BEING A NURSE: THE LIVED EXPERIENCE OF REGISTERED NURSES EDUCATED IN AN ACCELERATED SECOND DEGREE BACHELOR OF SCIENCE IN NURSING PROGRAM

BY

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VITA

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ABSTRACT

BEING A NURSE: THE LIVED EXPERIENCE OF REGISTERED NURSES EDUCATED IN AN ACCELERATED SECOND DEGREE BACHELOR OF SCIENCE IN NURSING PROGRAM

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Dr. Mary M. Hoke, Chair

This research was an interpretive phenomenological study aimed at exploring the lived experience of nurses educated in accelerated second degree bachelor of science in nursing (ASD-BSN) programs. The method used to investigate the phenomenon was based on the philosophy of Martin Heidegger, as articulated by Patricia Benner (1994) and Marlene Zichi Cohen, David L. Kahn, and Richard H.

Steeves (2000). The sample for this study was purposive in nature and drawn from registered nurses practicing in the southwestern United States who were educated in an ASD-BSN program. The results included the emergence of four major themes and a model of ASD-BSN nursing practice. The themes which emerged were the Headwaters, Tributaries and Turbulence, the Rolling River, and the Delta. This study adds to professional nursing's understanding of how ASD-BSN prepared nurses experience their career as professional nurses in terms of their motivation to become nurses, how they experience their nursing practice, and how they interact with the nursing profession. Based on this understanding, indications for ASD-BSN education, employment orientation, management, and career progression were identified.

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CHAPTER 1

FOCUS AND CONTEXT OF RESEARCH STUDY

The initial chapter of this dissertation presents an overview of the phenomenon of interest, to include the background, aim, research question and a brief discussion of the philosophical and conceptual foundation supporting it. Also included in this chapter is a discussion of the assumptions which result from my professional background. The significance associated with this research study is also presented.

Phenomenon of Interest

The phenomenon of interest for this study was the lived experience of being a registered nurse who was educated in an accelerated second degree Bachelor of Science in Nursing (ASD-BSN) program.

Background

It has been projected that the United States will face a shortage of some 500,000 nurses by the year 2025 (Buerhaus, Staiger, & Auerbach, 2008). This projection is just one of a series regarding the current and anticipated nursing shortage in the United States. Contributing factors to the shortage include an aging nursing workforce, declining admissions to nursing education programs and an aging population of baby boomers with chronic health concerns (Buerhaus & Auerbach, 2011). These factors have converged to form a perfect storm of shortages in the health professions, to include nursing (Allen, Van Dyke, & Armstrong, 2010). This shortage, coupled with reports on improved patient outcomes associated with

baccalaureate prepared nurses as providers of direct patient care (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Estabrooks, Midodri, Cummings, Ricker, & Giovannetti, 2005), has resulted in a proliferation of ASD-BSN programs. Further, calls by a variety of professional organizations and nurse leaders for BSN entry to practice (American Association of Colleges of Nursing [AACN], 2005; American Organization of Nurse Executives [AONE], 2005; Benner, Sutphen, Leonard, & Day, 2010; National Black Nurses Association [NBNA], 2003) have supported ASD-BSN program development.

The first ASD-BSN program in the United States started at St. Louis University in 1971 (Domrose, 2001). Over the following two decades, several other programs were initiated and subsequently abandoned as nursing workforce demands waxed and waned (Buonocore, 2009). ASD-BSN programs re-emerged in the new millennium in response to an impending global nursing shortage of proportions not seen previously (Carty, Moss, Al-Zayyer, Kowitlawakul, & Arietti, 2007). In a review of the literature associated with ASD-BSN programs and students, Cangelosi and Whitt (2005) reported that in 1990, 30 such programs existed in the United States; by 2005, there were 133 programs, with 50 others in the planning stage. In 2008, Siler, DeBasio and Roberts reported that there were more than 200 such programs in existence. More recent reports from the AACN Research and Data Center (AACN, 2010) indicate that there are over 230 ASD-BSN programs in the United States. These programs, designed for adults already in possession of baccalaureate or higher degrees in non-nursing fields and desirous of a career change

to professional nursing, represent the fastest growing segment of nursing education curricula in this country, far outpacing all other types of new entry level nursing education (Raines, 2011).

A major premise in the development of ASD-BSN programs is that they serve to facilitate rapid workforce entry for persons wishing to pursue nursing. Thus, a new population of potential nursing students can be tapped, students who might otherwise be unwilling or unable to devote up to three or four years pursuing a traditional nursing education (Seldomridge & DiBartolo, 2005, 2007). Further, it is believed that graduates from these programs will help address the nursing shortage, assuming they stay in the nursing field in the capacity of bedside nurses, nurse leaders, nurse educators, or providers of primary health care in advanced nursing practice roles (Cangelosi & Whitt, 2005).

What little related research published has focused on ASD-BSN program development, ASD-BSN student characteristics, and comparisons of ASD-BSN and traditional BSN students and new graduates in terms of academic performance outcomes and early professional transition to nursing practice. However, given the relative newness of ASD-BSN programs, there has been no research published related to ASD-BSN prepared nurses actively engaged in professional nursing practice beyond the first two years of their careers. Further, the need for research related to ASD-BSN program outcomes has been identified by a number of nurse researchers to include Akton, Bareford, Bliss, Connolly, DeYoung, Sullivan, and Tracy (2009), Brewer, Kovner, Poornima, Fairchild, Hongsoo, and Djukic (2009), Cangelosi and

Whitt (2005), D'Antonio, Beal, Underwood, Ward, McKelvey, and Guthrie et al. (2010), Penprase and Koczara (2009), Raines and Sipes (2007), Raines (2011), and Suplee and Glasgow (2008). This study sought to respond to those needs by exploring the lived experience of ASD-BSN prepared nurses further in their career progression than those who had been previously studied.

Aim of Study

The aim of this study was to gain an understanding of the lived experience of ASD-BSN prepared nurses engaged in their professional nursing careers. Through the participants' personal stories of being a registered nurse, interpreted in a manner consistent with hermeneutical or interpretive phenomenology, an understanding of how they experienced their professional nursing careers was explored. It was assumed that such an exploration would add to the body of knowledge related to ASD-BSN prepared nurses and how they practice nursing.

Research Question

The research question that guided this study was: What is the lived experience of ASD-BSN prepared nurses engaged in professional nursing practice beyond the new graduate phase?

Conceptual Framework

The guiding ontological framework for this study was phenomenology, which was defined by Audi (1999) as the study of the essence of the lived experience. Both a philosophy and a research methodology, phenomenology offers nursing education research a venue in which experiential context supplies the background for

understanding the present. More specifically, Heideggarian phenomenology (1962) provides a means to study the human experience of being, and to understand the personal meaning derived from that experience. Based on this philosophical stance, Patricia Benner (1994) developed her phenomenological research approach and labeled it the Interpretive Phenomenological Method.

In this model, the words hermeneutical and interpretive are used interchangeably (Benner, 1994). Benner posited that the methodological assumptions of logical positivism, and the disengaged criteria-based reasoning that accompanied it, created a systematic bias when applied to the human sciences. It was her stand that the positivist approach ignores the very essence of human transformation, which is the lived experience of transition within the context of a given situation.

Interpretive phenomenology recognizes that the phenomena associated with knowledge, experiences, concerns, and perceptions are embedded in the social interactive fabric of human society and that they can be uncovered and brought to consciousness through the process of narrative description and personal story-telling. Further, the interpretive account of a given experience serves to illuminate the world of those living it through articulating previously unspoken meanings, practices, habits, skills, and concerns (Cohen, Kahn, & Steeves, 2000). Thus, this methodological approach supports the stance that theoretical and logical understanding of these phenomena is insufficient in explaining them. Rather, they must be placed and explored within the situational context of the lived experience. Given that the purpose of this study was to gain understanding about the lived

experience of ASD-BSN prepared nurses beyond the new graduate phase of their careers, this approach provided the most appropriate philosophical foundation for this project.

Significance of the Study

A basic premise on which ASD-BSN programs are based is that persons possessed of a non-nursing degree represent a previously untapped resource for bolstering nursing school enrollment and graduation, thereby helping to address the nursing shortage. As a result, ASD-BSN programs have proliferated and graduates of these programs are entering the nursing workforce in ever increasing numbers. While some research had been published in the literature related to how ASD-BSN graduates experience their nursing education and early transition to professional practice, no literature existed regarding how ASD-BSN prepared nurses experience their professional nursing career beyond that stage. Nor had there been any research published which addressed how they experienced new graduate orientation programs, how they were managed as members of the nursing workforce, or how their ongoing career progression could be facilitated. This study adds to the professional knowledge regarding the lived experience of ASD-BSN prepared nurses as they engage in a nursing career which extends beyond the entry-to-practice phase.

Researcher's Professional World View and Assumptions

In accordance with Benner's (1994) Interpretive Phenomenological Method, which supported the study reported in this document, I understood that my world view of professional nursing and the assumptions that accompanied it needed to be

identified and recognized as contributory to the analysis of the stories of the 12 nurses who participated in this study. Additionally, I understood that my assumptions were not concrete and that they needed to be held as tentative and challengeable. For that reason, it was necessary to explain the evolution of my interest in the research approach utilized in this study and my interest in the phenomenon of the lived experience of the ASD-BSN prepared nurse.

My many years of experience as a staff nurse, charge nurse, nurse educator and manager in the acute care setting, as well as an educator and manager in the academic sector of nursing education, informed my current world view of nursing education and practice. In particular, Benner's (1984) Novice to Expert theory provided a framework within which I constructed my career. I first became acquainted with Benner's theory when I began developing orientation and training materials for the nursing unit on which I was employed. As my career progressed to more formal educational and management roles, my practice and my activities in these roles continued to be informed by Benner's theory. The Novice to Expert theory provided the background for designing, implementing, and teaching orientation and training programs for new graduates, as well as experienced nurses. Further, it provided a background structure from which I managed and directed professional and paraprofessional nursing personnel of varying experience levels in the direct delivery of patient care.

My recent experience included the implementation and ongoing development of an ASD-BSN program in a university located in the southwest region of the United

States which has produced over 150 ASD-BSN prepared nurses. In this capacity, I have functioned as an instructor in the classroom and clinical settings, as well as a counselor for students regarding their educational progression and career options. This experience vested me with an interest in these nursing professionals and their impact on the profession of nursing. This interest, coupled with my doctoral studies of the philosophy of science, specifically interpretive phenomenology, formed the foundation that led me to the following assumptions.

1. ASD-BSN programs are a successful strategy for the preparation of professional registered nurses who might otherwise not be able to pursue a nursing career.

2. ASD-BSN prepared nurses experience knowledge and skill acquisition in a manner consistent with Benner's (1984) theory of Novice to Expert, but with subtle, previously unarticulated differences in timing, progression, and meaning.

3. ASD-BSN prepared nurses play a role in helping to address the current and impending nursing shortage.

4. During an interview with me, ASD-BSN prepared nurses will be able to articulate their lived experiences as professional registered nurses.

5. Commonalities with respect to participants' lived experiences will be evident in the data obtained through interviews I will conduct as part of this study.

Definitions

Definitions for this study included:

1. An ASD-BSN program is an academic program of study at the baccalaureate level in which the normal or traditional upper division nursing program at a given university is condensed and offered over a period of approximately 12 to 16 months.

2. An ASD-BSN prepared nurse is a person who holds a baccalaureate or higher degree in a non-nursing field who subsequently pursued and graduated from an ASD-BSN program.

3. A BSN is the degree awarded by an accredited university to those who complete the required program of study (which usually includes approximately 120 credit hours of liberal arts, sciences, and nursing classes). This degree enables those who have attained it to sit for registered nurse licensure.

4. Registered Nurse (RN) is the professional designation of a person who has completed a nationally standardized licensure examination for nursing practice.

5. Traditional nursing programs are the normal or non-accelerated programs provided to students, leading them to their pre-licensure BSN degree.

6. National Council Licensure Examination for Registered Nurses (NCLEX-RN) is the licensing examination taken by all associate, diploma, and bachelor prepared nursing graduates.

Summary

Accelerated nursing education programs have become increasingly prevalent in response to the current and ongoing nursing shortage. These programs represent an alternate paradigm of nursing education which allows for rapid workforce entry of

individuals with varied educational and professional experiences. While some research has been published related to these programs and their students and graduates, there has been no research published which addresses their lived experience as they progress as nursing professionals. Further, the profession of nursing has not yet determined what, if any, differences in professional needs exist among this subset of nurses. Their lived experience as professional nurses, as described in this report, facilitates the profession's understanding of how these nurses impact the practice of registered nursing, as well as how they are impacted by their practice.

Organization of this Report

The remainder of this document is organized into five additional chapters. Chapter 2 presents the evolution of the professional literature related to ASD-BSN education and Benner's (1984) Novice to Expert theory of nursing skills acquisition. Chapter 3 provides a deeper discussion of the philosophical underpinnings of this study and the use of phenomenological approaches in nursing research. Chapter 4 provides a detailed description of the study design and methodology, including specific actions and processes deployed to gather and analyze the data. Chapter 5 presents the findings which emerged from the data collected, accompanied by a conceptual model of ASD-BSN nursing practice. Chapter 6 summarizes and reflects upon the findings and discusses the implications of the findings to professional nursing practice. The appendices and references associated with this study follow chapter 6.

CHAPTER 2

EVOLUTION OF THIS STUDY

As previously stated, the combination of my professional experience, doctoral studies, and the literature related to ASD-BSN programs and students, led to the research question that guided this study. This review is a summary of the literature surrounding ASD-BSN education and the use of Benner's (1984) Novice to Expert theory. It is presented in two sections. Section 1 will include literature specific to ASD-BSN education, students, and graduates, while section 2 will focus on literature related to the application of Benner's (1984) Novice to Expert theory.

ASD-BSN Education, Students, and Graduates

In a review of existing literature regarding accelerated second degree BSN programs by Cangelosi and Whitt (2005), the authors contend that much of what has been written is anecdotal and that there exists a paucity of research regarding these programs, their students, and their graduates. Further, almost every article dealing in any manner with ASD-BSN education seemed to include some statement regarding the lack of published research in this area, regardless of the date of publication.

That said, more recent analyses of the literature undertaken for this project revealed an expanding body of research on the topic of ASD-BSN programs, indicating a rich environment for scientific inquiry. The designs of published research and doctoral dissertations included quantitative, qualitative, and mixed method formats. Specific categories of research questions emerged, to include (a) individual student characteristics and experiences, (b) performance or outcomes comparisons to

traditional nursing education, (c) admissions processes and outcomes, and (d) program design considerations. However, minimal research specifically addressing graduates of ASD-BSN programs appeared in the literature, and what did appear focused on the entry level graduate nurse. What follows is a review of the existing literature related to ASD-BSN programs, students, and graduates, starting with graduates of ASD-BSN programs and followed by a general discussion of the categories as previously described.

Graduates of ASD-BSN Programs

A literature search specific to ASD-BSN graduates yielded only seven articles, four of which were research reports. Two of the remaining three articles were descriptive reports of ASD-BSN programs and the graduates they produced (Suplee& Glasgow, 2008; Walker, Scott Tilley, Lockwood, & Walker, 2008), and the other was a review of literature regarding ASD-BSN students and graduates (Penprase & Koczara, 2009). Common to all three of these articles was an affirmation of the need for research involving graduates of ASD-BSN programs as they progressed in their careers, as well as anecdotal comments on the attractiveness of ASD-BSN graduates to employers.

Of the remaining four articles, all involved graduates with less than two years of experience. Sweeney Rico (2010) reported on a qualitative descriptive study which focused on the ASD-BSN graduates' perceptions of the teaching practices they encountered as students, but did not address any transition to practice issues. Cangelosi (2007b) reported on a phenomenological study which explored the lived

experiences of ASD-BSN graduates with a focus on how their academic experiences as ASD-BSN students prepared them for practice. Raines (2009) reported on a quantitative study which used a mailed survey asking students to rate their perception of preparedness to practice at two points in time -- the first at graduation and the second after six months in practice. In both of the latter two studies, the ASD-BSN graduates perceived themselves as prepared for practice as a beginning registered nurse after having completed an ASD-BSN program. Further, both studies found that the participants/subjects were happy in their professional choices. In their opinions, they had settled into the RN role more easily than their traditionally educated counterparts, despite experiencing the same fears and concerns commonly identified in new graduate nurses. Further, they felt that that their previous professional experiences had contributed to their successful transition to nursing practice. Again, all of the researchers cited above recommended further research on graduates of ASD-BSN programs as they progressed in their nursing careers. In particular, Sweeny Rico (2010) referenced a 2007 summit held by Duke University School of Nursing with a purpose of developing a research agenda relevant to ASD-BSN program outcomes. The summit results specifically cited transition to practice and career progression of ASD-BSN graduates as one of four research targets. Also, all of the authors and researchers cited above mentioned anecdotal reports that ASD-BSN graduates were highly sought after by employers of registered nurses due to their maturity and previous professional experiences.

On the basis of this review, it was clear to me that more research in relation to the career progression of ASD-BSN graduates is needed. Further, the belief that their previous professional experience enhances their careers as registered nurses needs to be validated. The study reported on in this document addresses those issues.

