Nursing Educator and Nursing

Service Personnel Perceptions

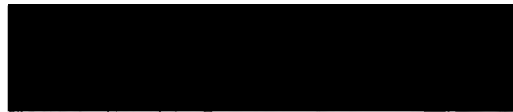of New Nurse Performance

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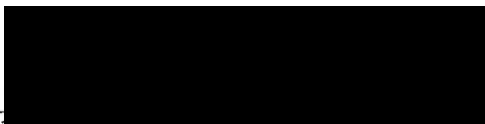
Nancy Ryan Brandenburg

A Thesis

Presented to
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School of Nursing
in partial fulfillment
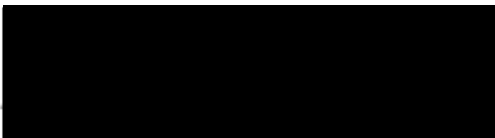of the requirements for the degree of
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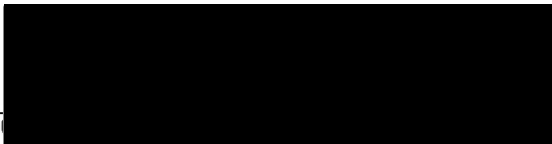Signatures

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ACKNOWLEDGEMENTS

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CHAPTER I

INTRODUCTION

It has been suggested that high job-turnover among new nurses may
be due, in part, to the transition difficulties experienced by the new
graduate moving from school to the workplace (Kramer, 1974; Benner &
Benner, 1979; Nahm, 1980). Views differ as to the cause of these
difficulties. Hospital administrators frequently attribute these
difficulties to the fact that the new graduate, particularly the
baccalaureate graduate, is inadequately equipped to function in
clinical areas. On the other hand, educators assert that the differing
values and rewards of the educational setting and the workplace produce
a diminished professionalism within nursing (Kramer, 1974, p. 23).
This diminished professionalism is expressed in terms of high job-
turnover and an exodus from nursing.

There is a growing body of research describing the transition
difficulties of the new baccalaureate nurse (Kramer, 1974; Benner &
Benner, 1979; Nahm, 1980), yet the results of this research are
inconclusive (Ford, 1977). Because the complexity of the problem makes
solution producing research difficult, the impact of this research on
nursing practice has been limited. This Literature Review will examine
those studies that give a historical perspective to the problem as well
as those studies that provide generalizable information pertinent to
the problem of transition.

Three aspects of the problem have been addressed in the literature: (1) the value conflict between nursing service personnel and nursing educators (Smith, 1965), (2) the transition difficulties of new baccalaureate graduates (Kramer, 1974), and (3) the mismatched performance expectations of students, educators, and service personnel (Benner & Benner, 1979).

Review of the Literature

Smith (1965) studied retrospectively the value assigned by head nurses and nursing educators upon personal characteristics of new baccalaureate graduates. This study demonstrated a significant difference in values and conceptions of desirable personality traits between the two groups. The data sources for the study were 108 randomly selected performance evaluations written by 13 head nurses and 14 nursing educators. These performance evaluations were content analyzed using an adaptation of Leary's interpersonal categories. The differences in the role specific values of head nurses and nursing educators established by Smith were as follows:

1. Head nurses emphasized independence to a greater extent than the nursing educators.

2. Head nurses emphasized staff nurse cooperation and acceptance of organizational standards to a greater extent than nursing educators.

3. Nursing educators emphasized emotional supportiveness and involvement with patient problems to a greater extent than head nurses.

4. Nursing educators stressed cognitive skills such as problem-solving, to a greater extent than head nurses.

5. Head nurses tended to value personality characteristics such as composure, helpfulness, and appearance more than nursing educators (p. 198).

Smith concluded that the head nurses and the nursing educators valued different personality traits and held differing conceptions of the nursing role. This opinion was shared by Ford (1977), who suggested that there are conceptual differences between nursing educators and nursing service personnel not only in their perceptions of the goals of nursing education but in what constitutes skilled performance.

In examining the transition difficulties of new baccalaureate graduates from school to the workplace, Kramer (1974) posited that the socialization and the psychomotor skills acquired by the new graduates in school did not serve to ease the transition from school to the workplace. Kramer suggested that differences in values and socialization led to "reality" or "culture" shock among new baccalaureate nurses (p. 192). The reality shock phenomenon was thought to have a number of undesirable side effects:

1. New nurses discarded the professional ideals of their nursing education in the process of adapting to those of the workplace.

2. New nurses became disillusioned with the workplace and left nursing.

3. New nurses "job-hopped" in search of an ideal job placement that embodied the ideals learned in school (p. 133).

Kramer asserted that the resulting impact of these side-effects was seen in increased nurse job-turnover, the increased cost of health

care, decreased job satisfaction, and diminished professionalism (Kramer, 1974). To test these assumptions Kramer initiated an Anticipatory Socialization Program at the University of San Francisco. That program had four phases and was based upon "Social Immunization Theory" (p. 45). According to this theory, an individual's ability to maintain beliefs and constructively resolve conflict when exposed to conflicting value systems would be increased if there was some opportunity for "pre-exposure" to the conflict (p. 45). Within Kramer's theoretical framework, the optimal adaptation to reality shock was exhibited as "biculturalism" or a balance of the values of the work subculture and the education subculture (p. 162). Biculturalism was measured on an investigator-developed instrument that used integrative role behavior scores. Integrative role behavior was operationally defined as:

>   an effective compromise between behavioral choices that
>   clearly support professional values and those that reflect
>   allegiance to bureaucratic values. They are the kinds of
>   behaviors that a nurse who is attempting to operationalize
>   professional values in a bureaucratic setting would choose (p. 113).

Integrative behaviors were measured using seven conflict situations. The respondent was asked to indicate "the extent to which she would elect to enact certain behaviors" (p. 113).

The four phases of the Anticipatory Socialization Program (Kramer, 1974) were Encounter, Reidentification, Resolution, and Affirmation. The purpose of the first phase of Encounter was to produce conflict in the student through "an attack upon the professional values"

presented in the first year of nursing curriculum (p. 69). This was done using taped incidents followed by seminar discussion. The Reidentification phase was offered to all students who worked as nursing aides during the summer between the first and second year of nursing school. The purpose of this phase was to help the student develop a bicultural adaptation to the potentially antithetical value systems of school and work. The purpose of the Resolution phase was to continue to develop the student's sense of professional-bureaucratic role. This was done by exploring Organizational Theory, and through examining Professional-Bureaucratic Conflict as it was presented in other fields. The fourth phase, Affirmation, consisted of a series of lectures and seminars which focused upon theories of conflict resolution.

A time-series design was used to study the effects of the Anticipatory Socialization Program. A comparison group was contrasted with two groups of nursing students who participated in the Anticipatory Socialization Program. The comparison group was a convenience sample of the 45 nursing students who graduated from the University of San Francisco, School of Nursing, in 1968. The two groups who received the intervention consisted of the 57 and 59 nursing students who graduated from the University of San Francisco, School of Nursing, in 1969 and 1970, respectively. All three groups were followed for two years after graduation. The major weakness in the time-series design is the lack of control over historic differences between the classes (Polit & Hungler, 1980). This must be kept in mind when considering the time-frame in question. The intervening variable introduced by the time-series design

is especially important to consider in this instance because the late 1960's were a period of tremendous social upheaval, particularly on college campuses. Consistent with this, the classes of 1969 and 1970 were characterized by faculty as "feisty", "troublemakers", "discontented", etc. (p. 105).

The Kramer Study (1974, p. 110) made the assumption that job satisfaction was reflected by tenure in initial jobs and in the extent of job movement over time. In terms of turnover and exodus from professional nursing, the Kramer Study (1974, p. 110) found that the nurses who had participated in the Anticipatory Socialization Program remained longer in their initial jobs than did the nurses who did not participate in the Anticipatory Socialization Program ($p \leq .05$). The nurses in the comparison group experienced a significant increase in "job-hopping" over the nurses who received Anticipatory Socialization ($p \leq .05$). The two groups of nurses who participated in the Anticipatory Socialization Program remained in hospital nursing longer than did the nurses in the comparison group ($p \leq .05$).

In addition, when the Kramer Study (1974) examined the integrative behaviors of the subjects in resolving their conflict between their professional ideals and the demands of the workplace, it was found that the two groups who participated in the Anticipatory Socialization Program selected more integrative behaviors than the comparison group.

