual frameworks for nursing programs by using three examples of programs that use Orem's self-care deficit nursing theory as a framework. Internationally, there is an example of an Orem-based curriculum in Germany. Hintze (2011) stated, "using the theory of self-care deficit as conceptual framework for curriculum development is a more systematic approach to nursing education and inspires a nursing-based mode of thinking and communication" (p. 66).

In 2002, Taylor and Hartweg (as cited in Hartweg, 2015) found that the self-care deficit nursing theory was the most frequently used nursing theory in nursing programs in the United states, which certainly includes its use amongst curriculum frameworks. The McEwen and Brown (2002) research (see Appendix A) also supported this statement because they found that Orem was the most reported nursing theory utilized in nursing curriculum out of a random sample of 160 undergraduate nursing programs (ADN, BSN, and diploma). A number of other nursing theorists are

also mentioned in their research: Roy, Watson, Neuman, Benner, Rogers, and Meleis (McEwen & Brown, 2002).

Drummond and Oaks (2016) applied Parse's humanbecoming theory as the basis for their nursing program curriculum. The authors focused the publication on the practical application of humanbecoming within the curriculum and did not include specific outcomes related to using Parse's school of thought. They did, however, recognize the value in theory-guided nursing education.

Sitzman (2007) described how one academic institution created a course based on the foundations of Watson's theory of human caring. Additionally, the theory of human caring is a popular framework for integration into nursing curricula, especially for programs with an emphasis on caring. Cook and Cullen (2003) provided one example that demonstrates the integration of caring throughout a curriculum. Their curriculum outline included progressive objectives, sample behaviors (with Watson tenets highlighted), specific teaching/learning strategies, and intentional assessment (Cook & Cullen, 2003).

Neuman's system model has also been widely used for curriculum frameworks, mostly due to its system approach, holism, and focus on wellness and prevention (Lowry & Aylward, 2015). Although more popular amongst nursing programs in the 1980s, some have moved away from using Neuman's system model singularly in favor of more eclectic curriculum models (Lowry & Aylward, 2015). Neuman and Fawcett (2011) (as cited in Lowry & Aylward, 2015) reported "28 programs currently using the NSM [Neuman's system model]" at the time of publication (p. 175).

Nursing theory is discussed less and less in nursing curriculum literature, especially upon examination of curriculum textbooks for nurse educators. For example, Bevis (1989) spent significant time describing the relationship and important considerations between nursing theory and curriculum in a chapter in the 1989 nursing curriculum text. Even then, Bevis recognized how choosing one nursing theory, as a theoretical conceptual framework, may be less flexible and too exclusive to use only that one nursing theory. However, the author went on to state:

Theories are necessary and very useful to teachers, for they influence the way we think, the way we organize our care for patients, and the way we give care. Theories are tools that nurses use in approaching care; the more tools we have in our toolbox, the more likely we can select the best/most appropriate tool to do the job. (Bevis, 1989, p. 327)

In the Bevis and Watson (1989) text, the language and inclusion of nursing theory in various discussions indicates there is value to the use of nursing theory in the nursing curriculum, whether in the theoretical conceptual framework or not. However, the same is not the case in more recent nursing curriculum textbooks for nurse educators. Take these two recently published nurse educator texts, Keating (2015) and Iwasiw and Goldenberg (2015), for examples; the predominant discussion is on a more practically structured curriculum. Keating described an approach to nursing curriculum known as the contextual approach to navigate delivery of outcomes model; whereas, Iwasiw and Goldenberg described a model for nursing curriculum known as the evidence-informed, context relevant, unified curriculum. These textbooks would be classified as general-use type books for nursing faculty, which would include nursing curriculum committee members and are certainly recently published. Again, there is little discussion in either text on the use of nursing theory in curriculum today, let alone examples of practical uses for nursing theory in curriculum. This research

study explored the current gestalt of nursing curricula. Data collected from this research study may be able to determine if the perceptions of curriculum leaders regarding the incorporation of nursing theory into their curriculums is consistent with the trends identified in the nursing education literature.

Concept-Based Learning

Concept-based learning or the conceptual approach is another initiative within nursing education that has become popular in practice and the literature. Many nurse educators are jumping on board with the conceptual approach in their curricula (Giddens et al., 2008; Giddens & Morton, 2010; Herinckx et al., 2014; Landen et al., 2017; Patterson et al., 2016) or in specific teaching/learning strategies (Nielsen, 2016). There does not appear to be a prescriptive use of this initiative, as there are multiple ways to implement into curriculum. However, the general idea is to break down each content area (or disease process) into core nursing concepts and integrate these concepts for individual care while addressing developmental, population, and clinical perspectives. It is an attempt to move away from the medical diagnosis approach in hopes of promoting more critical thinking (Patterson et al., 2016).

Patterson et al. (2016) provided a detailed description of how a concept-based curriculum is manifested in nursing education practice. The authors described how faculty at their educational institution transitioned from a biomedical curriculum model to a concept-based curriculum. Faculty integrated concept-based learning throughout the curriculum using three main categories: healthcare of the client, professional nursing concepts, and clinical practice (Patterson et al., 2016). Additionally, there are some ancillary courses woven throughout the curriculum to enhance the main courses, which include clinical specialty practice, competency-based

clinical, pathopharmacology, holistic health assessment, and evidence-based practice (Patterson et al., 2016).

Giddens et al. (2008) discussed some of the benefits of the conceptual approach as addressing the content saturation concerns by de-emphasizing content and better managing the content. Another benefit is that it can foster students' critical thinking and bring down boundaries within patient populations found in the traditional teaching and curricular styles. In the clinical setting, Nielsen (2016) described the use of concept-based learning activities. The results from Nielsen's multiple-case research study that included students caring for patients in the clinical setting indicated the use of these concept-based learning activities foster "deep learning, connection of theory with practice, and clinical judgment" (p. 365). Further, concept-based learning is an "educational approach that moves away from covering content and memorization of facts to focus on conceptual learning in context to support understanding" (Nielsen, 2016, p. 366).

Quality and Safety in Nursing Education

There has been much discussion and integration of quality and safety into nursing education across the nation (Balakas & Smith, 2016; Barnsteiner et al., 2013; Disch et al., 2013; Monsivais & Robinson, 2015; Pauly-O'Neill, Cooper, & Prion, 2015; Weiner, Trangenstein, Gordon, & McNew, 2016). The quality and safety in nursing education has been integrated within nursing curriculum, clinical education, and teaching/learning strategies. The quality and safety in nursing education has major support and sponsorship from the Robert Wood Johnson Foundation (Barnsteiner et

al., 2013) as well as recognition in nursing organizations (AACN and NLN) and publishing companies' nursing publications.

A common way to integrate the quality and safety in nursing education competencies is to revise language in the curricular, course, and program outcomes. Additionally, programs will pair this with new learning strategies at the course, clinical, and simulation levels (Barnsteiner et al., 2013). Specifically, the Pauly-O'Neill et al. (2015) research determined that more time in clinical with a focus on the quality and safety in nursing education competencies may be the key to seeing improved outcomes in nurse graduates.

Consortium Model

The consortium model in nursing curriculum is a newer topic to the nursing curriculum literature. The Oregon Consortium for Nursing Education is the likely trailblazer on the topic of statewide nursing curriculum consortium. The Oregon Consortium for Nursing Education set out in the early 2000s to address the nursing shortage (and ultimately the call for more BSN prepared nurses) in the workforce (Munkvold et al., 2012). The consortium is a two-fold collaboration between multiple community colleges and private/public nursing programs with an aim for seamless academic progression/transferability through the ADN and BSN programs and a common curriculum with a focus on core competencies for nurse graduates (Herinckx et al., 2014). The innovative pedagogies described by the Oregon Consortium for Nursing Education curriculum also includes conceptual learning, a spiraled approach, active learning, case-based learning, a clinical redesign (that includes simulation), and a limitation on content (Herinckx et al., 2014). The Oregon Consortium for Nursing

Education paved the way for other consortiums to develop in order to address issues in their respective states.

The State Nursing Consortium in Hawaii directly cited the Oregon Consortium for Nursing Education as the source and inspiration for their consortium model. The Hawaii State Nursing Consortium framed their consortium very similarly to the Oregon Consortium for Nursing Education (Tse et al., 2014). However, not all states with a known consortium use the exact formula used by the Oregon Consortium for Nursing Education. Instead, Jones and Close (2015) described the California Collaborative Model for Nursing Education as one that focuses more on the seamless transitions between ADN and BSN and less on the innovative curriculum design.

Another statewide consortium, the New Mexico Nursing Education Consortium, again focused on the seamless transitions between ADN and BSN degrees; it also has a core, shared curriculum amongst the consortium members. The New Mexico Nursing Education Consortium shared curriculum is a direct approach to the concept-based curriculum (Landen et al., 2017). Based on the literature on statewide nursing education consortium models, these consortiums typically share the common interest in easing the barriers of transitioning ADN graduates to and through BSN education and may but not always include a shared common curriculum.

Miscellaneous Curriculum Designs

The next curriculum designs left to be discussed, problem-based learning, community-based nursing, and competency based nursing education models are not as prevalent in a review of the literature. However, each of them continues to surface in the literature from time to time and is worth consideration in a discussion about nursing curriculum design.

Problem-based learning is considered a highly structured and learner-centered approach to nursing education. There are five steps to problem-based learning, “analysis of problems, establishment of learning objectives, collection of information, summarizing, and reflection” (Lin, Lu, Chung, & Yang, 2010, p. 375). Problem-based learning is best known for use in teaching strategies; however, there is some discussion on how it is also suitable for use in the nursing curricula, in particular to improve long-term retention of curricular content (Prosser & Sze, 2014). Additional benefits to problem-based learning is possible enhancement of student satisfaction, which problem-based learning also outperformed the traditional programs (Prosser & Sze, 2014) and students display more self-directed learning (Kocaman, Dicle, & Uga, 2009).

The community-based nursing curriculum has an emphasis on caring for individuals, families, and groups within a larger systems network while using the nursing process and being engaged in all levels of prevention (Thomas & Carroll, 2006). Thomas and Carroll (2006) used the community-based nursing practice along with the human ecology theory (amongst other components) to develop their final curriculum framework. Jacobs and Koehn (2004) implemented a community-based BSN curriculum, again with a content focus on the primary, secondary, and tertiary preventative care for the multiple BSN degrees offered at their educational institution.

The final design or curricular approach worth mentioning is the emphasis on competency-based nursing education. Some of the publications that address or highlight a competency-based type of design also overlap with topics previously discussed in the curriculum development literature. For example, Herinckx et al. (2014) is mentioned, as an example of the consortium curriculum model; however,

embedded into their curriculum is a competency-based approach. There is also an obvious overlap with much of the quality and safety in nursing education literature and competency-based curriculum, because the foundation of quality and safety in nursing education is based on its six competencies. Lastly, Fater (2013) used a competency-based approach in their curriculum as competencies from a variety of sources, such as the IOM, quality and safety in nursing education, and the Massachusetts nurse of the future nursing core competencies model inspired their curriculum. It is apparent that the use of a competency-based curriculum, especially as it overlaps with other topics within nursing curriculum design, may be a topic on the horizon.

These prevalent nursing curriculum designs have become popular in the nursing literature in the last five to 10 years. Many of these new curriculum designs were inspired by the motivators discussed in the curriculum revision literature review section. These curriculum designs highlight a focus on the practice–education gap in nursing. Based on the literature alone, it is also difficult to determine what has been added to the curriculum design or what nursing education is moving away from or toward. The literature also shows that there is a decline in the use of nursing theory as a curriculum design. This study explored the current trends in curriculum design and development and perceptions of curriculum leaders regarding the incorporation of nursing theory into their curriculums.

Curriculum Evaluation

There is much to learn from the literature on nursing curriculum evaluation. The “curriculum evaluation is an integral component of nursing program evaluation and provides a rigorous and systematic mechanism for assuring integrity and strengthening academic programs” (Schug, 2012, p. 302). Nurse educators are

fortunate to have a diverse collection of examples of curricular evaluations for review. The vast majority of literature on curricular evaluation pertains to evaluations of individual design and changes. The individual evaluations identified in the literature can be categorized into two groups: those that determine the level of integration (or fidelity) or how the curriculum impacts outcomes. There are only a few examples of publications that evaluate nursing curricula from the broader view (McEwen & Brown, 2002; Streubert Speziale & Jacobson, 2005). This research study aimed to explore the current gestalt of BSN curricula and add another example of evaluation of nursing curricula from the broader view to this body of literature.

Evaluations Following Curricular Change

Ideally, the curriculum evaluation plan after any change will be comprehensive (one that includes both fidelity and outcome-driven); multifaceted with focus on students, graduates, clinical agencies/employers, and faculty; and ongoing even years after the change has occurred (Jacobs & Koehn, 2004). Giddens and Morton (2010) provided the literature with a plan that meets these criteria. It is both a formative and summative curriculum evaluation plan. The plan specifically addressed the college's adoption of a concept based curriculum two years prior. The formative evaluation included course assessments, small-group instructional diagnosis, student surveys and focus groups, concept assessments, and standardized examinations. Summative evaluation included yearly graduation rates, NCLEX-RN examination pass rates, and an Education Benchmarking, Inc. exit survey. In addition, the summative evaluation included less frequent Education Benchmarking, Inc. surveys on alumni and employers every three years (Giddens & Morton, 2010).

The positive findings from the evaluation data included satisfaction with the conceptual approach overall, clinical intensives, and early patient care experiences. Also, faculty reported that the content load was lightened and that they were satisfied with the chosen concepts. Lastly, the evaluative data included information from preceptors and community members who indicated a change in the quality of the graduates for the better. There are still opportunities for curricular improvement related to the concept based approach:

improved clarity and delivery of the professional nursing concept courses, improvements in community-based clinical experiences, increased emphasis on concepts across multiple clinical contexts, and better use of the standardized exit exam. (Giddens & Morton, 2010, p. 376)

Determine level of integration (fidelity). Herinckx et al. (2014) conducted fidelity research as a form of curricular evaluation of the Oregon Consortium for Nursing Education. The authors described this type of fidelity research as a way to measure the extent to which nurse educators followed the Oregon Consortium for Nursing Education standards. The researchers developed a scale that would tell them whether each educational institution had a high or low level of fidelity. These data are valuable, especially when compared to the individual educational institution's outcomes as a means to determine whether higher fidelity could correlate with better outcomes (Herinckx et al., 2014).

Morris and Hancock (2013) conducted a mixed method quantitative and qualitative program evaluation of the IOM competencies in the researchers' educational institution. The researchers used triangulated data that consisted of a course objectives matrix, survey (from both students and faculty) data, and responses from an open-ended questionnaire. The IOM competency matrix used in the research

helped the educational institution determine that program objectives aligned with the IOM competencies fairly well. The qualitative data collected assisted the researchers in pinpointing areas for focus, especially in areas where there might be inconsistencies between the quantitative and qualitative data (Morris & Hancock, 2013).

The gap analysis to assess integration of program competencies within a nursing curriculum has a close tie to the fidelity research described previously. One educational institution used the gap analysis to ensure their 11 core competencies were apparent in their nursing curriculum (Fater, 2013). The ultimate goal of this analysis was to lay a foundation for curriculum revision because it brought to light several issues and strengths within the curriculum. Fater (2013) used this data, along with key curriculum stakeholders, to determine better program outcomes more suitable for the nursing workforce.

Since the goal of QSEN in nursing education integration was set on a larger scale, it used a different approach to determine the level of integration. Disch et al. (2013) provided an example of the level to which quality and safety in nursing education was integrated across multiple educational institutions. They examined educational institutions from the San Francisco Bay Area as part of a specialized privately funded QSEN initiative. Based on this longitudinal evaluation, they found that “the majority of schools have instituted many of the knowledge, skills, and attitudes for the 6 competencies; significant curricular change is occurring; and academic-clinical partnerships have been strengthened” (Disch et al., 2013, p. 75).

Outcomes-driven evaluation. Ostrogorsky and Raber (2014) used a survey to assess first-year experiences following implementation of the Oregon Consortium for Nursing Education curriculum redesign. The survey was developed using items from

the AACN Educational Benchmarking Nursing Exit Assessment and included seven factors: quality of instruction and curriculum, faculty and courses, course lecture and interaction, advising and facilities, administration, fellow students, and overall program effectiveness (Ostrogorsky & Raber, 2014). According to this survey, students were most satisfied with fellow student interactions followed by course lecture and interaction and faculty and courses. The survey did point out some areas for improvement, which included advising and facilities, administration, quality of instruction and curriculum, and overall program effectiveness (Ostrogorsky & Raber, 2014). This type of evaluative data allows an educational institution the opportunity to make informed decisions on the future of a nursing program.

There are examples in the literature of how evaluation of a nursing curriculum occurs when there are either perceived or identified issues with the curriculum or nursing program. For example, Munkvold et al. (2012) explored why a large number of ADN graduates were not persisting through to the BSN despite multiple changes in the process by way of the Oregon Consortium for Nursing Education. The findings from the evaluative survey indicated that the biggest reasons for not persisting to the BSN degree was because of financial concerns, conflict with time or energy due to work, and conflict with time or energy due to family.

Schug (2012) described how one educational institution frequently and systematically evaluates course objectives, content, and even curricular/program processes that uses a framework aligned with the Three Cs Model (context, content, and conduct) along with the NLN Accrediting Commission standards and criteria. This evaluative methodology aims to be non-threatening and focuses on improvement and overall quality outcomes of the nursing program at hand (Schug, 2012).

Additionally, an indirect outcome from using the standards set for by the NLN is that this method may better prepare the educational institution for an accreditation visit. Schug's case description of their evaluation methodology is not research-based, but still includes anecdotal outcomes, "an integrative curricular evaluation approach promotes the ongoing development, maintenance, and revision of nursing program offerings and integrity among sections or concentrations of the nursing program and across programs" (p. 305).

Theander et al. (2016) evaluated revision to a person-centered curriculum using the nurse professional competence scale with 119 nursing students. Overall, the researchers determined that there was an increase overall in competence in comparison of the means from prior to the change to after implementation. Statistically, however, only one competence area was significantly higher after implementation, which was in value-based nursing.

Research and evaluation by Lewis, Stephens, and Ciak (2015) took place after the revision of their diploma nursing degree program. Faculty adopted QSEN competencies into their curriculum and then evaluated the outcomes from this integration. To assess student nurse attitudes towards patient safety, they used the Healthcare Professionals Patient Safety Assessment Curriculum Survey. They used a control group from a cohort prior to QSEN integration for comparison. The outcomes of the evaluation did not show statistical significance; however, it does still provide an example for other faculty to use as they adopt QSEN and consider the use of this survey as a means to evaluate the change (Lewis et al., 2015).

Prosser and Sze (2014) used a qualitative meta-synthesis to report an improvement with long-term retention of content with the use of problem-based

learning in courses and better application of clinical skills. Another outcome the researcher investigated was student satisfaction, which problem-based learning also outperformed compared with traditional programs. Overall, the researchers could endorse problem-based learning for adoption in nursing education over the traditional approaches (Prosser & Sze, 2014).

Kocaman et al. (2009) discussed self-directed learning as an outcome of nursing education and even problem-based learning. The authors used a longitudinal survey over four years in a baccalaureate nursing program with integrated problem-based learning curriculum. Their findings suggested that self-directed learning is a positive outcome from using problem-based learning throughout a curriculum as the students scored higher on the survey than in previous years, especially in the fourth year and on sub-scales (self-management, desire for learning, and self-control) amongst all the years (Kocaman et al., 2009).

Nurse educator-specific outcomes are discussed less than student outcomes in the literature on curriculum evaluation. Tse et al. (2014) evaluated the impact of implementation of a statewide nursing consortium based on both nurse educator and student responses. The design for this evaluation was a quasi-experimental, mixed method design (Tse et al., 2014). The nurse educator domains explored were faculty work life, teaching productivity, and quality of education (Tse et al., 2014). Initially, the survey indicated that nurse educators reported increased burnout and less collaboration and collegiality. However, the researchers attempted to triangulate with key informant interviews and were unable to confirm these findings in the interviews. While the format of the evaluation was centered on both students and faculty, the

findings specific to the nurse educators brought to light a potential future implication in implementation and evaluation of nursing curriculum change.

Overall Evaluation of Curriculum

The literature review revealed an abundance of examples of curricular evaluations at the individual level. There are fewer examples in the literature for review from this century that are an overall evaluation of nursing curricula in the United States. The first example is the McEwen and Brown (2002) national survey of the types of conceptual frameworks used in nursing curricula. The survey queried about what type of model or conceptual framework was used in the nursing program, how long it had been integrated, and how specifically the framework was incorporated into the curriculum. The research supported the suspicion that there is a decline in nursing theory as a curriculum framework.

