PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING,
EVALUATING AND REVISING BSN CURRICULUM

by

Meredith L. Roberts

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The Dissertation Committee for Meredith Roberts certifies approval of the following dissertation:

PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING AND REVISING BSN CURRICULUM

Committee:

Judith Treschuk, PhD, Chair
Ruth Grendell, DNSc, Committee Member
Ela-Joy Lehrman, PhD, Committee Member

Jeremy Moreland, PhD
Academic Dean, School of Advanced Studies
University of Phoenix

Date Approved: December 10, 2015
ABSTRACT

Nurse educators are barraged with competencies, standards, outcomes, and initiatives to consider when developing, evaluating, or revising curriculum. The constructivist grounded theory study discovered and compared the perceptions and processes of faculty related to their preparedness and confidence in evaluating, developing, and revising nursing curriculum. Faculty’s constructions were used to develop a middle range descriptive theory *Challenged and Overwhelmed*. From further faculty recommendations on strategies *Supported and Empowered: a Model of Understanding to Support Faculty’s Growth and Competence in Curriculum Development, Evaluation, and Revision* was created to support faculty’s growth and competence in curriculum development, evaluation and revision. Findings such as the low confidence found in most faculty, including the very experienced when it came to assessing curriculum, and the inadequate knowledge of curriculum as well as strategies discovered to benefit faculty are shared that assist faculty’s growth and competence in curriculum development, evaluation and revision. These strategies can be used to improve faculty development, educational strategies, and graduate education, resulting in better nurse educator preparedness.

Improving educational strategies through better competency will improve the nursing profession. Educator competency, preparation, the faculty shortage, standards, initiatives, and educational competencies and curriculum reform were reviewed. Quality information for educators is provided for evaluating and improving current nursing curriculum, and to guide strategic planning and facilitate nurse program success. Faculty perceptions of how to increase competence, and improve preparation for their role developing, evaluating and revising curriculum were shared.
DEDICATION

I dedicate my dissertation to my husband David Ginter, whose support and patience were essential for my sanity and well-being, and to my daughter Dr. Victoria Cummings. We are the first two doctors in our family. I thank God and my ancestor’s spirits that include my parents, and my husband’s parents, three of which died during the last five years, the angels who watched over me, and my friends who stuck by me when I had little time to share. You sustained my spirit. Without you I would not have succeeded.
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I also thank the remarkable nurse educators I had the privilege to interview. You are extraordinary men and women who work beyond what is expected or required. Though you had little time, you shared time with me striving to improve the profession. Your assistance was vitally needed, and together nurses make a difference
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Chapter One

Introduction and Overview

Nursing educators for BSN nursing programs must ensure that organizational goals, Department of Education requirements, Board of Nursing, and national accreditation requirements are met, and that student learning outcomes (SLOs) are used to organize curriculum. Nurses often become educators after experience in a clinical position that does not prepare them how to develop courses or evaluate curriculum, and reviewing the many guideline recommendations can be overwhelming (Anderson, 2009). Faculty are placed into leadership positions where they often feel unprepared to direct curriculum reform (Halstead, 2013). Confusion about types of competencies, most effective strategies to evaluate outcomes, and which best standards should be embedded in outcomes perplexes many educators as they consider curriculum learning outcomes. Research is insufficient regarding preparedness and confidence in developing, evaluating, and revising nursing curriculum.

The Advisory Group (2008) performed a survey of 3,239 leaders that inquired if overall, new nurse graduates were prepared to provide safe and effective care in hospitals, and discovered that 90% of the nurse school leaders believed graduates were prepared; yet only 10% of the hospital nurse executives believed the graduates were prepared. Some of these same graduates will go on to become faculty, and their clinical experience is unlikely to prepare them to evaluate curriculum. In similar fashion, faculty and program administrators may have differing perceptions of what provides the best curriculum for students. Gebbie, Hutton and Plummer (2012) note there is a wide array
of competencies to choose from, and a lack of congruence regarding the most necessary core competencies and how to ensure all nurses achieve them. Webster (2001) noted that accreditation mandates and educational reform created new curriculum reform guidelines for community colleges, resulting in a need to revise templates and prepare facilitators to assist with faculty development. At the course level faculty learned to define SLOs, and at the program level curriculum committees defined learning outcomes and aligned courses with intended program outcomes (Webster, 2001).

Confusion about criteria confuses many educators who must tie course outcomes to program outcomes that shape new practitioners. There are many choices of competencies to consider for BSN programs. Pre-licensure Quality and Safety Education for Nurses (QSEN) (2012) competencies are available. Nurse of the Future core competencies are available. There are the Essentials of Baccalaureate Education and the 2010 National League of Nursing competencies for graduates of baccalaureate programs as well as the Competency Outcomes and Performance Assessment (COPA) competencies and more options to consider. Additionally, there are now multiple national nursing accreditation bodies to choose from. There are three national nursing accreditation possibilities in America that utilize different standards: Accreditation Commission for Education in Nursing, Inc. (ACEN), previously known as the National League for Nursing Accrediting Commission Inc. (NLNAC), the Commission on Collegiate Nursing Education (CCNE), and now the new accrediting organization from the National League for Nursing (NLN) that plans to incorporate the NLN core values of caring, integrity, diversity, and excellence and meet Department of Education criteria (NLN, 2013 August).
If a program is using CCNE for accreditation, the Essentials of Baccalaureate Education for Professional Nursing Practice written by the American Association of Colleges of Nursing (AACN) Task Force (2009) must be incorporated. NLN wants to include core values, and ACEN’s (2013) six standards with specific criteria allow for multiple nursing professional standards to be used in student learning outcomes (SLOs) as long as they are approved by a nationally recognized nursing organization. Hence an innovative program might want to use an amalgamation of standard and competency criteria, gleaning the best from each, though the criteria must be agreed upon by faculty and align with organizational values.

If a program incorporates values from a different accreditor, an educator could fear that a different guideline from a competing organization might influence the attitude of the accreditor evaluating the program in a negative way. For example, using NLN standards for an ACEN review might be perceived negatively due to their recent breach when ACEN attempted unsuccessfully to annul contracts the NLN and NLNAC (now ACEN) agreed to over 10 years ago (NLN, 2013). New faculty may be inundated with their teaching responsibilities, and not be aware of the need to evaluate curriculum using national guidelines until required to assist with preparation for an accreditation review. If a new program is begun, accreditors require faculty to assist in deciding what outcomes and competencies to use, and ongoing accreditation requires faculty input (CCNE, 2013; ACEN, 2013). The result may be that programs settle for the least difficult way to become accredited, and will select curriculum developed by accreditors rather than innovative faculty input.
Chapter one will involve an exploration of background information regarding faculty perceptions and preparation of nurse faculty in the area of curriculum development, evaluation, revision, leading to the problem. The faculty shortage, requirements of accreditors and national professional organizations, expertise requirements, the current nursing situation, and changing competencies influence nurse educator role requirements. Additionally, the purpose of the study is clarified, and research questions are proposed. The NLN (2002) position statement verified that the nurse educator role required specialized preparation, and that being a good clinician was important, but clinician skills were not sufficient preparation for the educator role (NLN, 2002). Iwasiw, Andrusyszyn, and Goldenberg (2009) revealed that few recent master’s or doctoral prepared graduates have preparation in curriculum development; hence, faculty may be ill-prepared to take on curriculum development or competently achieve their educator role. This dichotomy is the beginning of the conundrum.

**Background of the Problem**

National nursing accreditation organizations mandate that BSN nurse faculty must, in addition to teaching and scholarship duties, contribute to, develop, and evaluate nursing curriculum (ACEN, 2013; CCNE 2013); however, faculty may be unprepared to develop or evaluate curriculum, as this is not a part of usual nurse clinical practice (Anderson, 2009; Duffy, 2005). Many faculty are recruited from higher paying hospital roles, where they may have excellent clinical skills, but little or no experience developing nurse curriculum or new courses. Education regarding curriculum received by nurse faculty varies, though most Boards of Nursing require that BSN faculty be Masters
prepared. ACEN requires a minimum of a Master of Science in Nursing for faculty (ACEN, 2013). CCNE states that faculty be experientially and academically prepared, and that teachers hold a graduate degree (CCNE, 2013). Bartels (2007) notes that Master’s level education focuses on the development of teaching skills. Curriculum development is not a main focus. Bartels (2007) also revealed that Doctor of Nursing Practice (DNP) emerged to address the need for more highly educated nurses. However, the DNP focuses on clinical practice, rather than curriculum development (UNMC, 2013).

Faculty are often hired for clinical expertise, rather than their educational preparation (Anderson, 2009; Barth, 2003; Hewitt, & Lewallen, 2010). Gilbert and Womack (2012) confirm that most faculty entering academia were clinical practice experts, but only novices at education. Clinical expertise was defined by McHugh and Lake (2010) as a mixture of practical and theoretical knowledge, where expert clinical nurses have an intuitive grasp of situations, recognizing potential problems before they occur. The resulting difficulty is that faculty with a background or focus in clinical practice may perceive themselves as less-equipped to evaluate curriculum in the academic setting, yet curriculum review and development is part of the expected faculty role. It is difficult to learn the role of curriculum evaluator without guidance, and a new instructor must learn the new skill in addition to new teaching roles on top of other required work.

It is not difficult to be confused by the variety of choices that can be used as national guidelines for learning outcomes if the faculty member is inexperienced at developing courses, or evaluating curriculum. If the faculty member has not received
specific education on how to develop courses or evaluate curriculum, nursing leadership will need to further educate faculty that may already be teaching full-time, and have scholarship or other college service obligations. This can lead to stress due to lack of time or other factors (Weidman, 2013). Reece, Mawn, and Scollin (2003) reported that despite years of planning change and faculty approval of curriculum revision, during transition many faculty, including seasoned faculty, reported stress, and there was a large faculty turnover during curriculum change. Faculty development takes time and resources. Full-time faculty may not have time for additional educational preparation. When resources are minimal, there may not be excess funds that allows for further faculty development. Programs may settle for the easiest and least expensive way to become accredited, rather than identifying strategies for best practice, highest quality, or developing innovative curriculum.

Barth (2003) observed that nurses would never think of allowing someone to practice as a nurse practitioner without a sound knowledge base and highly developed skills, yet constantly individuals are allowed to practice as nurse teachers with only cursory knowledge and skill in teaching, curriculum design, program evaluation, outcomes assessment, and accreditation strategies. There is reduced benefit perceived by nurses to become educators that develop the best curriculum and most effective education strategies for Registered Nurses (RNs) returning for their baccalaureate degree at a time when the Institute of Medicine (IOM) (2010) is encouraging seamless pathways of transition to facilitate higher nurse education levels. Skill developing curriculum traditionally receives little or no credit toward promotion or tenure decisions (Iwasiw Andrusyszyn, & Goldenberg, 2009).
Choudhry (1992) performed a survey of full-time university and college faculty in Ontario that showed a sound knowledge base for curriculum development, implementation, and evaluation was one of three essential teacher competencies that faculty agreed was necessary with educational preparation. Yet Davis, Dearman, Schwab, and Kitchens (1992) found in their study that faculty perceptions were that new nurse faculty were not educationally prepared for their role. The NLN Board of Governors (2002) ten years later commented in their position statement regarding the preparation of educators, that nurse faculty needed to be better equipped for their role, which required specialized preparation. Bouchard (2011) found that curricula still did not prepare nurse faculty well. The call to improve curricula had not been heeded. After performing research on 20 nurse educators, Schoening (2013) recommended that nurses interested in the academic setting should take courses in curriculum design, as some enter academia without preparation, and faculty development is needed. Halstead (2007) confirmed that the ability to design and evaluate curriculum is a needed competency for nurse educators.

The National Advisory Council on Nurse Education and Practice (NACNEP)(2010) reported that a survey of nursing programs demonstrated that 76.1% of respondents attributed the need to turn away qualified applicants was due to the shortage of faculty. Some factors contributing to the faculty shortage include additional time, tuition, and loan payback incurred by obtaining a graduate degree, changing role expectations, intense faculty workloads, increasing demands for scholarship and service, and comparatively low salaries for master’s prepared nurse educators as compared to clinical nurse clinicians (NACNEP, 2010).
Holt-Waldo (2011) noted that despite good intent, there has been a lack of revision related to incorporating holistic curriculum, and she stressed the importance of how information was taught, not just what was taught. Faison and Montague (2013) noted the need for faculty to restructure content efficiently while still retaining essential components that prepare new graduates for practice. Revising of their Associate of Science in Nursing (ADN) curriculum resulted in time management issues, as teaching, service, and scholarly expectations were still expected, when working with a consultant, viewing webinars and added instruction.

Nursing education is at a crossroads. Nursing instructors can no longer provide only content and basic instruction of how to care for patients. Educators protect the public by insuring that graduates are competent to practice, and that their program produces high quality graduates that perform safely. Nurse educators must be competent in curriculum development, evaluation, and revision. Competence of nurse educators in curriculum development and evaluation is basic to creating an educationally robust curriculum (Iwasiw Andrusyszyn, & Goldenberg, 2009). Incompetently created curriculum could be disastrous for the nursing profession, and for the public all nurses have sworn to protect. Current curriculum for effective education strategies must incorporate evidence-based best practice. The NLN (2005) has called on educators to appraise teaching methods and conduct research on curriculum. Preparation in the area of developing, evaluating, and revising nursing curriculum may be lacking, and assessing faculty perceptions of their preparedness and confidence in their role will provide evidence to build a model of understanding that will support faculty’s growth and competence in curriculum development, evaluation and revision.
The Associate Degree in Nursing (ADN) remains the most common initial nursing education degree (NCSBN, 2011; NCSBN 2012; NCSBN, 2013). According to the National Council of the States Boards of Nursing (NCSBN), in 2011, 57% of nurses taking the National Council Licensure Examination (NCLEX) for the first time were ADN prepared while 40% were Baccalaureate of Science in Nursing (BSN) prepared, and less than 3% were Diploma prepared. In 2012 out of 150,266 applicants taking their NCLEX the first time 56% were ADN prepared, 41.6% were BSN prepared, and 2% were Diploma prepared (NCSBN, 2012). It has been the trend for more than ten years that the majority of nurses who take the NCLEX in America are ADN prepared, and with the Institute of Medicine (IOM) (2010) recommending that 80% of nurses should be Baccalaureate of Nursing Science (BSN) prepared by 2020, it is critical for educators to create the best curriculum possible for these students. In addition, as baby boomers age and retire, the shortage predicted of one million RN’s by 2020 (ANA, 2010) must be addressed. Nursing programs must strive continually to improve the quality of nurses and the nursing profession. Faculty educators identify the core competencies and student outcomes for their program. These should be educated decisions.
Problem Statement

There is a lack of knowledge regarding the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and a model of understanding supporting faculty’s growth and competence in curriculum development, evaluation and revision is needed. Faculty may be unprepared to develop, evaluate, or revise curriculum, as this is not a part of usual nurse clinical practice, and educational preparation is inconsistent. There is a need for strategies to be provided by nursing leadership and education to benefit nurse educators who evaluate, develop, and revise nursing curriculum.

Purpose Statement

The purpose of this study was to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding supporting faculty’s growth and competence in curriculum development, evaluation and revision. Additionally, strategies were unveiled to assist faculty’s growth and competence in curriculum development, evaluation and revision. It is a college requirement that nurse faculty will evaluate course outcomes, student outcomes, and develop program outcomes as these are accreditation requirements (ACEN, 2013). Yet it is questionable that faculty feel adequate to complete these tasks, especially while concurrently teaching classes and/or clinical and performing other required roles, such as advising, leading committees, research or other scholarship activities when descriptors during transition to the educator role used are overwhelmed.
and drowning (Anderson, 2009). There was a lack of research on faculty preparedness and confidence in developing, evaluating, and revising curriculum.

**Significance of the Study to Nursing Education and Nursing Practice**

The knowledge gained from the study increases the understanding of perceived needs and deficits of nurse educators, and provides data for a model to support faculty developing, evaluating, or revising curriculum. Additionally, information concerning strategies to benefit nurse educators who evaluate, develop, and revise nursing curriculum was discovered. The knowledge can be used to improve faculty development, and graduate education curriculum resulting in better nurse educator preparedness. New knowledge improves educational strategies to better prepare faculty for curriculum development. The research findings provided information to improve the development, evaluation, and revision of curriculum in nursing education. Improving educational strategies through better competency and outcome choices improves the nursing profession.

Quality information to guide curriculum for students completing their BSN is needed to reduce the gap between education and practice and to encourage innovative global and community strategies. Programs and their directors need competent faculty to guide strategic planning and facilitate nurse program success. The study provides quality information for educators creating BSN programs, or evaluating and improving current nursing curriculum. It will also benefit students returning for higher education. If faculty are better prepared for their role, they may be less overwhelmed, and more faculty will remain teaching and able to evaluate and design curriculum competently.
Nature of the Study

Exploring and comparing the perceptions and processes of educators regarding their preparedness and confidence in developing, evaluating, and revising curriculum requires a design focused on comparison. Constructivist grounded theory not only looks at how participants view their experiences, but theorizes and interprets their compared views (Charmaz, 2006). Grounded theory uses comparison, experienced participants, and tends to use a non-probability sample, so was most appropriate for the study.

The constructivist grounded theory design based on the work of Charmaz (2006) revealed faculty perceptions of their ability to develop, evaluate, and revise nursing curriculum. Grounded research is useful for focusing on similarities and differences, and contrasts, using non-probability sampling (Cutcliffe, 2000; Benoliel, 1996). The perceptions and experiences of different faculty were categorized and compared to create a model and theorize. Data collection was done via semi-structured interviews. Charmaz (2006) noted that in constructivist grounded theory, an assumption of researchers is that data and analysis are social constructions reflecting the result of their production, with the analysis contextually situated in the culture, time, and situation. Ghezeljeh and Emami (2009) agreed and further noted that due to facts and values being linked, researchers should attempt to be aware of their presuppositions.

Ajjawi and Higgs (2007) stated that research developed to understand the nature of the phenomenon of learning to communicate clinical reasoning from the experiences of people in clinical practice can be used to provide exploration of participants’ experiences with an interpretive element to extract meaning the participants may have difficulty articulating. Hence, qualitative research is useful to articulate and interpret
perceptions of experiences that nurses may have difficulty articulating, and grounded theory is useful to compare categories of information extracted from experiences.

In constructivist grounded theory, the ongoing interaction between the participant and researcher is what constructs data, with the researcher’s interpretation of how participants create their meaning and understanding of reality a result of the analysis (Ghezeljeh & Emami, 2009). Research findings inform practice by discovering themes and common experiences experienced by nurse faculty who develop and/or evaluate curriculum for BSN programs. The perceptions of faculty and their confidence were discovered and compared, along with ideas for strategies to support and benefit faculty who develop, evaluate or revise curriculum. Evidence informed knowledge to develop theory, and a model to support faculty’s growth and competence in curriculum development, evaluation and revision.

**Research Questions**

The goal of this study was to discover the perceptions of faculty preparedness and confidence in the development, evaluation, and revision of nursing curriculum. Through this understanding of faculty constructions, a substantive theory describing faculty preparedness and confidence and successful curriculum development was generated. The research questions were:

1. What are the perceptions of nursing faculty regarding their preparedness and confidence for developing, evaluating, and revising curriculum?
2. What strategies by nursing leadership and education might benefit nurse educators who develop, evaluate and revise nursing curriculum?
Excellence Framework

The purpose of nursing education is to improve the health of the nation via improving patient care (NLN, 2012). For patient care to improve, nursing students need education that uses sound curriculum to incorporate clear student learning outcomes (SLOs) on how to provide quality care. ACEN (2013) described the curriculum standard as preparing students to achieve the SLOs and program outcomes of the educational unit supporting safe and current practice in healthcare. The curriculum, which must be developed by faculty, must further incorporate professional standards and competencies, with SLOs used to guide delivery of instruction as well as the evaluation of student progress (ACEN, 2013). Educator preparedness is a component of the NLN (2006) Excellence in Nursing Education Model that discusses educator competence, hence the NLN (2006) Excellence Model is the framework used (Figure 1).

The Excellence in Nursing Education Model (NLN, 2006) is comprised of eight areas:

1. Clear Program standards and Hallmarks that Raise Expectations
2. Recognition of Expertise
3. Student-centered Interactive Innovative
4. Well-prepared Faculty
5. Quality and Adequate Resources
6. Evidence-based Programs and Teaching Evaluation Method
7. Well-prepared Education Administrators
8. Qualified Students
Figure 1. NLN (2006) Excellence in Nursing Education Model that depicts the eight core elements required to sustain excellence in nursing education developed by The National League for Nursing (2006). Used with Permission from NLN.
Excellence in education is comprised of all eight areas. In the area of the model termed well-prepared faculty, the topic breaks down into three areas for excellent well-prepared faculty: expert researchers, expert clinicians, and academic leaders. Each of these areas breaks down further into multiple components. There are ten areas listed for the academic leader (see Figure 2). Within the area of academic leaders is curriculum design, implementation, and evaluation (NLN, 2006). Nurse educator competence requires becoming well prepared faculty in multiple areas, including the area of curriculum design, implementation and evaluation as well as evaluation methods. The different areas that an academic leader, for instance a nurse educator, should become competent in include:

- Evidence based teaching
- Advancing the profession
- Citizens of the academy
- Curriculum design, implementation, and evaluation
- Providing leadership to transform and re-vision nursing education
- Mentoring neophyte educators
- Building the science of nursing education
- Teaching skills for diverse groups of learners
- Advisement and counseling skills
- Skills with evaluation methods for both programs and individual learners

(NLN, 2006; NLN, 2012)
Figure 2. Excellence in Nursing Education Model subsection that displays the core component Well-prepared Faculty from the NLN Excellence Model (NLN, 2006). Used with Permission from NLN

Johnson, Aasguaard, Wahl, & Salminen, (2002) noted that nurse educator competence is important to the quality of the nursing education received, especially during times of reform. Reform is occurring, as evidenced by the discussion of outcomes and competencies in Chapter two, and IOM (2010) recommendations. A basic set of requirements for educator competency seem to remain constant, and these requirements include: nurse educator competence in theoretical and practical nursing, teaching, evaluation, interpersonal relationships and personal traits (Johnson, Aasguaard, Wahl, &
Salminen, 2002). Domains in nurse educator competence used by these researchers included: nursing competence, evaluation skills, teaching skills, personality factors, and student relationships (Johnson, Aasguaard, Wahl, and Salminen’s (2002) research. Kalb (2008) discussed the Core Competencies of Nurse Educators with Task Statements, published by the National League for Nursing (NLN) in 2005, and how they can be used to prepare nurse educators and evaluate their practice; hence, advancing education and lifelong learning could transform future nurse education. The competencies outlined by the NLN (2005) include: eight core competencies:

1. Competency I: Facilitate Learning
2. Competency II: Facilitate Learner Development and Socialization
3. Competency III: Use Assessment and Evaluation Strategies
4. Competency IV: Participate in Curriculum Design and Evaluation of Program Outcomes
5. Competency V: Function as a Change Agent and Leader
6. Competency VI: Pursue Continuous Quality Improvement in the Nurse Educator Role
7. Competency VII: Engage in Scholarship
8. Competency VIII: Function within the Educational Environment

(Kalb, 2008; NLN, 2005)

Competency IV is listed in detail in Appendix D as curriculum is the central to the current research.

Reece, Mawn, and Scollin (2003) noted that faculty who are seasoned in teaching do not necessarily have proficiency in curriculum development, probably due to lack of
educational preparation. Fitzpatrick (2014) observed that expert clinicians enter educator roles with minimal understanding of the expected skill set, and currently only 25% of nurse educators nationally are doctoral prepared. George (2011) notes that Benner takes the stand that theory arises from practice, and practice impacts theory that changes practice. From the practice of education, researchers examine theory that emerges from research, which will affect practice. Kantar (2012) noted that novices have difficulty with transition, and Moore and Cagle (2012) agree that novices need mentoring to become competent professionals that feel prepared to practice. Mentorship of nurse educators could be lacking in curriculum development, evaluation, and revision. If nurse educators lack the ability to be an engaged curriculum evaluators or developers as they do not have many experiences developing, evaluating, or revising curriculum, the resulting curriculum may suffer. NLN (2005) Competency Four specifies that nurse educators have a responsibility to design curricula that prepares graduates to function effectively complex, changing, multicultural healthcare environment. Furthermore, Competency Four states that to participate effectively in developing, evaluating, and revising curriculum, the nurse educator is responsible for basing curriculum design on sound educational principles, developing competency statements, identifying student and program outcomes, and revising curriculum, and far more (NLN,2005). Curriculum does not remain static, but must be dynamic to remain current, and outcome types have also been shifting, making it more difficult to attain expertise in a flexing environment. Attaining competency in the faculty role in this area is essential for quality curriculum development, and faculty may require support.
The theoretical framework provides a structure that links the abstract to meaningful results, such as educator preparation required for an academic environment to become competent in the practice of developing, evaluating, and revising curriculum. Conceptual underpinnings used in the research need to be ontologically consistent. Increased understanding of the experience of faculty that evaluate, develop, and revise curriculum for BSN students is needed to inform knowledge for education. The NLN Excellence Model provides a framework for competence of the nurse educator that includes developing, evaluating, and revising curriculum.

**Concept Definitions**

**Competency**

Competency is generally defined as being capable and legally qualified to perform an act. Mosby’s dictionary of Alternative and Complementary Medicine (2005) defined competency as being sufficiently qualified to perform an action, possessing adequate knowledge, skills, training, and professionalism. Miller-Keane (2003) notes that competency involves the professional ability of the care provider to administer safe and reliable care consistently. In nursing, competent nurses must be both capable of performing nursing functions, and must be qualified legally by licensure to perform those actions or they would be practicing their profession illegally. Furthermore, the NLN glossary (2013) defines competency as a professional practice principle identifying expectations for safe, effective performance, whether it be a task, or a practice role. Competence is the application of knowledge, making decisions, and using physical skills to perform the task or role (NLN, 2013). The NLN (2006) Excellence in Nursing
Education Model specifies that educators should be competent in ten areas: evidence based teaching, advancing the profession, citizens of the academy, curriculum design, implementation, and evaluation, providing leadership to transform and re-vision nursing education, mentoring neophyte educators, building the science of nursing education, teaching skills for diverse groups of learners, advisement and counseling skills, and skills with evaluation methods for both programs and individual learners (see Figure 1).

**Curriculum**

Curriculum refers to the experiences, courses, and materials with which students will interact and be evaluated for the purpose of achieving student learning outcomes (SLOs). The Great Schools Partnership (2013) *Glossary of Educational Reform* confirmed that student knowledge and skills included in curriculum contained learning standards, and objectives, as well as assignments and lessons. The NLN (2013) refers to curriculum as interaction occurring in academia involving teachers, learners, and knowledge that is intended to accomplish goals identified by faculty, students, and the nursing profession. Nursing curriculum is the interaction involving educators, student learners and knowledge to accomplish the SLO goals that meet or exceed accreditation standards for the knowledge, skills, and attitudes needed by a professional registered nurse.

**Development**

Development refers to forming something over time into something more advanced. Benner (2011) refers to development of knowledge in nursing as being made of the extension of know-how through study and the understanding of the practical
knowledge of experience. In this context, development refers to the creation of curriculum, and identified SLOs.

**Evaluation**

Evaluation involves scrutinizing the curriculum for quality and alignment with SLOs when looking at the educational content. Curriculum evaluation is when faculty analyzes whether the curriculum is fulfilling its intended purpose, where students are actually learning the intended outcomes (Diflorio, Duncan, Martin, & Middlemiss, 1989). A program evaluation gauges whether intended program SLOs have been met by program completion, and a course summative evaluation assesses whether students learned expected course objectives and skills by course completion, which is best done in an organized way (Bastable, 2008). The NLN (2014) discussed the need for curriculum evaluation strategies to be innovative, evidence-based and varied, promoting interaction between faculty and students.

**Revision**

Johnson (2001) specified that effective curriculum revision involved curriculum review, rewriting and establishment by faculty using the program; furthermore, administrators should be involved, and faculty needs strong support, feedback, and discussion. The process of revision first involves recognition that revision is needed, which can be identified by many stakeholders such as administration, employers, advisory boards and faculty. Changing accreditation standards, lack of curriculum alignment, philosophy changes, and adding new resources are a few reasons for potential curriculum reform (Great Schools Partnership, 2013). The impetus for change leads to
buy-in for potential change, and identification of program outcomes from data. The current data were compared to desired data, then gaps or needs are identified and actions considered with a plan that takes into account outcomes and current capacity (Eberly, 2013).

**Student Learning Outcome**

A Student Learning Outcome (SLO) is defined taking the Accreditation Commission for Education in Nursing (ACEN, 2013) glossary context. An outcome is a statement reflecting achievement of identified goals. Learning outcomes are measureable student oriented capabilities. An SLO is an outcome that expresses what the students will know, do or think by the end of their learning experience.

**Limitations and Delimitations**

**Limitations**

Limitations of the study included a sample drawn from a limited geographic region where educators are located, selected and interviewed. The sample is a purposive sample, as educators with experience developing and evaluating curriculum are needed. Faculty from four colleges were used. As only Vermont colleges were used, the study can be generalized to similar colleges, but may differ from urban populations, although some generalizations may be possible to faculty or curriculums that adhere to similar standards.

There are a number of limitations:

- Participants were obtained through purposive sampling
- Participants were limited to Vermont
Sample size was 15

Limitations define applicability limits, and due to the size, sample type, and limited geographic region, the study cannot be considered to be representative of the general nurse population. Historically, in 2012 the Affordable Care Act was upheld by the Supreme Court, and a severe nursing shortage is predicted within ten years (ANA, 2010). A decrease in the faculty pool, and nursing numbers could impact the ability to recruit faculty, making it more difficult to find quality in educators. The Institute of Medicine’s (2010) recommendation encouraging more nurses to seek higher education could have an impact by having more nurses continue their education, thereby potentially increasing their preparedness.

Assumptions

The first assumption was that nurse educators would provide honest responses. Identities of participants were concealed and confidentiality was preserved, and a nonjudgmental environment was maintained, so educators could be authentic. A second assumption was that participants in the study had the experience they claimed to have, a year of experience developing, evaluating, or revising curriculum as well as had interest in the subject. Participants needed expertise and to be honest to answer the questions accurately. The interview questions revealed the participants had the needed expertise to answer, as they referred to expert terms known to experienced educators.

A third assumption was that information in the literature review was reliable. To confirm findings, or find disconfirming evidence, accurate literature is necessary. The study was able to confirm many research findings. The last assumption acknowledges that constructivist grounded theory approach rejects the existence of an objective reality.
Instead the constructivist approach views data and analysis as created from shared experiences with participants in their time, place and culture (Ghezeljeh & Emami, 2009). Multiple realities exist as reality is a social construct shared between the participant and researcher. Meaning is constructed in different social contexts; hence, participants did not all share the same view.

The scope of the study was guided by the problem that was identified in the research, lack of knowledge regarding the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum. The purpose was to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding supporting faculty’s growth and competence in curriculum development, evaluation and revision. Additionally, supportive strategies to assist faculty’s growth and competence in curriculum development, evaluation and revision were revealed. The purpose identified development of confident nurse educators well-prepared to undertake curriculum development, evaluation, and revision as the general scope.

**Delimitations**

Delimitations defining boundaries and study scope include that the participants chosen were limited to experienced registered nurse educators in Vermont. Experience developing and evaluating curriculum was necessary. The majority of nurse educators of BSN programs were expected to be Masters prepared educators, as this is the minimum requirement by the Vermont Board of Nursing.
Summary

Greater understanding of faculty preparedness and confidence related to curriculum development, evaluation, and revision is needed to inform the nursing profession. Faculty may initially be unprepared to develop, evaluate, or revise curriculum, especially when coming from clinical backgrounds with variable education while trying to learn to teach full-time (Anderson, 2009). Nursing educators need to be competent at developing and evaluating curriculum (Choudhry, 1992, NLN, 2005). The research findings inform the nursing profession of faculty perceptions of nurse educator preparedness and confidence regarding curriculum development and evaluation.

Chapter two contains a historical overview, an extensive review of the literature, and will delve into specific concerns related to faculty preparation. The curriculum development revision movement, the effect of the faculty shortage, and the preparation required for the nurse educator will be reviewed. Educator competency in curriculum, such as the ability to write different student learning outcome types, and knowledge of national nursing standards are used as examples of knowledge areas needed by educators in order to develop curriculum. Responses to curriculum reform by educators participating in curriculum development and evaluation are dissected to evaluate what is known about faculty who develop, evaluate, and revise curriculum.
Chapter Two: Literature Review

Chapter two includes known information about current educator preparation for developing, evaluating, or revising curriculum. The historical background provides detailed background information for comprehensive understanding. McCreadie and Wiggins, (2009) noted that performing a literature review in grounded theory is controversial due to debates regarding knowledge forcing preconceived ideas onto data, versus letting theory emerge; however, the nurse educator role is an area requiring specialized knowledge (NLN, 2013), and historical and current knowledge are relevant to context and understanding. Educator competency and concerns regarding adequate educator preparation are explored. The impact of the faculty shortage and economics are reviewed.

Nurse educators are barraged with competencies, standards, outcomes, and initiatives to consider when developing, evaluating, or revising curriculum. Additionally, educators must distinguish between content-based, outcome-based, and concept-based outcomes. Nurse clinicians in acute or long-term care are unlikely to be familiar with the multitude of competencies as they are caring for patients rather than creating curriculum outcomes. Faison and Montague (2013) found that curriculum revision involved extensive literature review and faculty needed to implement a comprehensive curriculum analysis to prepare for new curriculum. A curriculum expert was needed to train faculty about nursing curriculum, and continuous curriculum evaluation. Learning how to use student learning outcomes (SLOs) to guide curriculum is a skill that many faculty must learn on the job when working full-time teaching that may take years to perform with skill and expertise.
Cronenwett (2011) reported that the gap between nursing practice and education remains, with a 2008 survey reflecting that 39% of novice nurses do not feel they were well prepared for practice. It is a responsibility of educators to provide and encourage quality education to prepare nurse leaders of tomorrow, and in order to achieve that goal, accurate development, evaluation, and revision of curriculum is necessary. West, Griffith, and Iphofen (2007) also recognized the importance of creating strategies to bridge the gap between education and practice.

In 2010 the Institute of Medicine (IOM) recommended that 80% of nurses should be BSN prepared by 2020, with an imperative national priority to create seamless paths for ADN prepared nurses to complete BSN preparation before Baby Boomers retire when the nursing shortage is predicted to reach one million RN’s by 2020 (ANA, 2010). The same year the Tri-Council for nursing, comprised of four key organizations that drive the nursing profession (AACN, ANA, AONE, & NLN) issued a statement entitled Education Advancement of Registered Nurses saying it was critical for nurses to advance their educations, for without a more highly educated workforce, the nation’s health would be at risk (Tri-Council, 2010). This entails creating seamless curriculum.

Nurses are the largest single group of healthcare providers on the frontline disseminating healthcare (Smith, 2012; ANA, 2012). The United States Bureau of Labor Statistics (BLS, 2011) documents that as of May 2011, there were 3,453,710 nurses (2,724,570 RN and 729140 LPN/Vocational), and there were 305,590 physicians and surgeons. That translates as 11 nurses to every physician. Still, nursing school enrollment is not keeping up with the nurse need (AACN, 2014). In 2000 the supply of Registered Nurses (RNs) was only short by 6%, but by 2020 it is expected to grow to 36%
In 2009 the Bureau of Labor Statistics projected that over a half million new nursing jobs would be created through 2018. However, in 2008, 49,948 qualified nurse candidates were refused entry to baccalaureate and graduate nursing programs, and insufficient prepared faculty was cited as a major contributing factor (NACNEP, 2010). Guttman, Parietti, Reineke, and Mahoney (2011) stated that in 2009 54,991 qualified candidates were refused entry to nursing programs because of the faculty shortage. In the 2011-2012 school year U. S. nursing schools turned away 75,587 candidates, and in the 2014 the schools turned away 68,938 qualified applicants, with nearly two-thirds of nursing schools citing lack of faculty as a major contributing factor (AACN, 2014). The rising trend of turning away increasing amounts of qualified candidates was each time related to lack of nursing faculty.

In addition to the difficulty finding adequate numbers of qualified faculty, factors such as increased teaching loads; increasing demands for scholarship and service, comparatively low salaries for master’s prepared nurse educators as compared to clinical nurse clinicians after needing to take out a loan for education, contribute to the increasing faculty shortage due to increasing dissatisfiers in the educator role (NACNEP, 2010). Junior faculty dissatisfaction with workload was approximately 55%, and faculty put in extended hours advising and mentoring students, updating curricula, developing new courses, reading, mastering technology, with 73% of faculty feeling frustration due to lack of time to complete work (AACN, 2005). Zungolo (2008) shared that transition from clinician to faculty can be challenging, and though a clinician may be an expert in clinical they may not possess teaching skills or the ability to organize content. Rich and Nugent (2010) noted that adequate preparation to decrease stress and frustration are
needed, as novice faculty may become disillusioned and require mentorship. They further noted new faculty members were entering academia with insufficient preparation to teach nursing, and that educational content would better prepare aspiring teachers to enter academia and increase interest in teaching. Faculty employers complain that faculty applicants may know about their clinical specialty, but do not have courses in curriculum, and lack skill in writing objectives, student communication, curriculum, and deciding what is important for student learning (NACNEP, 2010).