Another study of the transition difficulties experienced by new nurses was done by Benner and Benner (1979). This study suggested a source of new graduate transition problems was and is the gap in expectations between technical or practical knowledge and

theoretical knowledge; nursing service emphasizing the former and nursing education the latter. In their study of nursing educators, nursing service personnel and new graduates, Benner and Benner hypothesized that each group had a different and not necessarily compatible set of expectations of how the new graduate would function in the work setting. This explanation was termed "the mismatched expectations" of new graduates, nursing educators and nursing service personnel (p. 33).

The major assumption of the Benner and Benner Study (1979) was that the difficulty experienced by new graduates in the transition from school to work was a result of differing values, differing rewards, and a lack of technical competence on the part of the new graduate. To test the hypothesis of mismatched expectations convenience samples of 160 new graduates, 29 senior level nursing educators and a randomized sample of 312 nursing service personnel were asked to comment upon a list of 112 nursing skills and activities. These three groups were asked to indicate the ideal degree of competence and the actual/real degree of competence they expected a new baccalaureate graduate to demonstrate upon entry into practice. The ideal and the actual or real competence ratings were formulated using a 5-point investigator-designed, Likert format, the Benner Competency Appraisal Scale. Ideal competence was operationally defined as "the level of competency most new graduates should have upon graduation" and actual competency was operationally defined as "the level of competency new graduates actually have" upon graduation (p. 137).

The greatest difference in performance expectations existed between the new graduates and the nursing service personnel groups. New graduates expected more of themselves both ideally and realistically than did nursing educators or nursing service personnel. The nursing service personnel were generally pessimistic about the performance capabilities of new graduates. Nursing service personnel had low ideal expectations for new graduates and they tended to be less satisfied with actual new graduate performance than were the educators. The nursing service personnel expected new graduates to ideally acquire competence with only 24 skills, and actually acquire competence with only 3 skills. Nursing educators expected new graduates to ideally acquire competence with 39 skills, and actually acquire competence with 10 skills.

A further analysis revealed significant discrepancies (p $\leq$ .05) in the way the three groups thought new graduates should be prepared and the way the new graduates actually were prepared on 93% of the scale items. In the Benner and Benner Study (1979), discrepancy scores were defined as the difference between the ideal new graduate performance and the actual new graduate performance, in the clinical setting, as reported on the Benner Competency Appraisal Scale (p. 43).

The value differences between groups were assessed using open-ended survey questions and focused interviews. These interviews revealed little agreement between nursing educators and nursing service personnel on the qualities possessed by the ideal graduate. The nursing service personnel emphasized attitude and the ability to "get the job done" (p. 54). Nursing educators emphasized "thinking, problem-solving and making decisions" (Benner & Benner, 1979, p. 54). These findings

lent support to the study's premise of mismatched expectations between nursing service personnel and nursing educators; practical knowledge versus theoretical knowledge.

The design of the Benner and Benner Study (1979) was incorporated into the A.M.I.C.A.E. Project; Achieving Methods of Intraprofessional Consensus and Evaluation (Nahm, 1980). The purpose of the A.M.I.C.A.E. Project was to develop follow-through evaluation strategies for schools of nursing, and assessment tools for staff development in hospitals (p. 1). A random sample of 286 new baccalaureate graduates from 7 participating schools of nursing, 189 nursing educators, and a random sample of 300 nursing service personnel from participating hospitals in the San Francisco Bay Area were asked to comment upon the ideal degree of competence and the actual or real degree of competence they expected the new baccalaureate nurse to demonstrate upon entry into practice.

The instrument used in this study (Nahm, 1980) was the Benner Competency Appraisal Scale. Prior to its use in this study the scale was revised and updated by a panel of nurse experts. In this way, the instrument was reduced to 80 items.

In the A.M.I.C.A.E. Survey as with the earlier Benner and Benner Study (1979), the greatest discrepancy lay between the nursing service personnel group, and the new graduate group (p $\leq$ .001). In examining the results, it became apparent that if new graduates could meet their own expectations they would have easily fulfilled the expectations of the nursing service personnel. It was noted that not only were the nursing service personnel's ideal expectations very low, they specified proficiency on only 13 skills, their real expectations were that the

new graduates would not have achieved proficiency on any of the 80 skills.

The Validity and Reliability Studies (Benner, 1981) on the Benner Proficiency Scale (Benner Competency Appraisal Scale) reveal a similar trend:

The Benner Proficiency Scale has consistently yielded significant differences between the performance expectations of nursing service persons and those of educators and new graduates (p. 10).

Two reasons have been given to explain this finding. The first reason is that new graduates are "negatively stereotyped" by nursing service personnel (p. 10). Negative stereotyping refers to the tendency of nursing service personnel to report that new graduates are incapable of competent performance of the most basic nursing skills. The second reason is that nursing service personnel may have a difference in their perceptions of what constitutes a skilled performance. The A.M.I.C.A.E. Project addressed these questions in later research reports (Benner, 1981).

To examine the possibility of negative stereotyping of new graduates, new nurses were asked to select a colleague at work to rate their actual performance using the Benner Proficiency Scale. It was predicted that the selected nursing service person would indicate a higher actual score when the assessment referred to a particular new graduate with whom that nursing service person was acquainted. This assumption was borne out by the data; nursing service personnel expected actual/real proficiency on 17 of the 80 skills when referring to a particular new nurse versus

none of the 80 skills when referring to new baccalaureate nurses in general (Nahm, 1980, p. 13). These results must be interpreted cautiously in light of the very low survey response of 18%, which increases the risk of response bias among respondents (Polit & Hungler, 1978).

The hypothesis of conceptual differences between nursing educators and nursing service personnel in appraising new graduate performance has led to the application of the Dreyfus Model of Skill Acquisition to nursing practice (Benner, 1981). The Dreyfus Model describes four levels of proficiency through which a learner passes in the acquisition and development of a skill. Initially the learner relies upon "abstract principles" in developing a skill (p. 12). As the learner gains proficiency in a skill, the "demand situation" is increasingly viewed as a whole, rather than as a set of related tasks or rules (p. 12). Research applying the Dreyfus Model to study nursing practice is the subject of more recent investigation by the A.M.I.C.A.E. Project.

Summary

The transition difficulties of new baccalaureate nurses have been related to differing systems of rewards and values in the educational setting and in the workplace. These transition difficulties are manifested by high nurse job turnover rates in hospitals, short-term job incumbency, and exodus from professional nursing.

In conjunction with the conflicting value systems of school and the workplace, it has been demonstrated that nursing

educators, nursing service personnel and newly graduated nurses hold different expectations and perceptions of the entry-level performance of new graduates. These divergent perceptions of the entry-level skills proficiency of new graduates, between nursing educators and nursing service personnel, have been hypothesized to result from conceptual differences in the perception of what constitutes a skilled performance.

Conceptual Framework

The Provus model of discrepancy evaluation is the conceptual framework for this research project. The discrepancy evaluation model involves comparison of the performance outcome against the standards and the goals of a particular educational program (Provus, 1969).

Provus (1969) recommends comparing existent program goals and standards to performance outcomes. Out of that comparison, the evaluator obtains discrepancy information. The discrepancy information is processed in a series of problem-solving steps. The discrepancy concept is used as a mechanism for feedback and revision of program objectives. The model depicts a process for use in evaluation of program development and content. The evaluation process as described by Provus has three major content specifications: input, process, and output. This study focuses on the identification of discrepant information, the input phase of the Provus Model.

In the context of this study, the two respondent groups will indicate the ideal standards and the real performance levels for a list of 60 nursing skills and activities. The nursing educators will be assumed to represent the academic component of nursing and nursing service personnel will be assumed to represent the clinical component of nursing. The difference between ideal and real performance ratings will be called

discrepancy information. Discrepancy information may indicate areas in nursing education and service which require renewed attention and collaboration.

Problem Statement

This study will investigate the discrepancy and/or congruence between nursing educators' and nursing service personnel's standards for entry-level nursing performance. The following relationships will be examined:

1. The difference between nursing educators and nursing service personnel in the ideal performance expected of new graduates.

2. The difference between nursing educators and nursing service personnel in the actual performance expected of new graduates.

3. The difference between nursing educators and nursing service personnel in the discrepancy between ideal and actual performance of new graduates.