Streubert Speziale and Jacobson (2005) surveyed nursing programs across the United States on six content areas: curriculum, teaching, evaluation, clinical/laboratory, faculty, and students. The curriculum section of this survey has 57 items, which included nursing theory. The researchers did not report whether nursing theory in curriculum would have more emphasis in nursing curricula based on this survey. However, since it was not listed as an area that was expected to receive less emphasis in the future, it might be assumed that nursing theory fell somewhere in the middle (Streubert Speziale & Jacobson, 2005). During this research study, the researcher interviewed curriculum leaders from six regions in the United States to explore their perceptions on the current BSN curriculum. This type of overall evaluation, one that evaluates nursing curriculum from a larger scale, is needed in

nursing education because it provides insight on the current gestalt of curricular content and priorities.

Both examples of overall evaluation of nursing curricula are outdated and provide evidence to support current/future research of similar nature. In the McEwen and Brown (2002) discussion, the trends discussed in nursing education are outdated, especially in comparison of the recent research and publications presented in this literature review. For instance, their new buzzwords were critical thinking, caring, lifelong learning, collaboration, empowerment, process skills, informatics, culturally competent, effective communicator, and coordinator of community resources (McEwen & Brown, 2002). Any of these terms that remain relevant have been subsumed by essential education standards, QSEN, or concept-based learning. These two examples highlight the need for updated research on the current gestalt of nursing curricula in the United States. This research study aimed to explore the perceptions of curriculum leaders regarding the incorporation of nursing theory into their curriculums and determine a current gestalt of nursing curricula in the United States.

Gaps in the Literature

This review of the literature on the topic of nursing curriculum brings to light several gaps that support research on nursing curriculum. First, an unexpected gap was on the topic of nursing curriculum leaders. While nursing education texts introduce the role, the majority of the resources cited for discussion were general leadership type of books (Iwasiw & Goldenberg, 2015). Research from the nursing curriculum leaders' perspectives could provide knowledge on a topic that lacks a general base of knowledge to begin with.

Next, it is important to understand that the literature focuses intently on the practice and education gap in nursing. It is important for nursing to address this gap because of the ever-changing and complex healthcare environment. The focus on the practice and education gap may also be playing a role in the steady decline in the use of nursing theory in nursing curriculum. There is a need for research to help determine what influences and changes have occurred within the nursing curriculum at the program level and especially those pertaining to nursing theory in the nursing curriculum.

The next gap in the literature is similar to the content saturation dilemma in today's nursing curriculum; there is a continuous influx of new strategies and designs, but it is difficult to assess what is significant and worthy of change and what is not. Nursing education has added many new reasons and motivations for curriculum revision, types of curriculum designs, and an abundance of individual curriculum evaluation plans. It is unclear what has come out of the nursing curriculum or what nursing education is moving away from or toward. Previous research and publications that pertain to an overall evaluation of nursing curricula are outdated and are no longer relevant to all the changes made in recent years. New research on the current gestalt of nursing education is needed and may provide insight into the current trends, problems, and development issues related to nursing curricula.

There are mixed reviews on whether all the new advancements mentioned in the literature review adequately support knowledge generation for the discipline of nursing. Some express apprehension in how essential education standards employ such a large position in nursing curricular content. Similarly, some believe that some nursing programs are solely relying on the essential educational standards as a

curriculum framework (Berbiglia, 2011). This becomes more of a concern as Yancey (2015) identified that there is less and less inclusion of theoretical underpinnings, in particular nursing theory in essential education standards, in nursing education. As Yancey warned, a loss of nursing theory at course and curricular levels could result in the loss of unique contributions of nursing and the potential for new knowledge development may be stunted. The effects of loss at the baccalaureate level may also ultimately impact the master's and doctorate levels, as well (Yancey, 2015). This study explored the current trends and perceptions of curriculum leaders regarding the incorporation of nursing theory into their curriculums.

Overall, this research study is likely a stepping stone for a program of research necessary to effectively explore nursing curricula. This is the first step in determining whether nursing theory is on the way out of nursing curricula and how this might impact the future of nursing as a discipline. Since this is the first step in a program of research, an exploratory method of research is appropriate and adequate to answer the research questions posed. The research methodology and procedures will be discussed further in Chapter III.

CHAPTER III

METHODOLOGY

The researcher uses the review of the literature to support the need to investigate today's Bachelor of Science in Nursing (BSN) curricula situated in an ever-changing and complex environment in healthcare and nursing education and the need to explore the perceptions of both faculty BSN curriculum leaders and BSN program directors as they navigate and lead BSN curriculums. The unique perspectives from these participants will be used to better understand the current gestalt of nursing curricula.

The research questions:

- Q1 What experiences do curricular and/or administrative leaders have about the needs for educating nurses for the future?
- Q2 What perspectives do Bachelor of Science in Nursing faculty curriculum leaders and/or administrative program directors have regarding the importance of nursing theory and its incorporation in their respective curriculum?
- Q3 What is the current gestalt of developing or revising nursing curriculum in Bachelor of Science in Nursing programs?

Research Design

The literature review on the topic of nursing curriculum highlights the lack of recent research on the current gestalt of BSN curriculum in the United States. Without previous research to draw from, the obvious next step was to explore this phenomenon using a qualitative research design. The researcher used the six characteristics of qualitative research as an overarching methodological plan:

1) A belief in multiple realities; 2) a commitment to identifying an approach to understanding that supports the phenomenon studied; 3) a commitment to the participant's viewpoint; 4) the conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest; 5) acknowledged participation of the researcher in the research process; and 6) the reporting of the data in a literary style rich with participant commentaries. (Streubert & Carpenter, 2011, p. 20)

Specifically, the researcher used phenomenology to answer the research questions posed. Van Manen (1997) posited that a phenomenological description assists the researcher in gaining a deeper understanding of an everyday experience. Therefore, the use of this type of qualitative design opens the possibilities for a deeper, personal account of the BSN nursing curriculum from a leader's perspective. The researcher aimed to better understand the changes or revisions that have been made, the greatest influences upon the nursing curriculum, and where or how nursing theory remains connected to the BSN level of nursing curricula. The overall goal of this research study was to provide valuable preliminary research and open the possibility for a future program of research on the phenomenon of decision making for BSN curriculum.

Some categorize phenomenology as a philosophy in addition to a research design (Matua, 2015). In this way, the researcher kept the goal of uncovering meaning as a priority in this research (Munhall, 2012b). There is fluidity in finding meaning and so the researcher adjusted certain aspects of the research process, such as specific questions during the interview. The journal or audit trail that the researcher used during the research process also served as a place to track and organize any minor adjustments made. Additionally, the researcher preferred to avoid an over-scripted design plan that may result in anticipated meanings or predicted hypotheses, which was not the intention of this type of research. It is important, however, that the

researcher did follow basic phenomenological tenets for research in order to stay true to the philosophic underpinnings and rigor standards (Matua, 2015).

The researcher acknowledges the differences between descriptive and interpretive styles of phenomenology. Interpretive or hermeneutic phenomenology takes the process of phenomenological qualitative research an extra step to further “describe, understand, and interpret participants’ experiences” (Cooney, Dowling, Murphy, & Sixsmith, 2013, p. 18). For this research study, the researcher used descriptive phenomenology to describe the phenomenon and during the process, the researcher intentionally put aside presumptions about the phenomenon (Cooney et al., 2013). Van Manen (1997) concluded and summarized this process as, “a good phenomenological description is collected by lived experience—is validated by lived experience and it validates lived experience. This is sometimes termed the ‘validating circle of inquiry’” (p. 27).

Description of the Phenomenon

In phenomenological qualitative research, the lived experience of a phenomenon is the start and end point (van Manen, 1997). In this research study, the phenomenon is the lived experience of leading and navigating a modern BSN curriculum. In order to study the essence of this phenomenon, the researcher relied on accounts from both faculty BSN curriculum leaders and administrative BSN program directors to share the lived experience within their current, respective BSN curriculum. There are three main interests of the phenomenon that were explored: recent curricular changes and/or revision, influences on the curriculum, and (if any) type of theoretical foundation remains in the nursing curriculum.

The Research Context and Significance

This research study positions itself in a time in nursing education amidst constant change. During the literature review, the researcher revealed that many BSN curricula have already become transformed to meet the challenges in an ever-changing, complex healthcare environment. The researcher identified numerous examples of how those in nursing education have adopted new curricula and/or revised existing ones. This research has potential significance to provide deeper meaning on the topic of BSN curriculum and may guide future research on how to suitably evaluate or implement additional changes to nursing curricula. This research study is also significant because it aims to explore the BSN curriculum and curriculum leaders, which are both under discussed topics in the nursing education literature (Munhall, 2012b).

Instruments Used in Data Collection

Due to the nature of this phenomenological qualitative research study, the researcher was the primary instrument for data collection during a semi-structured interview (Munhall, 2012b). The researcher as the interviewer extracted data in the form of narratives from the participants during the interview by asking both general and specific questions. Additionally, the researcher also contextualized the interview as a safe and open forum for sharing of dialogue (Paulson, 2009).

Since the researcher plays such an integral role in the research planning and procedures, there was great emphasis on the researcher's comfort and competence in phenomenology as a research method and philosophy. Munhall (2012b) recommended that the researcher conduct an immersion in to the methodology and philosophy of

phenomenology in order to achieve an adequate level of comfort and competence. This researcher worked towards this goal and spent significant time immersing into written and audio publications, including expert textbooks and examples of previous research. The researcher also reviewed older, original, and recent and updated versions of publications on the topic of qualitative research and phenomenology, specifically. The researcher was guided in this immersion process by more than one experienced qualitative researcher.

Another common practice in qualitative research is for the researcher to explicate his or her thoughts, feelings, and ideas prior to data collection. During this exercise, the researcher is able to identify areas on the topic where there might be bias. In interpretive or hermeneutic style of phenomenology, it is not essential to set these aside prior to data analysis but instead provides a valuable reflective activity for the researcher (Cooney et al., 2013). However, because the researcher chose to use a descriptive phenomenological methodology, the researcher determined it was important to use this exercise as a way to remain honest and open to the data and eventual analysis.

During this explication exercise (see Appendix B), the researcher uncovered at least one bias or closely held belief needed to be bracketed during the research process. The researcher identified that she has a strong opinion regarding the loss of nursing theory in nursing curriculum, especially in terms of the potential impact this could have on the discipline of nursing. The researcher utilized a peer and research advisor as debriefers to remain on target with being as unbiased as possible during data collection and interpretation processes. These peer debriefers were qualified for

these tasks because they had extensive qualitative research experience and were doctorally prepared nurses.

The researcher relied on an interview guide for the semi-structured interview to remain focused on the aim of the study. This interview guide (see Appendix C) was developed based on the overarching research questions and from the desire to better understand what the phenomenon is really like (van Manen, 1997). The interview guide is, as the name implies, a guide. It is not a complete list of questions for the participant, but it is a starting point for the interview.

Procedures Used

The researcher adhered to a high level of integrity, accountability, and validity throughout the course of the research study. To achieve this, the researcher acquired approval by an Institutional Review Board (see Appendix D) to ensure the researcher had multiple processes in place to protect the participants in the research study. During the Institutional Review Board approval process, the researcher prepared several documents that clearly stated the aim, purpose, and description of the research in a narrative form (see Appendix E). Further, it required that the researcher utilize some form of informed consent (see Appendix F), protection against actual/potential risks in participation, and overall protection of the participants' identities and sensitive documents. The researcher did not begin any research activities for the study until the Institutional Review Board granted approval to do so (see Appendix D).

Recruitment and Participants

The researcher initially recruited both faculty BSN curriculum leaders (or equivalent faculty role) and administrative BSN program directors (or equivalent administrative role) as participants in this research study. The researcher used a

purposeful, or deliberate, sampling method to choose participants who were experienced BSN curriculum leaders in either faculty or administrative capacities (Polit & Beck, 2008). Additionally, the researcher purposefully recruited participants from five regions of the country: Northeast, Southeast, Midwest, Southwest, and West (see Appendix G). This was important to the researcher because the research question was to explore the current gestalt of BSN curriculum in the United States. Recruitment of participants by region aimed to account for differences in nursing education philosophies that may occur regionally, if there were any. The researcher manually divided the country into regions, because the researcher was unable to locate a map that shared the researcher's preferences on regional borders. A corresponding number identifies each region: Northeast-1, Southeast-2, Midwest-3, Southwest-4, and West-5.

The recruitment of participants in this research study was a purposeful sampling strategy. Participants were chosen because of specific criteria for the research study: role and geographical location of the BSN program. Streubert and Carpenter (2011) described purposeful sampling by stating, "the participants are selected for the purpose of describing an experience in which they have participated" (p. 29). The purposeful sampling strategy targeted BSN curriculum leaders, who met the following inclusion criteria:

1. Registered nurse (RN) with a minimum of two years of experience working as a nurse educator in a BSN program.
2. A faculty BSN curriculum leader (chair, co-chair, or equivalent role) or an administrative BSN program director (academic dean, program/major chair, or equivalent role).
3. Self-identified as an expert to the BSN program curriculum.

4. Employed by an institution with a regionally and/or specialty accredited BSN program (Commission on Collegiate Nursing Education [CCNE], Accreditation Commission for Education in Nursing [ACEN], or National League for Nursing [NLN]).
5. Employed by a not-for-profit or non-profit higher education institution.

The initial goal was to recruit one faculty BSN curriculum leader and one BSN program director from the same higher education institution. However, once recruitment began, the researcher experienced numerous challenges in recruiting from the same higher education institution. The researcher, with support from the research advisor and dissertation committee, made an amendment to the recruitment process that allowed the BSN faculty curriculum leader and the BSN program director to be from the same region, but no longer required they were from the same high education institution. The amendment also allowed the researcher to recruit participants who were considered both the BSN faculty curriculum leader and the BSN program director into the research study. Both amendments greatly impacted the researcher's ability to recruit interested and qualified participants into the research study.

The recruitment of participants from both roles supported triangulation of the data collected during the research study. The researcher determined whether an institution's roles are considered faculty or administrative (or both) for this research study if the roles or titles were not clearly defined. The researcher also reserved the right to exclude certain roles or institutions if the researcher concluded that either did not fit the purposeful sampling criteria set forth for this research study. Other examples of exclusion criteria included members of a totally shared faculty curriculum committee (lack of individually designated BSN faculty curriculum leader), BSN

programs from the researcher's place of employment and current educational enrollment, and BSN programs in a for-profit higher education institution. The exclusion of for-profit higher education institutions was to protect the anonymity of those programs due to a smaller number of them; it may be easier to identify specific programs, especially once divided regionally.

The researcher began the recruitment process by reviewing BSN programs by region online. The researcher did not set specific criteria related to diversity of programs (private, state, university, college, hospital-based, small, or large). However, the researcher was mindful as sampling continued to avoid a totally homogenous sample. Once the researcher selected multiple BSN programs in each region, the researcher networked by telephone and e-mail with staff, faculty, and administrators at the higher education institutions to identify the BSN curriculum leaders. The researcher utilized a generic recruitment and networking guide (see Appendix H) to streamline and standardize these processes. The goal of networking was to identify the BSN program faculty curriculum leader and the administrative BSN program director. The researcher then communicated with the identified individuals in the two roles by personally using telephone and/or e-mail with a brief description of the research study and an invitation for them to participate in the research study. The researcher found more success in recruitment when the initial contact was made by telephone that was followed-up with an e-mail.

Once the BSN faculty curriculum leader and/or the BSN program leader agreed to participate in the research study, the researcher then e-mailed the participant packet, which included an introduction letter (see Appendix I), informed consent, purpose statement, scope of the study, a brief preview interview questions, and a

demographic questionnaire (Streubert & Carpenter, 2011). The participant was asked to sign and return the informed consent and the demographic questionnaire (see Appendix J) either via e-mail or a mail service. All participants returned their informed consent and demographic questionnaires via e-mail attachment. The researcher only proceeded with the next phase of research, the interview, once the signed informed consent and demographic questionnaire was in the researcher's possession.

Qualitative research sampling size differs from quantitative research. Qualitative research is less concerned with randomization for overall control and generalization than quantitative research. The intention of the two types of research also greatly differs, specifically in the inquiry into the phenomenon (Streubert & Carpenter, 2011). Polit and Beck (2008) suggested that a sample size of 10 or fewer may be appropriate for a phenomenological study. The plan for this research study was to aim for a minimum of 10 participants total (two from each region/educational institution).

The initial goal of 10 allowed the researcher to purposefully recruit one curriculum leader and one program director from each region. However, the overall sample size goal for this study was to achieve saturation in the data. After the 10th interview and analysis, both the researcher and research adviser agreed that saturation had been achieved. Saturation is defined as "sampling to the point at which no new information is obtained and redundancy is achieved" (Polit & Beck, 2008, p. 357). The researcher used the snowball or a similar technique to recruit additional participants as needed throughout the research study. Streubert and Carpenter (2011) referred to the term snowballing when the researcher "uses one informant to find another" (p. 29).

Data Collection

The following information was gathered using a demographic questionnaire: gender, age, ethnicity, nursing career, involvement and experience with nursing curriculum, characteristics of educational institution, and highest degree earned. The researcher used this data to explore characteristics of the participants along with expressed insights during the interview (Tucker, 2016). All interviews took place by telephone, based on the participant's preference. The interview was digitally recorded to capture both the researcher and the participant's voice on speakerphone on the researcher's telephone. The researcher and the participant planned for approximately 60 to 90 minutes for the interview. Most interviews conducted were closer to 60 minutes, with some being less or more.

Again, the interview guide was used to provide semi-structure to the discussion amongst the researcher and the participant. The questions included on the interview guide were open-ended in format to facilitate more open dialogue from the participants. The researcher, under the guidance of the research advisor, revised the interview guide after the first four interviews. The researcher remained neutral and in a listening stance during the interviews (Paulson, 2009).

The researcher took multiple precautions to protect the confidentiality of the participants and adhere to ethical standards (Streubert & Carpenter, 2011). The researcher had determined that there was little to no risk to the participant during this research study. However, one risk involved in the participation of this study was if personal information is shared. To protect confidentiality, the participant selected a pseudonym prior to the interview for use throughout the research study process. Only the primary researcher had access to the key of pseudonyms, which was kept in a

password-protected computer. The author also took caution and removed identifying locations, such as state, city, or school names, from the transcripts as another way to protect the identity of the participants.

The interview was transcribed verbatim into an electronic format. The researcher delegated the transcription to a qualified individual; a hired transcriptionist performed the verbatim transcription using electronic software. The researcher verified the accuracy of the transcript by listening and comparing it to the audio recording (Polit & Beck, 2008). During the member checking process, the participants were also able to ensure that the transcripts were accurate.

Quality and Integrity in Research

The researcher selected multiple safeguards to protect the identity of participants, as well as any other sensitive documentation from being inadvertently shared. Documentation that was hard copy was kept at the primary investigator's private residence in a locked cabinet. All electronic documentation, such as typed transcripts and digital recordings, were kept in a password protected file folder on the primary investigator's computer. Any data sent to any other researcher, hired transcriptionist, peer debriefer, or research mentor the individuals used a secure means to share the data.

The researcher used the Guba and Lincoln framework for trustworthiness and other best practices to promote quality and integrity in this research study. The Guba and Lincoln framework includes four techniques: credibility, dependability, confirmability, and transferability (Polit & Beck, 2008; Streubert & Carpenter, 2011). Matua (2015) suggested that following basic assumptions and essential

methodological considerations of phenomenology support a rigorous research study as one method in enhancing the credibility of qualitative research.

The researcher addressed credibility in this study with the use of member checking practices throughout the data collection and early analysis processes. Member checking is when either partial or entire transcripts are sent to the participant for review (Streubert & Carpenter, 2011). The researcher reviewed the verbatim transcripts initially from the transcriptionist to review for potential errors. Then, the researcher sent the transcription to the participant for review. All participants reviewed and verified the accuracy of their transcript. Member checking is used in qualitative research to again verify the accuracy of the narrative especially once it has been transcribed into written format (Streubert & Carpenter, 2011). The researcher's research advisor was sent all 10 transcripts to conduct member checking throughout the research study.

The researcher made the participants aware that the researcher may request a second contact for further clarification of meaning was deemed necessary. The researcher did not need to make a second contact with any of the participants to clarify meaning. Lastly, the researcher conducted the research under the guidance of multiple expert qualitative research mentors, which included close collaboration with the researcher's research advisor. The mentors provided expert advice on specific qualitative methods and as collaborative partners during the research process to conduct peer debriefing (Streubert & Carpenter, 2011).