Individual Student Characteristics

One group of research reports regarding ASD-BSN students that appears in the literature focused on individual student characteristics such as reasons for seeking BSN education and expectations of students and faculty (Cangelosi, 2007a; D'Antonio et al., 2010; Penprase & Koczara, 2009; Raines & Sipes, 2007; Raines, 2011). There was general consensus among these researchers that ASD-BSN students were drawn to nursing by widely varied personal and professional reasons. Further, all mentioned anecdotal reports that new graduates tended to adapt to the employment setting more readily than commonly seen in traditionally educated BSN new graduates.

Other research findings addressed stress levels in ASD-BSN students (Caldwell, Tenofsky, & Nugent, 2010; Cangelosi, 2007a; Hegge & Larson, 2008; Kohn & Truglio-Londrigan, 2007; Robert, Pomarico, & Nolan, 2011; Weitzel & McCahon, 2007). It appeared that ASD-BSN students frequently experienced feelings of stress, fear, and anxiety associated with self-perceived higher levels of expectation. Further, these studies indicated that a factor in the development of student stress was the presence (or lack thereof) of support mechanisms designed to facilitate student success. A common finding in all of these studies was that second degree students

held very high expectations in regard to their academic and clinical performance. Further, the students clearly understood the impact of their learning on the lives of the patients with whom they came in contact. Another common finding in these studies was that these students expected a high level of faculty engagement, in terms of removing pedagogical barriers and facilitation of accelerated learning through deployment of adult learning principles and reflective learning activities. As a rule, these students did not tolerate what they believed to be busy work -- seemingly senseless assignments that were not productive and were not directly related to academic and clinical success. Moreover, as a group, they had a much more developed sense of the ramifications of both academic and clinical failure -- not only for themselves, but also their families (McNiesh, 2011).

Prior to conducting this study, the literature on the individual characteristics of nurses who had graduated from ASD-BSN programs and progressed in their careers beyond the new graduate phase was nonexistent. As previously discussed, there was some literature which addressed the entry level ASD-BSN graduates; however, there existed a clear need to explore the experiences of ASD-BSN program graduates as they advanced in their nursing careers. It was hoped that undertaking this research would enhance the understanding of nurse educators and nurse administrators regarding what is, or is not, helpful in facilitating career progression and acquisition of the knowledge and skills among ASD-BSN prepared nurses.

Comparisons of Traditional and ASD-BSN Outcomes

Examples of quantitative study reports which compared traditional and accelerated nursing students in areas such as academic performance, NCLEX success rates, learning styles and demographics included Akton et al. (2009), Brewer et al. (2009), and Walker et al. (2007). These researchers agreed that the ASD-BSN students performed better academically, expected more integration of active learning strategies, and enjoyed higher levels of success on the NCLEX-RN, than commonly observed in traditional nursing students. However, it should be noted that, in both the Akton el al. study and the Walker et al. studies, the settings were limited to a single university. The Brewer et al. study was broader in scope, involving newly licensed registered nurses representing 35 different states. All three of the studies carried recommendations for further study of ASD-BSN graduates, in particular ongoing studies related to their career progression in the nursing profession.

Wu and Connelly (1992) provided one of the earliest demographic profiles of ASD-BSN students, which is at this date considered to be one of the foundational documents in this area. Their study involved all 10 of the existing ASD-BSN programs of that era, with a total of 166 participating students. They found that the average second degree student was older than the traditional nursing student with a mean age of 28.7 years; that almost one-third were married in contrast to a much lower rate commonly found in traditional programs; and that there were twice as many males when compared to traditional nursing education. Meyer, Hoover, and Maposa (2006) conducted a similar descriptive study of the demographics of one

class of ASD-BSN students. Their results mirrored those of Wu and Connelly with respect to age, marital status and gender. Additionally, they reported that the most common primary degree for this group of students was in the physical or social sciences.

Another area of research related to comparisons of traditional and ASD-BSN education was in the area of attrition, which has been noted to be higher for second degree programs than for traditional programs. Bentely (2006), Rosenberg et al. (2007), Rouse (2010), Seldomridge and DiBartolo (2005, 2007), Siler, DeBasio, and Roberts (2008), and Suplee & Glasgow (2008) reported attrition rates ranging from 10-25% as compared to attrition rates in traditional nursing education ranging from 3-12 %. These researchers cited causes such as financial strain, academic rigor, and personal issues as reasons for attrition in ASD-BSN students.

Other studies, such as one by Wietzel and McCahon (2008), confirmed that the most common primary degree among ASD-BSN students was in biology or psychology, both of which had limited employment opportunities at the baccalaureate level. This finding led these authors to surmise that one area of motivation for pursuing a second degree in nursing was that students saw it as providing a more secure employment future.

It is clear from these studies that as a group, ASD-BSN students were different than the high-school entry traditional BSN students. However, at the time of this study, how these differences play out over the careers of the ASD-BSN graduates had not yet been studied.

Admissions Processes and Student Outcomes

The admissions process for ASD-BSN programs was often cited in the literature as an area for further study. Despite support in the literature that ASD-BSN students differed in life experiences and motivation, the main criteria for admission to accelerated programs remained the same as that of traditional nursing education; grade point average (GPA) and standardized admission testing (Carty et al., 2007). Research studies on the predictive value of admission criteria in traditional baccalaureate nursing education have consistently demonstrated that pre-nursing GPA, either in total or sub-categorized by science GPA, was the most common and statistically significant factor in predicting NCLEX-RN success, with standardized pre-college and/or nursing aptitude testing as a second significant criteria (Crow, Handley, Morrison, & Shelton, 2004; Seldomridge & D'Bartolo, 2005).

Research which specifically addressed ASD-BSN students in regard to admission criteria, student characteristics, and student success included Abbot et al. (2008), Bentley (2006), Carty et al. (2007), Kay (2009), and Korvick et al. (2008). Abbot et al. determined that students with a primary degree in science were more likely to complete the accelerated program and be successful on the NCLEX-RN. Bentley found science GPA to be correlated with program completion and NCLEX-RN success. Carty et al. focused on a group of Saudi Arabian citizens sent to a specific American university to attend its ASD-BSN program. In this population, preadmission factors that were found to be correlated to program completion and NCLEX-RN success included a previous science degree as well as the preadmission

cumulative GPA. Conversely, a doctoral dissertation by Kay (2009) reviewed six years of data from an ASD-BSN program and found no correlation among preadmission characteristics, program completion, and NCLEX-RN success. The study by Korvick et al. indicated that ASD-BSN students had a higher level of confidence resulting from their previous academic work which they were able to transfer to their nursing studies and to program and NCLEX-RN success.

Program Design Considerations

The literature demonstrated that accelerated second degree nursing education was not simply the compression of a traditional nursing education program into a shorter time frame. A variety of designs emerged, each with distinct features. One design was that of an on-line didactic experience coupled with a precepted or mentored clinical experience, in which the preceptor or mentor was a staff nurse on an acute care, in-patient nursing unit. This design required significant collaboration between the academic entity and the acute care agency (Allen, VanDyke, & Armstrong, 2010). This model had an advantage in that students attending the program did not have to be physically located at the university and their clinical experiences could be obtained at a partner hospital near their home. The didactic content was taught by nursing faculty and the precepted clinical experience was overseen or managed by an appropriately prepared clinical instructor. Another advantage of this model was that the collaborating clinical agencies were able to recruit students to the program and support them during their education in return for a

post-graduation commitment of a predetermined period of employment as a registered nurse.

Another model of accelerated second degree education was that of a face-to-face hybrid format in which a portion (usually the first half) of the nursing program was offered in an accelerated manner and the latter portion was integrated with a traditional program. This format was generally offered using a cohort approach which facilitated socialization and peer support (Caldwell, Tenofsky, & Nugent, 2010). Inherent in this design was that faculty moved between accelerated and traditional students in a manner which ensured consistency in content between the two populations, while simultaneously removing redundancies from the curriculum. In the program referenced by these authors, the students engaged in an immersive didactic experience followed by an immersive clinical experience over a 16-week period. The content aligned with what was normally covered in the first two semesters of a traditional nursing program. Upon completion of the immersion experiences, the accelerated students joined the traditional students for their final year f the program, thus completing the entire BSN course work in a period of 15 months.

A third format was one in which the students remained in a separate track from the traditional students and were taught by faculty dedicated to the accelerated program. In this design, faculty taught the same group of students across the curriculum; in so doing, they were able to build on content from course to course, again eliminating redundancies in the curriculum (Cangelosi & Whitt, 2005). The advantage of this model was that faculties became well acquainted with the students'

experiential backgrounds. This allowed faculty to integrate and build upon the strengths and experiences of each student to make the nursing education more relevant and meaningful.

Consistently identified in all formats of ASD-BSN programs was the need for strategies which capitalized on the students' experiences, maturity, and goal orientation. D'Antonio et al. (2010) suggested clarification and open communication of both student and faculty expectations in order to identify congruencies and discrepancies between the two groups' understanding of the educational program. In their experience, pre-program meetings between faculty and students -- as well as periodic, scheduled focus groups to assess differences in perceptions regarding the students' progress -- were useful in maximizing the success of ASD-BSN students. McNiesh (2010) reported that the findings of her qualitative study of the experiences of ASD-BSN students included a need to assign faculty who were willing to embrace the philosophy of ASD nursing education. The need to include simulation and student rehearsals of clinical nursing with each other was also cited as a recommendation for this type of education. Penprase and Koczara (2009) reported that faculty understanding and acceptance of the differences between ASD-BSN and traditional nursing students was the basis for successful program implementation, as was incorporating teaching strategies which acknowledged the students' prior life experiences. They also advocated for the use of applicant interviews as part of the admission process, although they acknowledged the difficulty in implementing this strategy in light of the large number of ASD-BSN program applicants for the limited

number of seats. Robert, Pomarico, and Nolan (2011) found that experiential learning activities and assignments which required reflection and integration of learning were important strategies for ASD-BSN student learning. They also identified the need for faculty to provide emotional and programmatic support to address the higher stress levels found in ASD-BSN students. Finally, Suplee and Glasgow (2008) identified three major threads in ASD-BSN curriculum design as important for facilitating student learning. The first was the need for professional socialization initiatives, such as pre-program orientations and faculty and/or student led support groups. The second thread was the infusion of technology in the learning environment. The use of personal digital devices for accessing teaching and reference materials was specifically identified, as was access to on-line learning resources and high fidelity clinical simulation activities. The third thread identified was the need to incorporate evidence-based practice activities throughout the curriculum, in order to imbed the concept of best practices as a norm of clinical practice.

These strategies were not specific to ASD-BSN education. Indeed, arguments can be made that each and every strategy mentioned above had the same applicability in traditional nursing education programs as in ASD-BSN education. However, what was fundamentally different was the foundational need for understanding and acknowledging that ASD-BSN students, as a group, were different from traditional post-high school BSN students.

Summary

Clearly, ASD-BSN students and programs have inspired new research questions and trajectories among nursing education researchers. Varying facets of the topic have emerged, and are continuing to emerge as the number of programs increase along with the number of students enrolled in them and the number of graduates they produce. It is apparent from this literature review that studies of these programs, and their students and faculty, are increasing in frequency of publication.

However, as this literature review demonstrated, another area of research related to ASD-BSN education had not been addressed at all. That area was the career progress of ASD-BSN prepared nurses. Studies of the experiences and clinical performance of these nurses beyond their initial period of entry to practice have not yet occurred. Questions related to their impact on the nursing shortage, their progression in their nursing careers and education, and their longevity as registered nurses have not been answered, mostly due to the relatively recent proliferation of ASD-BSN education programs. In undertaking this study, I believed that the time had come to study this population of nurses in an attempt to answer these questions and understand their experiences as registered nurses.

Benner's Novice to Expert Theory of Skills Acquisition

As previously stated, Benner's Novice to Expert nursing theory (1984) served to inform me in this study. Patricia Benner's (1984) theory of nursing, *From Novice to Expert: Excellence and Power in Nursing Practice,* contributed to my personal framework for focusing on nurses who graduated from an ASD-BSN program and

have been in practice for at least two to three years. The following is a summary of Benner's theoretical model.

Benner (1984) based her model on the Dreyfus Model of Skills Acquisition. The model involved five distinct phases of skill acquisition which were labeled as novice, advanced beginner, competent, proficient, and expert. Originally developed within the context of how airline pilots gained skills, Benner adapted this model for her study of how nurses gain clinical skills and expertise. What follows is a brief discussion of each level, with emphasis placed on the *competent* and *proficient* levels, as these were the level of skills attainment among ASD-BSN educated registered nurses who were targeted for inclusion in this study.

Stage I: Novice

The novice nurse is a beginner who has no experience in the situation in which he/she is expected to perform. This nurse must call upon the knowledge gained from academic exposure to the relevant concepts in order to make decisions in the current setting. Because this nurse has no experience from which to base decisions, nursing actions at this level are task-oriented and require the direct supervision of a nurse/ instructor who can direct the novice's actions. In general, this level is ascribed to the student nurse.

Stage II: Advanced Beginner

The advanced beginner nurse has gained some clinical experience while functioning under the direction of those with more experience. This nurse is able to begin integrating concrete experiences gained in similar situations with academically

acquired knowledge to function in a more independent manner. Nonetheless, this nurse continues to require supervision and direction as he/she encounters new clinical situations. This level is generally ascribed to the new graduate nurse through the first year to two years of practice.

Stage III: Competent

The competent nurse has developed a preliminary sense of mastery of the clinical environment. This nurse is able to cope with the daily routine, as well as the many contingencies which arise during a given shift. However, the competent nurse still lacks the flexibility and speed to function maximally. In general, it is expected that nurses enter this stage after two-three years of clinical practice in the same type of clinical environment. This nurse is beginning to see his/her actions within the spectrum of long-range goals and outcomes for both the patients and the nursing unit. The competent nurse has moved beyond reacting to the clinical situation to planning how to manage the situation. They have established a routine that allows for organization and efficiency in completing their assigned workload. It is in this level that nurses begin to participate in shift management or charge nurse activities. He/she may also begin to participate in unit activities such as (a) shared governance roles, (b) committee work, and (c) precepting new graduates or newly hired nurses. This nurse has begun to understand his/her role within the structure of the whole clinical organization and the profession of nursing. It is frequently this level of nurse who begins to entertain thoughts of professional specialty certification and/or graduate nursing education.

Stage IV: Proficient

The proficient nurse has developed a keener sense of the whole of a given clinical environment. His/her practice is guided by perception and full integration of experience. It is no longer necessary to consciously develop a plan to manage the clinical environment; the plan simply presents itself in a manner which allows flexible and adaptive responses to rapid changes and increased complexity. Further, this nurse is able to find meaning in achieving long-term goals which go beyond simply carrying out a preconceived plan. In general, proficiency in clinical practice comes with three to five years of practice with similar patient populations and clinical environments. It is noted that most nurses are capable of reaching this level of professional performance. However, when a proficient nurse changes clinical or professional focus to another area of nursing, he/she sometimes regresses to the competent stage as they learn to cope with the new environment.

Stage V: Expert

The expert nurse is one for who clinical decision making and performance has become intuitive. This nurse no longer relies on explicit analytic principles, rules, or guidelines. He/she is able to connect the intuitive understanding of a situation to an appropriate and immediate action without exploring a large range of considerations and/or alternatives. Benner (1984) admitted that capturing a description of the expert nurse is difficult. Nurses at this level are generally not able to articulate their decision making process; rather, they describe their actions as just "feeling right" within the context of the situation. There is no time frame attached to the attainment of expert

status within this model. Indeed, some nurses will never attain this level of performance, despite many years in practice.

Examples of recent curriculum innovations, research studies, and doctoral dissertations which were supported by Benner's Novice to Expert theory of skill acquisition include:

1. the development of a new graduate orientation curriculum specific to a pediatric specialty hospital (Beecroft, Kunzman, Taylor, Devinis, & Guzek, 2004);

2. a survey of Australian nurses regarding the skills they believed to be necessary to develop expertise as health informatics professionals (Garde, Harrison, & Hovenga, 2005);

3. a study on the ongoing assessment of clinical competency among nursing students in the United Kingdom (Neary, 2001);

4. an exploration of nurses' competence as revealed by performing admissions assessments on an orthopedic ward in Denmark (Rischel, Larson, & Jackson, 2007);

5. a study of how experienced nurses teach nursing to undergraduate students during the students' clinical placements (Stockhausen, 2006);

6. a phenomenological exploration of the lived experience of nursing students and faculty who encounter a practice breakdown resulting in a clinical error (Rodriguez, 2007);

7. a study comparing advocacy behaviors among novice, experienced, and expert nurses (Thacker, 2006);

8. an exploration of perspectives of competence in newly licensed registered nurses (Bartolone, 2008);

9. a study of clinical reasoning in experienced nurses (Simmons, 2002);

10. how accelerated second degree nursing students acquire the existential skills of nursing (McNiesh, 2008);

11. a study measuring predictors of success among ASD nursing students (Kay, 2009);

12. overcoming: a theory related to ASD-BSN student success (Calhoun, 2010); and

13. a study of socialization of ASD-BSN graduates (Wolf, 2007).