Hypotheses

The primary hypothesis for this study is:

-   Nursing service personnel expect a greater discrepancy between the ideal and the actual performance of new graduates than nursing educators.

The two secondary hypotheses for this study are:

-   Nursing service personnel expect a lower level of ideal performance of new graduates than nursing educators.

-   Nursing service personnel expect a lower level of actual performance of new graduates than nursing educators.

CHAPTER II

METHODS

Design

This study partially replicated the study of Benner and Benner (1979)
concerning the actual and ideal performance expected of newly graduated
nurses. New graduates were defined as nurses who had graduated from a
baccalaureate nursing program within the past three months and who were
currently working in their first nursing position. This replication was
intended to explore further the findings of the original study: that
nursing service personnel expect a lower level of ideal and actual
performance of new graduates than nursing educators, and that nursing
service personnel expect a greater discrepancy between the ideal and
actual performance of new graduates than nursing educators.

The purpose of replicating the Benner and Benner Study (1979) with
a change in the sample and the setting, was to generalize the findings
of the original study (Polit & Hungler, 1978). In keeping with Provus'
Discrepancy Model of Evaluation, members from both the service and
education sectors of the nursing community indicated their their ideal
standards and evaluated the actual performance of new graduates on a
list of nursing skills and activities. In the Benner and Benner Study
(1979), all local nursing educators who taught senior students were
contacted. This sample included only those nursing educators with
clinical responsibility for students at the sophomore, junior and
senior levels. The Benner and Benner Study selected nursing service
personnel of varied professional status. This study sampled only

nurses who functioned in a management capacity in an acute care setting. The Benner Study surveyed new graduates. This study did not survey new graduates. For the purpose of this study, nursing educators and nursing service personnel were chosen to illustrate the Benner Study premise of conflicting sociocultural systems; work world values and practical role versus ideal practice and professional role.

Subjects

Nursing service personnel and nursing educators were asked to indicate their expectations of the real and the ideal performance of new baccalaureate graduates using the Benner Proficiency Scale. The rationale for using that sample was to explore the generalizability of the Benner and Benner Study premise of "mismatched expectations" between the service and the academic sectors of nursing (Benner & Benner, 1979).

Nursing Educators were represented by a convenience sample of all of the available faculty with clinical assignments from two of the baccalaureate nursing programs in Portland, Oregon (nursing schools listed in Appendix A). The sample consisted of 34 subjects, all of whom were female. Approximately 88% of the respondents held master's degrees and 12% had obtained doctorates. The average age for these subjects was 34 years.

Nursing service personnel were represented by a convenience sample of all available nurses who functioned in a management capacity from two acute care hospitals in Portland, Oregon (hospitals listed in Appendix A). All but one of the subjects was female and their average age was 38 years. Approximately 16% were graduates of hospital diploma programs, 54% held baccalaureate degrees, 22% had obtained master's degrees, and 8% held

baccalaureate degrees in other disciplines. Return rates for both groups were as follows:

Nursing Service Personnel	Nursing Educators
Benner Proficiency Scale distributed to all nursing service personnel functioning in a management capacity at the Oregon Health Sciences University and at Providence Medical Center in Portland, Oregon.	Benner Proficiency Scale distributed to all available nursing faculty with clinical assignments, at the Oregon Health Sciences University and at the University of Portland in Portland, Oregon.
Total number of surveys distributed: 58	Total number of surveys distributed: 34
Total number of surveys returned: 50	Total number of surveys returned: 34
Percent returned: 86	Percent returned: 100

Instrument

The Benner Competency Appraisal Scale underwent further revisions after its use in the A.M.I.C.A.E. Project (Nahm, 1980). A factor analysis was conducted on the scores obtained using the Benner Competency Appraisal Scale. Based upon the factor analysis of the ideal scores, the number of scale items was further reduced from 80 to 60 items. The 20 items which were omitted from this most recent revision were found

to be highly correlated with other items appearing on the scale (Benner, 1981, p. 8). This new version of the instrument is known as the Benner Proficiency Scale, and it was this version that was used in the current study.

The Benner Proficiency Scale is a list of 60 nursing skills and activities (Appendix B). These skills and activities can be sub-divided into seven factors:

Factor I - Prevention of Iatrogenic Illness (17 items):
This factor includes seventeen skills which reflect general safe practice items. They reflect performance areas aimed at preventing complications due to treatment and/or hospitalization.

Factor II - High Technical/High Risk (11 items):
This factor includes eleven skills which require a high level of clinical judgment. Many of the skills are performed by nurses working in specialized patient care areas and entail individual accountability for the nurse.

Factor III - Helping Role Skills (11 items):
This factor includes eleven skills which require a high level of interpersonal relationship ability. The areas include working with patients, families and staff, and require knowledge of communication, coping styles and teaching-learning strategies.

Factor IV - Medium Technical (9 items):
This factor includes nine skills which are predominately technical and require a medium level of clinical judgment. Many of the skills are unpleasant or difficult for the patient and require skillful communication.

Factor V - Work Role Skills (7 items):

This factor includes seven basic nursing skills which are performed by members of the nursing team. The majority are related to appropriate work practices.

Factor VI - Leadership Skills (3 items):

This factor includes three skills that relate to the areas of performance of a team leader.

Factor VII - Practitioner Skills (2 items):

This factor includes two skills which are diagnostic in their orientation (Nahm, 1980, p. 41).

The use of these factors helped compare more precisely nursing educators and nursing service personnel responses (Nahm, 1980, p. 42). Nursing service personnel and nursing educators were asked to rate the expected performance of new graduates in two ways. First, they were asked to rate the actual (real) performance of new graduates. Real performance is defined as the actual performance demonstrated by most new graduates upon graduation. Second, nursing service personnel and nursing educators were asked to state the ideal performance expected of new graduates. Ideal performance was defined as the ideal performance level which should be demonstrated by most new graduates upon graduation. "The ideal portion of the scale anchors the respondents' opinions in terms of their own standards" (Nahm, 1980, p. 5).

The ratings were performed using a five-point scale. Scale ratings were as follows:

Scale Levels

1.   High Proficiency: Able to perform competently and
                                efficiently without supervision.

2.	Moderate Proficiency:	Able to perform without supervision with reasonable efficiency.
3.	Safe but Practice Needed:	Able to perform without supervision but more practice is needed in order to perform efficiently.
4.	Supervision Needed:	Understands the theory and principles but would need supervision because of limited practice or experience.
5.	Supervision and Instruction Needed:	Was not introduced to the theory and principles and would need both instruction and supervision to perform the skill (Nahm, 1980, p. 5).

Using actual/real and ideal ratings on the Benner Proficiency Scale, 21 scores were computed for each group:

- 7 actual/real performance scores; computed by averaging real ratings for the items which composed each of the seven factors.
- 7 ideal performance scores; computed by averaging ideal ratings for the items which composed each of the seven factors.
- 7 discrepancy scores; computed by subtracting each real score from its respective ideal score for each of the seven factors.

The Benner Proficiency Scale also included a number of items which yielded information descriptive of the sample (please see instrument in Appendix B).

Pearson correlation coefficients were computed to quantitatively assess the relatedness of the constructs represented by each of the 7 factors; 7 ideal and 7 real. Table 1 presents the Pearson

correlations between the 7 ideal and the 7 real factor scores. Generally the ideal factor scores correlated highly with the real factor scores (Pearson $r \geq .30$). A notable exception to this trend is Ideal Factor Number 2 (High Technical/High Risk) which had relatively low correlations with all actual/real factor scores except for Real Factor Number 7 (Practitioner Skills).

Table 2 presents the Pearson correlations between ideal by ideal factor scores, and Table 3 present the Pearson correlations between the real by real factor scores. These correlations were consistently high, suggesting a very strong relationship among all real factor scores and among all ideal factor scores.

Tests for the internal consistency reliability of the 7 ideal and the 7 real factors were performed using Cronbach's alpha (Table 4). These values were consistently high ($\geq .77$), indicating a high degree of internal consistency among the items composing each factor.

Procedure

Advance letters were sent to each hospital director of research, and to each school of nursing program director. The advance letter provided a brief statement of purpose and an invitation to participate in the study (Appendix C). The advance letters were followed by a telephone call to solicit participation in the study. When participation was agreed upon, lists of nursing educators with recent clinical assignments and lists of nurse managers were obtained through the administration of the participating agency.