Next, dependability is described by Streubert and Carpenter (2011) as only possible once the researcher has secured credibility. One strategy suggested is the use of triangulation of methods as a way to promote dependability in a qualitative research

study (Streubert & Carpenter, 2011). Although, multiple methods were not utilized for this study, the researcher used two points of triangulated data by collecting data from two different curriculum leaders to address dependability in this research study.

The researcher used a notebook with personal notes that served as a reflective journal to record all steps of the research study to facilitate an audit trail process (Tucker, 2016). The purpose of an audit trail process is to document all thoughts and intentional processes along the way to demonstrate ways of thinking and rationales (Streubert & Carpenter, 2011). The researcher utilized the reflective journal throughout the research process to address confirmability in the study. The researcher shared aspects of the reflective journal with the peer debriefer and research advisor during the data collection, interpretation, and report of data phases of the research study. Streubert and Carpenter (2011) described this practice as reflexivity, which they define as the “responsibility of researchers to examine their influence in all aspects of qualitative inquiry—self-reflection” (p. 34).

Munhall (2012a) contended that generalizability is not an appropriate term for qualitative research. Instead, the concept of transferability is a more applicable term because it captures the idea that the research study may provide meaning for others in similar situations or phenomena (Streubert & Carpenter, 2011). Crowther, Ironside, Spence, and Smythe (2017) stated, “a story’s truthfulness (or concealedness) becomes known to us by how it resonates in felt, shared, plausible meaning, and this resonance cannot be reified into proof” (p. 828). Ultimately, the goal of quality and integrity in this qualitative research study was to ensure that the participant’s narrative is accurately and safely collected, ethically interpreted, and respectfully disseminated with the shared focus on describing the phenomenon of interest (Streubert &

Carpenter, 2011). During the interviews the researcher often repeated salient comments or statements back to the participants to validate accuracy and shared meaning was achieved.

Data Analysis

Morse's (1994) four cognitive processes informed the data analysis of this research study. The four cognitive processes for data analysis include "comprehending, synthesizing, theorizing, and recontextualizing" (p. 25). Prior to describing how the researcher used these four cognitive processes, it is important to note that the researcher began data analysis immediately after the first interview and continued throughout and to the end of the data collection process. The researcher applied these four processes in a non-sequential, at times simultaneously, and/or in a repetitive fashion (Morse, 1994).

The researcher began the first cognitive process of comprehending by the aforementioned immersion process. The immersion process not only includes the literature on the research methodology, but also on the content topic at hand. The literature review facilitated this process to highlight current research and publications to justify the proposed research study (Morse, 1994). However, the researcher heeded Morse's (1994) caution to use this knowledge to become a "wise and smart researcher, not a directed researcher" so as to avoid interference with the data or the researcher's viewpoint on the topic (p. 27). In order to immerse oneself into the data itself, the researcher started the data analysis process by carefully listening to the interviews and reading the transcripts within 24 to 48 hours after the interview was conducted. The researcher then listened to the interviews again while comparing to the transcripts. Lastly, as mentioned previously, the researcher kept both field notes and an audit trail

throughout the research process. These practices are further applications of the comprehending cognitive process.

Synthesizing began after more than one interview was completed. The synthesizing phase, or as Morse (1994) referred to it, “sifting” (p. 30), occurred as the researcher cut (in the literal form, copy) and pasted significant similarities into a separate document. At this point, the researcher focused the analysis on comparison of participant transcripts and any categories that emerged (Morse, 1994). This process was conducted using the software, NVivo 12 to read through transcripts and assign initial codes on those emerging categories.

As synthesizing continued, the researcher conducted further thematic analysis on the sifted data. This is the point in which, van Manen (1997) described as when the researcher has a “desire to make sense” of the data (p. 79). Polit and Beck (2008) stated that, “developing a high-quality category scheme involves a careful reading of the data, with an eye to identifying underlying concepts and clusters of concepts” (p. 510). In this next step, the researcher took the repetitive or salient clusters and formed them into codes or themes (Polit & Beck, 2008). This activity focused on identifying meaning within the data (van Manen, 1997) and continued in NVivo 12 qualitative data analysis software.

The researcher then took the themes and data and began to write (and rewrite) them into cohesive narratives. Morse (1994) described this cognitive process, specific to phenomenology, as theorizing. The researcher used the narratives in the recontextualizing cognitive process. In this process, the researcher began to determine implications and practical applications for these narratives in either practice or education (Morse, 1994). Specifically, the researcher gathered the narratives on the

lived experience of the modern BSN curriculum and determined how these meanings inform the literature and science of nursing education. The analysis was done under the supervision and guidance of the research advisor.

Summary of Methodology

The method of descriptive phenomenology qualitative research outlined for this research study allowed the researcher to achieve the overall goal of discovery into BSN curriculum. The researcher kept quality and integrity standards at the forefront in all stages of collection, storage, interpretation, and analysis data in this research study. The unique perspectives of the roles of faculty curriculum leader and administrative program director shed light on the lived experience of the modern and ever-changing BSN curriculum. This viewpoint provides a valuable current gestalt of BSN curriculum.

CHAPTER IV

RESULTS AND DISCUSSION

Introduction

The aim of this research study was to better understand Bachelor of Science in Nursing (BSN) curricula from the faculty curriculum leader and administrative program director perspectives, the greatest influences and/or motivators for curriculum revision in their program, and where or how does nursing theory guide BSN curricula. The researcher utilized a descriptive, phenomenology qualitative research method to answer the following research questions:

- Q1 What experiences do curricular and/or administrative leaders have about the needs for educating nurses for the future?
- Q2 What perspectives do Bachelor of Science in Nursing faculty curriculum leaders and/or administrative program directors have regarding the importance of nursing theory and its incorporation in their respective curriculum?
- Q3 What is the current gestalt of developing or revising nursing curriculum in Bachelor of Science in Nursing programs?

Ten nurse educators were interviewed for this research study. They were asked to discuss and share their perspectives on the BSN curriculum. The researcher used the narratives from the interviews to summarize pertinent characteristics of the participants and conduct a thematic analysis. Throughout the analysis process, seven themes emerged to describe the current gestalt of BSN curriculum in the United States.

Results and Findings

The researcher interviewed 10 nurse educators for this qualitative research study. The interviews lasted between 37 to 99 minutes in length. The majority of the participants were either a BSN faculty curriculum leader or a BSN program director. However, two of the participants were considered to be both of these roles at their educational institution. While the participants shared many similarities in characteristics, they each presented their own unique perspective on the BSN curriculum. All participants were female and Caucasian. The average age amongst the participants was 57 years of age, with a range in age from 38 to 63 years of age (see Table 1). The 10 participants were consistent with recruitment goals and represent two participants from each of the five regions. The first two sets of participants were from the same educational institution in the same region, the rest of the participants were from differing educational institutions but remained in the same regions, thus resulting in representation from a total of eight different education institutions.

The researcher used the narratives from the interviews as the primary source for data analysis. The researcher used NVivo qualitative analysis software to code the data based on significant similarities, which yielded nine original codes. Once in the codes, the data were analyzed further by identifying the salient and repetitive clusters. This process occurred over time by reading and re-reading through the codes to eventually determine seven themes with 14 sub-themes (see Table 2).

Table 1

Participant Demographics

Pseudonym	Age	Gender	Race	Admin/Fac Curr Time in role	Yrs as RN	Highest degree	Region
Katie	48	Female	Cauc.	Admin 4 years	22	MSN	West
Candy	55	Female	Cauc.	Fac Curr 4 years	21	EdD	Midwest
Cora	59	Female	Cauc.	Admin 1 month	36	PhD	Midwest
Jill	38	Female	Cauc.	Fac Curr 6 months	12	PhD(c)	West
Nancy	63	Female	Cauc.	Admin 4 years	43	PhD	Northeast
Linda	62	Female	Cauc.	Both New	40	PhD	Northeast
Rose	58	Female	Cauc.	Fac Curr 2 years	36	PhD	Southeast
Bea	61	Female	Cauc.	Admin 2 years	40	PhD	Southwest
Sandy	61	Female	Cauc.	Admin 5 years	35	PhD	Southeast
Diane	63	Female	Cauc.	Both 1 year	42	PhD	Southwest

Note. RN = Registered Nurse, MSN = Master of Science in Nursing, EdD = Doctor of Education, PhD = Doctor of Philosophy, PhD(c) = Doctor of Philosophy candidate.

Table 2

Summary of Research Findings

Themes	Sub-themes
1. Graduates readiness for practice and awareness of practice–education gap	<p>Critical thinking, clinical judgment, effective decision-making</p> <p>Awareness of healthcare changes evolving and environment</p> <ul style="list-style-type: none"> • Shift in care from acute to primary care settings • Shift in focus from illness to prevention and health maintenance
2. Clinical placements impact nursing curriculum	<p>Lack of clinical sites</p> <p>Use of simulation to augment clinical learning</p>
3. Faculty influences on nursing curriculum	<p>Faculty shortage and inexperience with nursing education</p> <p>Faculty’s knowledge about their role in the BSN curriculum</p> <p>Consistency and rigor in policies and/or teaching practices</p>
4. Students’ characteristics that influence nursing curriculum	<p>Students with disabilities and/or mental illness</p> <p>Generational, demographic, or attitude shifts</p>
5. Curriculum revision	<p>Workload involved in curriculum change</p> <p>Resistance to curricular change</p> <p>Concept-based learning</p>
6. educational standards predominantly guide and influence the BSN curriculum	
7. Nursing theory	<p>Movement away from a single-theory BSN curriculum</p> <p>Ambivalence about the relevance of nursing theory</p>

Note. BSN = Bachelor of Science in Nursing.

**Theme 1: Graduates Readiness
for Practice and Awareness of
Practice–Education Gap**

An important theme that emerged from analysis came forth because many participants shared a similar concern and awareness of a priority for the BSN curriculum to ensure that nursing graduates are prepared to enter the workforce as new Registered Nurses (RNs). Many of the comments made by participants were made in response to questions about the influences on the nursing curriculum, as well as issues within their curriculum. Katie addressed this by stating: “I think our biggest challenge is making sure we have nurses that are prepared and ready to step into that because I think that the gap from school to practice is getting bigger and bigger and bigger.”

Diane expressed a similar sentiment and challenged nurse educators to stay focused on one of the main priorities in BSN education:

But I think we always have to keep in mind that we’re preparing people for a workforce and not just abstract kind of field, it’s not just philosophical but people have to graduate and get a job and as long as hospitals are, they’re no longer being the most predominate employer of nurses.

Sandy made more than one comment on the subject of preparation of new graduate RNs for the workforce, “Probably the best example of the curriculum is really getting these students through NCLEX [National Council Licensure Examination], of course, is priority but then having them clinically ready to step into these hospitals.” She further reiterated this point by later stating, “The requirements that we have through NCLEX are to make sure that these students have minimal competency to function as a nurse. So, they are ready to go to a med-surg. [medical-surgical] floor.” Additionally, Sandy commented on specifically how she is addressing this priority within her educational institution:

Well, for us right now I'm looking at clinical models, I guess I need to speak to it from the clinical facilities that we use predominately the hospitals, making sure that these students have had what they need to be able to begin to be a practitioner in a basic hospital unit.

Additionally, based on the comments made by some of the participants, the priority of readiness for practice may be evidenced in how content and courses are designed within the BSN curriculum. Linda stated, "It goes way beyond content to what are the essential things that nurses need to know and it's all dimensions of practice." Whereas Candy's assessment on how to address preparedness in the workforce stated:

And then, of course, practice as anything, changes in practice then that will not really change our courses necessarily but maybe the content in which we focus in our courses, what becomes priority and practice should become as closely aligned in academics as well.

Sandy offered a specific solution made at her educational institution to address how the student is mentored into the role of a new graduate RN by the end of their BSN program. She described her educational institution's use of a practicum course at the end of the curriculum:

So, they're getting a real view of what it's like to be in the RN and at the very beginning they're also shadowing a nurse because they're trying to orient but by the end of their experience with the faculty they are evaluating and what they're questioning and how the preceptor evaluate, it's the preceptor now shadowing the student which is what should be happening.

Participants also commented on how they utilize curriculum evaluation processes to address how well they are addressing entry into practice in their BSN curriculum. For example, Rose provided three examples of these types of processes: feedback from clinical sites, research, and feedback from students/graduates. Sandy posed this question: "Is there something that we can do that would make these students better able to step into their role?" She then went on to state that she uses

feedback from potential employers of new RN graduates to begin assessing why the new graduates may or may not be meeting entry into practice expectations:

But right now I am meeting with administrators and directors of nursing and education leaders to see, because this seems to be a problem across different geographic areas, that hospitals are feeling like when they get these graduates that they're not ready to function. Well, why not? And that's my concern, what is it that they need that maybe we're not providing or that we can beef up in the program to make them better able?

Critical thinking, clinical judgment, effective decision-making. The first sub-theme emerged as the participants overwhelmingly echoed a united voice on the growing impetus that program outcomes need to include how graduate RNs should be prepared and ready to critically think, make decisions, and reason in their new practice. During Candy's interview, she emphasized the importance in helping the students see beyond the NCLEX, but instead, "I think we need to improve on a better way to increase the ability for our new graduates to think and to have better clinical reasoning skills." Cora's comment brings to light how as the healthcare environment continues to become more complicated, nurse educators will need to prepare graduate RNs to critically think for this current and future workforce. Cora stated:

The biggest thing is how do we teach these nurses to critically think. Because we don't want them to memorize things, that's not the purpose of nursing school, they need to really be able to apply it and learn to think critically and I think as their healthcare environment gets complicated and more acute and less resources, in order to be successful these nurses are really going to have to be able to think quickly on their feet and be able to problem solve.

Rose listed several priority characteristics for graduate RNs and nursing students in general. Amongst these characteristics, she said, "I just think good decision making, critical thinking, and good decision making is probably the major thing that we can incorporate into the curriculum that's going to help them the rest of their lives." Linda made multiple comments related to this sub-theme. She not only shared

the sentiments of clinical decision making skills, judgment, and reasoning as important characteristics of graduate RNs, but she also shed light on the motivation behind these priorities. Linda stated:

I think we are still teaching students content that maybe is not essential and we hear from our clinical partners that we need to do a better job at producing beginning nurses that have better clinical decision making skills, better clinical judgment, better reasoning skills. So that we really teach the students how to think like a nurse and be able to reason at basic level that is evidence of competency.

She went on to say:

Well, for me, it goes beyond content. For me, it's about teaching these soon-to-be nurses, how to get them to think like a nurse. How to build clinical reasoning skills, how to build clinical judgment skills. And so I mean the content is part of that but the biggest part for me is helping students and teaching students that everything we do is aimed at helping that student become a nurse who can think.

Linda attributed some of the reasoning behind the focus and drive for nurse graduates to be able to elevate thinking and reasoning to the National Council of State Boards of Nursing and upcoming changes to the NCLEX-RN. She said:

And I think as the NSCBN [National Council of State Boards of Nursing] and the NCLEX changes to even more of a decision making focus as a measure of someone being competent there's lots of reasons why we need to make sure that we're teaching that aspect of nursing practice because really that's what we should be doing anyway because it's all about application, analysis, and systematic evaluation.

Nancy acknowledged the importance of critical thinking when she said:

Because the big thing is you have to have that critical thinking ability, you can not teach what you do with every single disease that the patient is going to present with because there is always something that you've never seen before.

Similar to Linda, Nancy also recognized that the upcoming changes to the NCLEX-RN may be motivating nurse educators to focus on critical thinking within the BSN program. She stated:

The upcoming issue is going to be the impending, the plan for the next generation NCLEX. And we don't even know what that exactly is yet but we know it's coming. And it's going to focus more on critical thinking, which we seem to doing a good job of with our students.

Diane also addressed the upcoming NCLEX-RN changes and similarly made the connection with critical thinking, clinical judgment, and decision-making. Diane said:

Another area that I see that's important, and again, it could be just my particular bias but switching the language from critical thinking to clinical judgment and decision making, I think the changes that are coming up in the NCLEX is going to be a driver that we're going to have to teach students how to respond to new NCLEX, next gen NCLEX, I think that's going to require some changes on the part of curriculum to make sure the students are equipped to take the kind test but I think that leads more to the clinical judgment.

Bea described her priorities for graduate RNs preparedness for practice as, "They need to be able to communicate with others, to critical think, to be safe. Care for the patient and the family." She went on to share how her educational institution listened to the voices of their stakeholders' expectations of new graduate RNs in the practice setting. Based on their feedback, she stated:

What they all said was that they needed a student that could think on their feet, could think outside of the box and that could communicate. So, those were the skills that they really desired in a new employee because the idea that skills are fine but they can teach you how to do a skill. Anybody can do a skill but being able to critically think through a problem, problem solve, and communicate with others was really two critical skills that they wanted.

Awareness of healthcare changes and evolving environment. Some of the participants' comments regarding critical thinking and reasoning also touch on the next theme that emerged from the literature: the acute awareness that the healthcare

environment is rapidly changing. The participants shared how they felt that nurse educators needed to stay aware and educated on the upcoming changes in healthcare, including the shift in care from acute to primary care settings, shift from illness to prevention and health maintenance, and worsening nursing shortages in the workplace.

The participant Rose commented:

We have to be very careful with curriculum because of that and we've got such rapidly changing healthcare environments right now. It's really hard to make the curricular changes that you need to make without tipping the scale too far in one direction or the other.

Shift in care from acute to primary care settings. Multiple participants remarked on how healthcare's recent and impending shift from acute care to primary settings impacts the BSN curriculum. Cora specifically discussed how this change in healthcare may alter the types of clinical opportunities offered to students in order to prepare them for the reality of the nursing workforce.

Cora was influenced by nursing literature that encourages nurse educators to also include primary care settings as potential clinical sites as she stated:

I think what we need to move toward thinking about is preparing the nurse for primary care setting because; for example, the Josiah Macy report that came out in 2016 really is referencing the needs for educators to prepare nurses for primary care setting and not the acute care setting.

However, Cora is conflicted because she felt that students were not as enthusiastic about the primary care settings for clinical opportunities, "I struggle with that we really need to be preparing these nurses for being competent in the primary care setting because that's where we're moving."

Bea also acknowledged this shift and added that she felt that as nurses continue to be leaders and coordinators of care, the BSN program will need to adequately prepare them for those roles within the community settings. Bea stated:

Well, the fact that a lot of care in the future is going to be delivered in the community. So, an emphasis on community needs to happen. So, probably some of the clinical sites need to be more in the community than in the acute care hospitals. I know that in the big picture BSN nurses are going to be more coordinators of care and that kind of thing and so getting them ready for something like that is going to be important.

Diane desired for the BSN curriculum to be refocused to include more community and primary based care settings and less emphasis on the acute care setting clinical experiences. She said:

Students do not value until they are out of school how they can be in a more community-based primary care setting. So, I think that's one of the biggest challenges is to refocus curriculum to find more creative ways and other than hospitals for students to have their educational experiences but then you don't necessarily have nursing role models in those primary care settings because they don't always hire BSN nurses much less RNs to work in a primary care practice.

Rose made a similar statement:

Our curriculum is really going to have to change in order to meet the demands of the roles that nurses have and that the way the care itself will be delivered to the patient in acute care settings and in primary care settings/long term settings, any setting because there is so much going on right now.

Shift in focus from illness to prevention and health maintenance. Two participants acknowledged the changes in the healthcare environment and concluded that the BSN curriculum needs to be more emphasis on prevention and health maintenance with less focus on the medical and disease processes. For example, Linda stated:

We're still in many ways on the health and illness continuum too far towards the illness side. And that's understandable why that is. I mean, our whole nation is undergoing a transformation of that. But, for example, in curriculum you have to integrate into your curriculum that holistic side so that the nurses that you produce don't just think about acute care and about illness, they think about the whole continuum of the person. So, we have a lot we need to do as nurses that other providers don't really focus on in terms of health and wellness and health promotion and prevention and working in the realm of helping people manage their stress or the way they react to something.

Diane shared similar sentiments and acknowledged her potential bias on this topic due to her past experience working as a public health nurse. In this way, her reasoning may be less tied to the healthcare changes, but instead her personal priorities for providing nursing care, in general. Diane's comments included:

I think it needs to be re-conceptualized totally. That's a personal opinion. But that would introduce more health promotion earlier and focus less on diseases; but again, I have a bias as a public health nurse. But I think if we're really wanting to improve the health of the nation and health of people, we need to emphasize more health promotion, disease prevention, and then when that doesn't work then you go into the other typical sick nursing care, illness nursing care. Certainly a lot of it is needed on chronic illnesses and less on the acute, and that would be another change I would make would be more chronic illness focus.

