PERCEPTIONS OF NURSING EDUCATION ADMINISTRATORS AND NURSING SERVICE ADMINISTRATORS REGARDING ASSOCIATE DEGREE AND BACCALAUREATE NURSES IN HOSPITALS

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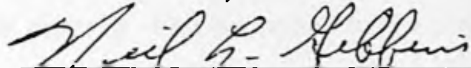

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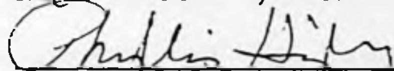

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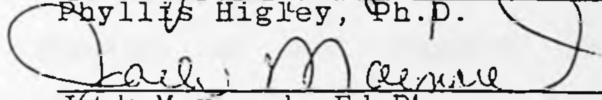

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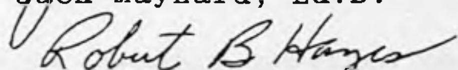

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CHAPTER 1

Introduction

Nursing education encompasses a variety of educational levels and programs. The uniqueness of each level of preparation is often not transferred into practice. This is especially true at the undergraduate levels.

Associate degree (AD) nurses are prepared for staff nurse positions in acute care settings, working under the supervision of a more experienced registered nurse. Baccalaureate nurses (BSN) have a broader education, going beyond that of the associate degree, to include community nursing and leadership roles in acute care facilities and community agencies. Baccalaureate nurses graduate from two different types of programs -- the four-year (generic) program and the upper division RN completion program. Employers usually do not differentiate between associate degree nurses and baccalaureate nurses, popularly, although sometimes controversially, referred to as technical and professional nurses respectively.[1]

Hospital schools of nursing confer diplomas rather than degrees. The diploma graduates, associate degree graduates and the four-year baccalaureate graduates all take the same state board examination and, upon

successful completion, become registered nurses (RN's). The RN's who enter upper division baccalaureate programs or career ladder tracks in four-year programs are not required to take another licensing examination, and they continue to be called RN's.

In the United States in 1982 there were 742 AD programs, 402 four-year BSN programs, 288 diploma programs[2], and 144 RN completion programs.[3] From 1973 to 1982 there was a steady increase in the number of AD programs and both types of BSN programs correlated with a steadily decreasing number of diploma programs.[4] As the shift has occurred in the educational preparation of nurses, confusion and controversy have increased relative to role responsibilities. In West Virginia in the 1983-84 academic year there were two diploma schools, eleven associate degree programs (one alternates between two locations), three two-year RN completion programs, three four-year generic programs, and five combination of BSN two- and four-year programs (one alternates between two locations). These are represented in Figure 1.[5] This distribution has naturally created areas of varied ratios of licensed associate degree and baccalaureate nurses. See Figure 2.[6]

Diploma

- ● — AD
- ■ — BSN - 2 year
- ► — BSN - 4 year
- ♦ — BSN - 2/4 year
- † — Alternates

Source: West Virgina Board Examiners for Registered Nurses Unpublished Statistics, Fall 1984.

Figure 1. Distribution of Undergraduate Nursing Programs in West Virginia.

Source: West Virginia Board of Examiners for Registered Nurses, Unpublished Statistics, Fall 1984.

Figure 2. Number of BSN nurses to AD nurses by County.

The two major nursing organizations, the American Nurses Association (ANA)[7] and the National League for Nursing (NLN)[8] have both published position statements indicating that the technical and professional nurses differ and each are needed. Many nurses disagree with the positions of these organizations. The West Virginia divisions of these two organization have differed from each other on their stands on the issue. The West Virginia Nurses Association has agreed with the ANA in recognizing the two levels.[9] In 1982 the West Virginia League for Nursing rejected a resolution which supported the NLN position.[10]

A Professional Nurse Study Group was formed in 1984 by the West Virginia Nurses Association to investigate the process by which the BSN as entry into professional practice could best be achieved. After several months, the group recommended the WVNA support the West Virginia Board of Examiners for Registered Nurses in establishing rules and regulations in West Virginia to make the BSN as the minimum level for entry into professional practice.[11] The West Virginia Board of Examiners has agreed to support this concept.[12]

A serious gap exists between education and practice due to a lack of collaboration between these two groups on professional issues.[13] Nursing education administrators and nursing service administrators have a great

influence on the preparation and utilization of different levels of nursing education. The purpose of this study is to determine and analyze the perceptions of nursing education administrators and nursing service administrators regarding job assignments and salaries for technical and professional nurses. It is expected that understanding these perceptions will lead to a lessening of the confusion and controversy which now exist. This research should be received with a high degree of importance among nursing education administrators as they provide leadership in the education of nurses preparing to assist in solving health care problems.[14]

Definitions

Academic education--education in an institution of higher learning.

Associate degree nurse (AD)--a nurse whose highest degree in nursing is an associate degree.

Baccalaureate nurse (BSN)--A nurse whose highest degree in nursing is a bachelor's degree. Unless otherwise stipulated, this term refers to both of the following:

(1) RN completion--An upper division program for nurses who are already RN's to attain the additional education leading to a BSN.

(2) Generic--a four-year baccalaureate nursing program leading to eligibility to take the state board examination to become registered nurses. Many include tracks for RN's to enter at an advanced level.

Basic nursing program--a nursing program from which the graduates are eligible to take the state board examination to become registered nurses.

Licensed practical nurse (LPN)--a nurse who has completed a one-year vocational program and has passed the LPN state board examination.

Nursing education administrator--the dean, chairman or coordinator who is directly responsible for an associate degree or baccalaureate degree nursing program.

Nursing service administrator--the assistant administrator, vice president for nursing or director of nursing service, who is the highest ranking nurse responsible for nursing service in a hospital.

Professional nurse--a registered nurse who has a bachelor's degree in nursing.

Technical nurse--a registered nurse whose highest degree in nursing is an associate degree.

Statement of the Problem

There is a definite gap between the educational preparation of nurses and their utilization.[15] Although

unique characteristics are evident in the education of associate degree and baccalaureate nurses, these differences are often not transferred into assignment and employment practices. The specific problem to be investigated in this research is the degree of incongruence between the perceptions of nursing education administrators and nursing service administrators in regard to the educational preparation and practices governing differentials in job assignments and salaries of technical and professional nurses which have contributed to discontent in the profession. Data gathered in this research was combined with information on the number of nurses with different educational preparation in West Virginia, the current number of graduates from technical and professional programs, the locations of those programs and the changing needs for nursing care in the state which will permit the projection of future trends in education and practice. This problem will be addressed by testing the following null hypotheses:

1. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether baccalaureate education should be a criteria for higher starting salaries than associate education for new graduates.

2. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether BSN nurses with at least three years of experience should receive higher salaries than AD nurses with an equal number of years of experience.

3. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether a BSN should be a requirement for promotions to head nurse and supervisory positions in acute care hospitals (Assuming availability of BSN nurses).

4. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether a BSN should be preferred for promotions to head nurse or supervisory positions in acute care hospitals (Assuming availability of BSN nurses).

5. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to the beginning practice abilities of AD and BSN graduates in acute care hospitals.

6. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to the practice

abilities of AD and BSN nurses in acute care hospitals with at least three years of nursing experience.

7. There is no significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to there being clear differences as to the levels of responsibility for which schools prepare AD and BSN graduates to function in acute care hospitals.

Population

The population surveyed was all nursing education administrators representing associate degree and baccalaureate nursing programs and all nursing service administrators in general acute care, non-federal hospitals in West Virginia. Diploma schools were excluded because they are non-degree granting institutions and are steadily declining in numbers. The practice setting was limited to hospitals since approximately 85 percent of the associate degree nurses and 73 percent of the baccalaureate nurses report the hospital as their principal field of employment.[16] Also excluded from the study were federal and state hospitals which include such facilities as Veterans Administration and mental health hospitals. These were omitted because of the special skills needed by nurses in these agencies and the methods of control.

Questionnaires were also sent to the selected groups of nursing administrators to determine profiles on the respondents, their perceptions on hospital personnel practices governing differentials in job assignments and salaries of technical and professional nurses and information on the institutions. The questionnaire sent to the nursing service administrators also included questions on the policies in use regarding job assignments and salaries of AD and BSN graduates. Statistical information was obtained from the West Virginia Board of Examiners for Registered Nurses.

Theoretical Framework

The framework for this study was developed from Argyris' and Schon's theory in relation to professions. Two assumptions were made in this research. The first was that there was confusion and controversy resulting in discontent in the nursing profession. The second assumption was that two theories govern actions -- espoused theories and theories-in-use, and these are incongruent in the nursing profession.