A minimum of 25 nursing service personnel and 25 nursing educators was set prior to data collection. Originally the intent was to randomly

Table 1

Pearson Correlation Coefficients Between Real and Ideal Performance Factor Scores

	Ideal Safety Orientation	Ideal High Tech./ High Risk	Ideal Helping Role	Ideal Medium Technical	Ideal Work Role	Ideal Leadership	Ideal Practitioner
Actual Safety Orientation	.59***	.27**	.56***	.33***	.49***	.34***	.35***
Actual High Tech./High Risk	.41***	.51***	.37***	.39***	.25*	.34***	.38***
Actual Helping Role	.42***	.14	.64***	.22*	.38***	.31**	.23*
Actual Medium Technical	.37***	.27**	.41***	.46***	.34***	.34***	.32**
Actual Work Role	.42***	.07	.49***	.21*	.61***	.29**	.28**
Actual Leadership	.42***	.29**	.50***	.32**	.38***	.52***	.31**
Actual Practitioner	.44***	.36***	.45***	.31**	.34***	.29**	.61***

*   p < .05
**   p < .01
*** p < .001

Table 2

Pearson Correlation Coefficients Between Ideal by Ideal Performance Factors

Performance Factors	Reliability Estimate	Safety Orient.	High Tech./ High Risk	Helping Role	Medium Tech.	Work Role	Leadership	Practitioner
Safety Orient.	(.949)	-						
High Tech./ High Risk	(.920)	.70***	-					
Helping Role	(.910)	.76***	.53***	-				
Medium Tech.	(.885)	.68***	.73***	.58***	-			
Work Role	(.785)	.72***	.42***	.65***	.56***	-		
Leadership	(.730)	.71***	.67***	.59***	.73***	.54***	-	
Practitioner	(.770)	.74***	.73***	.54***	.60***	.52***	.61***	-

*** p < .001

Table 3

Pearson Correlation Coefficients Between Real by Real Performance Factors

Performance Factors	Reliability Estimate	Safety Orient.	High Tech./High Risk	Helping Role	Medium Tech.	Work Role	Leadership	Practitioner
Safety Orientation	(.934)	-						
High Tech./High Risk	(.876)	.72***	-					
Helping Role	(.876)	.77***	.52***	-				
Medium Technical	(.846)	.72***	.71***	.63***	-			
Work Role	(.755)	.77***	.44***	.72***	.64***	-		
Leadership	(.720)	.72***	.66***	.62***	.71***	.67***	-	
Practitioner	(.730)	.71***	.66***	.63***	.61***	.59***	.56***	-

*** p < .001

Table 4

Internal Consistency Reliability Estimates
(Cronbach's alpha) for the Factor Measures

Factor	Number of Items	Average Inter-item Correlation Coefficient	Unstandardized Internal Consistency Coefficient	Sample Size[a]
Ideal Safety Orientation	17	.525	.949	77
Actual Safety Orientation	17	.457	.934	76
Ideal High Tech./High Risk	11	.512	.920	75
Actual High Tech./High Risk	11	.392	.876	71
Ideal Helping Role	11	.489	.910	81
Actual Helping Role	11	.398	.876	80
Ideal Medium Technical	9	.467	.885	79
Actual Medium Technical	9	.393	.846	77
Ideal Work Role	7	.350	.785	81
Actual Work Role	7	.310	.755	79
Ideal Leadership	3	.476	.730	81
Actual Leadership	3	.473	.720	81
Ideal Practitioner	2	.630	.770	80
Actual Practitioner	2	.570	.730	80

[a]Sample size based upon those subjects who responded to all items within the specified factor.

select subjects from employee lists provided by participating agencies. However, it was decided by the two hospitals and one school of nursing that data collection would be executed more efficiently at a management or faculty meeting.

Prospective subjects for the nursing educator group at the Oregon Health Sciences University received an advance letter (Appendix C). The advance letter served three purposes. First, it told the recipient that she would be contacted. Second, it identified the purpose of the study. And third, it asked the recipient for help in solving the problem posed by the study (Dillman, 1978, p. 162). Prospective subjects were then contacted by phone to request participation. When participation was agreed upon, the investigator met with the subject and delivered the survey. This self-administered survey required approximately 10 minutes to complete. The investigator waited and collected the completed survey. Experience has shown that personal contact encourages a higher rate of return than a mail survey format (Dillman, 1978, p. 2).

Prospective subjects at the two participating hospitals and at the University of Portland School of Nursing attended a five-minute presentation which identified the purpose of the study and requested participation. Surveys were then administered and collected from those who wished to participate immediately following the presentation.

Analysis

The data yielded by this study were ordinal. The use of parametric tests with ordinal level data is controversial, yet it is argued that non-parametric tests lack the "power and flexibility" of parametric

tests (Hensler & Stipak, 1979, p. 627). Although controversy exists over the use of parametrics with ordinal data, parametric tests were used because sample sizes were adequate ($N \geq 30$) according to guidelines set forth by Polit and Hungler (1978, p. 466). In addition, the range and distributions of scores for the ideal and the actual/real performance factors were judged to be suitable for use with parametric procedures.

T-tests were used to examine the differences between nursing educators and nursing service personnel in their expectations of new graduates' ideal performance, actual performance, and the discrepancy between the real and the ideal performance.

CHAPTER III

RESULTS

The Discrepancy Between Ideal and Actual Performance Expectations

The primary hypothesis stated that the nursing service personnel
would indicate a greater discrepancy between their ideal and their
real performance expectations of new graduates than nursing
educators. Ideal and real performance expectations were
measured with a 5-point Likert scale on a 60-item survey. The survey
items were grouped into seven factors; seven ideal and seven real;
for the purposes of data analysis (Appendix B). An average discrepancy
score was calculated based upon the difference between the ideal score
and the real score.   Group averages for each of the seven factors
were compared using a t-test. Table 5 presents a comparison of the mean
discrepancy scores of nursing educators and nursing service personnel.
Nursing service personnel indicated a greater discrepancy on each of the
seven factors than did nursing educators ($p \leq .001$). Therefore, the
hypothesis that the nursing service personnel would expect a greater
discrepancy between the ideal and the real performance of new
graduates is supported.

Ideal Expectations and Actual/Real Performance Expectations

The two secondary hypotheses stated that nursing service personnel
would have lower ideal performance expectations and lower real
performance expectations of new graduates than nursing educators.
Ideal and real performances were measured with a 5-point Likert

Table 5

Comparison of Nursing Educators and Nursing Service Personnel on Mean
Discrepancy Scores for Each of the Seven Performance Factors

Performance Factor	Mean (Standard Deviation)		Calculated[a] t Value	Degrees of Freedom[b]	Direction of Difference
	Group 1 Nursing Educators (NE)	Group 2 Nursing Service Personnel (NS)			
1. Safety Orientation	.52(.47)	1.06(.62)	-4.50***	81	NE < NS
2. High Technical/ High Risk	.52(.55)	.97(.70)	-3.34***	80	NE < NS
3. Helping Role	.58(.52)	.84(.55)	-2.24*	73	NE < NS
4. Medium Technical	.56(.56)	1.05(.62)	-3.80***	76	NE < NS
5. Work Role	.42(.46)	.91(.47)	-4.76***	72	NE < NS
6. Leadership	.44(.54)	1.11(.66)	-5.05***	77	NE < NS
7. Practitioner	.44(.61)	1.07(.78)	-4.08***	77	NE < NS

[a]The denominator of the calculated t uses a separate estimate of variance due to the unequal sizes of the two groups.

[b]Because the degrees of freedom for a t-test with separate variance estimates is often not a whole number, the number of degrees of freedom has been rounded to a whole number.

* $p < .05$
** $p < .01$
*** $p < .001$

scale on a 60-item survey. An average for each group was calculated for each of the seven factors; seven ideal and seven real. Table 6 presents a comparison of the group mean ideal factor scores for the nursing educators and the nursing service personnel. Although the nursing educators indicated greater ideal performance expectations than the nursing service personnel, the differences on all of the factor scores, with the exceptions of Factor 1, Ideal Safety Orientation and Factor 3, Ideal Helping Role, were not found to be significant. Thus, the secondary hypothesis, that nursing educators would indicate greater ideal performance expectations than nursing service personnel, was not supported.