Based on the participants' comments, nurse educators are feeling the pressure to meet the demands of the healthcare employers and environment. Some pressure may be coming from the feedback from employers of nurse graduates and the need for more employees in healthcare. Additionally, the participants have a pulse on the healthcare environment to know what trends can impact the nursing curriculum. For example, the shift in priorities from acute to primary- (or community-) based care and from treating illness to prevention of health likely impacts the clinical aspect of a nursing curriculum. There is a priority amongst these nurse educators to lessen the practice-education gap.

Theme 2: Clinical Placements Impact Nursing Curriculum

A number of the participants remarked on the impact that clinical placements has on the BSN curriculum. Participants typically discussed clinical placements when asked about issues in their curriculum or something they would like to see changed. Participants shared how some of the issues related to clinical placement can be

attributed to the shortage of healthcare workers, thus qualified nurses and/or preceptors for students to work with during clinical time. Due to these issues with either access to clinical sites or clinical preceptors, some of the participants reported that they utilize simulation as a way to lessen the gap left by the lack of availability in clinical placements.

Lack of clinical sites. The participants acknowledged that a challenge in meeting program and course learning outcomes was in part due to a lack of meaningful clinical site locations. Several commented that access is in large part due to having to share the clinical site with other nursing programs that are vying for similar clinical opportunities. Cora said:

We're struggling with clinical sites, not just for psych but for all of these areas because where we live there is a lot of different nursing schools and so we're all competing for multiple sites to place our students in these clinicals and that's a challenge."

Cora went on to elaborate when questioned by the interviewer whether she felt that clinical sites were a concern, she stated:

Yes. We have to share and that can be, I've actually had this conversation with my previous boss like, "We should get first dibbs on these clinical sites because we are kind of like the feeder school" for the hospital to get the nursing jobs. But the person in charge of clinical placement definitely agreed with us, but she thinks that other schools should get their choice. That can be frustrating for faculty and for the chairs because we want the students to be placed in a meaningful site where they're going to get some learning and be able to meet the objectives of the course.

In addition to the competition for clinical sites with other nursing programs, participants also touched on the issues with oversaturating the clinical environments with students and the potential impact that can have on clinical partnerships between nursing programs and healthcare organizations. Nancy discussed how there could be a variety of issues with the clinical site availability. First, she stated, "Well, just access

to clinical sites because we have so many schools vying for the same clinical hours where we want to have the students and so I think that influences the increased use of simulation.” Secondly, Nancy highlighted how in the real-world clinical environment, nurse educators have less control over the learning opportunities because as she tells her students, “You’re at the mercy of the uterus” in obstetrics clinical. Lastly, she discussed how at times in the clinical setting, students can overwhelm and even burn out the nursing staff, she said:

We have clinical faculty on the floor but we can’t be with every student, every minute of the time. We’re kind of moving targets there. And you have to be sure you’re not burning out your nursing staff and some nursing staff just aren’t good with students and probably never will be, everybody has different strengths.

Linda commented on how the lack of clinical placements limits their nursing program from growing in the number of students because there are not enough sites to accommodate. Linda said:

A lack of clinical resources to sustain the model that we currently have for how we educate our students clinically. So, for example, you want to increase the number of students that your program accepts, yet we can’t do that well because we don’t have enough clinical places for them. So, I think one of the things that is facing us is how do we use other teaching/learning strategies like simulation effectively so that we can continue to produce nurses that are going to be able to pass the NCLEX practice in order to meet the healthcare needs of the future.

Diane’s comments directly connect the issues with adequate clinical placements and their program’s solution to increase the amount of simulation into the curriculum. She said:

I think one of the biggest challenges are students practicing in the clinical settings. We’re not a health science center and so we don’t have a specific teaching hospital. These are community hospitals and they’re used by a number of different schools that are in our area and so we’re faced with nurses getting tired of having students and so we’ve added more simulation into the curriculum, and since it’s been demonstrated at simulation and takes place of

time in a clinical agency, they still need that hands on in the clinical setting experience to really see how people react.

For two of the participants, they discussed the nursing shortage and staff turnover, which has impacted these two participants' BSN curriculums. Cora shared how a recent discussion with clinical partners brought to light how the nursing shortage directly impacts the clinical education piece of the BSN curriculum:

They had a lot of new staff, and so I think the hospital is going through the same issue, they have nurses that are retiring and then they have brand new nurses coming in and so they don't want to burden the brand new nurses to do the precepting to our students because they're both learning. So, things are sort of tight right now and healthcare is undergoing such changes.

Sandy also took into consideration the nursing shortage, but instead felt the pressure of these shortages as a need to increase the number of students in the BSN program to meet the demands of the healthcare environment. Sandy said:

One of our local hospitals has 90 nurse openings right now, today. And even though we have seven schools of nursing in the area, they've got 90 openings so we can't keep up. Now, that's a hospital issue but our enrollment has increased; actually it's almost doubled for our traditional program this year so we're going to try to help meet that need. So, I guess you'd say that's a pressure from the community for the school to produce more, but I mean there is limited resources within any school environment, how many can you take?

Use of simulation to augment clinical learning. Participants discussed the use of simulation in their educational organizations and how simulation can address a variety of issues within the nursing curriculum. Jill echoed other nurse educators who were also using simulation to address the lack clinical placements in the healthcare environment:

And I could also add to that that something as simple as having clinical facilities can influence curriculum as well. One of the big things we've done is incorporate simulation to replace clinical. And part of it has to do with a lack of facilities and sites but it's also something that we can do, because it's approved by the board in the state of [location removed for privacy].

Candy discussed a benefit of simulation for student nurse learning and improving thinking processes to work towards the goal of being practice-ready for the nursing workforce. Candy went on to say:

In the simulation lab, having the ability for students to think their way out of a dilemma, to think their way through a situation where someone is dying, to think their way through a heart failure patient who keeps returning and returning for visits and what are missing?

Sandy discussed simulation throughout the course of her interview multiple times. She stated that she feels as if simulation is a positive solution to meet the changing learning needs of the nursing students in nursing programs today because the students need more active and kinesthetic ways of learning.

Sandy also stated that her educational institution has decided to invest in growing their simulation center from a two-bed unit to better align with the realities of the healthcare environment and to allow opportunities for more students to experience the simulation center. She stated:

So, now we will have a seven-bed unit and so sometimes you'll have a class of eight students in there and have seven beds with patients in them or other times you'll have med-surg [medical-surgical] on one side of the unit and pediatrics on the other or whatever. So, we're trying to bridge that gap with the simulated environment. I think that is very necessary in curriculums today.

In the nursing curriculum, the clinical component is crucial to learning for student nurses. The participants in this research study discussed the issues they face when trying to find meaningful clinical experiences and locations for their students. Some of the issues the participants highlighted were the competition for clinical sites with other colleges of nursing, the oversaturation and overwhelming of clinical sites with too many students, and the lack of available preceptors due to the current nursing shortage in healthcare. Nurse educators are using simulation to augment the clinical

learning and lessen the reliance on healthcare environments, especially acute care settings as clinical experiences.

Theme 3: Faculty Influences on Nursing Curriculum

The researcher did not ask the participants specific questions related to nursing faculty and their impact on the BSN curriculum. Several conversations regarding nursing faculty were sparked when the participants were asked about issues and factors in the BSN curriculum and what specifically influences the curriculum. The three sub-themes that emerged from the data included faculty shortage and inexperience with nursing education, faculty's knowledge about their role in the BSN curriculum, and faculty's role in establishing consistency and rigor in policies and teaching practices.

Faculty shortage and inexperience with nursing education. In general, participants expressed concern in some ways nursing faculty can influence the nursing curriculum. Specifically, participants discussed how faculty turnover impacts how the nursing curriculum is carried out with or without qualified nursing faculty to teach in it. Additionally, an increase in student volume can also put a strain on the number of qualified faculty to teach, as Cora stated, "And as our volume of students continues to grow we need more faculty. So, it's really a catch 22 because we want to grow our program but then we need more faculty. So, it's a challenge."

Cora continued the discussion on faculty turnover and how inexperienced faculty may impact the nursing curriculum due to the workload for mentorship of new faculty and maintaining integrity in the program with inexperienced educators. She stated:

Then we get new faculty in and so junior faculty really need a lot of mentoring on how to educate the students and how to challenge them and help them be critical thinkers and not inflate the grade, not cave in when the students complain and add points. And new faculty need lots of mentorship which has been an issue and I think that's probably going to be typical nationwide. It's a challenge to assign a mentor because it takes about a year to really get the onboard process and get the faculty up and running, especially if they are brand new to academia, so that's the another factor.

Linda commented on the faculty shortage more than once by stating, "the whole lack of faculty is a huge problem." She attributed the shortage to salaries and other lack of benefits to the career. She said, "they're not going to be able to deliver the curriculum if there isn't anybody here to facilitate it. And that's a huge issue for nursing education." She went on to clarify, "It doesn't influence the curriculum itself but those are peripheral issues that often impact the delivery of the curriculum is inexperienced faculty, not enough doctorally prepared faculty, etc."

Jill also agreed that faculty can influence the BSN curriculum in multiple ways as she stated, "It would be a lack of faculty and so without faculty to utilize the curriculum and teach our students, we can't move forward." Jill also addressed the lack of qualified faculty: the "lack of knowledge just about curriculum and the fact that it's ever-evolving." Jill expanded on her views on qualified nursing faculty with essential nursing education background knowledge to teach in the BSN curriculum.

Candy agreed that new faculty influences the BSN curriculum, "New faculty, I think is another reason to really, new faculty who are not educated in nursing education where they understand theory behind teaching and learning. That does have an impact, I believe." She gave credit to new faculty and their practice background by stating, "They're great clinicians." She went on to describe how new faculty do not

always have full understanding of what they can and cannot change within the curriculum.

Rose's comments regarding faculty echoed previous participants. She said, "Faculty availability, faculty experience as a nurse and faculty experience or abilities to actually bring that clinical practice into the classroom to help each student see where they're going." She specifically provided an example of new and/or inexperienced faculty who lack an understanding in the amount of time that should be spent on content areas can impact the overall nursing curriculum. She also touched on the workload aspect of mentorship of new and/or inexperienced nursing faculty as she said, "Especially if you don't have someone there to mentor you through your class and because of the financial issues and that sort of thing; replacing faculty is, you have to justify for budget purposes."

Sandy's concerns regarding faculty availability were directly related to her nursing program's increased enrollment, which she attributed to the pressure of healthcare organizations needing more nurse employees. In addition to the increased enrollment, she also described how her educational institution is understaffed one specialty faculty person to teach due to a resignation in faculty. Nonetheless, she concluded that, "But you've also got to have qualified faculty to teach those and this is the first year that we've experienced difficulty in hiring to meet the needs."

Faculty's knowledge about their role in the Bachelor of Science in Nursing curriculum. As Cora stated, "Now, one thing that's very important for faculty to understand is that faculty do own the curriculum and so they are responsible for reviewing it and updating it, working together, and then my role is to do the program overview." The majority of the participants acknowledged the importance of the

faculty role to BSN curriculum. Some expressed frustration when other faculty had a lack of knowledge on their role in the curriculum and faculty behaviors that may work against the overall curriculum outcomes. Similarly, Bea stated: “So the faculty are really the drivers, good or bad, of the curriculum. And basically we’ve been doing it this way for so long we’ve just been kind of been doing it that way since we’ve always done it that way to a large degree.”

Cora elaborated on her perspective of how faculty should maintain the nursing curriculum. Cora described an evaluative process used by faculty at her educational institution that involved, “looking at the syllabus, looking at the student learning outcomes, looking at the assignments, looking at the activities, the teaching learning strategies, etc.” This is a process used to determine whether the course and assignments are still working towards the outcomes of the course and curriculum.

Sandy shared her educational institution’s process for evaluating faculty’s role in the curriculum. She described how they meet twice per year to address strengths and weaknesses. Specifically, she stated, “we go through every single course in our curriculum and what are the strengths and the weaknesses, both identified by students and identified by the faculty.”

In Katie’s role as an administrative program director, she often witnesses how faculty’s lack of knowledge or compliance with their role in the nursing curriculum at the individual level can impact the overall curriculum goals or outcomes as she stated:

Some of the struggles that we have is faculty not completely taking ownership, faculty not understanding what it is that they’ve been called to do because we’ve laid out all of the curriculum in a curriculum working document so that you can see where you’re at.

She used the analogy of a spoke and wheel to illustrate her viewpoint on faculty's role within the nursing curriculum. She described when a spoke is missing or weak, how it can cause issues. Some of the examples she provides of these examples included when faculty do not adhere to the curriculum plan, "or faculty don't update that so then really, kind of nobody knows what's going on." In particular, she expressed concern about when there is a question whether faculty have taught content according to the curriculum plan. She explained how this can lead to topics being retaught and the possible implications that can have on faculty relationships as well.

Katie concluded her viewpoint by stating:

So, that's one of the challenges and that's a huge challenge. And then faculty understanding their role as well in relationship to the curriculum because you have academic freedom to teach however you want, but you don't have as much academic freedom meaning you can't just willy-nilly change it because "that's how and what I want to teach and that fits me personally better as a faculty member and my frame" because that's not what you've been called to do within the program and being part of the team and seeing the bigger picture, challenge.

Linda's comments discussed how faculty's individual practices, personal beliefs, and having shared vision of what the generalist nurse needs to know all impacts the BSN curriculum. She also provided an example of how the content is taught can be an issue and/or impact the BSN curriculum as she said, "So, some faculty are still vetted into a very prescriptive, lecture based teaching where I believe our curriculum needs to be more contemporary, how we deliver the curriculum in terms of our teaching strategies." She went on to say:

So, we have issues among our own faculty that I don't know that we're all aligned around what it is that we're trying to produce. What are the skills and the characteristics that we want the generalist baccalaureate-prepared nurse to have. It might be written down, it might be stated but whether or not people actually believe it and do it and teach that way, that I don't know. I think it can

be an issue or a factor influencing how your actual curriculum is implemented. And then that speaks to the quality of it.

Jill reflected on her experiences with faculty who may not have a clear idea of their role within the nursing curriculum, “We have interviewed a lot of people recently who have earned a higher level degree at the doctoral level that don’t really understand the role or how to function in that role and use the curriculum and provide quality education.” Jill’s commentary during her interview highlighted how these isolated individual issues can also manifest into a group-wide faculty dilemma. The dilemma she described has to do with faculty who reteach content that, according to the curriculum has been taught, but students are reporting that they have not heard the content. She said:

So, we had some turmoil within the faculty recognizing that everybody is working hard and mapping everything out gives all of the faculty a chance to see how things are being taught and in what ways so that they can hopefully have a little more faith and trust in the system and not believe the students. So, we had some students that do a little bit of dividing. It was good for everybody to see the hard work everybody is doing.

During Candy’s interview, she shared how not only the understanding of the individual role, but also knowing what all the faculty is doing, as a whole is important to the nursing curriculum. She described how faculty may not be communicating well amongst one another to share how they are individually implementing the curriculum. This can impact the nursing curriculum because it is difficult to determine whether there is evaluation or assessment occurring due to the lack of communication. She stated:

We have faculty on three different levels here and we’re ships passing in the night and so to even pin down someone to say, “Hey, what are you [doing],” it’s really hard to catch other faculty here at the same time because we’re always on the move.

Consistency and rigor in policies and/or teaching practices. Five participants' comments demonstrated how faculty can play an integral role in the nursing curriculum because of their influence over policies and teaching practices. The participants made these comments in response to questions regarding curriculum revisions, potential issues, and key factors in the nursing curriculum. The comments uncovered a common thread of consistency and rigor as they related to the nursing curriculum. Also, these behaviors and/or practices can impact how faculty implements the nursing curriculum as a whole.

Katie discussed how both faculty practices and in-class/clinical policies can influence the nursing curriculum. She addressed integrity and rigor of policies during her interview as she stated, "I think one of the other things that happened too, is policies changed. For example, upholding rigor and academic integrity becomes more evident." She specifically discussed behavioral policies related to clinical, such as tardiness, etc. She described how changes to the safe clinical policy provide greater consistency in clear expectations of behavior standards, which is especially beneficial when coaching students. She felt this ultimately impacts the faculty and the nursing curriculum.

Jill described how the dean of her nursing program, along with faculty, developed a rubric for faculty to use to improve consistency in following policies within the nursing curriculum, especially to address students' behaviors in clinical education that tie the learning objectives with the knowledge, skills, and attitudes. Jill stated:

But within this document that the dean put together it's really clearly identified as an inappropriate behavior. So, it's kind of helps facilitate that evaluative process. The students know what their expectations are and what appropriate

things would be if their learning and growing. And it really details out the positives; the negatives and can help faculty with evaluations.

Cora also addressed how improving rigor in policies and grading practices can impact the nursing curriculum. She specifically spoke about grading percentages, dismissal policies after two failed courses, and assisting faculty in being more mindful of over-inflation of grades. She stated, “The faculty have really tried hard to be more consistent and to be more rigorous in their evaluation and assessments.” Cora also highlighted a barrier to remaining consistent in policies as it relates to behavioral standards and practices. She had concern about different approaches faculty take to address if a student is absent or misses a quiz. She said, “Can they make it up or will they get a zero? We do have a policy and faculty do have the academic freedom in their syllabus to make that determination.” However, Cora still believed there is room for inconsistency, even amongst how an individual faculty person addresses some of these topics.

Well, this person was sick and so I’m going to let them retake the quiz without any penalty, but that can be tricky though because then if someone has a flat tire and they miss the quiz do they get to retake the quiz and get the penalty waived?

Nancy’s comments related to consistency and rigor in policies were focused testing policies at her educational institution. She attributed these changes to improving NCLEX-RN scores after implementation. Nancy stated: “We increased our passing score for exams; they have to meet a certain score on exams before anything else is added in. We don’t round up, and it’s really kind of low, it’s 75% but that’s higher than what it used to be.”

Rose also described how the faculty at her educational institution “tightened up testing” policies and how faculty improved their test writing to be more consistent with NCLEX-RN type of questions. She also discussed the policies for readmission back into the nursing program. Rose’s description of the changes made to the admission process as:

In the last couple of years we have gotten very formal with our readmission process. Before it was kind of haphazard because we weren’t having that many that were not completing a course or completing the course with a “D” or less who wanted to come back. And then we started getting more and more that wanted to come back and so that’s been a major change.

Bea’s perspective demonstrated how inconsistencies and a variation in how faculty implements the curriculum also have the potential to impact the nursing curriculum. Bea was asked about how the caring theory was integrated within her BSN curriculum and she said,

So, I couldn’t tell you how caring has mapped out through the curriculum. I know that all of the faculty believe in caring. I don’t know how it’s documented, I don’t know if anyone has looked at that lately. Like I said, there has been so many variations, it’s like having a document and you’ve got 10 versions of it, kind of like that.

Bea stated, “I don’t know if people think about variations in courses and how that could affect consistency.” She went on to share how it is her goal to improve on consistency when the new curriculum is implemented so it will be more clear who is teaching and doing what.

It is no surprise that faculty do impact the BSN curriculum, especially in light of the current and potential worsening nursing faculty shortage. The data from this research may be able to assist nurse educators in better understanding how faculty can impact the BSN curriculum. For example, the participants’ comments regarding mentorship and faculty development on topics of the nursing curriculum may be

useful for nursing education administrators to consider when on-boarding new nursing faculty.

Theme 4: Students' Characteristics that Influence Nursing Curriculum

Several participants shared how there are certain student characteristics that seem to influence the nursing curriculum. The participants were not directly asked to comment about students. Rather, the comments made by the participants were typically made in response to questions about what factors or issues impact the nursing curriculum. There were two characteristics that emerged in the data analysis: students with disabilities and/or mental illness and a noticeable shift in the generational or demographic descriptions of the students in the nursing programs today.

Students with disabilities and/or mental illness. Participants commented on how students entering the nursing programs today carry with them struggles and diagnoses that were not previously experienced in years past. Some of the participants question whether these additional struggles and diagnoses may influence how students are able to meet all competencies in the nursing program, namely in clinical education.

Nancy stated, "So, that issue of the changing mental health demographics in the population is going to be a big issue for faculty." She reflects on this shift in student characteristics and stated, "One, is the increase in mental health diagnosis among incoming students, depression, anxiety, and some of major bipolar disorders, things like that." She went on to share how these diagnoses were not recognized 20 years ago and even 10 years ago, minimally noticeable. She went on to state:

It's not just a matter of accommodations like "I have a learning disability and I need extra time." This really has to do with getting counseling treating, maintaining consistency in the use of medications because we have students

who can really if they maintain themselves on their meds they can do well. But as many people realize a lot of people are like, “Oh, yeah, I don’t like the side effects” or “I’m doing fine now, I don’t need them,” it becomes disastrous.