This review represents only a small portion of the literature which surrounds Benner's (1984) Novice to Expert theory. It has clearly been widely accepted throughout international nursing education and practice as a model for structuring observations of nursing education and practice in both the qualitative and quantitative research environments. Many schools of nursing have adopted it as a conceptual model for their curricula. Nursing administrators and service-based nurse educators have used it as a foundation for career ladders and staff development programs (Altmann, 2007). Some nursing authors have even elevated it to the level of a nursing philosophy (Altmann, 2007; Marriner-Tomey & Alligood, 2006). Whether one views it as a theory or a philosophy, it is clear that the science of nursing education, administration, and practice has been influenced by Benner's Novice to Expert theory.

To summarize, the most relevant stages of Benner's (1984) model to the lived experience of ASD-BSN prepared nurses are those of *competent* and *proficient*. Persons at these levels are presumed to have been working in the capacity of registered nurses for a minimum of two to three years in addition to their experiences in their first career.

Summary

Numerous anecdotal reports from nursing administrators were found which commented on the comparative ease with which ASD-BSN prepared nurses transition to the nursing environment, presumably due to their previous professional experiences. Representative of these reports were Borrello (2011), Brewer et al. (2009), Hader (2010); Kohn & Truglio-Londrigan (2007), Shiber (2003), Wujcik (2010), and Wyatt (2010). However, these claims were not validated in the professional literature. Nor were there any studies that provided quantitative evidence or qualitative explanations regarding how these nurses experienced their second career. It became apparent that to understand the contribution made by ASD-BSN prepared nurses to the profession of nursing, their experiences beyond the advanced beginner stage of their nursing careers needed to be explored. As a result of this need, the study reported on in this document was undertaken.

Summary of the Evolution of this Study

This review of literature thoroughly explored the published literature related to ASD-BSN programs. It was noted that while this body of knowledge is expanding, it has remained limited due to the relatively recent proliferation of such programs.

Clearly absent in the ASD-BSN literature to date were studies related to those nurses who are products of these programs. Also presented in this chapter was an explanation of Benner's (1984) Novice to Expert theory to include examples of nursing research which used the theory as a base. This portion of the literature review was provided as a means of illustrating the utility of the theory as a conceptual foundation for research of the type reported on in this document. Chapter 3 presents a discussion of Interpretive or Hermeneutical Phenomenology as both a philosophy and methodology for nursing research.

CHAPTER 3

HERMENEUTIC PHENOMENOLOGY

Introduction

This chapter provides a brief explanation of the philosophical basis of the phenomenological method used in this study. Simply stated, phenomenology is the study of events. According to Audi (1999), when applied to the human sciences, it becomes the study of human events and experiences. As a human science endeavor, phenomenology is directed by the nature of that which is being studied (Schultz & Cobb-Stevens, 2004). There are two distinct approaches to phenomenology. One is transcendental, which has primarily been attributed to Edmund Husserl (1965) and Maurice Merleau-Ponty (1962); the other is hermeneutic or interpretive, which has been associated with Martin Heidegger and Hans-Georg Gadamer (Cohen, Kahn, & Steeves, 2000). The transcendental approach to phenomenological study advocates that any potential bias on the part of the researcher be removed from the data analysis through a process of bracketing or reduction (Koch, 1995). Thus, transcendental phenomenology allows for study of a given phenomenon in its purest form, without the variables of context and mixed meanings.

However, the philosophical base used in this study lies not with transcendental phenomenology. Rather, it rests on the philosophical stance of the hermeneutic or interpretive approach, as articulated by Patricia Benner (1994) and Cohen, Kahn, and Steeves (2000). What follows is an explanation of the philosophical stance of hermeneutic or interpretive phenomenology.

Hermeneutical Phenomenology

The hermeneutical or interpretive phenomenological approach views phenomena as contextually based in the experiences of being in the world (Heidegger, 1962). It was originally concerned with the interpretation of biblical and sacred texts. Later, it was applied to documents which chronicled historical events and experiences. Departing from the transcendental values of identifying and bracketing out the experiences of the interpreter, hermeneutical or interpretive study embraces the reader's experiences as part of the interpretive process. These experiences are acknowledged and accounted for, but they are not systematically removed from the interpretation of a given phenomenon. Rather, they are accepted as inherent in the interpretive process (Benner, 1994).

This leads to the concept of the hermeneutic circle. First articulated by Freidrich Schleiermacher in the 17th century and later described by Dahlberg, Drew, and Nystrom (2002), it was introduced first in relation to the interpretation of written documents as described above. These rules created a context in which the circularity of interpretation and the relationship of the parts to the whole of a given text are dependent on the interpretation of the whole text. The first rule concerned the need to recognize the significance of the context in which the document was produced. The second was the requirement to view understanding the text as a train of thought that moves from the whole to parts and then back to the whole in a never ending process. Finally, the third rule required that the reader understand the psychology of the writer of the text as expressed in the narrative. The ultimate goal of this circular or spiral

process was the development of an accurate and descriptive understanding of a written document which would communicate the meaning of the experience from the perspective of those who wrote about it (Cohen, Kahn, & Steeves, 2000).

However, this view of hermeneutic phenomenology was seen as insufficient by the social scientists of the 19th and 20th centuries. As a result, Heidegger (and later Gadamer) further expanded the scientific and philosophical concept of hermeneutics to include phenomenological understanding of the human experience (Dahlberg, Drew, & Nystrom, 2002). In this way, the hermeneutic circle became a metaphor for the interpretive process of understanding the phenomenology of human experiences. It can be conceptualized in an expanded manner as a series of concentric circles, with the center being the understanding of the relationships between the parts and the whole of an individual, and outer circles concerned with understanding the meanings and relationships of the wholes of various experiences of all individuals within the phenomenon being explored, including the experiences of the interpreter.

Thus, one can view every phenomenon as experienced within the context of the situation and, as a result, view it reflectively in terms of one's own values as well as those of the participants. When supported by this philosophical stance, the researcher becomes inexorably linked to the phenomena as he or she recognizes and embraces personal experiences as part of the process. Recognition of researcher values is part of understanding the individual parts and how the parts interact with the whole. In this manner, previously hidden relationships among the various facets of a given phenomenon are uncovered from the stories of the participants (Crist & Tanner,

2003), and the experiences of the researcher add to the richness of the phenomenological expression (Koch, 1995).

Interpretive Phenomenology and Nursing Research

Patricia Benner, among many others, has been a strong advocate of hermeneutic phenomenology as a philosophy to support nursing and practice-based research. She, along with Davis Allen and Nancy Diekelmann (1986), posited that the goal of human science is not to simply describe and quantify the experience as is undertaken in analytical empiricism, or to simply evaluate the relationships between meanings, as in the critical social theory approach. The goal, when undertaken in a hermeneutical approach, is to interpret the role of cultural issues, skills, and experiential meanings within the *situatedness* of the experience itself. Hermeneutical study looks at what is important about the patterns of meaning or the interpretation they reflect as related to the context of living in the world.

In interpretive phenomenology, as explicated by Benner (1994), the goal of studying the experiences of persons is to understand their world, while assuming that it can never be completely articulated. To accomplish this, the interpreter moves back and forth between the background and foreground of the participants' experience, navigating and mapping the situational context that creates the everyday real or practical world in which they dwell. The background of the participants' experience are those ideas, values, and guiding principles which are taken for granted and which lie quietly behind everyday actions, guiding behaviors in an unconscious manner. These background operations, when uncovered and illuminated through reflective

narration, are brought to the foreground or forefront of our consciousness where they can be explicitly articulated. This is what is recognized as the interpretive foreground, the foundation from which the interpreter constructs the interpretation (Conroy, 2003). This requires both dialogue between the interpreter and the participants, and listening to allow the voice of the participants to be heard. No claims of full understanding can be made, because human beings and their worlds cannot be frozen for detailed dissection. They are fluid and constantly changing.

Another goal of interpretive phenomenology (Benner, 1994) is to uncover commonalities and differences with the context of a given phenomenon. It is through discovering these commonalities and differences that understanding can be gained. Five sources of commonalities in interpretive phenomenology are provided:

1. Situation is an articulation of how the participant is situated, both historically and currently. Questions related to situation center on issues of smooth social function versus social breakdown.

2. Embodiment refers to recognizing previously taken for granted or unarticulated knowledge. It involves perceptual acuity and pattern recognition gained through repeated analysis of a given experience.

3. Temporality refers to the manner in which one projects oneself forward into the future and understands oneself from the historical context. It is more than a linear representation moments in life. Rather, it includes the explanation of the lived experience of time.

4. Concerns are the way the person orients him/herself with regard to meaning in a situation. It is concerns that dictates what emerges as salient in one's story and constitute what is important to the individual.

5. Common meanings are accepted linguistic and cultural expressions among people. They define what it means to be a person located in a given situation.

According to Benner (1994), one must critically reflect on his or her own biases and blind spots in order to find meaning in interpretive phenomenological inquiry. Assumptions held prior to beginning their study must be clearly articulated. However, these assumptions must be held tentatively and allowed to be challenged or transformed by what is learned during the study. Further, the lines of inquiry, those questions which guide data collection, should be sufficiently broad and open such that they can be altered or shaped by the resulting dialogue.

The result of interpretive phenomenological dialogue allows deeper understanding of everyday life experiences to emerge, thereby giving access to the practical world. Paradigm cases are explored and, from that exploration, common themes regarding distinctions and similarities may be identified. Meaningful patterns which were previously hidden can be discerned and articulated. And, even though experiences differ from person to person, these experiences can be described, discussed, and discovered.

Summary

When dealing with human sciences, hermeneutic and interpretive phenomenology support the philosophical stance that it is simply not enough to (a)

understand that a phenomenon occurred, (b) predict its occurrence, (c) measure its impact and characteristics, or (d) compare its relationships and/or outcomes. In order to fully and clearly understand and appreciate the phenomenon, one must explore and interpret it for meaning and contextual relevance. The study reported on in this document was supported by this philosophy and methodology as I sought to understand the lived experience of ASD-BSN prepared nurses as they engaged in being a nurse.

Chapter 4 discusses the procedures which were deployed in this study. Included are the research design, sample selection, data collection, data management, and data analysis. Also addressed are issues of rigor and human subject considerations.

CHAPTER 4

METHODS AND PROCEDURES

Introduction

This chapter presents a detailed description of the processes which were deployed in this study, the aim of which was to gain an understanding of the lived experience of a registered nurse educated in an ASD-BSN program. Further, this study served as a means to inform the profession of nursing about their long-term impact on nursing practice and their professional needs as they progress in their clinical practice. Included are discussions of (a) the research design and its rationale, (b) how the participants were accessed, (c) the human subject protection considerations, and (d) how the data were collected, managed, and analyzed. Also included are issues related to rigor and validity as they relate to qualitative research in general and this study specifically.

Research Design

An interpretive or hermeneutical phenomenological approach was utilized as the design for this study. According to Speziale and Carpenter (2007), Benner (1994), and Cohen, Kahn, and Steeves (2000), this methodology is appropriate when the desired outcome of a research study is to explore the relationships and meanings that exist within the context of a lived experience. Given that the aim of this research study was to explore the lived experience of ASD-BSN prepared nurses, interpretive phenomenology provided an appropriate base from which to proceed.

The role of the researcher in this approach is that of an interpreter who, through the application of a multi-step process, is able to uncover previously hidden relationships among the various facets of a given phenomenon from the stories of the participants (Crist & Tanner, 2003). In this approach, the researcher is not required to set aside or bracket out his/her own preconceived notions or theories. Rather, those ideas are openly articulated and become part of the interpretive process which allows them to be recognized, embraced, and challenged.

Sample Selection

The population for this study was ASD-BSN prepared nurses. While precise numbers of graduates were not available from the AACN (2010) or any other source, I believed that the existence of over 230 programs in the United States indicated that ASD-BSN prepared graduates represented a small but identifiable segment of the nursing workforce. In communities where ASD-BSN programs were located, there were assumed to be even greater concentrations of ASD-BSN graduates among the local nursing population. In the southwestern region of the United States, where this research occurred, there were 17 programs listed by AACN (2010).

From this population of ASD-BSN graduates, a sample was selected. The sample participants had been engaged in professional nursing practice for a period of at least two years and no more than seven years, which was consistent with the competent and proficient levels as described by Benner (1984). As a result, the sample for this study was purposive in nature. Purposive samples are common in qualitative research, most especially in interpretive phenomenology. When this

research design is employed, the researcher invites participants to join the study on the basis of their experience with the phenomenon being studied (Denzin & Lincoln, 2005). Further, the fact that each participant's life story will be unique does not allow for a predetermined sample size (Speziale & Carpenter, 2006). Despite not being able to accurately predict a sample size, it was anticipated that saturation of the data in this study would be reached with approximately 8-15 participants. This expectation was based on reported studies of a similar design and with similar populations (Cangelosi, 2007a; Cangelosi, 2007b; Hegge & Larson, 2008; Kohn & Truglio-Londrigan, 2007; McNiesh, 2011; Raines & Sipes, 2007).

In this study, nine participants were interviewed and their stories explored until such time as no new themes emerged. At this point, a determination was made that data saturation had been achieved. Subsequently, an additional three interviews were conducted to confirm the findings from the previous nine.

The inclusion criteria for potential participants in this study were:

1. graduation from an ASD-BSN program at least two years prior to participation in this study;

2. at least two years of full-time employment in the capacity of a registered nurse; and

3. having worked in a professional capacity related to their first degree for a period of at least two-three years before entering the ASD-BSN program.

Exclusion criteria for potential participants in this study were:

1. a history of immediate enrollment in an ASD-BSN program following graduation from a non-nursing degree program; and

2. graduation from the ASD-BSN program with which I was associated.

Gaining Access to Potential Participants

As the Director and primary faculty of an ASD-BSN program, I had fairly extensive professional contacts in area hospitals which employed ASD-BSN graduates, and a number of schools of nursing in the southwestern United States which offered ASD-BSN programs. Further, I had access to a national professional nursing education network specific to ASD-BSN programs through the Robert Wood Johnson New Careers in Nursing Scholarship Program. I believed that these contacts would form a rich networking base for accessing potential participants for her study.

Upon receiving NMSU Institutional Review Board (IRB) approval for the study (Appendix A), I began soliciting participants by using two sampling strategies. The first of these strategies involved the use of gatekeepers (Seidman, 2006). Gatekeepers are persons who, either by formal or informal designation, have access to persons who are representative of the research study population. For this study, the gatekeepers were nursing administrators in clinical agencies in the southwest region of the United States thought to employ nurses who were graduates of ASD-BSN programs and nursing faculty in ASD-BSN programs, (also located in the southwestern United States), and who had remained in contact with their former students. Emails describing the study were sent to these persons, accompanied by participant solicitation flyers (Appendix B).

The second sampling strategy was that of snowballing or networking (Polit & Beck, 2008). This technique allows participants who have already agreed to participate in a study to personally contact other persons who were members of the same population. The already enrolled participant invites those persons who they know to be representative of the study population to contact the researcher.

I had assumed that these sampling methodologies would readily yield sufficient numbers of potential participants. However, it quickly became apparent that it would be far more difficult to locate participants than I had anticipated. A total of 10 hospital chief nursing officers were emailed the participant solicitation flyer. However, 6 of these were unable to electronically distribute or post the participant solicitation flyer due to internal anti-solicitation and labor relations policies. Despite numerous phone calls and visits to these chief nursing officers, this proved to be an insurmountable obstacle. Further, even though 4 of the agencies did indeed circulate the flyer, none of the participants who participated in this study were identified through this process.

I subsequently contacted nursing faculty and administrators in 17 universities across Texas, New Mexico, and Arizona. In response, the Dean of one school of nursing directed the school's alumni relations director to electronically distribute the participant solicitation flyer to their data base. This action resulted in the first four participants in the study being identified. Two additional participants were identified by classmates of mine who were associated with two of the universities contacted. One of those participants was able to solicit the participation of two other ASD-BSN

prepared nurses. An ASD-BSN program director from another university (also associated with the Robert Wood Johnson Foundation New Careers in Nursing program) was able to identify one other participant. The remaining participants were identified by a retired ASD-BSN-prepared program director contacted by my committee chair. In all, some 20 potential participants were identified, of which 12 met the inclusion criteria and agreed to participate in this study. Their demographic data are included in chapter 5 of this document.

Human Subjects Protection

Institutional Review Board (IRB) approval (Appendix A) was obtained from New Mexico State University, after which access to potential participants was initiated. Informed consent was obtained (Appendix C), and permission to record interviews was documented. Participants' anonymity was protected by assigning a pseudonym to each participant. Interview recordings and transcribed data were identified by the pseudonyms only and maintained in a secure manner in order to assure participants' confidentiality. Further, all text resulting from this study refers only to pseudonyms, never to the actual names of participants.

Participation in this study did not cause any discomfort or generate any risk on the part of any individual. Participants were advised of their right to withdraw from the study at any time without any repercussions. Participants were compensated for their time with a $30 prepaid Visa credit card which is a value roughly consistent with the base hourly income of a registered nurse with two to seven years of nursing

experience. The limitations and benefits of this study are discussed in chapter 6 of this document.

Study Setting

As previously mentioned, the setting for this study was the southwestern region of the United States. The data collection interviews occurred in locations of the participants' choosing, most often a coffee shop or small restaurant near their homes. The first and twelfth interviews were conducted in the participants' homes.