Table 7 presents a comparison of the group mean real factor scores for nursing educators and nursing service personnel. Nursing service personnel indicated significantly lower real performance expectations ($p \leq .001$) than the nursing educators. Therefore, the secondary hypothesis that nursing service personnel would expect lower real performance of new graduates than nursing educators is supported.

Table 6

Comparison of Nursing Educators and Nursing Service Personnel on Mean Ideal Factor Scores

Performance Factor	Mean (Standard Deviation)		Calculated[a] t Value	Degrees of Freedom[b]	Direction of Difference
	Group 1 Nursing Educators (NE)	Group 2 Nursing Service Personnel (NS)			
1. Safety Orientation	3.99(.66)	3.74(.69)	1.73*	73	NE > NS
2. High Technical/ High Risk	2.96(.70)	2.95(.80)	.05	77	No Difference
3. Helping Role	3.93(.66)	3.52(.61)	2.83**	67	NE > NS
4. Medium Technical	3.22(.70)	3.17(.66)	.34	68	No Difference
5. Work Role	4.30(.63)	4.10(.45)	1.64	55	No Difference
6. Leadership	3.34(.83)	3.32(.67)	.11	59	No Difference
7. Practitioner	3.59(.81)	3.53(.99)	.29	76	No Difference

[a]The denominator of the calculated t uses a separate estimate of variance due to the unequal sizes of the two groups.

[b]Because the degrees of freedom for a t-test with separate variance estimates is often not a whole number, the number of degrees of freedom has been rounded to a whole number.

* $p < .05$
** $p < .01$
*** $p < .001$

Table 7

Comparison of Nursing Educators and Nursing Service Personnel on Mean Actual Factor Scores

| Performance Factor | Mean (Standard Deviation) | | Calculated[a] t Value | Degrees of[b] Freedom | Direction of Difference |
	Group 1 Nursing Educators (NE)	Group 2 Nursing Service Personnel (NS)			
1. Safety Orientation	3.47(.54)	2.68(.57)	6.47***	74	NE > NS
2. High Technical/ High Risk	2.44(.49)	1.98(.54)	4.08***	76	NE > NS
3. Helping Role	3.35(.55)	2.68(53)	5.54***	69	NE > NS
4. Medium Technical	2.67(.46)	2.12(.47)	5.24***	72	NE > NS
5. Work Role	3.88(.52)	3.18(.54)	5.96***	72	NE > NS
6. Leadership	2.89(.70)	2.21(.52)	4.81***	54	NE > NS
7. Practitioner	3.15(.63)	2.46(.79)	4.35***	77	NE > NS

[a]The denominator of the calculated t uses a separate estimate of variance due to the unequal sizes of the two groups.

[b]Because the degrees of freedom for a t-test with separate variance estimates is often not a whole number, the number of degrees of freedom has been rounded to a whole number.

* p < .05
** p < .01
*** p < .001

CHAPTER IV

DISCUSSION

Characteristics of the Sample

Both groups of subjects in this study had a higher average level of education than the subjects in either the Nahm Study (1980) or the Benner and Benner Study (1979). The prevalence of nurses with baccalaureate degrees (54%) and master's degrees (22%) in the nursing service group may be explained by the use of management personnel as study subjects rather than the staff nurses used in previous studies; management positions frequently have higher educational requirements. The proportion of subjects in the nursing educator group with master's degrees and doctorates was greater in this study than in the Benner and Benner Study (1979) or the Nahm Study (1980). A possible explanation for this sample difference might be that there were simply more nursing educators in 1983 who had obtained master's degrees and doctorates than there were in the past.

The average age of the nursing service group was greater than that of the Benner and Benner Study (1979); their average age was 34 years as compared with 38 years in this study. The average age in the nurse educator group was less than the average age in the two previous studies of Benner and Benner (1979) and Nahm (1980). The demographic differences between earlier samples (Benner & Benner, 1979; Nahm, 1980) and the sample in the current study were examined for descriptive purposes only. Comparison of the results of this study with the earlier studies of

Benner and Benner (1979), and Nahm (1980), must take into account that the sample size of this study was much smaller than the sample size in either of those two earlier studies.

Findings Relative to the Research Question

The hypothesis of this study, that nursing service personnel would indicate a greater discrepancy between their ideal and their real performance expectations of new graduates, was supported by a comparison of group means (t-test) which indicated a significant difference ($p < .001$) between the nursing educator group and the nursing service personnel group. This finding was in keeping with earlier studies by Benner and Benner (1979) and Nahm (1980). In both the Benner and Benner Study (1979) and the Nahm Study (1980) these discrepancy scores were interpreted as a "measure of discontent" (Benner & Benner, 1979, p. 43) with the actual performance level of the new baccalaureate graduate.

The discrepancies between the ideal and the real factor scores were greater for the nursing service group than for the nursing educator group, because the nursing service personnel indicated lower real ratings than the nursing educators. The difference between the nursing educator and the nursing service personnel performance expectations may be explained in terms of differing perceptions of the real performance of new graduates. As proposed in the Nahm Study (1980), this difference is most likely due to differing conceptions of what comprises competent performance. The low real scores of the nursing service personnel could also be explained in terms of negative stereotyping of new graduates by nursing service personnel (Nahm, 1980). The explanation of negative stereotyping of new graduates

is based upon the human tendency to make generalizations. Thus, if new graduates lack competence in one area, they are presumed to be deficient in all others (Benner, 1981, p. 11).

In the Nahm Study (1980) it was predicted that the nursing service group would indicate a higher level of actual performance if asked to appraise a particular new graduate's actual performance. This is in fact what was found, but the return rate for that portion of the A.M.I.C.A.E. Survey was very low (18%), thus making interpretation of the data difficult (Nahm, 1980, p. 14). A couple of problems with that approach was that it required a very high level of coordination to administer the survey and the survey dealt with socially sensitive information; evaluation of a colleague. Both of these problems may have influenced the return rate (Dillman, 1978).

Response set bias could also be influencing the current study's results. The high Pearson correlations between ideal by ideal and real by real factor scores (Tables 2 & 3) may be indicative of a response set pattern in the way that respondents answered real versus ideal survey items (Polit & Hungler, 1978). One might expect nursing educators to indicate less of a discrepancy between ideal and real performance if that difference is perceived to be a gauge of that nursing educator's teaching ability. One might also expect nursing service personnel to indicate a greater difference between ideal and real performance of new graduates, if that difference is perceived to be a gauge of that nurse manager's clinical experience and expertise.

Another question which arises is whether similar results would be obtained if respondents were asked for only their ideal or their real

performance expectation. It has been suggested that in asking for
both the ideal and the real performance expectations, a difference
is implied, thus setting up a response pattern or questionnaire design
bias (Dillman, 1978).

The findings related to the secondary hypotheses, that nursing
service personnel would indicate lower ideal and lower real
performance expectations of new graduates than nursing educators,
differed from the earlier studies of Benner and Benner (1979) and Nahm
(1980). In the current study, the nursing service personnel indicated
uniformly lower ideal performance expectations than the nursing
educators, on all seven factors, but the differences between the group
averages were not found to be significant, except in the case of
Ideal Safety Orientation (Factor 1) and Ideal Helping Role (Factor 3).
These findings differ from the findings of the Nahm Study (1980) and
the Benner and Benner Study (1979), which found significant differences
between nursing service personnel and nursing educators on all factors.
A possible explanation for the findings of the current study could be
that between this group of nursing educators and nursing service personnel
there is agreement about how new nurses ought to perform, but a difference
of opinion about how they actually do perform. These findings still tend
to support either of the explanations proposed by the Nahm Study (1980);
negative stereotyping of new graduates or differing perceptions of
clinical expertise between the two groups surveyed; to explain the low
real ratings indicated by nursing service personnel.

The significant differences between the nursing educators' and the
nursing service personnel's scores for Ideal Safety Orientation and Ideal
Helping Role may also be indicative of the different values held by each

group. The items which compose Ideal Safety Orientation focus upon prevention and the items which compose Ideal Helping Role focus upon interpersonal skills. Thus, both of these factors emphasize cognitive more than technical proficiency. It was suggested that technical ability is valued in the service setting and that cognitive ability is valued in the educational setting (Kramer, 1974). This value conflict was of central importance to the Smith Study (1965) and later became a basis for the work of Kramer (1974), Benner and Benner (1979) and Nahm (1980).

