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The Great Divide — The Gap Between Nursing Education and Nursing Service

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Abstract

The Great Divide — The Gap Between Nursing Education and Nursing Service

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There appears to be a gap between nursing education and nursing service. This is attested to in nursing literature. Head nurses claim that nursing school instructors do not prepare nurses for the practice setting. Nursing educators lament that the practice setting does not allow nurses to practice the way they are taught. It would seem that what is valued in the educational setting is not valued in the practice setting.

For this study, a questionnaire was designed to elicit attitudes and expectation about educational preparation from four groups of nurses. Items deemed essential to education and to practice were included. Respondents were asked if they felt nurses were prepared for the practice setting.

This study contributes toward a better understanding of nurses' perceptions toward nursing education and nursing practice.

I gratefully acknowledge all the assistance and encouragement of Dr. Arpi Hamalian.

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Chapter I

The Gap Between Education and Practice — The Great Divide

1. The Problem

The nursing edcuation and the nursing service components of the profession seem to be drifting further apart. Isabel Maitland Stewart, a Canadian and one of the nursing professions most influential nurses, was adamant about education for service and not education *OR* service. She emphasized the importance of both a sound knowledge base and at the same time, becoming skilled in the technical, practical aspects of nursing.[1] However explicit Stewart was in her beliefs, the nursing education and the nursing service components of the profession seem to be drifting further apart.

Marlene Kramer, a nurse scholar, researcher and author, has contributed much to the literature on the subject of the great divide between nursing education and nursing service and the ramifications this is having on student nurses. In the November 1966 issue of the American Journal of Nursing, Kramer wrote about interviewing newly employed new graduates of nursing. They were disillusioned with the inflexible routines, the repetitive tasks, the amount of rules and regulations, being treated like slaves and not being able to practice nursing as they had been taught.[2] Other studies undertaken by Kramer indicated that the student nurse perceives two dichotomous images of nursing as portrayed by the nurse educator and the nurse in practice;[3] that there is, indeed, a "duel" between nurses in education and nurses in practice;[4] and that the student nurse learns a nursing role in her education that is incongruent with the nursing role in the

work-a-day world.[5,6,7,8] As a result of this incongruence, the new nurse may suffer from what Kramer called reality shock.[9] Kramer is not alone in her conclusions. Johnson pointed out that new nurses "have more knowledge than they have skill in using this knowledge." She also takes health care agencies and institutions to task for not spending enough resources to orient the new graduate to the world of practice.[10] Allan Pfnister, when he was associate professor of higher education at the University of Michigan, presented a paper at a meeting of nurses, which included this statement —

> Professional education must involve, therefore, actual practices in application and, ideally, this practice should tie in so closely with the study of the theory that the one reinforces the other. I am well aware of the debates about the proper relation between clinical experience in nursing and instruction in the basic sciences. The solution is not to ignore the one in favour of the other.[11]

Collins and Joel found that graduates of a baccalaureate degree program that emphasized professional autonomy still retained an image of the task-oriented traditional stereo-typical nurse.[12] Genn speaks about the abundance of literature telling how the image of nursing is changing with liberalized education. However, she doesn't see a changed image of the nurse practicing in hospitals.[13] Miller emphasizes the need for planned, clinical experiences to enable the student nurse to retain the theoretical knowledge.[14]

It has been noted, and importantly so, by Laros, that nursing educational curricula have been based on the utilization of conceptual models to teach nursing but conceptual models are rarely the basis for nursing practice.[15] Hence the dichotomy or gap that often results in reality shock.

The student nurse lives in a world of "ideals" and upon graduation is confronted by the "real" world. In nursing school, praise and other rewards are given for behaviours that are perceived as independent, autonomous and therefore professional. In the practice setting, nurses are rewarded for efficiency, time management, competency and conformity to the institution's policies and procedures. Corcoran emphasizes this by stating that the "priority in the service setting is service."[16] Kramer, in her book about reality shock, postulates that hospitals are concerned about the nurse being able to give service right now, whereas educators desire to inculcate learning behaviours that will develop skills and knowledge over a prolonged period of time. She refers to these two views as the "positive now" versus "the relative when."[17] Huckabay believes that nursing service is 20 years behind nursing education.[18] Dexter and Laidig state that different perceptions of nursing practice exist between nurses in the practice setting and nurses in the educational setting. "Educators are accused of living in an ivory tower, of not preparing students adequately for the real world. These accusations are substantiated to a degree by the reality shock noted in new graduates." These authors also state that they believe that nursing practice in any practice setting will be determined by the goals of administration of the institution and not the goals of the educational institutions.[19] Wagner states that the

> pendulum has swung from the days when nursing education was completely entwined with service to today, when they are distinctly separated. But in our efforts to correct the abuses in the apprentice-type, service oriented program, we have gone to the other extreme and prepared nurses removed from the realities of the employment setting.[20]

In the same article, Wagner quotes the feelings of one hospital director —

> Nursing schools do not prepare students for the realities they will face after graduation; that is, student team leaders are on the units only four or five hours during a work day. With this schedule, they have no interaction with the other two shifts and can't begin to perceive the role and responsibilities of a team leader. Because students are usually assigned to the day shift during Monday through Friday, they are ill-prepared to accept the limitations that week-ends and shift rotations will impose on their personal lives. The new graduate is ill-prepared to carry out the responsibilities of a staff nurse.[21]

Indeed, it has frequently been mentioned to me (author of this paper) that student nurses are, more often than not, discouraged from seeking employment in a hospital during vacation time or other time off. The nurse educators feel that this practical experience will "contaminate" or "pollute" the educational course of the student. (Many students, due to financial constraints, seek employment in hospitals during their time off. Some feel that this experience in the "real" world has been invaluable.)

One nurse, with whom I have worked, stated that she was unaware that she would be expected to work shifts and week-ends when she graduated. She found this fact out after she was employed as a staff nurse. This particular nurse is a graduate of a university nursing program. She was never required to work evenings, nights or week-ends during her student years.

According to Mallick, nursing schools focus on content, but do not teach the student nurse how it should be used. She emphasizes that there is a difference between understanding the conceptual nursing model utilized in the educational process and being

able to utilize it in practice. She states the conceptual model approach to nursing now dominates the classroom but

> although this approach may have produced nurses who have a broader understanding of nursing situations, after over ten years it has not seemed to produce nurses who can utilize the nursing process to plan, initiate and carry out organized nursing activities in specific patient situations.

Mallick also quotes a colleague as holding forth the view that since nursing is a practice discipline, all teaching must be directed toward application of knowledge in the clinical setting.[22] This statement seems to sound quite logical, sensible and appropriate. However, nursing education and nursing service remain at odds one with the other, as evidenced by the literature focusing on this topic.

Werner, like Kramer, feels that the student nurse suffers cognitive dissonance or reality shock due to the fact that the role models she sees in the classroom behave differently from the role models she sees on the hospital ward.[23] Hipps takes the nursing profession to task regarding the chasm between education and service. She asks how nurse educators can teach nursing utilizing a conceptual framework while the practice setting rarely recognizes any of the models in the day to day "real" life setting of the hospital ward.[24] Weisman and her colleagues found that the ideology of nursing education is at odds with the hospital service ideology. They feel, like others, that this dichotomy often leads to frustration, despair and burnout among nurses.[25]

Several authors address this dichotomy, this difference between education and practice in nursing in terms of a professional versus a bureaucratic role.[26,27,28,29] They

emphasize the difficulty — the reality shock or cognitive dissonance — with which the neophyte nurse has to contend. Some others speak of a covert curriculum and speak of the hospital service setting as suffering from collusion and chronicity.

Nursing education is now teaching nursing utilizing a conceptual framework that involves broad concepts of nursing. The students are socialized to be autonomous, independent thinkers and doers. However, the majority of nurses work in hospital settings with bureaucratic hierarchies that markedly influence the delivery of health care. Hospitals are service oriented, task-oriented and militaristic in organization with an abundance of policy and procedure manuals, rules and regulations that are supposed to ensure that the institution runs smoothly.[30,31]

Diers states quite emphatically that "there is no point to nursing unless it is to serve. There is no point to nursing education unless it prepares for service." She also says that nursing education must be closely aligned with nursing practice or else we will be producing people that don't know how to practice at all.[32] Lancaster emphatically agrees with other nurse authors ... "graduates of our schools fail to meet the needs of employers..."[33] And if the graduates of our schools are failing to meet the needs of employers, one can but wonder if they are also failing to meet the needs of the patients. Parsons sees the reality shock syndrome, suffered by neophyte nurses, as a set of complex responses to "the realization that the norms of the worlds of work and school are in conflict."[34] Nichols, (in an article published in a Pharmacy journal) then president of the American Nurses Association, has been told by many nurses she has met in her travels that they feel they are not able to assume the roles for which they felt they were educated.

They feel they are performing tasks, i.e. clerical functions — that other personnel ought to be doing.[35] Davison asks the timely question, "How well do local academic nursing programs match the needs — and the resources — of our institutions?"[36]

Kathleen Riffle and her associates, writing for the book, *Current Issues in Nursing*, have much that is positive to say in defense of the so-called traditional, apprentice-type nursing education conceived of by modern nurse educators to be inappropriate. Close relationships between the school of nursing and the hospitals resulted in the student becoming efficient in the clinical setting. Clinical experience was introduced very early in the program — often within the first month.[37] Clinical experience, in the curriculum based on a conceptual model, is often started later on in the program. The time set aside for clinical experience has been cut to allow time for teaching theory. Hathaway gives a succinct description of this — "School and work cultures differ in the way they approach tasks — this factor alone leads to much of the conflict experienced by new graduates." In school, students are assigned very few patients (often only one) and are directed to carry out "total patient care." Taking care of the whole patient and receiving assignments in such general terms are characteristic of the school culture. On the job, however, nurses seldom enjoy the luxury of having only a few patients assigned to their care. Because of these larger assignments, total patient care, in its true sense (as taught in school), is seldom accomplished. Instead, nurses must deal with the things or tasks that have to be done. The work culture forces nurses to turn away from the whole-care perspective practiced in school and move instead toward a part-care system seen in the work setting. This difference is made very clear when patient care

assignments are given in the work setting. The general (school perpetuated) "take care of the whole patient" assignment is replaced with

> take care of rooms 10 through 15, give morning care, take vital signs at 9:00, do a dressing change in room 12, bed 1, make sure room 14, bed 2 is ready for surgery, get patients fed and up in chairs, or walking, assist the doctor on rounds, etc., etc. ... Time factors have shifted the emphasis from the patient to the tasks.[38]

It would seem that the focus of nursing service is to try to beat the clock — do everything assigned, all the part-care tasks — and get off duty on time so as to keep down the overtime hours that strain the budget. Fawcett, quoting Croncatello, believes that a conceptual model should guide all aspects of clinical practice.[39] She also suggests that nursing service administration should utilize a conceptual model for their basis of organization.[40] Perhaps this would help in bringing the two components of nursing together along more integrated lines.