Nancy also shared her perspective on the issue of students with learning disabilities in nursing education. She expressed concerns about students with certain learning disabilities being able to function in simulation and clinical, “You don’t get time and a half in sims. You don’t get time and a half in clinical.” She went on to say: “You have more and more with learning disabilities and where that becomes an issue, it’s not so much for ‘Okay, you can get time and a half for testing’, you don’t get time and a half in the clinical area. You still have to function.”

Rose also discussed students with disabilities and the implications for clinical practice and expresses concerns for accommodations granted in the classroom versus the clinical setting. She related it back to a patient safety concern, because she believes that the student needs to be able to be fully competent in the clinical environment without accommodations. “It involves that other person, you’ve got a third person, instead of a dyad between a student and a teacher, you now have a triad and you’ve got that third person in this that changes the dynamic because of the clinical environment.”

Rose also stated:

And that’s kind of one of those issues that’s going to hit nursing education and I think it may have hit education as a whole with students wanting certain services and that sort of thing but for nursing, we make reasonable accommodations when we can but sometimes they’re just not reasonable and it’s hard for somebody who is unfamiliar with what nursing is or does and what the healthcare environment is really like to understand that.

Generational, demographic, or attitude shifts. Multiple participants commented on a variety of descriptive characteristics the nurse educators are

experiencing within their nursing programs. Although the participants may not have been able to all discuss the same characteristics, the fact that they are noticing a shift and the impact they can have on the nursing curriculum is apparent in the participants' narratives. Participants recognized shifts in students generationally and the complexity in the nursing student today. Several reflected on the shift in mindset and expectations in nursing students today.

During Diane's interview, she reflected on the generational differences she notices in nursing education and how one of the biggest frustrations amongst her and colleagues is how to effectively communicate with the new generation of students, "Because some of the biggest frustrations is 'they don't respond to e-mails, they don't read their e-mail, so how do we best communicate with them?'" She went on to say:

But I think it's a challenge of how do we not just get frustrated by the students but learn how to work with them. We can't change who they are and so how do we respond to them? I think that's one challenge that's going to be ongoing as faculty are a couple of generations ahead of the students we're teaching and learning to relate with them. And then just constantly staying on top of change. And helping faculty, I mean, to embrace and adapt to change instead of complaining and not wanting to change because that sometimes gets to be a barrier or we want things to happen in curriculum but the faculty teaching the courses aren't incorporated and so how do we maneuver getting that in.

Cora described her experience with an emerging and more complex demographic of students. Based on her perspective, students are coming to the nursing program with more outside responsibilities and displaying more stress than ever. Cora stated:

But now, a lot of these students, they're not your traditional students, some of them maybe are not necessarily young. I don't know what the average age is but, they're probably still 20 to 30 but we have had some older students and they're married, they have children, they're working. They have a lot of their plate. And these are rigorous programs that they need to keep with.

Cora went on to describe how it is important for nursing faculty to adapt to students in this demographic by incorporating more stress management and even mindfulness to help the students cope with the strenuous nursing program. She went on to state, “So, we probably need to do a better job of recruiting and retaining these students and really letting them know what nursing school is all about. I think some of them have unrealistic expectations of what nursing school is.”

Cora touched on the notion of unrealistic expectations of students in her comment regarding student characteristics. Nancy shared a similar perspective as she expresses concern about a changing mindset to finish nursing school in a shorter period of time, “It’s the idea of ‘I want to do this quickly. How fast can I do it?’ and even from a college standpoint this idea that oh, people want to finish in three years.” Nancy compared this expectation to other professions to illustrate how this may be an unrealistic expectation given the amount of responsibility the RN has at the bedside.

Rose shared how the students’ mindset and attitude impacts their journey to becoming nurses. She also stressed the importance of nurse educator’s to ensure that students have the right mindset to be prepared to enter into nursing practice after graduation because, “It is preparing them to affect the lives of many individuals down the road.” Rose stated:

We need people with the attitude they’re here to assist to promote healthcare, health promotion across the lifespan and across populations, not just getting a paycheck. And I think that’s a big problem that we have in education today is “Is this going to get me a job?” Yeah, nursing is going to get you a job but are you going to be good at it? Is it something you’re ready to do and can you make a difference and we’re here to make people’s lives better, we’re not here just to do something.

Sandy shared several comments related to students’ characteristics and the challenges that they present. She said, “For example, if a student has an issue it’s not

uncommon anymore that momma comes with them and in the past that never happened. That was extremely rare and now it's very common and so you almost expect it." Throughout the course of her interview, Sandy also mentioned students' coping and success in the nursing program, suicide, depression, and anxiety. She described how her educational institution has implemented new practices in order to address and set these students up for success coming into the nursing program. Sandy stated:

This year we have incorporated a boot camp into our curriculum model that we have not done before to kind of introduce the students to nursing and hopefully some of the rigors of that help them understand that this isn't going to be necessarily like other classes that they've taken because we're constantly building on learning, that you can't memorize this information. You have to learn this information because you're going to be using it over and over and over throughout the program.

The participants outlined several student characteristics that they felt were impacting the nursing curriculum. Although the participants did not share exactly the same student characteristic, they did share a common thread of concern for the populations of students and a message about setting realistic expectations for incoming students into a nursing program. Whether a student enters the nursing program with a learning or physical disability, a complex personal life, or as a new generation of student, they all must have a clear understanding of what will be expected of them during their journey in the nursing program and have the adequate tools available to them to be successful.

Theme 5: Curriculum Revision

Curriculum revision was a major aim of this research study because it was a primary thread throughout the nursing education literature review. There were two interview questions about curriculum revisions that probed the participants to share

about when their curriculum underwent a moderate-major revision with the last five years and what were the motivations or influences for the revision. The participants' answers to the two research questions are summarized in Table 3. The majority of the participants reported recent or current curricular revision in their BSN program. Participants attributed a recent or current curriculum revision to poor NCLEX-RN pass rates, a need to be more consistent with accreditation standards, and other program outcomes (e.g., decline in graduation rates). Some of the revisions discussed by the participants included restructuring of course sequencing and curricular content, changes to admissions or entry to program requirements, and/or revision of program or level learning outcomes.

Workload involved in curriculum change. The participants shared a variety of responses related to curriculum revision. Several of the participants made reference in their narratives about the workload involved when undergoing curriculum change. Some described how consultants and/or retreats were utilized to facilitate processes and how this may or not have changed how the workload impacted the faculty or curriculum committee. Diane referred to her recent curriculum revision processes as a "major task." As Cora discussed their curriculum committee's plans to move forward with future curriculum revision, she stated that the revision is, "Going to be a lot of work and fortunately our dean is going to support this with we're hoping like a consultant type, outside expert that will help facilitate and kind of lead the charge."

Table 3

Participants' Answers to Research Questions

Participant(s)	Curriculum model	Nursing theory	Curriculum revision	Motivation for revision (if applicable)
Bea	Non-Traditional, Eclectic	Yes, Watson's theory of human caring (will not have nursing theory in new curriculum)	Current major curriculum revision	Need to update (last revision was approx. 10 years ago)
Candy & Cora	Medical model	No	No major curriculum revision, plan for near future. Recent rejection of concept-based learning curriculum	Decline NCLEX-RN pass rates
Katie & Jill	Traditional model	Yes, Watson's theory of human caring	Within last five years, new BSN curriculum revised shortly after implementation	More consistent with Baccalaureate Essentials
Nancy	Non-Traditional, Eclectic	Yes, Neuman's system model	Moderate curriculum revision four years to revise admission and program standards	Decline NCLEX-RN pass rates
Linda	Traditional	No	None, brand new BSN program	Not applicable
Rose	Non-Traditional, Eclectic or "Blended" [R]	No	Recent and current curriculum revision to change program learning outcomes and courses/content sequencing	Decline NCLEX-RN pass rate
Sandy	Traditional	Yes, King's nursing theory	No recent revision	Not applicable
Diane	Medical model	No	Recent revision to revise admissions and entry to program standards	Poor graduation rates

Note. BSN = Bachelor of Science in Nursing, NCLEX-RN = National Council Licensure Examination-Registered Nurse.

Since Bea is in the middle of a curriculum revision, she made several comments related to the added workload and even burden that a revision can place on faculty. Bea described how they used a variety of methods to try and reduce the workload involved in the curriculum revision by offering a daylong retreat and hiring a consultant to guide the faculty through the process. Despite these actions, Bea commented on the workload on the committee chair, “And then that became such a burden for the curriculum council chair and so we let that person take the summer break and not be involved.” Bea also stated:

But I also know when you’re in a meeting with faculty and/or directors or deans and you say, “I’m going through a curriculum revision” it’s like the worst thing ever and people are just like, “Oh, you poor thing” you know? It’s like there should be a support group for it, but it’s big, it’s really big, it’s overwhelming.

Nancy made reference to a major curriculum revision that occurred approximately a decade ago. As she reflected on that major revision, she recalled the workload involved and stated:

We revised our curriculum back in 2008 when I first came here. I came here as faculty, I’ve been for four years and so we were all very much involved in this big transition which, as you know, was always challenging because you still have students under the old curriculum so that took a lot of work.

Candy reflected on the recent unsuccessful attempt at curriculum revision and acknowledges the work that was involved with that endeavor. Candy also credits the work that was done during that unsuccessful attempt at curriculum change for bringing faculty closer to a shared understanding of the salient priorities for the BSN curriculum. She also spoke to the workload that may be involved with the future plans of revision. Candy stated, “Oh, absolutely, that’s been a lot of work and a lot of

information and I think that the positive in it all is that we did bring those new faculty along in understanding.”

Resistance to change. During analysis of the data, a sub-theme of resistance to change emerged as the participants discussed curriculum revision. Bea, whose BSN curriculum is currently undergoing revision, shared her perspective about whether there was (or is) resistance to the change. She stated:

I mean, in some respects that’s nothing we can do about it, a new curriculum is inevitable so people just had to deal with it. But I never actually talked to anybody that was resistant but I heard people tell me about people that were resistant. So, I did know that people were resistant but they’re pretty powerless to do anything about it because it’s happening whether any of us want it or not, it’s a done deal.

Diane touched on the fact that faculty can be a source of resistance when making changes to the curriculum. She shared her perspective:

And helping faculty, I mean, to embrace and adapt to change instead of complaining and not wanting to change because that sometimes gets to be a barrier or we want things to happen in curriculum but the faculty teaching the courses aren’t incorporated and so how do we maneuver getting that in.

Candy experienced resistance from the faculty when discussing curriculum revision on more than one occasion. She reflected on the tenure of the previous curriculum chair’s experience with faculty and stated:

I’ve been the chair of this committee since last fall and prior to that the chair was in place had tried, had attempted to get something going and could not get anything off the ground, if it was just to do a simple review of courses. It was resisted by new faculty who didn’t understand, “Don’t touch my course” you know, academic freedom, misunderstanding what academic freedom is and so I think he really struggled with that and really not much was done.

Candy shared a second example of faculty resistance to curriculum revision. Candy had spent significant time during her interview discussing an attempt to revise the current curriculum model to a concept-based one. Ultimately, the concept-based

curriculum was not adopted. The interviewer asked Candy to share who resisted the change and she responded, “Yes, it was all faculty. We had the support of leadership to make a change to a different framework if needed but it was the faculty that we had the resistance and needed to understand more.”

Linda mentioned faculty resistance as she reflected on her past experience developing and implementing a concept-based curriculum at her previous educational institution. She said, “So, it was pretty radical and it took quite a while to convince the faculty, which was a big faculty, that this was the goal.”

Concept-based learning. Participants were not asked a specific question about a concept-based learning curriculum. The topic of concept-based learning or curriculum surfaced in multiple interviews, guided by the participants. The participants shared their thoughts, experiences, or opinions about concept-based learning curricula. There was an overall interest in concept-based learning, although out of all of the participants interviewed, none were currently teaching in a concept-based BSN curriculum. This is a salient finding within the data because it may represent a feeling amongst nurse educators that there is a barrier or some resistance to moving toward the concept-based learning curriculum, despite the growing popularity of it in the literature.

Some participants shared how their curriculum may have concept-based influences or nuances, but none considered it to be a concept-based curriculum and they seemed satisfied with that mixture. For example, Bea described the BSN curriculum that her educational institution was revising towards and stated:

Yeah, I definitely would say it is not traditional, but I don't know what to call it. But see the whole thing of concept-based curriculum, concept-based education is not what we were going for and we don't want to totally go there

and get the textbook on it. There may be some flavor of that I think any time you teach nursing you're teaching in a conceptual way but it's not like the traditional like going all in on that.

As Rose described her "blended" BSN curriculum, she described how there are tenets of concept-based learning threaded throughout the curriculum. She pointed out that there is a fine line between concept-based and a content-laden curriculum. She was in favor of teaching in concepts and using just enough content to illustrate the concept. She also commented on the number and variety of concepts as she stated:

We really need to focus on health concepts more so than even using NCLEX categories for that matter as our major concepts and use different things to illustrate them as opposed to everybody coming up with this list of a 140 concepts to base on their curriculum on.

The faculty and curriculum committee at Cora and Candy's educational institution collectively decided against moving towards a comprehensive concept-based curriculum. Cora admitted that she, personally, is attracted to concept-based learning, "Because it's teaching concepts and not necessarily all of the content." She added that she still identifies faculty using concept-based learning approaches throughout the curriculum in teaching practices and as she stated, "which is okay."

The final two participants that commented on concept-based learning or curriculum shared quite differing opinions. Nancy reflected on how the BSN curriculum used to be designed may have been concept-based, but not named as such. Nancy's comments also reflected how she was not ready to consider a concept-based curriculum at this time. She stated:

We're waiting really to see if the concept-based curriculum has any validity because several schools have jumped on that in this area and their NCLEX pass rates went down so that's not good. And there's not sufficient research of high enough quality, like a high enough level of strength and a high enough quality for us, we don't feel that that has sufficient evidence-base to change practice yet for education. So, we're waiting and watching that to see where

that goes. We don't want to just to jump on the next bandwagon and say, "Oh, we're going to do this, we're going to that." That's a substantial issue for faculty, for students, the whole nine yards. So, we're just watching that to see what happens.

Linda's perspective was unique from any of the other participants because she had experience being an administrator at an educational institution where the BSN curriculum was concept-based. She was a part of the development and implementation before she moved away and took her current position. Linda reflected on her own beliefs about teaching conceptually and shared how she is in favor of teaching conceptually because it improves their decision-making and develops their judgment and reasoning skills. She stated: "So, that's one thing is how we teach it and how can we teach more conceptually because it makes more sense to students to teach that way. Teaching things in isolated silos is not the best way to help people learn."

She described how the faculty at her previous institution recognized that their traditional curriculum was "very siloed." She reported that they relied on expert guidance from Jean Giddens and a consultant during this revision. She said:

And so the more we learned about it, the more we became convinced that this could be a radical transformation for our program. And so that's what we did, we developed into concept based, competency driven curriculum. So, the entire undergraduate curriculum was revised, we got our concepts and used a lot of outside consultants and over the course. It took two years to develop it, to develop all new courses and develop the whole philosophy of it and the structure and all sorts of things.

She also discussed how the concept-based curriculum promoted a more active learning philosophy and greater student engagement in learning. During the interview, the interviewer asked Linda about the outcomes after the implementation of the concept-based curriculum. She responded that she had left prior to determining the NCLEX-RN pass rates after implementation. She went on to state:

So, typically what you see when you move from a traditional to a concept-based curriculum is a small drop in your NCLEX scores and I do think they experienced that. But what I do know is that I was there for the first year of when we implemented and it was a constant process of improvement. We did a lot of evaluations, we did a lot of getting students' feedback. We had implemented all new sorts of tools to use and so there was constant looking at the courses and the teaching what to do as we're thinking and feeling and all that sort of thing to help us process improve as we went.

The data from the participants on the topic of concept-based learning curriculum indicated that there may be some hesitancy to adopt a concept-based learning curriculum. This topic will be discussed in more detail in consideration of the current nursing education literature. As the participants discussed curriculum revision, the sub-themes of the workload involved, resistance to change, and the topic of concept-based learning curriculum emerged. These findings demonstrate how there are multiple barriers when working through curriculum revision and are important for nursing education administrators to consider in preparation of curriculum change.

Theme 6: Nursing Educational Standards Predominantly Guide and Influence the Bachelor of Science in Nursing Curriculum

Throughout the interview, the participants were provided with several opportunities to share what or who influences the BSN curriculum. One question asked the participants to describe what factors or issues currently, or in the near future, influence the curriculum for BSN programs. They were also asked about what in general informs their curriculum and what is essential to be incorporated in to the curriculum. Nearly all participants commented that nursing educational standards such as accreditation requirements, quality and safety education for nurses (QSEN), and the National Council of State Boards of Nursing NCLEX-RN blueprint heavily guide and

influence the BSN curriculum. This finding in the data is significant to nursing education and the BSN curriculum because it demonstrates a shift in how nurse educators view the direction of the BSN curriculum. Bea's statement is powerful in that it illustrated how some nurse educators view the BSN curriculum and how there may be a strong movement towards an outcomes-based BSN curriculum. It also showed a greater influence by outside, external forces: nursing educational standards.

Bea stated:

I mean, personally, I think like the QSEN framework is more applicable than a specific nursing theory for curriculum. I'm a very strong QSEN supporter and for example, if I had to pick something that I would want in my curriculum to go after, I'd say QSEN. Because I think that picks out the critical issues.

Each of the participants was asked to share their perspective on what influences on the BSN curriculum. Bea stated:

Well, of course, AACN [American Association of Colleges of Nursing] essentials are key and then in [state removed for privacy] we have the DECS, Disseminated Educational Competencies. And then NCLEX plan. But the other thing that we really wanted to emphasize was the QSEN competencies.

Cora described a variety of influences on the BSN curriculum at her educational institution. She credited the whole college, including ancillary staff, for their engagement with preparing students for NCLEX-RN. For example, she discussed information technology's role in ensuring there is computerized testing to better prepare students for the NCLEX-RN in the curriculum. Although she mentioned these organizations or accrediting bodies on more than one occasion, she stated:

We are tied with the AACN [American Association of Colleges of Nursing] Essentials, which I keep waiting for the new ones to come out, they're old, like 2008, so, we're aligned with The Essentials, we're aligned with QSEN, we're aligned with HLC [Higher Learning Commission], and then we're making sure we align with the IPE [interprofessional education] competencies and the IOM [Institute of Medicine]. And a lot of these are overlapping as well.

When Candy was asked about what influences the BSN curriculum, she discussed accreditation, simulation, and NCLEX-RN standards and guidelines. She went on to discuss:

Looking at The Essentials for one, QSEN is another; I'm very involved with QSEN as well. Obviously, most of those align anyway. But, of course, current standards for each area, the curriculum itself as a curriculum framework, I think with each course it would be more appropriate for those. Interprofessional competencies are real important.

Nancy discussed several BSN influences as she described her administrative role in the nursing program. In this description she shared how the state board of nursing, NCLEX-RN, and interprofessional education all influence the BSN curriculum, in particular at her educational institution. She also stated:

We do our evaluation based on our accrediting body Essentials, so, we look at everything we need for our accrediting body, things for state board, QSEN, and then they will provide reports to me. I'm also responsible for involvement in the reports to the state board and the accrediting bodies. Anything where we're not meeting a standard that we've set, my role then is to bring that to the attention of the faculty during the department meeting and we work on "Okay, what is it that we need to do in order to bring us up to meeting a standard?"

Jill made a significant statement regarding the influence of nursing organizations on the BSN curriculum, "I think those leading nursing organizations really have a lot of power when it comes to curriculum and how education is implemented." She also discussed how they utilize the NCLEX-RN blueprint to align with curriculum content and then she also commented:

We just completed a CCNE [Commission on Collegiate Nursing Education] report and the BRN's [Board of Registered Nursing] visiting next year I believe in the spring. So, we've got a lot of things coming up and we've done a lot great work to capture where we're at and look at data but we've got a lot more to do.

She mentioned one particular resource on multiple occasions, the Boston, Massachusetts', collaboration, one example is when she said:

Boston, Massachusetts, has a knowledge skills and attitude model that is incorporated QSEN and IOM and some of the major leading nursing organization guidelines for baccalaureate education. So, we've recently asked the faculty to consider incorporating those as the core values in essence of the school so that's kind of a newer curriculum change but it is an established model used by Boston, Mass.

Linda provided a variety of influences on the BSN curriculum. She started by saying, "Well, I'd say our curriculum is built on the baccalaureate essentials. It includes the QSEN knowledge, skills, and attitudes." She made this statement as she is describing her administrative role in the nursing program:

My role encompasses everything and so ultimately I'm responsible for the curriculum and to make sure that it conforms to accreditation standards, is the best it can be, that it's continuously improved and then that's delivered the way that it was intended.