**Title Search**

An extensive literature search for scholarly journals was completed using the search engines of Academic Search Complete, CINAHL Complete, MEDLINE Complete, and Education source. EBSCOhost and ProQuest were used, and the Books, Dissertations, and Theses section of the University of Phoenix online library. Multiple web searches and Google Scholar were also used. Keys word searches included curriculum, faculty, nursing, nurse, education, curriculum development, BSN, constructivist grounded theory, educator, perceptions, and competency, and multiple combinations of these words were used.

Information from over 100 articles and 20 books were accessed as well as government reports. The year was limited to the last ten years and greater emphasis on the last five, with the exception of classical references such as Glaser (1967) or Lenburg (1999), or references to historical initiatives, such as NLN or IOM initiatives. Studies were not limited to America, so Canada and Australia were some countries represented in
the research. Themes such as educator competency, standards, initiatives, and educational competencies, and curriculum reform with faculty response emerged.

**Historical Overview**

Stokowski, (2011) noted that in the 1880’s nursing education entailed learning about dressings, enemas, ventilating sick rooms, cleaning utensils, and would take over two years, seven days a week doing 12 hour shifts with one afternoon off per week with only education as salary, practice taking 90% of your time, and evenings spent attending lectures by supervisors or physicians. In the more modern era nursing education followed an apprenticeship model where students took care of patients under the supervision of senior nurses. In 1917, the National League for Nursing Education published their first standard curriculum for schools of nursing (Stokowski, 2011). Fondiller (2001) noted it was during the late 1950’s that RNs began being directly admitted to undergraduate programs, and by 1964, 26 programs were approved by the National League for Nursing (NLN) to admit graduate nurses; therefore, the Council of Baccalaureate and Higher Degree Programs (CBHDP) started to question the evaluation processes of nurses admitted to BSN programs, and a resolution was passed in 1965 encouraging college-based nursing programs. Prior to 1960, curriculum design was content focused, with the instructor imparting knowledge to students who passively received knowledge (Webster, 2001). By 1962 Mager, as well as others, introduced behavioral objectives, and education began to move to a learner focus; at this point curriculum design began to shift away from content, instead identifying what the learner
could do at the end of instruction with instructors checking off lists of objectives or competencies (Webster, 2001).

Since the 1980’s the nursing profession has discussed the need for more highly prepared nurses, yet the ADN has continued to be the entry point for the majority of nurses (NCSBN, *NCLEX pass rates*, 2001-2013). Nursing curriculum was organized around medical nursing, surgical nursing, maternity nursing, and pediatrics, with students also learning ethics, psychology, professional issues, and history of nursing, with electives in public health or administration, and curriculum specifying that nursing was a profession. Starting in 1979, there was a 16 year decline in nurse educator enrollment that continued until 1995, but enrollment trends reversed with nurse educators going from 2% of enrollment in 2002, to 18% by 2009 (Ruland & D’ Meza Leuner, 2010).

College-based nursing programs and baccalaureate degree nursing students had the benefit of a university or college to supplement their education with core nursing curriculum revolving around the traditional medical specialties of medicine, surgery, obstetrics, pediatrics, and mental health (Stokowski, 2011). In 1988, the NLN was trying to break nursing schools loose from traditional, content-laden, lecture-and-test nursing education. In 2003, the IOM warned against the use of overcrowded content saturated curriculum. In *Curriculum Revolution: Mandate for Change*, nursing leaders called for an overhaul of nursing education that would change the way nursing was taught and learned; however, for 25 years, nurse educators updated the curriculum without changing the essence of the curriculum itself or the educational paradigm (Stokowski, 2011). Stanley and Dougherty (2010) noted curriculum had shifted from content laden to key concepts, with students focusing on essential contents, further noting that nurse
educators can no longer teach how they were taught. Nursing educators were shocked into the final realization that content could no longer be the focus when in fall 2012, Stanford, Harvard and Massachusetts Institute of Technology provided free online classes reaching millions through edX (Agarwal, 2012; NPR, 2012). Technically savvy students have abundant content available at their fingertips. Students can evaluate college pass rates, class descriptions, cost, and alignment with student values and interests online.

In the 1990’s outcome-based accreditation criteria was introduced and the shift from passive lecturing of content to active collaborative engagement of students to develop competency began in earnest, and the NLN Accreditation Commission (NLNAC) was created in 1996 as a response to recommendations from the U.S. Department of Education (Lenberg, 1999, Redesigning). Instead of focusing on a list of tasks, or objectives, the outcome focus looked at the knowledge, abilities, and attitudes of the learner. There was a shift away from preparing nurses for faculty roles, as graduate education was progressively more dedicated to preparing nurse practitioners (Ruland & D’ Meza Leuner, 2010). Late in the 1990’s the American Association of Colleges (AACN) was created and published the 1998 Essentials of Baccalaureate Nursing Education Practice, and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) required validation of competency of health care providers for institutions to be accredited (Lenberg, 1999, Redesigning). In 1998, the Essentials of Baccalaureate Nursing Education Practice five core values included human dignity, integrity, autonomy, altruism, and social justice (Fahrenwald 2005). In Health Professions Education: A Bridge to Quality (National Research Council, 2003), discussed the Core Competencies Needed for Health Care Professionals that listed outcomes such
as patient-centered care, interdisciplinary teamwork, evidence-based care, leadership, and improving quality that evolved from 21 PEW Competencies, noting that faculty shortages and lack of preparedness were barriers to implementing the core competencies.

In 2003, the NLN again advocated renovation of nursing education, and innovative pedagogies to help students learn to practice in rapidly-changing environments. Graduating nurses would lead health promotion and disease prevention, function in complex and unpredictable environments, demonstrate critical reasoning and flexibility, and execute a variety of roles throughout their nursing careers. The new approach would have relevance for the community-based, multidisciplinary patient care delivery systems of the future. By 2009 the Future of Nursing, a joint project of the Institute of Medicine and the Robert Wood Johnson Foundation, began a review of the nursing profession by holding three national forums, one of which focused on nursing education. Participants in the forum were led by Michael Bleich, RN, PhD, Dean of the Oregon Health & Science University School of Nursing and considered needed innovations for ideal future nursing curricula, such as teaching strategies, methods, and where nursing education would occur (Stokowski, 2011).

Nurses became aware of the importance of knowing how students learn best, and helping people live their lives to the fullest extent possible, with nurses performing at a higher level, participating and contributing to the quality and safety agenda of the organization. Nursing education became more than teaching students to perform tasks and learn content, but was about applying concepts, assessing use, and managing knowledge, with the public desiring optimal competency from nursing professionals (Stokowski, 2011). The focus of education has moved away from being content driven,
to assuring competency, yet curriculum developers still faced a multitude of alternatives that must conform to national accreditation standards.

The NLN (2007) encouraged nurse educators to achieve excellence by creating environments that enhanced student learning and professional development advancing the science of nursing education. NLN observed that for educational programs of the highest quality to occur, core elements including clear program standards, and evidence-based programs with teaching evaluation methods were needed as well as collaboration with students and clinical partners to ensure innovative evidence-based nursing education (NLN, 2007). In their competency model, the NLN (2010) noted that ADN graduates examine evidence underlying nursing practice, challenging the status quo and underlying assumptions and offering new insights to advance the quality of care, while BSN graduates contribute as scholars to advancing nursing practice, identifying questions, critiquing research and using evidence as a basis for practice. The NLN (2010) recognized that nurse educators require far more specialized knowledge.

The NCLEX measures minimum competency for practice; however, The National Council of State Boards of Nursing (NCSBN) concluded through its own research that passing an initial examination for licensure does not ensure continued competency, due to constant changes in health care knowledge and changing technology (Bolin, Peck, Moore, & Ward-Smith, 2005). Educator competency requires knowledge beyond that of clinicians, as displayed in the NLN Excellence in Nursing Education Model (2006) displayed in Figure 1. Knowledge of research, teaching, counseling and curriculum design and evaluation and more are needed (NLN, 2006, Figure 2). Educators need more than minimal practice competency to develop, evaluate and revise curriculum.
Current State of Knowledge

Multiple research studies discussed concern about nurse educator preparation, and that clinical preparedness did not constitute educator preparedness. The effect of the faculty shortage on educator recruitment where there is a limited pool of nurses with adequate credentials to select from, when accreditors require a minimum of Masters level preparation, and the difficulty transitioning from the clinician role to academia was an area of concern. Educator preparation was inconsistent, and there were many standards, and educational competencies that educators must assimilate then utilize, which are optimal to implement for their program as well as various initiatives such as IOM (2010) recommendations. Curriculum development and evaluation was an area multiple studies rated as important to the nurse educator role, but was found to be an area many nurse educators lacked preparation. Research findings revealed that curriculum reform created stress, increased transition, and onerous workload. Themes identified in the literature included educator competency, preparation for the educator role, the faculty shortage, standards, initiatives, educational competencies, and curriculum reform with an unfavorable faculty response.

Educator Competency, Preparation, and the Faculty Shortage

In the 1990’s there was concern about faculty preparation, as due to the small number of nurses with educational preparation, expert clinicians who lacked critical educational skills, rather than educators were filling faculty positions (Krisman-Scott, Kershbaumer, & Thompson, 1998; Choudhry, 1992). Krisman-Scott, Kershbaumer, and Thompson (1998) perceived that the clinically skilled experts did not have the knowledge
and skills required for the higher education role, and accepted a faculty position without clear understanding of the faculty roles, and that faculty might teach as they were taught. Slimmer (2012) found that faculty were continually being recruited from clinical departments to keep up with student increases and faculty retirements; hence, mentoring and faculty development was vital in role transition.

A study by the Southern Regional Education Board (SREB) in 2001 surveyed 16 states and the District of Columbia (Council on Collegiate Education for Nursing, 2001). Data from the 275 institutions that returned the survey revealed that only 28 faculty members that had doctorates, and 209 with masters degrees were formally prepared as nurse educators, and 971 did not have the minimal academic credentialing for national accreditation (Barth, 2003). Goode, Lynn, Krsek, Bednash, and Jannetti (2009) point out that nursing schools, hospital nursing leadership, and new graduates believe that additional competencies and knowledge beyond those obtained in education are needed for new nurses to transition to the professional nurse role. Faculty becoming nurse educators who are responsible for developing curriculum also transition to a new role and require additional preparation. The preparation received is variable, and may leave educators insufficiently equipped for their new duties.

Bouchard (2011) professed that professional education has not kept pace due to old static curricula that does not prepare graduates well, and educators note an increasing tendency to hire faculty without experience in academia. Faculty with less than two years of experience did not feel competent to develop curriculum, and were more likely to experience frustration and uncertainty (Krisman-Scott, Kershbaumer, & Thompson, 1998). However, experienced faculty also felt stressed and some lacked expertise in
A factor impelling innovation in nursing education is the lack of qualified faculty to meet nursing program enrollment needs (Paulson, 2011). Benner, Sutphen, Leonard and Day (2010) stated that efforts to recruit students into programs leading to faculty positions will be futile until the faculty shortage is addressed by providing faculty with resources and salaries commensurate with other disciplines.

There is a lack of qualified nursing faculty that is expected to worsen (Yordy, 2006; NACNEP, 2010). The Robert Wood Johnson Foundation (2007) reports that in 2006, 35% of budgeted faculty positions were unfilled, 63% of full-time nursing school faculty were between 45-60, and 9% were over 61, leaving too few to teach the additional 340,000 nurses needed nationally by 2020. AACN’s (2012a) sample survey showed only 50% of the current nurse workforce holds a baccalaureate or graduate degree. Halstead (2012b) found the average age of current faculty to be 57, and noted that the pipeline for replenishing faculty numbers was insufficient, with larger numbers of retiring faculty to be expected in the future. Halstead (2012b) further stressed the importance of looking at how nurse educators are prepared for their role. McEwen, White, Pullis, and Krawtz (2012) noted faculty shortage and cost limited nursing student enrollment. The faculty shortage is creating pressure on some states to allow nursing faculty to have BSN preparation, rather than a Master of Science in Nursing (MSN) as a minimum, and in 2006, 29% of part-time nurse faculty were only baccalaureate prepared (RWJF, 2007).

Choudhry (1992) remarked that clinical nurse expertise is not sufficient to prepare faculty for their role in academia. Being an educator requires skills and competencies essential to facilitating SLOs, and competency can be developed through educational
preparation, orientation, or faculty development (Billings & Halstead, 2012). However, this does not always occur. Shants, Kalanek, Moulton, and Lang (2011) found that faculty without formal teacher education reported significantly higher needs for understanding educational processes such as developing curricula, and in the same study concluded that faculty with just a BSN in Nursing, or a masters in a different field had higher faculty development needs. Weidman (2013) pointed out that nursing schools actively recruiting faculty might be open to hiring clinical experts who lack teaching experience and educational theory, even if they have not completed their master’s, and because of the shortage these schools might be more apt to hire part-time or adjunct faculty. Clinical nurses transitioning to the educator role in Weidman’s (2013) study expressed stress, frustration, and found it difficult to use new skills related to nursing education that were not expected in their clinical role. If the new clinical expert turned educator does not have teaching experience, or core knowledge of educational theory, the transition to educator is more difficult (NLN, 2005). Hence the faculty shortage could profoundly impact nursing students because the clinical expert is not prepared adequately for the expectations and challenges a new educator faces (Weidman, 2013). Poindexter (2013; Anderson, 2009; McDonald, 2010) confirmed that clinical experts may find themselves unprepared for a new educator role, and advanced practice clinical experts who assume new roles have historically not been prepared for academia in their graduate work. Penn, Wilson, and Rosseter (2008) confirmed that many clinically expert nurses have only a vague idea of what the faculty educator role involves.

Schriner (2007) study of the influence of culture on nurses transitioning to a faculty role also identified stressors and role preparation deficits, and faculty hired with
clinical rather than education skills. Faculty in Schriner’s (2007) study described their sudden role change and the desire to be an expert educator, but not knowing where to learn, or how to go from being an expert clinician to an expert teacher role without formal education. Another educator in the study expected teaching to be easy, and that she could just model previous good teachers, then realized that did not necessarily work.

Shriner (2007) noted that there is a cultural dissonance for new faculty, for the nurses bring to academia the values of their clinical role, but these values differ from the values rewarded in the academic setting. Cambier, Dejonge, Kelley, McDermitt, Miller, and Riddle, (2013) remarked that nurse faculty must adapt curriculum designs to accommodate the evolving delivery of healthcare to bridge the gap between education and practice, and that educators are responsible for finding effective resolutions. Hull, St. Romain, Alexander, Schaff, and Jones (2001) referred to changing curriculum as being as difficult as moving cemeteries. Halstead (2007) noted that limited work has been done on faculty competence in curriculum evaluation. Furthermore, competing numerous demands lead to role strain for the BSN nurse educator (Halstead, 2007).

Barth, (2003) noted the need for more than Masters level preparation for adequate educator preparation. Despite the need for formal preparation for the educator role, there is an abundance of literature that implies that adequate preparation does not always occur. Rich and Nugent (2010) identified that faculty may enter academia with inadequate preparation to teach and that the skills of an excellent educator are not necessarily those of a practitioner. McDermid, Peters, Jackson, and Daly (2012) noted that most nurse academics are from clinical backgrounds with little preparation for the faculty role. Duffy (2013) identified that nurses transitioning from the clinical nurse to hospital role
go through an identity transformation that encompasses five stages: pre-entry, reaffirming, surmounting, stabilizing and actualizing. In the pre-entry stage, some nurses mentioned feeling unprepared, and unsupported, and in the reaffirming stage some expressed a sense of loss for their former role, and lack of confidence in their new role.

Curriculum development is not typically used in the clinical setting, so despite expert clinical skills, the faculty recruited from the clinical setting may have difficulty transitioning, and will need to develop new skills; additionally, many working in practice settings lack advanced educational preparation (NACNEP, 2010). Clinicians are being recruited to fulfill the role of educator. Donley and Flaherty (2008) noted that during times of shortage often there is a call to decrease educational requirements and to change licensing and accreditation standards. Despite nursing advancing the call for quality in practice and education, this statement is still proving to be true.

**Nurse competency:** The entry level nurse needs to be minimally competent at graduation. Licensing law protects the public by establishing minimal legal qualifications. The graduate of a licensed nursing program may apply for licensure. The primary role is the ability to provide nursing care for patients experiencing common, well defined health problems, and each RN is directly accountable and responsible to the consumer for the quality of care delivered (Harrington & Terry, 2003). Harrington and Terry (2003) describe minimal competency areas that include:

- Professional behaviors
- Communication
- Assessment
• Clinical decision making
• Caring interventions
• Teaching & learning
• Collaboration
• Managing care

Mortality rates of surgical patients are less when an institution has more nurses that are BSN prepared or higher (Aiken, Clarke, Sloane, Sochalski, & Silber, 2003). Increasing education can better prepare nurses, but the clinical role is focused on providing client-centered care. As previously noted in the literature, clinical nurse expertise is not adequate to prepare faculty for a role in academia. The Clinical Nurse Leader (CNL) accepts responsibility for client care outcomes to design, implement, and evaluate client care plans (AACN, 2013). This is different from the responsibilities of a nurse educator. If nurse educators are baccalaureate prepared, their entry-level and clinical skills are likely to be inadequate for developing, evaluating, or revising curriculum.

Master’s level preparation for educators: Benner, Sutphen, Leonard, and Day (2010) in their study Educating Nurses: A Call for Radical Transformation discovered than many new nurses were “undereducated” to meet practice expectations across settings such as education, and challenged nursing Master’s programs to include educator content. Nursing faculty are required by accreditors to be prepared in the area they teach that is generally interpreted to be a Master’s degree, with knowledge of a clinical area; however organizations such as NLN advocate faculty be prepared in curriculum

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development, instructional design, and evaluation (Ruland & D’Meza Leuner, 2010).

The AACN Essentials of Masters Education for Advanced Practice focused on the clinical role, but recognized educational tools were also needed; in spite of this, curricular guidelines were not offered (Ruland & D’Meza Leuner, 2010). The NLN in 2005 developed Nurse Educator Policies for use to guide graduate programs in preparing nurse educators, but these were of limited use guiding faculty in curriculum development; however NLN nurse educator certification outlined courses to use, such as curriculum development, evaluation, and instructional design (Ruland, & D’Meza Leuner, 2010). Former NLN president Halstead (2012a) stated a curriculum guide from the NLN is now available. Certification in nurse education is not required to become faculty.

The lack of curricular guidance requiring educator preparation to design and evaluate curriculum has led to inconsistent preparation of nurse educators to develop curriculum. The Essentials of Masters Education in Nursing (AACN, 2011) noted under Essential IX the recommendations from the Carnegie Foundation report (2009), Educating Nurses: A Call for Radical Transformation, that specified that the nurse educator role requires preparation across all nine Essential areas, and preparation in curriculum design and development. The current study measured progress in this area, faculty perceptions of their preparedness, and educator needs.

A 2009 AACN report of 198 nurse educator programs in every state in America, and the District of Columbia and Puerto Rico noted that the average Master’s program contained 39 credit hours, and curricular content concerning program evaluation was in 176 programs (89%). Only a few programs had more than one course on program evaluation. Only a few programs had clinical hours where students developed learning
objectives and had experiences with faculty in their specialty area. When programs included all elements of the graduate core curriculum, the range of credits fell between 31 and 39 and was without educator courses.

Zungolo (2008) revealed that most master’s prepared new faculty have not taken an education course. Guttman, Parietti, Reineke, and Mahoney (2011) recognized the need to enhance traditional Masters curriculum that lacked preparation in curriculum development, evaluation and learning outcomes measurement, with enhanced coursework that included these features to better prepare faculty for education roles. Their collaborative partnership between schools to prepare 14 scholars was successful enough to be sustained. Ruland and D’Meza Leuner (2010) noted that faculty educated in programs with preparation for clinical specialization may have little or no instruction on how to be faculty, but the majority of Master’s programs now have a nursing educator track. It is unlikely that the majority of nurse educators were prepared on a nurse educator pathway if faculty were recruited from clinical areas.

Master’s level education has focused on the development of teaching skills, not curriculum, and the DNP focuses on clinical practice, rather than curriculum development (Bartels, 2007). Donley and Flaherty (2008) confirm that the DNP was intended as a clinical path into specialized advanced practice. Loomis, Willard, and Cohen (2007) noted concern over whether offering the DNP would decrease faculty numbers as it was theorized that DNP programs may decrease PhD enrollments, the standard for tenure-track nursing faculty positions, with a smaller pool of potential nurse faculty as a result. Meleis and Dracup (2005) had major concerns related to DNP prepared nurses seeking teaching jobs, noting that DNP proponents have argued that
DNP graduates will teach, but not seek tenure, setting up the potential for marginalization as second-class citizens in college hierarchy. However, DNP roles are now seen as the emerging degree to fulfill the doctoral preparation requirement needed to enter academia (Bartels, 2007). DNP education can be completed more quickly than the PhD, but the focus is on practice, not developing courses. Therefore, even doctoral prepared nurses may lack formal curriculum preparation. ACEN (2013) requires 25% of faculty teaching BSN student be doctoral prepared, and AACN (2005; 2012, March) advocates for doctoral preparation for nurses in academia. Colleges striving to survive and keep adequate numbers of doctoral prepared faculty to maintain accreditation are likely to welcome the degree regardless of whether faculty are prepared for their educator role. Hence, there is potentially a lack of educator preparation in developing, evaluating, or revising curriculum.

**Economics:** Schools that provide acceptable education that take less time for students are more apt to be in demand. Colleges are affected by the law of supply and demand, as they require income for survival, and will offer shorter preparation that meets criteria. It is less expensive initially to hire educators with less preparation, and less expensive for colleges to pay for fewer years of faculty educational development. Economic times are difficult, and costs of education continue to escalate. Hassmiller (2012) notes that new board governance competencies have emerged for nurse leaders that call for knowledge and skills that encompass the ability to evaluate success by measuring performance against benchmarks, with understanding of revenue sources. Resource allocation and economic factors drive curriculum decisions, as education is inexorably linked to market forces (Paulson, 2009). The survey conducted by AACN
(2012b) on vacant faculty positions contained responses from 603 schools, and 58%, or 353 schools reported full-time vacancies, with 72% having insufficient funds to hire new faculty. The AACN (2007) survey showed 243 vacancies for faculty.

Hurtado, Eagan, Pryor, Whang, and Tran, (2012) performed a survey in the 2010-2011 academic year of college and university faculty conducted by the Cooperative Institutional Research Program (CIRP) at the Higher Education Research Institute (HERI). The survey discovered that institutional budget cuts were the top source of stress for public university faculty. Additionally, the survey revealed that less than half of associate professors, assistant professors, and lecturers feel the preparation they received in graduate school prepared them well for their role as faculty (Hurtado, Eagan, Pryor, Whang, & Tran, 2012).

Academic salaries are not as competitive as they should be, with a gap between clinical and faculty pay, with a 2003 survey indicating many faculty are so displeased with their salary and heavy workload that it results in transition and early retirement (Yordy, 2006). The Bureau of Labor Statistics (2011) lists the mean annual salary of a post-secondary nurse educator as $67,810 and the mean salary of a staff nurse as $69,110. University of Maryland Dean Allan reported that in Maryland there is a $40,000-$60,000 gap between what is paid a mastered-prepared faculty member, and what they can earn in a clinical setting (RWJF, 2007). NACNEP (2010) reported even larger gaps. Advanced practitioners that move from clinical practice to education will suffer a decrease in compensation while being required to bear the considerable added cost of further education, and commonly the change from master’s prepared nursing to doctoral nursing involves increased cost personally, with a decrease in salary. Recruiting
faculty from the clinical arena typically requires newly recruited faculty to take a considerable pay cut. If faculty recruited from clinical settings are stressed and overloaded in the academic setting, feeling themselves less competent due to lack of preparation, faculty may return to their expert role in acute care settings where they felt capable. Nursing organizations and deans document difficulty in recruiting and retaining a waning faculty pool, and have given hospitals and hospital nurses greater roles in student education (Donley & Flaherty, 2008). It is no surprise that there is a faculty shortage.

Faculty may not have energy or money to pay for extra years of education that are often taken while working. Donley & Flaherty (2008) recalled that the reduction of funding provisions that support education have effected nursing education in the past. Federal funding support such as Title VIII programs are needed to support nursing education (AACN, 2012a; ANA, 2010).

To pay back loans or get better benefits, nurses may require a higher paying clinical role such as a hospital educator or manager after education that may be sponsored by a college is completed. The cost of these transitions impact college budgets, and contribute to economic decisions about reimbursing faculty tuition. These factors conjoin to encourage less preparation in curriculum for the faculty role resulting in less prepared faculty for the role of developing, evaluating, and revising curriculum.

**Nurse educator competency:** Halstead (2007) found it interesting that there was limited research on faculty competence in designing curriculum and evaluating programs, and she recommended curriculum development activities, curriculum design activities, and teaching on program and curriculum evaluation as well as accreditation. Engaging in
curriculum development activities included learning how to complete needs assessments to guide curriculum and receive input from stakeholders, and choosing strategies to aid curriculum development (Halstead, 2007). The NLN (2006) Excellence in Nursing Education Model found that well prepared faculty who were academic leaders should be competent in ten areas: evidence based teaching, advancing the profession, citizens of the academy, curriculum design, implementation, and evaluation, providing leadership to transform and re-vision nursing education, mentoring neophyte educators, building the science of nursing education, teaching skills for diverse groups of learners, advisement and counseling skills, and skills with evaluation methods for both programs and individual learners (see Figure 1).

Adequacy of educational preparation includes knowledge, and skills in order to assure safety and enhance quality. It is interesting to note that QSEN (2012) graduate level competencies do not mention curriculum development or evaluation, though it is graduate level education that is required for nursing faculty to become an educator. If nursing faculty were unable to develop, evaluate, and revise curriculum, they could be unable to fulfill the requirements of national accreditors such as ACEN, and CCNE, which require faculty participation in curriculum development. The NLN (2013, Hallmarks) stressed that nurse educators must have specialized education due to the core of knowledge and skills essential to their role, and it is critical that nurse educators who practice in academia require knowledge and skill in curriculum development, program outcome assessment as well as learning and evaluation. Otherwise, faculty could be unable to competently evaluate if students met their learning outcomes in order to practice safely, leading to potentially unsafe outcomes, questionable quality, and gaps
between education and practice. The National Council of State Boards of Nursing, Inc. (NCSBN) (2008) requires nursing faculty teaching in RN programs to be masters or doctoral prepared to facilitate student development of clinical judgment needed for safe care, noting that an expertise gap could prolong the nursing shortage. Penn, Wilson, and Rossetter (2008) noted that inexperienced nurse educators focused on their teaching abilities rather than student learning, and noted that the AACN (2007) survey listed teaching skills, knowledge, experience and faculty preparation, and curriculum/course development skills as the top three essential skills for nurse educators. The current study interviewed educators who have various levels of competency regarding curriculum development, evaluation, and revision.

The NLN (2005) lists participation in curriculum design and evaluation of program outcomes as number four of the eight core competencies. Core competency four lists that educators should be responsible for designing and evaluating curricula with up-to-date healthcare guidelines that enable graduates to perform effectively. Knowledge of curriculum development and the ability to write competency statement are just a few of the capabilities listed under the core competency (see Appendix D). The Excellence in Nursing Education Model (NLN, 2006) lists curriculum design, implementation, and evaluation as one of the areas under well-prepared faculty. Education competency in curriculum development, evaluation, and revision appears to be a priority with the NLN.

Benner, Sutphen, Leonard and Day (2010) noted that nurses must come to agreement about a set of clinically relevant prerequisites for nursing education. Adequate preparation for nurse educators is paramount. Understanding of curriculum development, evaluation, and revision is necessary to frame education goals for safe, quality patient
Improving educational strategies will advance the profession of nursing, and the research findings revealed perceptions of nurse faculty regarding their preparedness and confidence in developing, evaluating, and revising curriculum, providing information to build a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. Additionally, it may enable better curriculum to be developed to prepare, support and retain new faculty. Nursing knowledge will be used by educators to improve curriculum, competence and support nursing educators.

**Standards, Initiatives and Educational Competencies**

Nurse educators are bombarded with competencies, standards, outcomes, and initiatives that need to be considered when developing, evaluating, or revising curriculum. Tagliareni and Perkins (2008) recognized that an enormous challenge for nurse educators is to ensure that the next generation of nurses master necessary performance competencies to fulfill nursing's mission of human caring in a global world. In *Teaching for Nurses: A Guide for Faculty*, Dr. Finke noted that teaching strategies are being revolutionized, and that a core responsibility of the teaching and learning required of educators included more than teaching content, but involved expertise in developing, evaluating flexible curriculum as well as outcome assessment (Billings & Halstead, 2012). Yet, Smith (E, 2012) noticed that aging professors stressed by the faculty shortage were more comfortable with content driven curriculum, though the style may not be the best for the student. Hence, skill in curriculum revision will be needed by faculty stepping into the educator role of retiring baby boomers.

Faculty without education preparation cannot write objectives competently when designing curriculum without understanding of types of competencies used to write...
student outcomes. Webster (2001) noted confusion among faculty regarding outcome based competencies when curriculum reform was needed, and that it was not an easy process for the faculty to learn. Course outcomes were confused with program outcomes, and many meetings were needed for clarification. A review of some competencies will reveal an area of knowledge required to review curriculum where clinicians may be lacking.

Comparing competency criteria:

National League for Nursing (NLN): The NLN (2002, 2013) considers its mission to be promoting excellent nursing education in order that capable nurses are available to ensure the nation's health. NLN (2010) BSN competency areas included:

- Human Flourishing
- Nursing Judgment
- Nursing Practice
- Professional Identity
- Spirit of Inquiry

In addition to BSN competency areas the NLN recognizes excellence in nursing education for programs that demonstrate characteristics representing outstanding performance or service. Their excellence in nursing education model reflects the eight core elements aforementioned and listed on the model graphic on Figure 1. Well-prepared faculty who are academic leaders are listed on the model. NLN goals include advancing the science of nursing, encouraging continually improving education,
encouraging research, facilitating discussion among educators about how to achieve excellence, encouragement of innovation, and facilitating change based on evidence based practice to enable positive reform (Engelmann, Lynd, Hysell, Deblois, Mclaughlin, Rusin, Cabaniss, Burke, & Speakman, 2008). One of the three areas to excel in is *Creating Environments That Advance the Science of Nursing Education.*

The NLN Board of Governors previously elected the fifteen-member National League for Nursing Accrediting Commission Inc. (NLNAC) Board of Commissioners at the NLN annual meeting who oversaw the NLNAC Chief Executive Officer (NLNAC, 2008). However, after a breach between the NLN and the NLNAC, the NLNAC became the Accreditation Commission for Education in Nursing (ACEN) (Wood, 2013). Currently, The NLN has created its own accrediting department that is separate from the ACEN accrediting organization, but incorporates the NLN core values of caring, integrity, diversity, and excellence (NLN, 2013). The Commission for Nursing Accreditation (CNEA), the NLN’s new accreditation body has announced five categories of accreditation standards that have been presented for public review (NLN, 2015). The categories encompass a culture of integrity and accountability, excellence and caring for faculty and students, excellence in program outcomes, and learning and diversity related to curriculum, teaching, and evaluation processes (NLN, 2015).

*Outcome Based Education:* Formerly education for nurses involved covering subject matter, rather that competency based outcomes involving education striving to teach knowledge, skills, and attitudes of nurses and life-long learning. Outcome-based competencies focus on what a student can do at the completion of their studies. Webster (2001) stated the focus is preparing students for life (Webster, 2001). Lenburg (1999)
describes practice competencies as categories where an array of specific skills can be collected for levels, types, or practice emphasis. In comparison, concept-based competencies include concepts and principles that allow the brain to formulate patterns and connections as well as facts, processes and skills (Erickson, 2007). Conceptual thinking can also be used in outcome-based models. Both the COPA and Quality and Safety education for nurses (QSEN) are outcome-based models rather than content driven.

**Competency Outcomes and Performance Assessment (COPA):** Competency Outcomes and Performance Assessment (COPA) includes assessing competency of nurses by considering if by course completion the student nurse is competent in specific knowledge, skills, or attitudes. Instead of lecturing, where subjectively decided content was given and passively received, there is an intentional shift to learning focused on increasing competency in assessment, critical thinking, leadership and communication using collaborative interactive learning (Lenberg, 1999, Redesigning). The COPA model took Lenberg over three decades to develop (Galen College, 2011). Carrie B. Lenburg’s (1999) framework was expanded to support learning and assessment focused on clinical competencies. Using the framework made faculty aware that they differed in their perceptions of critical components of skill performances. Using standardized criteria for competence based on evidence-based practice, rather than subjective opinions and past practices, was more educationally effective and led to reassessment of grading practices.

The COPA framework involved an integrated outcomes-based system based on eight core practice competency categories that implemented interactive learning methods and psychometric concepts supporting a performance assessment process.
Instead of subjectively deciding what new content was critical to add or leave out, the framework assists in evaluating attainment of skills, knowledge and attitudes needed by competent nurses. Lenberg’s (1999, Framework) holistic framework assisted in solving the worrisome question of how to evaluate success objectively and legally. Educators pressured to cover an increasing amount of content often felt skills and content previously covered were crucial; therefore, faculty was inclined to burden students with an increasingly heavy workload in an attempt to adequately prepare them for practice and avoid criticism from employers of student graduates who complain of long orientations needed before graduates seem proficient to practice. Giddens, Brady, Brown, Wright, Smith, and Harris (2008) referred to this phenomenon as programs falling victim to content saturation, and encouraged a concept-based approach or web-based platform instead. Employers and preceptors of new graduates resent the time and funds needed to prepare graduates with extensive orientations before they can safely practice, while graduates are frustrated that despite heavy workloads in college they felt under-prepared and not confident (Lenberg, 1999). The COPA approach questioned that competence was determined by the amount of content delivered, instead expecting educators to examine the relevant environment to determine necessary content and competencies.

The eight core practice competency categories under which a range of specific skills is clustered by levels, to define practice are:

1. Assessment and Intervention Skills
2. Communication Skills (oral skills, writing skills, computing skills)
3. Critical Thinking Skills:

4. Human Caring and Relationship Skills

5. Management Skills

6. Leadership Skills

7. Teaching Skills

8. Knowledge Integration Skills:

   In outcome–based competency learning, nursing knowledge, skills, and attitudes (KSAs) necessary to continuously improve quality and safety for patients are the focus of learning. Working collaboratively with current practitioners, educators form relationships integrating the practice setting and academia. Understanding of learning outcomes that accreditors expect faculty to use to guide the instruction, direct activities, and evaluate student progress is essential.

   Quality and safety education for nurses: Myers, Reidy, French, McHale, Chisholm, and Griffin (2010) performed a study identifying the nurse education level that considered the learning needs of the transitioning nurse. Their findings regarding too much emphasis on tasks, and the need to teach strategies such as critical thinking and communication dovetailed with educational recommendations, such as the COPA Model (Lenburg, 2011). The study was not generalizable; thus, further study was needed.

   Quality and Safety in Education and Practice: The QSEN project:

   The Quality and Safety in Education and Practice (QSEN) criteria focus on knowledge, skills, and attitudes needed in an outcome-based framework.
There are different QSEN levels:

- Pre-licensure
- Graduate

The pre-licensure criteria include what the nurse needs to know by graduation at the BSN level, while the graduate level competencies are more difficult. Six QSEN competencies were identified: Patient-centered-care, teamwork and collaboration, evidence-based-practice, quality improvement, safety, and informatics, with discrete knowledge, skills, and attitudes (KSAs) for each competency (Armstrong, Spencer, & Lenburg, 2009; Preheim, Armstrong, & Barton, 2009; QSEN, 2014). In each area student competencies are listed under knowledge, skill, or attitude for nurse educators to use in curriculum for preparing student nurses to improve the quality and safety of healthcare. Fero (2009) reminds us that safety may be compromised if a nurse cannot provide clinically competent care. IOM (2003) criteria: delivering patient-centered care, working as part of an interdisciplinary team, using evidence-based practice, quality improvement, and information technology to improve patient safety was modified to create the QSEN framework, making a distinction between quality and safety competencies.

Susan Boyer, the Executive Director of the Vermont Nurse Internship Project - Vermont Nurses In Partnership, Inc. (VNIP) developed a COPA framework to evaluate the competency of RNs emphasizing leadership, management, knowledge integration, human caring relationship skills and critical thinking over tasks, shifting the focus to performance behaviors (Lenburg, Abdur-Rahman, Spencer, Boyer, and Klein’s (2009). Armstrong, Spencer, and Lenburg (2009) compared the six QSEN categories to the eight...
COPA competencies, and analysis revealed strong shared values, with advisement that all eight COPA practice competencies, and all six QSEN competencies be present in nursing courses.