Meissner, in an article with a very interesting title, takes both educators and nursing service personnel to task for "committing a kind of genocide when it comes to dealing with our young nurses."[41] A kind of great unexpectations situation is created. That there is a chasm between nursing education and nursing service is also mentioned by Storlie.

> The young nurse believes that caring matters, that loving and respecting others is what nursing is all about. She hopes to help people to heal, to cure ... But often she finds in the hospital setting, that 'what I was taught' and 'what I want to believe' clash with 'what really is.'[42]

Cass writes that "the modern staff nurse wrestles constantly with problems created for her by the difference between theoretical nursing, as she is taught to anticipate it, and the actual nursing practice."[43]

2. Historical Perspective

a. Development of Nursing Schools

The profession of nursing is as old as the concepts of time and man. Davison believes that nursing should be recognized as the cornerstone of the foundation of medicine.[44] Mothers as nurses certainly made an historical impact prior to the advent of the magician-priest-doctor.

Nursing has been labelled the oldest of the arts and the youngest of the professions. Amidst much confusion and frustration regarding nursing roles, nursing has progressed from a term indicating basic, unlearned human activity to one of a highly learned, sophisticated nature.[45]

Knowledge of facts and principles regarding nursing would soon become a necessity and would provide the foundation for modern day nursing.

The evolution of schools of nursing seems to be closely related to times of war and suffering in the world. The influences of the world wars and the changing status of women are related to the formation of nursing schools and also to the development of nursing societies.

In her book, *Notes on Nursing*, written after her service in the Crimean war, Florence Nightingale articulated the basic structure and functions of nursing as she perceived them. Inherent in her notes are the four main factors that have influenced nursing and established the foundations of conceptual frameworks of nursing and nursing theory. These four main factors are man, health, the environment and the nurse.[46] ("Man" refers to all mankind — hence the global terminology.) As well as focusing on

the man-health-environment-nurse relationship, Nightingale unequivocally maintained that nursing held specific responsibilities distinct from those of medicine. To this end, she established and assisted in establishing schools of nursing in Europe and the United States. The early schools of nursing in North America were based on the Nightingale model. She insisted that these schools of nursing be administered by women who were nurses. She also was adamant that the teachers should be nurses.[47] One of Canada's earliest training schools, patterned after the Nightingale system, was the Mack training school founded in St. Catherines in 1874. The second hospital to train nurses in Canada was the Montreal General Hospital. In 1821, the hospital sought assistance from five American Nightingale nurses. They were appalled at the filth of the hospital. Finally, in 1890, Nora Livingston succeeded in establishing a training school for nurses at the Montreal General Hospital.[48]

However, due to the fact that the medical system advanced at a very rapid pace and because women (as nurses) were thought to be passive, obedient and submissive to the goals of medicine, nursing as a profession in its own right lay dormant for an extended period in history. Nursing education and practice were primarily under the control and direction of doctors of medicine.[49] Consistent with the social history of women, nursing was viewed as a supportive and supplemental role to that of medicine.[50] Nursing duties consisted of many "wifely" and "mother-like" tasks. As such, there was no need for training studies or for a curriculum as all women should, by their very nature, know how to be nurses!!!

For the first half of the twentieth century, nurses were not in control of the nursing profession. Nursing practice was seen as doing what the doctor ordered and caring intuitively for the sick. This intuitive knowledge, wherein lies the basis for nursing practice, the development of nursing theory and the beginnings of a body of scientific knowledge, was unstructured, untested and fragmented. Nursing care became the major product dispensed by hospitals and the real function of the nursing school was not education but training for service.[51]

In the United States, new opportunities for educational advancement were available for graduate nurses at Teachers College, Columbia University. This program for nurses came about due to the efforts of the nursing group now known as the National League of Nursing in the United States. The initial program at Teachers College was developed in 1899 in order to better prepare nurses for leadership roles in the schools of nursing. The program was originally designed to prepare administrators of nursing service and nursing education. Regarding this course at Teachers College, Donahue states:

> The original course for nurses in hospital economics at Teachers College was at first rather heavily weighted with technical subjects in the household arts with some recognition of the sciences present. Pedagogical subjects such as psychology and the philosophy of education were soon identified as valuable in the study of the problems of nursing education and were incorporated within the program. Additional lectures by leaders in the society shared nursing experiences gained through accumulated years of practical service in hospitals and training schools. In 1906, a new department of institutional administration was established in the college, the course in hospital economics being incorporated within its structure. From this time forward, there was no longer any question as to the place of nursing in the general scheme of university education. The department continued to grow, broaden its educational program, emphasize the social and educational

> phases of the nurses work, and included nursing specialties such as teaching and supervision, public health nursing, school nursing and other related branches. Eventually, the name was changed to the Department of Nursing Education.[52]

Mary Nutting came to Teachers College in 1907. She was the first nurse in the world to occupy a chair on a university faculty.[53] Improvements in nursing schools began to be noticed in the early 1900's. Preparatory courses offering basic sciences and nursing principles and practice were being offered. The focus of these courses was primarily for educational purposes and not for the purpose of service.

b. Development of Nursing School Curricula

In 1917, the United States nurse educator group published a study, "The Standard Curriculum for Schools of Nursing." I. M. Stewart states:

> The purpose of this study was to bring about greater uniformity in the programs of nursing schools and to help in improving the content and quality of the teaching as well as other conditions affecting the education of nurses.[54]

Many nursing schools utilized this study as a basis for curriculum development. In 1927, a second study was published — Curriculum for Schools of Nursing. This ambitious project was undertaken by Miss Isabel Maitland Stewart, a Canadian nurse who organized curriculum study committees in all of the States that belonged to the National League of Nursing. Miss Stewart

> called for a co-operative research project that would encourage participation by many people. She hoped that, through wide-spread involvement, schools that had been too dependent on the 1917 curriculum outlines might learn to build their own curriculums by taking materials from the common stock and adapting them to their different situations and stages of development. She desired a serious analysis of the philosophy of nursing education, goals to be aimed for the values to be conserved, the kind of services nurses should be prepared to give to society, the kind of individuals nursing schools should select for preparation and the kind of preparation needed to fit them for living and serving.[55]

Following the example of the United States nurses, in 1929, the newly established Canadian Nurses Association, conjointly with the Canadian Medical Association undertook a nation-wide study of nursing education in Canada. The study was conducted under the supervision of Dr. George M. Wier, a well-known educator and sociologist in the

Department of Education of the University of British Columbia. This survey, known as the Weir Report, indicated weaknesses in the organization and the practice of nursing. No specific philosophy or objectives were formulated for the guidance and control of nursing service or nursing education programs. The most pressing lack expressed by Weir were fundamental weaknesses in the system of the basic education program of nurses. Amongst other shortcomings, deficiencies in basic curricula were outlined.[56] The report recommended a higher educational standard and increased affiliation between schools of nursing and qualified instructors.[57] As a result, the Canadian Nurses Association organized its own curriculum committee which published "The Proposed Curriculum for Schools of Nursing in Canada" in 1936. This study became the basis for the establishment of a sounder educational foundation for nursing in Canada.[58] Regarding curriculum, Weir, in his report, stated that "perhaps no problem in the field of nursing education has given rise to such divergence of opinion as has that of curriculum construction. (The same is largely true of the curriculum as it pertains to academic education.)"[59] Weir suggested that nurse educators obtain facts about actual nursing needs and to apply principles from leading authorities in the science and philosophy of education. He also suggested not to overlook other closely allied fields. He outlined a curriculum for nurses in terms of basic factors — called constants (required courses) — for example, anatomy and physiology, dietetics, hospital and sickroom housekeeping, mental hygiene and psychiatric nursing, practical nursing and demonstrations, principles of nursing, obstetrics and nursing of children. Of these subjects, the practical nursing course and the principles of nursing course required the most time. Weir suggested that

of a student nurse's day, six hours were to be spent on ward duty, one hour in classroom instruction and one hour in supervised study.[60] Many nursing schools at that time adopted Weir's suggestions and indeed, his suggestions for basic courses or constants may be seen today as the foundation of nursing curricula.

A 1937 study outlines three stages in the development of nursing and nursing education.

> 1873-1893 was distinctly a pioneering period. The immediate problem was not to build a finished educational structure, but to provide both nurses and patients with decent conditions. 1893-1913 may be called the 'boom' period in nursing education. Every hospital wanted a nursing school of its own (to provide necessary services). Nursing was a young profession and many hospitals set up their own schools of nursing g and ran them as they wished. 1913-1933 was a time for stock taking and standard setting. It was recognized that nursing schools would have to be brought into line with other recognized systems of professional education in order to crystallize the best thinking and experience of the professional group in regard to desirable objectives, standards, content and methods of nursing education."[61]

Brown, in her 1948 report on nursing, suggested that nursing programs be established within institutes of higher learning and that nurses as educators utilize already organized patterns of curriculum development used by other professional and academic institutions. She puts forth the premise that nursing education could be aligned similarly to that of medical school.[62] And, indeed, many nursing school curricula focused mainly on diseases and curing, rather than on the total human being, which includes the aspects of prevention of disease and rehabilitation.

Within 10 years following World War II, nursing education was slowly beginning to be established within institutes of higher education rather than in hospitals. Graduate

programs for nurses also began to make an appearance. Academic institutions required faculty with advanced degrees and encouraged them to meet the standards of higher education with regard to service to community, teaching, research and scholarship. Once nurse scholars developed the ability to pursue science, increased efforts began to develop nursing theory.[63]

About mid-century, the early 1950's produced nurse scholars who began to think seriously about nursing — the nature and purpose of the practice. Questions were raised regarding nursing and its traditional, intuitive basis. Questions also were raised about the knowledge and skill needed to pursue this profession. The very word profession itself raised questions as to whether nursing qualified. David defines a profession thus:

> A cohesive and autonomous body of trained persons who perform work for the benefit of the public on the basis of applied scientific knowledge."[64] Nurse scholars again questioned whether nursing did or did not have a unique or borrowed scientific body of knowledge upon which nursing practice was based.