Linda went on to discuss national movements or documents that promote population health, such as Health People 2020. She mentioned several times how the NCLEX-RN blueprint and testing inform the BSN curriculum, including salient concepts and content for the BSN curriculum. She also stated:

I think one of the things that is facing us is how do we use other teaching/ learning strategies like simulation effectively so that we can continue to produce nurses that are going to be able to pass the NCLEX practice in order to meet the healthcare needs of the future.

Diane, Rose, and Sandy also commented on the greatest influences on the BSN curriculum. They all mention the NCLEX-RN test plan as Diane said:

Oh, that's another area that informs our curriculum, the studies that are done by the NCLEX and the workforce surveys that they do and the documents that the National Council of Boards in Nursing produces so that we can make sure that we are including those things in our curriculum.

Rose stated, "QSEN, we looked at competencies from the ANA [American Nursing Association], we looked at the baccalaureate essentials, and then most of us have had a very robust clinical practice." Sandy mentioned the NCLEX-RN

requirements, test plan, and pass rates on multiple occasions during her interview.

Sandy stated:

Probably the best example of the curriculum is really getting these students through NCLEX, of course, is priority but then having them clinically ready to step into these hospitals and I've got a great program, a 100% pass rate on NCLEX.

The participants spoke about how these outside, external forces influence their BSN curriculum in a variety of contexts. The fact that so many participants echoed a similar message about the influences on the BSN curriculum speaks to the depth of the involvement in external organizations, both nursing and in healthcare. These findings were not unexpected and it does warrant further discussion in relationship to the future of the BSN curriculum. This discussion will be continued in Chapter V as it relates to implications for nursing education.

Theme 7: Nursing Theory

It was important for the researcher to investigate the participants' perspective on nursing theory in the BSN curriculum. The participants also shared whether their BSN curriculum was based on a single nursing theory (see Table 3). Together, this data provides valuable insight into nurse educators' opinions and possible implications for nursing theory within nursing education. Two overall sub-themes emerged on the topic of nursing theory within the BSN curriculum: movement away from a single-theory BSN curriculum and ambivalence about the relevance of nursing theory.

Movement away from a single-theory Bachelor of Science in Nursing curriculum. Many participants acknowledged the limitations that using a single-theory guided BSN curriculum may have on the curriculum. For example, Linda stated, "I'm not a big fan of trying to fit a program into a specific theory. I think that's

limiting.” Sandy pondered whether the single nursing theory guided curriculum framework outdates the BSN curriculum. She stated:

Well, I think we have to have theory for evidence-based practice and that we should base our curriculum decisions on theory. But I think sometimes we get so bogged down in trying to force a curriculum model into the theory that we may be creating an outdated curriculum. A curriculum has got to be something that is fluid and moving because it does change. Maybe your time model doesn't but the contents do, they shift and move.

Diane's reflection on nursing theory acknowledged her favor towards nursing theory because of the benefit nursing theory brings as an organizing framework of a curriculum and the historical value of nursing theory. However, she also acknowledged the limitations and the potential to be outdated if a curriculum is based on one nursing theory as she stated:

But to base a curriculum on one person's particular theory because it can be limiting for the students but I think that they need to know that there are nursing theories and I guess I'm more a proponent of middle range theories because they are more practice oriented.

Katie offered a similar message as others as she is beginning to question the use of a single-guided nursing theoretical framework for the BSN curriculum as she stated, “I think it's interesting that schools in nursing, pick one particular theorist, I'm finding that odder as I've gotten just a little bit older and am looking at that.”

Jill discussed the importance of having baseline knowledge of nursing theory, emphasizes the limitations that only using a single theory may have on a BSN curriculum and offers that perhaps exposure to multiple nursing theories is more consistent with nursing's holistic nature. Jill's comments included:

I also think nursing is holistic and see that research is integrated with the various disciplines so I don't know if one theorist can ever truly capture what a curriculum is for this holistic profession. So, I also see a challenge being figuring out how to look at different theorists and different models and how they can be integrated so that it doesn't appear exclusive or inclusive in nature.

Ambivalence about the relevance of nursing theory. Rose's perspective on nursing theory in the BSN curriculum included, "I have very mixed feelings about it or thoughts on it." There was a mixture of participants who acknowledged the benefits (actual or potential) of teaching or basing nursing theory in the BSN curriculum and the downfalls of nursing theory. Both will be discussed in this sub-theme of ambivalence about the relevance of nursing theory in the BSN curriculum.

Cora preferred to have a guiding theoretical framework for the BSN curriculum because of the organizational benefits. She shared that presently her nursing curriculum does not have a guiding nursing theory, although she has asked whether it should because, "When I started teaching here at this college there was a theoretical framework but that's kind of just drifted away." She then went on to state,

It's not like you have to have a theoretical framework but as long as everything is sort of threaded throughout the curriculum even like these competencies, talking about The Essentials, the QSEN, the IOM, the IPE [interprofessional education], and a lot of those do overlap. Safety, obviously, that's important to prepare a nurse that is going to be safe in practice.

Even as Katie questions the use of a single theory; she continued to voice the importance of theory, both nursing and not, in the foundation of learning in nursing education, she said, "I think that theory absolutely helps us ground our thinking and how we think and provides an approach to thinking and I think that our behaviors after the fact we could ground them in theory as well." She made a suggestion about how to work around the possibly limiting aspect of using only nursing theory by, "Maybe allow them [nursing students] to choose how they want to frame that because if they could take more ownership in that it might accelerate their learning." She went on to state:

Different theorists speak to different people because we all learn just a little bit differently so I got to pick the theorist that worked with me with where I was developmentally in my nursing knowledge might have more meaning versus making me work through the lens of the one that you've determined. But you'd have to really frontload that to make that work.

Rose discussed the organizational benefits to using a nursing theory to guide a BSN curriculum. She also acknowledged that not all of the nursing theorists were as grounded as the one she experienced as a student. This notion led her to highlight one of the issues with the integration of nursing theory, which is how not all nursing theorists' language is easily applied to knowledge or practice, "Nursing theorists make it very difficult, some things that are very, very easy to understand." She summarized her thoughts on nursing theory by stating:

And all of that because nursing theory means to me my knowledge base, means my preparation whereas nursing theorists means this is a person who has an idea of what a professional nurse looks like and what they do and they've tried to explain it and all that you can really say is that nursing is an art and a science that helps people in their time of illness and to prevent times of illness, it helps stuff with their healthcare.

Linda commented on the generation of nursing knowledge as another benefit to nursing theory in nursing when she said, "I also think all of that research is theory development, is an important aspect for baccalaureate students to understand, that part of their role, is the generation of new knowledge." Linda held the opinion that some of the classic theories were still applicable to practice, such as Jean Watson's theory of human caring. However, more so, she values nursing theories that are emerging and even those that are more closely connected with practice.

Those kinds of emerging theories I think are something nursing programs have to stay on top of and I don't have a good way to do that at the moment other than reading, reading, reading and going to conferences. So, I think helping students understand the relationship between theory and practice and research is essential.

A salient comment made by Diane was in regard to the trends of how popular it used to be to use a single nursing theory as a framework for the nursing curriculum and now how far away nursing has come from that trend. She stated: “I think it’s like a lot of things, the pendulum swings and I think we’ve gone too far to be a-theoretical but if we can teach students about theories and let them find one that works for them would be useful, that has its roots in nursing.”

The ambivalence identified based on this qualitative data on nursing theory, coupled with the findings related to the overly influential external forces may have on the BSN curriculum indicates that these participants may not have proper guidance on how to move forward with the use of nursing theory in and throughout the curriculum. These findings will be discussed further in comparison with current literature and in consideration of future implications for research in nursing education.

Summary

Chapter IV presented a narrative with the findings from this qualitative research study. The findings of the study revealed a current gestalt of the BSN curriculum that included influences, motivations, and challenges. The participants indicated that external forces such as essential education standards and nursing organizations heavily influence the BSN curriculum. The ever-changing healthcare environment and the desire to prepare nursing graduates for practice (including the NCLEX-RN) motivate these nurse educators and administrators to conduct curricular change. The participants identified more than one challenge to the BSN curriculum including clinical placements and a shift in student’s characteristics. Lastly, participants shared ambivalence regarding the use of nursing theory in the BSN curriculum. The findings from this study will be discussed further in connection with

the current literature and the implications for future practice and research in nursing education.

CHAPTER V
DISCUSSION AND IMPLICATIONS

Introduction

The aim of this research study was to better understand Bachelor of Science in Nursing (BSN) curricula from the faculty curriculum leader and administrative program director perspectives, the greatest influences and/or motivators for curriculum revision in their program, and where or how nursing theory guides BSN curricula. This chapter will review and discuss how the findings of this research study may be applied to nursing and nursing education in consideration of the aim and research questions of this study:

- Q1 What experiences do curricular and/or administrative leaders have about the needs for educating nurses for the future?

- Q2 What perspectives do Bachelor of Science in Nursing faculty curriculum leaders and/or administrative program directors have regarding the importance of nursing theory and its incorporation in their respective curriculum?

- Q3 What is the current gestalt of developing or revising nursing curriculum in Bachelor of Science in Nursing programs?

It is important to highlight some limitations of the research prior to applying the results to the literature, nursing education, and research. The first limitation is the potential for lack of generalizability due to a small sample size. This sample size was appropriate for the research method utilized, but still may make it difficult to generalize to all nurse educators. The researcher recruited participants from across the

country. However, due to the small sample, there may still be a limitation in the transferability of findings amongst all regions in the country.

In consideration of the demographics, the participants in this research study were all Caucasian and female nurse educators and/or administrators. This homogenous demographic may limit the findings from this research study's ability to reach saturation because it lacked diversity. For future research, the researcher could attempt to recruit participants in person at a nurse educator conference with a goal to achieve demographic diversity. This was not a feasible recruitment tool for this research because the researcher was recruiting remotely.

Another limitation of this research may be the researchers own biases. The researcher first addressed this by conducting an explication of her biases. Then, the researcher used her research advisor as a peer debrief and a self-reflective journal to remain aware of biases during data collection and interpretation of the data.

The application of the findings to nursing and nursing education will be discussed and organized into three sections: findings related to the literature, implications for nursing education, and recommendations for future research.

Discussion of Findings Related to the Literature

The findings from this qualitative research study are applied to the current literature in nursing education. In some ways, the findings are consistent with the literature and other ways they contradict. This narrative illustrates how the findings are applied to the literature that will include salient aspects of the reported themes from this qualitative research study.

Changes to Healthcare Environment

The ever-evolving healthcare environment's impact on the BSN curriculum was initially listed as a primary reason to conduct this research study. According to Benner et al. (2010), nurse educators are tasked with preparing new nurse graduates for the complex workplace using new and innovative methods. The American Association of Colleges of Nursing (AACN) (2008) also acknowledged the complex healthcare environment in their competency statements. The narratives from the participants of this study provided insight into specific challenges and priorities associated with the ever-changing healthcare environment.

Critical thinking, clinical judgment, and effective decision-making. There were multiple ways that the participants' comments touched on the practice–education gap. This was a major piece to the results discussion and was reported in the first theme. The participants expressed an acute awareness of the need to ensure critical thinking, clinical judgment, and effective decision-making are outcomes for new nurse graduates in order to meet the demands of the nursing workforce. They verbalized the importance in new graduate Registered Nurses (RNs) who are able to learn in new and innovative ways, ready to think and communicate effectively in complex situations. Seven of the participants commented on how critical thinking, clinical judgment, and/or effective decision-making are priority outcomes for graduate RNs as they enter the clinical workforce. There was a desire by the participants for new graduate RNs to be prepared beyond the minimum competency, which is typically known as the National Council Licensure Examination (NCLEX)-RN.

Three of the participants spoke about the upcoming changes to the NCLEX-RN. They acknowledged these changes, as they will change the minimum standard competency for entry into practice for nurses. Many recognized that they do not know yet what these changes entail, but they did express that the changes will likely include an emphasis on critical thinking, clinical judgment, and/or decision-making. There was a tone, amongst the participants who spoke of the changes to the NCLEX-RN, of uncertainty as they discussed the next generation NCLEX.

In the review of the literature prior to the study, the researcher identified that critical thinking was a component of curriculum outcomes to prepare practice-ready graduates (Mailloux, 2011). In years prior there was some confusion in which terms critical thinking or clinical judgment to use when evaluating students (Cazzell & Anderson, 2016). However, there is a general consensus in the literature and with nursing experts, such as Patricia Benner and Kathie Lasater, that clinical judgment is the preferred nursing student outcome (Cazzell & Anderson, 2016). Based on the variety of terms shared by the participants, nurse educators continue to consider multiple terms such as critical thinking, clinical judgment, and decision making as important BSN curricular outcomes.

Brenton (2018) outlined how the next generation NCLEX is based on a clinical judgment model because, “assessing clinical judgment is a critical component of the overall goal of NCLEX ascertaining minimum competency” (p. 6). The information about the new NCLEX-RN texting format was released to nurse educators in the summer and fall of 2018, which was the same timeframe as the data collection of this research study. There is little in the literature on the topic because it is a newly introduced idea in nursing education. The new format questions are estimated to be

implemented in the NCLEX-RN a few more years from now. Therefore, research and literature on the implementation of the new format will be forthcoming.

The participants' priorities for critical thinking, clinical judgment, and effective decision-making were aligned with the current literature and trends in nursing education. The participants who mentioned the new format of the NCLEX-RN demonstrated an understanding of the priorities within nursing education on the topic of changes in minimum competency for new graduate RNs. There was little to no literature on the topic of the Next Generation NCLEX prior to this research study, which indicates that this has been a rapidly approaching change in nursing education. This is a positive step for nursing because there is awareness of the need to close the practice-education gap and the actions of the National Council of State Boards of Nursing by encouraging development of thinking, clinical judgment, and decision-making in new graduate RNs. The participants of this research study summarized this best by describing how the new graduate RNs must be prepared to enter complex situations and think, act, and communicate effectively in the ever-changing healthcare environment.

However, this major change to the NCLEX-RN also presents multiple challenges to nurse educators as they prepare their student nurses for this new minimum competency for entry into practice. The first challenge will be preparing student nurses for formatting changes on the exam that will include more case study questions and more alternative type of questions (Brenton, 2018). Another challenge will be in the integration of the clinical judgment model into the nursing programs since the Next Generation NCLEX is based on steps of the clinical judgment model (National Council of State Boards of Nursing, 2019). Lastly, there is uncertainty for

many nurse educators since the National Council of State Boards of Nursing is still currently conducting research, and there remain many lingering questions about how the Next Generation NCLEX format will look (National Council of State Boards of Nursing, 2019).

Shift in healthcare trends. Four participants spoke about the trend in healthcare where there is transition of care from acute care to primary care areas. They were in favor of an additional focus on community and primary care settings, both in nursing practice and in BSN clinical education. Their comments indicate that there is a need for nursing education to also change how nursing students are trained in the BSN curriculum for the primary care settings in the workforce, since presently the focus is on the acute care settings.

During the interview, Cora mentioned the Josiah Macy report as a source for inspiration for transitioning the clinical settings from acute to primary care. The participants who spoke about this trend also spoke about the challenges in transitioning clinical learning opportunities to the primary care setting. For instance, Cora discussed how some students are less enthusiastic to have a clinical in a primary care setting instead of the acute care setting. Other participants shared how securing consistent primary care opportunities in the clinical environment are another challenge in moving to that type of care setting.

The participants also acknowledged the shift in healthcare from illness to prevention and health maintenance. Linda and Diane's comments indicated that they feel there should be a priority in nursing education to prepare graduate RNs for this shift. In fact, Diane called for a complete reconceptualization of the way nurses view patient care with a greater emphasis on a more holistic and health-focused paradigm.

The findings from this research study are consistent with recent national organization priorities and current literature on the topic trends in healthcare. Doenges (2014) highlighted the recent shifts in healthcare and states, “Nurses can and should play a fundamental role in this transformation of the healthcare system” (p. 1). Additionally, this chapter goes on to describe the nurses’ role within a healthcare environment that is more primary care driven. This supports the participants’ narratives regarding the recent changes in healthcare.

As mentioned previously, the Josiah Macy report outlined priorities within healthcare and nursing, which included the need to prepare for the changing environment and highlights how nurses can better function in the primary care settings (Josiah Macy Foundation, 2016). This report signified that the shifting environment is a priority within nursing practice. In order to stay current with nursing practice trends, nursing education should also follow suit and adapt clinical education to include the primary care settings, as well as a focus on health promotion.

The ideal situation is if student nurses can engage in the primary care settings, such as “preventative care, chronic illness management, practice operations, care management, and transition care” (Flinter, Hsu, Cromp, Ladden, & Wagner, 2017, p. 287). If there are not primary care settings available that can engage students in complex health situations, nurse educators may be able to simulate primary care experiences where the student nurse manages the complex needs of a patient as they transition from points of care. Observation in the primary care settings may not be sufficient; student nurses will need engagement in these settings because, as the Josiah Macy report outlines, the goal for nursing is to significantly advance nurses and expand their scope of practice (Josiah Macy Foundation, 2016). If neither simulation

nor experience in primary care clinical settings is available to a nursing program, another suggestion is to develop a teaching strategy that introduces student nurses to Learning from Effective Ambulatory Practices in the context of a complex case study (Flinter et al., 2017).

Clinical Education

In addition to the clinical education challenges previously discussed from Theme 1 on the topic of the changes in the healthcare environment (shifting from acute to primary care and a focus from illness to a health promotion), there were additional clinical education concerns outlined in the theme: clinical placements impact nursing curriculum. The participants spoke of the challenges in securing clinical placements, availability of nursing preceptors in the clinical settings, and the use of simulation to augment the challenges in typical clinical education within the curriculum.

The participants reported difficulty in securing clinical placements due to competition with other schools of nursing. Participants also discussed how there are times when students oversaturate a clinical environment, even burning out the preceptors, which then in turn impacts the clinical environment's availability to accommodate nursing students. Some touched on the topic of the retention of experienced nurses in the clinical environment impacts their availability to serve as preceptors to nursing students for clinical education.

The participants reported challenges in clinical education as being a primary reason to augment clinical education with simulation experiences. There was much discussion amongst the participants during the interviews about simulation, in general. The general consensus was that simulation could not fully replace clinical education,

but certainly is an important tool to use to fill the gaps left by the clinical environment. They reported that simulation offers more consistent experiences for the students, which is not something that is easily afforded in the typical clinical environment. Lastly, participants used nursing organizations and state boards of nursing recommendations as guidance for how much simulation should be used to augment clinical education.

During the initial review of the literature on the BSN curriculum, there was little discussion on how the clinical aspect of nursing education plays a role in the BSN curriculum and was, therefore, not included in the literature review. However, the findings from this research study indicated that clinical education is a high priority in the BSN curriculum to the nurse educators in this study. Therefore, the challenges of clinical education are also challenges and issues for BSN curriculum.

The nursing shortage in the nursing literature (Benner et al., 2010) may explain why some participants are experiencing difficulty identifying qualified preceptors in the clinical settings. Lippincott Nursing Education's blog recently connected the lack of clinical sites, the nursing shortage in the workforce, and the increased enrollment to meet workforce demands as factors impacting clinical education in the BSN curriculum (Lippincott Nursing Education, 2017). The blog also reported that simulation is a reasonable alternative clinical experience for nursing students for no more than approximately half of the clinical time (Lippincott Nursing Education, 2017). This literature is consistent with the narratives from the participants in this study.

Similar to what the participants reported regarding the use of simulation to augment clinical learning, Persico (2018) listed clinical placement limitations and

faculty shortages as motivations to incorporate simulation into BSN clinical education. According to Persico's review on simulation-based education, the literature supports replacing some clinical time with simulation but also calls for more rigorous research on the topic. Additionally, this review recommends that implementation of simulation into a curriculum requires adequate infrastructure such as dedicated and trained staff and faculty to oversee simulation education (Persico, 2018).

The challenges in clinical education within the BSN curriculum and the general comments made by the participants are consistent with the literature that is available on the topic. The general tone of the participants as they discussed this topic was frustration related to the availability of clinical placements. However, most seemed satisfied with simulation as a tool to augment clinical education with proper guidance on how much simulation replacement is appropriate within the BSN curriculum.

Increased Student Enrollment and Faculty Shortage

The theme, faculty influences on nursing curriculum and the theme, students characteristics that influence nursing curriculum, will be discussed together because they are quite blended when considering how the issues of one can impact the other and vice versa. Some of the participants reported an increase in enrollment of students and touched on the challenges this can present for nursing education administration and faculty. For example, Sandy remarked on how the nursing shortage demand has increased enrollment at her educational institution and it places a strain on resources. She did not elaborate specifically which resources are strained, however. According to other participants, one such resource may be the availability of qualified faculty to

implement the curriculum and preceptors in the clinical environment when there is an increase in student volume.