Discontent

Argyris and Schon contend there are general areas of discontent within professions. These areas relate to questions in regard to whom the services of the profession are provided, the competency of the professionals,

what effect cumulative learning has on the professionals and whether or not it is possible to change.[17]

Whom does nursing serve? Supposedly, it serves the nursing health care needs of society. The idealism of education and the reality of practice produce divergent perceptions concerning the provisions of this service. Kramer, in her research on reality shock among new graduates, concluded that nursing education functions within a professional system and nursing service within a bureaucratic system. These different environments result in problems for the new graduates who try to relate school idealism with action in the real world.[18] Hospital nursing is changing as patients are more acutely ill and there is a greater need for registered nurses.[19] At the same time the prospective payment system utilized by Medicare is causing cutbacks in nursing staffs in many areas.[20] The espoused theory for health care policy is that personnel and services be distributed equitably to the right people at manageable costs. The theory practiced is saving federal money, decreasing governmental expenditures for health and cost containment on health care.[21]

Are nurses competent? Nurses have been shown to be competent at a technical level. Professional competencies are still being evaluated.[22] A major factor making differentiation of abilities resulting from

different levels of nursing education difficult is that nursing performance is measured within the roles which are assigned. Hospitals, in general, place more emphasis on technical skills for which there may be no difference between nurses prepared in the different types of programs.[23] Educators believe their graduates are not being properly utilized and practitioners do not believe nurses are graduating prepared for the "work world".

Does cumulative learning have an effect on nurses in practice? Nursing relies too much on tradition and too little on research.[24] Much of the research done is not in the clinical setting. Research is more often carried out by faculty and graduate students rather than by nurses in practice. Nurses in the practice setting too often do not perceive research as part of their work. It takes them away from the unit and others view them as not taking care of their responsibilities. Research is rewarded in education but not in practice. There is, therefore, no bonding between education and practice in the area of scientific investigation.[25]

Nursing educators also encounter constraints in carrying out research in the clinical setting. Agency research approval committees primarily made up of physicians, a lack of personal commitment and a general lack of confidence in the clinical area, discourage faculty involvement in practice-based research.[26]

Can nursing be reformed? This question brings out the circular dilemma in which the profession finds itself. Schools can produce two levels of nurses, yet, as Walton states, it is the expectation of the employer which will determine the performance of the nurses.[27] Nurses in education and service develop different values because of the missions of their institutions and also because of the differences in their educational backgrounds. Nurses with higher degrees are much more often found to be educators and educational administrators. There is a serious shortage of highly qualified administrators in nursing practice.[28] Nursing education needs to produce graduates who are capable of bringing about change, and this has not been achieved in the past. Educators have a responsibility to develop inquisitive minds in their students.[29] Through research and using new knowledge, these students can facilitate changes in health care after they begin practice in the profession.[30]

Can self-actualization be achieved in nursing? If this is to happen, an association needs to exist between private and professional lives.[31] Most nurses do not belong to professional organizations which can assist in this integration. Nurses have been encouraged to be humanistic people in the work setting -- to act as persons as well as professionals. This has tended to

separate the person from the professional.[32] Another problem with larger impact is that much of health care is dependent on politics. Nurses, being primarily women, have lacked the leadership to make changes.[33] As women, most have not been socialized to work as team members as they grew up. This results in competition and dissensions within the nursing profession.[34]

Espoused Theories and Theories-in-Use

Argryis and Schon state there are two theories which govern action. The espoused theory of action is the one related when beliefs are conveyed to others. The theory-in-use is the one which governs actions. The two may or may not be congruent.[35]

Argyris and Schon describe what they call Model I behavior in regard to professions. Model I behavior is dominated by technique. Professionals teach arts and skills and then create settings in which these arts and skills may be used.[36] Hospitals are institutions created in which nurses may practice their arts and skills within controlled settings. Hospitals are governed by policies, rules, procedures and central controls. When a profession demonstrates Model I behavior then the espoused theory is not congruent with the theory-in-use.[37] Most problems within professions result from conflict between the institution in which the professional works and the

demands of the profession for changes.[38] The nursing profession espouses the theory that there are two distinct levels of nursing; yet, in nursing practice, the differentiation is not made. Incongruence results from the lag between educational changes and changes in practice.[39]

CHAPTER 2

Review of the Literature

Argyris and Schon believe the major reason for discontent within professions is rooted in their history. The professions seem to have evolved from religious beginnings, became secular, then more liberal and rational as they moved into higher education and finally became specialized. Idealism evolved from faith.[40]

The review of literature traces nursing from its religious beginnings through higher education and into specialization and demonstrates how discontent and incongruities have developed as ideals and reality clash.

Early Development of Nursing

Nursing first became organized in the early Christian era. During this time religious emphasis lead deacons and deaconesses to use nursing as a way for paying for their sins.[41] Later nursing developed in military orders and those nurses fought in the Crusades, then cared for the injured. Even in these groups the care of the ill was considered to be a religious duty.[42]

Regular orders were established in monasteries. Men and women who chose to serve the church nursed the sick. Secular orders developed for those who chose not to dedicate their entire lives to the church.[43]

During the Reformation, nursing sank to the lowest levels in the countries in which the Catholic organizations were attacked. The Protestants did not see their mission as charitable ministry to the sick. Women were to be in the home and only those of the lowest class became nurses.[44]

The origins of nursing evolving from the military and church resulted in rigid practices in both hospitals and schools of nursing. The remnants of these influences are still seen today.[45]

In the eighteenth century the Industrial Revolution brought an emphasis on individual rights and the push for emancipation of women.[46] It was not until the latter part of that century that higher education for women became more generally accepted.[47]

Modern Nursing

Modern nursing had its real beginning in the 1800's with the establishment of the Nightingale School at St. Thomas' Hospital in England.[48] The timing of this birth of modern nursing is crucial. It started at a time when Victorian values dictated that women were to serve the needs of men.[49] Florence Nightingale, although a leader, believed social struggles should be handled by the strong men. She initiated the doctor-nurse game as she encouraged nurses to make suggestions to physicians in an

indirect way so that the physicians believed they were creating the ideas.[50]

In America the first regularly organized nursing school was established by the Nurse Society of Philadelphia in 1839.[51] Early schools of nursing were conducted by hospitals and it was soon apparent that student nurses were cheap labor. Florence Nightingale had been correct when she professed a school of nursing could not be good if it was self-supporting.[52]

Schools in the latter 1800's were about one year in length. As science and medicine expanded, so did the knowledge necessary for nursing practice. The schools gradually lengthened to two years early in the 1900's, stretching eventually to three years.[53] During the nineteenth century nursing began to expand out of the hospital. Visiting nurses, school nurses and Army nurses appeared.[54]

Nursing organizations formed and, from those early beginnings, there still exists the American Nurses' Association and the National League for Nursing which were founded to improve standards of practice and education.[55]

In 1903 North Carolina passed the first act which allowed registration of nurses. By 1923 all states had registration acts for nurses. These, however, did not mention the scope of practice.[56]

Nursing programs in the early twentieth century were being developed to staff hospitals. There was no accreditation or standardization of programs. The Director of Nursing Service in the hospital was often the Director of Nursing Education in the school. Students usually lived in dormitories with a housemother and adhered to strict dress codes and curfews. Practically all students were young white females.[57]

Baccalaureate nursing education was established at the University of Minnesota in 1919. Several other schools soon followed with similar programs. This curriculum, five years in length, was in reality a three-year diploma program with two years of liberal arts added at the end.[58]

In 1938 New York passed the first mandatory practice act for nurses. Each state has followed the lead and, with the new laws, the scope of practice was defined.[59]

In health care, nursing was at the lowest educational level in hospitals; so, with its rigid tradition, it was easily influenced by the task analysis and emphasis on productivity. Functional nursing with well defined tasks for each nurse became the method of patient care.[60]

Technical and Professional Nursing

In 1952 a new type of program was established which

was to have a major impact on nursing education. The associate degree (ASN and AA) programs were two-year curriculums which developed just behind the community college movement. Half of the courses were nursing and half were general education. The graduates took the state board examination for registered nursing. With the development of this new preparation, a new term was born, the technical nurse. This person would function with less autonomy, working mainly at the bedside and under direct supervision of a more experienced nurse.[61] The term professional nurse was then recommended to be used to describe the baccalaureate graduate.

Associate degree programs often attract different types of students than the diploma schools. They enroll more older people, minorities, married women, men and students with a wide range of abilities. Associate degree graduates and diploma graduates take the same state board examinations as the graduates from the four-year Bachelor of Science in Nursing programs.[62] The state board examination is given only to assure the public that registered nurses have a minimum level of competence for safe care.[63] It does not distinguish between types of nursing programs.[64] This causes confusion to the public as to differences in educational preparation when they all become registered nurses (RN's).

In 1965 a paper which would pave the way for a further split in nursing was developed. The American Nurses' Association's Position Paper stated that nursing was a profession, that it should only be in institutions of higher learning, and that the baccalaureate in nursing would be the level for entry into professional practice. No efforts were made to implement the goals.[65] Most nurses, at that time being diploma graduates, certainly opposed this issue.

In 1974 the issue was raised again and created a controversy among nurses that is still present. At the time, the New York Nurses' Association restated the proposals and set 1985 as the target date for its implementation. Many states have since issued such position papers, but the state legislatures continue to refuse to legislate such a change.[66]

The thrust of the four-year baccalaureate nursing education, or generic education, came after World War II and gained the greatest momentum in the 1960's and 1970's. During that time diploma programs decreased and associate degree and master's degree programs increased.[67] In 1972 more nurses graduated from collegiate programs than from hospital schools of nursing. As nursing education moved from the hospital school it became free from hospital administrators and physicians.[68]

Issues which have affected the changing health care needs are consumer awareness, rising costs, more home care, an increase in the older population, the prospective payment system for Medicare which shortens hospital stays and a focus on wellness. Nursing is in a position to respond to these needs.[69] In the 1970's an eight-year study revealed that need for role change for nurses took place first in the health care setting and then is put into curriculums. For example, needs for community nursing have increased this area of study in schools.[70] In the early 1970's several states began to revise their nurse practice acts due to the expanded roles.[71] West Virginia still has not reflected this change.