The Oregon Consortium of Nursing Education: The Oregon Consortium of Nursing Education (OCNE) Core Competencies addressed evolving health care needs, significant changes in the delivery of health care, the growth of nursing science, and the likelihood of a diminishing supply of nurses (OCNE, 2013). In 2003, eleven colleges formed the OCNE, a pioneering partnership that offered students access to a full four year nursing program on any OCNE campus (RWIF, 2007).

The OCNE core competencies:

1. Shared core values
2. Insight through reflection, self-care
3. Intentional learning
4. Leadership in nursing and health care
5. Collaboration as part of health care team
6. Practice within the health care system
7. Relationship-centered care
8. Effective communication
9. Sound clinical judgments
10. Use of best available evidence

Nurse of the Future: Nursing Core Competencies from Massachusetts

Department of Higher Education: A group of 32 experienced professional stakeholders in nursing education and practice from a variety of practice settings and all degree levels, including representatives from Massachusetts Department of Higher Education, Massachusetts Center for Nursing (MCN), the Massachusetts Association of
Colleges of Nursing (MACN), the Massachusetts/Rhode Island League for Nursing (MARILN), and national accrediting agencies, including the National League for Nursing Accrediting Commission (NLNAC) and the Commission on Collegiate Nursing Education (CCNE) convened in 2006 in a facilitated working session entitled *Creativity and Connections: Building the Framework for the Future of Nursing Education and Practice* (Massachusetts Department of Higher Education, 2010).

A working group comprised of deans and faculty representing a spectrum of nursing education and nurse leaders to represent the continuum of care met until 2009, reviewing standards, initiatives, and best practice in nursing education, forming a foundation to move priorities forward. Two working committees were created to expedite the process: the Massachusetts Nurse of the Future (NOF) Competency Committee charged with furthering the development of a seamless continuum of nursing education by identifying a core set of nursing competencies; and the MONE Academic Practice Integration Committee, charged with using the competencies as a framework for developing a practice model. The *Nurse of the Future Nursing Core Competencies* (2010) sums up the work of the NOF Competency Committee. The committee used a multi-step process to define nurse competencies that included:

2. Information and data obtained through this process of research, analysis, and dialogue formed the basis for developing early Core Competencies.

3. The committee then obtained feedback on the initial set of core competencies from the nursing education and practice community within the state, including online, two state summits, meetings with faculty from nursing education, nursing leadership and practice councils, and used a gap analysis process developed in consultation with a QSEN expert. Eight nursing programs and their clinical practice partners evaluated their curriculum and identified gaps between what was taught and what they believed should be taught.

4. After synthesizing feedback, the committee reviewed the literature, comparing the initial core competencies against nationally accepted models, guidelines, and standards. The preliminary set of competencies was compared to the CCNE Essentials of Baccalaureate of Education (AACN, 2008), the Bologna Accords, the COPA model (Lenburg, 1999), the NLN’s educational competencies for graduates of associate degree nursing programs, and the Accreditation Council for Graduate Medical Education.

5. Information and data obtained by the review and feedback process was incorporated into an updated version of the Nursing Core Competencies (Massachusetts Department of Higher Education, 2010). The result included outcome-based knowledge, skills and attitudes in ten areas:

   1. Patient centered care
   2. Leadership
   3. Communication
   4. Professionalism

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5. Systems-Based Practice
6. Teamwork and Collaboration
7. Informatics and Technology
8. Safety
9. Quality Improvement
10. Evidence-Based Practice

(Massachusetts Department of Higher Education, 2010)

If we compare the ten Massachusetts core competencies with the COPA and QSEN, we find they are all able to be integrated. See Table 1.

Table 1.

*COPA Competencies Nurse of the Future, and QSEN Qualities Compared*

<table>
<thead>
<tr>
<th>COPA Competencies</th>
<th>Assessment intervention</th>
<th>Communication</th>
<th>Critical thinking</th>
<th>Humancaring relationships</th>
<th>Management</th>
<th>Leadership</th>
<th>Teaching</th>
<th>Knowledge integration</th>
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*Starred elements are the QSEN Competencies*
The Essentials of Baccalaureate Education for Professional Nursing Practice:

The nine Essentials of Baccalaureate Education created by AACN (2008) are not outcome-based, but instead discuss pertinent areas that BSNs should have included in curriculum. There are Essentials for the masters and doctoral level as well. These criteria are the foundation for many important nurse criteria, including the Commission on Collegiate Nursing Education (CCNE) accreditation standards, and Nurse of the Future Nursing Core Competencies. The essentials at the baccalaureate level include:

1. A solid base in liberal education as a cornerstone for practice and education.
2. Knowledge and skills in leadership, quality improvement, and patient safety to provide high quality care.
3. Educational groundwork to translate current evidence into practice.
4. Knowledge and skill in information management and technology to deliver quality care.
5. Healthcare policies, including financial and regulatory, how they directly and indirectly influence the nature and functioning of the healthcare system and nursing practice.
6. Interprofessional Communication and Collaboration among healthcare professionals to improve patient outcomes, delivering high quality and safe patient care.
7. Health promotion and disease prevention at the individual and population level to improve population health.
8. Professionalism and the inherent values of altruism, autonomy, human dignity, integrity, and social justice.
9. Generalist Nursing practice with patients, including individuals, families, groups, communities, and populations across the lifespan and across the continuum of healthcare environments, understanding and respecting the variations of care, the increased complexity, and the increased use of healthcare resources inherent in caring for patients (AACN, 2008).
ACEN standards: ACEN is a national accrediting organization for nursing, with specific criteria that must be met for the college or university to be accredited. BSN faculty should be minimally MSN prepared, and 25% of faculty must be doctoral prepared (ACEN, 2013). There are six standards:

1. Mission and Administrative Capacity
2. Faculty and Staff
3. Students
4. Curriculum
5. Resources
6. Outcomes (ACEN, 2013)

Each category includes many criteria. Standard 4 Curriculum (see Appendix B) notes that curriculum must be developed by faculty and regularly reviewed, and that student learning outcomes are used to organize and guide the curriculum. The curriculum should prepare students to achieve nursing education outcomes, and must include professional standards, guidelines, and competencies, clearly articulating student learning and program outcomes. Standard 2 notes that faculty performance needs to reflect scholarship and evidence-based practice, and systematic assessment of faculty performance must demonstrate competencies consistent with goals and outcomes. Evaluation methodologies need to vary and should reflect established professional competencies, and measure the achievement of student learning and program outcomes. A systematic plan for evaluation is required (NLNAC, 2008).
Summer 2015 the National Advisory Committee on Institutional Quality and Integrity (NACIQI) recommended to the Secretary of Education that ACEN lose its recognition as an accrediting body, putting at risk the over 1200 schools they accredit; however, ACEN addressed the federal mandate by working with the NLN to resolve issues (Stoll, 2015). Educators from many schools are affected by changing curriculum, faculty, student, and program guidelines that affect them. NLN decisions could affect ACEN bylaws, and ACEN recognition from the Department of Education (Stoll, 2015). ACEN’s (2013) glossary identifies a list of acceptable professional standards for nursing practice approved by a nationally recognized nursing organization to use to develop and evaluate curriculum that includes, but is not limited to:

- Consensus Model for APRN Regulation
- Core Competencies for Interprofessional Collaborative Practice (Interprofessional Education Collaborative)
- Criteria for Evaluation of Nurse Practitioner Programs (National Task Force on Quality Nurse Practitioner Education)
- Essentials of Baccalaureate, Master’s, and Doctoral Education (American Association of Colleges of Nursing)
- Health Professions Education: A Bridge to Quality (Institute of Medicine)
- NLN Competencies for Graduates of Nursing Education Programs (National League for Nursing)
- Nursing: Scope and Standards of Practice (American Nurses Association)
Standards of Practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs (National Association for Practical Nurse Education and Services)

• Statement on Clinical Nurse Specialist Practice and Education (National Association of Clinical Nurse Specialists)

• Quality and Safety Education for Nurses (QSEN).

**Commission on Collegiate Nursing Education (CCNE):** Another national nursing accreditation service is the Commission on Collegiate Nursing Education (CCNE). Again faculty are expected to be involved with curriculum, its revision, and faculty are responsible for evaluation of individual student learning outcomes (CCNE, 2013).

CCNE presents with four standards:

1. Program Quality: Mission and Governance
2. Program Quality: Institutional Commitment and Resources
3. Program Quality: Curriculum and Teaching-Learning Practices
4. Program Effectiveness: Aggregate Student and Faculty Outcomes (CCNE, 2013)

There are many criteria under each standard. Further details are listed in Appendix C. The CCNE standards incorporate the Essentials of Baccalaureate Education, the Essentials of Masters Education, and Essentials of Doctoral Education for Advanced Nursing Practice as appropriate, with guidelines updated by AACN.
**Other Competencies:** Bridging the Preparation-Practice Gap Volume One (2008) discusses 36 nurse competencies in six general areas of inquiry. Each competency had to be specific, actionable, and reflective of current hospital demands, and had six subsections. The six general areas included:

- Clinical knowledge
- Technical skills
- Critical Thinking
- Communication
- Professionalism
- Management of Responsibilities

In the National Council of State Boards of Nursing (NCSBN) (2010) *Tuning Analysis*, United States academic nursing competencies and European academic nursing competencies were compared, finding evidence to suggest that basic nursing education competencies are equally important, regardless of nursing role or geographic setting. Average importance ratings by surveyed nurses were similar for 47 competencies, with correlations for the competencies high and statistically significant (NCSBN, 2010). Four groups were surveyed: NCLEX registrants, first-year RNs, educators and supervisors. Though the focus claimed to be on the educational structures and content of educational programs, the competencies appeared to focus on clinical competencies rather than other settings, with one competency related to educating patients and caregivers. The researchers of the study recommended that the education competency statements be revised (NCSBN, 2010).
Dual surveys were done of hospitals and nurse leaders, a broad cross-section of experts. More than 100 industry leaders were interviewed. Their study intended to find a starting point to establish shared goals among hospital and nursing school leaders to improve new graduate nurse preparation. Valid responses were received from over 400 nursing school deans, and associate directors that looked at the emphasis on curriculum pertaining to 36 competencies in six general areas of inquiry: clinical knowledge, technical skills, critical thinking, communication, professionalism, and management of responsibilities.

There are many other potential competencies, such as Global Health Competencies for Nurses in the Americas. Duke University’s goal of the Global and Community Health Initiatives (OGACHI) addressed health disparities internationally and locally by promoting academic enhancement, service-learning, and research related to global health (2012). The NLN Educational Technology and Information Management Advisory Council in 2005 established the Task Group on Informatics Competencies (Thompson, & Skiba, 2008). There are other specialty competencies such as gerontological. There are international outlooks such as the Global Health Education Consortium (GHEC), the Pan American Health Organization (PAHO), and the International Council of Nurses (ICN).

Without preparation in types of competencies available to develop curriculum, it is more likely a faculty member would be unprepared to develop, evaluate or revise curriculum. Faculty who are expected to participate in curriculum development, evaluation, and revision may not know how, because they have not been prepared (Benner, Sutphen, Leonard, and Day, 2010).
Graduate degrees that are preparing for practice rather than academia often lack preparation in developing, evaluating or revising curriculum (Anibas, Brenner, & Zorn, 2009; AACN, 2009; Zungolo, 2008). There is a gap in research to evaluate the preparedness and confidence of educators who develop, evaluate or revise curriculum. The gap must be addressed to support educators, and ensure quality curriculum ensues.

_Institute of Medicine (IOM) recommendations (2010):_ Bartels and Bednash (2005) note that with the shortage of nurses predicted by 2020 due to the aging workforce, a 40% increase of RN graduates is needed, and the U.S. Bureau of Labor statistics places nurses at the top of the list of needed professionals in high demand. However, more than quantity is needed; quality is critically important to produce better patient outcomes. Nurses with a refined level of knowledge, education and skills are better qualified to yield high quality of care, or graduates providing care; and in _Crossing the Quality Chasm: A New Health System for the 21st Century and Health Professions Education: A Bridge to Quality_, the IOM notes that American healthcare, and the programs that educate health professionals need fundamental change (Bartels & Bednash, 2005). Bednash, leader of the AACN, QSEN innovations, and _Baccalaureate Essentials_ revision, encouraged pursuit of the six aims of the 2000 IOM Quality Chasm report: safety, effectiveness, patient centeredness, timeliness, efficiency, and equitable care for all as well as the IOM’s later call to fulfill those aims by transforming the health professions education by following the IOM (2010) recommendations. One of these is that nurses should achieve higher levels of education and preparation through an improved education system that promotes seamless academic progression. This necessitates curriculum development, evaluation, and revision.
Curriculum Reform and Response

The NLN Education Summit 2013 advocated renovation of nursing education, and discussed topics such as transition crisis, noting current nursing curricula and orientation fail to adequately prepare nurses for practice. Nurses practice in academia as well. The IOM (2010) concurs that quality preparation through improved education is necessary. Reform is needed.

Paulson (2009) noted that nursing educators often believe that curriculum reform comes from a nebulous source outside of the discipline’s domain, so they feel discouraged from beginning individual initiatives; however, data are needed to provide evidence-based educational improvements. Radical curriculum reform demands time and participation (Oliver, 2008). There is an increase in the number of stakeholders in higher education and society demands better teaching and curriculum strategies. Nurse educators are expected to consider current practices and use evidence-based decisions to support nursing curriculum (Cambier et al., 2013).

For curriculum development or revision to occur, faculty must have understanding of how to assess for the need, implement change, understand the concepts, and standards used, and be willing to be involved in the process as well as evaluate the result. Organization accreditation and patient safety may be at stake. Davis, Stullenbarger, Dearman, and Kelley (2005) surveyed 550 nurse education administrators about 37 competency statements in the roles of teacher, scholar, and collaborator. In the area scholar, only one competency statement was identified as very important to at least 60% of respondents, and that was in the area of using knowledge gained through practice to maintain and improve curricula. Staykova (2012) noted a research gap regarding
knowledge of the competencies a nurse educator should demonstrate when developing curriculum. Her pilot study examined the nurse educator role in curriculum design by requesting that educators complete two questionnaires and identified competencies for educators designing ADN curriculum. Identified first in importance was certification in nursing curriculum design, and nursing curriculum design courses taken that contribute to the development of educator competency developing nursing curriculum.

Salminen, Minna, Koskinen, Katajisto, and Leino-Kilpi, (2013) performed a cross-sectional survey in Finland to assess the competence of nurse educators in the five areas of nursing competence, pedagogical skills, evaluation skills, personality factors and relationships with students. Participants included educators, students, administrators and nurse leaders and mentors. In evaluation and relationships, educators rated themselves highly, while students gave educators low scores for the same items. In similar fashion hospital executives felt 10% of graduates were prepared to practice, while the nurse educators thought 90% of graduates were well prepared (Advisory Group, 2008). This may indicate a need to compare faculty self-perceptions to another group’s perceptions such as those of a program director, a form of triangulation using different informants to improve trustworthiness. Salminen et al. (2013) further noted the importance of developing methods to evaluate a nurse educator’s competence. Grounded theory can be used to develop a model to evaluate educator competency.

Poindexter (2013) performed a survey of 48 nursing programs to discover the perceptions of administrators about the entry level competencies novice nurse educators need to obtain a full-time position. Much lower levels of performance were expected of the new educators in the area of curricular development than in areas such as facilitating
learning or nursing practice. Yet, accreditors such as ACEN (2013) require that student learning outcomes (SLOs) be used to organize the curriculum, and direct learning activities. Poindexter (2013) suggested that research comparing educators expectations related to their entry level competence could provide added insights.

Darling-Hammond, Chung, and Frelow, (2002) examined a survey performed by the New York City Board of Education sent to all teachers with four or less years of experience regarding their views of their preparation for teaching, resulting in 2956 usable surveys. The findings were consistent with other studies that found greater educational preparation increased effectiveness with students, and teachers with less professional preparation had more difficulty with students in the classroom. The less effective teachers were more apt to leave the profession, and high-quality teacher preparation was recommended (Darling-Hammond, Chung, & Frelow, 2002). Nursing research results also suggest that educators whose preparation included teaching, experience more easily transitioned to the educator role (Baker, 2010; Cangelosi Crocker, and Sorrell, 2009; Hewitt & Lewallen, 2010; Poindexter, 2013; Schoening, 2009). Additionally, several nursing research studies included that new educators experiencing high levels of stress and strain in their new role are likely to have higher attrition rates (Anderson, 2009; Poindexter, 2013). Baker (2010) found that pretest survey scores were consistently low in the area of program curriculum, but after an orientation that included seminars and mentoring, a better retention rate for faculty occurred.

Hubball, Gold, Mighty, and Britnell, (2007) found that exposing faculty early to resources such as guest speakers, literature on curricula, and government or accreditation mandates was beneficial to assist faculty learning about curriculum. Additionally, support
of curriculum leaders was needful, and external expert consultants could assist with scholarship. Accreditation was the biggest factor influencing development, implementation, and evaluation of curricula (Hubbal et al, 2007).

Gilbert and Womack (2012) recognized that there was difficulty transitioning from clinician to the nurse educator role, and developed a two day workshop orientation that incorporated the eight competencies; however, it became evident that two days was insufficient, and monthly meeting follow up was arranged. An example of competencies needed by educators include: functioning within the educational environment, pursuing quality in the educator role, engaging in scholarship, and using assessment and evaluation strategies, just to name a few areas where a clinical nurse transitioning to an educator role potentially could encounter difficulty, and demonstrating the immensity of the nurse educator role (McDonald, 2010). Hence new educators feel inadequate, and overwhelmed, because though they were expert as a clinician, they are a novice educator, and a mentor would help to support these new faculty (McDonald, 2010; Anibas, Brenner, & Zorn, 2009). Weidman (2013) performed a study involving eight expert clinicians who transitioned to the faculty role, and discovered three themes: the clinical nurses had a desire to share their expert knowledge with students; transition caused stress related to lack of educational theory; mentoring aids the transition process. The eight faculty described the transition stress in concepts such as difficult, frightening, overwhelming, awful, scary, and stressful, and one mentioned a lack of education courses in their graduate preparation. McDermid, Peters, Jackson, and Daly (2012) discovered new faculty felt uncertainty, anxiety and isolation related to their new role and the unique academic environment. Education on the multiple competencies, curriculum, evaluation,
and formal educational preparation at the graduate level is needed to become a nurse educator (Beres, 2006; Billings, 2003). Deans and directors should provide opportunities for faculty to acquire knowledge and skills about curriculum development, as it cannot be expected that they know how to develop curriculum (Iwasiw Andrusyszyn, & Goldenberg, 2009). Garbee and Kellacky (2008) encourage nurse faculty to work with leadership to create a work place and workload where they can survive, and thrive. Faculty development may be necessary for educators to thrive.

What is known about nursing faculty’s response to participating in curriculum development and evaluation is that they respond to its impact in specific ways. Rich and Nugent (2010) noted more stress, frustration with the added workload, and increased transition. Krisman-Scott, Kershbaumer, and Thompson (1998) discovered frustration and uncertainty. Reece, Mawn, and Scollin (2003) reported not only stress, but a large faculty turnover during curriculum change. Cangelosi, Crocker, and Sorrell, (2009) studied the transition from expert clinician to novice educator and noted anxiety, fear and tension. Paulson (2009) noted that history and individual coping can affect adaption capacity, and education does not guarantee nursing faculty embracement of change. The effect of the nursing faculty shortage may impact faculty workloads, affect job satisfaction and increase stress as faculty attempt to manage all their job responsibilities (Paulson, 2009). Davis (2011) created a conceptual framework to guide faculty in curriculum revision. Review of admission standards, progression standards, graduation standards, revision of retention methodology, development of a preceptor course and a three day incoming student workshop that required faculty participation are a few components listed in the revision (Davis, 2011). Additionally, faculty competency began
to be evaluated. Review of multiple standards alone is enough to increase stress for some faculty. Giddons et al. (2008) stated that curriculum redesign was an overwhelming undertaking as it usually is, and immense oversight was needed. Many faculty were initially unaware that curriculum reform was needed, and needed to be guided. Faculty feel stressed, and strapped for time revealed Berrett (2012) discussing a Higher Education Research Institute at the University of California survey of over 27 thousand full and part-time faculty, where nearly half of responding professors had considered leaving.

MacCarrick (2009) experienced curriculum reform in a school of medicine. The Director of Medical Education was initially responded to with expressions of negativity, and later with lack of participation, arguing, and resignation. There was frustration that curriculum tasks were added without any relief from other teaching or scholarship responsibilities. Two clinicians resigned due to the increased workload associated with curriculum planning in addition to clinical responsibilities, and later several other members of the curriculum working group resigned. Rumors and politics added to the stress as quality was questioned, and lack of support led to feelings of betrayal. Gozu, Windish, Knight, Thomas, Kolodner, Bass, Sisson, and Kern, (2008) noted that medical education has an ongoing need for curriculum development; however few medical institutions teach curriculum development. Their cohort study concluded that a program that engaged and supported faculty in curriculum development could have a significant impact with 82% of participants reporting a moderate or great impact on their careers (Gozu et al., 2008). Steinert, Cruess, Cruess, and Snell, (2005) provided an example of a successful development program to support teaching and evaluation of professionalism that led to a curriculum change in medical curriculum where 152 faculty members
attended faculty development activities that enabled them to present to curriculum committees.

Morcke and Eika (2009) recall that successful curriculum change depends on involved faculty, but medical faculty’s assumptions regarding the huge amount of knowledge about curriculum varies. In-depth interviews and focus group interview were done on participants from three Denmark medical schools. Decision makers who understood curriculum design and associate professors were interviewed about their perceptions or assumptions regarding curriculum design. A variety of designs emerged: method-driven, pragmatic-driven, content-driven, outcome-driven, and vision-driven curriculum design models. Participants did not agree with each other, and most could not account for their design model (Morcke & Eika, 2009). Fraser and Bosanquet (2006; Mocke & Eika, 2009), explored understanding of the concept curriculum by academics, interviewing 25 Australian teachers from a variety of disciplines and found that curriculum was used four different ways: unit structure and content, program structure and content, student learning experiences, and the dynamic interactive teaching learning process.

Delaney and Bragge’s (2009) study discovered that a dominant theme that emerged from physiotherapy clinical educator focus group discussion involved transitioning from the clinical role to that of an educator. There was rapid transition from new graduate clinician to clinical educator managing a group of students with little time to reflect on the change in responsibilities, or reviewing the implications of their educational approach so they relied on experience to inform practice. Perceptions of the educator role involved imparting of knowledge strategically and incrementally to build
student knowledge using a teaching knowledge transmission model. Dr. Albert’s (2007) editorial discussed the need for rheumatology training programs to use an organized approach to developing successful curriculum, noting that medical education curriculum describes four main elements be required: curriculum design, instructional design, assessment of learners, and evaluation of curriculum. Curriculum design was considered to be the main support of the framework; setting student learning objectives (SLOs), and content to meet objectives that guided how teaching occurred, and created benchmarks for evaluation (Albert, 2007). She further noted that faculty could overestimate the relevance of their expertise, and that evolving competency-based national frameworks had a huge influence on the creation of learning objectives. Using clinical data collected on clinical problems encountered was suggested as a means to define which topics had enduring educational value. Clearly other professions have similar issues regarding the need for faculty preparation to better implement curriculum change or design so effective revision or development can occur.

Inadequate educator preparation and the hiring of expert valuable clinicians that lack educational skills has been a concern for the nurse profession since 1969, when the ANA shifted the emphasis in graduate education to clinical specialization (Krisman-Scott, Kershbaumer, & Thompson, 1998). Higher education leaders and accreditors call for well-prepared educators, but the profession faces a faculty shortage. Therefore, graduate level clinicians often take faculty positions without awareness they are lacking skills such as those needed for curriculum development. Research is needed to assess the current perception of nurse educator preparation as there is little information available
regarding nursing faculty self-perception of their preparedness or confidence about curriculum development, evaluation, and revision

**Summary and Conclusion**

The nursing profession is not alone with difficulty in educator competency regarding curriculum development, evaluation and revision. However, the nursing profession has organizations such as the NLN, whose mission is to promote excellence and competency in nursing education. Derickson (2012) recognized that NLN sets standards for nursing education programs and preparing nursing faculty. Competency for nurse educators is an area where standards are being set, and faculty can strive for excellence. McDonald (2010) noted the nurse educator skills defined by the NLN (2005) Scope of Practice for Nurse Educators included eight core competencies for which nurse educators are held accountable. One of these is to participate in curriculum design and evaluation of program outcomes.

There are increasingly more nurses with doctorate or advanced degrees, with 28,369 nationally having received a doctorate by 2008 (Harris, 2011), and 2196 graduating with a doctorate in 2011 (AACN, 2014). Yet, the faculty shortage is increasing (NACNEP, 2010). According to the Vermont Office of Nursing Workforce Research, Planning, and Development (2009), 57% of the nurses who live and work in Vermont are over age 50 and anticipate retirement in the next 20 years. One third of America’s nurses are over 50 (HRSA, 2013). Nursing academia is in an ongoing crisis with fewer and fewer educators available who are left overloaded with demands to teach growing numbers of students (Billings & Halstead, 2012). Stressed faculty recruited from
clinical settings feeling less confidence due to lack of preparation, and receiving less pay, may return to clinical settings where they feel proficient, resulting in faculty turnover, and increased recruiting and training costs to colleges.

There is a gap in knowledge regarding the effect of the increased demand on faculty to teach more students when faculty numbers are decreasing, and on how prepared and confident faculty feel about developing, evaluating, and revising curriculum. Research is lacking concerning how to ensure educators are consistently prepared to competently develop, evaluate, or revise curriculum. Another gap in knowledge is the effect that increasing technologies such as simulation and distance education have on aging faculty who are expected to adapt curriculum, or how best to retain educators.

A common finding was lack of time and heavy workload for nurse educators. Another discovery was that nurse educators have been recruited from clinical areas during times of faculty shortage and currently. These new faculty may be unprepared for their educator role, and may have little or no formal education regarding curriculum development, evaluation and revision, so may require support in these areas. Additionally, some faculty lack knowledge in accreditation or national standards, and competencies. Despite having expertise as a floor nurses, faculty transitioning to a new role as an educator may perform at a novice level. If they were trained as clinicians rather than educators faculty often lack formal education in curriculum development, evaluation, and revision. It was also recognized that most clinical faculty do not have sufficient education to become educators without further preparation, as they have been prepared for a practice role that does not involve curriculum. Evidence as to the best way
to support and better prepare these educators is needed. A correlation with curriculum development or reform and stress was another common finding, even outside of the nursing profession, but the cause of the stress is not well studied in nursing. Research on best practice on how to reduce the stress and support educators to increase faculty retention is needed. Best practice on how to mentor or support seasoned faculty about new competencies and curriculum development or revision is lacking. Minimal research exists on the self-perception of nurse faculty preparedness and confidence developing, evaluating, or revising curriculum. Previous research has focused on lack of preparation for the teaching role (Anderson 2009; Choudhry, 1992; Rich & Nugent, 2009). The self-perception of faculty confidence and preparedness in developing, evaluating and revising curriculum is not well understood. Additionally, the effect of the faculty shortage and the demand for increased enrollment adds further stressful considerations. It is important to learn how nurse educators, administration and others might support nurse faculty put in this position.

Better understanding of preparation that fosters excellence in academia would benefit employers, nurses, and students. The Future of Medicine Report in 2001 and in 2010 mention that there is a large gap between the care we have and the care we could have. Perhaps there is a similar gap between the educators we have and the educators we could have if they were consistently well-prepared. The current study may provide insight on the self-perception of faculty preparedness, and what can be done to improve or support educational preparation for developing, evaluating and revising curriculum.

This study may provide evidence as to the best way to support and better prepare nurse educators. Additionally, this study may provide insight as to the cause of stress
during curriculum development, evaluation, or revision, providing data on how to reduce the stress and support educators to increase faculty retention. Data on how to mentor or support seasoned faculty who may need to learn about new competencies, accreditation, or curriculum development may also result from the study.

Staycova (2012) perceived that nursing education is a multidimensional approach requiring skill in curriculum design in addition to teaching and clinical skills, and that educator knowledge in applying curriculum can directly affect student performance. The nursing profession must be sure that educators are well-prepared for their role, so that students have constructive experiences and are well-prepared for safe practice.

Inconsistent preparation for curriculum development, evaluation and revision at the graduate level, the faculty shortage, the many standards and competencies, and numerous current reforms may affect the perception of preparedness, and the confidence of educators. Perceptions of faculty educators must be assessed to see if they feel prepared or confident to develop, evaluate, and revise curriculum, to better understand the current experience, and to understand what is needed to improve and support faculty preparation of the educator role. Assessing faculty perceptions of their preparedness and confidence in their role will provide evidence to build a model of understanding that will support faculty’s growth and competence in curriculum development, evaluation and revision.

In Chapter three the method used to collect data from faculty regarding perceptions of preparedness, and strategies to support faculty is explained. Sample size, description of the study population, data storage and method of analysis are outlined. Ethical considerations are considered, and the appropriateness of the method and design are supported.
Chapter Three

Method and Design

Chapter three contains a description of the research method and design, and evaluates the appropriateness of the method and design, research question, and sample for this research. Confidentiality and safety of participants were addressed. Charmaz’s (2006) qualitative constructivist grounded theory research design was used to explore perceptions of faculty regarding their preparedness and confidence in developing, evaluating, and revising nursing curriculum. By identifying perceptions of current nurse educators, a model of understanding was developed to support faculty’s growth and competence in curriculum development, evaluation and revision, and strategies to benefit educators were revealed.

The intent of the research was to discover and compare the perceptions of preparedness and confidence regarding curriculum development, evaluation, and revision capabilities, of faculty who are expected to revise and evaluate BSN curriculum in addition to teaching responsibilities, using a constructivist grounded theory design. Developing a model of understanding from faculty constructions to support faculty’s growth and competence in curriculum development, evaluation and revision will benefit educators and provide information to improve faculty competence, retention, and curriculum in the nursing profession. Additionally, strategies that support educator competency may improve student outcomes. Semi-structured interviews of nurse faculty who had a minimum of one year of experience in an educator role developing, evaluating, or revising curriculum occurred. Some nurses had practiced over 40 years, with a mean of 30 years over all.
Outcome-based education focuses on developing knowledge, skills, and attitudes (KSAs) needed by nurses, and nurses that teach need specific KSAs. The outcome of educational preparation for developing curriculum has not been well evaluated. The perceptions of practicing educators were discovered and compared to illuminate their viewpoint on preparedness and confidence in their role for developing, evaluating, and revising curriculum. Discovering perceptions and challenges about developing, evaluating, and revising nursing curriculum, and the preparation needed to perform well may assist other educators in overcoming similar hurdles in academia, so that more nursing educators and programs can be successful as a result. Successful nursing programs due to competent educators are likely to graduate more nurses, which assists in alleviating nursing shortages. Finding the most effective strategies to address faculty preparation involved studying the processes and perceptions of educators. Better understanding of how to assist faculty to achieve confident competency in curriculum development, evaluation and revision which better prepares faculty to be successful in the workplace will benefit colleges, students, and other educators creating courses, curriculum, and preparing for accreditation.

**Research Method**

A qualitative method, constructivist grounded theory, was chosen for the research study. A clarification of methodology provides the rationale behind using the qualitative methodology. Furthermore, constructivist grounded use is justified, and the process used in the research is clarified.
Quantitative versus qualitative. Qualitative research concerns striving to understand meaning, and understanding of what is occurring. Quantitative research involves quantities and frequencies, and evaluates how often circumstances occur. Wahyuni (2012) noted that quantitative data involve drawing inferences from mainly numerical data. Quantitative research is better for statistical analysis and generalizability, while qualitative research addresses the meaning of experiences. Qualitative research is more appropriate for thorough exploration and rich descriptions (Creswell, 2013). When a study strives to understand meaning of a lived experience, compares perspectives, processes, or outlooks of a culture or group, rather than focusing on quantities and numerical information, the viewpoint is qualitative.

Appropriateness of qualitative method. Qualitative studies allow for in-depth study to discover the meaning of peoples’ lives, represent their perspective, and contribute insight into emerging concepts (Yin, 2011). Qualitative designs pursue knowledge that fosters understanding of an individual, or group’s perspectives or experiences. Patterson and Krouse (2015) note a qualitative design allows for a comprehensive summation of phenomena. Individuals shared their perspectives, actions, experiences, and their meaning. These constructions compared with the experiences of others resulted in a theory grounded in the co-created experiences. Interpretation of a unique group’s perspectives required a qualitative design.

Consideration of how people come to understanding means examination of fore-structure, and being aware researchers cannot allow ourselves to be confined by conventional meanings (McManus Holroyd, 2007). Charmaz (2006) notes that interpretation may require being alert to the possibility of moving analysis beyond the
definitive evidence already gathered, and theoretical sampling is a means of gaining access to specific experiences, and making categories explicit. Hence, when interviews were completed, questions were added to later interviews to refine theoretical categories.

The researcher is encouraged to be aware of presuppositions because facts and values are linked and research can be affected (Ghezeljeh & Emami, 2009). Charmaz’s (2006) view was that data are not discovered, but that researchers are part of the world they study, and the data collected, and that grounded researchers construct theory through past and present involvement and interactions with peoples, perspectives and practices. As an active member of the world of nursing education, I could identify with the struggles of faculty, recognizing similar perspectives in colleagues at my own college which could not be used as I was an interim administrator at the time of the study. By setting up collaborative situations, it helps participants to reflect on experiences that can assist them in finding the underlying meaning of their experiences (Fleming, Gaidys, & Robb (2003).

Each encounter with the world involves interpretation, and the cumulative effect of each person’s world lens filled with historical experiences colors their view. One needs to become as aware as possible of the influences that shape how interpretation occurs, and the hermeneutic circle that does not stop spiraling until meaning is clear and free from contradiction (Laverty, 2003). Charmaz (2006) assumed that any theoretical rendering is an interpretive depiction, which cannot be an exact representation, for the theory depends on the researcher’s interpretation, and researchers do not live in a social vacuum. Gadamer noted that it is helpful for the person attempting further understanding to be connected to the subject matter and the tradition from which it speaks (Laverty,
As a current nurse educator, the researcher of this study is connected to the subject matter and tradition, and sought to link constructions of faculty educators, and interpret their perceptions to increase understanding of faculty phenomena.

**Justification for use of grounded theory as the qualitative method.** Grounded theory is a type of qualitative inquiry that focuses on emergent understanding and perspectives based on experience to develop theory (O’Connor, Netting, & Thomas, 2008). Constructivist grounded theory specifically looks at how and sometimes why participants construct meaning and actions, viewing how participants perceive their situation (Charmaz, 2006). Newton (2012) expressed that constructivist grounded theorists explain feelings of participants experiencing a phenomenon, but avoid preconceived data categories. As faculty shared their self-perceptions and confidence about curriculum development, evaluation, and revision, common constructions emerged between faculty. Common struggles they shared, effective strategies that supported them, as well as insights into the perspective of how prepared and confident they felt for the role of curriculum development, evaluation and revision were revealed.

Phenomenology was considered; however, the intent of the study was not just to develop a deeper understanding of educators’ lived experiences. Hermeneutic phenomenology was specifically considered, but the goal of hermeneutic phenomenology is to develop a rich description of a phenomenon being investigated in context (Ajjawi & Higgs, 2007). However, more than dense description was needed, for the intent was to discover and compare the perceptions and processes of faculty when developing, evaluating, and revising nursing curriculum and to use these constructions to build a model of understanding supporting faculty’s growth and competence in curriculum
development, evaluation and revision that would benefit current educators and provide strategies. A design was required that focused on comparison. In grounded theory, data are collected, refined, categorized, with constant comparison, coding and theoretical sampling used as strategies to develop concepts (Kolb, 2012). Cutcliffe (2000) pointed out that grounded theory continually compares, likes to use more experienced participants, and a non-probability sample, so grounded theory was most appropriate for the study.

Sharing information on how to better prepare educators to be confident and prepared in their role benefits the nursing profession. Grounded theory can be used to find different kinds of insights. For example, Chotkevys (2009) performed grounded research to find insights into social phenomena about spiritual care. Chotkevys (2009) noted that there was the traditional positivistic grounded theory viewpoint referred to by Glaser and Strauss (1967), and the interpretive viewpoint that is constructivist grounded theory, which requires imaginative understanding of the studied phenomenon, and assumes emergent realities with multiple viewpoints, provisional truth, and social processes used by Charmaz (2006). Chotkevys (2009) preferred Charmaz’s interpretive outlook, not the positivistic, and used open ended interview questions to provide information appropriate for constructing theory. Schoening (2013) found grounded theory design useful to gain insight on individuals’ reactions and behaviors responding to phenomenon, and to examine processes, and used Charmaz’s (2006) theoretical coding and memo techniques.
**Grounded theory types.** O’Connor, Netting, and Thomas (2008) noted that researchers use grounded research differently, some as originally conceived, others to establish deep meanings, some for constant comparison, and some without developing theory. There are different types of grounded theory. Grounded theory emerged in 1967 with Glaser and Strauss, but their method diverged over time, with Glaser keeping to the empirical approach with concepts considered to be variables for many years (Charmaz, 2014). Strauss co-authored books with Corbin in the 1990’s discussing a methodology that applied techniques and procedures with defined data analysis steps, rather than focusing on emergent categories and comparative methods (Birks & Mills, 2011). By 2000 more scholars were moving away from the traditional grounded theory positivism of Glaser, Strauss, and Corbin, and constructivist grounded theory emerged, developed by Charmaz, who incorporated the inductive, emergent, repeated comparisons and open ended approach of Glaser and Strauss with an emphasis on action and meaning (Charmaz, 2014).