Cora referred to this as a “catch 22” perhaps because increasing student enrollment may assist in meeting nursing shortage needs in the nursing workplaces, but it may be exacerbating the faculty shortage situation within nursing education. The shortage of available and qualified faculty came up frequently in the interviews, even though the interviewer did not specifically ask a question on this particular topic. Of those who commented, not all attributed the faculty shortage back to the nursing shortage. Both Linda and Nancy alluded to the notion that the faculty shortage may be partially due to the poor benefits and salaries for faculty or those in academia.

However, based on the data from this research, the lack of available and experienced faculty has created an additional strain on educational institutions and existing faculty. For instance, Cora and Rose discussed the hardship of mentoring and on-boarding new faculty. Multiple participants commented on how inexperienced faculty often struggle to understand their role within the curriculum, especially when it comes to teaching salient content that aligns with curricular and program outcomes. The lack of understanding in the nursing was troublesome to the participants, especially as Cora shared the important mutual understanding amongst several of the participants that the nursing curriculum is owned and guided by the nursing faculty.

The literature is consistent with the findings from this qualitative research study. Gillette’s (2018) report on the current state of the union in nursing, reported that the “growth in nursing school enrollment is 3.6%” (para. 6) may be impacting classroom space, availability of instructors, access to clinical sites, and preceptors. This recent information, paired with the Institute of Medicine’s (IOM) (2010) call for

more bachelor-prepared RNs by the year 2020, coincides with the participants' reports that needs from the nursing workforce may be influencing enrollment in nursing schools, as well as the resources within the educational institutions.

In the initial review of the literature prior to this research study, the researcher identified faculty as having an important role within the BSN curriculum. For instance, the researcher acknowledged the Patterson et al. (2016) assertion that nursing faculty has ownership over their BSN curriculum. In this way, the literature and general consensus in nursing education is consistent with the findings in this research study.

At the time of the initial literature review for this study, articles specific and focused on nursing faculty's specific role within the BSN curriculum in the nursing education literature were sparse. Faculty's role within the BSN curriculum was, in many ways, embedded into the discussions on curriculum revision, development, and evaluation throughout the literature review. An example is the Patterson et al. (2016) description of a tool for faculty to use as they assess a concept-based curriculum. Simultaneously, the authors highlight faculty's role within the BSN curriculum.

Based on the finding from this qualitative research study, there is a gap in the literature that focuses on faculty's specific and important role within the BSN curriculum as a whole and not only during segmented processes of curriculum development, revision, and evaluation. The participants of this study identified that there is a lack of understanding of faculty's role in the BSN curriculum, specifically as it relates to how teaching practices and content flow into the overall curriculum organization and plan. The researcher's specific implications based on these findings will be discussed in the implications for nursing education section of this chapter.

Students with Disabilities

When the participants were asked about issues within the nursing curriculum, five identified student characteristics as being a concern in their BSN curriculum. The topic of students with disabilities was a salient sub-theme to Theme 4: students' characteristics that influence nursing curriculum in the findings. It was salient because some of the participants had concerns about how students with disabilities, especially those with accommodations in the classroom, would be able to meet competencies in clinical practice.

Rose and Nancy both spoke specifically about disabilities as they relate to clinical education within the BSN curriculum. Both commented on how if a student with a disability is permitted extra time to take exams in the classroom, they may not be permitted extra time in clinical settings. Reasonable accommodations in the classroom may not be reasonable in the clinical setting. Both Nancy and Rose's comments highlight how nursing is different than other disciplines in academia because it is not just the student and the educator. Rose pointed out that there is the third component to learning in nursing education, which is the patient. These types of limitations are in place because they may have an impact on patient safety. The participants brought forth these concerns in nursing education and related them back to their BSN curriculum.

The participants' discussion on the topic of students with disabilities is timely with the current literature. The actual concerns brought forth by the participants regarding nursing education's unique dilemmas in accommodating students with disabilities are not consistent with the literature. This appears to illuminate a gap in the

literature. However, the general topic of diversity has been a recent source of discussion in nursing education on multiple fronts.

The National League for Nursing (NLN) (2016) has been a leader and proponent for increasing diversity and inclusion in the nursing education. The NLN (2016) outlined how there remains persistent discrimination within nursing against and disregard for those with disabilities despite changes in legislation. There are multiple ways in which students with disabilities may be discussed in the literature. Some have examined nursing students' attitudes towards other nursing students with disabilities (Shpigelman, Zlotnick, & Brand, 2016), the exploration of the different types of disabilities, (i.e., physical limitations, mental illness, learning disabilities), cultural diversity, (i.e., first time college student, English as the second language), the outcomes of nursing students with disabilities to complete a BSN program, and faculty perceptions of students with disabilities.

In a discussion on persons with disabilities in nursing, Davidson et al. (2016) outlined the current laws and professional guidelines set forth to reduce discrimination in nursing students with disabilities. For instance, the authors highlight the legal responsibility of schools of nursing to provide reasonable accommodations for students with disabilities, with an emphasis and definition of the term reasonable. Davidson et al. (2016) claimed that there has been dialogue on the topic for many years and still there remains barriers and lack of visualized practical progress noted.

Shpigelman et al. (2016) found that nursing students had negative feelings toward their nursing student peers who had disabilities, mostly physical and mobility disabilities. Ashcroft et al. (2008) reviewed and discussed nursing students with disabilities from the faculty perspective. The authors acknowledged the challenges of

making accommodations in the clinical setting and encouraged nurse educators to focus on the outcome and not always the specific task to achieve an outcome. Primarily, the authors' strategies for working with nursing students with disabilities are centered on collaboration and setting clear and mutual understandings of the outcomes for the course, clinical, and/or program (Ashcroft et al., 2008). The downfalls to this particular article are that it was not research and it is currently over a decade old.

Based on the findings from this research study, there may be some persistent lack of clarity for nurse educators and administrators in how to adequately accommodate nursing students with disabilities. It is important for nursing students with disabilities to have an academically level playing field, but it is also paramount in nursing to maintain patient safety at the bedside during clinical education. There is more to be said on the topic of nursing students with disabilities.

The findings from this research should spark further discussions and research to investigate practical solutions and more clear guidance from nursing education leadership to answer their questions and address the valid concerns raised by the participants. It is important to share that the comments made by and the tone of participants on the topic of students with disabilities was not discriminatory. Instead, there was a strong sense of advocacy for patients who may be cared for by students with disabilities.

Concept-Based Learning and Curriculum

As discussed within the theme, curriculum revision, the researcher identified a salient sub-theme on the topic of concept-based learning and curriculum. As discussed

in the results section of this research study, the participants were not directly asked a question about concept-based learning and yet it still emerged into the conversations. During the study there were no participants who presently use a concept-based learning in their BSN curriculum. Some of the participants reported an interest in or an attraction to concept-based learning. Some participants described how they use small aspects of concept-based learning teaching strategies in their curriculum without a full adoption of a concept-based learning curriculum. One participant specifically rejected the concept-based curriculum design because she was not convinced there was sufficient literature and research to move forward with adoption.

In general, the participants listed potential pros and cons of the adoption of a concept-based learning curriculum. For example, Cora discussed the potential benefit of concept-based learning as a response to an over-crowded curriculum. Linda was in favor of a concept-based learning curriculum to improve decision-making and development of judgment and reasoning skills. Both Nancy and Linda acknowledged that there may be an initial drop in NCLEX-RN scores and may be one deterrent to adopting concept-based learning. Nancy spoke about the lack of research and evidence to support this change.

In the literature review prior to the conducting the qualitative research, the researcher identified concept-based learning as a popular movement in nursing education. Concept-based learning curriculum has been recognized as a potential solution to many of the BSN curricula issues, such as content saturation in the curriculum and the need for fostering critical thinking (Giddens et al., 2008). The literature review on nursing curriculum revealed several examples of the integration of

concept-based learning to into nursing curricula (Giddens et al., 2008; Giddens & Morton, 2010; Herinckx et al., 2014; Landen et al., 2017; Patterson et al., 2016).

In the literature, there are few examples of integrated concept-based learning curriculum listed with primary research to evaluate student outcomes following implementation of a concept-based curriculum. For example, Patterson et al. (2016) was an evaluation of a tool that is used to organize concepts within the curriculum. Although the authors did mention some outcomes related to implementation, no research methods were utilized. Other evaluations of the concept-based learning curricula are on an individual case evaluation (Giddens & Morton, 2010).

Participants suggested that there may be some resistance or fear of change towards the concept-based learning curriculum. Candy's description of faculty voting to reject a concept-based curriculum is an example of resistance to change. Bea also mentioned how faculty at her educational institution intentionally did not want to go towards a concept-based learning curriculum, but rather use certain aspects in their newly revised non-traditional curriculum model.

In consideration of a model for change, these nurse educators are still in a stage of unfreezing (Connelly, 2016). None of the participants were in a stage of active transition towards a totally concept-based learning curriculum based on their narratives during the interviews. This may be an important implication for nursing education and research to explore if and why nurse educators are in this state of unfreezing in consideration of the adoption of a concept-based curriculum.

There are nurse educators who support the concept-based curriculum, just as the participant Linda voiced during her interview. There are documented benefits in the literature, although according to Nancy, what is reported is not sufficient evidence

to support the drastic change that comes with revising to a concept-based curriculum. Seldom does a nurse educator attend a nursing education conference and not see the topic of concept-based learning and/or curriculum on the conference offerings. In consideration of all of these caveats, this research study indicates that a totally concept-based curriculum is not the preference amongst nurse educators and/or administrators, but tenets of concept-based teaching strategies are permissible. There are implications for nursing education from these findings and will be discussed in the recommendations for research.

Essential Educational Standards and Nursing Theory

The participants' responses on the essential educational standards and nursing theory in the nursing curriculum were represented in two themes in the results of this research study. These two themes will be discussed together because of the important relationship with one another and the potential for implications for nursing education based on this relationship. As the researcher reported in the results section, the participants highlighted a significant shift in nursing education and the BSN curriculum. This shift has to do with the moving away from nursing theory guided curricula and the heightened focus on the essential educational standards as the framework and foundation of the BSN curriculum.

Nearly all the participants reported that the greatest influence on the BSN curriculum today related back to essential educational standards. It is considered best practice in nursing education to include these standards, such as NCLEX-RN blueprint, accreditation standards, and quality and safety education in nursing (QSEN) in the content within the BSN curriculum. The data from this research study indicate

that is a shift in these standards instead of nursing theory, as the framework of the BSN curriculum.

The participants exhibited ambivalence towards nursing theory in the BSN curriculum. For instance, the general consensus was that the use of a single nursing theory guided nursing curriculum was “limiting,” as one participant, Linda stated. Multiple participants did not support the use of a single nursing theory to guide a BSN curriculum. However, many expressed the benefit of using nursing theory but were unsure how to effectively utilize nursing theory either within the BSN curriculum content or in the curricular framework. Some thought that perhaps the inclusion of multiple theories or the ability to offer a choice of nursing theory might be one solution.

This research study’s findings on the topic of essential educational standards being used to guide curricula are consistent with the available literature. Similar to responses from the participants, Berbiglia (2011) suggested that nursing programs are heavily using essential education standards as a framework for their BSN curriculum. The concern lies in whether the essential education standards have overtaken the use of a nursing theory or any theoretic foundation as a curriculum framework. It is also important to consider Yancey’s (2015) message that often the essential educational standards lack theoretical, especially nursing theory, underpinnings. The lack of a theoretical foundation unique to nursing threatens the profession’s ability to generate new and unique knowledge (Yancey, 2015).

The participants’ perceptions about nursing theories as a guiding BSN curriculum framework are consistent with the nursing literature. The comments that were made by the participants about using nursing theory within the curriculum and

the literature both concur that a single nursing theory is no longer an appropriate guiding framework for the BSN curriculum of today (Karnick, 2013). Even older literature identified the drawbacks in using a single-guided nursing theoretical conceptual framework for the BSN curriculum, so this is not a new concept in nursing education (Bevis, 1989). However, there appears to be some continued confusion amongst the participants in this study and the literature on where nursing theory fits within the BSN curriculum.

The findings of this research study confirms that there may be merit in the fear that nursing theory is being removed from the BSN curriculum and replaced with essential educational standards that lack a nursing theoretical foundation. Again, the loss of nursing theory in the nursing curriculum as a framework and in curricular content has potential ramifications for the profession's generation of new and unique nursing knowledge. If baccalaureate nurses are not educated with a theoretical foundation, what are the consequences at higher educational levels? These findings support several implications for nursing and nursing education, which include a need for renewed support and guidance from leading nursing organizations on how to teach nursing theory and use theory as a framework within the BSN curriculum.

Implications for Nursing Education

The findings from this qualitative research study support several recommendations for nursing education. These recommendations intend to reach individual educational organization level to national nursing organizations as they set forth priorities for nursing education and faculty development.

Clinical Education

The participants identified a need for clinical education to better adapt to the changes in the healthcare environment. The transition in BSN clinical education to more primary care environments requires administrative and nursing community support and creativity in order to meet the needs of the student learners as well as the needs in the clinical environment. Nurse educators can intentionally emphasize health promotion and maintenance in teaching strategies in the classroom and in the clinical environments to better prepare new graduate RNs for the shift in healthcare away from illness and disease.

Faculty Knowledge of Role within the Bachelor of Science in Nursing Curriculum

There may be a knowledge deficit regarding faculty knowledge of their role within the BSN, especially amongst novice nurse educators. This knowledge deficit should be addressed at the national and individual educational organization levels. At the national level, there may be a need to provide additional educational opportunities for novice educators with programming on faculty's unique role and responsibility to the BSN curriculum. One way this can be accomplished is through nursing organization conference programming.

Additionally, graduate students should achieve competency of essential educational standards at the master's level on the knowledge of faculty's role in curriculum development. Tucker (2016) recommended using a teaching practicum modeled upon elementary and secondary education as one possible way to practically apply these competencies.

At the individual educational organization level, nursing education administrators need to support mentorship and on-board new faculty and clinical preceptors with adequate orientation. Orientation and mentorship should include education on the program's BSN curriculum framework, philosophy, and salient content sources within the BSN curriculum. Inclusion of these topics may promote adherence to the unique BSN curriculum as outlined by the faculty at the educational organization. The inclusion of the content sources, such as the essential educational standards, may facilitate novice educators in understanding the rationale for content decisions at each level throughout the curriculum.

Essential Educational Standards and Nursing Theory

The findings from this research study indicate a need for more clear guidance for nurse educators on how to integrate or teach nursing theory at the undergraduate, BSN curriculum. This is important for all levels of nursing graduate studies, as well as for research within the profession. One future step may be for nursing professional organizations and accreditors to address the lack of (nursing) theoretical foundations within their recommendations and provide rationale for the omission of nursing theory within essential education standards for nursing education. It may also be beneficial to consider the use of nursing theoretical tenets when revising these standards or by providing exemplars of integration from other educational institutions.

Recommendations for Future Research

The data from this research study have added to the body of knowledge on the current gestalt of the BSN curriculum in nursing education. The researcher has

identified several recommendations for future research based on the findings of this research and identified gaps in the literature.

Graduate Registered Nurse Preparedness for Nursing Practice

The participants' discussions conveyed an emphasis on the practice–education gap that is present in nursing and nursing education. The participants voiced both priority and concern for the graduate RNs preparation for entry into the nursing workforce. Many of the participants reported that on an individual level, they assess and evaluate the satisfaction and preparedness of their graduate RNs within their local workforce market.

Based on these discussions, it may also be beneficial to also evaluate the preparedness of graduate RNs on a larger scale and whether employers as a whole are satisfied with new nurses' abilities to enter the nursing workforce. This type of evaluation could be accomplished using mixed methods via an electronic survey to gather satisfaction ratings as well as qualitative narratives to explore level of competencies across the nations reported by employers of new graduate RNs. In light of the nursing shortage in clinical practice, especially in acute care areas, this data could assist in pinpointing the direction nursing education will need to take in order to meet satisfaction and competency expectations of potential employers.

In a similar fashion, a large scale survey from the new graduates' perspectives may also be a worthy investigation. Again, the use of a mixed methods approach via an electronic survey may be beneficial to gather data to assess how prepared new nurse graduates feel as they enter in to the nursing workforce. The timing of this type

of research may be crucial since their initial feelings regarding competence may change the longer they are in practice.

Nursing Students with Disabilities

On the topic of nurses and student nurses with disabilities, there is a gap in the literature related to studying nursing students with disabilities in general (Shpigelman et al., 2016). This gap, coupled with participants' comments about students with disabilities in nursing programs, suggests a need for recent research to explore faculty's perceptions of nursing students with disabilities. The research should also include the aspects of nursing students that make them unique from other higher education students, namely their interaction and need for competency in the clinical and simulation environments.

A phenomenological qualitative research study would be appropriate to explore the lived experience of faculty who teach nursing students in the clinical and classroom settings with disabilities. Data from this type of study could facilitate in identifying specific faculty concerns when establishing accommodations for nursing students in the classroom and the clinical settings. This type of research could also isolate particular types of disabilities that may not be conducive with nursing practice. Similarly, a phenomenological qualitative research study may also be an option to explore the lived experience of nursing students who have disabilities as they navigate establishing accommodations in a nursing program. Another suggestion on this topic is to replicate existing research studies that examine attitudes towards students with disabilities and apply the methods to faculty with nursing students (Shpigelman et al., 2016).

Concept-Based Learning Curriculum

As stated previously, there is the possibility that nurse educators are still in a stage of unfreezing when it comes to curriculum change, especially in a revision to a concept-based learning curriculum. Since there was a disconnect between the literature and the findings, further research may be warranted. A large scale survey of nursing educators across the United States may be useful to gather qualitative data on nurse educators' lived experience with concept-based learning curriculum. Then the findings could be developed into a quantitative measure to further assess which stage of change nurse educators are on the topic of concept-based learning.

Additionally, there is a need for further research and outcomes after on the adoption of concept-based learning curriculum. Based on the comments from some of the participants, the reported outcomes in the literature on the concept-based learning curriculum are not convincing enough evidence to make the change. A systematic review of multiple research studies that evaluated concept-based learning curricula could offer guidance to nurse educators on whether the concept-based learning curriculum has positive long-term outcomes.

Essential Educational Standards and Nursing Theory

Previously discussed was the usage of essential education standards as a framework and inspiration for the BSN curriculum today. Also, it was identified that there are fewer and fewer BSN curricula with a nursing theoretical foundation. As identified in the review of the literature prior to this research study, research that determined how many and which nursing theories are utilized in BSN curricula are outdated. This research study determined that a nursing theoretical framework guides

approximately half of the participants' BSN curricula. Unfortunately, due to the small sample size, the researcher is not able to generalize that this finding is consistent amongst all BSN nursing programs. In future research, a survey could be used to determine the number of schools still utilizing nursing theories across the United States. This survey should also include questions to assess the names of specific theories that guide BSN curricula. This survey would be beneficial to determining a more accurate scope of the decline of nursing theory or specific theories in the BSN curriculum.

Another research suggestion on the topic of nursing theory in the BSN curriculum is the use of the Delphi technique. This method of research may be appropriate to investigate what nursing leaders consider being the future of nursing theory. The expert guidance nursing leaders and experts may be the next step necessary to determine how and where nursing theory might be appropriate to include within the BSN curriculum.

Conclusion

This research study yielded valuable results and applications to nursing practice and nursing education. The participants discussed some of the most prominent topics in nursing education literature and research. The findings on critical thinking, clinical judgment, and effective decision-making; the trends in healthcare; and the use of simulation for clinical education were consistent with the literature. Whereas, the findings related to concept-based learning curriculum contradict the recent trends on concept-based learning in the literature. There has been a recent increase in enrollment of students in nursing programs. The participants reported feeling this increase in enrollment and attributed it, by some participants, to the nursing shortage in practice.

However, the rise in student numbers may also be impacting the faculty shortage and the available resources in nursing education. This information is valuable to nursing administrators as they set enrollment goals and plan on boarding and mentorship of novice nurse educators.

The topic of nursing theory was an important aspect of this research study. Based on the findings of this research, nurse educators are in need of guidance in how to integrate nursing theory in and within the BSN curriculum. Leading nursing organizations and accrediting bodies should be aware of this need and begin to identify ways in which nursing theory may also be practically integrated into the BSN curriculum and potentially the essential education standards.

Based on the findings from this study, the researcher was able to identify multiple suggestions for future research. Graduate RN preparedness and competency, employer satisfaction with graduate RNs, and nursing students with disabilities are some of the topics included in the suggestions for future research. All of the applications into nursing practice and nursing education based on the findings from this study indicate that the researcher was able to successfully answer the aim and research questions of the study.