The Southern Regional Education Board (SREB) defined levels of care as primary, secondary and tertiary. Primary care is the initial contact with the health care system and the basic lifelong contact. It is usually rendered in out-patient settings. Secondary care is given as clients experience common illnesses which are episodic and usually in community hospitals. Tertiary care is more often given in larger hospitals requiring specialized services.[72]

In 1973 a study by the SREB concluded that different levels of nursing must be defined based on roles.[73] In 1976 the SREB published a report of a curriculum study.

The recommendations were that the associate degree graduate should be prepared to give secondary care and the baccalaureate graduate, primary, secondary and tertiary care.[74] Baccalaureate nursing programs emphasize prevention of illness, primary care and promotion of health. There is less emphasis put on secondary and tertiary care. This has resulted in criticism from the traditional hospital setting.[75]

Non-traditional education in the form of two-year baccalaureate nursing programs, or RN completion programs, developed for registered nurses as a result of the entry-into-practice issue. The National League of Nursing was slow to accredit such programs as they individualized curriculums for registered nurses as adult learners and were not standardized in relation to generic programs.[76]

Relationship Between Education and Practice

Research has been carried out in an attempt to determine if indeed baccalaureate graduates give different nursing care than the associate degree nurses. A survey of the research shows evidence that some difference may exist between the skills of baccalaureate and associate degree nurses. Howell found that baccalaureate nurses rated higher than associate degree graduates in both technical and process skills.[77]

In another study it was concluded that baccalaureate nurses performed better than associate degree nurses in areas of technical skills, teaching, leadership and communications.[78] Nelson also found supervisors rated baccalaureate nurses significantly higher in technical, communicative and administrative skills.[79]

Baccalaureate nurses have been found to function better in leadership roles.[80] Frederickson and Mayer report BSN nurses were better able to think critically; but, without encouragement from the employer, the critical thinking skills were not used to develop problem solving.[81]

McCloskey's research on job effectiveness in relation to education indicated a small but positive correlation. She drew a profile of an effective nurse from her study which showed the nurse had returned to school after receiving an associate degree or diploma. Four-year baccalaureate nurses rated somewhat lower. The effect of education on job performance was correlated with years of education rather than the nursing degree.[82]

Research has shown some evidence of the difference in skills of the two groups but problems exist in such studies. Research comparing the effectiveness of nursing care are usually weak as they rely on perceptions rather than measurement of performance.[83] Howell concluded a bias exists on the part of the person ranking nurses of

various levels. Those with less than a bachelor's degree are less likely to rank BSN graduates higher than AD graduates.[84]

Research which indicated baccalaureate nurses perform more effectively could also be measuring the type of person who seeks more education as opposed to the education itself. Lysaught reported nurses who aspire to commitment and leadership are being drawn away from the practice in a clinical setting.[85]

Leadership, planning and collaboration are skills upon which baccalaureate education is focused. These are difficult to measure and may not be a priority in many hospitals. Research has shown that nursing service personnel rate higher psychomotor skills as essential for baccalaureate graduates than do nursing faculty.[86] Group members form norms based on the group goal and they then in turn evaluate others based on those norms.[87]

The evidence has still been insufficient to warrant changes in the practice setting. Studies show the roles nurses are assigned in hospitals are not influenced by their educational level.[88] A study by Johnston reported in 1982 concluded associate degree and baccalaureate degree nurses were not being used effectively and efficiently. It was stressed that nursing educators and nursing service should agree on competencies and utilize the skills of each level of nursing.[89]

In 1975 the Western Interstate Commission for Higher Education (WICHE) undertook a project to analyze and plan for improved distribution of nursing manpower. The criteria which was developed in that study for the educational preparation of nurses in different positions were, that for head nurse and supervisor, twenty-five percent should have masters degrees and seventy-five percent should have a BSN. It was proposed for administrative positions, directors of nursing and assistant directors, ninety-five percent should have masters degrees and five percent doctorates.[90]

In a study on ASN nurses, Miller found they were being used beyond the scope of their education. Sixty-six percent indicated they were in supervisory roles at least part of the time.[91]

Howell found that most nursing service administrators reported no differential in salary based on education. In smaller hospitals, slightly over half of the respondents stated they believed a difference should be made while 72 percent in larger hospitals agreed.[92]

Nurses in general do not differentiate between levels. It becomes apparent when surveying articles on nursing care in journals that the expected level of education is seldom, if ever, mentioned. Reference is made only to "the nurse".[93] Many nurses believe that

education alone should not determine roles.[94] Schoen reported seventy-two percent of the nurses surveyed opposed the BSN as a criteria for supervisory promotion.[95] According to Walton, studies are needed to show the overall cost of proper utilization of nurses would decrease when the quality of health care can be shown to increase.[96]

Curran, in a study on nursing administrators' perceptions of the direction of education and practice, found that those in both academia and service favored different levels of education and practice with the education administrators being more favorable (87 percent) than the nursing service administrators (69 percent).[97]

Nurses do not comprise a community of professionals with common values, but are fragmented into a work group and a group that is concerned with advancing the profession. Nurses working in the practice setting tend to be more concerned with employment conditions, and those in education are more concerned with specialty certification, research and political involvement. Nurses involved in the educational setting have limited contact with patients or clients; they are not as visible and are fewer in number. Educators are concerned with achieving the ideal objectives which are set for their students.[98]

Nursing service administrators are caught in the middle. Traditionally, they have not been considered colleagues of nurses in practice and have been looked down upon by hospital administrators. They have often been dismissed if they tried to initiate change.[99] These people, though, are now in a position to make changes in nursing care. Nursing service administrators are expected to reflect changes in nursing services through sophisticated financial plans.[100] Recently they have taken a broader view of the world, not limiting the scope to the bureaucratic operations. This has allowed primary nursing to evolve as a method of patient care which gives more accountability and autonomy to nurses in a decentralized structure.[101]

There has been a separation between nursing research and practice similar to the education-practice dichotomy. Research is often done out of the practice setting.[102] Nursing practice is more often guided by procedure books than by research.[103] Research should guide the practitioner, yet the knowledge base may be inadequate or incomplete.[104]

Future Trends

Several trends in health care will affect nursing practice in the future. The most significant factor is the aging population.[105] In West Virginia, the

population over sixty five is projected to increase from 250,300 in 1985 to 270,300 in 1990 and 282,800 in 2000.[106]

It is predicted that by 1990 there will be a significant oversupply of physicians in the United States, 41 percent over the 1980 figures. It is forecasted that physicians will maintain their incomes by increasing their fees or expanding their services.[107] Increasing health care costs will pave the way for nurse specialists at the masters and doctoral levels to substitute their services for the more expensive physician services.[108] Nurses will meet opposition as physicians will seek to restrict other health care professionals as they expand their own services.[109]

Prospective payment plans by Medicare have decreased the hospital census. West Virginia hospitals have experienced a decrease in hospital occupancy rates. In 1983 the rate was 74.8 percent, and there was a decrease to 61.01 percent for the first three quarters of 1984.[110] Nurses will be needed more for home care as people are released earlier from hospitals and need highly technical care in their homes.[111]

Consumer interest in health care promotion and self care will affect nursing practice. Nurses have the skills to offer guidance in the home, school or work

setting. The elderly especially will require health promotion and education.[112]

Finally, high technology will challenge professional nurses. Computers can now do routine monitoring and analyze test results cutting down on the need for nurses for some tasks. At the same time, nurses who use high technology to accentuate their practice will be in demand in highly specialized areas.[113]

Related Studies

Only two studies were discovered directly relating to this research. Curran's study on perceptions of nursing education administrators and nursing service administrators on levels of practice and education had a similar focus. Curran demonstrated that significant differences exist in the opinions of nursing education administrators and nursing service administrators in regard to nursing education.[114] There were, however, no observations reported on the actual utilization.

The only manpower study in West Virginia which differentiated levels of education was done in the late 1970's by a West Virginia Consultant Panel. Perceptions of administrators were not sought. In 1978 and 1979, the manpower study was done by the now defunct West Virginia Governor's Commission on Nursing. One of their assumptions based on data and their expertise was that the

nurse of the future must have a broad education and be able to function in a variety of settings.[115]

That study revealed the highest degree held by the employed registered nurses was 59.8 percent diploma, 25.8 percent associate degree in nursing, 9.2 percent BSN, 2.6 percent bachelor's degree in another field, 1.4 percent master's in nursing, 1.2 percent master's degree in another field, and 0.1 percent doctorates.[116] Most associate degree graduates were working in outpatient settings as opposed to inpatient agencies. Most nurses with a bachelor's degree in nursing were employed in education (43.2 percent) with only 12.7 percent in inpatient settings.[117]

After extensive searches of the literature, the writer concluded the combination of perceptions on education and practice with the utilization is an area thus far unresearched.