It is clear that educational programs for nurses developed outside halls of higher learning. However, with the efforts of Stewart and other nurse scholars, nursing is endeavouring to establish its basis for practice on a sound theory-based scientific body of knowledge. The nursing profession has increasingly sought support from the general education system in establishing educational programs for and of interest to nurses and nursing. It was evident that articulation was needed between nursing educational programs and institutions of higher learning.[65]

Curriculum development studies and studies in scientific theory sparked the present-day efforts to base nursing curricula on a "conceptual framework." These efforts have seen much advancement in the area of research in nursing and development of "models" for nursing that represent the bases of nursing practice. Florence Nightingale attempted to organize the content of and delineate a concept about nursing. Man, the environment, the nurse and health were the salient components of Nightingale's concept and these components have been solidly set into the various "models" or "concepts" of nursing that exist today. Longway has mentioned how the curriculum concepts have developed and changed over the years.

Nightingale taught technical skills and environmental control. Advances in science (medicine) and technology changed this focus to one of pathology or disease as it affected systems of the body. Then the focus shifted to a more humanistic phase — the patient or client centred approach. Curricula focused on writings by theorists in social sciences, natural sciences and the humanities. Maslow, Erikson, Bertalanffy and Abdellah contributed to the organization of "concepts" for the development of nursing curricula.[66-70]

c. Development of Conceptual Frameworks as Bases for Curriculum

Nurse educators came to realise that a nursing educational curriculum should be based upon a conceptual framework of nursing. So strong was this belief that in 1972, the National League of Nursing (USA) stated (legislated) that in order to be accepted as a "legitimate" school of nursing, the curriculum had to be based upon a conceptual framework.[71] In 1980, the Canadian Nurses Association stated that "A specific definition of nursing practice necessarily derives from a conceptual model of nursing. Nursing practice requires that a conceptual model for nursing be the bases for the independent part of that practice."[72]

"Conceptual framework" is a term that has been utilized with increasing frequency in the nursing profession with regards to establishing curricula for nursing education. Lippitt gives examples of conceptual models in the early Chinese and Egyptian civilizations. He felt that these models were influential in shaping the world.[73]

Conceptual models are derived, or evolve from, observations and insights of scholars. The models present diverse views of certain phenomena around us that influence our perception of the world.[74-79]

Tanner and Tanner emphasize that "Paradigms are not concocted out of a hat but from the world of practice."[80] Nash and Agne state that there must be close and open association between concepts and performance in any profession. There must be association between principles and practice.[81]

With the appearance of nurse scholars, educated in institutes of higher learning, more diverse and creative thinking about the nursing profession became evident.

Attempts at defining nursing were legion. Attempts at constructing a curriculum for nursing education were multiple and diverse. Conceptual models of nursing, philosophies of nursing, definitions of nursing became part and parcel of the growing and much needed trend to establish nursing as a legitimate and credible profession.

In its early stages, nursing evolved out of a need for care and was practice-oriented. Nurses emphasized ways and means of providing care and comfort for those who suffered from disease and other illness related aspects of daily living. The practice related portion of nursing soon became the basis for the educational portion — the curriculum. Different methodologies were tried — however, the dominant theme remained the function or practice of the nurse. Curriculum content was initially focused on tasks and an apprenticeship-like service. Then physiology and pathophysiology became a main point.

However, focus was still largely centred on what the nurse "did" for normal and abnormally functioning patients/clients. Body systems, anatomy, physiology and pathophysiology then became predominant in curriculum content. Again the major emphasis was the "how to" of practice. The nurse scholars, the experts in education and curriculum design, soon realized that research was needed to identify the aims of teaching and learning. Without this research, they felt that the education and therefore the practice of nursing could not be improved. To this end, the first nursing research journal in the world was published in the United States in 1952. The Western Council for Higher Education in Nursing (WCHEN) was founded in the 1960's. The objectives of the nurse scholars were three: 1) improve nursing education; 2) enhance nursing research; and

3) raise the quality of nursing research.[82] Out of this search to define the knowledge base of nursing came the many efforts by nurse scholars to identify the specific and unique body of knowledge that could be called the science of knowledge of nursing. Rogers stated that there are two overall facets of nursing — one being the science of nursing and the other being the practical application of this science for the betterment of mankind.[83]

Thus, in order to become accepted as a legitimate profession, nursing and nurse scholars focused attention on developing curricula for nursing education that were based on scientific knowledge related to the concepts and constructs that defined the process of nursing.

Scholars in the area of general education greatly influenced the nurse scholars in the area of curriculum development, theoretical development and development of conceptual frameworks. Tyler suggests that there be a "general organizing framework" for the structure and development of curriculum concepts.[84] He gives examples of how concepts can be organized or arranged in a framework.

Taba felt that complex curriculum development needed a theoretical or conceptual framework to guide it. She states

> A conceptual system for the curriculum or a theory of curriculum is a way of organizing thinking about all matters that are important to curriculum development: choice of objectives, selection and organization of content and of learning experiences and evaluation.[85]

Curriculum development is a complex endeavour. In the nursing profession, an absence of well-defined methodology pointed to the need for an ongoing process of review and revision. Conley says that a conceptual frame of reference is needed to provide a guide for the selection of content, which in turn, gives direction to the formation of the objectives of the curriculum.[86] While the above mentioned authors each espouse a particular conceptual framework in conjunction with education and curriculum development, one is struck by the multiplicity of the existing frameworks. One might wonder whether or not this multiplicity would hinder curriculum development and thus the educational process.

3. Conceptual Frameworks for Curriculum Development

a. General Frameworks

Many nurse scholars have developed conceptual frameworks for nursing. And in developing these conceptual frameworks, they have drawn upon concepts, models and theories developed in disciplines other than nursing. These concepts, models and theories have been applied in nursing to offer different explanations of the interrelationship between the components of nursing, namely, man, the environment, health and nursing.[87] Among the models, which were drawn upon to develop nursing models, are the Systems model; the Stress and Adaptation model; the Growth and Development model and the Interaction model. Systems models were, in part, generated from the works of Bertalanffy.[88] Stress and adaptation models grew out of the research of Selye and Helson.[89,90] Developmental models were developed from the works of Maslow and others in his discipline.[91] Interaction models came about from the works of scholars such as Benoliel and Heiss.[92,93]

Although there are many conceptual models developed by many nurse scholars, there are some that are more well-known than others, such as Johnson's Behaviourial System Model;[94] Orem's Self-Care Model;[95] and Roy's Adaptation Model.[96]

Nursing Models — An Overview

Johnson — Behaviourial System Model

Dorothy Johnson believes that the focus of nursing is man as system. The system's (man's) behaviours are regulated and controlled by bio-psycho-social forces. The system

(man) strives to maintain balance. Subsystems, of which there are seven, have a special function dependent on their structure. The structural elements consist of a goal; a predisposition to act; choices for action; and behaviour. Functional requirements include protection; nurturance; and stimulation. The seven subsystems are delineated as 1) affiliative — relating to security, 2) dependency — relating to nurturance, 3) ingestion — refers to appetite, 4) elimination — excretion of waste, 5) sexual — procreation and gratification, 6) aggressive — related to self-protection and preservation, and 7) achievement — related to mastery or control of self and environment. Nursing becomes involved when problems arise and the system (man) has lost stability and seeks to regain or retain equilibrium. The nurse acts as a change agent. The goal of nursing then, is "to restore, maintain or attain behaviourial system balance and stability at the highest possible level for the individual."[97]

Orem — Self-Care Model

Orem proposed that self-care is a necessary requirement in order for man to live and function in conjunction with the environment, and is a learned behaviour. She divided self-care needs into three categories — 1) universal — pertaining to basic body needs; 2) developmental — pertaining to the human developmental processes; 3) health-deviation — pertaining to seeking help when ill. She states that an inability to meet self-care needs is a self-care deficit. The nursing process focuses on the individual and the need for self-care. The nurse assists individuals to meet their self-care needs and where a deficit exists, the nurse provides safe, supportive, comprehensive care. The goal

of nursing is to maintain persons in a self-care state or support persons with a deficit. The goal being to return the client to a state of self-care.[98]

Roy — Adaptation Model

Roy developed her model based on the work of Harry Helson, a physiologic psychologist. She describes man as being a bio-psycho-social entity, constantly interacting with his environment. Since health and illness are part of man's changing world, man must adapt through the changes. Roy states that a person needs nursing services "when unusual stresses or weakened coping mechanisms make man's usual attempts to cope ineffective"[99] and thus hamper adaptiveness. The goal of nursing is to promote adaptation whether in health or illness.

b. The Dawson Framework

Dawson CEGEP School of Nursing uses a Needs Framework upon which to develop the curriculum. Their philosophy of nursing and definition of nursing refer to the bio-psycho-social needs of man. The framework is loosely drawn from Maslow's hierarchy of needs and Orem's Self-Care Model.

The stated needs are related to seven areas deemed pertinent to the optimum function of man: Comfort; Rest and Activity; Safety; Nutrition; Interpersonal Interaction; Oxygenation and Self-Esteem.

The general nursing behaviors commonly used to meet needs are caring — feeling concern for patients; comforting — helping activity; communicating — transference of ideas, thoughts, feelings and facts.

The terminal objectives are structured around the needs and the nursing behaviors to meet those needs.

4. Conceptual Frameworks for Evaluation — Bridging the Gap

The overall, general objective of any nursing education program is to prepare and enable nurses to function in the practice setting. Nursing is a practice (service). It is all very good and very important to talk about including nursing theory in nursing education programs; to expose the student nurse to concepts that are unique to nursing and to expose the student to basic aspects of research. However, the ultimate test — the proof of the pudding, as it were — resides in not so much what the student nurse knows but what the student nurse will be able to do with what she/he knows. Conceivably, there should be a relationship between what is taught and what is practiced. The evaluation process might prove helpful in defining these relationships.

Evaluation, whether explicit or implicit, has been around for a long time. God viewed his handiwork and declared that it was good. In the field of medicine, evaluation codes were developed in the year 1240.

Evaluation could be thought of as a means of communication. Somewhat like a road map, evaluation could tell from whence we have come, where we are now and assist in planning strategies to arrive at a pre-planned destination.

In nursing, the destination is the provision of quality care services based on the needs of society. Evaluation, like quality-assurance, could assist in relating health care needs of society to the preparation of nurses to meet those needs.

Difficulties surrounding evaluation are seemingly boundless — lack of understanding about the purpose of evaluation; fear of failure; fear of change; lack of experienced evaluators and lack of time, money and appropriate materials for evaluation.

Schwab[100] comments on the difficulties surrounding development and use of valid and reliable tests.[101] Reilly states this is an impossible quest. McGuire,[102] a doctor from McMaster University, refers to an abundance of studies on individual evaluation of medical students yet very little documentation to justify changes in medical school curricula. Neufeld[103] refers to difficulties in assessing clinical competence of physicians.