Another concern, related to high Pearson correlations between the factor scores; real with real and ideal with ideal (Tables 2 & 3); is that of construct validity. One must question whether or not the factors measure separate and distinct qualities or whether the entire instrument measures one quality of or aspect of nursing care. While this study didn't specifically address the validity of the Benner Appraisal Scale and the use of factor scores, it is of interest to note that all of the factors are highly correlated. It is possible that the instrument, through its design, forces the respondent to make a distinction between ideal and actual performance. It comes as no surprise that the subjects surveyed never indicated that the new graduates were able to perform at a level greater than the "ideal".

CHAPTER V

SUMMARY

The purpose of this study was to investigate the perceptions of nursing educators and nursing service personnel in regard to the entry-level skill proficiency of new baccalaureate nurses. Three relationships were examined:

1. The difference between nursing educators and nursing service personnel in the ideal performance expected of new graduates.

2. The difference between nursing educators and nursing service personnel in the actual performance expected of new graduates.

3. The difference between nursing educators and nursing service personnel in the discrepancy between ideal and actual performance of new graduates.

The primary hypothesis for this study was:

-   Nursing service personnel expect a greater discrepancy between the ideal and the actual performance of new graduates than nursing educators.

The two secondary hypotheses for this study were:

-   Nursing service personnel expect a lower level of ideal performance of new graduates than nursing educators.

-   Nursing service personnel expect a lower level of actual performance of new graduates than nursing educators.

Nursing service personnel were represented by 50 nurses who served in a management capacity from Providence Medical Center and The Oregon Health Sciences University in Portland, Oregon. Nursing educators were represented by 34 nursing instructors with clinical teaching assignments from The Oregon Health Sciences University School of Nursing and the University of Portland School of Nursing in Portland, Oregon.

The survey subjects indicated their "ideal" and "real" performance expectations for newly graduated baccalaureate nurses using the Benner Proficiency Scale. The respondents were asked to indicate the ideal and the real performance level of new graduates on a list of 60 nursing skills and activities using a 5-point scale.

The 60 items were subdivided into 7 factor scores. The group responses were then compared in terms of the level of ideal and real group performance expectations for each factor.

The data yielded by this study revealed significant differences between ideal and real performance expectations between nursing educators and nursing service personnel on all seven factors. To account for these differences, ideal factor scores and real factor scores were compared between the two groups. Generally, significant differences were not found between the two groups' ideal factor scores. However, significant differences were found between the two groups for all real factor scores.

These results implied that there was a difference in the performance expectations for new graduates between nursing educators and nursing service personnel and that this difference was strongly related to differing perceptions of the real performance capabilities of new baccalaureate nurses.

Limitations of the Study

A limitation of this study was the use of convenience sampling which limits the generalization of the study results (Polit & Hungler, 1978). All employees within the specified sampling categories were given the opportunity to take part in the survey. Thus, the primary difference between the sample in this replication and the samples of the earlier studies of Benner and Benner (1979) and Nahm (1980) is the use of a convenience sample comprised of only nurse managers versus a randomized, mixed group of staff nurses, head nurses, etc.

A second limitation of this study is related to the validity of the Benner Proficiency Scale. Although the Benner Proficiency Scale has consistently yielded similar results, other explanations for these results findings must be examined. A weakness of the instrument is its division of responses into ideal and real categories. Even though the difference between ideal and real categories may be genuine, there is the possibility that the difference is being inflated through the design of the questionnaire (Dillman, 1978). Another concern about the instrument related to construct validity is the possibility that the questionnaire is measuring some other quality or difference between nursing service personnel and nursing educator perceptions of clinical competence.

Recommendations

For future study, it might be productive to perform additional analyses to further establish the validity of the Benner Proficiency Scale. Several interesting options could be pursued to achieve this end. The study could be replicated using the same type of sample used in this study, but asking for only the real performance ratings or the ideal performance ratings at a given time.

Further analysis could also be performed using the same data but different factors or constructs for grouping subscale items. For example, the items could be grouped according to psychomotor and cognitive categories. Through the creation of new subscales, it could be more clearly established that certain groups of items measure the separate and distinct constructs proposed in the Nahm Study (1980).

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Appendix A

Hospital Participants

Nursing School Participants

Appendix A

Hospital Participants

1. Oregon Health Sciences University

2. Providence Medical Center

Nursing School Participants

1. University of Portland, School of Nursing

2. Oregon Health Sciences University, School of Nursing

Appendix B

Benner Proficiency Scale

This section is a scale listing 60 nursing actions ranging from frequently performed, central skills, to infrequently performed, specialized skills. This survey asks you to indicate the level of performance you think *most* new graduates *should have upon graduation*, and the level of performance you think *most* new graduates *actually have* upon graduation. The scale contains two parts: IDEAL reflects how you think most new graduates should be prepared; REAL reflects how you think most new graduates actually are prepared. The scale is composed of five levels of performance:

1. High Proficiency:	Able to perform competently and efficiently without supervision.
2. Moderate Proficiency:	Able to perform without supervision with reasonable efficiency.
3. Safe, but Practice Needed:	Able to perform without supervision but more practice is needed in order to perform efficiently.
4. Supervision Needed:	Understands the theory and principles but would need supervision because of limited practice or experience.
5. Supervision and Instruction Needed	Was not introduced to the theory and principles and would need both instruction *and* supervision to perform the skill.

For example, if the nursing skill is "Able to start intravenous fluids" and you think *most* new graduates *should be able* "to perform without supervision but more practice is needed in order to perform efficiently," you would mark IDEAL "Safe but Practice Needed," by filling in box #3, as shown in the example below. Then, if based on your experience, you think *most* new graduates *upon graduation* understand "the theory and principles but would need supervision because of limited practice or experience," you would mark REAL, "Supervision Needed" by filling in box #4, as illustrated.

Able to Start Intravenous fluids	IDEAL ⊏1⊐ ⊏2⊐ ●3● ⊏4⊐ ⊏5⊐ REAL ⊏1⊐ ⊏2⊐ ⊏3⊐ ●4● ⊏5⊐

Note: Both parts IDEAL and REAL should be marked for each nursing action. Please use a #2 pencil to mark your responses, and erase completely any response you wish to change.

Please use this key to complete Part II of the scale. The following 11 questions correspond to items 1-11 on page 4 of your answer sheets. For example, the first question listed below, "How old are you?" corresponds to item 1, "Age", on page 4 of your answer sheets. The four responses for the first question - "under 23 years old", "24 to 29 years old", "30 to 39 years old", and "40 years old or older" -correspond to the four numbered boxes to the right of item 1. So if you are 28 years old, you would mark box 2 to the right of item 1 as illustrated.

1. Age	⊏1⊐ ⊏2⊐ ⊏3⊐ ⊏4⊐

Please use a #2 pencil to mark your responses, and mark only one response for each question. Please erase completely any response you wish to change.

1. How old are you?

    1. Under 23 years old
    2. 24 to 29 years old
    3. 30 to 39 years old
    4. 40 years or older

2. If you are a new graduate, what is the amount of nursing-related experience you had *before entering* your most recent nursing program? If you are *not* a new graduate, please go on to question #3.

    1. None
    2. Less than one year
    3. One to two years
    4. Three to four years
    5. Five years or more

3. What is your present employment status?

    1. Full-time employment   4. Armed Forces
    2. Part-time employment   5. Unemployed and seeking work
    3. Full-time student   6. Unemployed but not seeking work

4. In what area do you work the most? If you are *not* employed in an *acute care hospital,* please go on to question #5.

    1. Adult medical or surgical   6. Emergency room
    2. Pediatrics   7. Psychiatric unit
    3. OB-GYN   8. Staffing registry
    4. ICU/CCU   9. Other
    5. O.R./Recovery Room

5. If you were to describe your career direction during the next five years, which of the areas listed below would be your first choice?

1. Clinical nursing role in the acute care hospital
2. Clinical nursing role in an ambulatory care setting
3. Clinical specialist role
4. Nursing education
5. Nurse practitioner
6. Nursing administration
7. Academic administration
8. Psychiatric or community mental health
9. Other nursing role
10. Career outside nursing

6. Please indicate the type of *nursing* program you completed.

1. L.V.N./L.P.N.
2. Hospital diploma program
3. Associate degree program
4. Baccalaureate degree program

7. Please indicate the highest degree you have obtained.

1. Hospital diploma R.N.
2. Associate degree R.N.
3. Baccalaureate degree R.N.
4. R.N., Masters degree
5. Doctor of Nursing Science
6. Non-nursing B.A. or B.S.
7. Non-nursing M.A. or M.S.
8. Non-nursing Ph.D. or Ed.D.