**Traditional grounded theory.** Grounded theory originated from the collaboration of Glaser and Strauss, and their need to pioneer a methodology where theory was grounded in empirical research (Méabh & Fourie, 2014). Glaser and Strauss (2008) warn that theoretical sensitivity may be disrupted if research begins with the researcher having a preconceived potential theory that could fail to allow the data to dictate the findings. Literature reviews are discouraged as it may make the researcher less open-minded (Glaser, 2004). An effective initial strategy suggested was to ignore theoretical literature and facts about the area studied (Glaser & Strauss, 2008). Yet, though there was concern about insights being stifled or contaminated by prevailing theory, Glaser and Strauss
(2008) acknowledged that one cannot erase from the mind all theory known before beginning research, but a researcher could line up what might be theoretically probable.

Shank (2006) noted that Glaser found approaches such as constructivism and naturalistic inquiry provided too many concepts and ways of looking at the world, because a clearly delineated process of interacting with the setting was required to raise conceptualizations prior to bringing preconceived notions to a setting. Constant comparison is done, with all relevant data coded, and axial coding is commonly done in intermediate coding prior to advanced coding and theory integration (Birks & Mills, 2011). Glaser (2012) noted that traditional grounded theory categories are generated by constant comparison of many interviews. Glaser (2012, p. 28) mentioned that “all is data”; what is happening on the research scene is the data, whether the data be interviews, observations, journals etc., and the data includes the conditions and how the information is told to enable the researcher to ascertain precisely what is going on. Glaser (2012) elucidates that data are discovered for conceptualization into becoming theory, after data collection, coding and analysis and that the constructivist orientation uses interacting interpretations (Glaser, 2012). In both traditional and constructivist grounded theory, data must not be forced into predetermined codes and categories, and researchers must not force preconceptions on data (Charmaz, 2006).

**Constructivist grounded theory.** Constructivist grounded theory was developed by Dr. Kathy Charmaz who studied at the University of California, San Francisco and who was taught by both Glaser and Strauss, yet she diverged from their methodologies significantly, from Glaser’s philosophy, to Strauss’s coding procedure (Méabh & Fourie, 2014). Both traditional and constructivist grounded theory find theory induced from the
data gathered (Cutcliffe, 2000; Charmaz, 2006). However, in constructivist grounded theory the researcher interacts with the participants, interpreting their social world and meaning to understand what is going on, and avoids preconceptions before the research begins (Hunter, Murphy, Grealish, Casey, & Keady, 2011).

One can try to enter research with an open mind, but not an empty head, yet Glaser in traditional grounded theory maintained that researchers must not engage with literature about their research topic, but instead review literature on related topics to ground themselves in data (Bryant 2009). Strauss and Corbin later challenged the idea of abstaining from literature and after Strauss’s death, Corbin affirmed the constructivist view (Méabh & Fourie, 2014). A literature review is permitted in constructivist grounded theory (Charmaz, 2014).

Research is an involved interpretation of reality and the interpretation of the collection and analysis is the foundation for theory derived from social reality (Hunter, Murphy, Grealish, Casey, & Keady, 2011). Constructivist grounded theory requires that a sense of reciprocity be developed between the researcher and participant in the co-creation of meaning, eventually resulting in a theory grounded in the co-created experience (Mills, Bonner, & Francis, 2006). Additionally, reducing the power imbalance between the researcher and participants, so that the participant does not feel subordinate to the researcher, by having the researcher take a “more reflective stance” during planned time together is needed (Mills, Bonner, & Francis, 2006).

Allan (2003) noted that the researcher should avoid preconceived ideas when coding, and should not force the data by looking for evidence of preconceived notions. Hence researchers must be wary of their assumptions and biases. Researcher ideas about
what they believe may have affected participants should not influence data findings. Hence, the researcher framed questions carefully, was careful of body language, and was careful not to share an opinion during interviews. However, Charmaz (2006) noted that researchers’ assumptions and perspectives may assist them in detecting possibilities and processes in data. The constructivist view dismisses the notion of the neutral observer, recognizing that researchers must examine rather than erase preconceptions, and notes that values can aid in identifying information (Charmaz, 2014). Additionally, constructivist grounded theory emphasizes reflexivity, self-examination that examines preconceptions (Birks & Mills, 2011).

Bryant (2009) attested that constructivist grounded theory, as developed by Charmaz and reinforced by Bryant, addressed methodological challenges of past years to provide a more robust structure for researchers, but warns further clarification is needed on how theories and concepts build knowledge and further research. Though constructivist grounded theory provided a firmer conceptual basis, some felt it complicated the method; however, the unavoidable re-interpretation linking it specifically to pragmatism, where theories or concepts are considered via their usefulness, clarified imprecise methodological ambiguities (Bryant, 2009).

Information found in interviews supplied rich information to be compared, but a causal relationship could not be inferred due to the purposive sample. Enquiring about perceptions of nurses who had experience transitioning to their educator role developing curriculum and coursework required qualitative inquiry for better understanding of how to navigate the currents of the changing nurse educational system.
Justification for use of constructivist grounded theory. Constructivist Grounded theory is used to compare and discover. Additionally, the researcher’s position, perspective and interactions are considered as part of the research reality (Charmaz, 2014). Quantitative methodology is inappropriate, because a flexible methodology appropriate for a unique sample that would provide rich data were required. This study’s intent was not to quantify dependent and independent variables or test previous theory, but to generate theory that evolved from interpretation of faculty constructions, and create a model to support faculty. Additionally, Constructivist grounded theory is appropriate as it quickens the process of gaining a well-defined focus on what is occurring with the data without forfeiting fine points, and it can be a sharp tool for generating and mining data (Charmaz, 2006).

Hopwood (2011) found that constructivist grounded theory provides a dynamic approach that can focus on the past, present, or future. Rich data were provided by open-ended questions that facilitate the participants thought flow (Dillman, Smyth, & Christian, 2009). Gorra (2007) noted that grounded theory was a useful tool when seeking knowledge about participant perceptions and feelings about a subject area.

Breckenridge, Jones, Elliot, and Nicol, (2012) share how Charmaz advocated that her view took a middle ground between postmodernism and positivism, offering assessable methodology with meaning constructed by individuals as they interact and interpret, rather than an objective truth to be discovered. Researcher and participant co-construct data, giving voice to participants, and unlike classic grounded theory that looks for one main concern, multiple participant perspectives are valued (Breckenridge, Jones, Elliot, & Nicol, 2012). In the current study multiple perspectives are valued as it is not
just one concern that leads to difficulties, but a complex array; hence, the constructivist view is more appropriate, taking views about many concerns from multiple participants.

Additionally, Mills, Bonner, and Francis (2006) note that the design must agree with the researcher’s beliefs about the nature of reality. Constructivism denies that an objective reality exists, a relativist ontological view, while classic grounded theory perceives a more objective reality (Mills, Bonner, & Francis, 2006). I believe that perceptions and experiences shape how reality is interpreted. Hence, constructivist grounded theory is a better fit.

Drury, Francis, and Chapman (2008) used constructivist grounded theory as a method to decrease data and develop categories with data collection and analysis occurring both together and cyclically. Open-ended questions were used. Data were compared, and categories were constructed, and ultimately codes became saturated, and relevance was more easily apparent with this method. The open-ended question type, data comparison, and construction of data categories were required for the constructivist grounded theory study.

Newton (2012) noted that constructivist grounded theory that examined processes and made studying actions central to interpretive understanding was a more flexible grounded research design than the traditional grounded approach; furthermore, from the theoretical perspective, the traditional approach was to predict and explain, treating concepts as variables, while the constructivist approach conceptualized the phenomenon, understanding it in abstraction to offer an imaginative interpretation. Wilson (2006) noted in her constructivist grounded study, that perceptions were socially constructed with
meaning assembled from life experiences. In this study, faculty perceptions, assembled from experiences, were interpreted to create theory.

Meadows and Hyle (2010) discussed qualitative methodology, noting concern about rigour and reliability and the absence of comparative analysis, but concluded after their research that their grounded meta-analysis research offered a comprehensive and sequentially stepped procedure for analyzing multiple case-study data that was very effective. Benoliel (1996) contended that how meaning is constructed in different social contexts and by different people is a basis for the grounded theory qualitative view. In the current study the experiences, perspectives, and strategies of the nurse educator were examined as they reflected on their self-perception when developing, evaluating and revising BSN curriculum. See Table 2 for further clarification of the grounded theory categories.

Table 2.

Comparison of Traditional and Constructivist Grounded Theory

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<th>Traditional Grounded Theory</th>
<th>Constructivist Grounded Theory</th>
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<tr>
<td>Previous</td>
<td>A literature review is either not done or is minimally done. Glaser (2004) believes</td>
<td>Lillemor Hallberg, editor-in-chief of the International Journal of Qualitative Studies on</td>
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<td>Knowledge</td>
<td>the researcher’s view is clouded by a literature review and without one the researcher</td>
<td>Health and Well-being (2010) stated that in grounded theory, when a model or theory can be</td>
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<td>Brought to</td>
<td>will remain more open-minded; additionally, he considered a literature review a waste of</td>
<td>perceived from the data, a literature search should be completed and connected into the</td>
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<td>the Study</td>
<td>time that could impede analysis. Classic grounded theorist researchers were expected to</td>
<td>evolving theory. Some reasons Hallberg (2010) stated that an early literature review is</td>
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<td></td>
<td>avoid an extensive literature review before conducting the study to avoid preconceptions,</td>
<td>needed include:</td>
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<td></td>
<td>as what</td>
<td>• To see if similar research has been done before.</td>
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<td></td>
<td></td>
<td>• For background information and to motivate interest for the research.</td>
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<td>• Because it is requested by authorities</td>
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is important will emerge during the study (Hallberg, 2010). when researchers apply for grants, ethical permission to conduct research, or when a doctoral student applies as a PhD candidate.

McGhee, Marland, and Atkinson (2007) concluded that researchers close to the field may have theoretical sensitivity, and be familiar with research on the topic, but use of literature should not prevent grounded theory from emerging. Keeping an open mind does not require the researcher to be ignorant. Brown, Stevens, Troiano, and Schneider (2002) note that the researcher must demonstrate theoretical sensitivity as researcher beliefs about phenomenon are critical, and that in order to achieve theoretical sensitivity, the researcher must be saturated in the professional literature as well as personal experiences.

| **Researcher Role** | There is an assumption of an external reality (Mills, Bonner & Francis, 2006). Objective detailed description of data are desired. Grounded theory procedures use constant comparison resulting in a continuous evolving analysis that produces theory, with accurate description preferred over abstraction. (Glaser, 2004). Classic grounded theory is a theory generating method that produces concepts from data with the researcher maintaining analytic distance, entering the study with as few predetermined ideas as possible (Glasser, 2004). Data are coded in every way into as many categories as possible, and data are constantly compared (Glaser, 2004). The researcher compares participant’s actions and processes and interprets the construction of participants. Mills, Bonner, and Francis (2006) note that the researcher and participants co-construct meaning, and constructivism emphasizes the subjective relationship between participant and researcher. Prior researchers did not acknowledge their construction and interpretation of data, erasing the subjectivity rather than exercising reflexivity; however, to Charmaz (2006) subjectivity could not be separate from social existence, and she recognizes researchers are part of their research, not detached from it. The constructivist outlook puts an end to the idea of an objective value-free expert, with the researcher instead scrutinizing how their preconceptions may affect the research analysis but also meaning that values held by the researcher may be used to shape truths identified (Charmaz, 2014). |

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| Reflective Process | Social reality can be different to different people, and is a process that is constructed, so the researcher’s position, perspective, and interactions are an intrinsic part of the study, which is itself a construction (Charmaz, 2014). The research reality includes what both the researcher and participant bring to it and do, with relativism portraying what is co-constructed rather than objective description. Research actions are not given, but constructed, fostering researcher reflexivity about the activities and decisions made between participant and researcher (Charmaz, 2014). In the 1990’s many scholars moved grounded theory away from the positivism used by Glaser and Strauss, and Corbin’s earlier works, espousing a comparative open-ended approach that answered criticisms about earlier versions (Charmaz, 2014; Babchuck, 2009). Constructivist grounded theory has liberated grounded theory from positivism, aligning with interpretive approaches better suited to explore research and practice, facilitating analysis of dynamic interactions between participants and researchers (Babchuck, 2009). Reflexivity is emphasized (Birks & Mills, 2011). |

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Mills, Bonner, and Francis (2006) also affirm it is important for the researcher to reflect upon their assumptions yet in their research conclude that the researcher should partner with the participants in the research process rather than just be an objective analyst of their experience. A sense of reciprocity between participants and researcher in co-creating meaning and eventually a theory grounded in the participants experience with the researcher is vital in constructivist grounded theory (Mills, Bonner, & Francis, 2006).
Charmaz (2006) clarifies that constructivist grounded theory gives priority to the phenomenon or process, rather than the setting description. Charmaz (2006) defines process as consisting of “unfolding temporal sequences” that may have markers at the beginning and ending that are linked, leading to change (p. 10). Smaller events are linked to the larger whole. Ghezeljeh and Emami (2009) describe the constructivist approach to grounded theory as seeing data and analysis created from shared experiences and relationships with participants in a time, place, and culture, noting that there is not an objective reality due to realities being a social construct of the mind, invented by each individual. Therefore, constructivism attempts an interpretive understanding of participant’s meanings by constructing data through interaction between the researcher and the participant, with the understanding that social realities are inseparable (Ghezeljeh & Emami, 2009). Charmaz (2006) describes grounded theory as a way to learn about worlds, and develop theory to understand them; grounded theory is constructed through past and present associations with people, perspectives and practices. Interpretivists, feel that social actors and peoples’ perceptions construct reality, and individuals have a variety of backgrounds, assumptions and experiences that contribute to their construction of reality that exists in social context though social interaction (Wahyuni, 2012).

Constructivist grounded theorists may write analytically, but their writing needs to evoke the participants experience, and make connections (Mills, Bonner, & Francis, 2006). These connections demonstrate the value the researcher places on the participant (Mills, Bonner, & Francis, 2006). As the researcher tries to look through the eyes of the participants, the researcher offers respect, even if they do not agree, and there is no need to adopt their views, but instead the views are interpreted (Charmaz, 2006).
In keeping with constructivist grounded theory, to explore the perceptions and confidence of faculty, interviews of faculty were held to collect data. The constructivist approach was useful to interpret the perceptions of faculty experiences developing, evaluating, and revising curriculum. Charmaz (2006) notes that the constructivist approach does more than look as how participants view their experiences, but also theorizes their view, acknowledging the theory as interpretation that depends on the researchers view. Nurse educator experiences with curriculum and outcome development were categorized, compared, and interpreted, not just described. Interpretive understanding of how nurses create understanding and meaning in their reality was the result of analysis. An imaginative theory “may spark bursts of insight but offer frames with porous borders” (Charmaz, 2006, p. 149). There were unknown possibilities such as gaps in understanding or preparation discovered, as well as how to better support faculty, and provide strategies for those who evaluate, develop, and revise curriculum.

During the constructivist grounded theory study, I remained aware of the larger picture, then focused more and more closely on the details. The analytic categories and the relationships described between the categories discovered provided conceptual scaffolding upon which to build levels of abstraction (Charmaz, 2006). As the purpose of the present research was to discover and compare the insights and processes of faculty related to their preparedness and confidence to develop, evaluate, and revise curriculum, constructivist grounded theory was viable. After faculty reflected on their experience of developing, evaluating, or revising curriculum, and their preparedness, some of them better understood their role, one even specifically stating it would better prepare her for an accreditor visit.
Research Design

The study used a constructivist grounded theory approach to explore and compare the perceptions and processes of nursing faculty regarding their preparedness and confidence in developing, evaluating, and revising curriculum and the processes used for preparation. The Excellence in Nursing Education Model (NLN, 2006) provided a framework to portray well-prepared faculty who need competence in curriculum design, implementation and evaluation. A theory describing how faculty challenges lead to becoming overwhelmed with curriculum development, evaluation, and revision and a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision was developed with strategies to benefit educators.

Grounded theory is a methodical and flexible way to collect and analyze qualitative information to construct theory that is grounded in data (Charmaz, 2006). In constructivist grounded theory, data are constructed though observations, interactions and information about the topic, and initially memos about ideas, comparisons and codes were written to ascertain the best match to interpret preliminary analytic categories as recommended by Charmaz (2006).

The purpose of the research. The purpose of this study was to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. Educators are expected to revise and evaluate BSN curriculum in addition to teaching responsibilities. It
was hoped strategies would be unveiled to assist faculty’s growth and competence in curriculum development, evaluation and revision. There was a lack of research on faculty preparedness and confidence in developing, evaluating, and revising curriculum. A constructivist grounded theory design was used to discover and compare BSN program nursing faculty perceptions of preparedness and confidence in curriculum development, evaluation, and revision, with a model created, and strategies discovered.

**Data collection procedure.** Initial contact occurred via email to the nurse director, dean, or chair of the nursing program of four colleges to request permission to use the premises and participants. Information about the study, including the purpose, problem, consent forms, and protocol to be used, were available for them and their organization’s board to review. Participants were contacted via email or telephone after the premises form (Appendix F) was signed allowing for recruitment to occur. Fifteen nursing faculty from a University, two state colleges, and a private college setting in Vermont were interviewed to achieve theoretical saturation. The problem and purpose of the research and the informed consent were presented via email, and the participant role was described. If the potential participant agreed to be interviewed, a time and place was planned to meet with the participant. I then met with the participant, and brought a paper copy of the informed consent form that included the problem and purpose of the research. The informed consent was reviewed verbally as well, and also that the participant understood the problem and purpose, and that the consent was signed before beginning the face-to-face interview. All interviews were recorded with permission. The informed consent form included permission to record the interview. It was also reviewed that the participant could withdraw at any time without any repercussions, and a contact email and phone number was
provided. Interview times ranged from 30 minutes to an hour and a half depending on how long the participant wanted to talk. Interviews continued until data saturation was achieved, with insights gained about the research topic to inform theory construction.

Each participant was also offered an opportunity to ask questions, and was verbally made aware they could withdraw at any time. The interview protocol is listed in Appendix G. Descriptive characteristics collected include: age, gender, race, education preparation level, total years of experience, and educator preparation, including courses in curriculum development if any. Participants were asked how long they had been a nurse, and how long they had been an educator in years.

The purpose of the study, to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision was provided at the beginning of each interview on the consent form (Appendix H). Participants were recorded after they were asked if they understood the purpose, and consented, when the lack of coercion was also confirmed in participation. The colleges used either Commission on Collegiate Nursing Education (CCNE) or Accreditation Commission for Education in Nursing (ACEN) for accreditation.

Interviews were offered away from the workplace to ensure privacy and anonymity; however, the location was at the discretion of the interviewee and college. Some faculty preferred to use their office, as it was more convenient and private for them. Faculty were able to choose what felt most comfortable and safe for them.
Demographics regarding age, gender, race, education preparation level, total years of experience, and educator preparation requested are listed in Appendix K. An additional demographic question added was how long the participant had been at their current location. The participants were asked to share what it was like for them to develop, evaluate, or revise curriculum and what challenges he or she faced. Recorded semi-structured in-depth interviews were performed. Participants’ responses were collected via both a digital voice recorder and cell phone voice memo, then listened to, transcribed, and read to get a sense of the faculty experience.

The initial questions are listed in Appendix K. Participants were encouraged to give details of their experience in order to better discover and interpret meaning. Reflection of meaning needing clarification and consideration of physical, emotional, sociocultural, and spiritual concerns was done prior to the interview process, usually when driving through the countryside to the interview, which often took hours. All interviews were commutable by car within a four hour drive, and were located in Vermont. Participation was voluntary, with voluntary informed consent obtained. Additionally, the participants’ ability to participate and what facilitated their ability to describe the meaning of their experience was considered. After confirming permission, presencing was used to facilitate understanding of the participants’ characteristics and uniqueness. Interviews were held at a college, small conference room, book store, restaurant, or private office, depending on participant preference.

To answer the two research questions:

1. What are the perceptions of faculty regarding their preparedness and confidence for developing, evaluating and revising curriculum?
2. What strategies by nursing leadership and education might benefit nurse educators who develop, evaluate, and revise nursing curriculum?

Faculty were asked seven demographic questions and seventeen interview questions. These are listed in Appendix K. After initially being asked to tell about their experience developing, evaluating and revising curriculum, more specific questions were asked to address each research question. As interviews progressed, several questions were added for theoretical sampling.

Benner, Tanner and Chesla (2009) suggest that the researcher interviewer should encourage a full narrative of a challenge faced that includes context and history of the episode, how the experience presented and evolved and the educators concerns and actions; hence, examples of challenges faced were requested during the interview. Charmaz (2006) encourages the use of clarifying questions or comments to keep a story coming, but chooses questions carefully to promote participant reflections, exploring rather than interrogating. After involving the participants using presencing to connect and engage them, an interpretative account from the participants was encouraged. Charmaz (2014) notes that intensive interviewing is a flexible technique that allows the interviewee to observe sensitively, encourage ideas to arise, allow for immediate follow-up, and results from participant and interviewer co-construction of the dialogue. Laverty (2003) noted that Gadamer made use of co-creation between researcher and participant using a self-reflective attitude as part of the process that continued until meaning was found without inner contradictions. Intensive interviewing encourages participants to interpret their experiences, describing and reflecting with the interviewer (Charmaz (2006). Hence, intense interviews that took from a half hour to an hour and a half were
done through semi-structured one-on-one face-to-face interviews. The perspectives of faculty brought valuable meaning to inform practice. After an interview was complete, I would reflect upon the dialogue, and consider how it compared to other interviews, to my own life experience as faculty for 12 years, nurse for 25 years, and consider new themes that emerged. Face-to face interviews undertaken facilitated optimal communication.

At the end of the interview period a request for a 300 word or less reflection participants recalled from when they were developing, evaluating, or revising curriculum was requested. The interviewee had the opportunity to review the transcript of the interview to make any needed corrections. Discussion of the reflection and follow-up to offer review of the interview transcript with the participant is another example of sufficient time allowance with participants to create a trusting relationship. Few participants chose to add a reflection, but several encouraged further contact. A final visit was offered to review findings, but most participants chose to review their interview via password protected encrypted email. Sufficient time was spent with participants in order to create a trusting relationship. Time spent with participants created a trusting relationship, reducing the likelihood of misleading and distorted information, or withheld impressions that participants might consider undesirable (Rubin, 2008). Recording interviews and rereading information improved accuracy. The tone of the interview was informal. This clear description of the study process provides other researchers to ability to transfer the process to another population or setting.

**Population for the study.** The target population was adult nurse educators of any gender, race or religion. Nurse faculty participants were required to have a minimum of one year as an educator who evaluated revised, or developed curriculum in a BSN
program in Vermont. Adult was considered to be over 18 years old. The BSN programs
that received IRB approval for the study were located in Vermont. The educators were
not required to reside in Vermont, but needed to have been faculty at one of the Vermont
IRB approved college locations for a minimum of one year. All the educators were over
18 years old.

Inclusion criteria included being an adult nurse educator at the BSN level who had
a minimum of one year of experience developing, evaluating, or revising curriculum at a
nursing college in Vermont. Any gender, religion, or ethnicity was welcome. Education
level was BSN and above, though MSN preparation was expected. All study participants
met inclusion criteria, so were adult faculty members of nursing programs in Vermont,
with a minimum of one year as an educator who had evaluated, developed, or revised
curriculum of any gender, race or religion. All participants had a minimum of an MSN
degree.

BSN educators were expected to be minimally MSN educated as the Board of
Nursing in Vermont requires that faculty have a minimum of a graduate degree with a
nursing major (ACEN, 2013). However, baccalaureate prepared educators with at least
one year of experience were not to be excluded. All the educators had a MSN degree or
higher. Four of the participating educators had as their highest degree attained the MSN,
three had a DNP, one had a Doctor of Health Science degree, and seven were Ph.D
prepared. Area Health Centers Education Program (2014) reports that in Vermont there
are 266 registered nurses with an MSN, and 37 with a doctorate. There are 57,020 health
Statistics (BLS) (2014) reports there are 6,540 registered nurses in Vermont. The AACN (2014) *State Snapshot* lists the average age of Vermont nurse faculty as 54 years.

Findings from the U.S. Department of Health and Human Services Health Resources and Services Administration (2010) in their 2008 survey disclosed the average age of a registered nurse in America was 46, and that nearly 60% of nurses who were primarily nurse faculty were over 50, which is appropriate as according to Benner (2011) it takes at least five years to develop expertise. The average age of the American nurse is rising. The 2013 survey by the National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers, revealed 55% of the United States nurse workforce was 50 or more (AACN, 2014). There are 250 health educators listed for Vermont (BLS, 2014). There were 81 nurse educators listed on the web pages at the five colleges in Vermont. This includes not only the participant’s colleges, but additionally the researcher’s college.

Participants from four colleges were interviewed. The age range of the study participants was 34 to 65, with an average age of 53 years of age. The majority of those interviewed were female, thirteen women (87%). There were two males (13%) interviewed, which in nursing is roughly representative of the nurse population, as the percentage of males in nursing in America is only 8.1% (U.S. Census Bureau, 2013). Participants had been a nurse for 11 to over 45 years, with an average of 29.6 years of experience. Participants had been educators for three to 34 years, with an average of 13.7 years. They had been at their current location from one to 14 years, with an average of six at their current location. All educators were Caucasian, but varied in their ethnicity from “native Vermonter” to Irish, Polish, Italian, French, British, and European. Educators
that were not Caucasian were approached, but did not have time to participate in the study.

Exclusion characteristics included less than a year as an educator engaged in curriculum. Two potential participants responded via email but did not meet the qualification of having a minimum of a year of experience developing, evaluating, or revising curriculum in a BSN program, so were excluded. Education related to curriculum ranged from 0 to 20 courses and one person could not quantify the number but stated, “a lot.” All of the 15 educators worked at a college or university in Vermont with an average of 4 participating from each college. All 15 educators provided rich and valuable descriptive data to share that addressed the study purpose.

**Setting.** The setting was academia in Vermont. Interviews were held privately in a Vermont college, small conference room, or private office, a restaurant, or library area depending on participant preference. Some faculty preferred to use their office, for convenience and privacy. Faculty were able to choose what felt comfortable and safe for them. After the participant selected the location, I would schedule a conference room or reservation if needed, then, drive to their location. One participant chose to drive to my campus where a private conference room setting was reserved. Privacy and confidentiality were maintained.

**Research sample.** The research sample was a non-probability – purposive sampling, which is commonly used when there are limited participants with expertise in the area of study (Anderson, 2010). A purposive sample uses a subset of a larger population such as nurse educators who develop, evaluate, and revise curriculum. Nurse
educators are a subset of nurses, and nurse educators with curriculum expertise are a subgroup of nurse educators. Experience in curriculum evaluation, revision, or development was needed for the participants to be able to respond with relevance to interview questions that pertained to the problem and purpose of the research, providing useful information to address the research questions.

**Sampling method.** A purposive sample is common in qualitative research, with particular individuals chosen who have characteristics relevant to the study (Anderson, 2010). Subjects have a common characteristic such as experience developing curriculum. Purposeful sampling chooses particular subjects because they make possible the expansion of developing theory, but it is not random. (Bogdan & Biklen, 2007).

Participants needed to have knowledge, specifically about curriculum development, evaluation or revision. Non-probability – purposive sampling is primarily used when there are limited participants with expertise in the area of study, such as nurse educators who develop, evaluate, and revise curriculum, which is part of the college nurse educator role.

A sample of current experienced nurse faculty from colleges in Vermont was recruited. Results from a purposive sample from a region or state could be compared to a national study, or a different region study using a similar sample with the same characteristics, but findings are not considered to be generalizable to the general population. It is normal for educators to develop, evaluate, and revise curriculum in educative settings; however, permission from deans, department chairs, or program directors as well as faculty participants were obtained. Taking participants from multiple colleges makes the sample more representative of the population. The Dean of Nursing,
nursing chair, or program director received an initial request (see Appendix E) that their faculty could participate in the study, then permission to recruit faculty and be on the premises was requested (Appendix F). Premises forms to allow recruitment for participation were received from each college. The initial interview protocol is listed in Appendix G. Participants had to sign an informed consent (see Appendix H).

**Sampling recruitment.** Initial contact occurred via email to the nurse director, dean, or chair of the nursing program of each college to provide the problem and purpose of the study, to request permission to interview nursing faculty members from their organization, and obtain permission to use the premises and recruit participants (see Appendix E and F). The director or department chair was asked to provide a list of faculty who met criteria to assist in recruiting qualified participants. Half of the directors or chairs shared a few candidate suggestions, and half alerted their faculty to the research. Several participants shared that potential participant names were available through their website. Of the few names provided, most of those named did not respond.

In three colleges contact was attempted on all qualified faculty to get adequate participation by email or phone. In the fourth college, full-time professors and assistant professors with experience in curriculum were approached using the college website, as they were most likely to qualify, until the sample was sufficient. An invitation to faculty form was sent out to inform faculty of the study via email after the permission to use premises form was signed (see Appendix J). Regarding measurement issues, a translator could be contacted if language made it difficult for an educator to understand questions, invitations, or to write responses in order that an accurate understanding was obtained, but this was unnecessary as all potential participants spoke English without difficulty.
Sample size. Sandelowski (1995) described how qualitative sample sizes vary, but generally require 10 to 50 participants; however, an adequate sample size is one that is not too large to permit meaningful case analysis, and not too small to find new and richly textured meaning. Charmaz (2006) noted that sampling to develop properties of the categories should continue until no new properties emerge. Theoretic sampling to develop emerging theoretical categories is done to obtain data to help the researcher explain categories, and when the categories are full, the qualities of participants experiences provide analysis for understanding (Charmaz, 2006). By checking emerging questions, and comparing data to data, conjectures about categories can be made (Charmaz, 2006). A small sample size of 15 Vermont nurse educators was used. Because the data focus is on the richness of the data and researchers conclusions, qualitative studies usually have smaller samples than quantitative studies that could perform a power analysis to determine size (Schmidt & Brown, 2009).

Rudestam and Newton (2007) clarified that in qualitative research, saturation shows adequacy of sample rather than high numbers, as enough data/data saturation needs to occur, and appropriate, purposeful participation rather than random provides for theoretical needs in the qualitative scenario. Creswell and Plano Clark (2007) discovered that too large a sample size may prevent the researcher from obtaining rich description of detail needed for a qualitative investigation. The sample size was small, and used non-probability sampling. More experienced respondents were better able to answer questions about developing, evaluating or revising curriculum. Benner’s (1984) Novice to Expert model of skill acquisition in nursing, notes that it takes years for a novice to develop proficiency.
Anderson (2010) recognized that a small sample was necessary in qualitative research due to the detailed and intensive work required; therefore, sample sizes do not use the mathematical rules and probability statistics employed in quantitative research, but the sample is described in terms of characteristics and pertinence to the greater population. DeBoor (2010) notes that qualitative research such as phenomenology uses a smaller sample size without a specific rule as to size, that stops adding participants when no new information is obtained during sample selection. In other words, interviews are conducted until data saturation occurs. Schmidt and Brown (2009) specify that the sample size is sufficient when the researcher achieves data saturation, when collecting data from more participants adds no new information. In research such as phenomenology or grounded theory, saturation shows adequacy of sample, not numbers, as data saturation needs to occur, and appropriate, purposeful participation rather than random provides for theoretical needs in a qualitative scenario (Rudestam & Newton, 2007).

In the current study, by the second and third interview, there began to be redundant findings on the need for mentors and the need for faculty education. By interview three communication deficits and knowledge gap findings were recurring. By the fourth interview the findings related to confidence become apparent as well as the need to discern the challenges and barriers more clearly to clarify the difficulties faced. Hence, the question about what made it more difficult was added by interview seven as the question about challenges was not providing enough clarity. Theme three and six also recurred frequently within the first six interviews.
The interesting term “hidden curriculum” emerged in the first interview, but did not emerge again until the tenth interview. It was explored with inadequate results to support a theme in the remaining interviews. Later interviews confirmed earlier findings from the first six interview, but offered some new strategies. Interview 14 was confirming of other information but provided little new information. For example, repetition about too much content being required, and the heavy workload, had been mentioned multiple times. Interview 15 provided only redundant confirming information.

Thomsom (2011) noted that when interviews are repetitive and provide no new data, saturation has been met. It could take 10, 20 or 30 interviews for data saturation to be met, but in the current study 15 was sufficient, as redundancy was occurring. In the qualitative study by Patterson and Krouse (2015) that used a purposive sample, 15 leaders in nursing education were used, the same amount as the current study. By targeting more knowledgeable participants, the data quality increases, and with more usable data from each participant, fewer participants may be needed (Thomson, 2011). In this study the least experienced nurse had practiced 11 years, with an average of 29.5 years, so the sample was very experienced, and excellent data were found.

Guest, Bunce, and Johnson (2006) found 12 to be an adequate number of interviews for most qualitative research, but noted that a smaller sample could be highly accurate, particularly if the sample shared participant homogeneity, noting purposeful samples are chosen due to common criteria. Ninety-four percent of codes were realized in their first six interviews out of 60 interviews, and by the 12th interview 97% of codes were present. Additionally, experts tend to agree with each other more frequently (Guest, Bunce, & Johnson, 2006). Hence, it was expected that at least 12 interviews would be
required, and interviews would continue until saturation was met, which was expected to be less than 20. The intended sample size of between 12 and 20 was met by the realized size of 15 current experienced nurse educators, which exceeded the recommended sample size and met saturation.

The last interview confirmed data saturation had already occurred, where only similar data rather than new findings emerged. During the study, back and forth comparison between data and theory continued until theoretical saturation occurred, when new data or settings produced no new insights or theoretical category properties, and the research circle was finally closed (Silverman, 2011). Too large a sample would not allow for meaningful analysis. An oversized sample may prevent the researcher from obtaining the rich description of detail needed for a qualitative investigation (Creswell and Plano Clark, 2007). The sample size of 15 was over 10, not oversized, achieved data saturation and obtained rich descriptive data.

**Protection of human subjects**

*Informed Consent.* Lincoln and Guba (1985; 2005) warn that the keys of access are apt to be in the hands of many gatekeepers, both formal and informal, who want to be informed of the inquiry to assess the risk the research may pose to themselves and others. Quality Review Board approval is required from the University of Phoenix. Permission was received from nursing department chairs, and nursing directors to recruit faculty (see Appendix F). Participating in the study was voluntary. Faculty participating in the study signed a voluntary informed consent form (see Appendix H) and were allowed to withdraw at any time. Several state colleges, a private college, and a public university
were where participants were recruited. By recruiting participants from several colleges, it is impossible for readers to trace individual responses of participants easily, and names were coded and kept confidential. Instructions included information that reminded participants of their rights and showed no coercion was used, such as:

You may decide not to be part of this study or you may choose to withdraw from the study at any time. If you want to withdraw, you can do so without any problems. There will be no penalty if you decide to quit the study (Appendix H).

Participants were treated ethically, and the Belmont Report (HHS, 2011) reminds researchers to not only protect participants from harm, but also to make an effort to secure the participants well-being. Respect involves making sure participants are aware they are free to withdraw, even if they initially agreed to participate. Consent was obtained. It was important that participants comprehended the information about the study, along with the ability to opt out, and participation voluntary not coerced by an inappropriate or excessive reward (HHS, 2011). Hence, verbal as well as written information was provided. The benefit outweighed the risk for harm, as society will benefit from the result of improving nursing curriculum, and less overwhelmed faculty.

Social justice in participant selection was observed. Transparency about the reason for why the study is being done was achieved, and participants were asked if they understood the problem and purpose before interviewing occurred. External forces can influence the participant responses, such as perceived pressure or influence from supervisors or peers to respond a specific way. In qualitative interviews, a participant may say what they think the interviewer wants to hear; therefore, how responses are structured and how, such as emotion, tone, and nonverbal communication was considered (Anderson, 2010). 

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Emotion, tone and nonverbal communication were considered during the interview to achieve a more neutral response, so as not to encourage a specific perspective, and reinforce that there were no right or wrong answers.

There was minimal risk to participants, as curriculum development is normally done in the educational environment. Furthermore, coded names maintained confidentiality and anonymity. Voluntary consent was obtained and the consent form stated that the participation was voluntary, and that if the person becomes a participant, they could change their mind, deciding not to take part, or to quit at any time without penalty. Consent was obtained without duress prior to participation, and it was verbally confirmed when face to face prior to interviewing that consent was voluntary, and the terms understood when the participant signed their form. Participants were aware they were free to withdraw, even if they initially agreed to participate.