With regards to nursing education, curricular changes apparently have been made based on philosophical argument with very few data documenting the impact of these changes on programs, students or patients.[104] Levine[105] laments that, in nursing, "curricular change and reform progressed more by enthusiasm than by documentation." Rosinski suggests that for all the health professions, curricular change was made for the sake of change rather than on data gathered through evaluation.[106]

a. General Framework for Evaluation

Scriven, in his article on evaluation, describes and discusses important facets of evaluation.[107] He believes a touchstone for understanding evaluation is a clarification and comprehension of terminologies. He cautions against confusing the goals of evaluation (i.e. questions related to comparative merit or worths of educational instruments) with the roles of evaluation (i.e. in what educational context is evaluation used). He stresses that curricular evaluation is not complete until both the goals (intrinsic evaluation) and achievement of the goals (extrinsic, pay-off or outcome evaluation) have been assessed.

He suggests that evaluative test-questions be designed in tandem with formulation of goals and objectives at the beginning of curricular development. By doing these concurrently, an evaluative mechanism would be constructed that would demonstrate the consistency and interrelatedness between goals, course-content, performance standards, outcomes and examinations. Comparative data, upon which to base need for change, could then be generated. Regular reviews and revisions, both from internal and external faculty sources, would be necessary in order to determine clarity of goals, objectives, course-content and tests.

Scriven outlines a framework upon which to develop criteria for evaluation of a curriculum. The framework utilizes Bloom's taxonomy of the cognitive, affective, psychomotor variables around which to develop conceptual descriptors followed by manifestational descriptors. Upon this foundation would grown the operational descriptors. These, in turn, would give rise to the development of test questions relevant to

learner goal-achievement and questions relevant to the merit or worth of the goals themselves.

Comments related to cost, financial and otherwise (i.e. anxiety and frustration for faculty) suggest that the benefits would far outweigh any risks. Using the framework would help to clarify the roles of evaluation and establish a common thread of connectedness throughout all aspects of curricular development.

Bevis, in her book on curriculum development for nursing education, discusses evaluation in one of the last chapters.[108] While she stresses the importance of both formative and summative evaluation, she equates the latter with student goal-achievement evaluation, saying this is the same as curriculum evaluation. (Here, according to Scriven, the role of evaluation blurs the goal of evaluation.) She also expresses concern about the miasma of difficulties surrounding evaluation. Like Scriven, she suggests "alter" nurse faculty groups to assist in reviewing and revising curricular goals.

Bevis thinks of curriculum development as a "living process" and considers evaluation as a means of obtaining feedback that can then be used to guide future changes. She also uses an evaluation framework loosely based on Bloom's taxonomy of cognitive, affective and psychomotor variables. However, she describes only its role in evaluating learner goal-achievement.

Reilly uses Bloom's taxonomy with relation to cognitive, affective and psychomotor variables in developing her system or conceptual framework for evaluation.[109] She focuses mainly on learner goal-achievement and refers only briefly to the value of overall curricular assessment.

She states that an aspect of evaluation may not be directly related to the goals. The term she uses to describe this aspect is "goal-free" evaluation. Although she does not explicate further, perhaps this aspect may be similar to what Scriven calls "pay-off" evaluation — evaluation of outcome exclusive of goals.

She expands the conceptual evaluation framework by incorporating the components of the Nursing Process (assessment, planning, intervention, evaluation) in order to generate behavioral objectives which then serve as a basis for development of test questions.

b. Evaluation — Educational Setting — Dawson

Student nurses at Dawson are supplied with workbooks each semester that outline, more or less, behavioral objectives — the students are aware of what is expected of them. Parameters have been defined for them. Both formative (occurring during semester or course unit) and summative (occurring at end of semester) evaluation of the student is them facilitated.

Evaluation of overall curriculum goals and objectives appears to utilize what Scriven might describe as "arm-chair" methods — discussing what "appear" or "seems" to be a problem for the faculty, (personal communication). According to the literature, this "arm-chair" method of evaluation is frequently used by nurse educators.

c. Evaluation — Practice Setting — Queen Elizabeth Hospital

Evaluation of the student nurse during clinical experiences in the practice setting, is largely the responsibility of the nursing instructor, with little input from head nurses or staff nurses.

Evaluation of the staff nurse in the practice setting, carries negative connotations. Disliked and disregarded by many, it is perceived as primarily a paper-pushing routine forced upon nurses by quality assurance, the nursing department and hospital accreditation. Most nurses would rather fill out income-tax forms or have root canal work done than deal with what is perceived as a yearly nuisance.

The Evaluation or Performance Appraisal form used at the Queen Elizabeth Hospital refers in very general terms to the staff nurse job description and the philosophy of the department of nursing. Behavioral objectives are implicit — left to the discretion, judgement, opinion of the head nurse. The hospital policy and procedure manuals — guidelines for technical skill intervention — are generally considered to be "behavioral objectives." Thus evaluation in the clinical setting focuses more on technical skills and compliance with institutional rules and regulations.

As a student, the nurse is given explicit guidelines and directions for achieving curricular goals in the form of behavioral objectives. The conceptual framework of nursing is prominent throughout — in the case of Dawson, the patients "needs." For a new graduate, the hospital/practice setting is dramatically different. Few, if any, explicit behavioral objectives to use as guidelines. And the patients needs seem to take second place to the institutional need of finishing tasks on time.

Evaluation, in both the nursing educations and practice settings is given lip-service as a worthwhile endeavor. Yet it is this area that is most often given short-shrift.

It may well be that the area of evaluation could serve as a bridge across the perceived gap between education and practice. The bridge could possibly enhance and smooth transition from school to practice and facilitate two-way traffic (collaboration) between educators and practitioner. Collaboratively evaluating curriculum content relative to the roles and functions of the practice setting would assist in goal clarification. And, as Neufeld has stated, it is in the evaluation system that the true goals and objectives are to be found.[110]

While the task of evaluation is of seemingly monumental proportions, it should be recognized that evaluation is a complex, dynamic and never-ending process. This concept needs to be enhanced and actively incorporated into all aspects of education and practice.

Chapter II

1. The Case Study

a. Statement of the Problem

Withdrawal of schools of nursing from service institutions and placing them in institutions of higher learning has seemingly created a gap between the service and the educational branches of nursing. And it appears that the neophyte nurse is caught between a professional role versus a bureaucratic role — a role promulgated in the educational setting versus a role promulgated in the practice setting. It would seem that nursing is divided over the desire to create the ideal nurse — and the desire to create an efficient member of a task-oriented care facility. The question to be asked is — Are nurses educated for service?

b. Method

For the purpose of the descriptive study, series of questions were developed which describe behaviours related to the terminal (behavioural) objectives of the nursing curriculum and the performance expectations of the employer. The questions are in a statement-like format. The statements are attitudinal in nature and are related to whether or not the new nurse perceives or feels she has been prepared for the practice setting. The graduate of one year will be asked the same questions, as will the nurse educator and the head nurse. It is proposed that the new graduate will be related more positively with the nurse educator. The graduate of one year or more will be more aligned with the head nurse.

The statements on page one of the questionnaire were drawn from the terminal objectives of the nursing school curriculum. Curricular structure based on a conceptual framework is generally developed within the framework of the philosophy of the school of nursing. Terminal objectives also evolve from this source. Incorporated within these statements is the idea that the professional nurse was able to give complete nursing care in all fields, utilizing the nursing process.

The statements on page two of the questionnaire were drawn from the staff nurse job description of the hospital and the unwritten performance expectations of the head nurse. While the elements of the philosophy of a hospital nursing department may closely resemble those of the educational department, expectations and emphasis of the employers often differ from those of the educational institution.

The statements on page three of the questionnaire are items thought to be fundamentals of a professional practicing nurse and therefore valued by all nurses.

This descriptive study is not without limitations. the samples, all English-speaking females, was small and not randomly chosen. The study was not longitudinal. The questionnaire was designed to elicit information about perceptions, which are difficult to measure. It would be difficult to extrapolate findings from this study. Similar studies would need to be conducted.

c. Objectives

The objective of this descriptive study was to determine whether or not nurses perceived they were educated for practice.

This study will examine the following:

a) the new graduates' perceptions of educational preparation for practice;

b) the nurse educators' perceptions of new graduates' educational preparation for practice;

c) the head nurses' perceptions of new graduates' educational preparation for practice;

d) the one year graduates' perceptions of new graduates' educational preparation for practice.

The aspects of practice for which the new graduate did or did not feel prepared might help identify aspects in the curriculum that need attention and revision. Also, these aspects of practice might help identify areas for practice institutions to focus on during orientation of the new graduate nurses and for development of continuing educations programs. The perceptions of the nurse educator and the head nurse would provide information regarding their views as to whether or not education was effective in preparing a new nurse for practice.

- It is proposed that the new graduate and the nurse educator will perceive that preparation for practice is adequate.

- It is proposed that the head nurse and the new graduate nurse who has worked for at least one year will perceive that preparation for practice is inadequate.

- It is proposed that the conceptual framework, upon which the curriculum is supposedly based, will not be valued by the head nurse and the one year graduate as much as by the nurse educator and the new graduate.

d. Sample

The questionnaire was administered to seventeen (17) new graduates of a CEGEP nursing program whose first employment experiences were as staff nurses in a hospital service setting; six (6) CEGEP nursing graduates who have been employed in a hospital service setting for at least one year; ten (10) head nurses to represent nursing service management and three (3) instructors of nursing education in an anglophone CEGEP nursing program.

e. Results

The proposal that the new graduates and the nurse educators alike will perceive that preparation for practice was adequate was not upheld. According to the survey responses, the majority of the new graduates felt they were prepared to practice, whereas the majority of the nursing instructors felt the new graduates were not prepared to practice. Thus, the new graduates felt that the educational curriculum had indeed prepared them adequately for the practice setting, but their instructors, the ones who prepared the terminal objectives and taught the courses, felt the new graduates were not adequately prepared to practice.

The proposal that the head nurses and the graduates who had worked for one year would perceive that preparation for practice had not been achieved was not upheld. The majority of one year graduates felt they had been adequately prepared to practice, whereas the majority of head nurses felt the nurses had not been adequately prepared for practice.

The new nurses and the one year graduates felt that they were adequately prepared to practice. However the head nurses and the nurse educators felt that new nurses were not adequately prepared to practice.

The proposal that the conceptual framework, upon which the curriculum was based, would not be valued by the head nurse and the one year graduate was not upheld. According to the survey responses, all of the head nurses and the one year graduates felt that it was essential that the nurse utilize a conceptual framework as a basis for nursing practice.

The majority of the respondents agreed on essential items.