Data Collection

The general steps for contacting, soliciting participation, obtaining consent, and interviewing participants were as follows:

1. Upon identification of a potential participant, I directly contacted him/her by telephone and/or email to ascertain interest in participating in this research study.

2. Potential participants who expressed interest at the point of initial contact were assessed to ensure that they met the inclusion/exclusion criteria as previously defined. During this assessment, potential participants validated that they understood that the actual data collection interview was to be digitally recorded for later transcription and analysis. These assessments were completed in telephone or email conversations prior to obtaining informed consent or collecting any demographic or qualitative data.

3. Those persons who met the inclusion/exclusion criteria, and who agreed to the recording of the single face-to-face interview required for data collection, were then scheduled at a convenient time and place for the interview.

4. I traveled to the scheduled appointment by car for eight of the interviews. I flew on a commercial airline, rented a car, and travelled to the interview location for the remaining four interviews. I assumed all expenses associated with said travel.

5. As previously described, the appointments took place in locations of the participants' choosing. All locations were sufficiently private to facilitate recording the interview, as well as ensuring the rights to privacy of the participants. I assumed all expenses associated with refreshments consumed during the interviews.

6. At the beginning of each meeting, the participants were provided with the opportunity to ask any questions or voice any concerns they might have regarding the research study or process. Upon having questions and/or concerns addressed, the participants then completed the informed consent for this study (Appendix C).

7. After completion of the informed consent, the data collection began by having each participant complete a brief demographic questionnaire for the purposes of describing the sample (Appendix D).

8. Next, the digitally recorded interview commenced. The interviews sessions ranged in length from 50-90 minutes.

9. Upon completion of the interviews, each participant was given a $30 pre-paid VISA gift card to compensate them for their time.

10. After each interview, I added my thoughts, observations, and impressions related to the interview to my reflective journal.

Interview Process

Consistent with interpretive phenomenology (Benner, 1994; Cohen, Kahn & Steeves, 2000), this study used an open-ended interviewing process which flowed more like a conversation than an interview. Other than the question establishing historical context and the grand question, the questions and probes were not numbered or asked at predetermined points in the interview. Instead, they were woven into the conversations in a manner which encouraged the participants to reflect upon their experiences of being ASD-BSN prepared nurses. Further, the exact verbiage of the questions was not consistent from interview to interview. Rather, the questions were worded in relationship to what was being said by the participants.

The interviews began with a question designed to set the tone and to serve as an ice-breaker. In accordance with Benner's (1994) method, this question also served to establish the participants' historical context of being a nurse:

> *"Thank you for agreeing to participate in this study. We are here to talk about your experience as a registered nurse. Please tell me how you came to nursing."*

If the participant being interviewed had not already cited a specific event or experience which prompted the career change to nursing, I followed up the historical context question with a probe to the effect of:

"Can you describe a specific event or experience that made you think about changing careers to nursing?"

Subsequent to the questions and probes which established historical context, a grand question was asked. This question set the tone for the essence of this study which was the lived experience of the ASD-BSN prepared nurse.

"You've been a nurse for X years now. Would you please describe your experience as a nurse who graduated from an ASD-BSN program?"

Open-ended questions such as this are instrumental in phenomenological interviewing, and the interviewer must possess the skill to remain neutral and avoid structuring questions which may lead the participant to a desired response. According to Cohen, Kahn, and Steeves (2000), the key to phenomenological interviewing is to start the interview with a broad question and then to imbed follow-up questions or probes in a conversation with the participants, in which information is exchanged between the interviewer and the participant. Strategies for imbedding follow-up questions focus on clarifying narratives which describe experiences in some detail, the best manner in which people make meaning of their experiences.

Pursuant to the participants' stories of being a nurse, several follow up questions or probes were asked, depending on how the participants' described their experiences as nurses. These questions were similar to:

"Tell me a story about a recent memorable event from your practice."

"Describe a typical day for you as a nurse."

"Tell me a story about what happens when a day is not typical."

"Tell me a story about how your life outside of nursing influences your current nursing practice."

As suggested by Cohen, Kahn, and Steeves (2000), I avoided interrupting the participants to ask a follow-up question by jotting down key words as ideas occurred and then followed up on them later in the interview when there was a pause in the participants' narrative. Additionally, as I transcribed and reviewed each interview and then reviewed them with my committee chair, other probes emerged which were woven into the subsequent interviews. These probes addressed areas related to how the participants' nursing experience impacted their personal lives; what their expectations of nursing were; how they worked with traditionally educated nurses; how they experienced communications within the healthcare team; and what advice they would give to those who were considering ASD-BSN education or were recent ASD-BSN graduates.

At such time as the participant and I exhausted the exploration of the participants' nursing experiences, the following question was asked to bring closure to the interview:

"Is there anything you would like to add in relation to your experiences as a ASD-BSN prepared nurse?"

I then concluded the interviews by thanking the participant for their assistance with this research project and gave each one a pre-paid Visa card valued at $30.

Data Management

Data, inclusive of the informed consent documents, demographic surveys, digital recordings of interviews, and my reflexive journal, were managed in a manner which ensured both confidentiality and anonymity for the participants, as described below. Further, the data was managed in a manner which is compliant with the requirements of the Institutional Review Board of New Mexico State University.

The participants' confidentiality and anonymity in this study was protected through the following measures:

1. The demographic surveys were stored in locked files located in my personal home office. Access to these files was restricted only to me. The informed consent documents were stored in a separate notebook, which was maintained in a locked file cabinet in my office at my place of employment. This ensured that documents with the participants' names could not be linked to any data.

2. The device used to record the interviews was stored in a locked file cabinet in my home office, accessible only by me.

3. The interview recordings were downloaded to my password protected personal computer.

4. I personally transcribed all of the interview recordings.

5. The transcriptions were housed on my personal password protected computer in a password protected file. Backups of the file were maintained on a password-protected data storage device dedicated to this project.

6. Said data storage device was stored in the same locked file cabinet as previously mentioned.

7. Upon completion of the transcriptions, the interview recordings on the digital recording device were erased. The backup recordings remained stored on my personal computer as previously described.

8. My entire computer system was regularly backed up onto a password-protected external hard drive.

9. Data files and other information, having had all identifying information removed, were retained and stored as previously described in the event subsequent studies using the same data are conducted. The files will be retained for a period of three years at which time they will be permanently deleted from all computers and digital storage devices associated with this study.

Data Analysis

Demographic data were summarized for the purpose of producing a description of the sample and are included in chapter 5 of this document. Given that data analysis in qualitative research begins with data collection, tentative understandings were formed as the data was collected, reviewed, transcribed, and analyzed. These tentative understandings were recorded in my reflective journal and reviewed in periodic meetings with my committee chair. As per Cohen, Kahn, and Steeves (2000), they were also revised in relation to new data as it emerged from subsequent interviews.

Within 24-36 hours of each interview, while the interview was fresh in my mind, the interview recordings were reviewed for the purpose of adding notes as needed to my reflexive journal. This journal created a narrative of my own observations, thoughts, and impressions as they related to (a) the interviews, (b) my role as the interviewer, (c) the research process, and (d) the participants' stories.

Subsequent to this initial review, I transcribed the recordings into MS-Word documents, with each line of each transcript numbered for referencing. When possible, the transcriptions occurred before the next participant's interview, so that additional interview questions could be derived. Once transcribed, I read the transcripts while simultaneously listening to the digital recordings for the purposes of ensuring accuracy. Following that, the transcriptions were analyzed using the basic iterative and interpretive steps of hermeneutic research data analysis, as described by Speziale and Carpenter (2007):

1. Step 1 is described as *naïve reading.* This term is defined as reading the whole text in order to formulate initial thoughts about its meaning. During this phase, I noted my initial impressions of the text for later analysis.

2. Step 2 is described as *structural analysis.* It involved iterative reading of the transcripts to identify patterns of connections, commonalities, and discrepancies among the various participants' stories. This step is often referred to as the process of interpretive reading. I documented my ideas about the structure which was emerging by writing preliminary code words in the margins of the transcripts and by underlining passages of the text. I subsequently recorded these preliminary code

words as tentative understandings in my reflexive journal. The text was then sorted into segments and the codes were refined for each. In much the same manner that Seidmann (2006), Benner (1994), and Cohen, Kahn, and Steeves (2000) recommended to cut sections of the transcripts and place them in files organized by codes, I constructed a computerized spreadsheet which listed the codes as one axis and the participant as the other axis. Specific line numbers from each transcript were recorded in the appropriate cells of the spreadsheet, creating a data matrix; this procedure provided a clear picture of the frequency of the occurrence of each code. During this process, I repeatedly spiraled in and out between the whole of the text and the parts of the text in order to truly understand and interpret the experiences documented therein. In consultation with my committee chair, the codes identified in this process were continually revised and adjusted as new interpretations and understandings emerged.

Phenomenological research is not a solitary experience (Benner, 1994; Cohen, Kahn & Steeves, 2000). It is a process which is enhanced by multiple interpretations of the data to ensure consistency and accuracy in interpretation. Therefore, assistance by my committee chair occurred during this step. She reviewed all of the interview transcripts and then met periodically with me to review and discuss my analysis to determine if I was consistently interpreting and categorizing the data. The interview transcripts and the data matrix were also provided to another member of my committee and a meeting between her, my committee chair, and me occurred after the first eight interviews were completed. During this meeting, my tentative

understandings and data analysis process was discussed and she concurred that my research and data interpretation was progressing appropriately.

3. Finally, step 3 is defined as *reintegration of and reflection on the categories in order to understand the whole.* This involved reflecting on the initial reading and the various coded understandings in order to formulate overall themes which provided an interpretation of the whole phenomenon. Through this process I, with assistance from my committee chair, was able to synthesize the meaning of the lived experience of the participants. This synthesis was then recorded in an exhaustive written document, organized by relevant codes, which told the participants' stories. The codes and the related stories were then organized into themes, each with several identified sub-themes. Upon great reflection and thought, these themes and sub-themes were illustrated by a conceptual model of the ASD-BSN prepared nurses' practice. This interpretation then led to the construction of a paradigm case of the ASD-BSN prepared nurse's lived experience, inclusive of assertions related to each theme uncovered during the data analysis (Munhall & Chenail, 2008). In this manner, the phenomenon as a whole was analyzed, without losing or distorting the richness of each piece of data.

Reliability, Validity, and Issues of Rigor

Debate over whether reliability and validity are concepts applicable in qualitative phenomenological research persists in the nursing research literature (DeWitt & Ploeg, 2006). Speziale and Carpenter (2007), noted authors on qualitative research in nursing, indicated that the qualitative research terms of credibility,

transferability, dependability, and confirmability replace the empirical criteria of internal and external validity, reliability, and objectivity. These qualitative research terms can be defined as follows:

1. Credibility: That which is demonstrated when participants recognize research findings as accurately representative of their experiences.

2. Transferability: Qualitative research findings which may have meaning to others in similar situations. The term is interchangeable with fittingness.

3. Dependability: A term which is applied congruently with credibility -- i.e., credible findings are considered dependable.

4. Confirmability: A process criterion confirmed by an audit trail or similar documentation that subsequent researchers of the same phenomena can follow.

Similarly, Twycross and Shields (2005) addressed qualitative rigor in terms of credibility, transferability, and auditability. Conversely, Morse (1999) bemoaned the fact that while qualitative researchers have developed a plethora of mechanisms to ensure rigor in their work, turning their backs on the terms *reliability* and *validity* as part of those measures has cost the profession dearly and resulted in continued discounting of valuable nursing research by other sciences.

Roberts, Priest, and Traynor (2006) contended that these alternate terms for measuring rigor actually fall within the bounds of reliability and validity. They equate having additional reviewers review data to ensure similar interpretation as a form of inter-rater reliability. Also, keeping detailed notes in a reflexive journal as previously

described adds to the audit trail, which addresses validity. A further means of ensuring reliability and validity in qualitative research includes strategies such as ensuring technical accuracy in transcription of data and expert review of potential interview questions in order to avoid inadvertent use of leading phrases or verbiage otherwise suggestive of a desired response. Moreover, published reports of qualitative data should include verbatim reports of informant comments as another means of demonstrating reliability in the analysis, thereby allowing the reader of the report to determine if the data interpretation by the researcher is reliable.

It is my opinion that this is a discussion of semantics, not substance. Qualitative research has value, particularly in the human sciences. It allows understanding of not only frequencies, similarities, and differences among phenomena, but also the substantive humanity underlying the phenomena. The keys to rigor, no matter how it is phrased, are (a) an appropriate research question, (b) a well thought-out and careful research design which is reflective of the question, (c) a careful and thorough analysis of the data, and (d) a research report that ultimately adds to the body of scientific knowledge for the discipline. To that end, the issues of rigor in this study were addressed in the following manner, thereby creating an audit trail for this project:

1. I maintained a reflexive journal during the period of data collection and analysis. It is discussed in chapter 6 of this document, as part of the reflections on this project.

2. I reviewed the digitally recorded interviews within 24-36 hours after each interview was concluded in order to allow notes to be added to my reflexive journal while my memory of the interview was still fresh.

3. Whenever possible, I transcribed each interview prior to the next one scheduled. They were then read while simultaneously listening to the digital recording of the interview to ensure transcription accuracy.

4. The interview transcripts were provided to the chair of my committee for review and confirmation that I was consistently interpreting and categorizing the data.

5. My committee chair and I met regularly to review the transcripts and emerging interpretation.

These measures to ensure rigor in this study are consistent with the discussions of rigor, reliability, and validity found in Denzin and Lincoln (2005) and Speziale and Carpenter (2007).

Summary

Chapter 4 provided a detailed description of the methodology and processes that were associated with this research. A discussion of the research design and the rationale for choosing it, the access and recruitment of participants, human subject protection considerations, data collection, data management, and data analysis was provided. Also provided was a discussion of how issues related to rigor and validity were addressed in this study.

Chapter 5 presents the findings of this research study, including excerpts from the interview transcripts representative of themes and sub-themes which emerged through data analysis. Chapter 6 presents the overall conclusions and summary of the study, as well as the implications for nursing education, administration, and practice. The limitations of the study are identified and recommendations for further research related to the phenomenon of interest are included. Following chapter 6 are appendices and a reference list.

CHAPTER 5

FINDINGS

Introduction

The aim of this study was to gain an understanding of the lived experience of ASD-BSN prepared nurses engaged in their professional nursing careers. The participants' personal stories were explored and interpreted in a manner consistent with interpretive phenomenology (Benner, 1994; Cohen, Kahn, & Steeves, 2000). After immersing myself in the data for several months, I was able to identify a number of themes and sub-themes which depicted the lived experience of ASD-BSN prepared nurses. The findings were organized according to these themes, using the analogy of a river system. The chapter begins with a brief description of the participants, and then addresses the findings as reflected by the flow of a river from its headwaters, through a confluence of streams and tributaries, meandering through plains and across a delta to its ultimate contribution to the ocean of professional nursing practice. The chapter concludes with a figure depicting the lived experience of the ASD-BSN prepared nurse as represented by a river system, followed by a summary of the themes which emerged from the data.

Description of Study Participants

A total of 12 participants were interviewed for this study. Of those, 75% were female and 25% were male, consistent with the gender distribution found in ASD-BSN programs in the United States (Cangelosi & Whitt, 2005). The age for the sample ranged from 26-57 years, with a mean age of 35 years. One of the participants

self-identified as being Hispanic, the remainder of the group self- identified as Caucasian, non-Hispanic. The participants had worked in fields related to their primary degree from 2-28 years, with a mean of 8 years of work experience. They had been in professional nursing practice from 2-7 years, with a mean of 4 years nursing experience. Their first baccalaureate degrees were in education, information technology (IT), community health education, history, business, social work, university studies, microbiology, and engineering. They received their BSN degrees from five different ASD-BSN programs in the southwestern United States. The participants were employed in a variety of acute care, in-patient clinical settings, including psychiatric care, pediatrics and pediatric oncology, neonatal intensive care, women's health/obstetrics, adult intensive care, telemetry, endoscopy, and emergency departments. At the time of the study, they resided and worked in seven different communities in the southwestern United States: three in New Mexico, three in Texas, and one in Utah. Of the participants, 33.3% (n=4) were either enrolled in, or recently graduated from, master degree programs in nursing, with another 33.3% (n-4) indicating intent to pursue graduate nursing education in the near future. The remaining 33.3% (n=4) indicated that they were not planning on pursuing graduate nursing education or that they might consider it in the distant future. Based on their descriptions of their nursing practice, it appeared that all of the participants were either in the competent or proficient stage of their careers (Benner, 1984).

Table 1 describes the participants in terms of their demographic background. The information provided on table 1 includes (a) age, (b) gender,

(c) ethnicity, (d) previous degree field, (e) years of non-nursing professional experience, (f) previous professional work setting. Table 2 provides (a) years of nursing experience, (b) nursing work setting, and (c) graduate school status. Pseudonyms have been assigned to each participant to protect their anonymity.

Despite variances in the participants' ages, backgrounds, and nursing employment settings, four themes emerged -- each with multiple sub-themes -- which describe how they experienced nursing. The themes, when analyzed collectively, create a model of the lived experience of ASD-BSN prepared nurses. This model is illustrated using the analogy of a river system which starts as a trickle at its headwaters and gains volume and force as it rolls down its course, converging with tributaries and other rivers while nourishing the surrounding environment. Finally, the river slows and spreads out over a delta, creating a rich and fertile environment. Ultimately, the river mixes with a larger ecosystem, adding moisture back into the atmosphere, creating rain and snow, thus recharging the river's essence (Canadian Centre on Geological Education, 2012).