Participants were treated ethically, and the Nuremberg Code and the Belmont Report remind researchers to protect participants from harm and make an effort to secure the participants well-being (HHS, 2011). To protect autonomy, participants must be informed of the benefits and risks of participating in the study in order that informed consent regarding participation is obtained (Schmidt & Brown, 2009). The risk of any intervention must be clearly listed as well as the benefit, to protect the participant from harm. The harm could be psychological or physical. It is also expected that researchers minimize subject burden, the demands on the participants (Schmidt & Brown, 2009). The more burdensome the study, the less likely it is that the participant completes it. Additionally, selection protocols reduce bias. Researchers should not be persuaded to enlist participants without following selection protocol, nor should they coerce subjects to
remain in a study. Participants were nurse educators who were literate in English. Instructions included understandable language that reminded participants of their rights and showed no coercion was used, and the study was not burdensome.

**Confidentiality.** As explained under faculty recruitment, permission from the nursing chair, Dean, or director was acquired before contacting faculty via the premises form that allowed a researcher to recruit participants. Participant information was not shared with chairs, directors or Deans. By interviewing participants from multiple colleges, it not only made the sample more representative of the population, but additionally made it exceedingly difficult to ascertain who the participants were. Any data shared via email were password protected and thereby encrypted, with the password sent in a separate message using a laptop with a firewall that also had password protection. Recorded information did not use or record any names, and files were saved using a number or letter. Confidentiality must be maintained; hence, data collected and permission forms were kept in a locked file cabinet, and electronic data were coded and encrypted, with names kept in a separate place from the text files. The identities of nursing faculty utilized remains confidential. Each participant name was coded to maintain confidentiality. Faculty responses could disagree with management philosophy, so privacy was critical. NVivo software assisted the security of data via coding and access. The laptop computer used to analyze data required a log in password, and a firewall was in place with encryption. Additionally, data files were password protected within the laptop. Nurse Directors had given permission for faculty to be utilized, which shows support for the research, though they have their own beliefs that may differ from the participants. To protect participants from any administrative pressures that could
skew data, participant names selected for the study were not shared, and names were coded in software. Information provided from each participant was not traceable. Participants have their identity protected. Interviews were done where the participant felt safe and comfortable.

**Ethical considerations.** An ethical consideration was that the researcher was an Interim BSN Director at a state college in Vermont, though is currently faculty. I did not evaluate any faculty being interviewed, and did not interview faculty from my college. To further protect the rights of faculty, permission was received from participating college leadership for faculty to voluntarily participate in the study if faculty desired. Faculty promotion, retention or discharge was not affected. Informed consent was required from the participants who had the research problem and purpose explained to them when voluntary consent was requested. Other educators tried to ascertain if I had an opinion on the topic, so I was careful to remain non-judgmental and open to all views without revealing personal opinion, despite feeling empathy. Experience developing curriculum assists with understanding, yet theoretical sensitivity could be disrupted if the researcher had a preconceived potential theory that could fail to allow the data to dictate the findings (Glaser & Strauss, 2008). Participants were treated ethically, and participants were informed of the benefits and risks of participating in the study. To maintain confidentiality, all names were coded and kept apart from data in a secure location.
Data storage and maintenance. NVivo software assisted in keeping the information secure, and coding data. It was useful in organizing data from interviews. Computer storage was encrypted. Names were removed and codes used for data analysis. Paper files were shredded after data completion then burned, except for journal reflections that contained no identifying participant details. Names were removed, stored securely, and were not kept in the same locked file cabinet as the codes. Electronic files were backed up onto a hard disc and kept securely at a home network with a firewall. Electronic files will be deleted after three years. All paper files were kept securely in a locked file cabinet and computers used were encrypted. Names of participants were not kept in the same file cabinet as data from interview and reflections or journaling. Computer virus protection was maintained on the laptop.

Validity

Internal validity. Threats to internal validity include history, maturation, mortality, instrumentation, and regression (Marczyk, DeMatteo, & Festinger, 2005). History refers to events that occur during the time of the study that might cause a difference; however, there were no noteworthy events that occurred fall 2014 that appeared to affect the study. The IOM (2010) report’s recommendation that 80% of nurses should be Baccalaureate of Nursing Science (BSN) prepared by 2020, the faculty shortage, and the nursing shortage of one million RN’s by 2020 (ANA, 2010) could impact responses, as a shortage may result in fewer qualified faculty availability with more pressure to produce graduates.

Information about the college accrediting organizations was easily found on line so was verified. It was noted that one organization was changing their accreditation
affiliation, and would soon be expecting surveyors. The finding did not appear to have
affected data, as findings were similar across colleges, but it is likely that accreditation
standards were reviewed more carefully recently at one college.

Maturation over time was not an issue as the participants were adults and
interviews took place within a few months. The aging process did not appear to affect
participants over a few months. Mortality, when some participants drop out or die, was a
potential concern. However, no participants dropped out or died.

Instrumentation refers to the reliability of the instrument, in this case, the
researcher, and interview questions. It was the same researcher, myself, who interviewed
each participant for less than two hours. The same initial questions were asked, though, in
constructivist grounded theory, part of the process is that questions are added to later
interviews to clarify what emerges.

Regression, extreme or polarized characteristics, is another threat to validity.
Participants with a minimum of a year of experience were selected from four different
colleges. In this way, characteristics would be more representative of the general
population, rather than a narrow perspective that would be more likely to have polarized
views. In addition, I had the perspective of a fifth college in Vermont, my employer.
Hence, the views from five colleges reduced the likelihood of extreme outlier views.

**External validity.** Chen (2010) noted the increased awareness of the importance
of external validity in evaluation, and the difficulties of a study maintaining both internal
and external validity. External validity involves the ability to extend study findings
beyond specific individuals and the setting, with generalizability linked to the target
population to whom the researcher wants to generalize findings (Mertens, 2014).
External validity looks at the extent findings can be generalized, examining transferability of findings. Research participants had experience with nursing and curriculum work; hence, knowledge of participants aided credibility and trustworthiness. Mertens (2014) noted that the researcher needed to provide rich descriptive data to enable readers to understand the context in the setting to enhance external validity; therefore, full descriptive data were shared to elucidate readers. Participants also reviewed their interview transcripts.

Aldermatt (2009) notes that external validity often discusses the contexts: people situations and times. Humans do not live isolated from each other, but are studied and understood in the context of their culture, lived world, and social connections (Qualitative Research Network, 2006). Participants were interviewed during the fall semester of 2014, but not the first few weeks of the semester, as faculty would have been too busy. One college had decided to change accreditors as there were difficulties with the previous accreditor, and they wanted to remain accredited. I did not work for any of the colleges where faculty were interviewed. Interviews were carefully reported in context.

The sample size was small, but recently collected so findings would be more apt to apply. It was not a convenience sample, but was a non-probability purposive sample, as experience with developing, evaluating, or revising curriculum was required. The participants interviewed were Vermont educators who discussed real life processes that did not occur in a controlled lab environment, but across multiple colleges. Findings were from four different colleges within Vermont, which were different types of organizations: a private college, two state colleges, and a university. Whether insights gained in this study from the northeast hold true in other regions should be tested. Altermatt (2009)
notes that a concern regarding generalization is the effect of culture, and cultures in different regions or countries may vary. However, similar cultures could have similar findings. The situation would be the setting of academia. Generalization would be to the target population of nurse educators, particularly those within similar cultures in the northeastern United States.

Silverman (2011) noted that the techniques used in quantitative research are not the only way to establish validity of findings for qualitative research, and many practices originating from quantitative studies are inappropriate for qualitative research. For example, assuming research is only valid if based on dependent and independent variables, experimental data, and random sampling may exclude data resulting from observation of behavior and attitudes (Silverman 2011). Gorra (2007) noted that grounded theory values participant perspectives, experiences and involves an interactive process between researcher and participants where data collection often includes in-depth interviews. Grounded theory is not intended to seek representativeness to accomplish generalizability, but advocates generating new theory from interrelated concepts (Gorra, 2007). As statistic generalizability is not the goal of qualitative research, non-probability purposive sampling is a popular preferred method for most qualitative research, for the researcher can select a sample from which the most can be learned (Merriam, 2009). Non-probability purposive sampling was used for the study. Ensuring the perspective of an expert researcher aids in reducing the likelihood of the novice researcher making errors. Creswell and Miller (2000) encouraged a second lens to check how accurately participants’ perspectives are portrayed to improve validity. Triangulation using different researchers to review data in the same qualitative study and then compare findings, or
different data sources improves validity (Guion, 2002). If researchers reach similar conclusions, and perspectives are accurately portrayed, or different sources confirm findings, greater validity may be established. As minimal triangulation was used, reflexivity, a search for disconfirming evidence and a review of negative cases was done. Reflexivity was done by reflection and examining relationships during the research process as well as using a journal. Guba and Lincoln (2005) encouraged us to be interpretively rigorous to ensure our co-created constructions can be trusted.

Using an interview protocol provides an organized process of gathering and recording data essential to the qualitative research process (Creswell, 2013). A research interview protocol was utilized and is listed in Appendix G. This guide provided a reliable methodology for co-creating in the interview process. This also assisted with research validity by ensuring that consistent methodology in the interview process was used.

**Data analysis.** Initially the first participants’ responses were collected, listened to, and read to get a sense of their experience. The analysis of early encounters shaped later data collection by evolving to collect more data around emerging themes, and questions were added. This phenomenon was what Charmaz (1996) referred to as simultaneously collecting data and performing analysis. Initial data analysis indicates areas that need to be explored; therefore, the data collecting process was guided by continuous theory development, with the collection and analysis of data-taking alternating (Gorra, 2007).

As data were recorded on two devices, the digital recorder, and password protected voice memo, if any part of data were unclear it could be verified on the other.
Participants were also provided their transcribed data to verify accurate transcription occurred. News releases and email lists provided verification of frequent leadership changes mentioned by multiple research participants, and confirmed their employer. A self-study supplied by one college provided additional information that confirmed a substantial faculty load, but did not assist most themes.

Charmaz (1996, 2006) encourages coding for actions and processes to define what is happening in the data, rather than remaining descriptive. Coding shapes the analytic frame upon which the analysis is built much like bones can assemble into a skeleton (Charmaz, 2006). Texts were constructed for each participant from interview transcripts, field notes, and recordings. To become familiar with the information, engage in preliminary meaning and to get a feel for the preliminary interpretation to aid in coding, the texts were reread. Benner, Tanner, and Chelsa (2009) suggest identifying paradigm cases, which come in two types. The first shows a new or puzzling aspect of nursing that is significant but largely unarticulated that might alter interpretation of practice (Benner, Tanner, & Chelsa, 2009). The second enriches understanding of the demands and the skills involved that change or reorient a nurse’s practice (Benner, Tanner, & Chelsa, 2009). In contrast, the constructivist approach does not just theorize the interpretive work done by researchers, but acknowledges that the theory also interprets (Charmaz, 2006). Charmaz (2006) also notes memos can be used to capture thoughts, connections found, and directions to pursue that may occur in the moment. Memo writing is used during initial coding, focused coding about key issues, continually until new data emerges, and later memos are integrated when concepts are developed and an initial theory draft is written (Silverman, 2011).
At least two phases of coding are used in constructivist grounded theory. Phase one involves word, line, or segment coding, then phase two recognizes selected phrases that use the most frequently used or most significant codes identified in phase one (Charmaz, 2006). Word and segment coding was used in phase one. Data were repeatedly read for new categories, with immersion in the experience useful to correct previous categories and constructions, and the data differences were then analyzed. Participants’ ideas in their own words, are linked to topics such as competency, and new emerging themes or processes. During thematic analysis thoughts, feelings, and rationale for behavior of participants were explored, and category meanings were analyzed and integrated into themes. Categories are not core variables; however, relationships may be shown between categories (Charmaz, 2006). Only after discovering how participants create meanings and actions will the analyst be able to figure out why they act the way they do (Silverman, 2004).

Codes of participants distinctive terms were referred to as *in vivo* codes, which provide a useful way to preserve participant meanings and views of actions that need to be carefully scrutinized (Charmaz, 2006). Specific meanings to terms may be used by a specialized group, such as nurse educators. Axial coding was not used to define subcategories, as Charmaz (2006) warned it can apply too rigid a frame to data analysis. Reflecting on categories and sub-categories to ascertain connections is preferred.

Two phases of coding were used. Phase one involved word and line coding, then phase two recognized selected phrases using the most frequently used or most significant codes identified in phase one. Focused coding was done after phase two coding. Focused coding involves taking the significant and/or frequent previous codes to sift
through much data, and requires the researcher to decide which of the previous codes make analytic sense for categorizing the data (Charmaz, 2006). Focused coding requires the researcher to choose the most significant codes to characterize the participant’s voice; subsequently, the focused codes are applied on later interview to test the adequacy of concepts (Gorra, 2007). Theoretical coding is then needed to conceptualize how codes may be related to one another, and to lend form to collected codes to tell a coherent analytic story. The theoretical coding theorizes possible relationships between codes, postulating connections between categories formed from the focused coding as a hypothesis to be integrated into theory (Charmaz, 2006). Focused codes were reviewed and further information was gathered in subsequent interviews to verify the category, then how the emerging concepts related to one another was examined. Careful coding of common themes into theoretical categories occurred. Examining the relationships between the concepts were the initial steps of the theory synthesis. In Grounded theory, theoretical sampling is used to gather new data to confirm properties of a theoretical category, and define variation in the process or phenomenon under study by looking at the setting or situation where the properties of the category emerge; then, when properties of the theoretical category are saturated with data, the grounded theorist may end data collection (Silverman, 2011; Charmaz 2006). Categories that are full from theoretic sampling reflect qualities of the participants’ experiences that are useful for understanding (Charmaz, 2006). Theoretical sorting is a means of generating and filtering theoretical links that prompts comparisons between categories (Charmaz, 2006). Theoretical sorting organized codes using the research problem, comparing data at the conceptual level. Memo writing was used during initial coding, focused coding and
continually until new data emerged. Later memos were integrated when concepts developed and an initial theory draft was written. Repeatedly reading and listened to data, searching for new categories, being immersed in the experience was ongoing until the study was complete. See Table 3. for a graphic view of the process.

**Table 3.**

*Constructivist Grounded Theory Coding Analysis Process*

<table>
<thead>
<tr>
<th>Collect Initial Participant Responses</th>
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<tbody>
<tr>
<td>- Data is collected with the researcher remaining open and close to data</td>
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<tr>
<td>- Texts are constructed for each participant</td>
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<tr>
<td>- Memos can be done at any time</td>
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<tr>
<td>- Simple precise codes are made after data collection</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase One Coding</th>
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<tbody>
<tr>
<td>- Use memos, texts, and recordings to create codes</td>
</tr>
<tr>
<td>- Coding is used to shape the analytic frame</td>
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<tr>
<td>- Use word, line, segment coding</td>
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<tr>
<td>- Coding is done before next data is collected</td>
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<table>
<thead>
<tr>
<th>Phase Two Coding</th>
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</thead>
<tbody>
<tr>
<td>- Identification of phrases used most frequently or most significant codes identified in phase one coding</td>
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<tr>
<td>- Note in vivo terms</td>
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<table>
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<tr>
<th>More Data Collection</th>
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<tbody>
<tr>
<td>- Adjust questions to reflect new data as needed</td>
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<tr>
<td>- After Phase one and two coding, compare codes and categories to previous data for similarities and differences</td>
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<table>
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<tr>
<th>Focused Coding</th>
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<tbody>
<tr>
<td>- Phase one and Phase two coding is done after each data collection</td>
</tr>
<tr>
<td>- Identify and review categories</td>
</tr>
<tr>
<td>- Take most significant and frequent previous codes to sift data</td>
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<tr>
<td>- Determine adequacy of previous codes</td>
</tr>
<tr>
<td>- Review previous data and compare</td>
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<tr>
<td>- Determine codes that make the most analytic sense</td>
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<tr>
<td>- Look for relationships across categories</td>
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<table>
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<tr>
<th>Theoretical Coding</th>
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<tbody>
<tr>
<td>- Review codes collected during focused coding and introduce theoretical codes to conceptualize how codes may relate, Theoretical samples need to be gathered to confirm properties of theoretical categories or define variation, looking at the situation where properties emerge</td>
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</table>

<table>
<thead>
<tr>
<th>Data Collection</th>
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<tbody>
<tr>
<td>- Continues collecting data until saturation occurs</td>
</tr>
<tr>
<td>- Repeat Phase one and Phase two coding, identifying categories after each collection</td>
</tr>
<tr>
<td>- Use focused and theoretical coding</td>
</tr>
<tr>
<td>- Begin to synthesize and explain data segments</td>
</tr>
</tbody>
</table>

Interviews transcripts were transcribed into Microsoft Word. The transcription method was a literal transcription of the spoken words and utterances with pauses indicated by commas and long pauses indicated by a sequence of periods. I typed into a password encrypted laptop computer while listening to the recorded interviews, then listened to the interview while reading the transcribed document to check for errors multiple times. Transcriptions of the interviews were provided to all participants, and
were approved by the interviewees. Transcripts of interviews were downloaded into NVivo software and initial nodes were selected. After all interviews were done, word frequency queries were done using 125 word exact matches and similar words. Words such as challenging and time were on the list. Words such as just, or, and, were excluded.

Participants’ ideas in their own words were linked to topics such as competency, and new emerging themes or processes. Reflecting on categories and sub-categories to ascertain connections occurred. During focused coding, the most significant codes representing the participants were selected. For example, development was highly important to faculty, but what that development entailed was unclear initially. The focused codes were applied to later interviews to test the adequacy of concepts, then theoretical coding conceptualized relationships between codes. Theoretical coding was then used to conceptualize how the codes were related to one another, theorizing possible relationships between codes as a potential hypothesis for a theory. Theoretical sampling gathered further data to confirm properties of a theoretical category. When properties of the theoretical category were saturated with data, data collection ceased. A journal entry was made after interviews were done to ensure specific insights were not forgotten and to ensure that awareness of similar experiences among faculty at my college and my experiences did not distort interpretation.

Hernandez (2010) noted that data analysis needs to be done by the researcher because immersion in the data is essential for the researcher to discover codes that emerge from the data, and that analysis should be done from the moment the first interview begins until it ends. Data gathering and analysis occur simultaneously in constructivist design using comparative analysis to validate data (Charmaz, 2006).
According to Chamaz (2006), a line-by-line, experience by experience, and even word-by-word analysis using NVivo helped to ensure categories are not missed.

**NVivo software.** The QSR NVivo 10 qualitative software can facilitate the organization and management of large amounts of transcribed data, reducing the time needed working with the data. The NVivo tools can help the researcher make subtle connections, and assist with coding data by themes, participants, or places (QSR, 2014). The NVivo software can be used at a site or at home, and is useful to track data and increase efficiency in qualitative research (QSR International, 2014). NVivo was used for coding interview data as it is useful in collecting and organizing large data transcripts from interviews. Interviews transcripts were initially transcribed into Microsoft Word, and to facilitate the transfer of information into NVivo, specific formatting was used, such as headings was used on most transcripts. A heading formatting example used was that questions were assigned a Heading format, so that questions were displayed in the content panel in NVivo, and I could jump to different questions more easily. In NVivo, not only can text searches be done, but a specific word frequency query can be done, exact word, or with synonym, which can then be analyzed and a cluster analysis or tree map created. This can provide a pictorial view of how data are clustered. For example, I performed a tree map of challenges coded that provided feedback that the area of communication needed to be more closely reviewed. See Figure 3.
Audio files were embedded, so that potential codes can initially be tagged. Coded information with similar meaning was stored under categories called nodes in NVivo. This is referred to as Phase One in Table 3. Phase Two reviews the most significant and frequent themes. The NVivo software also assists with identifying frequently used words or phrases, and segments that are significant were tagged as well as in vivo terms. This assisted with focused coding where key phrases were searched. Themes were then looked for within the categories, and the connections, with theoretical coding conceptualizing how codes related. Comparing data with data assisted with understanding participant perceptions on their preparedness and confidence for developing, evaluating, and revising curriculum. The NVivo program can take each question response and list all participant responses. Multiple responses to each question were listed. In this way the researcher is more able to compare data, and see common categories and themes that emerge that were stored under appropriate nodes. When looking at multiple questions together, such as what would help the educator more effectively develop curriculum and

Figure 3. NVivo tree map of challenges.
outcomes, what would have made it easier for them to evaluate courses, and curriculum, and what actions a nurse leader could take to benefit nurse educators, a content analysis assisted in clarifying code definitions such as what constitutes categories to benefit nurse educators. The same method of transcription then coding of common themes or actions was done on the reflection as well.

Initially, thoughts were written on memos, or recorded using a password protected cell phone voice memo or note, then were transcribed into NVivo, and significant findings linked to relevant sections of the texts linked using NVivo software. The recordings were listened to again while looking at the text and field notes, a process known as immersion in the data (Ajjawi & Higgs, 2007). Abstraction was clarified by reading and re-reading data, continuously moving backwards and forwards comparing data between the participants. The moving backwards and forwards and comparing coded areas from different interviews was facilitated by the NVivo software jumping between sections and participant questions. Interviews were coded by word, and section, and after coding, it was possible to retrieve passages assigned to specific codes for viewing. Sections or lines of texts were coded in interviews, in order that a search could compare similar data from every interview. Searches by word text, word frequency, and searches by phrases were done. Newton (2012) found NVivo useful for comparative and content analysis, using it to analyze the data and to generate new codes. Additionally, interviews transcribed into NVivo can be listened to while viewing the data to ensure accurate transcription of data. An encrypted IPhone was also used to listen to interviews. This was done a minimum of three times after transcription for each interview.
Condon (2010) describes extraction synthesis as conducting a story of essential ideas about the phenomenon, removing essences from their language to form a structure that is the paradoxical living of the remembered, the now, and future moment in the incarnate all-at-once description that elicits the meaning of the experience as described by the participants. In constructivist grounded theory, an interpretation of processes or actions that requires comparing data, rather than just describing a story is completed, which can be aided by NVivo software. Constructivist grounded theorists reflect on the research process to see how theories evolve, with both researchers and participants interpreting meaning and actions. The process of how faculty perceive their preparedness to develop, evaluate and revise curriculum was examined. What makes educators perceive themselves as confident and well-prepared was examined.

Thematic analysis is possible using additional understanding of the phenomenon due to interpreter engagement with the text, and then attempting to articulate the broader understanding gained by reading of key common categories (Benner, Tanner & Chesla, 2009). Narratives that demonstrate themes, rereading and comparing, and using the researcher’s personal and theoretical knowledge to interpret themes, aid in analysis as the researcher identifies and checks themes and categories for accurate representation of the participant responses. Hence, after theoretical codes were considered, further data were required to saturate the category. Using computer software allows frequency of coded key words to be tracked and linked with phrases. Identifiers were coded to protect participant identity, yet the identifier was linked with a theme, quickly verifying common themes among participants. Single codes or linked code searches were done, and review of segments, with multiple segments on a code displayed. Codes were defined, and
memos written on segments using NVivo. This assists in organizing review for further synthesis and theme development from review of themes and sub-themes and refining of theoretical categories and focused coding.

In this way data collected on perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum was used to formulate a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. After coding of common themes or processes that were extracted into categories and constructions, results were used to develop a model to support educators. NVivo software was used to create a model that shows the theoretical connections.

**Bias and trustworthiness.** Shank (2006) illustrates that trustworthiness in qualitative research is represented by dependability, credibility, transferability, and confirmability. Krefting (2000) noted that trustworthiness is enhanced by these four qualitative criteria strategies. A purposive sample was used due to the need for educators experienced with curriculum development, evaluation, and revision, and all faculty at each facility were given the opportunity to respond. For example, at one university the nursing chair mass emailed her nursing faculty with the invitation to faculty listed in Appendix J that included researcher contact information. Other leaders provided suggestions as well as sharing the invitation. Some specific emails were shared by the leaders, but their response was insufficient; therefore 34 listed faculty on the websites were emailed directly, using available emails on the colleges website. All those that responded were provided a consent and the study was discussed if the faculty met the criteria of one year of experience. Bias was reduced by allowing the response of available
participants dictate who participated rather than researcher choice. Two faculty who responded, who did not meet the criteria of at least one year of experience developing, evaluating, or revising courses or curriculum, were excluded. The components of trustworthiness are discussed below in greater detail, with their application to this study.

**Dependability.** In dependability, the audit trail, a clear constant path between collection of data and its use is key. Another researcher should be able to follow the exact method of data collection, analysis, and how data were interpreted (Krefting, 2000). Krefting (2000) perceived that dependability criteria can include triangulation, and peer review as well as detailed description of the research method and the description of method that informs the ability to replicate the study. This study clearly outlines the method of how data were gathered through interviews and a reflective statements, then analyzed, and interpreted. An interview protocol was used, and the same invitation was sent out initially to each faculty member. NVivo software stamps a date on data, so actual time can be tracked. Reflective journaling was used by the researcher to ensure fresh insights were transcribed before they were forgotten, and the journaling provided discussion of decisions I made, which provided evidence of the audit trail. Computer documentation was also done, and memos were ongoing. Recordings were used to ensure accuracy. The research protocol was listed so the interview method was consistent. Krefting (2000) clarified that audits, dense descriptions, peer examination and code-recode procedures were useful ways to establish dependability.
**Credibility.** Credibility, that the information is worthy of trust, may be found when the interpretation of an experience is so true that people who share that experience immediately recognize it (Krefting, 1990). Glaser and Strauss (2008) note that credibility is judged by not just the vicarious experience, but also the assessment of how the researcher came to his or her conclusions, noting who was interviewed and the experiences found. Describing in rich detail the setting, participants and theories aids in credibility (Creswell & Miller 2000). Therefore, rich detail was provided. Creswell and Miller (2000) found it important to check the accuracy of participant perceptions being represented by having the participants review transcribed information such as interviews. Transcriptions of interviews was checked at least three times to ensure accuracy, the first time when transcription occurred, and twice after. Interviews were also reviewed by participants for accuracy. Rather than member checks being done, where the information is sometimes summarized and unclear information rechecked with the participant being interviewed to ensure the interviewee’s perspective is correctly portrayed. Participants were allowed to review their interview transcript for accuracy. Guba and Lincoln (1985) felt member checks were a critical technique for ensuring credibility. All participants were able to review their interview transcript. Credibility was assisted by follow up with participants to request their reflection post interview providing more extended contact, and verifying that previous data collection was accurate. Schmidt and Brown (2009) note that effective recruitment and retention is important for research credibility, and initial contact may determine if subjects participate and remain in the study. Hence, contact with program directors and chairs was used to request a list of faculty who met criteria, and receiving permission via
the signed permission site form assisted in recruiting qualified participants (see Appendix F). Names of faculty who volunteered to participate were not provided to the director, dean, or chair.

Triangulation adds rigor, breadth, complexity, richness and depth to inquiry (Denzin & Lincoln, 2007). Data were collected via recorded interviews, and reflections, a journal, and memos. A weekly journal was kept during the study that contained insights, ah ha moments, ideas, frustrations, but no names.

Holtzhausen (2001) found that triangulation was a powerful way to aid qualitative validity and trustworthiness. Shenton (2004) noted data source triangulation using a widespread choice of informants, whose viewpoints were verified increased trustworthiness and provided a more rich picture of the attitudes and needs of those under study, so participants were taken from across Vermont, from multiple colleges, rather than one college. Collection of more information from different individuals will increase trustworthiness, and additional narratives will enrich the data, and may elucidate findings. Different types of colleges, a private college, a university, and state colleges were used, but all participants were faculty.

Guion (2002) specified that data triangulation used different sources of data. In addition to faculty interviews, a few pieces of peripheral data were shared, such as a BSN curriculum model, and a copy of a format where a method of verifying outcomes were met could be done using a column for the outcomes, a second column for learning activities, and a third column for how the activities were evaluated. Verification of accreditor information was assessable on-line. Information such as accreditation standards for CCNE, the Baccalaureate Essentials, and ACEN criteria, formerly known as
NLNAC, were available on-line. Information about the multiple changes in leadership that occurred in several colleges was verified via news releases about new leadership when a position was filled and employment listings. As an interim director, and participating member of the Vermont Action Coalition, and a Vermont Nurse Leadership Fellow, I was aware of leadership changes, and where many people were employed for a minimum of one year. I was cognizant of leadership changes that were occurring in the community as well through statewide leadership meetings, and had access to a college’s recent self-study with permission from their director. The information provided a small amount of information for data triangulation.

Krefting (2000) noted that spending more time with the participant, known as prolonged engagement, allowed the participant to become more comfortable with the researcher and to better allow the researcher to portray perspectives accurately; hence, there was follow up with the participant after the initial interview to review the data, and collect the reflection, though most choose not to share more data. Glaser and Strauss (1967) believed rigour in grounded theory involved helping people in their situation make sense of what they are experiencing, to enable them to better manage their experiences. Reflection and interaction during interviews helped participants make sense of their experience.

Transferability. Transferability entails providing adequate description to transfer the process used to a different population or setting, so details needed to be clearly provided. Dense description was provided in the study to enable the transfer process to another population or setting. For example, any profession that develops, evaluates, and revises curriculum could be used for participants. Any state could be used to replicate
data using the same protocol with different or similar programs. Krefting (2000) specifies that comparison of participant characteristics to demographic information is important to transferability; therefore, demographics were requested:

**Demographic data:**

1. What is your age?
2. What is your gender?
3. What is your ethnicity?
4. How many years have you been a nurse?
5. How many years have you been an educator?
6. What is your education preparation level?
7. Please list the number of formal education courses you have taken related to curriculum development, evaluation, or revision, or zero if none.
8. How long have you worked at this organization?

**Confirmability.** Confirmability is provided by giving adequate description of details to replicate a similar study. Clear steps of how participants were chosen are displayed in the sampling technique and size sections. Colleges and the university within one state that had a BSN approach were approached, as listed, with the exclusion of the college where I worked and supervised faculty, in keeping with ethical standards. The technique of semi-structured interviews were utilized, with initial questions presented in Appendix K, and the study framework and design are specified and described in chapter two and three. Permissions and informed consent are listed as well as a research protocol. Adequate details are provided in this study for another researcher to be able to replicate the study in another state, or region. Krefting (2000) noted that using different types of records assisted confirmability. Computer documents, journal, audio recordings, memos, and paper documents were used. Reflection is also useful for confirmability,
hence, the journal included reflections. Reflecting critically on the self as researcher and reflecting on the self in the research aided confirmability (Krefting 2000, Guba & Lincoln, 2005).

**Conclusion**

In conclusion, chapter three encompassed the methodology and the constructivist grounded theory design. Sampling technique and size sampling were addressed. Ethical concerns and confidentiality were carefully scrutinized. The research questions sought understanding of perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum, which was used to formulate a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision.
Chapter Four: Results

Chapter four contains the results of the data collection. The results identified perceptions of current nurse educators in order to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision, with strategies to benefit educators. Charmaz’s (2006) qualitative constructivist grounded theory research design was used to explore perceptions of faculty regarding their preparedness and confidence in developing, evaluating, and revising nursing curriculum. Chapter four is comprised of participants descriptive information, describes the interview process, reviews the research methodology and presents findings from the 15 interviews with faculty educators.

The purpose of this constructivist grounded research study was to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. It was intended that strategies would be revealed to assist faculty’s growth and competence in curriculum development, evaluation and revision. The NLN Excellence Model provided a framework for competence of the nurse educator that included knowledge beyond that of nurse clinicians, as displayed in the NLN Excellence in Nursing Education Model (2006). How educators can best attain the knowledge and confidence to develop, revise and evaluate curriculum was the process under scrutiny. It is a college requirement that nurse faculty evaluate course outcomes, student outcomes, and develop program outcomes as these are accreditation requirements (ACEN, 2013). Yet it is questionable that faculty feel
adequate to complete these tasks while concurrently teaching classes, clinical and performing other required roles, or when newly transitioning to the educator role from the clinician role.

Charmaz’s (2006) qualitative constructivist grounded theory research design was used to explore perceptions of faculty regarding their preparedness and confidence in developing, evaluating, and revising nursing curriculum. The research contains knowledge about the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum. Strategies and propositions are suggested to benefit nurse educators who evaluate, develop, and revise nursing curriculum.

**Problem Statement**

There is a lack of knowledge regarding the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and a model of understanding that will support faculty’s growth and competence in curriculum development, evaluation and revision is needed. Faculty may be unprepared to evaluate, develop or revise curriculum, as this is not a part of usual nurse clinical practice, and educational preparation is inconsistent. There is a need for strategies to be provided by nursing leadership and education to benefit nurse educators who evaluate, develop, and revise nursing curriculum.

**Review of the Research Questions and Interview Questions**

The research questions were designed to reveal the perceptions of educators regarding their confidence and preparedness to evaluate, develop and revise curriculum.
Themes were categorized between the two questions. The constructivist grounded theory study was informed by two questions:

1. What are the perceptions of nursing faculty regarding their preparedness and confidence for developing, evaluating, and revising curriculum?
2. What strategies by nursing leadership and education might benefit nurse educators who develop, evaluate, and revise nursing curriculum?

**Research Method and Design**

The study used a constructivist grounded theory approach to explore and compare the perceptions and processes of nursing faculty regarding their preparedness and confidence in developing, evaluating, and revising curriculum and the processes used for preparation. Charmaz (2006) found grounded theory to be a methodical and flexible way to collect and analyze qualitative information to construct theory that is grounded in data. Data were constructed through observations, interactions and information about the topic, initially using memos about ideas, with comparisons and codes written to ascertain the best match to interpret preliminary analytic categories (Charmaz, 2006). There was first awareness of the big picture, then a closer focus on the details. Analytic categories and the relationships between the categories provided conceptual scaffolding, and the comparisons made between data and data and codes transformed analytic understandings due to openness regarding the exploration of theoretical possibilities (Charmaz, 2014). The relationships between categories providing conceptual scaffolding, and comparisons, aided understanding of the nurse educators shared challenges and the methods used to address them.
The Study Participants and Demographics

The specific population for the study is Vermont adult nurse faculty educators of any gender, race or religion who have a minimum of one year as an educator who evaluate or develop curriculum in a BSN program. The sample included faculty from four colleges, both public and private. Members of the population tended to be white women with an average age of 53 years, with 87% of the sample being female, and 13% male.

The age of participants ranges from 34 to 65. Details are provided in Table 4 below.

Table 4
Characteristics of Study Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Range</th>
<th>Mean</th>
<th>Mode</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34-65</td>
<td>53</td>
<td>56(3)</td>
<td>Below 40 = 2 (13%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>41-54 = 5 (33%)</td>
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<td></td>
<td></td>
<td>Over 55 = 8 (53%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13% M, 87% F</td>
</tr>
<tr>
<td>Gender</td>
<td>Male/Female</td>
<td>Female</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Years as RN</td>
<td>11-45+ years</td>
<td>29.6</td>
<td>All Different</td>
<td>Below 12 = 1 (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12-25 = 4 (27%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 25 = 10 (67%)</td>
</tr>
<tr>
<td>Years as Educator</td>
<td>3-34 years</td>
<td>13.73</td>
<td>5(2)</td>
<td>1-5 = 5 (33%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6-15 = 4 (27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 15 = 6 (40%)</td>
</tr>
<tr>
<td>Highest Degree Attained</td>
<td>Masters to Ph.D</td>
<td>N/A</td>
<td>Ph.D</td>
<td>4=MSN (27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3=DNP (20%)</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>1=DHSC (7%)</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>7=PhD (47%)</td>
</tr>
<tr>
<td>Years at Current Location</td>
<td>1-14 years</td>
<td>7</td>
<td>5(3)</td>
<td>1-4 = 5 (33%)</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>5-9 = 7 (47%)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 10 = 3 (20%)</td>
</tr>
<tr>
<td>Number of Education Courses Taken Related to Curriculum</td>
<td>0-20 courses</td>
<td>4.4</td>
<td>5(3)</td>
<td>0 courses = 4 (27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2-3 = 5 (33%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 4 = 6 (40%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>100% White</td>
<td>European, Polish, British, French, Italian, Irish, “Vermonter”</td>
</tr>
</tbody>
</table>

15 Educators from 4 Colleges
It was interesting to note that the number of education courses taken related to curriculum for those PhD prepared ranged from zero to 20 credits and averaged eight, while the number of education courses taken related to curriculum for those DNP prepared ranged from two to five and averaged 3.5. The MSN prepared educators ranged from zero to 20 courses, and the average number of education courses taken related to curriculum was 7.25. The person who was DHSC prepared with an MSN did not recall any courses taken related to curriculum.

**Interview Results**

The following section contains the results of the interviews of 15 faculty members from four different colleges in Vermont. Three to five educators from each college were interviewed, an average of four from each organization. Thirteen women (87%) and two men (13%) ages 38 to 65 participated. The first section reviews the procedures used to collect and interpret data. The second section summarizes the themes revealed through the data analysis and the resulting analysis.

**Data Analysis Procedures**

Data analysis was done using the technique developed by Charmaz (2014) described under data analysis in Chapter three using phase one, and phase two coding, focused coding, and theoretical coding. Repeated review of the data were needed. NVivo10 software was used to create nodes and assist in coding, word searches and frequency analysis. After data were gathered and transcriptions made, a word frequency analysis was done to get a broad picture of the data with the most frequent word being curriculum at 692 hits. Initial data analysis indicated areas that needed to be explored
such as mentoring practices. Coding for actions and processes was done as Charmaz (1996, 2006) encourages coding for actions and processes to define what is happening in the data, rather than remaining descriptive. The Excellence in Nursing Education Model (NLN, 2006) assisted in providing a framework to characterize well-prepared faculty that included competence in curriculum design, implementation and evaluation. Using the model did not disrupt theoretical sensitivity, as it was used to clarify the constituents of the excellent educator, and the need for expertise in curriculum evaluation, revision and development; hence, the NLN Excellence in Nursing Education Model did not make cloudy the emerging concepts, and their relationships, but instead facilitated emergence by clarifying what characteristics of excellence were lacking. Seven themes emerged from the data that led to creation of a theory and model of understanding.