Differences occurred in the following areas:

Questionnaire Page 1 — Items 2, 4 & 5:

Item 2. *Using nursing diagnoses in formulating written nursing care plans*

Item 4. *Demonstrate positive communication techniques with patients, families and members of health care team*

Item 5. *Use a conceptual framework as a basis for nursing practice*

These items deal with some important aspects of the nursing curriculum, diagnosis, communication and conceptual framework. The items above are important components of the nursing curriculum, and are articulated in the terminal objectives. Yet, the majority (2 out of 3) of the instructors felt the new nurses were not prepared, while the new nurses, the one year nurses and the head nurse felt preparation was adequate. Why did the instructors feel that the new nurses were not prepared? Perhaps the instructors are overly idealistic or perhaps they are overly pessimistic about their own ability to impart knowledge of these components to the students. Perhaps the instructors underestimate the learning capabilities of the students.

Questionnaire Page 2 —

Item 2. *Perform technical skills in caring for patients:*
- *a) starting an IV*
- *b) inserting a foley*
- *c) changing a dressing*
- *d) administering an enema*
- *e) inserting an NG tube*

This item deals with some important technical skills that are utilized daily in the practice setting. The majority (8 out of 10) of head nurses felt that the students were not prepared in this area. The majority of the other three groups felt the nurses were prepared. This finding suggests (as do other studies) that head nurses and nursing service personnel expect the new graduates to have an extensive repertoire of skills on entering the practice setting. Since seven of the ten head nurses who participated graduated from hospital-based schools of nursing, perhaps this could be reflective of the head nurses' general lack of confidence in graduates of academically-based schools of nursing rather than the a lack of education or ability on the part of the new graduate nurse.

Some of the new graduates had also worked in the hospital during summer vacations and may have learned these skills from staff nurses, thus the positive perceptions.

This area of technical expertise seems to cause a great deal of disagreement between head nurses and nursing instructors. Perhaps the "ideal" versus the "real" needs more focus. Perhaps the skills and knowledge imparted by the educational institution are neither sufficient nor relevant to the clinical practice setting.

Questionnaire Page 2 —

Item 3. Comply with institutional and nursing policies and procedures

This item deals with complying to institutional nursing policies and procedures. All the nursing educators (3 out of 3) felt that the new graduates were not prepared. This area refers to the bureaucratic and hierarchical nature of institutions — keeping the place

ticking — performing functions and tasks. Perhaps this is not an area of concern for the nursing educators. Yet the majority of the other three groups felt that preparation was adequate. Perhaps the instructors felt more clinical time was necessary for the students to become familiar with the hospital bureaucracy.

Questionnaire Page 2 —

Item 4. Provide safe, individualized nursing care for 4 – 6 patients

This item concerns the number or quantity of patients a nurse can manage in one shift of work. All of the head nurses (10 out of 10) felt the new graduates were not prepared in this area. The majority of the nursing instructors (2 out of 3) also felt the same way, which is unusual. Most of the other studies in the literature have indicated that the nursing instructors feel that new graduates are prepared in this area. In this study, the new graduates and the one year graduates felt they were prepared in this area.

Providing safe, individualized nursing care is vital to the profession. It is the profession's foundation. If new nurses cannot meet this objective, then things are amiss, and the patient population is at great risk. The instructors agreed with the head nurses — the new nurses are not adequately prepared. Head nurses have been saying this for some time. For the nursing instructors to agree, is unusual. The terminal objectives indicate that the new nurse should be able to provide safe, individualized nursing care. The objectives use the term "a group" of patients. The job description of a staff nurse does not mention quantity of patients in work assignments. The instructors decide quantity of patients per student during the educational term. The terminal objectives of

the curriculum state one or two patients. The head nurses decide the quantity of patients per nurse once the nurse has graduated. The student nurse rarely cares for 4–6 patients. As a staff nurse, this is a normal quantity. Expectations and perceptions of quantity vary between the instructors and head nurses. Perhaps the instructors are too "idealistic" compared to the more "realistic" head nurses. The focus of the instructor is "total" care while the focus of the head nurse is more fragmented — get the important tasks done, on time.

Questionnaire Page 2 —

Item 5. Organize patient care and complete within a reasonable length of time

This item pertains to the ability to organize and complete patient care within the shift period. The majority of head nurses (8 out of 10) felt the students were nor prepared. The other three groups felt they were prepared, again demonstrating divergence in performance expectation between head nurses and nursing instructors.

Here again the head nurse disagreed with the nursing instructors, the new graduates and the one year graduates. Perhaps the head nurses are pessimistic about the ability of the new graduate to organize her time and set priorities. Perhaps the head nurses have observed that new nurses are not able to cope with the reality of the practice setting. Perhaps the head nurses are not communicating their feelings to the other three groups, since they all felt that the students were prepared in this area.

Questionnaire Page 2 —

Item 7. Understand the bio-psycho-social factors that underlie normal and abnormal human functions

This item pertains to the ability to correlate theory about man and health with the practice setting, which often deals with abnormalities in health. The majority of head nurses (8 out of 10) and nursing instructors (2 out of 3) felt the students were not prepared in this area. However, the new graduates and the one year graduates felt they had been adequately prepared in this area.

Head nurses have long felt that new nurses were not prepared in this area. That the nursing instructors felt the new nurses were not prepared in this area is again, unusual. The terminal objectives indicate that the new graduates should be able to correlate theory with practice in the bio-psycho-social sphere at least on a basic level. Again the perceptions of the instructors may be quite pessimistic with regard to their own ability to teach this subject, and pessimistic with regard to the learning capabilities of the students.

Questionnaire Page 3 —

Item 1. Act as a role model

This item pertains to acting as a role model. Most of the one year graduates felt that student nurses were prepared in this area. The other three groups, however, did not agree. Perhaps the other three groups felt that acting as a role model requires more time and experience that can only be gained as a graduate, practicing nurse.

Questionnaire Page 3 —

Item 2. *Actively participate in independent and group nursing activities; committees; nursing rounds; in-service; staff meetings; quality assurance; audits*

This item pertains to participation in group activities on a nursing unit. The majority of all four groups felt that the students were not prepared in this area. Even though student nurses must participate in group activities with other students and nursing instructors, perhaps the older and more experienced nurses on the nursing unit act in a manner that inhibits the neophyte from participating in an active and positive manner.

Questionnaire Page 3 —

Item 3. *Plan written objectives for self-development*

Item 4. *Perform self-evaluation*

These items pertains to the fact that most nursing service departments require all nurses to be able to write self-developmental objectives and self-evaluations. The majority of head nurses and nursing instructors felt that the students were not adequately prepared to do this. However, the majority of the new graduates and the one year graduates felt that they had been adequately prepared to do this.

Chapter III

1. Discussion

The gap between education and practice is borne out by the literature and seems to have gotten even wider since nursing education has been taken out of the hospital setting and transplanted into the setting of academia. The knowledge and skills valued in academia are not always the same as those valued in the practice setting. Too often, hospitals have been accused, by nursing educators, of being too bureaucratic and thus imposing on the values the neophyte nurses learned in nursing school. Hamalian comments that many educators feel school bureaucracies "... substitute rigid conformity to rules in the place of sound professional judgement and orientation."[11] This perception could easily be extrapolated to the nursing profession.

Head nurses and nursing service personnel feel that vital clinical experience time has been sacrificed for the so-called benefits of a more liberal arts based nursing education. Nursing is a service profession. A "hands-on" profession. An applied discipline. Clinical experience builds clinical judgement, clinical responsibility and clinical skills. Graduate nurses should be prepared for the realities of practicing their chosen profession.

While a liberal arts based nursing education is a worthwhile achievement for the general intellectual development of the student as a nurse and as a citizen, the practical skill aspect of the profession and the quality of patient care must not be neglected in the pursuit of academia.

More focus needs to be placed on the components of nursing education and practice upon which the head nurses and nursing instructors agree and disagree. Nurse educators and nurses in the practice setting have long disagreed with one another regarding adequate education. At the same time, both seem to be operating on different wavelengths with different perspectives as to what constitutes adequate preparation for the practice setting. They seem to be confusing the roles of nursing with the goals of nursing.

The results of this study indicate that even though there are some disagreements between head nurses and nursing instructors as to adequate educational preparation, there are also some areas where the nursing instructors agree with the head nurses that the educational preparation has not adequately prepared the neophyte nurse for the practice setting. This study seems to indicate an overall dissatisfaction on the part of the nursing instructors with regard to educational preparation of the new nurse. Perhaps these two groups — head nurses and nursing instructors — are more alike in their attitudes and perspectives than was previously thought. Another interesting aspect of this study is the largely positive attitudes of the new graduates and the one year graduates with regard to feeling adequately prepared for the practice setting. They seem to be quite confident and optimistic about their ability to perform in the practice setting. In spite of the head nurses and nursing instructors, the new graduates do not seem to lose these feelings even after a year in the practice setting.

As for curricula based on conceptual frameworks or models of nursing, they have apparently not diminished the gap. Conceptual frameworks developed by nurse

educators and scholars are multiple and varied, creating a towering sense of pluralism and confusion. Different schools of nursing utilize different frameworks. Most hospitals do not follow through with utilization of conceptual frameworks. One glaring factor that detracts from utilization of conceptual frameworks is that very few of them have been tested in the practice setting. Hence there is little or no sense of continuity between the professional educational phase and the professional practice phase.

A single conceptual framework may be practical for utilization in a single area of nursing practice. For example, Roy's Adaptation model has been utilized with apparent success in a psychiatric outpatient unit. However, it would not be practical in all nursing settings. Also, conceptual frameworks are often subjected to updating and revision by their authors. Thus, a curriculum based on one particular framework would need to be revised and updated as well. To develop a curriculum that is based on one model alone may prove to be futile and the knowledge gained may not be applicable in the practice setting. Frissell cautions against dogged adherence to conceptual frameworks as this may result in linear thinking which would be limiting and detrimental to the nurse both in the educational and practice setting.[112] A linear approach would not prepare the nurse to deal with the multiplicity of complex situations found in the practice setting.

Since nursing models or conceptual frameworks are in a constant state of change and flux, it would seem impractical and unrealistic to adhere to a model too rigidly in education or practice.

The current nursing shortage and on-going budgetary restrictions have made work difficult for nurse practitioners and nurse educators. Clinical instructors in the hospital setting used to serve as a link between education and practice. With budget cuts, the number of clinical instructors on the wards has been drastically decreased. The onus falls on head nurses and staff nurses to orient new nurses and provide stimulus for continuing education. Nurses, already overburdened, often consider new graduates a nuisance. There is no time to teach the new nurses what they, ostensibly, should have learned in nursing school. Ill-feelings develop toward nursing instructors for shirking their responsibility. Also, remedial education, such as some form of orientation and continuing education programs are very costly to the practice institution. Nursing instructors also feel the financial pinch. There are too few instructors for the number of students in the clinical setting, therefore performance evaluations may be difficult. Nursing instructors also may find it difficult to schedule clinical experience time in a practice setting due to closed bed and shortage of staff nurses.