The Themes

The first theme identified is that of *Headwaters*, which includes the motivators that prompted the participants' interest in nursing as a career. The second theme is *Tributaries and Turbulence,* which includes various influences identified by the participants as having impact on their nursing practice. The third, and most important, theme is that of *The Rolling River.* This theme includes characteristics which are integral to the participants' perceptions of themselves as nurses and how

Table 1. Participant Age, Gender, Ethnicity, and Non-Nursing Academic and Employment Demographics

	Age	*Gender*	*Ethnicity*	*First Degree*	*Non-Nursing Professional Experience*	*Non-Nursing Work Setting*
Kristin	32	F	Caucasian	Education, IT*	10	Teacher IT* professional
Rose	57	F	Caucasian	Education	28	Teacher/Office Administrator
Roberta	34	F	Hispanic	Community Health	3	Health Educator
Sandra	30	F	Caucasian	University Studies	5	Research Coordinator
Dawn	26	F	Caucasian	Community Health	2	Health Educator
Gina	28	F	Caucasian	History Business	2	Insurance Sales/Support
Amanda	32	F	Caucasian	Microbiology	4	Medical Record Reviewer
Bobby	31	F	Caucasian	Engineering	4	Engineer
Veronica	32	F	Caucasian	Social Work	2	Social Worker
Charles	41	M	Caucasian	Business	13	IT* Professional
Tina	45	F	Caucasian	Business/ Accounting	10	Finance/ Accountant
Bradley	36	M	Caucasian	American History/ Military Science	8	U.S. Military Officer, Air Defense

Note. *Information Technology

Table 2. Participant Nursing Specific Demographics

	Years of Nursing Experience	*Nursing Work Setting*	*Nursing Graduate School Status*
Kristin	3	Psychiatric Care	Not planning
Rose	7	Psychiatric Care	Not planning
Roberta	7	Women's Health	Planning in distant future
Sandra	3	Pediatrics	Planning in distant future
Dawn	2	Pediatric Oncology	Currently Enrolled
Gina	2	Adult ICU**	Currently Enrolled
Amanda	5	Neonatal ICU**	Planning near future
Bobby	2	Telemetry, ED***	Planning near future
Veronica	3	Telemetry	Already Graduated
Charles	4	Burn ICU** Hospice	Planning near future
Tina	5.5	Adult ICU**	Planning near future
Bradley	6	ED*** Endoscopy	Already Graduated

Note. **Intensive Care Unit *** Emergency Department

they experience nursing. The fourth and final theme is *The Delta*, which includes the beliefs about nursing as a profession and the participants' roles within their professions. What follows are excerpts from the interviews, organized by themes and sub-themes. In order to avoid excessive redundancy, not all comments from each participant for each sub-theme have been included. Rather, selections of relevant excerpts, which are illustrative of the sub-themes, are presented.

The Headwaters: Becoming a Nurse

In a river system, the headwaters begin as mere trickles of snowmelt, or a bubbling spring. These waters are the germination of the river, the beginning of the river's life. So, too, are these trickles the beginning of the ASD-BSN prepared nurse's experience as a nurse. They serve as the foundation, the elemental molecules which coalesce to begin the experience of being a nurse

The participants, upon reflecting what brought them to nursing, spoke about several things that motivated them to enroll in an ASD-BSN program. These things were identified as sub-themes of the larger theme of *Headwaters*. The most commonly cited sub-theme was a desire to help others. Also cited were (a) a family connection to health care, (b) the need for balance between their personal and professional lives, and (c) the job and financial stability of nursing.

Desire to Help Others. All 12 participants cited the desire to help others as a reason for pursuing nursing education. For some, this desire was expressed through a history of volunteerism. Others had professional experience in helping professions, but found them too limiting in scope.

Kristin: I had volunteered with the Red Cross and helped after Hurricane Katrina. It was such a huge disaster and there was so much need, especially for the medical field.

Rose: I always wanted to help people. When I was a massage therapist, I liked assisting [my clients] with their health and lifestyle, helping them to do better.

Roberta: [In] college I had done volunteer work at a hospital. I just knew I wanted to help people somehow.

Gina: [I] realized how much of life is about your work and I wanted it to be something meaningful. I wanted to do something that would help people, change someone's life.

Dawn: I love helping other people.

Bobby: The main [reason I went into nursing was to] help people. I enjoy that, I get satisfaction helping others.

Veronica: I've always been a helping person, a service oriented person. I thought that as a nurse I could do more for people than I was doing as a social worker.

Charles: One of the driving factors to become a nurse was my desire to do missionary work through my church. I believe strongly in that.

Family Connection to Health Care. A number of the participants had family members who were nurses or members of other health professions.

Roberta: My mother's a nurse.

Dawn: My mom was a nurse when I was young.

Gina: My family's all in the medical field. My mom's a nurse, my sister is a surgical tech, [and my] uncle is a doctor.

Amanda: My aunt is a neonatal nurse.

Bobby: My grandma is also a nurse, I think that influenced me.

Charles: My mother was a nurse [and] my brother's a physician.

Balance Between Personal and Professional Lives. Some of the participants spoke about the need to balance their personal lives with their professional lives in terms of their lifestyles and their family obligations.

Rose: It suits my lifestyle to start work at 3:30 in the afternoon and work until midnight.

Roberta: [Nursing] allows me to be at home with my kids, which is what I want to do.

Dawn: I love that I can work just three days a week and have four days off to do other things. I have a lot of control over when I work and I can usually set it up so I can do the things that I want during my time off.

Amanda: [As a nurse] you can have a good work life and good personal life, you know, have a balance. I love my schedule.

Charles: I can work three days a week. I can have a full-time job and still have time off with my wife and baby.

Bradley: [I love] the schedule. I'm grateful for the time I'm home with my family.

Job and Financial Stability. In an era of economic downturns, layoffs, and outsourcing of jobs to other countries, I did not find it surprising that several of the participants also mentioned the financial and employment security associated with nursing.

Rose: I was really very financially motivated. We make pretty good money.

Roberta: I think [nurses make] good pay for the job that we do.

Dawn: And the money's not bad either.

Gina: Insurance was the only thing I could find [after I graduated from my first degree]. I couldn't teach history because I didn't get my certificate while I was in school, and there weren't any positions for history teachers either.

Amanda: I [like working] a lot of hours to pay for everything I like.

Bobby: The fact that I can find a job in any state that I want to is nice.

Tina: [As a traveling nurse] I really like the freedom to renew my contract every few months. I'm not obligated to stay and somehow that makes it easier to just stay on. I guess it just fits me. I like being able to decide whether I want to stay there or take a break by going somewhere else for a while.

Charles: They moved my information technology division to India and my wife and I said, we're not moving to India for $8/hour.

Tributaries and Turbulence: Navigating Rough Waters

As gravity pulls water from the headwaters of a river downstream, other sources such as streams and smaller rivers contribute to the greater flow. These tributaries influence the main body of the river, strengthening it, deepening and widening it, and adding to its character. Sometimes, the confluence of a tributary creates turbulence or rapids in the river. In much the same manner, the ASD-BSN prepared nurses' experiences are influenced by events and situations which sometimes cause turbulence or rough waters in their careers. The participants spoke about the turbulence caused by these situations as necessary elements in their development as nurses. The sub-themes that were identified as part of the theme of *Tributaries and Turbulence* included (a) participants' experiences as new nurses, (b) management's expectations of new ASD-BSN graduates, (c) doing more with less, (d) inter-professional communications, and (e) dealing with the psycho-social aspects of caring for patients and their families.

Experiences as New Nurses. Despite the interviews not being focused on their early careers as nurses, 10 of the 12 participants spoke about how their transition from student nurse to registered nurse influenced their overall nursing experience. For some, their experience as a new graduate nurse resulted in turbulence which influenced a decision to change nursing units or nursing jobs.

Rose: The first thing they did was put me into med/surg. I didn't really feel like I got a whole lot of support from my preceptor. I was just kind of winging it. I struggled through for several months and [then] I [asked the residency program director to] please move me. I had a very brief psychiatric care rotation during school [and] I felt good there. I could relate to the patients [there] and I just knew that [it was an area] I was interested in. They [transferred] me to the in-patient [adult] psychiatric ward where I had done a clinical rotation as a student. I've been [there] for almost 7 years now.

Roberta: I worked pediatrics [in the beginning but] I did not find that environment very supportive. I was about an inch from [being] pushed out of the profession there. [Now] I work on an obstetrical special care/women's care unit. We [take care of] gynecological patients and high risk pregnancy patients, and sometimes I [work on the] mother/baby [unit].

Being scared was another element of the sub-theme of experiences as new nurses.

Rose: I was scared to death, probably like all new graduate nurses.

Gina: It was quite scary working in intensive care. I couldn't believe that they were handing over the control over somebody's life [to me].

Some of the participants spoke about comparing themselves -- or their managers comparing them -- to traditionally educated new nurse graduates who were hired at the same time. The ASD-BSN educated nurses felt that while their clinical skills were comparable to the clinical skills of the traditionally educated new nurses, their communication and professional work habits were superior.

Dawn: I felt as equipped to practice as the traditionally educated nurses. There was one girl who graduated from [a] traditional nursing program at the same time as I did. I honestly felt like I was just as strong as she was when we started. She may have had a little more experience with clinical skills than me, but in general I felt like we were comparable.

Amanda: There were two new graduates that were [from a] traditional [program] who started with me. We all went through orientation together. I think that I was better able to form relationships with the rest of the staff than [they were]. I also think I caught on faster than they did. And I'm the only one who lasted [on that unit]. They both went on to other places within a year.

Bradley: The hospital had just started a brand new RN residency program, so I was put in with [new] graduates [from] of all kinds of [nursing] programs. I actually got to compare what I could do versus what they could do. I wasn't any less prepared

on the technical side and I was more prepared on just life experience.

Management's Expectations of ASD-BSN Graduates. Another sub-theme of *Tributaries and Turbulence* was the participants' perceptions of a difference in their managers' expectations of them as compared to traditionally educated graduate nurses. Similar to their own perceptions of superior work related skills, the participants believed that the managers also perceived them to be more professionally mature.

Gina: The manager here really likes the accelerated second-degree program graduates. He says that in his experience they stay there longer, they're goal oriented, they want to get involved in shared governance, and they want to get involved in committees and things like that. Also, they want to go on and advance their education in nursing.

Bobby: [The managers] were expecting a lot more from me. I was a lot older and had worked as an engineer [so] they expected more. They expected me to learn quicker and to be able to handle a bigger load than what a regular new graduate nurse would be able to handle.

Tina: I feel like I got cheated on my orientation little bit. From my eighth day I was on my own. I think they did that because they thought I was more mature and that I could handle it.

Doing More with Less. The lack of sufficient resources was another sub-theme of *Tributaries and Turbulence*. Several participants spoke about the difficulties associated with staffing shortages.

Kristin: One of the problems that we face on an ongoing basis is [the] lack of nurses in the behavioral health field. We are constantly struggling with not having enough hands to take care of the work.

Roberta: It seems like in the last year or so that the people we [take care of] are just sicker. It feels like we're doing a lot more with a lot less. There are [fewer] of us and we're doing more with the sick people.

Bobby: You know, [in nursing] we need people. We need bodies out there and that's sad to say. But we need them.

Veronica: It's difficult, taking care of seven telemetry patients at one time. I think it would [be] ideal if you had five or six patients.

Inter-Professional Communications. Another sub-theme related to *Tributaries and Turbulence* identified by the participants related to their perceptions of the communication norms in the health care environment -- in particular, the communication imbalance between nurses and physicians and the inherent power and authority issues in that relationship.

Roberta: I'm always taken aback by the way people interact with each other in the medical world. The way people feel they can talk

to each other. The way physicians talk to one another, the way physicians talk to nurses, even the way nurses talk to each other. I think learning to be aggressive back was probably my biggest struggle in nursing. [It's about] learning to talk back to doctors as rudely as they speak to you. One of my friends that I used to work with is also a second-degree nurse and she commented on the same thing.

Tina: There are some [doctors] that [seem to think] that you are beneath them [and you] probably shouldn't even be talking to them because you're not on their same level. [One doctor in particular] has a horrible personality and he treats the nurses horribly.

Veronica: I got really reamed out by the doctor. I had been calling and communicating with her [all night about what] was happening so she would know what was going on. [Later], the doctor came up to the hospital and had me in the hallway and was screaming at me [because the patient had died]. She said it was my fault.

Amanda: The attending physicians can be harder to deal with [than the residents]. It took me a while to learn this, but you have to term things so that they think that they suggested it. You have to phrase it as a question, that way they can make the actual

decision. If you make the suggestion to directly, a lot of times, they will say no, end of discussion. They want to be the ones who direct the care. As a nurse you can phrase anything to get what you want, if you do it correctly. It's almost like you're tricking them into doing it.

Psycho-Social Aspects of Caring for Patients and their Families. The last sub-theme of *Tributaries and Turbulence* is related to the psycho-social aspects of caring for the patients and their families. The participants spoke about being unprepared for the amount of drama associated with all of the non-direct patient care activities dealt with by the ASD-BSN prepared nurses. Such issues included family dynamics, societal ills, and the breakdown of family structures.

Kristin: If you're not prepared to deal with a 4 year-old girl that's been repeatedly raped by her mother and stepfather for a long period of time, then behavioral health is not for you. Many of our patients are not having an early psychotic break. They don't have some kind of organic thing going wrong. Their problems are based on what was done to them or what was not done, in the case of neglect.

Roberta: The other day, I had a patient who was there for getting off heroin through the methadone program that we have. They [the patient and her boyfriend] were smoking heroin in the room. I had to call the police and risk management. [Meanwhile, the

police are] searching the room and the patient's freaking out and her boyfriend's freaking out. It's like some kind of social issue vortex that you get sucked into. I didn't expect [nursing] to be such a social drama. I mean, we deal with so many social issues, and not normal social issues. They're hyper-social issues sometimes. There's sex abuse or prostitution or totally unstable schizophrenic children having more children. I didn't expect to see so much of it.

Gina: You run into situations you never even thought you'd have to deal with. [Once] we had a mother who was pulling opiates out of her daughter's feeding tube. It was really bad. [And then there are the] end of life decisions. Families panic [and it] blows up right there at the bedside. It's just sad. Situations, like death and dying and those decisions that you have think about. The first couple of times [someone died and there was family drama] I was distraught. It was just so hard for me.

Sandra: I think for me, it's the difficult people, the difficult families, the noncompliant families. Like the patient I had yesterday, her family just basically spoke for her. She's an 18 year-old girl. [When I] would ask her if she had pain, the grandmother would [immediately] say yes, she has a lot of pain in the back of her legs. And I was thinking [to myself], give the poor girl a

chance to talk! [The family was] refusing medications, refusing everything for her. She's at the age where she's between the pediatric world and the adult world. Sometimes it's really hard for patients [and families] to make that transition when the child has a lot of complex medical problems.

Dawn: So many of the parents are divorced or getting divorced. There's all that kind of stress and sometimes we [see] violence [on the unit]. Dad hits mom or mom hits dad, or the siblings fight with each other. [There are] arguments and lots of drama sometimes. We see pretty high [family] stress levels. There are so many people; divorced mom, divorced dad, new husband, new wife, and everyone trying to work it out. It just turns into a mess.

These tributaries, and the turbulence they cause, contributed to how the ASD-BSN prepared nurses experienced their careers. They could be disruptive to providing what the participants identified as safe nursing care, as was the case with the staffing situations. Some were emotionally draining, ethically challenging, and legally significant, such as those that dealt with death, child abuse, substance abuse, and family dynamics. There were frustrations such as the inter-professional communications tributary which made the participants feel disempowered or dismissed. Situations such as those mentioned above created turbulence in the lives of these nurses. However, just as the turbulence caused by the confluence of tributaries

and rivers eventually smoothes out, balanced by the waters of the main channel, so did the experiences of the ASD-BSN prepared nurses. Their balance came from a sense of self-identification and knowledge, from the personal reward and fulfillment found as a nurse, as a team member, and as a member of a respected and important profession. What follows is the most important theme in this report, that of *The Rolling River: Being a Nurse*

The Rolling River: Being a Nurse

As the river rolls out over the plains, it slows a bit as it gets deeper and wider, having absorbed the contents and quieted the turbulence of the tributaries that fed its earlier development. Similarly, the ASD-BSN prepared nurses in this study appeared to quiet the turbulence in their careers through finding a deeper understanding of themselves as nurses. Further, just as the river provides nourishment and sustenance to the land it travels through, so did these ASD-BSN prepared nurses give and receive nurturance and sustenance through caring for their patients. The theme of the *Rolling River*, with its sub-themes of (a) always a nurse, (b) the past as present, (c) teamwork, (d) emotions, (e) power, (f) advocacy, (g) nurturing through caring, and (h) the best thing I ever did, describes the depth and breadth with which the participants in this study viewed and understood themselves as nurses.

Always a Nurse. Several of the participants made statements about defining themselves as nurses, both in their professional and personal lives.