CHAPTER 3

Design of the Study

The research methodology is a descriptive survey selected to determine and analyze the perceptions of nursing education administrators and nursing service administrators on educational preparation, and job assignments and salaries for technical and professional nurses in general acute care hospitals in West Virginia. Survey research was selected because it is the method by which a researcher may show distribution, attitudes and behavior which are crucial to examining the problem.[118] The population studied was all nursing education administrators in AD and BSN programs in West Virginia and all nursing service administrators in general acute care hospitals in the state. The academic population was composed of eighteen administrators from twenty-two programs in sixteen institutions. The programs included eleven associate degree, three two-year RN completion, three four-year generic baccalaureate, and five BSN two-year and four-year combinations. There were sixty-seven nursing service administrators from hospitals and medical centers which varied in bed capacity from thirty to six hundred and twenty-nine.[119]

The instrument selected was the mailed questionnaire because of the reasonable cost; it offered anonymity and

the absence of an interviewer decreased the chance of bias.[120] The disadvantages of such a survey instrument are the inability of the researcher to check the responses and the poor response rate.[121]

According to Kerlinger, an effort should be made to obtain a return rate of ninety percent on mailed questionnaires; however, usually only fifty to sixty percent are returned and less than forty to fifty percent are common.[122] In order to encourage responses, four activities were carried out. First, just prior to the mailings, the researcher attended meetings of both the West Virginia Council of Schools of Nursing and the West Virginia Society of Hospital Nursing Service Administrators and spoke briefly about the purpose of the research and the importance of their participation. Second, the questionnaires were commercially printed on attractive paper with a distinctive border (See Appendices A and B). Third, each of the questionnaires were addressed to the administrators by name. The names were obtained from the West Virginia Board of Examiners for Registered Nurses and the West Virginia Society of Nursing Service Administrators. Fourth, the Chairman of the Doctoral Committee added a postscript to the letter accompanying the first mailing to encourage participation (See Appendix C). For purposes of the study, a return rate of at least forty percent for each group was

anticipated. A second mailing was carried out to non-respondents two weeks after the first mailing. A letter from the researcher was included. See Appendix C.

The questionnaires were designed by the writer. The original drafts of the questionnaires were sent to three nurses with education administration experience and three with nursing service administration experience. They were asked to respond on the clarity of the questions and the feasibility of obtaining the answers. All six responded with suggestions which were used in the next draft. The Doctoral Committee of the writer also reviewed the revised questionnaires and submitted suggestions. The instruments were then structured for computer input.

The questionnaires mailed to the education administrators and the service administrators were identical in Parts I and II. Part I was designed to obtain demographic information about the respondents. Part II explored the perceptions of the respondents on AD and BSN preparation and whether employment practices should differentiate between the two levels of education. Part III differed for education and practice. Each was designed to obtain information on the employing agency or program (See Appendices A and B).

Demographic and institutional information was treated by frequency and percentage comparisons.

Selected demographic and institutional information was correlated by means of the F test with responses to perceptions within each group using a SAS program.[123] Null hypotheses relating to no signigicant differences between perceptions of nursing administrators was computer tested by the use of the Mann-Whitney U Test on a SPSSX program.[124] The null hypothesis is that the obtained U value minus the expected U values will equal zero.[125] The statistical question is whether the obtained U value deviates far enough from the expected U value to justify rejection of the null hypothesis at the alpha level of .05. The Mann-Whitney U Test was chosen due to the number of violations in the assumptions which underlie the t-Test. When sample sizes are markedly different and the variances are shown to be unequal, the assumptions underlying the t-Test are violated.[126] Since the sample sizes were markedly different and the variances were shown to be significantly different on three variables, the Mann-Whitney U Test was deemed the appropriate test. Non-parametric statistics are also recommended for psychological variables[127] such as perceptions, when data is only in ranks that can be measured by more or less rather than how much.[128] The perceptions were computer analyzed using the t-Test to determine if there were differences in the results. The levels of significance proved to be the same for both the

Mann-Whitney U-Test and the t-Test.

Limitations

All research has its limitations. This study is limited by:

1. the abilities of the beginning researcher.

2. the interpretation by the respondents of the questions in a mailed questionnaire.

3. bias which may unintentionally be included in the development of the questionnaires.

4. the reliability and validity of the questionnaires.

5. the percentage of returns on the questionnaires.

6. the representativeness of the respondents.

7. the type of hospitals used for surveying.

8. using only education administrators in associate degree and baccalaureate programs. Those preparing practical, diploma and master's level nurses were not included.

9. perceptions being influenced not just by one's current position but by past experiences.

10. possible exposure primarily to nurses predominately from only one type of baccalaureate program which may affect the beginning abilities of these nurses.

CHAPTER 4

Data Analysis

The data presented in this chapter is divided into two parts. The first part is the demographic and institutional data. The second part is the report of the comparisons between the perceptions of nursing education administrators and nursing service administrators in regard to the educational preparation and personnel practices governing differentials in job assignments and salaries of technical and professional nurses.

Demographic and Institutional Data

Responses to the questionnaires far exceeded the minimum of forty percent projected for both groups. Out of the total population of nursing administrators, 88.9 percent of the nursing education administrators and 71.6 percent of the nursing service administrators responded to the questionnaires after the first mailing. The second mailing yielded final results of 100 percent and 89.6 percent, respectively. See Table 1. Further demographic and institutional information was treated by number and percentage of responses. Percentages were figured from those responding only. Non-responses were listed only by frequency.

Table 2 shows the breakdown of the respondents by type of program or size of the hospital. Of the eighteen

Table 1

Population and Return Rates
of Nursing Administrators
by Number and Percentage

Group	Population Size	Returns After First Mailing	Returns After Second Mailing
Education	18	16 (88.888%)	18 (100.00%)
Service	67	48 (71.642%)	60 (89.552%)

Table 2

Type of Institutions of Nursing Administrators
by Number and Percentage

Group	Frequency of Responses
Education	
Program Type	
AD	9 (50.000%)
BSN (2 yr)	1 (5.556%)
BSN (4 yr)	3 (16.667%)
AD/BSN (2 yr)	2 (11.111%)
BSN (2 yr)/BSN (4 yr)	3 (16.667%)
Total	18 (100.000%)
Service	
Bed Capacity	
Less than 100	29 (48.333%)
101-200	10 (16.667%)
201-300	13 (21.667%)
More than 300	8 (13.333%)
Total	60 (100.000%)

education administrators, nine or 50 percent were from AD programs, one or 5.6 percent was from a two-year BSN program, three or 16.7 percent were from BSN four-year programs, two or 11.1 percent represented AD and two-year BSN programs, and three or 16.7 percent represented a combination of two-year and four-year BSN programs. Nearly half of the hospitals in West Virginia have a bed capacity of less than one hundred.

Of the sixty responding nursing service administrators, twenty-nine or 48.3 percent were from hospitals with less than one hundred beds, ten or 16.7 percent were from hospitals with one hundred one to two hundred bed capacity, thirteen or 21.7 percent represented hospitals with two hundred one to three hundred bed capacity, and eight or 13.3 percent reported a bed capacity of greater than three hundred.

Nursing administrators in education reported higher educational levels than those in service. Over two-thirds of the administrators in education had at least a master's degree in nursing, compared to slightly over one-fifth of those in service. Table 3 shows the breakdown in educational levels between those two groups. The eighteen nursing education administrators reported the highest level in nursing education, as follows: one (5.6 percent) diploma, four (22.2 percent) bachelor's degree, twelve (66.7 percent) master's degree, and one

Table 3

Highest Educational Level of Nursing Administrators by Number and Percentage

Level	Education (n = 18)	Service (n = 60)
Nursing		
Diploma	1 (5.556%)	24 (40.000%)
Associate Degree	0	7 (11.667%)
Bachelor's Degree	4 (22.222%)	16 (26.667%)
Master's Degree	12 (66.667%)	13 (21.667%)
Doctorate	1 (5.556%)	0
Total Responding	18	60
Non-Nursing		
None	6 (33.333%)	39 (67.241%)
Associate Degree	0	1 (1.724%)
Bachelor's Degree	0	9 (15.517%)
Master's Degree	8 (44.444%)	9 (15.517%)
Doctorate	4 (22.222%)	0
Total Responding	18	58

(5.6 percent) doctorate. Nursing service administrators reported the following as the highest educational levels in nursing: twenty-four (40 percent) diploma, seven (11.7 percent) associate degree, sixteen (26.7 percent) bachelor's, and thirteen (21.7 percent) master's. Degrees in non-nursing fields were reported more often in education than service, approximately two-thirds to one-third, respectively. Education administrators responded as follows: six (33.3 percent) no non-nursing degree, eight (44.4 percent) master's degree, and four (22.2 percent) doctorate. Nursing service administrators reported as follows on non-nursing degrees: thirty-nine (67.2 percent) none, one (1.7 percent) associate degree, nine (15.5 percent) bachelor's degree, and nine (15.5 percent) master's degree. Two did not respond.