In summary, the proposals set forth in this study were not upheld. Both the nursing educators and the head nurses felt on the whole that new nurses were not prepared to practice. On the other hand, the new graduates and the one year graduates felt they had been adequately prepared for work in the practice setting. These data reflect the attitudes of the nurses in the four respondent groups. They also might provide the bases for future inquiries, which could focus on some or all of the following:

- Do the results of this study indicate the gap between nursing service and nursing education is narrowing?

- Why do the nursing instructors feel the new nurses are not prepared for practice?

- Are the expectations of the head nurses and nursing instructors unrealistic?

- Are the terminal objectives of the curriculum unrealistic and incongruent with the practice setting?

- Are evaluative measures sufficient? Appropriate?

- Is the job description of a staff nurse relevant to the practice setting?

- Does the gap between nursing education and nursing service affect the quality of care given to the patients?

Addressing these issues promptly and continually might result in narrowing the gap between nursing education and nursing practice, and assist in bringing more congruency between the two aspects of the profession.

2. Recommendations

In order to address the issues that continue to concern the profession of nursing with regards to the gap between practice and education, the following recommendations are made:

- nurses in the educational setting and nurses in the practice setting must conjointly review and collaboratively address the problem
- define and describe nursing collaboratively; identify incongruences
- collaboratively identify the goals and expectations of nursing practice and nursing education in order to establish congruencies
- identify essential skills and competencies necessary for the beginning practitioner
- collaboratively discuss, review and research evaluation methodologies
- identify ways and means to effectively measure those competencies
- identify methods of enhanced integration of education and practice
- consider consultation with educators in medical schools
- review conceptual framework models
- discuss feasibility of using a broader conceptual framework on which to establish Anglophone CEGEP nursing curricula

- develop a standardized approach to the utilization of conceptual frameworks in both the educational and practice setting

- establish advisory council to nursing schools made up of nurses from the practice setting and vice versa

- establish methods to gain feedback from nursing students and staff nurses in the practice setting to facilitate addressing areas of concern

- discuss methodologies to outline commonalities between all Anglophone CEGEP nursing programs

- encourage and develop research projects that will test the conceptual framework models in the practice settings

- consider joint appointment of practice nurses to establish educational content of curricula

- consider joint appointment of nurse educators to establish aspects of practice setting that are pertinent to this issue of the gap between practice and education in the nursing profession.

- consider ways to increase clinical experience — internships with hospital preceptors or mentors.

3. Conclusion

The removal of nursing education departments from the practice settings has resulted in a perceived gap between the two branches of the profession.

The development of conceptual frameworks and their subsequent use in the development of nursing school curricula has progressed rapidly over a few short years. The practice setting, however, remains essentially unchanged. Nursing schools, in colleges and universities, have kept abreast of educational advances and most use curricular frameworks based on "patient needs." Hospitals, on the other hand, because of their militaristic, bureaucratic, hierarchical and task-oriented focus, could be described as utilizing a practice framework based more on "institutional needs." As such, hospitals may perhaps be the worst places for new nurses to practice nursing as taught. Data are lacking to assess the hospital setting in relation to the practice of the new nurse. However, it would seem that new wine does not sit well in old skins.

Theoretically, nursing education and practice should be interrelated, naturally connected. That connection or bridge seems to be a vital component that is lacking. Independent advancement on the part of education without changes and modifications in the practice setting seems only to lead to frustration and a sense of futility on the part of nurse educators and nurse practitioners alike. Hence, the perception of a gap. And no one has assessed the impact of this perceived gap on the patient.

Nursing education and nursing practice can no longer afford to stand so independently. A more collaborative cohesive approach to nursing by educators and practitioners must be defined and operationalized in order to establish interrelatedness

between what is taught in nursing schools and what is needed to practice. The nursing profession can no longer tolerate education OR service. We must strive toward education FOR service.

George Langill focuses squarely on the issue. In the winter issue of *Forum* magazine, he writes

> We must be more realistic from a societal, professional and organizational perspective. Organizations geared to the formal education of nurses and to their continuing education efforts must be prepared to deal with this matching of professional expectancies and real world behaviours. We cannot continue to function with some of the major discrepancies that have been defined in the literature between the expectations of the educational system and the realities of our hospital wards.[113]

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Appendix A

Philosophy of Nursing — Dawson College School of Nursing

We believe that human beings are social individuals who have needs. They are inter-dependent in satisfying these physiological and emotional needs. Human beings are subject to internal and external stresses and have the potential to deal with these stresses. They have the right to privacy, health, individuality and respect, as well as a right to make decisions for which they are accountable.

We believe that our society consists of groups of human beings living within a defined geographical area governed by socio-political institutions. There is interaction between groups within the society. Society should provide the members with resources to help them meet their needs.

We believe that learning is a dynamic process which continues through life. Each learner has individual patterns of learning which take place in a variety of ways and result in a change in behaviour.

We believe that teaching is the systematic management of the environment and resources to assist individuals to learn.

We believe that nursing is a caring, helping profession based on a biopsychosocial body of knowledge. It is a process of interaction whereby the nurse assists individuals to reach and to maintain their optimum level of functioning.

We believe that nursing education teaches students to use a biopsychosocial body of knowledge to help people meet their needs. It assists the students to assume responsibility and to be accountable for their actions. Nursing education should adapt to the needs and demands expressed by the student.

Appendix B

Nursing at Dawson College

Nursing is helping individuals and groups within a structured environment to deal with problems that are significant to them. Using a relevant biopsychosocial body of knowledge in a problem-solving manner, the nurse, as a health team member, will help individuals or groups attain optimum functioning through direct and indirect care. Nursing is not only relating to others in a caring, professional manner, but also accepting responsibility for his/her individual growth.

Appendix C

Dawson College School of Nursing

Conceptual Framework or Model

Needs Framework or Model

We believe that man has many needs which vary, at times, according to the individual and his/her setting. For our purposes we have defined these needs as:

- Comfort
- Rest and Activity
- Safety
- Nutrition
- Interpersonal Interaction
- Oxygenation
- Self-Esteem

Appendix D

Dawson College School of Nursing

Terminal Objectives

	Level I	Level II	Level III
1.	Using the nursing process with emphasis on assessment together with a relevant biopsychosocial body of knowledge to give safe individualized direct nursing care to meet the needs for comfort, rest, and activity for a client from any age group.	Using the nursing process with emphasis on assessment and planning and implementation together with a relevant biopsychosocial body of knowledge to five safe individualized direct nursing care to meet the needs for comfort, rest, activity, safety, nutrition, interpersonal interaction for one/two clients from all age groups.	Using the nursing process with emphasis on evaluation together with a relevant biopsychosocial body of knowledge to give safe individualized direct nursing care to meet the needs for comfort, rest, activity, safety, nutrition, interpersonal interaction, oxygenation and self esteem for several clients from all age groups.
2.	Identifies the principles of communication in her/his written/verbal interaction with clients, peers, instructor and staff. Uses the principles of communication without making appreciable change in patient behaviour.	Uses the principles of communication to interact with peers, instructor, staff and in a therapeutic manner with one/two clients with problems related to the need for comfort, rest, activity, interpersonal interaction, safety and nutrition.	Uses the principles of communication to interact with health team members and in a therapeutic manner in meeting the needs of all her clients.
3.	Demonstrates proficiency in performing psycho-motor skills relevant to meeting the needs for comfort, rest and activity in one client of any age group.	Demonstrates proficiency in performing psychomotor skills relevant to meeting the needs for comfort, rest, activity, safety, nutrition, and self esteem for one/two clients of any age group.	Demonstrates proficiency in performing psychomotor skills in meeting the needs for comfort, rest, activity, safety, nutrition, interpersonal interaction, oxygenation and self esteem for one/two clients of any age group.
4.	Demonstrates professional behaviour in her nursing actions involved in meeting the needs for comfort, rest, and activity for a client of any age group.	Demonstrates professional behaviour in her nursing actions involved in meeting the needs for comfort, rest, activity, safety, nutrition and interpersonal interaction for one/two clients of all age groups.	Demonstrates professional behaviour in her nursing actions involved in meeting the needs for comfort, rest, activity, safety, nutrition, interpersonal interaction, oxygenation and self esteem for one/two clients of all age groups.

Appendix E

Queen Elizabeth Hospital of Montreal

Philosophy of Nursing

Nursing believes in the worth and individuality of the person and in the preservation of dignity. It is a profession rooted in caring, recognizing that patients have specific needs which require crisis intervention, health maintenance and health promotion.

Nurses value a holistic view of the patient. Care is person and family focused respecting the individual's rights and responsibilities to be involved in decision making concerning care. using a systematic process, the nurse helps the patient to identify stresses and health problems, to make plans to solve these problems utilizing the patient's strengths, and then to initiate or implement and evaluate a plan of care. Nursing recognizes its role in collaborating with the patients and their families to further develop ways of coping with life events and to learn strategies for healthy living. Nursing has a responsibility to facilitate patient learning, and to ensure integrated and continuous nursing care until maximum health potential is achieved. Nursing provides a central role in the delivery of health care to patients while working collaboratively with other health care professionals within an interdisciplinary team.

The nurse is committed to the development and implementation of nursing standards and is accountable for ensuing actions. Nursing supports and participates in research activities for the advancement of nursing knowledge. Nursing provides expertise, guidance and clinical facilities for nursing students and other health care professionals.

Nursing recognizes the value of professional growth and the importance of involvement in societal issues affecting the profession. Nurses are encouraged to take an active role in the development of the profession and in the promotion of health to society.

Rev. 9/86

Appendix F

Queen Elizabeth Hospital of Montreal

Department of Nursing

Position Description

Title:	Staff Nurse
Organizational Relationship:	Responsible to the Head Nurse
Qualification:	A licensed member of the Order of Nurses of Quebec
Summary of Functions:	Responsible for assessing, planning, implementing and evaluating the nursing care for a group of patients

RESPONSIBILITIES

I. Nursing Process:

1. Nursing history is obtained to provide a data base for assessment of patient care.
2. Includes patient, family and/or significant person where appropriate in planning for individualized nursing care.
3. Develops and implements nursing care plans that enhance the effectiveness of the general therapeutic plan for each patient.
4. Provides patient and family teaching, evaluates patient's comprehension and contributes to discharge planning for a group of patients.
5. Documents and communicates verbally patient outcomes to care, and other pertinent information.
6. Evaluates care given and revises plan as required.
7. Delegates activities to auxiliary personnel as required.