Sandra: I feel like I'm a nurse to my kids, to my parents, to my friends. I'm always a nurse, every day I'm a nurse.

Gina: This has become almost a way of living for me, almost a lifestyle. I work as a nurse, but I also identify myself as a nurse.

Others talked about how being a nurse carried over into their lives outside of nursing.

Bobby: [Even when I'm out, away from the hospital,] I'm always assessing people. I know that I can help somebody if something happens. I see somebody with an oxygen tank and I automatically look at their skin color, how they're breathing, stuff like that. I'm always in that frame of mind, assessing and planning. [That makes me] feel comfortable. If something were to happen to one of my family members or anybody around me, [even] here in this restaurant right now, I'd feel comfortable that I could help them.

Kristin: [In my personal life] I'm much more prone to notice behavioral health issues such as avoidance, eye contact, or shielding away from a subject. And at the same time, I also tend to engage in techniques that I would not be aware of had I not been in behavioral health. [I recently saw two children fighting in the grocery store], and my response to them as a behavioral health nurse was so effective that it probably [startled them], much the same way as a policeman [telling them to stop fighting might have].

Veronica: I find myself looking at people like at Sam's or somewhere and I [think] wow, I hope that guy is getting treated for congestive heart failure!

Tina: Being a nurse now, [I] get more calls. I've pretty much become the go-to person, the family health expert. [And] I have a habit [now] of looking at people and thinking, wow look at that one, I could get an [intravenous line] in that one. Or, look at that person; I hope he's getting treated for that!

Bradley: [When I'm at home] I get calls from neighbors and [they ask] can you please check on this person, can you please check on that person? [Or, they] have a question about [a] medication. [Now as a nurse practitioner], the question [I ask myself] is do I still consider myself a nurse? And yes, I most certainly do. Nursing stamps you. It puts its mark on you.

Roberta: The other day my son had croup and I didn't know. He didn't have that croupy cough but he turned totally blue and told me he couldn't breathe. And [I told myself] he's not that blue, and then [I thought] I'm at home, call 9-1-1! But still [my] nursing brain was [saying], I'm overreacting, I can manage this. [I was] running through scenarios [in my head while my] own kid was turning blue.

The Past as Present. All of the participants, upon reflecting on their experiences as nurses, indicated that their past professions and professional maturity helped them in their nursing practice. For some, their previous career had a direct effect on the patient care that they provided.

Kristin: I can say that [one thing] I bring in as a second-degree person is education. I used to teach 11th and 12th grade English, so I know what it looks like when little kids have no idea how to read or write. The [other] degree that I can say that has really been a benefit in the field of nursing is IT. If [someone has] a problem [with the electronic medical record], they know they can call me. I come, I don't just fix it. I show them how to fix it so they don't have a problem in the future [and] so that they can help others.

Rose: Well, I'm also a yoga teacher, that's my outside life, who I am, but I'm bringing it in [to my nursing practice]. I teach yoga on the unit from time to time. I also practiced something called tai-chi-cha (...) it's about movement, moving energy. I use that with my patients.

Gina: When [there are] insurance questions from family members, [I'm able to] help them with things like that.

Charles: I was in the IT industry before I went into nursing school. [There's] this new push [in healthcare] to move to

computerized charting. Our division, the hospice division, is the first one to move to it. So now, [the company] is making me a nursing informatics instructor. My IT background definitely helps me in my nursing practice.

For others, it was more personal, such as Dawn's experience as a pediatric cancer survivor.

Dawn: Occasionally I'll see a kid with the same [kind of cancer] I had. I can say, look at me, and I can tell them about my experiences. I don't tell everyone, but sometimes it's just really good to share that and see them go, wow, you look normal and you're a nurse.

Many of the participants talked about their professional maturity, work ethic, and understanding of the gravity of a nurse's actions.

Sandra: Every patient, every job that I do, I do to my fullest. I think in some ways it helped to have a career before I went into nursing. I have more age, maturity, and experience. [I've] worked in a professional field where I had to deal with management and performance evaluation, and [things like that]. I have some experience to draw on, [I've] worked with difficult people and supervisors.

Gina: I think [second career nurses] have a better [understanding of] the bigger picture and the communication skills and experience

in a job environment. There's the communication and the responsibility of already having a job before, and knowing what it's going to take. That 8-5 experience and knowing that people are depending on you to be there, I think that prepares you for the responsibility you're going to have [as a nurse].

Amanda: I think that I knew how to communicate better with the physicians because I had already had a professional job. I [also] think that I was better able to form relationships with the rest of the staff than the other new graduates. I think that working before I was a nurse gave me an advantage.

Bobby: Some of the things that we are told to do by our nurse manager I don't agree with. [However,] knowing where [the managers are] coming from, because I was a manager, I take that a little bit easier. I'm calmer towards my job and not so frazzled. [Some of the] younger [nurses] who haven't had experience in other fields or even in nursing in general, get thrown off track [by management directives].

Veronica: [As a second-degree nurse] I have something else to offer. Even if I'm not implementing [my previous career skills] in everyday life, the fact is that I have more. [As a second-degree nurse, I] come to the table with something else."

Bradley: I'd been in the Army before [I went into nursing]. [Having that experience] really helped [me as a nurse]. I struggled a lot less with figuring out what it was to have this job and [I was able] to focus on [mastering] the technical aspects. I didn't have some of the [being in] my first real job issues that [the other new graduates] had to deal with. I [also] think [my experiences in the military made] it was easier to accept people as they were, just kind of meet them at their own level. [In the military] I'd already seen a lot of different perspectives and [different cultures]. In the ER [I saw] some crazy stuff, but, I'd seen crazier [when I was in the army]. So for me, it was easy to kind of move beyond that and say OK, how can I help you? Some of my supervisors referred to it as having lived in the real world. Having lived all over, having lived with people from all over, I think it was just easier to suspend judgment and just kind of take care of people.

Teamwork. As a river rolls on through the plains, the turbulence from the tributaries is calmed as the water mixes with the main channel. In much the same manner, the turbulence caused by the tributaries in the careers of ASD-BSN graduates was calmed by the teamwork they experienced on their respective nursing units. This sub-theme was discussed by all 12 of the participants.

Rose: I'm now at the point in our staffing situation where I'm working with a handful of nurses that I know well and they're good nurses. I really like that team work.

Sandra: I work with great nurses. Whenever I encounter a difficult situation where I'm not sure how to deal with it, I get the charge nurse involved. I [may talk] with the nurse practitioner and the physician, I [may] get everyone [involved in the situation] together for a big meeting. I [even get] risk management involved, or the unit director [depending on the situation]. [It makes] it a little easier because I [don't] have to deal with [difficult situations] by myself.

Dawn: We have really great team work on the floor. [After report] we huddle and discuss our patients, go over the critical ones and [develop] a plan. We try to help the nurses we know are going to be busy. Everyone works on helping, sometimes taking over [another nurse's] patients if there's an emergency they are dealing with.

Gina: We have such great teamwork [where I work]. When I was new, they were really supportive. They wanted me to survive and do well. I think that's [one of the reasons nurses] change careers or jobs in two years, when they don't have a good team.

Charles: [Now that I've left the burn unit], I miss the people that I worked with because it was a team environment. It was very team oriented in the burn intensive care setting. You had to rely on everybody else. There was camaraderie on the unit.

Bradley: We were a really good team [on the endoscopy unit]. There were only 12 RNs for this busy, busy department and we got to know each other really well. It was a close working relationship and we knew each other's strengths and each other's weaknesses, [which] led to being able to do more.

Emotions. As they engaged in reflection on their experiences as part of the interview process, the participants brought forward some of their background operations to the interpretive foreground (Benner, 1994). In doing so, several of the participants reflected on the emotions that they carried with them as nurses. They spoke of sadness, of joy, of appreciation, and of frustration. Regardless of the emotion, it was evident that emotions in general were a sub-theme to the depth of the rolling river that is analogous to the lived experiences of the ASD-BSN prepared nurses.

Sandra: I came to care for him so much. [Later, I met] the foster family. I felt like he was going to a good place and so that was really special. Knowing that once he left our care, he would be going somewhere where I felt like he would be safe. So, that was really, that was really good.

Dawn: It was terrible, [that first clinical emergency]. I felt like I should know what to do but I just couldn't [think of it]. That was the first time I actually cried at work.

Gina: I didn't realize how much emotional investment it was going to be. [Where I work] it's not surgery where they come in and get fixed and then they're out. It's a lot of chronic diseases so it's really kind of emotional, you get attached to the patients.

Amanda: [When a baby is dying] we let the parents stay [in this little room off of the unit] and take care of the baby until it passes. [When it's one of my patients] my job is to go in there and check on the baby's heart rate and breathing. [That's] just the most emotionally draining thing I [have] to do. [When I have a day like that] I just sit in my car and cry afterwards. [Even back in nursing school] I'd see so much, I mean sad things, bad things. Emotionally, I struggled.

Bobby: I guess you can say emotionally [nursing has] been up and down, sort of like a roller coaster. But I try not to let that affect me. It's also joyful [and] I'm grateful that I have the job that I do, the part in the community that I play. I don't know how else I can describe it.

Tina: I was just there with him. I held his hand and I [told him] you know you're going to die now. He didn't have any family

there, all his family was gone. I told him I'm not going to leave you and I just literally stayed there with him and watched in helplessness as he died. Oh my God, it just made me cry and cry.

Power. The participants also spoke about the power of being a nurse. This power seemed to originate from being able to control their environment. In turn, this control acted as another calming influence on the turbulence that resulted from some of the tributaries discussed earlier. For others, the power was more personal, a strength that seemed to develop through taking care of their patients.

Amanda: Sometimes we have a little power struggle [with the families]. Some of them really need to do something. They need to touch the baby. [I] give them tasks that they can do and they'll focus on that task. [They'll] make sure that it's perfect. As long as I give them that, and they have something to do, then they usually are fine with my being in charge of their baby.

Gina: [I] just feel the power of the position [I'm] in to inform and help people out. Sometimes it's those situations where you've saved somebody. Sometimes it's not the saving that stands out, but that you gave them peace of mind or a peaceful passing. Sometimes it's about empowering them to make a decision that's right for them. [Sometimes], I just [feel] the power of

nursing, the power of healing not just the body, but the person and its really awesome.

Charles: In the hospital, in the ICU, the nurse is in control of the environment. If you have a combative or confused patient, [you can sedate them with drugs like] Ativan intravenously. Then they go to sleep. [I'm] in control of the environment [in the hospice setting too, although the] control changes in the way you respond and communicate with the family in the home.

A contrary case of power was presented by one of the participants. Rather than feeling in control of her environment and able to exert her personal power, she felt powerless in her nursing setting.

Kristin: When I go to talk to administration about [the staffing], I tell the same story every time. I'm sure they're quite tired of hearing of it and nothing ever gets changed.

Advocacy. Another sub-theme of the *Rolling River* theme was that of advocacy. Several participants spoke about their ability to exercise independent nursing judgment in order to advocate for the care that was, in their opinion, best for the patient. On occasion, their advocacy behaviors conflicted with the directives of other members of the health care team. However, the participants seemed to find strength in themselves as nurses through implementing independent nursing behaviors that were of benefit to their patients.

Kristin: I [feel that I] have great skill in identifying which children would do well with an animal, and because I am a charge nurse, I can make individual referrals for pet therapy. Kids who are having verbal issues or are having trouble with post traumatic stress disorder might say far more in a therapy session if they have a dog beside them than if they're on their own or given an inanimate object.

Rose: I started a relaxation group on the unit. Shortly before bedtime I go around and [ask the patients] who wants to come to relaxation group? It's totally voluntary, whoever's interested. I do progressive relaxation, we do a little neck stretching and I talk them through progressive relaxation of their muscles. Then [we do] a guided visualization kind of thing and then a silent meditation.

Dawn: The nurse is the person who is directly there, all of the time. She sees what's going on. So when we need a consult for a child life counselor or social worker, the doctors really don't [usually] order that, we do. They look at the medical, the physical response but they don't always see the need for the social assistance. That's where the nurses really help people, really advocate for their needs.

Veronica: [As a social worker] I was always a patient advocate. As a nurse I advocate for my patients even more so. It's about the patient. [The whole health care team is] supposed to be interdisciplinary, working for the best care of the patients and the families. However, it is the nurse who really speaks for the patients when plans for their care are being made.

Nurturing Through Caring. In spite of the emotions the participants experienced as nurses, or perhaps because of them, the sub-theme of nurturing through caring emerged as part of the *Rolling River* theme. In a river system, the main river channel flows out over a flood plain or though a valley, providing nourishment and renewal of the surrounding soil. Similarly, the lived experience of the participants included a number of examples of how they both nourished their patients and renewed their own emotional commitment to nursing.

Rose: I really relate to [my patients], I feel for them. I've found my niche [in psychiatric nursing], the place where I can really do the most good.

Sandra: As a nurse, I feel like it's all the little things that we do for people, like the bath, the cuddles, holding a baby, comforting a child. [That's what] stands out in my mind as important, life changing, and memorable for me, versus all of the tasks that we do.

Roberta: I just really like what I'm doing. I like being a floor nurse and taking care of my patients and making a difference.

Bobby: I want to give good patient care because that's the ultimate goal. [I] try to be caring at all times. It's the little things that make the difference. I think if it were me in there, I would want somebody that would be knowledgeable and understanding and good at what they do [and to] have a caring attitude.

Veronica: As a nurse, you're very caring and you're very intimate with a patient on a professional and respectful level. You're very involved. I get [this] emotional joining with the patient [that lets me] really help serve them. [It's a] way to work together, collaboratively, on the diabetes, hypertension, and so forth. It's not about being the best nurse, it's just about caring.

Charles: I'm more forgiving than what I used to be. And I think I'm more caring, more compassionate than I used to be. When I wasn't a nurse, I viewed people differently. Now, I understand that everyone has a story and that sometimes we can't know what they're going through. [That's] especially [so] now, after working in hospice.

The Best Thing I Ever Did. The ongoing renewal that the nurses in this study experienced as a result of caring for patients (as described in the previous section) was evident in their words about how they felt about nursing. Almost everyone

interviewed spoke about how much they loved being a nurse and how personally rewarding they found it. Their words resulted in the identification of the final and perhaps most important sub-theme of the *Rolling River*.

Rose: [After spending some time talking with a patient] he turned to me and he said thank you, I think you've done more for me in this half hour than all my therapists. That was the most rewarding thing [I had ever experienced as a nurse]. I felt so good. I'm so grateful that I've found my niche, the place where I can really do the most good. This is the best thing I ever did.

Sandra: I love being a nurse and I love working with kids. It doesn't get much better than seeing them get better. I love my job, I'm still a happy nurse I can't imagine doing anything else. It's the best decision I ever made.

Dawn: I love being a nurse, I absolutely love it. It was just something I wanted to do. Sometimes there's good and bad, but the job itself is just phenomenal. I wouldn't change it. I'm very happy where I am. I'm really glad I did it.

Gina: I am so very proud of what I do. It was the best decision I ever made! It just changed my life, I'm so glad I had the opportunity to do what I did and I'd do it all over again if I had to start over. I love it and I know that it changed me. I always

say I didn't even know who I was before the [ASD-BSN] program.

Amanda: I really love what I do, it's incredibly rewarding. [It's so nice when families] give me a hug and say that they want to thank me because I was the one who had personally taken care of them. I totally plan on staying in nursing. I have a friend that asked me about [the accelerated program]. I had just finished and she asked if she should do it. I told her yes so she did it too. She's been a nurse for a year now and she loves it too.

Bobby: I thought [that nursing] would be satisfying as a career [and now] I love it. Every day, it's the best job I could ever have and I don't want to change. How many people can say that they've affected that many lives? [It's] just the reward that you get from patients and [all] the little things that you do. And the family members, [when they say] thanks for doing a good job, there's just something about it that I just wouldn't change. I would do it over in a heartbeat.

Veronica: I had this one patient who had nearly died. When she came back to the unit she thanked me. She said I remember, it was really dark and all of the sudden I saw your face and you were my angel. [Her family said] if [I hadn't] been in the room with her it might have gone the other way. It was so rewarding [to

hear that]. I love being a nurse and I'm proud to say I'm a nurse. It makes me happy to help people and see a difference in their lives because of what I've done. I'm glad I went through [the accelerated nursing program].

Charles: I expected nursing to be hard work. [Once I started working as a nurse I found that] it was worth it. I loved the burn unit. [Now, working in Hospice,] I love what I'm doing and I can't see myself doing anything else.

Bradley: I've never regretted it for a moment. I've had hard times and really good times. But overall, I've never made a better decision. I've not regretted it one bit. I think it was one of the best decisions I ever made.

Only one of the participants, Kristin, said that she found nursing to be unsatisfying career choice. She presented a strong contrary case to what the other participants said about their love of being nurses. When talking about whether she would recommend nursing to others she said:

Kristin: I would say, definitely think about what you're doing before you go into the nursing field. If you have any idea that you're going to do those things they advertise in the Johnson and Johnson commercials about saving a life, changing the world, and making the world a better place, then don't go into nursing. I see myself out of it in two years, tops. I don't know [where

> I'll go]. Somewhere that's not nursing. Probably IT, because computers never lie, never hurt their offspring. I'm just going to quietly let go, [I] probably won't even mention it on a resume.