The survey results on nursing education and nursing practice experience were as expected. See Table 4. Nursing service administrators had more direct patient contact and practice administration experience. Education administrators reported more experience in academic education and administration. All educators had at least one-year of direct patient contact, with two-thirds having five years or more in contrast to over two-thirds of the nursing service administrators reporting no academic education experience.

Nursing education administrators responded to years

Table 4

Years of Experience of Nursing Administrators by Number and Percentage

Years	Education (n = 18)	Service (n = 60)
Direct Patient Contact		
None	0	0
Less than 1	0	0
1 - 4	6 (33.333%)	14 (23.333%)
5 - 9	8 (44.444%)	15 (25.000%)
10 or more	4 (22.222%)	31 (51.667%)
Total Responding	18	60
Practice Administration		
None	10 (58.824%)	0
Less than 1	0	0
1 - 4	1 (5.882%)	8 (13.333%)
5 - 9	4 (23.529%)	22 (36.667%)
10 or more	2 (11.765%)	30 (50.000%)
Total Responding	17	60
Academic Education		
None	0	42 (70.000%)
Less than 1	0	2 (3.333%)
1 - 4	2 (11.111%)	6 (10.000%)
5 - 9	4 (22.222%)	9 (15.000%)
10 or more	12 (66.667%)	1 (1.667%)
Total Responding	18	60
Education Administration		
None	0	50 (86.207%)
Less than 1	1 (5.556%)	0
1 - 4	8 (44.444%)	3 (5.172%)
5 - 9	5 (27.778%)	2 (3.448%)
10 or more	4 (22.222%)	3 (5.172%)
Total Responding	18	58

of direct patient contact, as follows: six (33.3 percent) one to four years, eight (44.4 percent) five to nine years, and four (22.2 percent) ten or more years. Nursing service administrators responded to the same question, as follows: fourteen (23.3 percent) one to four years, fifteen (25 percent) five to nine years, and thirty-one (51.7 percent) ten or more years. Experience in academic education for education administrators was: two (11.1 percent) one to four years, four (22.2 percent) five to nine years, and twelve (66.7 percent) ten or more years. Nursing service administrators reported the following for experience in academic education: forty-two (70 percent) no experience, two (3.3 percent) less than one year, six (10 percent) one to four years, nine (15 percent) five to nine years, and one (1.7 percent) ten or more years.

Educators indicated fewer years of experience in education administration than service respondents did in nursing service administration. Nursing education administrators reported the following on experience in practice administration: ten (58.8 percent) none, one (5.9 percent) one to four years, four (23.5 percent) five to nine years, and two (11.8 percent) ten or more years. One did not respond. Nursing service administrators responded to the same question as follows: eight (13.3 percent) one to four years, twenty-two (36.7 percent)

five to nine years, and thirty (50 percent) ten or more years. Experience in education administration for the educator group was one (5.6 percent) less than one year, eight (44.4 percent) one to four years, five (27.8 percent) five to nine years, and four (22.2 percent) ten or more years. Nursing service administrators' experience in education administration was, as follows: fifty (86.2 percent) no experience, three (5.2 percent) one to four years, two (3.4 percent) five to nine years, and three (5.2 percent) ten or more years. Two did not respond.

Education Programs

Table 5 illustrates changes which nursing education administrators anticipate in their program over the next five years. Ten of the eighteen (55.6 percent) stated they anticipated changes in the type of programs they offered in the next five years. Six of the ten were associate degree programs with anticipated plans to develop baccalaureate programs. Two which had upper division RN completion programs planned to change to the four-year generic programs. Two administrators responded with curriculum changes rather than program changes. One associate degree administrator noted plans to add management to the curriculum. One generic program administrator planned to increase clinical competence and

leadership.

Eleven (61.1 percent) of the eighteen nursing education administrators anticipated changes in the number of graduates during the next five years. Two associate degree programs and five baccalaureate programs were expected to increase the number of graduates. Two associate degree programs and two baccalaureate programs anticipated decreases in the number of graduates. The total number of graduates reported for the 1983-84 academic year were six hundred thirty-four associate degree, two hundred twenty-nine two-year BSN, and one hundred sixty-two four-year BSN.

Hospitals

Most hospitals in West Virginia do not differentiate between associate degree and baccalaureate nurses in salaries. See Table 6. Among new graduates, eighteen (30 percent) of the nursing service administrators indicated higher salaries for new BSN graduates than new AD graduates while forty-two (70 percent) did not. Nursing administrators reported for nurses with at least three years of experience, sixteen hospitals (27.6 percent) paid a higher salary for baccalaureate nurses than associate degree nurses while forty-two (72.4 percent) denied such differentiation. Two did not respond to the question.

Table 5

Changes Anticipated Over the Next Five Years
by Nursing Education Administrators
by Number and Percentage

Response	Type of Program	Number of Graduates
Yes	10 (55.555%)	11 (61.111%)
No	8 (44.444%)	7 (38.888%)

Table 6

Higher Salaries for BSN Nurses
than AD Nurses by Number
and Percentage

Experience of Nurses	Higher Salaries for BSN	Salaries Not Higher	No Response
New Graduates	18 (30.000%)	42 (70.000%)	0
Nurses with at Least 3 Yrs Experience	16 (27.586%)	42 (72.414%)	2

Over half of the hospitals have within their RN staff less than 5 percent with a BSN. Table 7 shows the breakdown of registered nurses with a minimum of a baccalaureate degree in nursing. One nursing service administrator did not respond to the question. Of the fifty-nine who answered, thirty-four (57.6 percent) indicated less than 5 percent, thirteen (22 percent) indicated 6 to 10 percent, seven (11.9 percent) stated 11 to 20 percent, and five (8.5 percent) responded they had greater than 20 percent of their RN staff with a minimum of a BSN.

Most West Virginia hospitals do not have job descriptions with a requirement for a BSN but, the majority do list the baccaluareate as preferred for some positions. See Table 8. Twenty-three (38.3 percent) of the nursing service administrators stated their hospitals had job descriptions which required a BSN while thirty-seven (61.7 percent) said they did not. Among those job descriptions listed as requiring the bachelor's degree were fifteen for nursing administration (director or assistant director of nursing), seven for education (inservice or staff development), three for supervision and one for head nurse. Forty-three or 71.7 percent of the administrators reported their hospitals had job descriptions which listed the BSN as preferred while seventeen or 28.3 percent did not. Positions most often

mentioned as having preference for a BSN were twenty-three for nursing administration, eighteen for supervision, fifteen for head nurses, twelve for education, and nine for coordinators.

The majority of hospitals reported offering some tuition reimbursement for both RN's working on a BSN and licensed practical nurses (LPN's) pursuing degrees leading to state board examinations to become RN's. Table 9 illustrates the responses. Thirty-six (60 percent) offer tuition reimbursement for RN's working toward a bachelor's degree while twenty-four (40 percent) stated they did not. Thirty-eight (63.3 percent) answered they offered tuition reimbursement for LPN's toward becoming RN's, and twenty-two (36.7 percent) stated they did not.

Twenty-seven, less than half, of the nursing service administrators reported vacant positions for RN's. Nineteen listed ten vacant positions or less, four listed eleven to twenty, and four indicated twenty or more vacancies for registered nurses. Only six reported vacancies in positions specifically for baccalaureate nurses and these all numbered five or less.

Of the sixty nursing service administrators surveyed, forty-three or 71.7 percent reported student nurses used their hospitals for clinical experiences while seventeen, 28.3 percent, stated no student nurses

Table 7

RN's with a Minimum of a BSN by Number and Percentage of Hospitals

Responses	Less than 5%	6-10%	11-20%	Greater than 20%	No Response
Hospitals	34 (57.627%)	13 (22.033%)	7 (11.864%)	5 (8.474%)	1

Table 8

Job Descriptions with Requirement or Preference for BSN by Number and Percentage

Hospitals	Require BSN	Prefer BSN
Yes	23 (38.333%)	43 (71.666%)
No	37 (61.666%)	17 (28.333%)

Table 9

Tuition Reimbursement by Hospitals by Number and Percentage

Reimbursement	RN's for BSN	LPN's for RN
Yes	36 (60.000%)	38 (63.333%)
No	24 (40.000%)	22 (36.666%)

affiliated with their hospitals. Among those who did have student nurses in their institutions, most reported LPN and BSN students. Practical nurse students and baccaluareate nursing students each were reported as affiliating in thirty-six hospitals or 83.7 percent. Associate degree students had clinical experience in twenty-six, 60.5 percent, of the institutions while only three, 7 percent, reported diploma students. See Table 10.

In general, baccaluareate nursing programs were located further from hospitals than associate degree programs. See Table 11. Twenty-eight, 47.5 percent, of the hospitals reported associate degree programs within ten miles, eleven, 18.6 percent, eleven to twenty-five miles, nine, 15.3 percent, twenty-six to fifty miles, eleven, 18.6 percent, more than fifty miles, and one did not respond. The distance from baccalaureate nursing programs was reported as follows: twenty, 33.3 percent, less than ten miles, seven, 11.7 percent, eleven to twenty-five miles, ten, 16.7 percent, twenty-six to fifty miles; and twenty-three, 38.3 percent, more than fifty miles.