After each interview was done, and recorded, they were listened to again. It was at this time I most often reflected upon the findings, reflecting critically on the self as researcher, and the growth self-perceived. Journaling about the empathy felt for faculty occurred at the interviews conclusion. My experience was not an anomaly. Though at a fifth college in Vermont not represented in the interviews, as I was the interim administrator with ten years as faculty and 25 years of nursing experience when interviews occurred, I reflected on how I also had felt unsupported at times, both as faculty and administrator. I also had felt the fear of failure when placed in a leadership position, knowing I needed to learn more quickly, even while furiously attending courses to learn while working full-time. I also had felt stressed developing curriculum and coursework, and the pressure to make sure that course outcomes aligned with student learning outcomes, as my college was creating a new BSN program and was
collaborating with accreditors. I recollected being immersed in research about best practice, sharing articles explaining how to write outcomes, and holding meetings to provide faculty support and share knowledge, while trying not to pull my hair out with frustration when resources sent were unread or forgotten, and examined if my responses were colored by my experiences. I reflected upon reaching out to a director at another college for feedback, and to other experts outside of her college, as there were no expert mentors in curriculum development within my college, after my faculty discussed the need for consultants and the difficulties they were experiencing writing and aligning objectives in the curriculum during the creation of our BSN program. Hearing the angst in the voices of the faculty interviewed brought back memories of my own start as a novice educator searching for objectives and outcomes when handed a pile of papers and told to prepare to teach a class within two weeks, so I needed to carefully monitor body language. Charmaz (2014) notes that researchers are not passive receptors that data can be poured into, and do not come to a study untouched by the world; hence, are obliged to reflect on what we bring as well as how and what we see. Reflexivity about preconceptions is significant in focused coding as the codes shape the analysis, and unwittingly researchers may start from their preconceptions about what an experience means (Charmaz, 2014). Charmaz (2014) suggests keeping a reflective journal to assist in preventing preconception of data. As interviews with nurse educators progressed, additional questions were added to the interviews. After the first interview, an added demographic requested how long participants had been at their current workplace, a participant and expert researcher suggestion that added useful information. These questions were added due to the need for more information, and to verify emerging
themes such as inadequate time. Frustration from educators that was emerging due to inadequate time to work on courses or improvement was widespread. Later questions added included after question 15 that asked what made it easier for an educator, the addition: what made it more difficult? The information retrieved provided clarity to the area of challenges emerging. As workload came up so frequently, there was an addition to question 18: Anything you want to say about workload, or learning environment to inform about the workload distress. Another interview question added later was: What supports innovation and excellence?

Some interview information was verified though online information, as well. For example, many faculty credentials were listed on college websites. News releases verified information about recent leadership changes. Emails domains and visits to campuses verified where faculty were employed. Accréditor information was available as well. The other data verified educators had provided honest responses in these areas, indicating likelihood that other data provided was truthful.

**Study Findings Related to Question One: Perceptions of Preparedness and Confidence**

**Theme one: low confidence.** The following are responses from experienced faculty when asked how long if ever, it takes for a nurse educator to become confident and effective assessing whether the curriculum supports the achievement of the learning outcomes and creating developing and revising curriculum. Thirteen out of 15 (86.6%) faculty could not express confidence in curriculum development, evaluation, and revision, though some felt educator confidence was achievable in content areas.
Participant 11 shared, “One of my early mentors said the day she doesn’t get anxious before the first day of class she knows it’s time to resign, because we should be caring about it and wonder how it goes. I think when you’ve taught something, if you really are a master in a certain content area and you’ve had some success with teaching that course, I think you can feel confident in that course. But, how do you keep it fresh? How do you not calcify into what worked for you at one time? I think it’s very difficult to know how the whole thing is working for students, because students have very different learning styles, learning needs, they start at different places, they end at different places. So I think in a way we don’t ever know… So I don’t think that I would ever feel confident that the curriculum is set. And it should never be set because it should be a live organic thing.”

Educator eight with 39 years of experience, and 25 as an educator stated, “I would hope there wouldn’t be that total self-assurance the day that you walked in and picked up things to do, but that that would be gained over a couple of maybe years of really doing some solid work and looking at yourself and looking at your documents and so forth and looking at the whole process…. ” Continuing speaking to participant eight, I asked participant eight if he felt confident yet. He responded, “I don’t think so. I feel more comfortable, let’s put it that way, in what I’m doing when it comes to my curriculum, but I would never feel so confident and comfortable that I wouldn’t take it to another faculty and ask them to at least give it the once over or give them some feedback on what I’m doing so. I’ve also again looked at that in terms of students, especially students at different levels.”
Participant six declared, “I don’t know. I’ve been doing it now since 2005 and I think had we been able to work within the first curriculum we developed in 2006 and 2007 I would maybe feel better than I do now, but as I said, we have redone our curriculum three times we have revised and this is complete, so I’m hoping that at the end of the next three years, we will gain much more insight and then be able to make some tweaks and changes and so within five years you know really feel competent that we’re where we are, that where we are is where we need to be. Where am I on that spectrum, I’m going to say I’m still…I’m still climbing. I feel far from being competent that everything is what it needs to be and I don’t think we’ll know for many years.”

Participant five, 32 years a nurse, noted, “Nurses teach all of the time, but they don’t design curriculum you know and so it was completely out of my skill set. I mean it was nothing that I had even considered before. I’ve been doing this since 2006, eight years now and I still don’t feel anywhere near competent or confident in my abilities. What book was it that talked about how you feel like a fake, you know how you feel like you’re just faking it and I think I don’t know if you ever get over that. I think you feel like a fake your whole life. You’re just trying to do the best you can. And you ever feel like oh my god I’m an expert at this -I don’t think so. I mean I mean maybe some people do, but not me.”

Educator one, with 40 years of experience declared, “I think certainly as you’ve had years of experience you can perhaps have more impact on curriculum because you can see where the bigger picture is going, but it is I mean that’s one thing about nursing and medicine, it’s constantly evolving. I think in some sense nursing curricula are far ahead of medical curricula in it views a person as a whole. I think medicine is beginning
to figure that out, but they have a long way to go, and so I think in some sense I think we are farther ahead than some, but we have the most complex; our curricula has to be the most complex because it’s dealing with human beings and their responses. And that’s about as complex as you can get, as broad based as you can get. So it’s a tough task. I think the processes of curriculum development people do get comfortable with, and I think their own view on curriculum gets developed and so they feel freer to try different things in the classroom. That happens very individually for people as with any developmental process. I think it depends on how much support they get in terms of trying things new, how much access they have to new methods, how much community support they have within their own colleges and universities around that, how much external pressure there is to get good student teaching evaluations. That’s huge. So I think it happens very individually. I think I’ve learned a lot. I don’t know but it’s my perspective and it’s from my own personal experiences both inside and outside the classroom. So I don’t know how some of it is transferable, some of it may not be depending on a person’s personality and how they view the world”

Educator 13 testified, “Every class is different. Every year it’s a different class and each class has their own kind of traits about them. Like last year’s class might have been a little more independent, more go getting, and this year’s class might want everything spoon fed to them. I think that has to do with the generation’s progress as well. So I really think you can’t really ever just say you know I got this because every year’s different, so it’s really you’re always modifying or trying to modify how the curriculum supports the students, but every year’s different, so obviously you can’t change it constantly. I feel like it’s constantly evolving, but also I haven’t ever been
through a major curricular like complete curriculum redesign, because that was done before I got there, they just redesigned everything and I think going through that would be very beneficial especially if the right, there are supports obviously involved and it’s usually the committee that does it so a blend of novice to expert faculty on it. So really I think it’s something that’s definitely on-going. Right now I wouldn’t have a clue even where to start.”

Participant three who had 25 years of nursing experience, but only four as an educator, shared that her confidence was tied to the performance results of the graduating class and “What happens to the graduate nurse when they get to the NCLEX.” She believed “because this is a new curriculum. I think the test is going to be that first graduating class. So because it’s a new program I think it’s going to take the full required four years to learn, and I don’t want it to get to four years, but I think that’s going to be proof of how well. So with the first cohort that graduates from that curriculum… I think a lot of it is based upon the performance you know, so what are they actually teaching in that specific course, and I think the performance on the floor reflects what and how well we’ve developed our curriculum.” She later adds “It’s stressful. It really is. And the stress that I get is this, okay honestly I’ve been a nurse 25 years, I feel comfortable and confident in my ability to practice as a nurse, so I try to be confident. I know that I don’t know everything but I can I can use my experience to help me prepare.” Another of her comments, “So I feel like I’m still a student absorbing everything and one day it’s just like an epiphany and I’ll say I get it.”

Participant 12 also shared that the NCLEX student score results and ATI results were tied to his confidence; “I was able to evaluate myself rather quickly. I looked at
previous ATI scores “The second year, once they graduated, I saw NCLEX results and how did they do on the pharmacology section as opposed to other areas, and so I directly saw results there that improved. So, that’s improved two years and then this last year we had a glitch and so you know I look at those as guidelines as to okay, as feedback as to, am I doing my job or am I not. What happened? Why did we have drop? I think you know some people have a kind of a knee jerk response and try to compare us to everyone else. It’s my students. They’re, I’m student centered, I care about my students, not that I don’t care about other students, but and I think it’s nice to have other universities as a reference as to okay did everyone do poorly ….I like that evaluation because I am a very much a numbers oriented and driven individual. I like to see numbers. I remember numbers. Numbers drive me and motivate me to perform. And so as well as having competent nurses, that drives me… you know you hypothesize and say okay I think I know what may have happened and did a few people slide through that maybe should not have been successful? I think to have the knee-jerk response is the wrong approach. I think you need to look at it systematically and say what can I do in the future to improve and optimize, because somewhere and so I look at some feedback as an opportunity to improve as opposed to an opportunity, you know as a negative context.” And later…. “I think it’s an ongoing continuum, because I think to be confident, I was confident enough through the first year that the students you know the people who weren’t successful should not have been successful. That they just did not possess the knowledge that you need. Now I think sometimes, the longer that you’re in education, your confidence will grow but at the same token I think it can also, I’ve seen other people where it actually retreats if you will because they start to become, oh am I being too difficult, and is this
manageable. Have I lost context as to what they really need to know versus what I feel is important. And that’s one of the issues as to why I remain in clinical practice.”

Participant two, who started nursing as a teenager and who had 20 years of experience in executive roles stated “I am entering my fifth year (as an educator) and I don’t really have the scope or really good sense of this.”

Educator three, a nurse for 25 years, stated, “I feel like a novice.”

Educator seven with 30 year of experience and 19 as an educator avowed, “I’m still learning and that’s just simply because we’re in multiple paradigm shifts right now….once you finally get confident with something, it’s going to change again. I think it’s just because of society and financial funding and technology. There’s going to be a level of confidence but I think if the individual holistically thinks or if the individual that’s working in this is geared in an open minded wide-lens they’re always going to have thoughts ideas, and opportunities to make it better. I think they’re so many variables out there that come into play that just keeps that balance from becoming comfortable. It’s just one of those things where I don’t know if we’ll ever. It’s not static. It’s constantly changing”

Participant seven added, “myself, I always have a lot to learn and that’s just simply because the nature of my profession…I have my own perceptions on as far as pedagogy and adult learning per se but with nursing specifically it’s always a challenge because the acuity of health care changes. For a new instructor, I think it’s going to take, for me starting off it took me probably a good five years just to understand the concepts and the definitions of what they were talking about and again without that I mean if you
don’t have the opportunity to constantly apply this and to work whatever educational format that you use to assess your curriculum. If you don’t use it constantly it can be very confusing.”

Participant nine with 26 years of experience, but only three as an educator concurred, “It’s quite eye opening, it really is. Yes and I’ll be the first to admit I don’t know, I didn’t, I still don’t exactly really know what I’m doing.” She continues later, I’m still in the process. I never, I have not been evaluated about on whether my curriculum is effective, I mean. I look at again, I use ATI as a gauge, I really do. It’s like have I got the information to these students that they need that they can pass the ATI practice assessment or the proctored assessments rather, because then I feel comfortable. If they can pass those proctored assessments then I’ve given them the information that they need to do at least to do well on the NCLEX.”

Participant ten, nurse of 28 years, makes a good point: “I think it probably takes a good five years of teaching to really understand the whole thing. You know I’m not basing that on anything except sort of intuition and having watched people go through it. But it takes a long time to understand, to get the whole picture. You know the first couple of years you’re just working on instructional technology, methods, trying to you know understand students, figuring out the curriculum and the place negotiating the rest of the college or university and then when you’re ready to start you know diving in and you’ve been through a cycle, let say it’s a four year school, you’ve been through a three year cycle with students or a two year cycle with students and you see them from freshmen to seniors and yeah, I say about five years before you’re really able to get all those pieces together and start thinking about how well you’re doing.”

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Participant 15 shared, “the whole thing is really a huge challenge. Because really what I have found is that a lot of the language in the 50 page documents… it’s a lot of material to be responsible for when you have no experience. There’s a heavy weight on your shoulders to ensure that you’re meeting all of those criteria to pass your review when you have no experience. You know. I felt like I had no business doing that myself.” She added later, “I have been teaching maternal child health for six years and although I feel confident that I know the material and how to portray the material, it changes every day. That’s a hard question to answer because the practice changes all the time. And unless I’m at the bedside too, and following those changes, and in those changes, it’s a really difficult to keep up with current strategies in that arena. Really. It is a lot of work to maintain that. Especially considering professional standards and competencies it’s a full time job. And it’s year round for me to maintain those kinds of things. It’s constant and I think that I maintain my ability to care for patients and that helps me but I don’t think I’ll ever be fully competent. I don’t’ think that will ever fully happen.”

Only a few nurses considered themselves to be an expert or confident, despite many years of practice. Some educators only felt themselves to be successful if the entire graduating class achieved high NCLEX pass rates.
**Theme 2: poor support and communication.** Theme two is the area of communication and support. Only one educator did not mention frustration related to poor support and communication, so 93% have experienced challenges in this area.

Educator two “My expectation when I was hired was that I would have a level of support… I thought I would co-teach with faculty and I thought I would staff and support program evaluation, but didn’t realize I would carry the responsibilities. Those were some miscommunications, misunderstandings ….I began to feel some risk in terms of the reason why I came in terms of my goal was to teach and be with students I had felt some risk around that I wasn’t achieving what I was here for. And I also felt some risk in terms
of the administrative responsibilities that were on faculty and that I could be faulted for not being able to handle it all.” She continues, “Well, you know I mean. For me what would have been helpful I think looking back on it would have been support and encouragement in terms of regular kinds of contact and speaking to the strengths of whatever I was doing….having responsibility in areas where you have no control, and having that in an environment where you didn’t feel trust and respect and you didn’t feel communication was effective, you know those were some of the things that really I think need have to be put in place for new faculty. Leadership you know and sensibility and around workload and being able to take on the administrative management around issues when it needs to happen in term of resources and deployment of resources”

Later she added, “if you’ve got issues in terms of learning environment and you know you don’t have the structure and you don’t have the supports, then you know you are somewhat waylaid.”

Educator three mentioned, “get the right people involved, within the college too to support us. All of the divisions actually, they know when you think about______, one of the biggest programs here is the nursing department, so just having the support of everyone within the college.” She later added, “so many times within the nursing profession you hear about nurses eat their young. I think even at a higher level it’s that way too. People get in a position of power and instead of sharing and saying what works, oh no, no. I’m powerful and I’m all that…”

Educator four discussed communication between departments: we said at graduation, what do we want our students to be able to do and we developed those and those were using Blooms. We used a high-level of the taxonomy and we wrote them. And
then we backed up to the beginning and we said for the pre-licensure BSN their first year of prerequisites, those were our level one course objectives. What did we want; and we invited all of that faculty to join us at the table. And so we had humanities come, we had the biological sciences come the natural sciences come, we had English come, we had Psych come, we had sociology come, we had support staff come so we could truly meet the mission of ___. And then we shared with them our new curriculum model, our philosophy, our mission and we showed them our course layout and said this is what we need the student to achieve as level one outcomes in your courses, meet us at the table and they did.” She also shared about support that it is important to be able to “actually go to someone of that experience and ask her questions, ask for just brainstorm with her and the fact that she can sit in on your classes and evaluate how things are that she’s very supportive of this experiential learning community at ___ and what does that mean for nurse faculty.”

She mentions another point, “turmoil in administrative changes was very stressful.”

Educator five mentioned, “The challenges have been almost insurmountable…we had changed directors three times, so that was almost an insurmountable barrier in that you know the learning curve for the directors, I mean the interim director we had in the middle had no academic experience whatsoever. She had been a hospital administrator. Okay, so it was like spitting in the wind. You were just lost at sea.”

Educator six shared, “We have had six division chairs, leadership changes, since I came on board in 2005 and with each leadership change there has been a change in expectations.”
Educator seven pointed out “Only till I actually was in the process did I have the committee, the committees and things of that nature. I don’t recall any other faculty as far as faculty support in maybe a knowledge refresher, a type of tutorial or anything in addition other than the information that I would hold down in written form from the Internet on the accreditation and what they were looking for. There wasn’t anything, it was kind of learn, trial by fire shall we speak. Shall we say you write something, somebody takes a look at and says no that’s not what they want and the interesting thing is everybody’s perception of how curriculum should be designed or how it should meet standards, everybody’s perception is different. So, it made it difficult. It made it extremely difficult on taking what, because I even had my own perceptions of the community and what the needs were and you know taking a look at evaluations from the students and the colleges on the program so it was it could have been debatable, it was it was very subjective, perceptions.” Educator seven also mentioned: “I had very little peer support because I was it for that program. Nursing did not want to co-collaborate with medical assisting because it belonged to the medical association accreditation, not the board of nursing, so I had no I really didn’t have a nursing peer support.”

More from educator seven, “you don’t want to make a change because you know, it’s almost like the reactive problem, problem-based reaction change that people make a change in curriculum or because they see a problem in it. I think there needs to be an opportunity more for assessment and follow up whether it be the formative or the summative, either one of those. I don’t think we work well with the assessment piece of it in getting the support in order to make a change. I think we make the change just because….As far as curriculum advancement, I think nursing curriculum is unique in the
sense that if administrative support is not acclimated or really exposed to nursing care, it may be a little more difficult to reach those objectives that the curriculum needs to continue its growth.”

Educator eight noted, “There’s a lot less nurses that come out with the Ed.D. so there are more nurses that are kind of tossed to the wolves, even though I’m involved with the ANCC at a research level on a committee and there’s this whole thing going on right now about the DNPs and the PhDs and you know whether we even want them in academia, the DNPs teaching, you know” He further shared, “I know that there’s this whole push with academia to do more with less. I mean you can go so far as to say work wiser not harder, but when you don’t help somebody to do that to figure that out that’s just even more frustrating to hear those words. I mean I think it provokes more anger in terms of well don’t say that to me because you’re not helping me at all.”

Educator nine spoke “And quite honestly without any kind of guidance at all, here’s your text book over there, we had to develop the syllabus we had to I mean develop a whole course in 5 days essentially” and later, educator nine shared further, “you’re given this title of system professor and you know it’s Doctor This, and everybody thinks you know what you’re doing and the best I’m doing is winging it. So, um and quite honestly sometimes I’ve found I’ve been very fortunate in my mentors previously. I have yet, I haven’t found a mentor here yet. I really haven’t. I think one person would be very good, but she’s very very busy and also very new, but it’s just kind of go ahead, go on, let’s do it, you know. Whatever you want to do is fine, so.”
Educator ten shared, “there’s a lot of resistance” when discussing curriculum change. She later expounded, “Until you get buy-in from everybody, nothing’s going to change.”

Educator 12 began, “The challenges within a curriculum become with ownership, with you own staff….it is the staff that are your biggest obstacles.” Educator 12 spoke quietly, “I think the greatest challenges are with your staff. Ensuring that you have adequate by-in is huge. You, despite having 8 people on a committee, if you don’t have direct buy in into the courses that are going to be impacted you will encounter great resistance. Not a little resistance, I’m talking great resistance. I’ve seen it. I’ve seen and I’ve also seen political propaganda where, when that happens and that person perceives that they were not approached in a friendly way or contributory to that curriculum revision that is impacting their course, they will challenge you on many different levels. They’ll challenge you by actually coordinating opposition, directly not support a curriculum change. They will also challenge the work environment in which you have an environment that becomes from less friendly to more hostile. You also, I’ve seen to the point where someone walked out of the meeting saying I’m tenure track and left it at that. I don’t have to do this, and then you have allegations that now you’re starting to impinge on academic freedoms and teaching. So these are all issues. It’s a very complex dynamic processes that occur with curriculum revision which really opened my eyes when I went through the process. The key is really keeping your stakeholders, identifying your stakeholders, all of them, not just teaching the course, not just the people on the committee, but your chair and how supportive they are going to be of those curriculum revisions.”

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Educator 12 shared, “I’ve always, well I believe inherently that change, processes, changes in problems are best identified by novice staff. Novice staff usually are not viewed as a favorable change agent. And so while the ideas are great for novice staff the support often lacks. So I really when I was asked to sit on the back-end I was somewhat apprehensive, because my issue is I’m not going to be part of the solution, if I’m, I don’t want to be, if I can’t be part of the solution I don’t want to be part of the problem per se.”

Educator 12 shared more, “The mature eyes have a sound working knowledge of the organizational dynamics and policies in place. The fresh eyes often see the problems right before their eyes that everyone else is pretty much kind of ignored or they become immune to. And then the people in the middle they actually help balance the two groups and kind of smooth over and come up with dynamic solutions as to how we can embed some of the new proposed ideas into their curriculum. And so that is, that can be a challenge is not disrupting nests too much, having staff buy in and then having it threaded throughout the curriculum becomes another challenge and then looking at your curriculum evaluations and how you are going to evaluate, how you’re going to word, you would think that wording would be very straight forward. Wording of your curriculum, your objectives and your threads throughout the curriculum becomes a whole another agenda of which people will debate on.” Then a later addition, “I’ve always felt that an idea is great regardless of who puts forth the idea. It shouldn’t matter who you are. But the reality, hard reality is it does matter who you are. It does matter, your experience. And you know I’ve got a history, if I can’t be part of the solution, I’m not going to be part of the problem and so when I sat on the, when I started on the back-end I pretty much let my, I had to learn to choose my battles, I had to learn to not be verbal,
and you know essentially translate every…every viewpoint that I differed from because
the reality, the hard reality was there were so many views that I differed from
philosophically that I would be opposing endlessly. So it became a very challenge for me
as a novice staff member was to really identify what are the key issues, what are the
issues I really need to speak up and be strong on, and what are the issues I can kind of be
quiet and yet you know either support or decide not to support. But that’s a real challenge
as a novice faculty member.”

When asked what actions a nurse leader could take, educator 13 responded,
“Mostly I think it’s like most things, just being supportive, in helping with that
(curriculum development, revision, and evaluation). Educator 13 stated, “I can’t tell
somebody who’s been working there for 30 something years, this isn’t working, this part
here or your course isn’t working and have them change that. I can’t make people change
how they teach…And that’s why I feel really stuck as a member on that curriculum
committee. We can talk a whole lot, talk and talk and talk and sure we might be able
change objectives and learning outcomes and you know switch a course here and there,
but unless the people who are teaching the courses change their approach you’re going to
still get the same outcome because, they’re not teaching it to the way the students need to
learn it then that’s, you can’t make them change. You can’t make them do anything they
don’t want to do. So, it’s very, you’re like between a rock and a hard place. Because like
I said, the overall curriculum you can modify, you can modify the heck out of that, but
the people who are teaching, teaching the courses in the curriculum, you can’t touch
them. A lot of people once they develop their course, you know they’re set in it. They
don’t want to modify it in any way.”

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Educator 13 disclosed “You almost feel like you’re asking too many questions. So you don’t want to ask anymore” and “really what supports it (innovation and excellence) is having a lot of experience behind it and being able to share that with other people so that they can, they can learn how to be innovative and what-not.”

Educator 14 shared, “The other thing that really is frustrating is that they start piling content on top of content on top of content without taking anything away. Or they go, Oh, I think that goes in your course. You teach that. Rather than looking at the bigger picture. And as a public health nurse, I see the bigger picture. And I can see how for example public health concepts could be in every course that you teach. Oh no, we don’t have room for that in our course. We can’t do that. Well, fine, I’ll just make sure I have it in my course. But then you get it the other way. Well, you could teach that and I go, no, I can’t sorry, keep it in your course.”

Educator 14 specified, It is frustrating. Mostly because people always say they want to change the curriculum, but when it comes down to the nitty gritty they really don’t want to change. They like the niche they’re in and if they change the curriculum it means they have to change their little niche. And so it gets very frustrating.”

It’s not so much our faculty in our department that’s the issue. It’s sort of the broader university.”
“When educator 15 was asked what made it more difficult, her response was, “I was completely isolated.” Her hands were clasped together very tightly as she spoke.

Figure 5. Graphic depiction of theme poor support and communication.

Theme 3: lack of knowledge related to curriculum alignment to outcomes.

Eleven out of 15 faculty, 73.3% did not believe they saw the big picture or understood how their course fit with the curriculum when they developed their first course.

Educator one shared, “The first years I was more or less trying to put together classes and lectures and things that were very specifically focused on the topic and was not particularly worried about the big picture of the curriculum.”
“When I first started it, I’m not sure I had the big picture of what curriculum as a framework meant.”

Educator two said, “I had all I could do to get my feet on the ground with regard to teaching and advising. I sort of did the best I could. I understood the importance and the groundedness of the curriculum committee as the foundation and that program evaluation to evaluate then the curriculum, the program and all that’s required by CCNE; however, I really didn’t understand the curriculum in terms of how it needs to be integrated, the standards that must be met and how faculty need to coalesce around the evaluation and development of the curriculum. I didn’t have that sense. I was very sort of focused on just getting up in front of people and delivering the courses.”

From a different educator that used similar terms:

“I didn’t get enough of that information in my master’s program to deal with accreditation. It was very briefly summarized that this was something I had to really learn when my feet were on the ground.”

Educator three, “many times, there’s been a clinical instructor I kind of like stand in the shadows, but the reality is I can’t because I have to know how to integrate that curriculum and how it affects me and bring that to the clinical for the students. Tie it all in.”

Educator four stated, “When I was first hired I had been in academia for one year, so was still transitioning to my new role, …and at that point they were going for an accreditation visit and I was just a passenger on that trip. I had not had that experience before”
Educator four shared, “It’s very difficult, I think because I think it’s so time consuming and you no sooner feel that you have developed something that’s going to meet the needs of the now and by the time you’re able to begin to implement it those needs have already changed, but you can’t even evaluate for a minimum of three years. Well you know to evaluate to make a substantive change for three years to collect the data and by then you feel like you’re already behind the eight ball again with all the changes, certainly within the healthcare environment between you know the real push to move back out into the community again, changes in the acute care, changes in pair sources, and so it’s been, it’s been challenging.”

Educator five exclaimed, “So, I had no clue about curriculum development at all. And when I got here I just kind of assumed that the curriculum would be designed okay, and that I would just teach what they told me to teach type thing. Then, when I got here there were issues because the faculty had completely turned over in 2006….even though we weren’t at that point going from and ADN to a BSN, we were still in the ADN, we had to completely revise the curriculum…”

Educator six shared, “I didn’t have a firm grasp on what was uh all of what nursing education entailed. I had a picture in my mind from having been taught and having been a nurse and a practitioner and precepted and that kind of thing so moving from the service side to the academia side, I don’t feel like I really thoroughly understood it and I don’t think that I really thoroughly understood it until we revised our curriculum for the third time”
Educator seven shared, “so if it hadn’t been for that accreditation process I think we would still have a major knowledge gap on how the whole curriculum is designed developed and implemented because it was only through one person historically.”

Educator seven felt her “biggest challenge was in to seeing it move forward was understanding academia process. Once I understood the process of how academia and curriculum committees and policy changes worked it made it a lot easier. But there was a learning curve just in the institutional processes. It’s you know much slower. There’s a few more things to understand as far as paper work process and things of that nature so once I figured that out it was better but I would have to say institutional processes were a barrier, definitely a learning curve.” And “what we’ve recognized is it’s a lot larger than just your own class, it’s really getting everybody to see this in a big picture.” She later mentions, “It’s been quite a learning process for everybody you know trying to see this in a bigger picture. Since the accreditation we now have program evaluation committee that’s been ad hoced. We have the program curriculum committee that’s been put into place. Um we have individuals that are now focusing on NCLEXs blue prints as far as community needs and acuity of care”

Educator seven said, “I knew I was being hired to teach didactic and to teach clinical, but was not completely aware of all of the accreditation processes that were going to be happening, so I had a momentary panic attack…”

Educator eight “Some specific courses on how to develop those development tools. I think that would have been helpful. I think we know how to ask the questions, but I’m not sure if we know if those questions are getting at what we really need to know.
You know, I think that if we had had more I mean I think we’re doing it by again by the seat of our pants.”

Educator nine responding to Did you get familiar with influences such as ACEN, or CCNE… “Honestly, I haven’t had the time to really look at them. I really haven’t. So have I used them? No, I haven’t”

“It’s been very difficult because I really don’t have the educational preparation.”

Educator 11 shared,” one of the biggest frustrations I have is, most, in my view many nursing curricula are still based on a medical model that’s rooted in the different hospital floors. Medical nursing, surgical nursing, you know we may call it different things now and then community nursing is sort of everything outside a hospital. So that’s been a big frustration on me and I think one of the biggest challenges is curriculum is shaped by faculty and faculty have been marinated in the same kind of socialization.”

Educator 12 “I didn’t envision that I would be part of curriculum revision.”

Educator 13 spoke, “you’re thrown kind of into it. There’s not a lot of preparation for what you’re getting yourself into.”

“I would definitely say ask for help from the beginning. I think I didn’t tap into my resources as well as I could of the first year. But I think it’s important to definitely seek help from other people. I think that a lot of it coming in was just being overwhelmed and I might have even, even if I had learned it during my master’s program I think the feeling of overwhelming would have been, kind of trumped my knowledge almost.”

Educator 14 shared, “When you first start, you probably don’t know how it all fits together. It’s not until you get on those committees and sit on the committees and see the
kind of work that gets done and the reporting out to the faculty department and you’ve been in the system a few years to realize, oh, all of this fits together…”

Educator 15 shared, “I wasn’t educated that much about the use of course objectives….I had no idea what I was doing, and I felt really unsupported. In my role I was required to come up with answers for specific objectives. It wasn’t until I actually learned a lot about CCNE standards in the last year on my own where I was able to actually figure out what I was supposed to put in for language.”

Educator one noted, “there’s a lot of external pressures to have certain pass rate, have a certain retention rate, have outcomes that define a nursing program that are not very real. There a lot of advertisement and I mean pass rates are real, but it doesn’t necessarily say a lot about the teaching or the curriculum. I mean there are too many external factors that go into what we know are pass rates. So, I think the challenge is to keep all of that in perspective in terms of first of all not changing the curriculum the first time you have a pass rate that you are not as enamored with as much as you would like. We have had that through the years. We have had pass rates that have declined and have gone up and have, you know I think it’s important to not react so much but have data to support the types of changes you want to make…. another challenge is continuity of faculty. When I first started teaching we had very few part time faculty. Who’s core faculty? They are full time; everybody knew the curriculum, everybody taught both in clinical and in lecture. And that’s not the case anymore, So how do you maintain the cohesiveness of the curriculum when you have a lot of part time people… another challenge to curriculum is changing curriculum sometimes based solely on student input. First of all I think sometimes the types of questions we ask students like is the content
appropriate, well on what basis are they going to make that decision. They are newcomers and novices. They can say if it’s up to date. I guess they think the text book is up to date, that’s you know it’s already out of date before they even get it.”

Findings: Question Two: Strategies to Benefit Nurse Educators

Theme 4: need mentorship and relationships. All those interviewed (100%) felt that mentorship was an essential component of learning the faculty educator role when it came to developing, evaluating, and revising curriculum. When asked what it was like, terms such as frustrating, and challenging often came up, and the most frequent strategy recommended was mentorship.
Educator two, a 65 year old who had been in nursing over 20 years before she became faculty found that “colleagues made it easier for me and what made it ease off a little bit was to know that others went through this too. My own experience helped out because I knew that the size of this organization was not amenable to a lot of learning, a lot of experience and that it depended a lot on your personal collegial relationships with people.” She added a question later:
“The most effective tactic I’ve used to develop curriculum, I would say is interpersonal relationships.”

Educator four, a nurse with seven years of experience as an educator and 33 years as a nurse remarked, “When I was in my master’s program, my preceptor for student teaching was an incredible mentor. When I came here our CCNE curriculum consultant was very good at developing the new curriculum and she gave us a great number of resources so that we didn’t have to start from scratch.” She added,
“I think that faculty need, when they’re a new faculty member, they need a mentor; someone that will work with them for a whole year, so that they can actually understand what’s going on in this process…and will understand our curriculum and how to write outcomes.” And later,
“I think the best actions that we’ve had up to date is availability of resources and mentorship of faculty, that we have an experienced nurse leader who has decades of experience, so she’s able to help us.”

When asked about what adequately prepares faculty, educator seven, nurse veteran of 30 years mentioned webinars and “I think mentorship, peers, people that have been through it.”
Educator 13 stated, “It’s not easy as a brand new faculty coming in and having to develop an entire course essentially…I think it would be helpful for you know experts, senior faculty to really kind of take novice faculty and provide them with you know with their knowledge, essentially. Even if it’s just helping them, If I had to write my own outcomes for my course, my own objectives that definitely would have, I think helps me a little bit more in determining how to make outcomes. So there’s a lot of, I think if you’re working side by side with somebody who’s an expert it definitely helps. And starting from scratch. I feel like I pretty much started from scratch with my course but like I said the course objectives were there, so , If I had to write my own objectives, I think I probably would have understood how to make the outcomes a little bit better.”

She later shares her feelings about curriculum: “I feel like it’s constantly evolving, but also I haven’t ever been through a major curricular like complete curriculum redesign, because that was done before I got there, they just redesigned everything and I think going through that would be very beneficial especially if the right, there are supports obviously involved and it’s usually the committee that does it so a blend of novice to expert faculty on it. So really I think it’s something that’s on-going. Right now I wouldn’t have a clue even where to start.”

Educator one, a faculty member with 40 years’ experience noted that, “I first taught in the Associate Degree Program … and we were going to be undergoing accreditation….I certainly relied a lot on the people I was teaching with. My Department Chair, she had was a Columbia Grad, so she had in her master’s program 60 credits of education, so she was well versed in curriculum, so I’ve relied a lot on her experience and knowledge base…. my department chair because she was so much more… first she had
had a lot of years of experience but she, she had a clear understanding of curriculum and
the big picture. She also was a personality completely different than me, like on the
opposite end. So then I tended to approach things much more methodically. She was a
lot looser in terms of could see a lot of other approaches, think out of the box, ask really
good question that I hadn’t thought about and so that was really helpful to me because it
showed me there were other ways of thinking about things and other perspectives and
other approaches and so it’s not the world according to ___ necessarily. And that was
very very helpful.”

Educator 12, a faculty member with 19 years of experience before becoming an
educator shared,
“you’ve got teaching show and tell. In didactic, you basically can tell, you can’t always
show and sometimes you can show, but it’s not always like show and tell relationship that
exists in the clinical setting. So developing that art is challenging. In order for myself to
grow, luckily I was fortunate that there was a fellow who taught me, a fellow colleague
that was a first year as well, so together we shared ideas. Anything I didn’t know, she
seemed to know. Anything that she needed to know I seemed to know, so we
complemented each other. We found a buddy if you will, we aligned with each other and
really kind of would listen in on each other’s lectures, providing positive constructive
feedback, guess what you’re beating around the bush too much, we’re going to need
concise, make it a little more concise, stay on track, don’t tangent, and I know sometimes
I can, and I get excited about something, and she’ll say well, he’s disorganized, but in a
good way.”
A different educator with 19 years of nursing experience when asked how she began to create her first course remarked how her college “utilized mentors. I, we did not have, we had lost, they had lost all of their faculty here at this program and they were in transition. There was not a chair in place and when I came on initially, and as an adjunct and then over time working with an adjunct, I was teaching a lot of classes within a course prior to coming on full time, so in my areas of specialty I was coming in and teaching those content areas for whatever faculty was in charge at that time for the course. And I think that having the disadvantage of six different chairs in the last few years was also an advantage in that I had six different leadership styles, learning you know teaching styles, learning styles, trying to sift through it and really taking the advice from them and looking at that. I’ve reached out over the Internet and worked with other faculty members, having gone to conferences, you know and networking getting some contacts in other areas, particularly Meredith Kaiser had been a tremendous-tremendous help.”