This qualitative research study was able to capture a current gestalt of the BSN curriculum. This study identified that the greatest influences and motivations for the BSN curriculum are greatly influenced by the practice environment in a number of ways. This is likely due to the nursing shortage and recent shifts in healthcare. Additionally, clinical education and faculty issues greatly impact the BSN curriculum. According to the findings, nursing organizations and essential education standards heavily influence the BSN curriculum to the detriment of curricula based on

theoretical foundations. The data from this study captured the perplexity that nurse educators expressed about nursing theory. Their perspectives may, and hopefully will, have an impact on the future of integrating nursing theory within the BSN curriculum and in nursing education.

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APPENDIX A
NURSING THEORISTS USED AS A COMPONENT
OF THE CURRICULAR CONCEPTUAL
FRAMEWORKS

Nursing Theorist	Number of Nursing Programs
Orem	11
Roy	10
Watson	6
Neuman	5
Benner	4
Rogers	3
Meleis (Nursing Transitions)	2

From "Conceptual Framework in Undergraduate Nursing Curricula: Report of a National Survey," by M. McEwen and S. Brown, 2002, *Journal of Nursing Education*, 41(1), p. 10.

APPENDIX B
RESEARCHER'S EXPLICATION OF
THOUGHTS AND BIAS

Researcher's explication of thoughts and bias:

My experience in nursing education began in 2008, when I first took a position as a part-time adjunct faculty in the clinical setting. Since then, I moved forward in nursing education, full steam ahead. I earned my MSN in 2011 and am currently working on my Dissertation for my PhD. Presently I am employed at a small, private college of nursing in the Midwest. This was the same program where I graduated with my BSN in 2006. I am very proud of our nursing program. It is a successful program with great outcomes and we have a wonderful work environment. I have always been particularly interested in my college of nursing's curriculum framework. During my doctoral coursework, I learned more about this curriculum framework and I completed more than one research study on the topic. One of the research studies was a narrative study on how the unique, eclectic framework was developed during the 1990s. During this research, I became more passionate for the general topic of curriculum and developed a greater interest in qualitative research. The rich narrative during data analysis speaks to my heart and soul as a nurse, scholar, educator, and researcher. Although theoretical nursing was never something that interested me as a student in my other programs of study, today I have more appreciation for nursing theory as it relates to nursing's history and future as a discipline. I will admit that I am concerned about what may happen to nursing as a discipline if we no longer use nursing theory as a foundation for curricula across the country. I do not believe we understand the potential consequences, which is why I am passionate about finding out whether this is truly occurring at the program level. To address this identified bias, the researcher will bracket this bias and utilize a peer and research advisor to remain on target with being as unbiased as possible during data collection and interpretation processes.

APPENDIX C
INTERVIEW GUIDE

Interview Guide

Date and Time of Interview:

Interviewer:

Interviewee:

Research Study:

Introduction:

First, I would like to thank you for agreeing to participate in my research study and for meeting with me (via telephone or videoconference). As a reminder, I will be digitally audio recording the interview today and I will be taking notes during the interview as well. Next, I would like to invite you to choose a pseudonym for me to use throughout the research study. _____

Once we have completed the interview and it has been transcribed to an electronic version. I will plan to send the transcript to you in an electronic document for you to review and approve. I may make a second contact with you if I need to clarify any meaning that is not clear.

The introduction letter you received reviewed the purpose, scope, and intent of this research study. Today, we will be discussing your role as either a faculty curriculum leader or as an administrative program director. We will primarily focus on your experience with the Bachelor of Science in Nursing (BSN) curriculum, especially in the last few years.

Do you have any questions before we get started?

Interview Questions (and optional prompts):

In the demographic questionnaire, you described your curriculum leadership role as _____. Can you elaborate on the role and share what are some of the duties of this role?

Can you describe your BSN curriculum theoretical/conceptual framework and design?

What factors or issues currently, or in the near future, influence the curriculum for BSN programs?

Can you talk some about what you think are the issues facing nursing educators in developing a curriculum that addresses the educational needs of nurses in our future healthcare environment?

Has your BSN curriculum undergone moderate-major revision within the last five years? If so, please describe?

What would you say influenced or motivated your recent revision? And if no revision, what in general informs your curriculum?

Would you please describe what you think is essential to be incorporated in the curriculum to develop nurses for today's healthcare environment?

What could be changed or deleted from typical curriculum to make room for different content?

Tell me your perspective on nursing theory related to BSN education?

Is there anything else you could share with me about current BSN education and curriculum that describes the current state of affairs for nursing education?

Thank you for time and insights.

APPENDIX D
INSTITUTIONAL REVIEW BOARD
APPROVAL LETTER

University of Northern Colorado IRB Approval Letter: Exempt Status



Institutional Review Board

DATE: May 23, 2018

TO: Brandi Venvertloh, MSN, RN
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1243438-1] Current Perspectives on the Gestalt of Nursing Curriculum
SUBMISSION TYPE: New Project

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS
DECISION DATE: May 23, 2018
EXPIRATION DATE: May 23, 2022

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Brandi -

Thank you for a clear and thorough IRB application submission. Your recruitment materials are very detailed which is much appreciated in the efforts to protect human participants in research.

Please add the current updated UNC logo to your letterhead and your research advisor's name and contact information to the heading of your consent form before use in participant recruitment and data collection. Those changes must be made before using the form but submission as an amendment for subsequent IRB review is not necessary.

Best wishes with your study.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX F
INSTITUTIONAL REVIEW BOARD SUBMISSION

Title: Current Perspectives on the Gestalt of Nursing Curricula

A. Purpose

1. The aim of this phenomenological qualitative research study is to investigate today's Bachelor of Science in Nursing (BSN) curricula situated in an ever-changing and complex environment in healthcare and nursing education. This study will explore the current experiences and perceptions of nursing leaders involved in curriculum for their BSN programs regarding what influences curricular decisions, what is important for nursing education, and future trends. This research will explore the current gestalt of nursing curricula.
2. The research question(s): What experiences do curricular and/or administrative leaders have about the needs for educating nurses for the future? What perspectives do Bachelor of Science in Nursing faculty curriculum leaders and/or administrative program directors have regarding the importance of nursing theory and its incorporation in their respective curriculum? What is the current gestalt of developing or revising nursing curriculum in BSN programs?
3. This research study qualifies under the exempt category of research according to the UNCO IRB procedures document because the research will not disrupt or manipulate participants' normal life experiences, or incorporate any form of intrusive procedures. The research also involves data collection using an interview procedure. The researcher will use a unique pseudonym in place of the participant's name to protect the identity of the participants. The participant will not be identified by educational institution affiliation, but may be identified by region or simple demographic information. The researcher will also aim reduce the risk of sensitive participant information from being inadvertently shared by using locked cabinets for hard-copy documents and password protected files for electronic documents.

B. Methods

1. **Participants**
The researcher will use a purposeful, or deliberate sampling method to choose participants that are experienced BSN curriculum leaders in either faculty or administrative capacities. The researcher aims to recruit a minimum of 10 participants (one faculty BSN curriculum leader and one administrative BSN program director from each of the five sampling regions (See Sampling Map).
For inclusion in the research study the participants will need to be: a registered nurse (RN) with a minimum of two years experience working as a nurse educator in a BSN program; a faculty BSN curriculum leader (chair, co-chair, or equivalent role) or an administrative BSN program director (academic dean, program/major chair, or equivalent role); self-identified as an expert of their BSN program curriculum; employed by an institution with a regional

and/or specialty BSN accreditation; employed by a “not-for-profit” or non-profit higher education institution. Age, gender, and race are not characteristics of the participants that will impact inclusion in this research study. The sample of nurse educators is not anticipated to be from a vulnerable population.

The researcher will utilize a recruitment and networking guide (see networking and recruitment guide) for the selection of participants for this qualitative research study. The goal of networking will be to identify the BSN program faculty curriculum leader and the administrative BSN program director. The researcher will then reach out to the identified individuals in these two roles personally using telephone and/or email and invite them to participate in this research study.

2. Data Collection Procedures

Potential participants of the research study will be asked to review and sign an informed consent form (see Consent Form) and return to the researcher via standard mail or electronically via email. The participants will be asked to also complete a brief demographic questionnaire (see demographic questionnaire) and return with the informed consent form. The participant will then be invited to schedule a time to conduct a telephone or videoconference (e.g. Skype or FaceTime) interview with the researcher. The interview will be digitally audio recorded only (even if the interview is video conferenced). The interview will be semi-structured with the researcher using an interview guide (see Interview Guide) to partially guide the interview process. The researcher will also keep both field notes and an audit trail throughout the research process, which will be used during data analysis. The interview is expected to take approximately 60-90 minutes.

Transcripts of the interview will be made by a professional transcriptionist and shared only with members of the researcher’s dissertation committee. The researcher. During the analysis of data, the researcher will use member-checking practices and send the transcripts in an electronic document to the participants for review and may contact the participant to offer a follow-up interview as a way to verify the data. A copy of the final analysis will be sent to the participant upon request.

4. Data Analysis Procedures

The researcher plans to start the data analysis process by carefully listening to the interviews and reading the transcripts. The researcher will begin to sift through the data and cut (in the literal form, copy) and paste significant similarities, into a separate document (Morse, 1994, p. 30). At this point, the researcher will focus the analysis on comparison of participant transcripts and any categories that emerge. Then, the researcher will conduct a thematic analysis on the sifted data. This is the point in which, van Manen describes as when the researcher has a “desire to make sense” of the data (van Manen, 1997, p. 79). Polit and Beck state that, “developing a high-quality category scheme involves a careful reading of the data, with an eye to identifying underlying concepts and clusters of concepts” (2008, p. 510). In the next step, the researcher will take the repetitive or salient clusters and form them into

codes or themes (Polit & Beck, 2008). This activity will not follow any particular rules on determining the themes; instead it will focus on identifying meaning within the data (van Manen, 1997). The researcher will then take the themes and data and begin to write (and rewrite) them into cohesive narratives. In this process, the researcher will begin to determine implications and practical applications for these narratives in either practice or education

Morse, J. M. (1994). "Emerging from the data": The cognitive processes of analysis in qualitative inquiry. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 23-43). Thousand Oaks, CA: Sage.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* [Kindle version]. Retrieved from Amazon.com

4. Data Handling Procedures

To protect confidentiality, the participant will select a pseudonym prior to the interview for use throughout the research study process. Only the primary researcher will have access to the key of pseudonyms, which will be kept under a password-protected computer. Documentation that is hard copy will be kept at the primary investigator's private residence in a locked cabinet. All electronic documentation, such as typed transcripts and digital recordings will be kept in a password protected file folder on the primary investigator's computer. Any data from this research study will be retained for three years following IRB approval.

Should the data need to be sent to any other researcher, hired transcriptionist, peer debriefer, or research mentor the individuals will use a secure means to share the data.

C. Risks, Discomforts and Benefits

There are no direct benefits for participating in this research study, aside from the general benefits to the discipline as a result of what is learned from the research project. One minor risk to the participant during this research study is the time commitment for the interviews. Another minor risk, although unforeseeable, is the risk of breach of confidentiality of personal information shared during the interview.

D. Costs and Compensations

There are no identified costs to the participants associated with this research study, aside from the time spent during data collection. The researcher will not offer any compensation for participation in this research study.

E. Grant Information (if applicable)

Not applicable.

Attach all relevant materials to the application.**These materials may include, but are not limited to:**

- ✓ Consent Documents – Follow the guidelines for construction of consent documents.
- ✓ Letters of Permission – Attach written permission from site of data collection if external to UNC. Letters or forwarded e-mails should document the permission of appropriate officials to recruit participation from and collect data in schools, child care centers, hospitals, clinics, and other universities.
- ✓ Survey Instruments – Copies of widely used standardized tests are not necessary.
- ✓ Questionnaires
- ✓ Interview Questions/Potential Questions/Protocols/Range of Topics
- ✓ Debriefing Materials (if applicable)
- ✓ Documentation of IRB Training (required for federally funded research and for full board review protocols)

APPENDIX F
CONSENT FORM FOR HUMAN PARTICIPANTS
IN RESEARCH



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Current Perspectives on the Gestalt of Nursing Curricula

Researcher: Brandi Lynne Venvertloh, MSN, RN, CPN
999-999-999
smit0173@bears.unco.edu

Research Advisor: Lory Clukey PhD, PsyD, RN, CNS
Gunter Hall 3140
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Purpose and Description: The aim of this research study is to investigate today's Bachelor of Science in Nursing (BSN) curricula situated in an ever-changing and complex environment in healthcare and nursing education. This study will explore the current experiences and perceptions of nursing leaders involved in curriculum for their BSN programs regarding what influences curricular decisions, what is important for nursing education, and future trends. This research will explore the current gestalt of nursing curricula.

Procedures: If you decide to participate in this study, you will be asked to review and sign this informed consent and complete a brief demographic questionnaire that will take less than 10 minutes to complete. Then, return the informed consent and demographic questionnaire to the researcher. The researcher will then contact you to schedule an interview via telephone or video conferencing (e.g. Skype or FaceTime) at a time that is convenient for you and does not interfere with your teaching or work-related schedule. The interview is expected to take between 60-90 minutes of time. The interview will be audio recorded only using a digital recorder (even if interview is conducted via video conference).

Transcripts of the interview will be made by a professional transcriptionist and/or primary researcher and shared only with members of the researcher's dissertation committee. The researcher may make a second contact with a participant, if needed to clarify meaning. During the analysis of data, the researcher send the transcripts in an electronic document to the participants for review and may contact you to offer you a follow-up interview as a way to verify the data. A copy of the final analysis will be sent to you upon request.

Benefits and Risks: There are no direct benefits to you for participating in this research study. One minor risk to participation in this research study is the time commitment for the interviews. Another minor risk, although unforeseeable, is the risk that someone not involved in the research process inadvertently obtains private information shared during the interview.

Confidentiality: The researcher will take multiple precautions in order to protect the confidentiality of the participants and adhere to ethical standards. First, the participant will select a pseudonym prior to the interview for use throughout the research study process. Only the primary researcher will have access the key of pseudonyms, which will be kept under a password-protected computer. Any hard-copy documentation (e.g. printed and signed consent forms and/or demographic questionnaires) will be kept at the primary researcher's private residence in a locked cabinet. All electronic documentation will be kept in a password protected file folder on the primary investigator's computer. The information obtained in this study may be published in scientific journals or presented at scientific meetings or conferences, but the data will be reported without personally identifying information.

Compensation: There are no costs associated with participation in this study and there will be no compensation for participation in this research study.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, IRB Administrator, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

page 2 of 2 _____
(participant initials here)

Subject's Signature Date

Researcher's Signature Date

APPENDIX G
SAMPLING MAP OF THE UNITED STATES
OF AMERICA

Sampling Map of the United States of America



Sampling Map Key:

Northeast (yellow)= 1

Southeast (green)= 2

Midwest (blue)= 3

Southwest (red)= 4

West (orange)= 5

APPENDIX H
RECRUITMENT AND NETWORKING GUIDE

Recruitment and Networking Guide

Project Title: Current Perspectives on the Gestalt of Nursing Curricula
Researcher: Brandi Lynne Venvertloh MSN, RN, CPN
Phone: 999-999-9999 **Email:** smit0173@bears.unco.edu

- Select Region:
- Identify personal or professional contacts that are nurse educator peers within the selected region and make contact via email or telephone.
- If no personal or professional contacts exist within the selected region, begin search for an educational institution that meets the inclusion criteria online to identify the BSN program director.
- Use the following written prompt in verbal or written communication with initial contacts and/or potential informants or participants

Hello, my name is Brandi Venvertloh and I am a PhD student in nursing education at the University of Northern Colorado in Greeley, Colorado. I am in the process of completing my doctoral research study that will explore the current gestalt of the nursing curricula from faculty BSN curriculum leaders and administrative BSN program directors perspectives.

I am in the process of looking for participants for my research study. I am seeking your assistance in identifying nurse educators who will meet the following inclusion criteria for my research study:

(a) Must be a registered nurse (RN) with a minimum of two years experience working as a nurse educator in a BSN program, (b) a faculty BSN curriculum leader (chair, co-chair, **or** equivalent role) or an administrative BSN program director (academic dean, program/major chair, or equivalent role), (c) self-identifies as an expert to the BSN program curriculum, (d) employed by an institution with a regionally and/or specialty accredited BSN program (CCNE, ACEN, NLN CNEA), (e) employed by a “not-for-profit” or non-profit higher education institution.

The research involves the completion of the informed consent and a brief demographic questionnaire. Then the participants in this research study are invited to participate in a semi-structured interview via telephone or video conference (e.g. Skype or FaceTime) that is expected to take approximately 60-90 minutes of their time.

If you have any further questions about the research study or have suggestions for potential participants, please contact the researcher via email and/or phone.

Thank you in advance for your assistance and support of my research.

- Once the faculty BSN curriculum leader **and** the administrative BSN program director have been identified and had initial contact, the researcher will send the letter of introduction to the potential participants via email or standard mail (per their preference).

APPENDIX I

**LETTER OF INTRODUCTION TO
POTENTIAL PARTICIPANTS**

Letter of Introduction to Potential Participants

Hello, my name is Brandi Venvertloh and I am a PhD student in nursing education at the University of Northern Colorado in Greeley, Colorado. I am in the process of completing my doctoral research study that will explore the current gestalt of nursing curriculum from faculty BSN curriculum leaders and administrative BSN program directors perspectives. You have been identified as a potential participant for this research study because of your role in your BSN curriculum. I would like to extend an invitation to you to become a participant for this qualitative research study. This research study has received approval from the University of Northern Colorado Institutional Review Board (IRB) for solicitation of participants.

The aim of this research study is to investigate today's Bachelor of Science in Nursing (BSN) curricula situated in an ever-changing and complex environment in healthcare and nursing education. This study will explore the current experiences and perceptions of nursing leaders involved in curriculum for their BSN programs regarding what influences curricular decisions, what is important for nursing education, and future trends. This research will explore the current gestalt of nursing curricula.

The specific criteria for being a participant in this research study are: (a) that you must be a registered nurse (RN) with a minimum of two years experience working as a nurse educator in a BSN program, (b) a faculty BSN curriculum leader (chair, co-chair, or equivalent role) or an administrative BSN program director (academic dean, program/major chair, or equivalent role), (c) self-identifies as an expert to the BSN program curriculum, (d) employed by an institution with a regionally and/or specialty accredited BSN program (CCNE, ACEN, NLN CNEA), (e) employed by a "not-for-profit" or non-profit higher education institution.

I would be most appreciative if you would accept this invitation to participate in this research study. First, I encourage you to review the attached informed consent document. If you wish to move forward as a participant in this research study, I ask for you to return the signed consent form (and keep one copy for your records) and brief demographic questionnaire back to me via standard mail or email. Then, we will work together to schedule an interview for you to share your experiences and expertise of your BSN curriculum and support this research study. It is anticipated that the interview should take approximately 60-90 minutes of your time and may be conducted via the telephone or video conferencing (e.g. Skype or FaceTime). The interview will be scheduled at a time that is convenient for you and does not interfere with your teaching or administrative schedule. The interview will be digitally audio recorded only (even if the interview takes place via video conference) and transcribed into an electronic document. During the analysis of the data I will send the transcripts in an electronic document to you for review. I may contact you to offer a second interview as a way to verify the data. Any information obtained during this study, which could identify you, will be kept strictly confidential and your decision to participate if you choose to do so will not be shared with your employing institution.

No monetary compensation will be given for participation and participation is completely voluntary.

If you choose to participate in this study please reply via email with your name and information so that I may contact you by telephone to arrange a time for the interview. Your assistance is greatly appreciated.

Respectfully,

Brandi Lynne Venvertloh MSN, RN, CPN
Doctoral Student/University of Northern Colorado

APPENDIX J
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Project Title: Current Perspectives on the Gestalt of Nursing Curricula

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Participant Demographic Survey:

1. How old are you?
2. Gender (check one):
 - Male
 - Female
 - Other
3. Race/Ethnicity (check one):
 - African American
 - Caucasian
 - Latino/Hispanic
 - Native American
 - Other
4. Years in nursing as a Registered Nurse?
5. Educational background? (check all that apply)
 - BSN
 - MN or MSN
 - Specialty area of Master's degree
 - DNP
 - PhD

Comments:

6. How would you best describe your involvement with your BSN curriculum (check one)? Please check only one description:
 - Faculty BSN curriculum leader (chair, co-chair, or equivalent role)
 - Administrative BSN program director (academic dean, program/major chair, or equivalent role)

7. Years as either faculty BSN curriculum leader (chair, co-chair, or equivalent role)
OR administrative BSN program director (academic dean, program/major chair, or
equivalent role)?