II. Leadership:

1. Promotes and maintains effective communication between team members.
2. Participates in orientation of new staff including preceptor role.

II. Leadership — continued:

3. Assists nursing students as they learn how to nurse in cooperation with the instructor.
4. Accepts responsibility for the management of the nursing unit when delegated by the Head Nurse.
5. Is accountable for and assumes responsibility for the total nursing care of assigned patients.
6. Provides direction and supervision to peers and auxiliary staff as necessary.

III. Professional Responsibilities:

1. Care to patients is delivered in accordance with the philosophy of nursing, nursing care standards and accepted policies and procedures.
2. Active participation in nursing committees and programs.
3. Is aware of current trends in health care and assists with the implementation of these changes as they relate to nursing practice.
4. Practices her profession in accordance with the policies and obligations embodied in the Code of Ethics.

IV. Self-Development:

1. Participates in and supports studies and research conducted by nursing and other health care professionals.
2. Participates in the quality assurance program to evaluate nursing care.
3. Attends and/or participates in in-service and continuing education programs to maintain competence.
4. Sets written objectives, evaluates own performance and reviews performance periodically. (Q12 mos)

Appendix G

Questionnaire

The following statements represent some of the behaviours expected of a nurse upon graduation.

Please complete BOTH sections for the following statements.

Place a check mark under the appropriate heading.

Section A represents whether or not you fell the item is ***Essential*** for a new graduate

Section B represents whether or not you feel you are ***Prepared*** to implement the item.*

	Section A Essential		Section B Prepared	
	Yes	No	Yes	No
1. Using the nursing process in the approach to nursing practice				
2. Using nursing diagnoses in formulating written nursing care plans				
3. Document observations and interventions				
4. Demonstrate positive communication techniques with patients, families and members of health care team				
5. Use a conceptual framework as a basis for nursing practice				

* *Questionnaire instructions for new graduates.*
Section B will read as follows:
represents whether or not you feel you are prepared to implement the item.

* *Questionnaire instructions for one year graduates:*
Section B will read as follows:
represents whether or not you feel you were prepared to implement the item.

* *Questionnaire instructions for Nurse Educators and Head Nurses:*
Section B will read as follows:
represents whether or not you feel the new graduate is prepared to implement the item.

	Section A Essential		Section B Prepared	
	Yes	No	Yes	No
1. Administer medications to assigned patients				
2. Perform technical skills in caring for patients				
a) starting an IV				
b) inserting a foley				
c) changing a dressing				
d) administering an enema				
e) inserting an NG tube				
3. Comply with institutional and nursing policies and procedures				
4. Provide safe, individualized nursing care for 4 – 6 patients				
5. Organize patient care and complete within a reasonable length of time				
6. Assist other members of nursing care team				
7. Under[illegible] bio-psycho-social factors that underli[illegible]l and abnormal human functio[illegible]				

	Section A Essential		Section B Prepared	
	Yes	No	Yes	No
1. Act as a role model				
2. Actively participate in independent and group nursing activities; committees; nursing rounds; in-service; staff meetings; quality assurance; audits				
3. Plan written objectives for self-development				
4. Perform self-evaluation				
5. Assume responsibility for own behaviour and competence				
6. Practice within the framework of the profession's legal and ethical responsibilities				

Appendix H

Analysis of Questionnaires

A. Nursing Instructors N=3

Sex:	All female
Age Range:	38 – 46 Average age: 41
Year of Diploma graduation:	1965
	1970
	1978
Nursing Education:	(1) Diploma, Baccalaureate, Masters in nursing
	(1) Diploma in nursing
	(1) Diploma, Baccalaureate in nursing

B. Head Nurses N-10

Sex:	All female
Age Range:	27 – 58 Average age: 36
Year of Diploma graduation:	Range 1952 – 1987
Nursing Education:	(5) Diploma in nursing
	(1) Diploma, Baccalaureate in nursing
	(3) Baccalaureate, Masters in nursing
	(1) Diploma, Baccalaureate, Masters in nursing

C. Nurses Who Graduated One Year Ago N=6

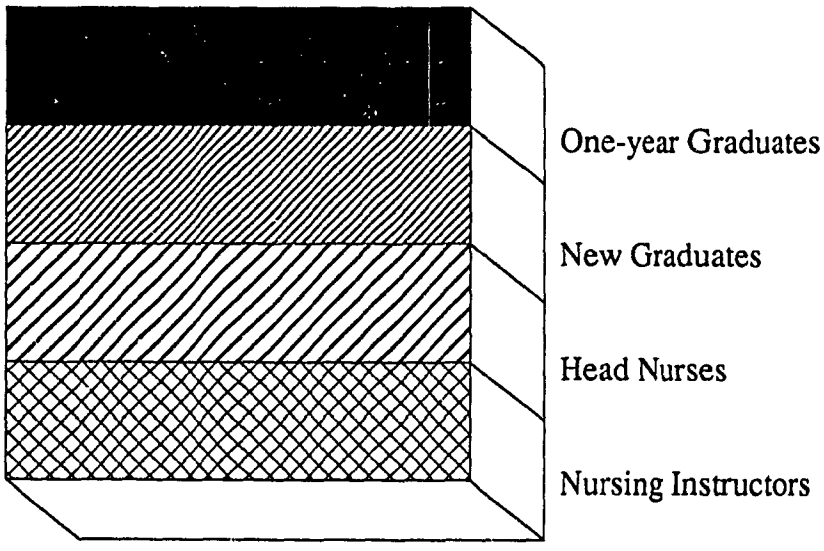
Sex:	All female
Age Range:	21 – 29 Average age: 24
Year of graduation:	1987
Nursing Education:	Diploma in nursing (all);
	CEGEP — Anglophone

D. New Graduates N=17

Sex:	All female
Age Range:	19 – 25 Average age: 21
Year of graduation:	1988
Nursing Education:	Diploma in nursing (all);
	CEGEP — Anglophone

Appendix I

Graphic Representation of Questionnaire Results



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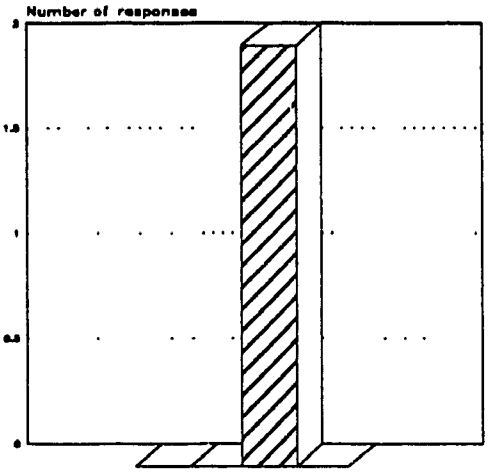

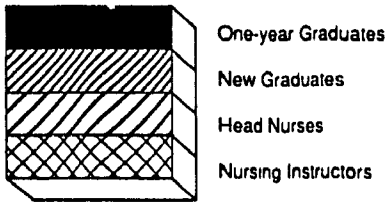

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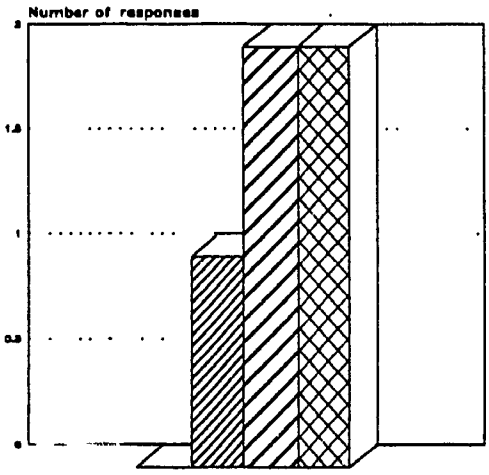

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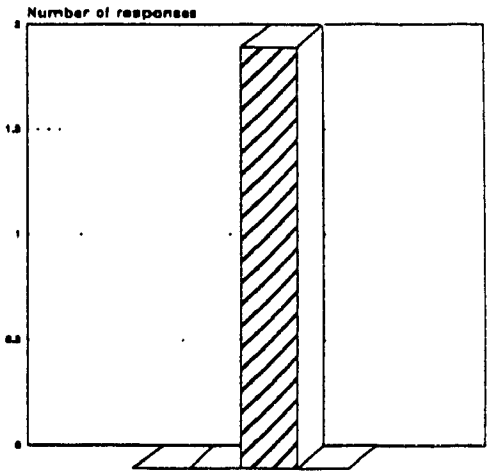

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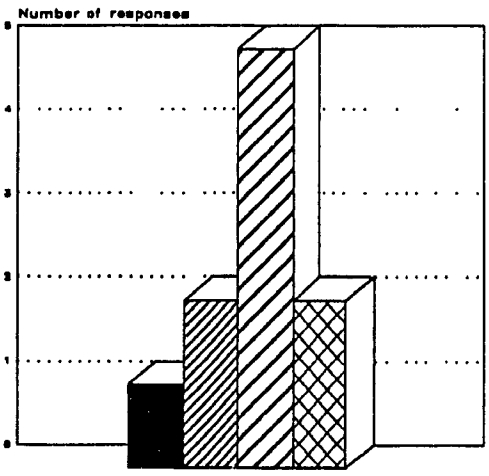

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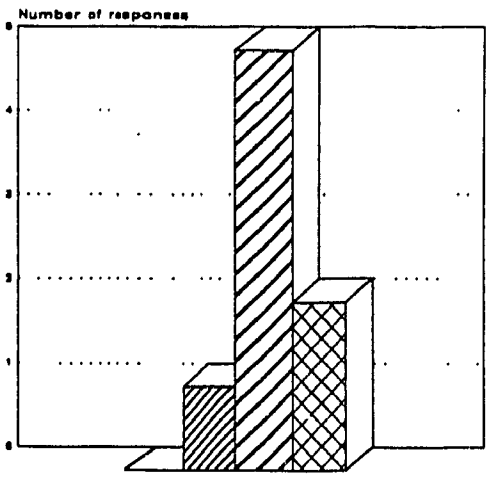

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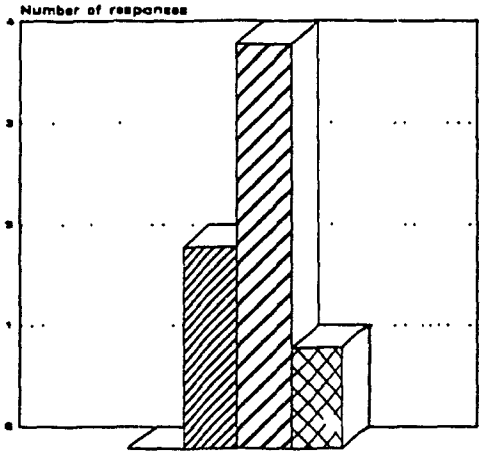