Educator three with 25 years of experience and 4 years as an educator shared, “obviously I’ve had to be mentored by a few and as far as ____ (previous director) ____ too, we all need to be developed farther so we can give quality education to our students. As a team learning to work together, you know I teach that to the nursing students too, you know everybody has weaknesses, everybody has strengths. But knowing as a director, not me, but ____ to bring us all together and take each for their one strength to develop that curriculum. I’m not an expert in it, I’m learning. So there are many challenges I think for each and every one of us.”
Educator seven: “If it hadn’t been for the VP a lot of, I mean that individual really helped my knowledge process. She took me under her wings and really helped me start off my education instructor experience.”

Educator eight: “I think that it’s very very important that we, we have support from those national nursing organizations. Either supported to go to conferences where there is more information about to novice faculty about how to develop curriculum or let’s say conferences for faculty who are chairs of faculty development committees or curriculum committees. I think it would be incredible help to just have that kind of support or if there were mentors you know, people who had some really great experience that might mentor five or six people. Who not every day, but somebody who you could get on the phone and say hey look I’m struggling with this, or am I on the right course with this and not be afraid to turn to them. I just think that that would be so incredibly helpful. From our national organizations, I think that that would ensure in many ways that the legacy isn’t lost. Cause somehow, I think we had it and somehow I think we’re moving away from that and it distresses me that you know what we’re seeing out there is the product of our schools is not what we used to see and is that a good thing or not?”

Further on in the interview the same educator adds: “I think that there are some amazing people in academia. And I think that if you got together in smaller groups then larger groups where there are think tanks about how you can do this or how you can work this out better, like I’m not a component that I have to work in a silo when nursing. I’m a component that I work in the university and that there are other brilliant people out there in other schools that I would love to tap their minds. I’m fortunate enough to work on some wonderful committees where I can tap into some people’s minds and I’m not afraid
to say hey look, can I call you? Can you give me your card, can I call you when we’re outside of the meeting because I have an issue or a question. Can I use you as a resource and I’ve gotten some people they seem to be very willing to volunteer and then some people have come to me so it’s a give and take, it’s a two way street, and that’s what I think would work wonders in terms of the administration not having to spend a lot of time teaching or coaching us or whatever or mentoring us when there’s a lot of people even in the faculty ranks who could help each other out in these things. And I hope that you know I would be one of those people at some point in time. Yeah”

Educator nine, who is doctoral prepared and who has a Master’s in nursing, but no education courses, when asked how else she learned to evaluate course and outcomes stated “I used experienced educators to you know, does this look appropriate, is this where, am I going in the right direction here, because I didn’t know. I didn’t. I still don’t know. You know I still don’t know.” She later adds about a colleague, “she is also having to learn the material as well as teach it as we go and I started out like that. I started in med-surg and I was one chapter ahead of the students all of the way through which was in hindsight wasn’t a bad thing because there were lots of practices that I wasn’t really, You don’t do that? So it wasn’t necessarily a bad thing. But I think it’s been an extremely stressful for her, so I find myself mentoring a brand new faculty member when I’m brand new in this role here too and that’s another additional challenge that I’ve found.”

She further mentions, “ the mentors that I had in my previous position made it easier for me. There wasn’t the same pressure there that I have here, because I went there as a new educator, so there wasn’t that expectation. When I came to____, now the expectation is well you’ve been doing this for a couple of years, you must know what you’re doing.”
Educator ten, “: Mentors, you know people that I worked with over the years. And I worked, I was very fortunate to work at ____ College which has an entire division devoted to assessment. So and part of the process of developing courses and curricula at ____ is the gathering together of large groups of super experts. I’m not talking just experts, but super experts in the field, so I got to meet people like Roy Simpson, and Mary Anne Rizzolo and Diane Skiba to develop our informatics curriculum and there was a process outlined for me to do that and so I think I had this wonderful introduction.” When answering the question who or what made it easier for you, educator ten mentioned, “ I had a wonderful mentor at ____ College, she was my boss and she definitely guided me. I also had my first teaching job was with a highly seasoned faculty member at Russell Sage and she was just wonderfully, tremendously helpful, so mentors, you know people that I worked with or under over the years.”

Educator eleven found a helpful mentor “I had a wonderful mentor Inez Hinsberg who had been dean in Milwaukee and had been pulled out of retirement to start this baccalaureate program and she mentored me. She sent me everywhere. She sent me to AACN executive development program, she insisted that I serve on key committees within the college, and another woman that was brought out of retirement was Catherine Norris, sort of a great grand dame of concept development and so they were it was really brilliant people and an exciting time and the hospital administrators told me that they were determined to have a really good nursing program so they poured money into this cause they were kind of going to show the state where they would be without a nursing program.”

Educator 13 noted that a mentor made it easier for her.
“I had a mentor coming into it. And they were very helpful to me, but they’re also one of those people who said it was kind of second nature to them so I don’t think they realize that it was a lot more difficult for me than I think they were expecting only because they had been at it so long, so it’s like you should just know how to do it. And just because you went to college and got two master’s degrees in nursing education doesn’t mean you just know how to do it especially if you’ve never done it before, so I definitely tapped into them as much as I could. They mentored me through it. Definitely they were helpful.”

Educator 14 mentioned, “you know working as a team makes things so much easier. The other thing that makes it easy is when the curriculum education committee says you must include these three objectives in every course.”

Educator 15, “I don’t think that my nursing degree actually helped me teach. No. Nursing degrees don’t, unless you have a masters of nursing education, you don’t know how to teach you just have a master’s degree in something. So what I did was actually so when I taught that course I was a nurse manager and I had actually gotten recent roles in a nurse manager in a birthing center and I took a nursing leadership course through the hospital I worked at and the teacher of that course was amazing and I basically lobbed
onto him and I said show me show me.”

**Figure 7.** Graphic depiction of theme mentorship and relationships.

**Theme 5: faculty development and education.** On the word frequency, there were 274 hits on education, and 132 on develop. 100% of educators feel faculty development is needed. When asked how many education courses faculty had taken related to curriculum development, evaluation, or revision, 27% had none, no courses, 33% had two or three courses related to curriculum, and 40% had five or more courses.

Educator one commented, “I think they need the resources. First of all they need to have continuing education around that. They need to have consultants that work with them, they need to have in-service, they need some stimulation. They need to have people that can work with their curriculum as they’re doing it rather than after the fact.
That takes time. It takes faculty that’s fairly stable and it takes you know resources and development. It takes an administrator who understands curriculum and that’s not always the case.” She also mentioned, “I think it helps to have some education courses within your graduate education, but that’s not how higher ed is.” Educator one noted that “I worked in a Navy Surgeon General’s office in Washington and there were legal cases that come up that they asked me of in terms of looking at this, in terms of standards of practice and how would you evaluate that, so it was again taking a standard and looking at it in terms of you know achieving the practice outcomes that you wanted to achieve. So that was probably also a helpful experience.”

She added, “my masters was a clinical nurse specialist so I was much more focused on cardiology and being a clinical nurse specialist than being a teacher. I did have a couple of courses but I guess my own nursing probably background prepared me more than my education courses. In terms of looking for outcomes, having goals, having interventions that you know, that’s how my mind works. So it was probably much more experientially driven than it was from a curricular, from a course preparation viewpoint… I never expected my clinical nurse specialist program to prepare me in education, I guess I always have been focused that way I’ve always liked education and I’ve you know I’ve was kind of inherently driven by education so I you know my propensity for understanding what students wanted and I have very good high school education and so I’ve had some models in mind that as I said were much more experientially driven than my education. So you know I had to take a course on curriculum whenever, but I’m not remembering that that had significant impact on me… Well practice makes perfect. Going through a number of accreditation processes will certainly help you.” Educator one
when asked what adequately prepares faculty to develop curriculum and write outcomes that meets accreditation requirement confidently, the response “practice does. I think experience, knowing what the standards mean, what kind of evidence are they looking for, knowing ahead of time is helpful in your own practice experience what was most helpful to you in terms of developing as a professional”

Educator two, a nurse with 45+ years of experience but only five as an educator remarked, “quite frankly I don’t understand developing curriculum, I don’t understand what that is. My sense is once you’ve got the curriculum it’s sort of a stationary kind of thing you know and I worry more and not less about developing it but about integrating it.” Her recommendation, “What helped me more effectively develop curriculum and outcomes? Time, focus, you know development of faculty. Faculty development around that would help. You know what would have made it easier? If you did that with courses and program curriculum. You know faculty education, faculty development you know when you hire people in you know the certain set of skills if you if the skills, if you’re looking at other skill sets that you are going to be needing you know some allocation of time, some focus, some respect, you know for that faculty’s environment and learning would be important.” Educator two when asked what adequately prepares faculty and write outcomes to meet accreditation requirements competently, “just do it. Sit down and do it. Go through it.”

Educator three began “Let me read this, how did your education prepare you to develop your course outcomes and align with the program curriculum? A lot of it was based on different models. So, within the MSN program that I went to at _____University it was based on developing the course, evaluating the outcomes with specific models and
I’m not clear on all of that still. You know it’s true if you don’t use things all of the time, you don’t specifically keep them in your brain. So, I’m not 100 percent sure how that did except for the fact that as an educator I have to have some information, some kind of education on curriculum development if I plan to implement it as an educator…. so my course focused mostly on because it was a course of Master’s of Science in Nursing Education was how to develop objectives, and then how to assess learning outcomes as an educator. And because this is I’m still being developed in this role I haven’t made all of the connections, so I’m being honest.” Additionally, “You know I think about I’m an expert in my field as a clinical instructor, but I’m a novice in this so if I could be in my shoes, which I’m in, I would want to be able to know every aspect. So every aspect includes how was it developed, how in the nation are others programs compared to ours?” ….Later she states, “Continued education. Let’s go. Let’s get a meeting of the heads so to speak from other colleges. You know to show us or to help support them on things that have worked. Like take a prestige nursing program, even Vermont Tech you know because I’m I’ve graduated from parts of Vermont Tech, but what makes them successful? What makes their curriculum different from ours? What makes people within the community, obviously feel more confident with a nurse graduating from one program versus another.”

When asked how else she learned, “I learned through watching the faculty, being part of curriculum development meetings you know at least being included in those and as much as I didn’t have a lot of experience, just being brought in and learning the whole process, learning through you know, what are the requirements, another good thing based on, and this is it’s not awful, but the thing is I had no idea many of these things
existed, you know. My focus is always on the clinical aspect.” Educator three suggested” in order to develop the curriculum, I think having people, guest speakers, come in …”

Another recommendation she had was to “offer more incentives, offer more loan forgiveness that would be an incentive for nurse educators to get the education they need so if colleges are all about, or nurse educators are all about getting that high level of education, help us so that we can.”

She added, “if there were more opportunity to pay for certain things, I think it would help nurse educators continue on with their education and to become better developers in curriculum. Give an incentive, and it’s not always about money, but make me feel respected. Make me feel you know that I can obtain the next degree. If you’re going to help me with that mountain of debt.”

Educator three continued later in the interview, “Soooo. When I know more about the curriculum I’ll be sure, but it’s still like a process, every day I feel like I’m sitting in a college class and I’m like okay I know I’m going to get this, but it may not be until OH I’m in clinicals and now it all makes sense to me. So I’m still learning as your still learning and hopefully we’ve learned from each other’s work.”

Educator four shared how at her institution faculty presented what they are doing in their courses as part of experiential learning, and faculty discuss what works and does not work for students. She shared “Evolve webinars were absolutely helpful for me and we actually constantly passed that information back and forth to each other. The recorded webinars are very helpful because you can access them at anytime so when we were looking at test blueprinting as an evaluation there was a webinar and if we couldn’t all watch the webinar, some of us would watch it and then we would actually present it to
each other at a faculty meeting. If we found a good article in a magazine we would look at it.”

A faculty educator five, with 32 years of experience as a nurse and eight as an educator describes her first year at a college; “I had no concept absolutely none, okay, so I took three courses from _____ University that are teaching in nursing whatever it is for the CNE. Okay, so I took those three courses. So that gave me a clue as to what I was doing, but certainly not; basically, what it showed me was I knew nothing, okay, and I really needed to learn what I was doing because my Master’s degree was as a nurse practitioner it. I had no education courses whatsoever, so after, I realized from those three courses from the NLN that I really needed education courses.” Later in the interview she added, “What the accreditors were expecting has like grown exponentially since before I started so even when they came in 2010 we weren’t prepared at all. I mean there was a boat load of stuff that they expected that we didn’t have okay, so the accreditation process was a huge learning curve, so in 2010 we learned a lot in 2012 they expected even more and the problem between 2010 and 2012 we had changed directors three times, so that was almost an insurmountable barrier in that you know the learning curve for the directors, I mean the interim director we had in the middle had no academic experience whatsoever. She had been a hospital administrator. Okay so it was like spitting in the wind. You were just lost at sea.”

She later recommends, “We had a consultant who came from Sacred Heart in Connecticut that first time when we went for the 3x5 to the 4x4. And she came and helped us write learning objectives. And she would literally before she came each time I mean she would say, this is what we’re going to accomplish today this is what we’re
going to accomplish the next day so the fact that she knew what she was doing and that she could tell us so we could prepare in other words I know I’m going to be doing this so let me quick read about that before she gets here cause we wanted to be as efficient as possible. She was coming from Connecticut. We didn’t want to be wasting her time so, she was tremendously helpful that consultant and like I say the consultant we had last fall and our current director has been tremendously helpful.”

When asked what adequately prepares faculty, she responded, “I’m sure there are other people who can learn it from hands on and just doing it. But for me I had to have the courses. I had to feel like I had taken the courses and done the work and written the papers and all that kind of stuff so that I had I understood what I was supposed to be doing.” In her reflection, the educator notes that what helped the most with learning how to plan curriculum “was the first curriculum consultant we had. Having a working knowledge of what we were supposed to be doing from the curriculum classes I had taken at _____ helped a lot, because I understood what she was expecting us to do. After our first accreditation visit, I understood even better because of all the questions the accreditors asked, and having to explain why we had done this or that. The last time we redid the curriculum we started from scratch, but we could do that because of the prior experience we had rewriting program outcomes and course objectives.” She later adds in another response, “as long as they continue to take courses because this is not something that comes from just sitting down and talking about it.”

Educator six explained, “I didn’t have a firm grasp on what all of what nursing education entailed. I had a picture in my mind from having been taught and having been a nurse and a practitioner and precepted and that kind of thing, so moving from the service
side to the academia side, I don’t feel like I really thoroughly understood it and I don’t think that I really thoroughly understood it until we revised our curriculum for the third time.” She later adds,

“Continued education I think is key, having faculty development where you can have guests come in who it is there are of … There are so many areas within developing curriculum there are so many particular areas that are special areas of expertise, whether you are looking at test development and analyzing you know measuring from that standpoint. Whether you are looking at developing a course and a curriculum and then comparing it to the current needs in the service side of things. I think just by having continuous education and continuous staff development on top of everything else you’re doing, but that’s the only way to really kind of keep it fresh because it is just such, it’s always evolving”

When asked what action a nurse leader could take that would benefit the educators that evaluate, revise and develop nursing curriculum, she responded,

“Again, supporting continued education and faculty development. I think also if they were able to supply the resources to keep the workload in mind and perspective when looking at both development as well as… The development and revision you know, looking at revision, that’s constant. You can revise for every class, you can revise you know based upon things, but in looking at the absolute development of things and then knowing what it will take when we’re looking at our systematic program evaluation, and to go forward, the amount of time that it takes to really to do a good job and at the same time making sure that you’re taking caring of the students and the seats. If we didn’t have to juggle both I think that would you know from a leadership perspective um if we could
do that and I think our leader is working on that you know aggressively trying to find us additional faculty to help lessen the work load for us right now.”

Educator seven exclaimed, “accreditation really is what moved the whole curriculum vision into gear if you will, and everybody now is like going HOLY COW you know this is a whole new world.”

When asked if she felt well prepared, educator seven said, “Yes and no. Because in yes, I was prepared in that in the sense that I had an idea of what a curriculum should look like based on community needs based on a lot of the evidence support with that. And no in the sense that I have not at that time had not had the opportunity to apply the knowledge…”

Later she stated, “I was assigned standard 3 which was the curriculum standard. Learning the CCNE and getting updated into some of the new um nurse of the future type thoughts and doing the comparison and congruency between the CCNE standards and the Nurse of the Future objectives was a bit of a learning curve, because nursing is unique in their own standardization.” When asked if she expected to be doing curriculum development, evaluation, her response, “Nope. I knew it was a part of my instructor role, doing the syllabus, the objectives…”

Educator seven stated “Because right now, everybody sees an issue, well let’s make a change because of this issue not really fully thinking about the evidence base as far as an education baseline or background. They see an issue, they want to make the change and then reassess it, but there’s no underpinning to the rational of the change and that a lot of times makes it difficult.”

She further shared “Probably the best experience you could get to prepare somebody is making it a part of your everyday work habits as far as applying it into faculty meetings,
of course you have to do, once you go through accreditation you constantly have to assess the curriculum anyway. Getting faculty involved in those areas and not in just one area. Rotate them through the areas so they have a good sense of everything. I think that would be the key."

Later in the interview she reinforces the importance of “providing the opportunity for application. Keeping current on what the community and the whole process of community, curriculum evaluation, whatever format that is being used to be able to apply the information.”

Educator seven shared, “I felt very comfortable in the instructional design because I had a good understanding of Bloom’s taxonomy, so the curriculum piece was a larger lens and it took me a little bit to learn how to apply that knowledge, whereas the instructional development per course was a little narrower and of course a little more frequently applied as far as knowledge, so I felt a little more comfortable with that than I did the curriculum. It’s the lack of opportunity to apply the, I think they were just going on their seventh year to begin the accreditation process, so you know it’s one of those things if it doesn’t happen every year with that whole accreditation process or the curriculum design type thing, if you’re not on it yearly you kind of miss that opportunity of application of the knowledge.”

Educator eight declared, “I think that it’s very very important that we have support from those national nursing organizations. Either supported to go to conferences where there is more information about to novice faculty about how to develop curriculum or let’s say conferences for faculty who are chairs of faculty development committees or
When asked about what made it difficult, he shared, “when things change and you have to keep up with the changes.”

When asked how her education prepared her to develop course outcomes that aligned with program curriculum, educator nine responded, “It didn’t. I haven’t had any (curriculum courses). I really haven’t.” Educator nine replied, “nobody’s really looked at it (her course) to see if it was appropriate and I mean I cut and pasted from other examples of course syllabus here and then just plugged in what I thought I needed to plug in, then later, “you probably need a good year of teaching becoming familiar, familiarizing yourself with the program, becoming familiar with the different standards, and then not be this expectation of you right off the bat to start developing your curriculum. I think that’s probably the biggest mistake if you will that I have encountered, Is that. You can’t start doing these things if you don’t have some kind of idea. You just can’t I mean, there has to be some kind of benchmark that you meet before you move on, because I don’t think all of us are meant to develop curriculums. I really don’t, you know, I just don’t.”

Educator nine expounded, “In England you have to have a certificate in higher education to teach and part of that is curriculum development and I was oh that’s silly. Why would you need to do? Now I get it. It makes perfect sense and if you don’t have it then you can do it as you go along in your first year. So and then but there aren’t any expectations of you either to start developing curriculum in that first year. I don’t believe this is something you should be doing if you don’t have any experience in it cause how do you know, again, how do you know that what you’re doing is effective? You know, I’m winging it. And I’ll be completely honest with you. I really am.”
When asked if anything made it more difficult? Educator nine lamented, “what I’ve already expressed and that’s not having a baseline, education. I mean it’s one thing when you learned it in a didactic setting but at least you have that to fall back on, so you have some kind of idea. When you don’t have any idea at all and you have to do Google searches, I mean seriously, Google? YouTube, and I’m really not joking.” Educator nine states, “I would think and again I’m going to go back to you have to have a base education and recognize that without that I don’t think you can be effective because you’re just winging it, you’re pulling stuff out of the air that you think is appropriate and I really don’t know whether it’s appropriate. I don’t even know at this stage who those accrediting agencies are and I need to be looking at. I really don’t.” She ends, “I really believe that because unless you are willing to keep learning and keep developing then there is no innovation. You stagnate.”

Educator ten recommends three things: “Course work in it, mentoring and doing it. Accreditation helps. Going through the accreditation process really helps you learn it.” She explains, “You really do need to be taught, guided and then you need practice. You need to do it you know repeatedly until you realize what you’ve done well and what you haven’t done well. But I pity the poor nurse practitioner coming out with no background in curriculum and being expected to evaluate it and so forth. I wouldn’t want to be them. Cause it’s hard. It’s very confusing and you know one of the first courses I had in curriculum was What is Education, and I think you have to start with that fundamental question, what are we trying to do here.” She later declared, “if you’re going to teach you should have an education background you know you should have coursework in education. You know it’s vital. I don’t know how you could do it without it. You know I
don’t get it, so taking a clinician, plunking them out of practice and thinking they can teach is wrongheaded.”

Educator 11 shared, “I feel like we are not moving to transform the workforce anywhere nearly quickly enough and I, we’re not, I don’t see nurses being as prepared as they should be…”

Educator 11 later continued, “a lot of nurses go back and they get their PhD. It’s hard to recognize that they’re actually a novice faculty, a novice nurse scientist and they may be a novice nurse educator. So I think that that can be really hard you know. So somebody’s been in practice for a long time. So and I think that programs very widely emphasize for faculty, so I think staying immersed in some sort of practice and that could be broad like, it doesn’t have to be being a clinical nurse specialist or something, whatever it is you’re teaching and then getting exposed to other parts of the country, I think that’s really important.”

Educator 12 shared, “I don’t have a number of courses related to curriculum development” and later, “too often people can’t write decent objectives. If they don’t really write a decent objective it can’t be measured…”

He added, “when someone, you know they start stereotyping your profile and oh, we know more than these individuals because they’re only maternity nurse, oh they’re only psychiatry nurse, or they’re only, you know when we do this like negative, we create a negative culture for ourselves sometimes that doesn’t need to be created. And what it needs to be is Yes that’s great, you’re a maternity nurse, that’s what you love to do, you’re good at it. You don’t want me being your maternity nurse. You’re the maternity nurse. I’ve delivered a couple of pigs. I know enough to be dangerous. And you know, in
psych, do I want to interview and psychologically decompress day in and day out? Absolutely not. So I believe everyone kind of adds to the equation. It’s kind of like making a pie. You need all the ingredients to be successful.” He reminded, “The truth is that we live in a financial driven society in which you need to look at the cost of your proposals. Whether it’s a feasible to do so, whether there’s money available, whether there’s staff available, whether there’s room within the curriculum to have all these other agendas that people on the committee don’t necessarily take into consideration. They’re just looking at it as, this is the problem, this is the solution, and they’re not necessarily looking at from an organizational, budgetary approach. Nor is it their responsibility to, but the leaders if they’re involved in the process might be able to suggest a design, alternative strategies that may be able to embed it or adopt it in a way the curriculum that would be manageable.”

Educator 12 added, “Educator 12 stated, “administrators need to frequent the curriculum redesign, restructuring on a delineated interval. Having faculty with a leader within that committee. Direct and streamline without having that direct leader or supervisor or chair involved in the curriculum process throughout the year creates for a proposal in the end that potentially would not be supported by the chair or the staff. And also, addresses issues whether it’s feasible or not. We’re told and charged with develop the curriculum and we’ll see to it that your needs in staffing reality to make it a reality. So, the hard truth is that’s not true. The truth is that we live in a financial driven society in which you need to look at the cost of your proposals. Whether it’s a feasible to do so, whether there’s money available, whether there’s staff available, whether there’s room within the curriculum to add it, all these other agendas that people on the committee don’t
necessarily take into consideration. They’re just looking at it as, this is the problem, this is the solution, and they’re not necessarily looking from an organizational, budgetary approach. Nor is it their responsibility to, but the leaders if they’re involved in the process might be able to suggest a design, alternative strategies that may be able to embed it or adopt it in a way the curriculum that would be manageable.”

Educator 15 stated, “Well my Master’s degree was in nursing administration so my courses had nothing to do with my ability to teach.”

Figure 8. Graphic depiction of theme faculty development and education.

**Theme 6: overloaded and inadequate time.** By interview seven it became apparent that lack of time to work on curriculum and revise courses time was a common
issue and the question was added: Is there anything you want to share about workload or learning environment. All the faculty alluded to being extremely busy and having inadequate time either currently or previously in a faculty position. It came up most frequently as a response when faculty were asked what would have made it easier. Prior to the additional question, educator one shared, “I think they need somebody who understands it (curriculum) who can provide the resources for and even actually have departmental time where you talk about educational issues and curricular issues that are not to get something done, but to really have some reflective time for faculty about what are we trying to achieve here?”

Educator two requested, “Time. Focus, you know development of faculty. Faculty development around that would help. You know what would have made it easier if you did that with courses and program curriculum. You know faculty education, faculty development you know when you hire people in you know the certain set of skills, if you’re looking at other skill sets that you are going to be needing you know some allocation of time some focus, some respect, for that faculties environment and learning would be important.”

Educator Three shared, “it’s not an easy task being an educator. And so you did it one way one day following a specific course objective, it didn’t work so what do you do? You go back….just getting through the day, one day at a time and realizing that everything we go through in a day’s event is always a learning experience. You reflect on what you like, you reflect on what you didn’t like, but you don’t beat yourself up over it and you move on. I can’t stand the past. And you take all of those things based on evidence based on what works, based on your strengths and you do the best you can. So
with that said there are many days I just want to just throw my hands up. I’m an over achiever so I try to do too many things at once and I have to realize myself that I’m not 20 years old anymore…”

Educator Four shared “a challenge I face is the work load as in academia. I’ve been a nurse for many decades and I’m used to working hard, but I think for me the balance of working in the community as a nurse and as a nurse educator was very challenging. I think just physical exhaustion. I think turmoil in administrative changes was very stressful.

Educator five “I’m hoping that now at least for a while it will be tweaking and not recreating because the recreating process takes a tremendous amount of time.”

Educator six mentioned the need for “supporting continued education and faculty development. I think also if they were able to supply the resources to keep the workload in mind and perspective when looking at both development as well as… The development and revision you know, looking at revision, that’s constant. You can revise for every class, you can revise you know based upon things, but in looking at the absolute development of things and then knowing what it will take when we’re looking at our systematic program evaluation and to go forward, the amount of time that it takes to really to do a good job and at the same time making sure that you’re taking caring of the students and the seats. If we didn’t have to juggle both I think that would you know from a leadership perspective if we could do that and I think our leader is working on that aggressively trying to find us additional faculty to help lessen the work load for us right now.”
Educator six shared more, “maintaining a full-time work load as well as in addition to full-time 12 credit teach load, clinical and clinical oversight of 60 students and then in addition 14 Baccalaureate students RN to BSN students so they had their own licensure but hadn’t to oversee their clinical experience. Having to then be working on anywhere from 12 to 16 credits of course development in a new program and trying to find some time to sleep and brush your teeth in between.” Later she adds, “If there were two or three of me, that would make it so much easier. If I didn’t have to do both, in an ideal situation we could we could factor in the development as part of the work load.”

When answering: What would have made it easier for you to evaluate the program the curriculum? Educator seven stated, “Time. Time and availability. Absolutely. Absolutely.”

Educator seven stressed ” Being out there. Being able to be available, time to be a part and exposure, being able to expose yourself to whatever area in order to come back and have the observation or the experience to support the change in addition to research.” and later she mentioned, “Ah, work load… we need more nursing educators. Laugh that’s the bottom line right there.” Educator seven added, “Being out there. Being able to be available, time to be a part and exposure, being able to expose yourself to whatever area in order to come back and have the observation or the experience to support the change in addition to research.”

Educator seven recommended “allowing the time whether it be through adjusting didactic requirements or clinical. Maybe finding educational offerings so that nurse faculty would have an opportunity for continuing education or in an idea too is I don’t know if the sister colleges such as, here at ___ we have all these various colleges, every nursing department
goes through, you know everybody goes through a curriculum evaluation or accreditation. Would it be beneficial to offer the opportunity to other nursing faculty to go in and serve as a visiting faculty to help provide a bias objective viewpoint on the sister, if that makes any sense. Rotate around, so that we have that constant exposure, so that we’re not just dealing with our own program or curriculum evaluation, we have the opportunity to experience what other people are doing and apply the knowledge. It’s that constant repetitive use of the information that we get over the years, you know.”

Educator eight expounds, “Oh, yeah. I think that workload is hard. I know that there’s this whole push with academia to do more with less. I mean you can go so far as to say work wiser not harder, but when you don’t help somebody to do that to figure that out that’s just even more frustrating to hear those words. I mean I think it provokes more anger in terms of well don’t say that to me because you’re not helping me at all. I think that I don’t know that the dean or the director know just exactly how much work each one of us is doing, so I’m not even sure they’re even aware of the work assignments and that’s been the contention of the faculty here. If they do, it often time doesn’t feel like they do because more piled on and more piled on.” He later adds, “You go home and you’re working all evening or you’re working all Saturday or you’re working all Sunday and you’re not getting any rest and people are wondering why you’re cranky or why you know so, so yeah, I think that there’s kind of a sense that there isn’t any sense of what’s going on there, you know, and I think that that’s why you’re losing a lot a lot of good faculty or there a lot of good people who aren’t coming into academia because they know what’s going on. You know? And they’re not willing to put themselves into that situation.”
Educator nine shared, “I just don’t know how to do it in that short a period of time. It’s crazy, actually. It really is. And the amount of lecture time that I have is frustrating. It is because, I feel, I feel you know I feel for these students. They need this material but all I can do is give them the basics they need. They have to be able to pass the NCLEX which is what it all comes down to. So, the information and the curriculum, it’s purely, I want to say this, it’s all geared towards NCLEX. Completely, there’s no fluff at all. None of the niceties. I don’t have time. I just don’t have the time allocated…. so the clinical workload is horrendous.”

“We really don’t know how effective this is because we really haven’t had enough time to truly look at it. So, that’s extremely challenging.”

More from educator nine, “I was given the task to get this course up and running in 5 or 6 days”

And later in the interview “it’s 3 ½ weeks. It’s, you know, I just don’t know how to do it in that short a period of time. It’s crazy, actually. It really is.”

Educator ten explained, when asked what would have made it easier for you to evaluate the courses, develop curriculum, “I wished we had a better curriculum mapping systems so again technology I think would have made it a lot easier. Time, you know release time to do that. Nobody ever has that. And over the summer you’re working in the hospital to make up for the salary you lost by being a nurse educator during the school year. So time and probably funding you know paid time to do it, release time.” She explains frustration related to workload, “I think it’s nuts that you know nurse educators leave because it’s a black hole. It’s because of clinical and the hours, you know the clock hours that get or student contact hours that get put. Sometimes it’s 3:1, or 4:1, 2:1, that’s
crazy. You’re in clinical. If you’re put there with 8 hours, with 8 students for 8 hours that’s harder and more difficult than any lecture on the campus and you should get paid accordingly. In education they’ve figure that out. You know they get one credit for every student that they supervise. So, it would make a lot more sense if we had two clinical groups, that would be it. That would be our credit load. We would have two clinical groups. And then you’d have that opportunity as a lecturer to revise the curriculum. To really make a difference and really do the kind of things that you’d like to do so you know workload in nursing is a huge problem and I think we have to figure out something with practice so nurse educators can continue to practice.”

Educator 10 later added, “What I’ve found is that nurse educators are the first ones there on a Monday morning and the last ones to leave at night, on Friday night. And that’s just taking care of business. Doing curricular revision or even mapping is going to happen on nights and weekends after you’ve had an exhausting 50 hour week, so I just don’t think there’s time.”

Educator 11, “I was asked to teach a course in health and physiology cause I have a minor in biochemistry and physiology at the graduate level and I was gathering data for my dissertation in North Dakota so I did that but I found out pretty soon they wanted me to work half-time so I did that and then I realized I was working full-time in a half-time job. I had two babies at that time, I was finishing my degree.”

Educator 12 lamented, “Oh my god. Workload. What about workload. Workload is very subjective. It’s not measurable. Workload is really a discretionary at best. There’s no solid formal allocation of workload. So, and by this there are certain areas of one’s workload that can be directly measured and accounted for. So like if you’re teaching a 4
credit course, you know, that translates into a 4 credit course. Now, so you’re teaching a 4 credit course that has 12 students, I’m teaching a 4 credit course that has 100 students. So is our workload the same? Does it get accounted for and translated into the actual workload? Yes and no is the answer. Sometimes it does and sometimes it does not. It won’t unless you are active in seeking out that there is a difference. So it's really important, which I didn’t clearly understand as a novice educator. I understand better today having gone through some discrepancies in workload. I think that’s part of you know of nursing kind-of-like rites of passage. If you will, unfortunately learning the ropes as to what translate into workload. And that’s something I wish would have been more formally discussed in my program.”

Educator 12, “They tell me that it’s an equal amount of work when I have 12 students in my class versus when I have 100. I can tell you point blank that the workload it’s grossly different. And in fact if you have 100 people you’re going to expect you know your e-mails to at least triple, your meetings with students who might not be doing as well are going to at least probably triple. You have you know, you’ve got at least what 12 you’ve got a hundred you’re almost 10 times class size. So if they say, that is the same workload it’s ludicrous.”

Educator 13 “Lack of time. I was trying to work full-time and work on my doctorate and you know have a life and there just wasn’t a lot of time. I’d find that on the weekends I’d be doing my own coursework for my doctorate, you know on Saturday and then on Sunday I’d be starting from scratch trying to make a lecture for Monday and you never really got ahead, so it was, that’s what made it more difficult was I just didn’t have time.” Educator 13 responded again, “Allowing them the time to do it because there is a
lot of research that goes behind changing curriculum especially, but providing, you know, the resources that are needed so that they have the time to do it.” Educator 13 added, “that’s the challenge though when you start with curriculum revision, you often impact workloads. And so is that workload impact that people don’t think about or if you start shifting where you’re going to place your hours, you start shifting inadvertently ruffling feathers if you will, within nests.”

Educator 14 spoke, “At our institution there are 3 parts to our position. We have to teach and usually teaching is about 45% of our time. Research is 35% of our time and service is 15% of our time and the clinical practice, you also have to maintain a clinical practice. So 40-45% is about 2 ½ days but that teaching can take over your whole life if you let it. You know the preparation, the grading, the agonizing over, oh my god I did that wrong, if you let it. And I can see new faculty they just sort of because it’s concrete, it’s there, the students are there, so they will let the whole week get tied up into that workload. Whereas you’re also supposed to spend a day and ½ on research, or scholarship of some sort and then you also got time for service so all the committee work and nurses by and large do way too much service.”

Educator 15, “we as faculty are overloaded every semester and I have been for 3 years. And so I don’t have a lot of time to work on curriculum at all. The only time… we were forced to do it this semester because of mid cycle review. I was assigned three sections to complete. That’s it. It’s been really hard to do because I teach 24 credits a semester sometimes so it’s impossible.”
Figure 9. Graphic depiction of theme overloaded and inadequate time.

**Theme 7: suggested strategies.** Different strategies were offered by all of the educators, with tips for other educators. Additionally, suggestions for administration were recommended. All shared their knowledge.

**Strategies for educators.** Educator One: “First understand the structure of the curriculum. What is it that? What are the expectations for each year that so you’re not so driven by the course but what’s the larger goal? Where are the expectations for development of the student? So you kind of need the bigger picture first at least I did. But that’s how I think so I don’t know if that, it may be not the way that everybody approaches it which is fine. So I guess I would have that person identify some of their
own questions that come out of the curriculum. I mean do they even understand the structure of the curriculum? Why are things placed the way they are….are the course objectives and even the topic objectives are aligned with learning outcomes. They don’t each have to be aligned with learning outcomes but that at least you can see that the learning outcomes are covered by a variety of courses.”

“clear guidelines in terms of what the criteria is, what the evidence is, what they are looking for, so that you know we can develop those types of data and evidence to show that we’re doing what we’re saying we’re doing. I think what is really hard is to get graduate feedback after they’ve been out of the educational environment. You know going through it at the same time struggling with it you have often a very different perspective once you’re out in practice. And we just have a good way of getting that. We have very poor response rates from both alumni and even employers and there is no good way to get that.”

“Be helpful not to change quite so much the standards.”

Her most effective tactic was” Flipping it, from having it teacher directed to student directed I think made a huge difference. And I think it what makes students remember the classroom the most is that it was meaningful to them. It wasn’t what I decided was important.”

Educator two: “What adequately prepares faculty and write outcomes to meet accreditation requirements competently? Just do it. Sit down and do it. Go through it, and get collegial help with that.”

“the most effective tactic I’ve used to develop curriculum I would say interpersonal relationships and sort of cross teaching”
“for me what would have been helpful I think looking back on it would have been support and encouragement in terms of regular kinds of contact and speaking to the strengths of whatever I was doing.”

Educator three: “in order to develop the curriculum, I think having people, guest speakers, come in like throughout the summertime…who are more experienced in the development of curriculum.” She added, “more education….more tuition reimbursement, more focused education in that development, not only would you know the people that they bring in for lectures, but send me to the conferences, send me to other schools, let me see, because I learn very well by just being a participant.”