The theme of the *Rolling River*, with all of its sub-themes, illustrated the degree to which the participants were able to reflect upon their experiences as nurses. For many, it seemed that participating in the interview actually solidified their self-understanding and gave voice to their previously unexplored feelings and beliefs about their nursing practice and how it had changed their lives. They believed themselves to be members of a noble and respected profession; their words on that subject led to the last of the themes identified in this study, that of *The Delta: A Member of the Profession of Nursing.*

The Delta: Being a Member of the Profession of Nursing

As a river system reaches the end of its course, it spreads out and splits up into multiple small, shallow channels. The essence of the river, and the nutrients it has picked up along the way, are deposited in this area, called a delta. The environment of the delta is rich and fertile. There are areas of quiet water and luxuriant growth. Meadows of beautiful flowers and grasses are abundant in the delta and trees and flowering shrubs silently watch over the teeming life contained therein. Ultimately, the delta mixes its fresh water with the saltier composition of the ocean. The ASD-BSN educated nurse does the same. These nurses have experienced both turbulent and calm waters in their careers. Opportunities for both giving and receiving

nurturance and sustenance have been embraced. Upon entering the delta, the river that is the lived experience of the ASD-BSN educated nurse joins with the profession of nursing as a whole. This is the theme of the *Delta*, with its sub-themes of (a) options, (b) lifelong learning, and (c) caring about the profession.

Options. One of the sub-themes related to the profession of nursing that emerged during this study was that of options. Several of the nurses spoke about the opportunities that professional nursing offered them -- opportunities to change practice settings, to travel, to take time off for family, and to resume their careers when the time is right.

Roberta: If I get bored with women's health, I can be hospice nurse, I can transfer to the emergency department, or I could work in the operating room. I can stay home with my kids while they are young and go back to nursing later. The possibilities are endless. I can [work] when I want and where I want. There are just so many opportunities.

Sandra: I feel like there's so much opportunity in nursing, I can do so many different things in nursing. It really opens up so many doors. I can [even] go back to research in even a greater capacity now that I have this education.

Amanda: If I have children, I can just stay [in nursing part time] so that I can [be there for my family].

Bobby: [One of the reasons I went into nursing is] all [of] the opportunities within the nursing field. You can always advance your career, you can change it, [there are] all the different fields that you can go into. [When I left the telemetry unit] I wanted to do something different, I wanted something that would challenge my skills and I thought that the emergency room would be the place to do that. I'm enjoying exploring the different types of nursing. [There are] just so many options.

Tina: Nursing has a lot of opportunities. If you get tired of one area, then you can move on to something else.

Bradley: Nursing [offers] endless possibilities. If you burn out on one thing, there's something else a lot different that you can do. You can find something that matches your personality. You can find something that suits you.

Lifelong Learning. Another sub-theme related to the profession of nursing was that of lifelong learning. As mentioned previously in this report, 33.3% of the participants were either already enrolled in, or recently graduated from, an advanced-degree program in nursing. Another 33.3% indicated that they would be pursing an advanced degree in nursing in the near future. Even those who, at the time of their interviews, did not intend to go back to school for an advanced degree, spoke about the importance of continuing to grow and learn as a nurse.

Sandra: I've learned that I definitely don't know everything. I'm still learning, and probably will be all my life. I want to go back and pursue a masters degree but I don't know if that will be in education or a nurse practitioner degree.

Dawn: I'm actually starting a family nurse practitioner program in the spring. I'm excited to start [and] I'm looking forward to learning more and getting more experience.

Gina: Every single day as a nurse it's like being in the classroom again, learning new things. [I'm in a] family nurse practitioner [program now], the first semester of three years. Hopefully, I'll go on to the Doctor of Nursing Practice [program].

Charles: There is a [master] program in nursing education and leadership at one of the schools here in town. I'm [planning on] doing that in the relatively near future.

Bobby: The rest of the plan is to get a master degree in nursing. I'm thinking about a nurse practitioner or the certified nurse anesthetist. I think that's an important thing in [nursing], to keep learning.

Tina: You are always learning in this job and that's good, you need to stay up on things. My long-term plan and goal is to [become] a family nurse practitioner and my longer-term goal is to get a doctorate of nursing practice degree.

Amanda: I don't know that I would go further and get a nurse practitioner degree. I like bedside nursing and there are plenty of opportunities for learning there.

Rose: I think that it might be more appropriate if we were required to actually go to a university and take some real courses to renew our RN license, not just weekend workshops that give you 16 contact hours. We need better educated nurses.

Caring about the Profession. The last sub-theme related to *The Delta* is *Caring about the Profession.* Several of the participants spoke about their desire for nursing to continue to be well regarded by the public. They expressed reservations about the reasons that some might be drawn to nursing, such as those related solely to the potential income and job stability, as opposed to having the desire to care for others. They also had concerns about the proliferation of proprietary associate degree programs in nursing.

Rose: In the private schools, where they're coming out with associate degrees, they're not passing the NCLEX-RN. They're not prepared, they're not ready.

Sandra: There are just so many private nursing programs now, it's like the professionalism [and] the standard of education is going down. That worries me. I know that in general, the public really trusts nurses and I want it to stay that way. [In some programs,] it seems like in if you pay enough money you can

get a nursing degree. That worries me, because I want us to continue to be a trusted field and a highly educated field.

Bobby: I tell [people who are thinking about nursing] to make sure that it's what they want to do because it's not a career to mess around with. I think it's a career that needs to be taken seriously. I don't think that [people who don't care] do a bad job. I just don't think they do the best job. [Nurses] should rise above the standard and give excellent care.

The ASD-BSN Prepared Nurse Depicted as a River System

Through the analysis of the participants' experiences, a conceptual model was developed which provided a graphic representation of the lived experience of the ASD-BSN prepared nurses. This model was illustrated as a river system, complete with *Headwaters, Tributaries and Turbulence, the Rolling River,* and *the Delta*. Each component of the river system related to a theme, each with sub-themes as previously described. The model is represented in Figure 1.

Summary

Chapter 5 presented the findings of this research study, the aim of which was to explore the lived experience of ASD-BSN prepared nurses who have been in practice for two to seven years. Following a demographic description of the 12 participants, four major themes which emerged from the study were articulated, each with a number of sub-themes. The themes were

1. The Headwaters: Becoming a Nurse

2. Tributaries and Turbulence: Navigating the Rough Waters
3. The Rolling River: Being a Nurse
4. The Delta: Being a Member of the Profession of Nursing.

These themes were conceptualized through a model of a river system, complete with headwaters, tributaries, main river channel, and the delta which ultimately merges with larger ocean representing the profession of nursing. Consistent with the phenomenological methodology of Benner (1994) and Cohen, Kahn, and Steeves (2000), each theme was illustrated using the actual words of the participants in the study.

Chapter 6 focuses on the process of phenomenological writing, to include the development of a paradigm case describing the ASD-BSN prepared nurse in each of the four domains as presented, with support from the nursing scientific literature for each assertion. Additionally, a discussion of how the researcher stayed true to the interpretive phenomenological method is included as a means of documenting and acknowledging her role in the research process and interpretation of the data. The chapter concludes with the implications of this study for nursing education, administration, and practice as well as the study limitations. Areas for future research related to this population of professional nurses are also identified.

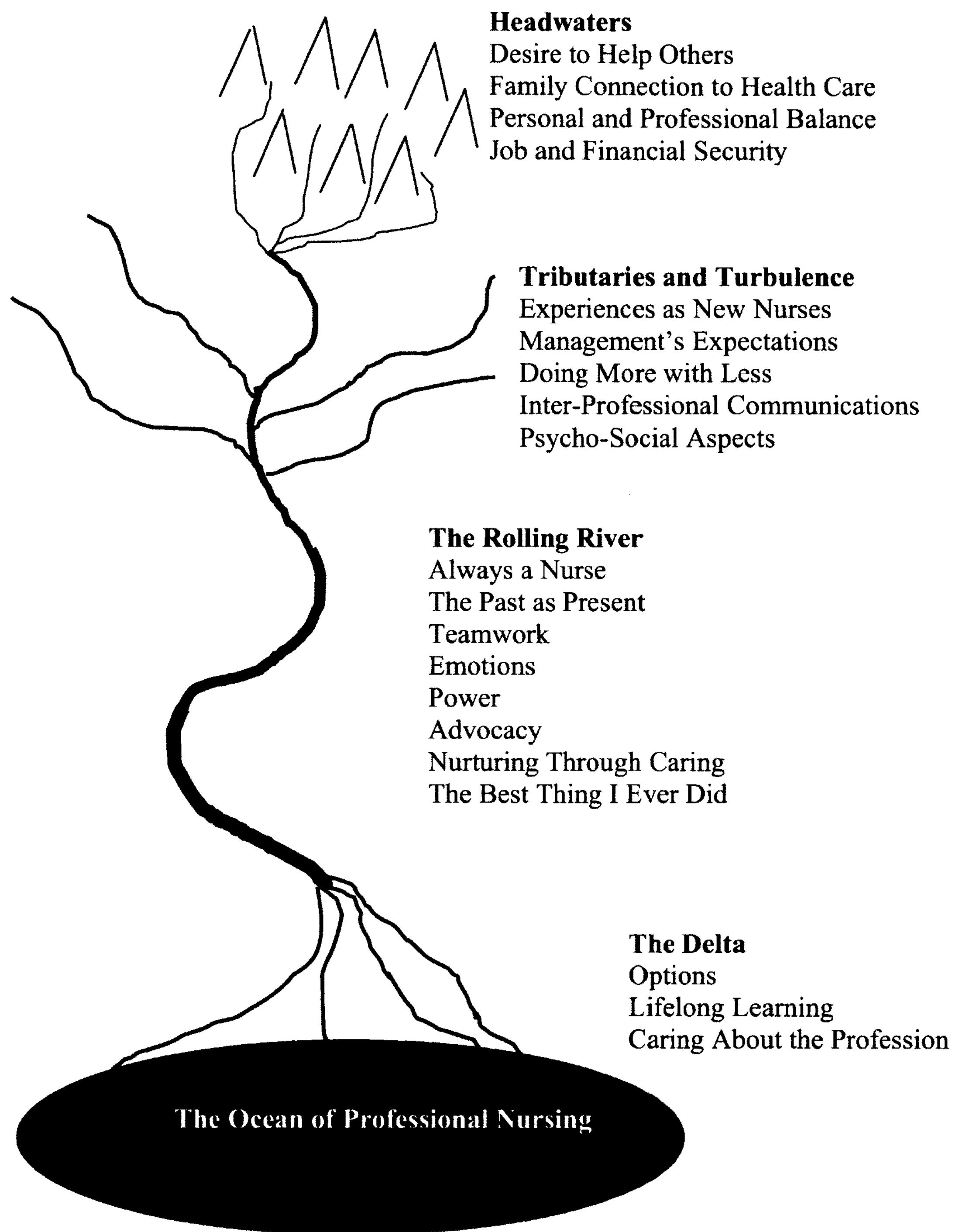

Figure 1. Hennessy's River System Model of ASD-BSN Nursing Practice.

CHAPTER 6

REFLECTIONS ON THE FINDINGS

Introduction

Chapter 6 presents the interpretation of the findings of this study. It begins with a presentation of a paradigm case of the lived experience of ASD-BSN prepared nurses who are engaged in their nursing careers. The paradigm case will be articulated through a series of assertions based on each of the themes which emerged from the data. Each assertion will be supported by relevant literature from nursing science. Following the presentation of the paradigm case, the research process, as experienced the researcher will be discussed. The chapter will conclude with a discussion of the implications of this research for nursing education, administration, and practice. The limitations of the study will also be presented.

The Paradigm Case of the Lived Experience of ASD-BSN Educated Nurses with Supporting Literature

Combining the collective experiences of the participants in an interpretive phenomenological study allows for the construction of a paradigm case representative of the phenomenon being researched (Benner, 1994). Further, and more importantly, constructing such a description from the data allows for a deeper understanding of the phenomenon. Such is the case with this research study. What follows is the paradigm case for the lived experience of the ASD-BSN prepared nurse. Wherever possible, the assertions made in this interpretation are supported by scientific nursing literature specific to this population of nurses. However, as previously stated, the literature

regarding how ASD-BSN prepared nurses experience their careers is very limited. As a result, some of the assertions are supported by the literature from nursing science in general.

Assertion 1: Motivation to Become a Nurse

The ASD-BSN prepared nurse is primarily drawn to nursing out of a desire to assist, serve, and/or care for other people in terms of their health and overall functioning as human beings. Also, it is likely that the ASD-BSN prepared nurse will have engaged in some sort of health-related volunteer activity and/or had a family member or close friend who was a health care provider. Further, the nurse may have actively sought out a career change due to frustration or lack of personal fulfillment in a first career. The nurse may have also been prompted to pursue a career in nursing as his/her first career proved financially unsustainable or by a position being terminated due to economic forces in that particular field.

Confirming this assertion are studies by Akton et al. (2009), Siler et al. (2008), and Raines (2011). In all three studies, it was determined that students entered ASD-BSN programs out of a desire to serve others, as well as a desire to utilize the skills acquired in their first careers. While not specific to ASD-BSN prepared nurses, another study compared Guatemalan and United States nurses' attitudes towards nursing (Coverston, Harmon, Keller, & Malner, 2004). In their study, the participants from both countries cited a desire to help and serve others as the primary reason for entering professional nursing, again supporting the assertion in the ASD-BSN paradigm case. Further, the international nursing literature demonstrated that the

desire to help others is a motivating factor for pursuing a career in nursing. Altruism, or the desire to serve or help others, was identified as the primary reason for entering the profession of nursing in studies in both Great Britain (Miers, Rickaby, & Pollard, 2007; Waters, 2004) and Australia (Newton, Kelly, Kremser, Jolly, & Billet, 2009). All of the reports cited above related that a history of volunteerism was common among nursing school applicants, who were often exposed to nursing by close friends or family members. Authors also mentioned the attractiveness of the extrinsic rewards of nursing as one of the less dominant reasons for becoming a nurse.

Assertion 2: The ASD-BSN Prepared Nurse's Experiences upon Entering Nursing Practice

The ASD-BSN prepared nurse enters nursing practice full of trepidation and excitement. The period of transition from student nurse to practicing nurse carries challenges and not a little frustration as he/she learns to navigate the health care culture. ASD-BSN prepared nurses deal with common issues associated with professional nursing practice, including (a) understaffing, (b) difficult inter-professional relationships and communications, (c) managerial expectations, and (d) the psycho-social aspects of caring for patients and their families. However, ASD-BSN nurses feel well prepared for the challenges and use skills and professional maturity gained in previous careers to answer these challenges. The maturity the nurse brings to the practice, along with solid interpersonal communications skills gained through previous professional and life experiences, aids in negotiating this transitional period and in establishing her/his nursing practice.

This assertion is consistent with the results of a study by Raines and Sipes (2007), in which 21 ASD-BSN graduates from a single university were surveyed regarding their nursing careers one year after graduation. In that study, the respondents indicated that they were adequately prepared for nursing practice upon graduation. Further, they felt that they had developed strong interpersonal communication skills in their first careers which facilitated their transition to practice. In another study by Raines (2009), 58 ASD-BSN graduates were surveyed regarding their preparation for nursing practice immediately upon graduation and again six months into practice. She noted that while the subjects indicated they perceived themselves to be prepared at both survey points, they rated their preparation higher on the six-month survey than they had on the graduation survey. Again mentioned as an element of preparedness were the skills brought to nursing from the subjects' previous professional experience. Wolf (2007) also affirmed this assertion in her phenomenologically-based dissertation on the socialization of ASD-BSN graduates, as did Calhoun (2010), whose grounded theory-based dissertation resulted in the Theory of Overcoming. This theory posited that ASD-BSN-prepared new graduate nurses used skills from previous careers to ease the transition from graduate nurse to professional nursing practice. In both studies, the investigators discovered that the ASD-BSN graduate encountered the same challenges as all new nurses, but that they were more adept at deploying professional maturity and skills attained in their first career to overcome those challenges and more quickly progress to full engagement in professional nursing practice.

The general nursing literature was replete with studies regarding the negative consequences of intra- and inter-professional communication. Recent examples of such literature included Lally (2009), Longo & Sherman (2007), Robinson, Gorman, Slimmer, & Yudkowsky (2010), Tschannen et al. (2011), and Woelfle & McCaffrey (2007). Lateral violence or hostility was even identified by the Joint Commission as a threat to patient safety in health care settings (Joint Commission, 2009; Nadzam, 2009). Further, various researchers confirmed that the existence of lateral violence often led to nurse turnover, burnout, and even career abandonment (Aiken et al., 2002; Rosenstein, 2002; Vahey et al. 2004). Clearly, it is an issue of high importance for professional nursing practice. Perhaps the continuing contribution of ASD-BSN prepared nurses, with their diverse professional backgrounds -- as well as a higher percentages of males -- will hasten the movement toward a more civil work environment in which the historical inequities of professional hierarchal structures are minimized or altogether abolished.