Anticipated changes in bed capacity over the next five years varied among hospitals. Ten, 16.7 percent, anticipated an increase in bed capacity; twenty-three, 38.3 percent, were planning for decreases, while

twenty-seven, 45 percent, anticipated no change. See Table 12.

The most dramatic change anticipated was that of services to be provided. Table 13 displays the responses. Forty-nine or 83.1 percent anticipated changes in services over the next five years while ten or 16.9 percent responded negatively. One person did not respond. Some respondents did not specify what changes were anticipated. Among those who did, twenty-eight indicated adding or increasing some sort of outpatient or ambulatory services. Ten listed adding or increasing home health care while only thirteen indicated development or increases in specific inpatient services in specialty units.

Perceptions

The Mann-Whitney U Test revealed the perceptions of nursing education administrators and nursing service administrators on the educational preparation and hospital personnel practices governing differentials in job assignments and salaries of technical and professional nurses differed significantly, each at less than the .05 level of significance.

The statement, considering other qualifications being equal, new BSN graduates should be paid a higher salary than new AD graduates, showed a significant

Table 10

Student Nurse Affiliations Reported by Hospitals by Number and Percentage

Responses	LPN	Diploma	AD	BSN
Hospitals	36(83.721%)	3(6.977%)	26(60.465%)	36(83.721%)

Table 11

Distance of Hospitals to Closest Nursing Program by Number and Percentage

Program	Less than 10 Miles	11 - 25 Miles	26 - 50 Miles	More than 50 Miles	No Response
AD	28 (47.458%)	11 (18.644%)	9 (15.254%)	11 (18.644%)	1
BSN	20 (33.333%)	7 (11.666%)	10 (16.666%)	23 (38.333%)	0

Table 12

Anticipated Changes in Bed Capacity in Hospitals by Number and Percentage

Response	Increase	Decrease	No Change
Hospitals	10 (16.666%)	23 (38.333%)	27 (45.000%)

difference between nursing education and service administrators at the .0097 level of significance. The mean rank for educators was 27.83 while the mean rank for service people was 43.00. See Table 14.

Table 15 illustrates the comparison of perception of nursing administrators regarding higher salaries for BSN nurses than AD nurses when other qualifications including three years of experience are equal. The responses differed at the .0007 level of significance with the mean rank for educators, 24.11, and the mean rank for service administrators was 43.54.

Table 16 displays the results of comparing perceptions of nursing administrators on requiring a BSN for promotion to a head nurse or supervisory position. Education and service administrators' responses differed at the .00001 level of significance. The mean rank for nursing education administrators was 21.42 and, for nursing service administrators, it was 44.92.

In comparing perceptions of nursing administrators on preferring a BSN for promotion to a head nurse or supervisory position, education and service differed at the .0004 level of significance. The education mean rank was 23.83, and for service it was 43.63. See Table 17.

Perceptions of nursing administrators differed at the .0141 level of significance on the statement -- there are no definite differences in the beginning nursing

Table 13

Anticipated Changes in Hospital Services over Next 5 Years by Number and Percentage

Response	Yes	No	No Response
Hospitals	49 (83.050%)	10 (16.949%)	1

Table 14

Comparison of Perceptions of Nursing Administrators on Whether the New BSN Graduate Should Receive a Higher Salary than the New AD Graduate Using Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	27.83
Service	60	43.00
U =	330.0	
Z =	- 2.5869	
p =	.0097	

Table 15

Comparison of Perceptions of Nursing Administrators on Whether the BSN Nurse with over 3 Years Experience Should Receive a Higher Salary than the AD Nurse with Same Experience Using Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	24.11
Service	59	43.54
U =	263.0	
Z =	- 3.3902	
p =	.0007	

Table 16

Comparison of Perceptions of Nursing Administrators on Whether a BSN Should Be the Requirement for a Head Nurse or Supervisory Position Using the Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	21.42
Service	60	44.92
U =	214.5	
Z =	- 4.0667	
p =	.00001	

practice abilities of AD and BSN nurses in acute care hospitals. The mean rank for educators was 49.81 and for service people, 35.70. See Table 18.

Table 19 compares perceptions on no definite differences in the practice abilities in acute care hospitals of AD and BSN nurses with at least three years experience. Perceptions of nursing administrators differed at the .0006 level of significance. Mean ranks were 54.61 for education administrators and 34.97 for service administrators.

The statement, there are presently no clear differences as to the levels of responsibility for which schools prepare the graduate of AD and BSN programs to function in acute care hospitals, drew differences in perceptions of nursing administrators at the .0020 level of significance. See Table 20. The mean ranks were 52.53 for educators, and 34.87 for service people.

Correlations Within Groups

Correlations of selected demographic and institutional information was analyzed as a point of interest rather than directly relating to the hypotheses.

In looking within groups to determine if education for either group, program type for nursing education administrators, or bed capacity for service administrators significantly correlated with perceptions,

Table 17

Comparison of Perceptions of Nursing Administrators on Whether a BSN Should Be Preferred for a Head Nurse or Supervisory Position Using the Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	23.83
Service	59	43.63
U =	258.0	
Z =	- 3.5299	
p =	.0004	

Table 18

Comparison of Perceptions of Nursing Administrators on No Definite Differences in Beginning Abilities of AD and BSN Nurses in Acute Care Hospitals Using the Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	49.81
Service	59	35.70
U =	336.5	
Z =	- 2.4539	
p =	.0141	

Table 19

Comparison of Perceptions of Nursing Administrators on No Definite Differences in Practice Abilities of AD and BSN Nurses in Acute Care Hospitals with at Least 3 Years Experience Using the Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	54.61
Service	60	34.97
U =	268.0	
Z =	- 3.4165	
p =	.0006	

Table 20

Comparison of Perceptions of Nursing Administrators on No Clear Differences as to the Levels of Responsibility for which Schools Prepare Graduates of AD and BSN Programs to Function in Acute Care Hospitals Using the Mann-Whitney U Test

Cases	N	Mean Rank
Education	18	52.53
Service	59	34.87
U =	287.5	
Z =	- 3.0848	
p =	.0020	

interesting results were discovered. There were no significant correlation at less than .05 level for education administrators. Bed capacity was not a significant factor in perceptions for nursing service administrators. Three perceptions did correlate significantly with highest educational level in nursing for this latter group. The statement, considering other qualifications being equal, including experience over three years, the BSN nurse should be paid a higher salary than the AD nurse, positively correlated at the .0453 level of significance. The statements that the BSN should be required or preferred for head nurse or supervisory positions drew a .0057 and .0506 level of significance, respectively, with nursing education level.

These correlations reflect the influence of the educational level of the nursing service administrators on their perceptions. The demographic data illustrates the highest educational level of the service administrators is less than that of the education administrators. The literature review reflects a need for a higher educational level for nursing service administrators. Should this occur, it might lead to more congruence in the profession. The verification of this idea would be dependent on further study. Incongruencies have resulted from the difference between educational changes and practice in nursing. The incongruencies are evident when one con-

siders the following information:

1. the conclusions from the previous section
2. the espoused theory of two levels of education and responsibilities
3. the theory-in-use of no differentiation
4. the changes which are occurring and will occur in health care.

The education administrators and the service administrators reported plans to change programs to keep up with health care needs. If the incongruencies described are permitted to remain, it would appear that the projected changes will be impacted and the incongruencies will become more important. These factors indicate that the time may be right to address the problems which create the incongruencies and to unify the educational and service areas of the profession of nursing.

CHAPTER 5

Summary and Implications

This chapter presents a review of the study. Conclusions are drawn from the data analyzed. Recommendations and implications for future research are included.

Review of the Study

This research examined the degree of incongruence between the perceptions of nursing education administrators and nursing service administrators in regard to the educational preparation and hospital practices governing job assignments and salaries of technical and professional nurses. Seven null hypotheses were formulated. Questionnaires were developed. Data was also gathered concerning the population, the number of nurses with different educational levels in West Virginia, the location of nursing programs, the current number of graduates from technical and professional programs and the changing needs for nursing care needed to project future trends in education and practice.

The population surveyed included all nursing education administrators in AD and BSN programs in West Virginia and all nursing service administrators in general acute care hospitals in the state. Eighteen, 100

percent, of the education administrators participated in the study. Sixty, 89.6 percent, of the sixty-seven service administrators, responded to the questionnaire.

Conclusions

All seven null hypotheses were rejected at less than the .05 level of significance.

1. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether baccalaureate education should be a criteria for higher starting salaries than associate degree education for new graduates. The nursing education administrators more positively agreed with the higher starting salaries for new BSN nurses than did the nursing service administrators.

2. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether BSN nurses with at least three years of experience should receive higher salaries than AD nurses with an equal number of years of experience. The nursing education administrators more positively agreed with higher salaries for BSN nurses with at least three years of experience than did the nursing service administrators.

3. There was a significant difference between the

perceptions of nursing education administrators and nursing service administrators in regard to whether a BSN should be a requirement for promotions to head nurse and supervisory positions in acute care hospitals. The nursing education administrators more positively agreed with the BSN being a requirement for these positions than did the nursing service administrators.

4. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to whether a BSN should be preferred for promotions to head nurse or supervisory positions in acute care hospitals. The nursing education administrators more positively agreed with the BSN being preferred for these positions than did the nursing service administrators.

5. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to the beginning practice abilities of AD and BSN graduates in acute care hospitals. The nursing education administrators more strongly perceived a difference in beginning practice abilities of AD and BSN nurses than did the nursing service administrators.

6. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to the practice

abilities of AD and BSN nurses in acute care hospitals with at least three years of nursing experience. The nursing education administrators more strongly perceived a difference in practice abilities of AD and BSN nurses with at least three years of experience than did the nursing service administrators.

7. There was a significant difference between the perceptions of nursing education administrators and nursing service administrators in regard to there being clear differences as to the levels of responsibility for which schools prepare AD and BSN graduates to function in acute care hospitals. The nursing education administrators more strongly perceived clear differences in the academic preparation than did the nursing service administrators. This finding correlates with Curran's conclusion that education administrators and service administrators differed significantly in their opinions on nursing education.[129]

The survey indicated that most hospital policies do not differentiate between the technical and professional nurses in regard to job assignments and salaries. This data is consistent with that of Johnston[130] and Miller[131] who found AD and BSN nurses were not being effectively utilized. It is also consistent with the findings of Howell that differentials are not made in salaries based on education.[132]

Demographic data showed the two groups of administrators differing in educational preparation, with nursing education administrators in general reporting higher levels of education achieved. Seventy percent of the nursing service administrators had no teaching experience, whereas all nursing education administrators had nursing practice experience. However, the information did not indicate how recently they had nursing practice experience.

Education administrators anticipated shifts toward more utilization of baccalaureate graduates. Service administrators report trends toward more outpatient and ambulatory care.

Discussion

The major nursing organizations espouse the theory that two levels of nursing, technical and professional, exist. Nursing curricula for the two levels vary from one another in length and content. In practice, the espoused theories are not used for staff assignments.

The theory-in-use is that there are no differences between the technical and professional levels. The central theme of this study was that there was incongruence between the perceptions of nursing education administrators and nursing service administrators about the educational preparation and utilization of associate

degree and baccalaureate nurses. Significant differences in perceptions of those who educate and those who employ nurses exist.

Several factors contribute to the incongruence between the espoused theory and the theory in use. In West Virginia, there is a maldistribution of baccalaureate nursing programs, most of them being located in the northern part of the state. This has created an uneven geographic distribution of BSN nurses. Over sixty percent of the nurses graduating in 1983-84 in the state were from associate degree programs. Should the trend continue, a larger percentage of those associate degree graduates than baccalaureate graduates will be employed in hospitals.

Changes in health care needs will lead to new roles for nurses. The increasing older population, the decreasing census in hospitals, the increase in outpatient and home care, and the emphasis on preventive care will require nurses to be prepared in these areas of health care. More nurses with baccalaureate and higher degrees will be needed to work more independently in less structured settings. The acute care setting itself will require well educated nurses who are able to provide patient centered care in the midst of high technology.

The schools and hospitals in West Virginia are anticipating these needs in their planning. Schools of

nursing are shifting toward more advanced programs and hospitals are planning more outpatient, ambulatory and home care services.

Recommendations

The response rate to the questionnaire demonstrated an interest in the research on the part of both nursing education administrators and nursing service administrators. The expressed interest and the participation are viewed as first steps toward solving the problems which exist between nursing education and nursing practice. Both groups are planning and their plans must be coordinated so that existing problems do not continue. The following recommendations are provided as a series of steps in solving problems which exist between nursing education and nursing practice.

1. It is recommended that leaders in nursing education and nursing practice join forces in planning in order to decrease the incongruence and discontent in nursing.

2. It is recommended that working together be accomplished through a Statewide Task Force to Study Nursing and Nursing Education.

3. It is recommended that this task force consist of individuals suggested by the West Virginia Board of Regents from state and private college programs and the

West Virginia Nursing Service Administrators and be under the auspices of the West Virginia Board of Examiners for Registered Nurses.

4. It is further recommended that the task force be made up of representatives from associate degree, baccalaureate degree and masters degree nursing programs, and representatives from primary, secondary and tertiary care agencies.

5. It is recommended that the task force study include: (a) the present and future needs for nursing care of West Virginia residents, (b) the availability of nurse manpower, and (c) the educational system's ability to meet present and future manpower needs.

6. It is recommended that the task force develop a series of short-term and long-term goals related to each area of the study.

7. It is also recommended that the results of the study be presented to the West Virginia Board of Regents for use in the statewide planning for higher education, and to the West Virginia Society of Nursing Service Administrators for their endorsement.

The coordination between those who educate nurses and those who utilize the knowledge and skills of nurses in the years ahead should lead to more comprehensive nursing education and nursing care which will result from the outlined recommendations. Planned changes will occur

as people work together on their ideas and are committed to the goals as a result of having had a part in their development.

Based on the areas of incongruence and the interest demonstrated in this study, it is concluded that the time is right for the development of a task force. Positive findings which indicate some congruence exists are:

(1) although most hospitals do not have job descriptions which require a BSN, the majority have job descriptions which list the BSN as preferred.

(2) although perceptions between nursing education administrators differed significantly, they were not polarized at totally opposite ends of a continuum.

(3) 60 percent of the hospitals offer tuition reimbursement for RN's pursuing a BSN.

Support and interest in the study were demonstrated by the high rate of returns on a mailed questionnaire. Several of the respondents requested a report on the results. A copy of the research has been requested by the West Virginia Board of Regents and the West Virginia Board of Examiners for Registered Nurses.

Implications for Future Study

This study reveals a lack of understanding between

nursing education administrators and nursing service administrators on the educational preparation and utilization of technical and professional nurses in general acute care hospitals. Future studies need to (1) document differences in abilities of AD and BSN nurses through observation in the practice setting, (2) compare the responses of patients to nursing care provided by technical and professional nurses, (3) identify competencies for professional nurses, (4) analyze technical and professional nursing outside of the general acute care hospital, and (5) implement a nursing manpower study in all settings.

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APPENDIX A

Questionnaire for Nursing Education Administrators

QUESTIONNAIRE FOR NURSING EDUCATION ADMINISTRATORS

PART I.

Please cirle or fill in the most nearly correct answer. Write any comments at the end of the questionnaire. Confidentiality is guaranteed.

Q-1. Your primary position:
1. Nursing education administrator
2. Nursing service administrator

Q-2. Please circle the **highest** educational level you have completed in **nursing.**
1. Diploma
2. Associate degree
3. Bachelor's degree
4. Master's degree
5. Doctorate

Q-3. Please circle the **highest** educational level you have completed in a **non-nursing** field.
1. None
2. Associate degree
3. Bachelor's degree
4. Master's degree
5. Doctorate

Q-4. Total number of years of full time clinical experience with **direct** patient contact (example: staff nurse, team leader, charge nurse or head nurse):
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-5. Total number of years of experience related to **practice administration** (example: supervisor, director of nursing service, director of inservice, director of staff development, etc.)
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-6. Total number of years of full time teaching experience in **academic** nursing education programs:
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-7. Type(s) of nursing program(s) you have taught in (if any):
1. None
2. LPN/LVN
3. Diploma
4. AD
5. BSN (four year)
6. BSN (two year RN completion)
7. Graduate
8. Other________________

PART I. (cont'd)

Q-8. Total number of years experience related to **academic education administration** (example: director, dept. head, coordinator of program or dean of nursing):
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

PART II.

The following statements deal with nursing educ… and practice. Please circle the one number that most closely corresponds with **your perception** of the statement.

1 — Strongly Agree
2 — Agree
3 — Neither One Nor the Other
4 — Disagree
5 — Strongly Disagree

Q-9. Considering other qualifications being equal, **new** BSN graduates should be paid a higher salary than new AD graduates.

1 2 3 4 5

Q-10. Considering other qualifications being equal, including the amount of experience (over 3 yrs.) the BSN nurse should be paid a higher salary than the AD nurse.

1 2 3 4 5

Q-11. Assuming availability, a BSN should be the **requirement** for a head nurse or supervisory position.

1 2 3 4 5

Q-12. Assuming availability, a BSN should be **preferred** for a head nurse or supervisory position.

1 2 3 4 5

Q-13. There are no definite differences in the **beginning** nursing practice abilities of AD and BSN nurses in acute care hospitals.

1 2 3 4 5

Q-14. There are no definite differences in the practice abilities in acute care hospitals of AD and BSN nurses with at least 3 years experience.

1 2 3 4 5

Q-15. There are presently no clear differences as to the levels of responsibility for which schools prepare the graduates of AD and BSN programs to function in acute care hospitals.

1 2 3 4 5

PART III.

Please circle or fill in the most nearly correct answer.

Q-16. For what type(s) of program(s) are you responsible?

1. AD
2. BSN (2 year RN completion program)
3. BSN (four year program)

Q-17. Do you anticipate any changes in the type of programs you offer in the next five years?

1. Yes
2. No

If yes, please specify ______________________

Q-18. How many graduates did you have in the 1983-84 year?

1. AD ______________________
2. BSN (RN completion) ______________________
3. BSN (four year) ______________________

Q-19. Do you anticipate any changes in the number of graduates in the next five years?