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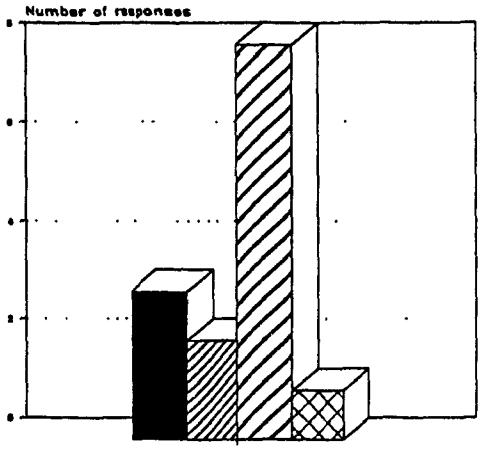

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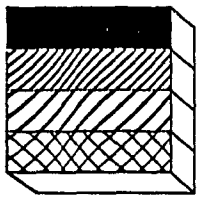
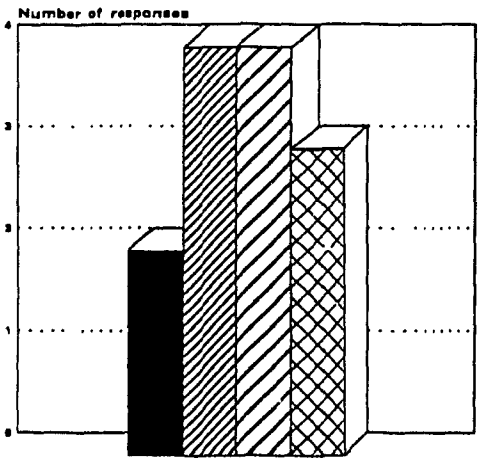


One-year Graduates

New Graduates

Head Nurses

Nursing Instructors



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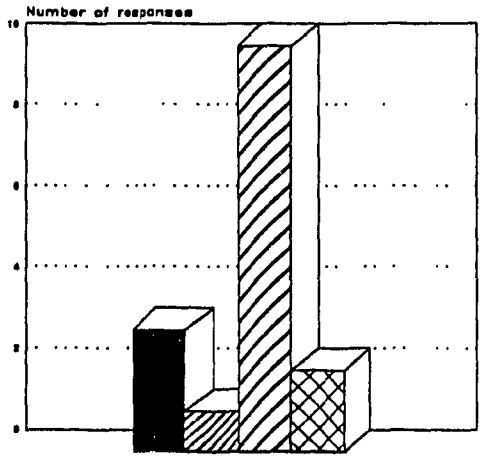

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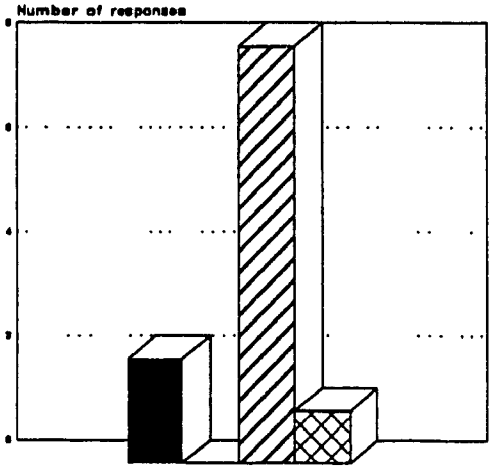

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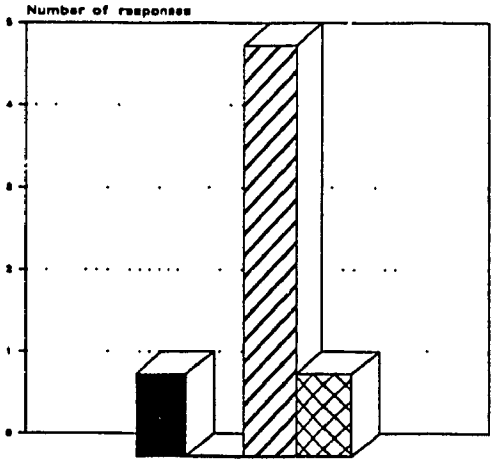

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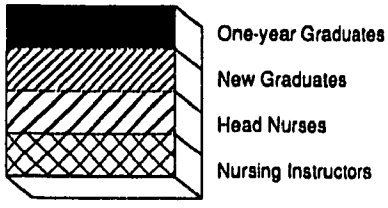

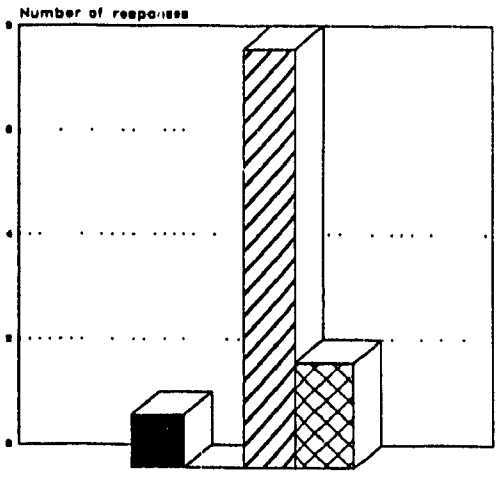

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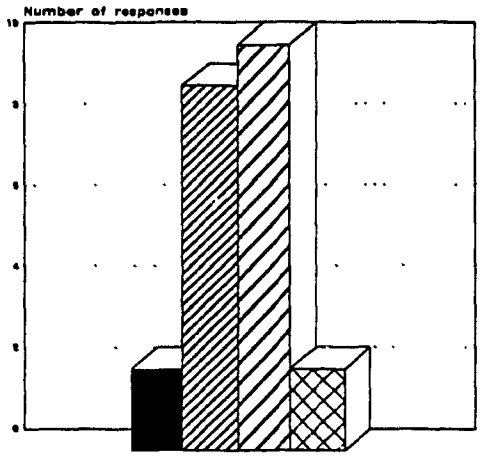

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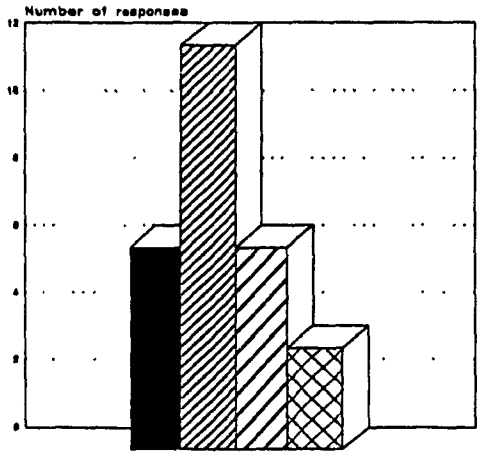

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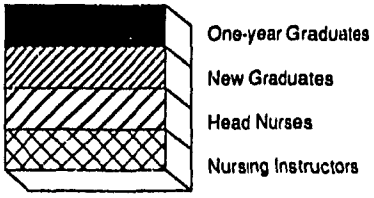

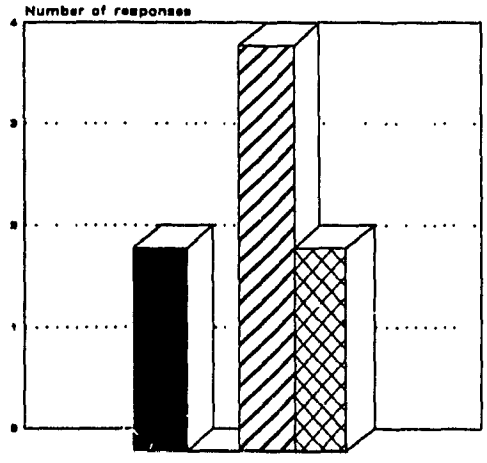

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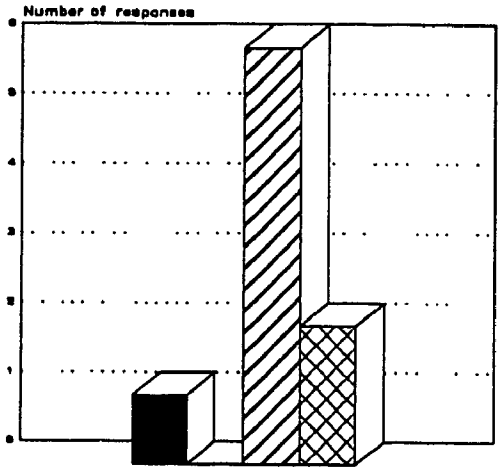

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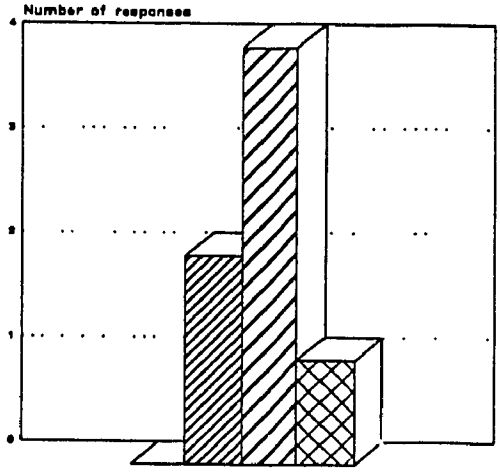

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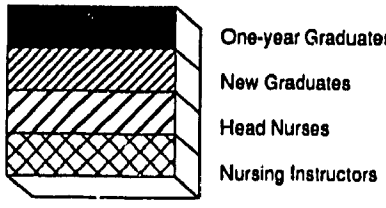

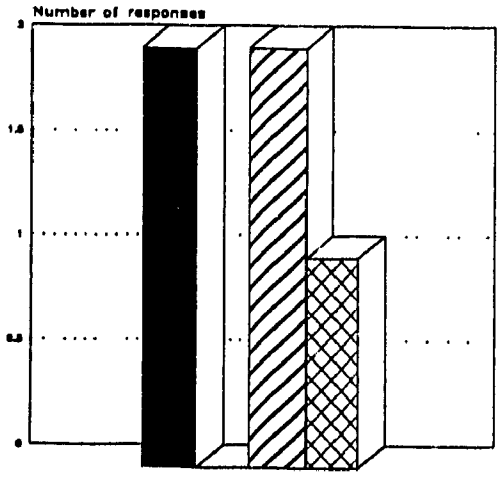

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