Assertion 3: The ASD-BSN Prepared Nurse's Experiences once Fully Engaged in Practice

First and foremost, the ASD-BSN prepared nurse loves being a nurse and believes that the entering nursing was the best decision he/she ever made, indicating a high degree of job satisfaction. For the ASD-BSN prepared nurse, nursing is a way of being, an ever-present mindset in all life's big and small events. He/she is always a nurse and intends to remain a nurse in the future. The nurse augments her/his nursing practice with skills gained in previous careers, and values each and every professional relationship and teamwork experience. He/she understands that emotional highs and

lows are to be expected in this career and has a well-developed sense of personal power brought about by an ability to help and advocate for patients, as well as an ability to exert some control over his/her practice. Through providing nurturance and sustenance to patients through caring, the nurse is, in return, nourished and sustained by providing that care.

While not specific to ASD-BSN prepared nurses, there was a plethora of literature related to job satisfaction and intent to stay in the nursing profession. A number of recent research studies demonstrated that the level of job satisfaction was the most significant indicator of whether a nurse stayed in nursing or left either their current work environment or the entire profession (Apker, Propp, & Zabava Ford, 2009; Cho, Lee, Mark, & Yun, 2012; Laschinger, Letier, Day, & Gilin, 2009; Perry, 2008; Skillman, Palazzo, Hart, & Keepnews, 2010; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2009; Zurmehly, Martin, & Fitzpatrick, 2009). Identified by these authors were specific components which contributed to overall job satisfaction. These components included feelings of power and empowerment (Zurmehly et al., 2009); interpersonal relationships with colleagues and within work units (Tourangeau et al., 2009); individual and family influences, and level of education (Cho et al., 2012). Interestingly, in a study of nurses who left the profession, the researchers reported that 86% of the subjects still considered themselves a nurse despite having allowed their licenses to expire (Skillman et al., 2010). These findings were consistent with the paradigm case of the ASD-BSN prepared nurses' experiences as previously described.

Zurmehly et al. (2009) specifically addressed power and empowerment as it related to intent to leave the profession. In their study of 1,355 nurses in the United States, they found that lack of empowerment was the strongest predictor of intent to leave the profession. They also found that the higher the level of education among the subjects, the greater the perception of empowerment, suggesting that nurses holding bachelor degrees or higher in nursing were better empowered to navigate complex healthcare settings. This finding was consistent with the education of ASD-BSN prepared nurses in that they have -- at minimum -- two bachelor degrees.

Also related to high levels of job satisfaction were positive relationships with co-workers and managers (Apker et al., 2009; Laschinger et al., 2009). Within the realm of positive relationships, caring relationships with patients and the ability to advocate for those patients were identified as being contributory to high degrees of job satisfaction for nurses (Perry, 2008; Tourangeau et al., 2009). These findings were consistent with the paradigm case of the ASD-BSN prepared case as presented.

Assertion 4: The ASD-BSN Prepared Nurse's Experiences as a Member of the Nursing Profession

The ASD-BSN prepared nurse is committed to continuing her nursing career. He/she values the diverse opportunities presented by nursing and considers lifelong learning a professional obligation. This nurse is highly likely to pursue graduate nursing education. He/she is proud of being a nurse and wants the profession of nursing to remain respected and honored in the eyes of the public. This concern led

him/her to be concerned about the quality and motivation of those entering the profession.

This assertion echoes the results of two studies involving ASD-BSN prepared nurses (Brewer et al., 2009; Raines & Sipes, 2007). In the Raines and Sipes article, the researchers investigated the work activities of ASD-BSN graduates with one year of experience. They reported that 100% of the subjects indicated the intent to pursue graduate nursing education. A similar finding was reported by Brewer et al. in their study which compared ASD-BSN and traditionally educated new nursing graduates in similar domains. Penprase and Koczara (2009) also identified that a master's degree in nursing was a goal for many ASD-BSN students. Additionally, both Calhoun (2010) and Wolf (2007) reported that advanced nursing education was a commonly held professional goal among the participants in their studies.

While not specific to ASD-BSN prepared nurses, the general nursing literature provided a few citations which were consistent with the assertion that ASD-BSN prepared nurses valued the public's trust in nursing and wanted to see it sustained. In an editorial by Ellen Olshansky (2011), the author commented that maintaining the public's trust may result in other health care professionals being more likely to view nursing's contribution to patient care decisions with greater respect. Takase, Kershaw and Burt (2002) conducted a study in which the correlation between positive self-concept in nurses and the public image of nursing was measured. They found that positive public perception of nurses was associated with the development of both individual and collective positive self-concept. Further, in a study report of nursing

students' perception of nursing (Sand-Jecklin & Schaffer, 2006), the researchers suggested that the public trust and value of nurses helped motivate nursing students to successfully complete their nursing education. These examples from the general nursing literature were consistent with the assertions articulated in the paradigm case of the ASD-BSN prepared nurse.

This paradigm case illustrated that the ASD-BSN prepared nurses who participated in this study were just that -- nurses. They were drawn to nursing and experienced nursing practice in much the same manner as nurses educated in other types of programs. They encountered the same challenges and issues as did all nurses, but were perhaps better prepared to deal with them by virtue of their previous careers and professional maturity. They considered themselves to be members of an honorable and trusted profession, and they intended to continue in that profession, some in advanced practice roles. In short, ASD-BSN prepared nurses were well socialized into the profession.

Staying True to the Methodology

A basic premise of interpretive phenomenology is that the researcher must acknowledge his/her own biases and preconceptions of the phenomenon he/she wishes to study. Further, the researcher must accept that these biases and pre-conceptions impact the research process as well as his/her interpretation of the data and the ultimate understanding of the phenomenon. The researcher is a part of the research in interpretive phenomenology (Benner, 1994; Cohen, Kahn, & Steeves, 2000). To that end, I kept a reflexive journal which documented my participation in

this study. I wrote about conducting this study, the participant interviews, and the process of interpreting the data. Keeping the journal and meeting with my advisor throughout the data analysis process helped protect the integrity of this study by keeping me focused and helping me to not stray from the aim of the study, which was to explore the experiences of these particular participants, and to avoid comparing them to other groups of nurses. Further, I acknowledged my pre-conceived assumptions and commented on them in my reflexive journal. My notations referenced how my assumptions were or were not borne out by the participants' stories.

Defining the terms I applied to the sub-themes helped organize my thoughts and the coding of the transcripts. Organizing the coded data by emergent sub-themes and subsequently organizing the sub-themes by thematic category allowed the interpretation of the lived experiences of ASD-BSN prepared nurses engaged in their practice to become fully articulated. Further, a model which conceptualized the ASD-BSN prepared nurse's experience as analogous to a river system was developed. Finally, delving into the literature to investigate similar assertions to those of the paradigm case validated my interpretation of the ASD-BSN nurse's experience. As a result of staying true to the methodology, this research provides a glimpse into the impact ASD-BSN nurses can have on the nursing profession.

Implications of the Study

The findings of this study have implications for nursing education, nursing administration, and the nursing profession as a whole. The implications for nursing

education are that programs of this nature need to continue to be offered in order to allow those persons who already have a non-nursing baccalaureate degree to gain rapid entry into the nursing workforce. Despite a transient easing of the current nursing shortage due to the poor economic conditions, the underlying reasons for it have not disappeared. There is every reason to believe that a strengthening economy will result in an exodus of older nurses from the profession and a return to pre-2009 registered nurse vacancy rates (Buerhaus, 2009). Thus, the need for increased production of baccalaureate prepared nurses is expected to persist well into the next decade. Further, nursing curricula need to emphasize more fully the social aspects of professional nursing practice, to include intra- and interdisciplinary communications and societal pressures which impact taking care of diverse patient populations.

As has been anecdotally reported in the nursing literature (Wujick, 2010; Wyatt, 2010), the implications of my study for nurse administrators were that standardized orientations or residencies for new graduate nurses might not meet the needs of ASD-BSN prepared nurses. Their orientations need to be individualized in order to maximize the incorporation of their skill sets from their previous degrees while also allowing sufficient time for their transitions from student nurses to practicing nurses. Care must be taken to not shorten the orientation time for these nurses based on their maturity and professional experience in another field. Conversely, nursing administrators should recognize that the professional maturity these nurses have may propel them more rapidly into nursing management and advanced practice roles. Further, nursing and hospital administrators must proactively

address the issues related to inter-personal communications and lateral violence in the work place. They must also deal firmly and quickly with characteristically bad actors whose behaviors are disruptive to intra- and interdisciplinary cooperation and the resultant compromise of patient safety (Lally, 2009; Longo & Sherman, 2007; Robinson, Gorman, Slimmer, & Yudkowsky, 2010; Tschannen et al., 2011; and Woelfle & McCaffrey, 2007).

The implications of this study for nursing practice are that nursing organizations such as the AACN or state boards of nursing should track this population of nurses separately from traditionally educated baccalaureate nurses. My difficulty in locating participants for this study was illustrative of the lack of identification of ASD-BSN prepared nurses once they enter professional nursing practice. Clearly, their impact on the profession needs to be studied and documented in much the same way that differentiation of practice between those prepared at the associate degree level and those prepared at the baccalaureate level have been studied and documented in the past. However, as a profession, nursing cannot begin to determine the impact of ASD-BSN prepared nurses if there is no mechanism for tracking them in their practices.

Limitations

Phenomenological research requires education and practice in the methodology in order to gain expertise. Therefore, this study is limited by the lack of experience of the researcher. Other limitations include the lack of generalizability of qualitative research in general, as well as the voluntary nature of participation in this

study. It is possible that the results of this study did not accurately reflect the overall experiences of ASD-BSN prepared nurses, given that those who are dissatisfied in nursing may have exited the profession and, as a result, were unable to be recruited for this study.

The Need for Future Research

It is clear that further research regarding ASD-BSN prepared nurses is warranted. Studies which examine their specific contribution to the profession of nursing need to be conducted, as well as studies of their (a) career trajectories, (b) educational accomplishments, and (c) longevity in the nursing workforce. Also, given that the negative social and family dynamics, and their impact on the ASD-BSN prepared nurses' practice, were cited with such frequency indicates a need to conduct further study in this area. Instruments which measure these characteristics in quantitative terms need to be developed, tested, and deployed to answer these research questions. From this study in particular, a survey instrument could be developed, the purpose of which would be to validate the themes and sub-themes that emerged from the qualitative data obtained. This survey could then be deployed to a much larger sample of ASD-BSN prepared nurses in order to test the preliminary model which resulted from this study.

Conclusion

This study resulted in the identification of four themes and a preliminary model of the lived experience of ASD-BSN prepared nurses engaged in professional nursing practice. Through this study, I have gained a deeper understanding of how

these nurses experience nursing and I've come to a preliminary conclusion that they are well socialized into the profession. This exploration has allowed me to understand what motivates ASD-BSN prepared nurses to enter the profession. It is now understood that -- not unlike most nurses -- ASD-BSN prepared nurses experience challenges in their practice. It is also understood that despite these challenges, most of them have very high levels of job satisfaction and, as a result, intend to stay in nursing practice.

This study's finding expanded the current literature by expanding what was known about ASD-BSN prepared nurses as they fully engage in nursing practice beyond the new graduate phase of their careers. Further research is warranted to ascertain how they progress in their careers in nursing, as well as how they impact the profession.

APPENDICES

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

Office of the Vice President for Research

INSTITUTIONAL REVIEW BOARD (IRB)
Dr. Luis A. Vazquez, Chair

MSC 3RES-PSL
New Mexico State University
P. O. Box 30001
Las Cruces, NM 88003-8001
Phone: 575-646-7177 Fax: 575-646-2480
Email: ovpr@nmsu.edu

DATE: September 08, 2011

TO: Lisa Hennessy

FROM: Nellie Quezada-Aragon

SUBJECT: Application for Permission to Use Human Subjects in Research IRB Application Number: **7320 (Expedited)**

The NMSU Institutional Review Board Interim Chair, Dr. Miriam Chaiken, has reviewed your application for the conduct of research involving human subjects for the project titled **"Being a Nurse: The Lived Experience of Registered Nurses Educated in an Accelerated Second Degree Bachelor of Science in Nursing Program."**

The application was reviewed in accordance with the expedited review process outlined in 45 CFR 46.110(b)(1) - Category 7. Dr. Chaiken approved the application on behalf of the IRB on September 07, 2011.

Your IRB approval is valid for the period: **September 07, 2011 - September 06, 2012.**

The research must be conducted according to the proposal/protocol that was approved by the IRB. Any changes in the research, instruments, or the consent document(s) must be submitted to the IRB prior to implementation. Additionally, any unexpected hazards or adverse events involving risk to the subjects or others must be reported immediately to the IRB.

Please note that the IRB approval is valid for only one (1) year. The IRB must review and approve all research protocols involving human subjects at intervals appropriate to the degree of risk, but not less than once per year. Therefore, in order to continue your project after the approved period, you must submit a request for continuation **45 days prior** to the end date of **September 06, 2012.**

If you should have any questions, please do not hesitate to contact me at 646-7177 or via e-mail at ovpr@nmsu.edu.

cc: Dr. Miriam Chaiken, IRB Interim Chair

APPENDIX B

PARTICIPANT SOLICITATION FLYER

Participant Solicitation Flyer

Are you a graduate of an Accelerated Second Degree BSN Program?

If yes, I'd love to talk with you about a research study aimed at exploring your experiences in your nursing career.

To participate, you will need to have

- Worked in the same or a similar clinical environment full time for at least 2 years since graduating from your BSN program.
- Worked in a field related to your first degree for at least 2 years prior to starting your nursing education.

Interested? Contact Lisa Hennessy, PhD(c), MSN, RN

- By email at XXXXX
- By phone at XXXXX

APPENDIX C

INFORMED CONSENT FORM

CONSENT FORM

Being a Nurse: The Lived Experience of Registered Nurses Educated in an Accelerated Second Degree Bachelor of Science in Nursing Program

PRINCIPAL INVESTIGATOR:
Lisa Hennessy, PhD(c), MSN, RN, CRRN
Doctoral Student
New Mexico State University
School of Nursing
email: XXXXX
phone: XXXXX

DESCRIPTION:

I am interested in the experiences of second career nurses who graduated from an accelerated second degree BSN program and who have been engaged in professional nursing practice for at least 2 years. You have been identified as fitting that description and as such, you are the best person to describe your experiences. This research study will involve one face to face interview with you, lasting approximately 75-120 minutes. The interviews will be recorded using a digital voice recorder. The digital recordings will be transferred to the researcher's computer and subsequently typed out as word-for-word transcripts of the interviews.

CONFIDENTIALITY:

Your name will not be attached to your interview responses. Your name and any other identifiers will be kept in a locked file that is only accessible to the researcher. Any information from this study that is published will not identify you by name. The master document linking your name to the pseudonym assigned to you for this research study will be destroyed upon completion of the project.

BENEFITS:

The results of this study may enhance the nursing profession's understanding of second career nurses and the role they play in addressing the nursing shortage. The only direct benefit of participating in this research to you is a payment in the amount of $30.00 given to compensate you for the time involved to participate in this study. Should you agree to participate in the member checking aspect of this research, you will receive an additional payment for your time, again valued at $30.00.

RISKS:

It is possible that reflecting upon your experiences in adopting a second career as a registered nurse may make you feel sad or uncomfortable. However, there are no other known risks to you.

CONTACT PEOPLE:

If you have any questions about this research, please contact the Principal Investigator at the phone number listed above. If you have any questions about your rights as a research subject, please contact the Institutional Review Board (IRB) Chair, through the Office of Compliance at New Mexico State University at (575) 646-7177 or at ovpr@nmsu.edu.

VOLUNTARY NATURE OF PARTICIPATION:

Your participation in this study is voluntary. If you don't wish to participate, or would like to end your participation in this research study, there will be no penalty or loss of benefits to you to which you are otherwise entitled. In other words, you are free to make your own choice about being in this study or not, and may quit at any time without penalty.

SIGNATURE:

Your signature on this consent form indicates that you fully understand the above research study, what is being asked of you in this study, and that you are signing this voluntarily. If you have any questions about this study, please feel free to ask them now or at any time throughout the study.

Signature ____

Date _________________________

A copy of this consent form is available for you to keep.

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

DEMOGRAPHIC QUESTIONNAIRE

Being a Nurse: The Lived Experience of Registered Nurses Educated in an Accelerated Second Degree Bachelor of Science in Nursing Program

Lisa Hennessy, Principal Investigator

Instructions: Please complete this questionnaire completely and as accurately as possible. Your responses will be coded for anonymity and maintained in a confidential and secure manner, accessible only to the principal investigator on this project. All hard copy results will be secured in a locked file cabinet. Your assistance with this project is greatly appreciated.

1. Age in years: _________
2. Gender: ______ Male _____ Female
3. Ethnicity:
   _____Caucasian _____Black _____Hispanic _____ Asian
   _____Other

4. What was the highest college degree you had earned prior to entering the accelerated second degree BSN program?
   _____ Associate's _____ Bachelor's _____ Master's _____Doctoral

5. What field(s) was (were) your prior degree(s) in?

6. How many years of full time professional employment (related to or after your prior degree) did you have prior to entering an ADD-BSN program?
   ______ years

7. How many years of experience do you have as a registered nurse?_____ years

8. Have you enrolled in, or completed a graduate nursing program or other graduate program? ______ no _______yes

9. If yes, what type of graduate education are you, or have you pursued?

For Office Use Only

Informant pseudonym: _________________
Data Complete? ___yes ___no
Data Entered into data base: __________date

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