8. If you are a nurse educator, which response *best represents your teaching role with undergraduate students? If you are not* a nurse educator, please go on to question 9.

1. Primarily clinical instruction
2. Primarily classroom instruction
3. Approximately equal amounts of clinical and classroom instruction

9. Please indicate how long it has been since you have had a position where the major amount of your time was spent giving direct patient care.

1. Presently involved
2. 0-2 years
3. 3-5 years
4. More than 5 years

THE LAST TWO QUESTIONS PERTAIN ONLY TO THOSE IN NURSING SERVICE POSITIONS.

10. In your present position, approximately how many new nursing graduates do you work with during a year?

1. None
2. 1 to 2
3. 3 to 4
4. 5 to 6
5. 7 or more

11. Please choose the *one* description which *best identifies your current position.*

1. Staff nurse, shift charge nurse or team leader
2. Director or associate/ assistant director of nursing
3. Head nurse
4. In-service educator
5. Clinical specialist
6. Supervisor

PART I: PERFORMANCE EXPECTATIONS

1=High Proficiency
2=Moderate Proficiency
3=Safe but Practice Needed
4=Supervision Needed
5=Supervision & Instruction Needed

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PLEASE SEE THE ENCLOSED YELLOW SHEET
FOR DEFINITIONS OF THE ABOVE TERMS AND INSTRUCTIONS
FOR MARKING THE FOLLOWING SCALE.

- ERASE COMPLETELY TO CHANGE
- EXAMPLE:

	1	2	3	4	5
IDEAL	:1:	:2:	:3:	▬4▬	:5:
REAL	:1:	▬2▬	:3:	:4:	:5:

		1	2	3	4	5
1. Turn and position a patient in bed	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
2. Ensure patient's rights to continuity of nursing care when patient is transferred	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
3. Ask for assistance in completing assignment when needed	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
4. Ambulate post-operative patients for the first time after surgery	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
5. Do colostomy irrigation	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
6. Respect the patient's rights to privacy when discussing patient's condition with colleagues	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
7. Contribute to productive working relationships with other health team members	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
8. Prepare and give oral meds to groups of patients	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
9. Write patient care standards for patients with similar problems	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
10. Do closed chest massage for patient requiring resuscitation	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
11. Do urinary catheterization	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
12. Use therapeutic communication skills to identify and reduce anxiety in the patient and/or family	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
13. Complete daily assignment within regular working hours (excluding emergencies or staff shortages)	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
14. Assess the stages of labor during the childbirth process	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
15. Measure central venous pressure	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5

2=Moderate Proficiency   4=Supervision Needed

#	Item		Rating
16.	Communicate therapeutically with emotionally disturbed patients.	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
17.	Carry out role and responsibilities of team leader	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
18.	Convert medication dosages and units appropriately for children	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
19.	Assess the resources, constraints and demands of the patient's social support system	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
20.	Give an inter-shift report with all pertinent Information	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
21.	Observe for reactions and complications with blood infusions	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
22.	Give tracheostomy care, including dressing change	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
23.	Insert naso-gastric tube	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
24.	Help patient break down the management problems of chronic illness into workable units	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
25.	Notify appropriate physician about significant changes in patient's condition	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
26.	Recognize early trends in vital signs associated with impending shock	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
27.	Assume responsibility for the level of care provided by team members	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
28.	Instruct patient on how to detect pacemaker failure	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
29.	Give gastric tube feedings	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
30.	Help families choose a mutually satisfying level of participation in caring for the dying patient	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
31.	Teach the patient routine measures to prevent post-operative complications	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
32.	Detect major dangerous cardiac arrhythmias on cardiac monitors	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
33.	Help patients sort and understand health information so they can make informed choices about therapy	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
34.	Participate effectively in a multidisciplinary team conference	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5
35.	Place electrodes on patients for cardiac monitoring	IDEAL	1 2 3 4 5
		REAL	1 2 3 4 5

		1	2	3	4	5
36. Ensure that the dying patient is not abandoned	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
37. Identify need for community and home health referrals and initiate discharge planning	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
38. Detect signs and symptoms of acute pulmonary edema	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
39. Coach the patient in pain management techniques	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
40. Provide for the safety needs of patients having seizures	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
41. Use isolation techniques correctly e.g., hand washing, gowning, and gloving	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
42. Help patients take responsibility for their own health	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
43. Teach stoma care to ileostomy patients	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
44. Take nursing histories that guide the provision of individualized patient care	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
45. Participate in identification of unsafe patient care practices and assume responsibility for intervention	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
46. Write nursing care plans for individual patients	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
47. Check arteriovenous shunts for patency and flow	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
48. Interact purposefully with other team members to keep them informed of changes in the patient's condition	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
49. Prepare and administer sliding scale insulin	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
50. Detect signs and symptoms of digitalis toxicity	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
51. Administer and monitor oral-nasal oxygen therapy	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
52. Evaluate P.R.N. medications so patients are not undermedicated or overmedicated	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
53. Assist with a spinal tap	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
54. Predict the influence of physiological responses, such as shivering, on Central Venous Pressure readings	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5
55. Start intravenous fluids	IDEAL	1	2	3	4	5
	REAL	1	2	3	4	5

56. Conduct physical exam of the chest	IDEAL	c1b c2b c3b c4b c5b
	REAL	c1b c2b c3b c4b c5b
57. Evaluate signs of increased intracranial pressure	IDEAL	c1b c2b c3b c4b c5b
	REAL	c1b c2b c3b c4b c5b
58. Monitor the fluid and electrolyte balance of patients receiving hyperalimentation therapy	IDEAL	c1b c2b c3b c4b c5b
	REAL	c1b c2b c3b c4b c5b
59. Observe for and prevent circulatory problems for patients with orthopedic casts	IDEAL	c1b c2b c3b c4b c5b
	REAL	c1b c2b c3b c4b c5b
60. Judge changes and trends in infant's hydration by palpation of fontanels	IDEAL	c1b c2b c3b c4b c5b
	REAL	c1b c2b c3b c4b c5b

PART II: PLEASE SEE THE ENCLOSED WHITE INSTRUCTION SHEET FOR COMPLETE QUESTIONS AND RESPONSES FOR THE FOLLOWING SECTION.

1. Age	c1b c2b c3b c4b
2. Nursing-related experience prior to your most recent nursing program (new graduates only)	c1b c2b c3b c4b c5b
3. Employment status	c1b c2b c3b c4b c5b c6b
4. Area of employment	c1b c2b c3b c4b c5b c6b c7b c8b c9b
5. Career choice	c1b c2b c3b c4b c5b c6b c7b c8b c9b c10b
6. Nursing program you completed initially	c1b c2b c3b c4b
7. Highest degree obtained	c1b c2b c3b c4b c5b c6b c7b c8b
8. Teaching role (educators only)	c1b c2b c3b
9. Involvement in direct patient care.	c1b c2b c3b c4b

THE LAST TWO QUESTIONS PERTAIN TO NURSING SERVICE PERSONS ONLY.