1. Yes
2. No

If yes, please specify ______________________

Thank you!

COMMENTS ARE WELCOME:

APPENDIX B

Questionnaire for Nursing Service Administrators

QUESTIONNAIRE FOR NURSING SERVICE ADMINISTRATORS

PART I.

Please cirle or fill in the most nearly correct answer. Write any comments at the end of the questionnaire. Confidentiality is guaranteed.

Q-1. Your primary position:
1. Nursing education administrator
2. Nursing service administrator

Q-2. Please circle the **highest** educational level you have completed in **nursing.**
1. Diploma
2. Associate degree
3. Bachelor's degree
4. Master's degree
5. Doctorate

Q-3. Please circle the **highest** educational level you have completed in a **non-nursing** field.
1. None
2. Associate degree
3. Bachelor's degree
4. Master's degree
5. Doctorate

Q-4. Total number of years of full time clinical experience with **direct** patient contact (example: staff nurse, team leader, charge nurse or head nurse):
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-5. Total number of years of experience related to **practice administration** (example: supervisor, director of nursing service, director of inservice, director of staff development, etc.)
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-6. Total number of years of full time teaching experience in **academic** nursing education programs:
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

Q-7. Type(s) of nursing program(s) you have taught in (if any):
1. None
2. LPN/LVN
3. Diploma
4. AD
5. BSN (four year)
6. BSN (two year RN completion)
7. Graduate
8. Other______________________

PART I. (cont'd)

Q-8. Total number of years experience related to **academic education administration** (example: director, dept. head, coordinator of program or dean of nursing):
1. None
2. Less than 1
3. 1-4
4. 5-9
5. 10 or more

PART II.

The following statements deal with nursing education and practice. Please circle the one number that most closely corresponds with **your perception** *of the statement.*

1 — Strongly Agree
2 — Agree
3 — Neither One Nor the Other
4 — Disagree
5 — Strongly Disagree

Q-9. Considering other qualifications being equal, **new** BSN graduates should be paid a higher salary than new AD graduates.

1 2 3 4 5

Q-10. Considering other qualifications being equal, including the amount of experience (over 3 yrs.) the BSN nurse should be paid a higher salary than the AD nurse.

1 2 3 4 5

Q-11. Assuming availability, a BSN should be the **requirement** for a head nurse or supervisory position.

1 2 3 4 5

Q-12. Assuming availability, a BSN should be **preferred** for a head nurse or supervisory position.

1 2 3 4 5

Q-13. There are no definite differences in the **beginning** nursing practice abilities of AD and BSN nurses in acute care hospitals.

1 2 3 4 5

Q-14. There are no definite differences in the practice abilities in acute care hospitals of AD and BSN nurses with at least 3 years experience.

1 2 3 4 5

Q-15. There are presently no clear differences as to the levels of responsibility for which schools prepare the graduates of AD and BSN programs to function in acute care hospitals.

1 2 3 4 5

PART III.

Please circle or fill in the most nearly correct answer.

Q-16. What is the bed capacity of your hospital?
1. Less than 100
2. 101-200
3. 201-300
4. More than 300

Q-17. Does you institution pay a higher starting salary for new graduates of BSN programs than new graduates of AD programs (everything else being equal)?
1. Yes
2. No.

Q-18. Does your institution pay a higher salary for BSN nurses than AD nurses, both with at least 3 years of experience (everything else being equal)?
1. Yes
2. No

Q-19. In your hospital, approximately how many RN's have a minimum of a BSN?
1. Less than 5%
2. 6-10%
3. 11-20%
4. Greater than 20%
5. Do not know

Q-20. Are there any job descriptions in your institution which **require** a BSN?
1. Yes
2. No

If yes, please specify for which jobs. ________________

____

Q-21. Are there any job descriptions in your institution which state a **preference** for a BSN?
1. Yes
2. No

If yes, please specify for which jobs. ________________

____

Q-22. Does your hospital offer tuition reimbursement for LPN's seeking an AD?
1. Yes
2. No

Q-23. Does your hospital offer tuition reimbursement for RN's seeking a BSN?
1. Yes
2. No

Q-24. How many budgeted full-time positions does your hospital have for RN's? ________________

Q-25. How many of the budgeted full-time positions for RN's are specifically for BSN nurses?

____

Q-26. What is the number of vacant full-time positions for RN's which you presently have?

____

PART III. (cont'd)

Q-27. What is the present number of vacant positions specifically for BSN nurses? ________________

Q-28. Are student nurses provided clinical experience in your hospital?
1. Yes
2. No

Q-29. If yes, from what type(s) of program(s)?
1. LPN/LVN
2. Diploma
3. AD
4. BSN (2 yr. RN completion)
5. BSN (4 yr.)

Q-30. What is the approximate distance of the closest AD program to your hospital?
1. Within 10 miles
2. 11-25 miles
3. 26-50 miles
4. More than 50 miles

Q-31. What is the approximate distance of the closest BSN program to your hospital?
1. Within 10 miles
2. 11-25 miles
3. 26-50 miles
4. More than 50 miles

Q-32. Over the next five years do you anticipate:
1. An increase in bed capacity.
2. A decrease in bed capacity.
3. No change in bed capacity.

Q-33. Over the next five years do you anticipate any changes in services?
1. Yes
2. No

If yes, please specify: ________________________

____

Thank You!

COMMENTS ARE WELCOME:

APPENDIX C

Cover Letter for Questionnaires

MARSHALL UNIVERSITY

SCHOOL OF NURSING

HUNTINGTON, WEST VIRGINIA 25701

October 23, 1984

&name&
&address1&
&address2&
&address3&
&address4&

Dear &title&:

Nurses in both education and service are concerned with the educational preparation of nurses. These two groups often differ in their perceptions of how nurses from different educational programs should function.

I am currently conducting a study for a doctoral dissertation on the perceptions nursing education administrators and nursing service administrators have concerning the preparation and utilization of associate degree (AD) nurses and baccalaureate nurses (BSN). This research deals only with collegiate based programs. Diploma nursing has been excluded as it represents another category of educational preparation. With your assistance, I will identify where differences may exist in perceptions.

I hope you are willing to complete the attached questionnaire and return it in the enclosed stamped self-addressed envelope by November 12, 1984. It is important that you answer all questions to the best of your ability. Your input is extremely important and your responses will be kept confidential. It is anticipated the findings will serve as a basis for instituting more collaboration between these two groups of nursing leaders in planning for the future nursing needs in the state.

Thank you very much for your participation.

Sincerely,

Judith Sortet, R.N., M.S.

As Chairman of Mrs. Sortet's Doctoral Committee, I urge you to assist with this study. I believe this research will be helpful to your profession. A high rate of return is necessary for the student to draw meaningful conclusions and complete her dissertation. Please respond as soon as possible.

Sincerely,

Robert B. Hayes, Chairman
Doctoral Committee

MARSHALL UNIVERSITY

SCHOOL OF NURSING

HUNTINGTON, WEST VIRGINIA 25701

November 16, 1984

&name&
&address1&
&address2&
&address3&
&address4&

Dear &title&:

Several weeks ago I sent you a questionnaire dealing with perceptions of nursing education administrators and nursing service administrators on the education and utilization of associate degree and baccalaureate nurses in West Virginia. Since I have not yet received your response, I have enclosed another copy of the survey with a stamped return envelope.

Please take a few minutes to assist with this research. The response thus far has been enthusiastic, but your participation is still very important since this study is limited to West Virginia.

Thank you very much.

Sincerely,

Judith Sortet, R.N., M.S.
Doctoral Student

ABSTRACT

The problem investigated was the degree of incongruence between the perceptions of nursing education administrators and nursing service administrators in regard to the educational preparation and employment practices for technical and professional nurses which has contributed to discontent in the profession. The population studied was nursing education administrators in AD and BSN programs and nursing service administrators in general acute care hospitals in West Virginia. The research method was a descriptive survey using a mailed questionnaire developed by a researcher. Eighteen (100%) of the nursing education administrators and sixty (89.6%) of the nursing service administrators responded.

Seven perceptions were examined to determine significant differences between the nursing education administrators and the nursing service administrators on preparation, job assignments and salaries of AD and BSN nurses. The data was analyzed using the Mann-Whitney U Test. All perceptions differed at less than the .05 level of significance. These perceptions revealed that the nursing education administrators more than the nursing service administrators believe that BSN nurses should receive higher salaries and should receive promotions to head nurse and supervisory positions over

AD nurses. Nursing education administrators also perceive a difference in abilities between BSN and AD nurses more than do the nursing service administrators. Finally, the education administrators more strongly perceive a clear difference in the academic preparation of technical and professional nurses than do the service administrators.

The survey revealed two broader concerns which affect the incongruencies. First, hospitals do not differentiate between professional and technical nurses in job assignments and salaries. Second, the uneven distribution of AD and BSN programs in West Virginia has created pockets of concentration of technical and professional nurses in the state.

The demonstrated incongruence in nursing combined with the changes in health care which are developing has intensified the need for coordination between nursing education and nursing practice in order to deliver comprehensive nursing care. A statewide task force is recommended to study nursing practice and nursing education to make the efforts of the two groups more congruent.