10. Number of new graduates you work with	c1b c2b c3b c4b c5b
11. Current position	c1b c2b c3b c4b c5b c6b

Appendix C

Seven Subscales
(Factors 1-7)

Appendix C

Factor I - Prevention of Iatrogenic Illness:

8. Prepare and give oral meds to groups of patients.

21. Observe for reactions and complications with blood infusions.

25. Notify appropriate physician about significant changes in patient's condition.

26. Recognize early trends in vital signs associated with impending shock.

29. Give gastric tube feedings.

31. Teach the patient routine measures to prevent post-operative complications.

36. Ensure that the dying patient is not abandoned.

38. Detect signs and symptoms of acute pulmonary edema.

40. Provide for the safety needs of patients having seizures.

41. Use isolation techniques correctly, e.g., handwashing, gowning and gloving.

45. Participate in identification of unsafe patient care practices and assume responsibility for intervention.

46. Write nursing care plans for individual patients.

48. Interact purposefully with other team members to keep them informed of important changes in the patient's condition.

49. Prepare and administer sliding scale insulin.

51. Administer and monitor oral-nasal oxygen therapy.

52. Evaluate p.r.n. medications so patients are not undermedicated or overmedicated.

59. Observe for and prevent circulatory problems for patients with orthopedic casts.

Factor II - High Technical/High Risk:

28. Instruct patient on how to detect pacemaker failure.

32. Detect major dangerous cardiac arrhythmias on cardiac monitors.

35. Place electrodes on patients for cardiac monitoring.

43. Teach stoma care to ileostomy patients.

47. Check arteriovenous shunts for patency and flow.

50. Detect signs and symptoms of digitalis toxicity.

53. Assist with a spinal tap.

54. Predict the influence of physiological responses, such as shivering on central venous pressure readings.

55. Start intravenous fluids.

58. Monitor the fluid and electrolyte balance of patients receiving hyperalimentation therapy.

60. Judge changes and trends in infant's hydration by palpation of fontanels.

Factor III - Helping Role Skills:

9. Write patient care standards for patients with similar problems.

12. Use therapeutic communication skills to identify and reduce anxiety in the patient and/or family.

19. Assess the resources, constraints and demands of the patient's social support system.

24. Help patient break down the management problems of chronic illness into workable units.

30. Help families choose a mutually satisfying level of participation in caring for the dying patient.

33. Help patients sort and understand health information so they can make informed choices about therapy.

37. Identify need for community and home health referrals.

39. Coach the patient in pain management techniques.

42. Help patients take responsibility for their own health.

44. Take nursing histories that guide the provision of individualize patient care.

34. Participate effectively in a multidisciplinary team conference.

Factor IV - Medium Technical:

5. Do colostomy irrigation.

10. Do closed chest massage for patient requiring resusitation.

11. Do urinary catherterization.

14. Assess the stages of labor during the childbirth process.

15. Measure central venous pressure.

16. Communicate therapeutically with emotionally disturbed patients.

18. Convert medication dosages and units appropriately for children.

22. Give tracheostomy care, including dressing change.

23. Insert naso-gastric tube.

Function V - Work Role Skills:

1. Turn and position a patient in bed.

2. Ensure patient's rights to continuity of nursing care when patient is transferred.

3. Ask for assistance in completing assignment when needed.

4. Ambulate post-operative patients for first time after surgery.

6. Respect the patient's right to privacy when discussing patient's condition with colleagues.

7. Contribute to productive working relationships with other health team members.

13. Complete daily assignment within regular working hours (excluding emergencies or staff shortages).

Factor VI - Leadership Skills:

17. Carry out role and responsibilities of team leader.

20. Give an inter-shift report with all pertinent information.

27. Assume responsibility for the level of care provided by team members.

Factor VII - Practitioner Skills:

56. Conduct physical examination of the chest.

57. Evaluate signs of increased intracranial pressure.

Appendix D

Introductory Letters

July 15, 1983

Coordinator
Office of Research
Hospital
Portland, Oregon 97201

Dear_____:

     During the week beginning July 25, I will be calling to discuss
participation of your hospital in a research study. This is a study
in which we are seeking to understand what entry-level skills first
line hospital managers feel newly graduated nurses need to enter
the job market.

     We would like to survey the head nurses and assistant head
nurses at your hopital. This could most easily be done by adminis-
tering a questionaire at an administrative meeting which head nurses
and assistant head nurses will attend.

     The questionaire is a four page check list which should require
a maximum of ten minutes to complete. Your help and that of the
others being asked to participate in this effort to find out what
nurse-managers require of new graduates, is essential to this study's
success. We greatly appreciate it.

     If you have any questions, please don't hesitate to contact
me by phone at 225-7957 or by mail.

Cordially,

Nancy Brandenburg
Graduate Student
Oregon Health Sciences University
CDRC North Unit
P.O. Box 574
Portland, Oregon 97207

NB:ks

July 15, 1983

Program Director
School of Nursing

Dear _____:

During the week of July 25, I will be calling to discuss the participation of _____ School of Nursing in a research study. This is a study in which we are seeking to understand what the entry-level skills proficiency new graduates have upon entering the workplace.

We would like to survey all Sophmore, Junior and Senior level clinical instructors. This could be done by administering the survey at a department meeting or by administering the survey upon an individual basis. This will depend upon the preference of the participating agency.

The questionnaire is a four-page check list which should require a maximum of ten minutes to complete. Your help and that of the others being asked to participate in this effort to develop entry-level skill standards for new graduates, is essential to this study's success. We greatly appreciate it.

If you have any questions, please don't hesitate to contact me by phone at 225-7957 or by mail.

Cordially,

Nancy Brandenburg
Graduate Student
Oregon Health Sciences University
CDRC North Unit
P.O. Box 574
Portland, Oregon 97207

NB:ks

July 15, 1983

Clinical Instructor
School of Nursing
Portland, Oregon 97201

Dear _____ :

Within a week or so I will be calling you as part of a research study. This is a study in which we are seeking to determine the entry-level skills proficiency of newly graduated baccalaureate nurses. as a clinical instructor you will have an accurate impression of the skills proficiency of the Seniors graduating from the_____ School of Nursing program.

The questionnaire is a four-page check list which should require a maximum of ten minutes to complete. Your help and that of the others being asked to participate in this effort to develop entry-level skills standards for new graduates is essential to this study's success. We greatly appreciate it.

If you have any questions, please don't hesitate to contact me by phone at 225-7957, or by mail.

Cordially,

Nancy Brandenburg
Graduate Student
Oregon Health Sciences University
CDRC North Unit
P.O. box 574
Portland, Oregon 97207

NB:ks

Appendix E

Informed Consent

Informed Consent

I have agreed to participate in the study entitled "Nursing Educator and Nursing Service Personnel Perceptions of New Nurse Performance" by Nancy Brandenburg, R.N., under the supervision of Marie Scott Brown, R.N., Ph.D. The study is a comparison between nursing educators and nursing service personnel concerning the entry level skill proficiency of new baccalaureate nurses.

My participation in the study involves answering a questionnaire which takes 10-15 minutes to complete. Although I may not personally benefit from this study, my participation will be of value in the general effort to develop performance standards for entry-level practice in the profession of nursing.

Information obtained from this study will be strictly confidential. My name will not appear on any records and anonymity will be insured by the use of code numbers. The study findings will be presented to all participating agencies at the completion of the study.

Nancy Brandenburg has offered to answer any questions that I might have about my participation in this study. I understand that I may refuse to participate or withdraw from this study at any time without affecting my relationship with, or my employment at, the Oregon Health Sciences University.

I have read the foregoing and I agree to participate in this study.

_____   _____   _____   _____
Signature of participant   Date   Signature of witness   Date

AN ABSTRACT FOR THE THESIS OF

NANCY RYAN BRANDENBURG

For the MASTER OF NURSING

Date of Receiving this Degree: June 8, 1984

Title: NURSING EDUCATOR AND NURSING SERVICE PERSONNEL PERCEPTIONS

     OF NEW NURSE PERFORMANCE

Approved: _____
       Marie Scott Brown, R.N., Ph.D., Thesis Advisor

This descriptive study partially replicated the earlier studies of
Benner and Benner (1979) and Nahm (1980) in examining the perceptions of
nursing educators and nursing service personnel in regard to the entry
level skill proficiency of new baccalaureate nurses.

Nursing service personnel were represented by a convenience sample
of 50 nurse managers from two acute care hospitals in Portland, Oregon.
Nursing educators were represented by a convenience sample of 34 clinical
nursing instructors from two baccalaureate nursing programs in Portland,
Oregon.

The survey subjects indicated their "ideal" and their "real"
performance expectations for newly graduated baccalaureate nurses using
the Benner Proficiency Scale. The scale consists of a list of sixty
nursing skills and activities. Respondents were asked to indicate the
"ideal" and the "real" performance level expected of new graduates
on these sixty skills and activities using a 5-point scale.

Group responses were compared in terms of the level of "ideal" and "real" performance expectations, and the discrepancy between the "real" and the "ideal" group performance expectations.

The major findings specific to this study were as follows:

1. Nursing service personnel expected a greater discrepancy between the "ideal" and the "real" performance of new baccalaureate nurses than nursing educators.

2. Nursing service personnel expected a lower level of "real" performance of new baccalaureate nurses than nursing educators.

3. Nursing educators and nursing service personnel did not significantly differ in their expectations of "ideal" new baccalaureate nurse performance.