Educator four: “When they’re a new faculty member they need a mentor. Someone that will work with them for a whole year. So that they can actually understand what’s going on.”

“I think for me the webinars and reading the professional journals are keeping me current. I think that that is the most effective way for me to stay current, and then secondarily our meetings where we talk twice a month about curriculum and we share whatever we found or whatever we think is new and helpful to the group…Having a chair with an academic background”

Most effective tactic: “when we sat at the table with all of the other divisions and shared with them this is what we want at the end. This is what we want our graduate nursing students to be able to do. Can you help us get this started?”

Educator five, “Use Mary McDonald’s Guide to assessing learning outcomes 3rd edition nurse educators.”
Educator five, “it seems that every time I read something new, I think, oh my god was I doing that before? So I think that that’s kind of a lifelong learning process where I’m constantly reading.”

Most effective tactic “knowing ahead of time what I was going to be doing on any given session….I have to feel prepared”

Educator six, “Continued education I think is key, having faculty development where you can have guests come in who it is; There are so many areas within developing curriculum there are so many particular areas that are special areas of expertise…Whether you are looking at developing a course and a curriculum and then comparing it to the current needs in the service side of things. I think just by having continuous education and continuous staff development on top of everything else you’re doing, but that’s the only way to really kind of keep it fresh because it is just such, it’s always evolving.”

Educator six, “Continued education…. I have just kind of now broached the surface, kind of gotten through the surface of things and I think it’s going to take years. It took me 20 years to hone my cardiac experience. It’s going to take me 20 years to feel that too I think, but education is important.”

Most effective tactic: “key things like being persistent, but being very organized and very thorough and even when you think you have it done, going back again and then having six other sets of eyes go through it and look at it again to see you know and comparing it with the standards that you’re relying the foundation and your theoretical framework and making sure you remember to encompass all of the threads. I just think it takes tremendous patience because if you don’t check dot all your I’s and cross all your t’s it’s
not going to work, you’re going to work, you’re going to have to come back again and redo so just taking the time up front I think.”

Educator seven, “we had program evaluation written format surveys, we had alumni now and again this was at __ Community College in ____ we had alumni feedback that came actually to the department every three, six, and one year periods. I believe evaluations for this program, but I have not seen them. And in addition to that we have the college feedback forms that get sent to us, but I have not since I started have seen the program evaluations from the students to the department and that is being those are kept in the director’s office, so with that other than that I don’t other than just verbal feedback from the students there really isn’t and of course the community which I teach clinical out in the community so I hear feedback in that aspect too.”

Educator seven shared, “being a part of the larger community of academia; Having the opportunity to experience the opportunity of application with it.”

Most effective tactic: Breaking it down into subsections. I’m a very visual person and I think in order to really get the big picture on how it all fit together, understanding not just my section, but understanding how each standard affected the whole curriculum build. And again it’s using that ADDIE format and I would have pieces of paper, like sticky paper everywhere and fitting in all the standards and how it affected that area. So, I think it took a lot of just personal time into self, you probably would say self-educating.”

Educator eight, don’t be afraid to share this stuff with someone else who you admire, who you think is good at this. Maybe somebody you don’t even like, but could give you some wonderful feedback about you know, you’re doing a good job over in this area, but this area might need a little attention and this is one suggestion. Have you
thought of this? Or this is an article recently that I found in the literature that might help you to consider this information or this area and help you to improve on it or this is a book or this is a chapter of a book or this an author you might want to give them a call there if you’re at the University of Vermont or Vermont Tech or wherever…Don’t be afraid. People like to be asked.”

Educator eight found “the most effective tactic is to be as creative as possible, to keep the art in the science of nursing and to make sure that that art is also in the curriculum. So, um I’ve had days when I have put people together in a room and just banged out the curriculum, but I’ve also made them take breaks, or had ice breakers or had them have fun or have them food so that there’s something for nourishment sustaining them where they’re not burned out and their not exhausted and they haven’t had a relief from something that’s so serious.”

Educator eight “being on the committee is one, but I think having me a consultant to call up or e-mail or just run things by would be extremely helpful…We’re sort of the blind leading the blind.”

“…more direction from the ANCC or some of these different nursing organizations, I’m not sure I have those letters right. But, it’s important that I think that it’s very very important that we, we have support from those national nursing organizations. Either supported to go to conferences where there is more information about to novice faculty about how to develop curriculum or let’s say conferences for faculty who are chairs of faculty development committees or curriculum committees. I think it would be incredible help to just have that kind of support or if there were mentors you know, people who had some really great experience that might mentor five or six people. Who not every day,
but somebody who you could get on the phone and say hey look I’m struggling with this, or am I on the right course with this and not be afraid to turn to them. I just think that that would be so incredibly helpful. From our national organizations, I think that that would ensure in many ways that the legacy isn’t lost. Cause somehow, I think we had it and somehow I think we’re moving away from that and it distresses me…”

Educator nine, “Take a certificate class. Seriously and that’s on my list of things to do. It’s kind of shutting the gate after the horse is already bolted, but I really feel like when you learn experientially, it’s great but there are so many gaps in your knowledge. There really are. So now I need to do something that really pulls it all together.”

“You have to have a base education and recognize that without that I don’t think you can be effective because you’re just winging it, you’re pulling stuff out of the air that you think is appropriate.”

Educator nine, “then not be this expectation of you right off the bat to start developing your curriculum. I think that’s probably the biggest mistake if you will that I have encountered, Is that. You can’t start doing these things if you don’t have some kind of idea.”

Most effective tactic: think the most effective thing I did was ask for help, and knowing when I was out of my depth anyways and recognizing that I needed help, and feedback from experienced educators.”

Educator ten, “I think you need classes. I really do. I think you need coursework in curriculum design, curriculum evaluation in evaluation and assessment period. This stuff doesn’t just pick this out of a tree. You really do need to be taught, guided and then you need practice. You need to do it you know repeatedly until you realize what you’ve
done well and what you haven’t done well. But I pity the poor nurse practitioner coming out with no background in curriculum and being expected to evaluate it and so forth.”

Educator ten, “Probably just repetition, you know doing it. I do it on a spotty like course by course basis of learning object by learning object. If I were a dean or director of a 2 or 4 year program, just doing it repeatedly.”

“We have very blunt measurement techniques. And what a person knows at one time may not be what they know at another, so I think that as the sophistication around measurement increases and our capacity to gather data, that will help us. But I’m still not sure, because somebody you know you think about some of the real innovators in the world, they’ve been often people who the world thought was wrong, didn’t do well in school or whatever”

Educator ten mentioned three things that could help: “Course work in it, mentoring, and doing it. Accreditation helps. Going through the accreditation process really helps you learn it.” She adds “repetition, you know doing it. I do it on a spotty like course by course basis of learning object by learning object. If I were a dean or director of a 2 or 4 year program, just doing it repeatedly,

just going through that process numerous times both curriculum revision and accreditation. I also think there’s lots of technology out there to help faculty and deans and directors. Not only revise but really analyze it.”

Most effective tactic: “I think starting with the end point in mind is the is the best. I have actually hired consultants and had developed a scope of work for the development of a curriculum. I’ve had to do that a number of times and what I do is start with the end point in mind and then that is we’ve got a seven week course in X and I want to be sure the
students understand X, Y and Z and here are the outcomes, the learning outcomes we’re working towards and then you know here’s the technology we have available, here are the textbooks we’ve used in the past. We don’t have to use them now. Go. And I think usually you get pretty good results.”

Educator 11: “One of the things that I would want to share with a novice faculty member is that there is this challenge with what I call Curricular Drift. And so the curriculum is set in a particular kind of way, maybe thoughtfully or not, but then the person that comes into it actually in some ways brings that to life and that’s important, but they may underscore certain things and not other things and that type of thing, and so it can really change and shift over time. And so you know the whole issue of behavioral objectives which is part of the world we’re in, I guess and the course description tends to be fixed for how people operationalize that can vary. So I would actually encourage them to understand curriculum, go to curriculum meetings, I would really encourage to go to the AACN meetings on baccalaureate or master’s or doctoral education where they’re at. Cause then they’re immersed with people doing you know a lot of different kinds of things. And then the whole issue of having evaluation at by course some programs do course and by level, and then others do course, level and terminal outcomes. I don’t have the answer to that. And there is some software opportunities now that are like the old competency based education except people can really do things at their own pace and if you think about somebody knowing, 75% of the material and passing, well is that ok? Right? Or is there a level of mastery that they need to have before they can go on to the next level?”
Educator 11 “sophisticated measurement techniques, cause I think we have very blunt measurement techniques. We have very blunt measurement techniques. And what a person knows at one time may not be what they know at another, so I think that as the sophistication around measurement increases and our capacity to gather data, that will help us. But I’m still not sure, because somebody you know you think about some of the real innovators in the world, they’ve been often people who the world thought was wrong, didn’t do well in school.”

“The most effective tactic is to have a conceptual framework that’s elegant. I know the whole framework’s in and out thing, but if you have an elegant conceptual framework, an elegant conceptual model then it makes sense to students why things are where they are and when they are.”

Educator 12 encouraged use of “Bloom’s Taxonomy, if you look at that, then look at where, what are your expectations within the curriculum you can essentially translate objectives that are appropriate, or that are at the appropriate level for your students. And so as a novice educator, you come in; it’s very difficult to assess where exactly should the students be, and so sometimes asking a senior staff, at what level of taxonomy, should I really expect? What’s reasonable, what’s not? And that’s key I think to putting forth a bunch of objectives only to have this other staff shoot them down saying that’s too high, that’s too low, and so kind of meet where should they be. And it may be less of an issue I think in the 2 year programs, it becomes a little muddied when you get into 4 year programs only because you’re looking at where are they taking pharm, they’re taking it at the 3rd year of school, so would you expect them to have a higher level of taxonomy? But then remember that they’re just now starting their immersed in courses so that sometimes
there’s a disconnect as to college career versus nursing content career and they’re not necessarily interchangeable from my experience.” An additional suggestion, “novice staff you have to look at what is your goal of the course. So, if you have your goal, and so once you have your, you identify your goal, you can devise your objectives as to what are the components that people need to reach that goal successfully and so, you’ve got to, once you clearly delineate the goals they’re multiple components that you need to reach that goal. And so breaking those down and having other people review your objectives is equally important, because what you may feel is really important, another individual can add in 1, going to add 2, going to sometimes add 3 and so and sometimes those objectives can be combined.”

Most effective tactic: “The most effective one is actually using the previous objectives as well as looking at Blooms Taxonomy, because Bloom’s Taxonomy, if you look at that, then look at where, what are your expectations within the curriculum you can essentially translate objectives that are appropriate, or that are at the appropriate level for your students. And so as a novice educator, you come in it’s very difficult to assess where exactly should the students be, and so sometimes asking a senior staff, at what level of taxonomy, should I really expect? What’s reasonable, what’s not?”

Educator 12 “I think being more organized because sometimes you know I think organizing drafts and keeping a logical file of those drafts, because how often when you do curriculum design, what do people do in curriculum design, they’re scratching it down on paper instead of actually putting it down on a computer and saving it and revision 1, revision 2, revision 3, and so sometimes that translation of not using paper and pen and using hard copy saved into the cloud somewhere is key.”
Educator 13: “ask for help from the beginning. I think I didn’t tap into my resources as well as I could of the first year. But I think it’s important to definitely seek help from other people.”

“it’s doing it I think you have to do it in order to learn it and I think the faculty that have been there a really long time, you know they learned by doing and they remember the strangest most bizarre policy type things or you know they just know it because they been doing it for so long it’s now like second nature. So I think you have to learn by doing.”

Educator 13 “experts, senior faculty to really kind of take novice faculty and provide them with you know with their knowledge, essentially.”

Educator 14 “what do you want the students to actually learn from this course. Don’t worry about the wording, don’t worry about the outcomes or anything like that. What is it you want them to come away with? If there were three things that the students would learn from your course, what would they be and then based on that, So you write those down. Once you’ve written those down, what are some things that you need to do to ensure the students learn those three things? Write those down. Based on all of that as well as our outcomes, what are some of the objectives that you could write using Blooms Taxonomy, you know the outcomes or the objectives have to be whatever acumen you want to use, but they have to be measurable. You can’t use understand. So, I guess just working methodically would be the easiest way to do it. And a good format. And then the objectives should, you should write your objectives. They go to the baccalaureate education committee who play with them, change them and reword them, and then it goes to the faculty meeting where again they get further wordsmithed. They go back to the
person who then goes back to the curriculum education committee, so by the time you’re at the end you’ll have decent objectives.”

“You can see pretty much anybody’s curriculum across the country now or around the world if you wanted to look at it….. I worked with the college of nursing over there that’s actually the first in the country that was teaching to the international standards. And they were based on ICN and they’ve actually had one of their students in the states successfully pass the NCLEX.”

Educator 14 mentioned (AACN, VSNA )”providing the expertise and they’ve got the bigger picture sort of across the country so they can provide examples.”

Educator 15 “sometimes the concepts in that are difficult for younger maybe less mature students to grasp. So I actually had to revamp my entire course in order for course outcomes, for the students to actually grasp the material I had to teach it a completely different way I had to bring it down to their level and then build it back up.” Educator 15 shared, “I have taken it upon myself to take five nursing education courses. I need strong nursing leadership to help guide faculty who are busy on the ground, you know, teaching classes in clinical settings. A leader that knows academia is helpful so they can help guide you through that process. And also if you are responsible for keeping up with certain standards and developing your curriculum and maintaining your curriculum you’ll understand those over time and you’ll get to know those standards better. You’ll understand what your role is…” She also said “I use ATI.”
Figure 10. Graphic depiction of theme suggested strategies.

Suggested strategies for the administrator. Educator one: “they need the resources. First of all they need to have continuing education around that. They need to have consultants that work with them, they need to have in service, they need some stimulation. They need to have people that can work with their curriculum as they’re doing it rather than after the fact. That takes time. It take faculty that’s fairly stable and it takes you know resources and um development. It takes an administrator who understands curriculum and that’s not always the case.”

Educator two: “Time, focus, development of faculty…know faculty education, faculty development you know when you hire people, the certain set of skills, if the skills,
if you’re looking at other skill sets that you are going to be needing you know some allocation of time some focus, some respect.”

“structure, attention, kindness, you know that kind of thing, respect you know. Working with faculty in terms of the strength based, um you know focusing development, faculty development that would all work well…I listen to my colleagues, that’s not always there in academia.”

Educator three: “Continued education. Let’s go. Let’s get a meeting of the heads so to speak from other colleges. You know to show us or to help support them on things that have worked …let’s help each other you know. So collaborating across the state, across the nation won’t work. If there is a nursing shortage then why not work together I mean in a bigger aspect of producing good nurses, because the truth of the matter is for most of us as educators, I’m not sure about the whole world, but I’m 51 years old. I want to ensure that somebody learns good nursing practice by the time I reach the elderly age, so I’m going to get good care no matter where I go.”

Educator four: “the best actions that we’ve had up to date is availability of resources and mentorship as faculty.”

Educator five: “most nurse educators want to get as much education as they can themselves. And I think the finances is a huge barrier. Um my program, my doctorate was fairly reasonable, and it cost me $80,000….Okay so that’s a huge financial burden. And if there was something administrators could do to make that it wasn’t such a huge burden I think that there’s educators would get more education because they need it.”
Educator six, “factor in the development as part of the work load. We are currently down two full time faculty members, because there is such a short supply of nursing faculty in our remote area.” “again, you know supporting continued education and faculty development. I think also if they were able to supply the resources to keep the workload in mind and perspective when looking at both development as well as… The development and revision you know, looking at revision, that’s constant. You can revise for every class, you can revise you know based upon things, but in looking at the absolute development of things and then knowing what it will take when we’re looking at our systematic program evaluation um and to go forward, the amount of time that it takes to really to do a good job and at the same time making sure that you’re taking caring of the students and the seats. If we didn’t have to juggle both …to help lessen the work load for us.”

Educator seven “Providing the opportunity for application. Keeping current on what the community and the whole process of community, curriculum evaluation, whatever format that is being used to be able to apply the information.”

Educator eight: “being very proactive with the curriculum committee in every school of nursing, throwing support to that committee and providing advice to the committee if they’re not on course or they need some direction or whatever or if the committee had questions or not. Our director sits on our committee and does offer us advice. But I think, I think that sometimes if even again there can be a consultant especially when you’re changing from the NLN to the ANCC accreditation body if you had a consultant that you could turn to, because I think a lot of the time there’s a lot documentation that’s needed in terms of the reports. And the only way you learn is
because you do them wrong. You know and it’s very frustrating; it’s very time consuming. It distracts from the time that you could teach because you can’t do both…”

Educator nine, “I would not ask a charge nurse, or a nursing supervisor to perform a task I didn’t know they could perform adequately. It’s not fair to them and it’s not, you can’t, you know you sometimes risk your program when you do those kinds of things whether it’s in a hospital setting or whether it’s in an educational setting.”

“Time to do it.”

Educator ten, “Time, you know release time to do that. Nobody ever has that. And over the summer you’re working in the hospital to make up for the salary you lost by being a nurse educator during the school year. So time and probably funding, paid time to do it, release time.”

“provide continuing education or encourage faculty to go back for education courses that are doing this, or get consultants who can help. You know, I would say make it a priority. You know if that’s you you’re doing this because you need to revise your curriculum to reflect current practice or because you’re being accredited or there’s been enough changes in something this that or other.”

Educator 11 encouraged, “Probably one of the most useful things would be to bring in individuals who have done things very different from each other and very different from the program to really help us all think about what other places have done that have gone well. I think another thing that’s really helpful is being a site visitor of other programs, because you go and think that’s really cool, but the other thing people oh we did that and it didn’t work, and it’s working here. EW, we’re not doing that. So I think that can be very very useful.”

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I probed, “Bringing people in from outside the organization?” She responded, “Yeah as well as going outside to other places. Because it’s just, you can just see so many interesting things.”

Educator 11 also mentioned, “Innovation is supported by an environment in which risks can be taken and there isn’t punishment for things that don’t go well…”

Educator 12 “the administrators need to frequent the curriculum redesign, restructuring on a delineated interval. Having faculty with a leader within that committee. Direct and streamline without having that direct leader or supervisor or chair involved in the curriculum process throughout the year creates for a proposal in the end that potentially would not be supported by the chair or the staff. And also, addresses issues whether it’s feasible or not.”

Educator 13 “just being supportive, in helping with that. Allowing them the time to do it because there is a lot of research that goes behind changing curriculum especially, but providing, you know, the resources that are needed so that they have the time to do it.”

Educator 14 Providing the time. Safe Environment, where people can at least professionally disagree with each other and that’s okay. Providing the resources. Mostly resources meaning time more than anything.

Educator 15 She or he (the administrator) needs to understand it themselves. They need to know it 100%. I feel like that rests solely on their shoulders and how they distribute it to faculty. And guide us through the process. The director needs to be an expert on curriculum development and designing outcomes. So I think they need to educate themselves on a regular basis and maintain their knowledge with the state and
national level. What’s happening with the Board of Nursing etc… I have felt serious uphill battle in educating the director this year about specific things like a baccalaureate nurse can’t be in a clinical by herself with 7 nursing students. Things like that. But also I feel like the leader or administrator needs to encourage and seek out and assist us with our continuing education. Organizing those type of things for us because we are too busy. We can’t even go to conferences because we have no time….We should be encouraged to take courses.”

**In vivo codes.** Of interest are what Charmaz (2014) describes as *in vivo* codes, that when studied allow a deeper understanding of what is happening, as the codes anchor analysis to the participants worlds. These are particular, or remarkable wording phrases that are used that offer clues to interpretation. These codes of participants distinctive phrases, referred to as *in vivo* codes, provide a useful way to preserve participant meanings and views of actions that need to be carefully scrutinized (Charmaz, 2006). There was a specific meaning to a term used by the specialized group of nurse educators. The interesting *in vivo* term used by numerous participants was “hidden curriculum.” Charmaz (2014) refers to “In vivo Codes as telling statements discovered in interviews, documents, or everyday language. Hidden curriculum was used as a telling term and the following is a description by nursing educator ten:

“There’s also the hidden curriculum, you know, I think most nurse educators nod their head when you say that and I think that has to do more with a subjective ethical framework that we know what an empathetic student looks like, what a caring student looks like, what a moral student looks like and I think we all feel a responsibility to the public. It’s the question a lot of us ask, most of us I would say ask, would I let this
student take care of my mother? You know, so that’s the hidden curriculum and I think that’s a standard to which I adhere because I think it’s true and I think it’s a valid standard. And it’s not necessarily covered anyplace else.”

More examples of hidden curriculum:

Educator one, 40 years an RN, 34 as an educator shared, “You know I think learning about it in a lecture hall or classroom is certainly a lot different, as it always is. When you actually experience it, it’s much messier. And what I really began to find out and as I did more of my own reading is that the hidden curriculum really is what drives the curriculum and it’s not what makes it, who the faculty you have there, what kinds of experience, what is their emphasis and background, where are the students, what is making sense to them, and so I think a lot of what I learned over the years through my practice was that it’s not a matter of taking the top of the head off, and the brain off and pouring it in and closing it before it leaks out but it’s a matter of what has meaning for the students, what do they bring to the classroom with their experience. How does this make sense to them.”

She continued, “We have the formal structures that we have a baccalaureate education committee …that group takes a look at the curriculum overall you know the big picture and are we achieving the outcomes that we’re trying to achieve, so there’s those formal committees and then how it gets done informally I think is by the individuals who teach in the courses, what feedback they’re getting and the experience of the clinical feedback, agency feedback that they’re getting and what needs to be changed. But also the having to be responsive to the rapidly changing practice world and trying to respond to that and electronic health records and all the other changes... So, I think there
is both the informal and formal mechanisms. The formal mechanisms take the longest and probably see the least amount of change. I think the hidden curriculum and what gets changed informally is what happens most regularly because people have most control over that, but also it can also do damage to the curriculum because then you don’t know if it’s holding together or not or if there is any overall structure anymore or what. So, it’s a delicate balance.”

Educator 14, “To me the hidden curriculum is what we teach our students that’s not written down. How we model, our behavior. What students get told to go forward.”

and

“Hopefully there are some good parts of the hidden curriculum in terms of collaboration and teamwork and we’re trying to push interprofessional education because everybody’s schedule is so different. That’s not the easiest one to get in there.”

When educator 12 was asked about the hidden curriculum, the educator responded, “So individuals would look at the hidden curriculum or other motives of what you desire your graduates to meet. I think there are a few hidden curriculum issues. I think you know passing NCLEX is up there for a lot of individuals. Sometimes, you’ll see people with, you know, I have seen, you know select teacher, but that’s not so much in curriculum, that’s more in student selection of making it more difficult. But I think that kind of translates into nursing eating their young, rather than support. I’m not going to like everyone I work with but we have to work together and be professional about it. I think the other hidden curriculum is that our graduates are able to find jobs. So, you know reality is you want them to pass the NCLEX and second you want them to be employed.
That, and then thirdly if you are doing that you are going to have recruitment. So a hidden agenda item also is does your curriculum appeal to marketing.

So moving on to the hidden curriculum, I will transpose that I am philosophically had some differences with individuals and some items within our curriculum which are quote unquote you know why we try to say we want to promote public health...”

Educator 13 conjectured, “I’ve never heard the term hidden curriculum, but it makes me think of faculty freedom in the sense that we could do whatever, we could change the curriculum completely, we can revise the entire thing to try and make our student outcomes better in the end.” When they graduate they are what we want, But really, that’s where faculty freedom comes in. Each faculty teaches their own course.”

Educator 14 referred to curricular drift, and how faculty may “underscore certain things and not other things and that type of thing, and so it (curriculum) can really change and shift over time.”

So the results regarding hidden curriculum were not consistent in meaning, and multiple participants were unaware of the meaning of the term. Data were inadequate to support the term as a theme, but it was enough to make it of interest for future research. Hence it was not used.

Summary of Findings

The study result revealed seven themes in the research. The first three themes fall under the purview of the first research question, and the last four fall under the second research question. The first theme is low confidence. The second theme is poor support and communication. The third theme is knowledge related to curriculum alignment and
outcomes, or the “big picture.” The fourth theme is needs mentorship. The fifth theme is faculty development and education. The sixth theme is overloaded and inadequate time. The seventh area was suggested strategies shared by educators for other educators and for administrators.

1. What are the perceptions of nursing faculty regarding their preparedness and confidence for developing, evaluating, and revising curriculum?

2. What strategies by nursing leadership and education might benefit nurse educators who develop, evaluate, and revise nursing curriculum?

- Low confidence
- Needs mentorship
- Poor support and communication
- Overloaded and inadequate time
- Lack of knowledge related to curriculum, and alignment to outcomes
- Faculty development and education
- Suggested strategies and tips

Figure 11. Graphic portrayal of the seven themes and two research questions.

Conclusion

Chapter 4 included a summary of findings from 15 interviews conducted on nurse faculty from four colleges to discover and compare the perceptions and processes of nursing faculty regarding their preparedness and confidence for evaluating, developing and revising curriculum, and what strategies could be used by nursing leadership and education to benefit nurse educators who evaluate, develop, and revise nursing curriculum. Common themes related to research question one, perceptions of preparedness and confidence include low confidence, poor support and communication,
and knowledge related to curriculum alignment. Themes on research question two, strategies to benefit nurse educators, include needs mentorship, faculty development and education, overloaded and inadequate time, and suggested strategies. These themes were used to build a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. Additionally, it may enable better curriculum to be developed to prepare, support and retain new faculty.

In Chapter 5 the model and theory developed from the study findings are presented. Chapter 5 includes the interpretation of the information generated by the study. It concludes with a summary of the study.
Chapter 5: Conclusions and Recommendations

The perceptions of faculty preparedness and confidence concerning developing, evaluating, and revising curriculum are not well understood. Most educators felt unprepared to evaluate, develop or revise curriculum when becoming an educator, as this was not a part of their nurse clinical practice, and had low confidence. There is a need for strategies to benefit nurse educators who develop, evaluate, and revise nursing curriculum.

The purpose of this study was to discover and compare the perceptions and processes of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and to use the faculty’s constructions to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. Additionally, strategies were explored to assist faculty’s growth and competence in curriculum development, evaluation and revision.

Charmaz’s (2006) qualitative constructivist grounded theory research design was used to explore perceptions of faculty regarding their preparedness and confidence in developing, evaluating, and revising nursing curriculum. A theory “Challenged and Overwhelmed” emerged from the data, and describes faculty perceptions regarding their preparedness and confidence in developing, evaluating, and revising curriculum. Faculty recommendations related to strategies that would support growth and competence in curriculum development, evaluation, and revision were described. Understanding from the theory “Challenged and Overwhelmed” as well as the suggested supportive strategies led to the development of a model of understanding to support faculty’s growth and
competence in curriculum development, evaluation and revision. In Chapter five findings are appraised and results compared to literature as well as exploring the significance of the findings, possible uses, recommendations for future research, and my reflections.

**Interpretations from Literature Review**

The research supports multiple previous research findings. Smith (E, 2012) noticed that aging professors stressed by the faculty shortage were more comfortable with content driven curriculum, though the style may not be the best for the student. There were comments from multiple faculty made that faculty who had been in their role for a long period were resistant to change, such as from participant 12 “instead of looking at the best interest of the students some look at the best interest of what is most convenient for them.” The participant also mentioned hostility and resistance encountered when initiating change. Participant ten also mentioned “there’s a lot of resistance” when discussing curriculum change. A few comments from educator one:

“You’ve got baccalaureate programs that take five years to get through you’ve got masters programs that are sixty and seventy credits long and you know it’s like what are we trying to do here, and so I don’t know if we’ve our curricula figured out. That you can’t just add more and is it more content that we really need to focus on and so it’s a delicate thing because people have to be able to be prepared to deal with a very changing acute complex environment and that’s not easy to prepare somebody for. It’s not necessarily content driven. It has to be much more about how one thinks and how one uses knowledge.”
“That’s like what are we trying to do here? What are, how are we trying to develop our discipline, so I think and it’s not more and more content about diseases and symptoms and that sort of thing you know, that I don’t know that we’ve figured it out yet as a discipline and I’m worried about that. So I think personally people have developed a confidence in it, but I’m not sure the discipline has yet.”

Educator 13, “But, it’s a lot a lot of work. A lot of content. The course I teach is very broad so it’s. I teach Medical-Surgical nursing. You can’t get any more broad than that. So really, you know trying to come up with creative ways of making sure the content is there and that you know you’re still meeting some of these objectives …”

Educator 11 stated, “I think one of the biggest challenges is having people think in new ways, and so if you think about the whole care delivery system is dramatically being changed and higher ed is way behind health care change. I think that’s the biggest thing. Most people want to see the piece that they taught remain relatively the same. We’re still really educating on the model that was started with the Flexner Report rooted in the reductionist biomedical model.”

Comments from faculty confirmed Paulson’s (2011) findings regarding the lack of qualified faculty to meet nursing program enrollment needs. For example, one comment was “there is such a short supply of nursing faculty in our remote area.” Educator 15 said, “I think our biggest problem is there aren’t enough people. There aren’t enough boots on the ground. There aren’t minds working collaboratively to do so and I believe the reason for that is that we have you know a nursing shortage demand on the service side that pays double and sometimes triple in some areas what an educator makes. My students graduate making almost twice as much as I do teaching them and
I’ve been on both sides of the spectrum…. we need to come up with a balance in the payer source, the payers because, and I don’t know who’s going to come up with that; I don’t know who controls that and how it’s going to happen, but I think until that happens you’re not going to really get the number of faculty necessary. ”Educator three also stated, ”yes there is still a nursing shortage…”

Research confirmed Anderson’s (2009) findings that clinicians transitioning to the educator role feel like they are drowning, and additionally confirmed Reece, Mawn, and Scollin’s (2003) findings both that faculty who are seasoned in teaching may not have proficiency in curriculum development and that faculty found curriculum development stressful. Multiple faculty used words such as frustrated, overwhelmed floundering, lost at sea, in their new role as faculty, particularly in the area of curriculum. For example, from educator eight:

“If even again there can be a consultant, especially when you’re changing from the NLN to the ANCC accreditation body if you had a consultant that you could turn to, because I think a lot of the time there’s a lot of documentation that’s needed in terms of the reports. And the only way you learn is because you do them wrong. You know and it’s very frustrating; it’s very time consuming. It distracts from the time that you could teach because you can’t do both to have to do this and think if we just had that ability to have the direction so we didn’t feel like we were floundering. I mean I guess once you do them, we’re hoping that that’s happening with our mid-term report that once we do one, the next one won’t be quite so bad, but I’m not sure.”

Educator 13; “I think the feeling of overwhelming would have been, kind of trumped my knowledge almost.”
Educator five mentioned feeling “lost at sea.”

Participant three mentions, “It’s stressful. It really is. And the stress that I get is this, okay honestly I’ve been a nurse 25 years, I feel comfortable and confident in my ability to practice as a nurse, so I try to be confident. I know that I don’t know everything but I can I can use my experience to help me prepare.”

Not all comments were negative; for example from educator eight:

“It’s one of the most challenging positions, and one of the most fun.”

Faculty are often recruited from acute care, where they may initially start out as a part-time associate assisting in clinicals. As acute care pays more in Vermont, the potential educator must be prepared to take a pay cut to join academia, but often the new employee is looking to give back to the profession. Working a second job in acute care to maintain expertise is not an unusual expectation and assists with the reduction in pay.

The many roles that the educator is expected to fulfill, is often a surprise as new educators know they will need to teach, but curriculum development, evaluation, and revision are often not discussed during the hiring interview. Faculty without a mentor struggle to learn and implement the many facets of the educator role.

The world of academia is different from an acute care hospital, and is intimidating to some, a new culture with different expectations. Visionary leader Dr. Halstead, recommended reform, and a greater commitment to training nurse faculty leaders and aligning with the recommendations of the Future of Nursing report since her NLN presidency (2012a). Now as executive director, leading the new NLN accreditor CNEA, her recommendations continue. The research results confirm her concern that much still needs to be done. Former U.S. Secretary of Health and Human Services and Former
Chair of the committee on the Future of Nursing at the Institute of Medicine Dr. Donna Shalala, and Vice Chair of the study Dr. Linda Burnes Bolton, when interviewed recognized the importance of nursing education, the need for significant change, more educators, and the need for collaborative improvement efforts with other health professionals to reduce defects in the healthcare system (Brown, 2012). Educators need support to become empowered to develop, evaluate, and revise curriculum with confidence.

**Interpretations from Data Analysis**

Research results were divided between the two research questions. The first research question was:

1. What are the perceptions of nursing faculty regarding their preparedness and confidence for developing, evaluating, and revising curriculum?

   Three themes emerged to answer the first research question. The majority of faculty have low confidence. Faculty need improved support and positive communication. The majority of novice educators lack knowledge related to curriculum alignment with course outcomes.

   Four themes emerged that addressed the second research question that asked:

2. What strategies by nursing leadership and education might benefit nurse educators who develop, evaluate, and revise nursing curriculum?

   The four themes that emerged involved the need for mentors, faculty development and higher education, designated time to develop, evaluate and revise curriculum, and a multitude of tips and strategies successful faculty used that were
effective. Suggestions address both faculty and administrators. Interpretation of themes is offered on the following sections.

**Theme 1: The majority of faculty have low confidence.** The majority of educators interviewed did not feel confident about developing, evaluating or revising curriculum when they became an educator. Additionally, most nurse educators, even those who were very experienced, expressed low confidence assessing curriculum, and recognizing whether it supports achievement of student learning outcomes. In spite of many years of experience, an average of over 29 years, and an average of 13 as an educator, 87% of faculty could not express confidence in curriculum development, evaluation, and revision. Only two out of 15 felt confident. One instructor that said she had confidence had only four years of experience as an educator and mentioned feeling “expert in my field as a clinical instructor, but I’m a novice in this” so it was interesting that experience did not correlate with confidence. The two most experienced educators did not express confidence. Even one nearing retirement with 39 years as a nurse and 25 years as an educator said “I don’t think so” when asked if he was confident yet, and suggested that having a “consultant to call up or e-mail or just run things by would be extremely helpful.” The study upheld Duffy’s (2013) finding of the new educator feeling unsupported, with lack of confidence in their new role. However, the study findings also reveal that not only new faculty had low confidence when it came to the area of curriculum development, evaluation and revision. Even experienced faculty with 39 and 40 years of experience did not feel confident, for these noted that curriculum needs to change with the evolving needs of students and practices in the workplace, and that curriculum should be dynamic. The NCLEX exams, accreditation standards, and
community needs also change, and therefore curriculum continually needs to be adjusted. Curriculum adjustment takes buy-in from many faculty, and resistance can occur through other staff, or institutional processes.

Curriculum was perceived as something that was not static, but was instead alive and continually evolving to changing needs in healthcare and students. As stakeholder needs changed, the curriculum would change to meet the need of the community. Different classes and generations had different needs and learning styles. The result of what was trialed in the current years was not seen until after the student graduated, and became a functioning nurse. Many faculty expressed that they were still learning the process, of developing, evaluating, and revising curriculum, or that they did not feel competent in that area.

Practicing curriculum review frequently was considered to be a beneficial practice as it could become confusing if not used constantly; however, curriculum revision is most often performed when accreditation is upcoming, and accreditation may not be performed more than every eight years, unless the program is new. Hence, it may take a long time to get the complete picture. Additionally, as nurse practice changes and standards are revised, educators can find it difficult to keep up with current strategies. It takes time and resources to stay current. The enormous amount of information a faculty needs to learn and stay current on, the constant evolution of practice and the changing needs of different generations that require differing strategies that a clinician may not be familiar with, can result in a let’s see how it goes method, evaluating success as an educator by the results of testing rather than confidence from knowledge, experience, and proven skills for the majority of educators, despite many years of experience.
Theme 2: Faculty need improved support and positive communication. It was clear that many faculty did not have an easy or positive transition to academia from clinical practice. Most faculty feel unsupported developing, evaluating, or revising curriculum. A high majority, 93%, experienced challenges in communication and support.

Comments such as Educator two “My expectation when I was hired was that I would have a level of support… I could be faulted for not being able to handle it all.” Or educator 13 “you almost feel like you’re asking too many questions. So you don’t want to ask anymore” led me to recognize in faculty the same sense of risking too much, one’s reputation, license, fear of failure… that can be seen in novice nurses in the clinical setting that feel overwhelmed when too much is expected without knowing how to find needed time and support without being perceived as poorly prepared or incapable. When hired, 60% of faculty remember that curriculum development was not brought up as part of their role. They expected to be teaching, not having any role with curriculum, and some mentioned expecting to have materials provided for them, and not having to create courses or objectives. Two faculty (13%) were told it would be part of their role, and three were not clear or had “no expectations.” Communicating unclear role expectations is an area of improvement to consider for those in administrative hiring positions. Increased communications between departments can have a positive effect.

The educators who do not feel knowledgeable about course development and how curriculum ties in feel unsupported, and these are often those with less educational preparation or background, and understanding of how weekly objectives support course goals, and class outcomes, which support overall program outcomes and student learning
objectives. If faculty are feeling inadequate, they are unlikely to want to bring attention on themselves. Four faculty received good support from a mentor, but the other eleven needed and wanted support, and felt the lack of it. It was noticed that faculty with a mentor did better. It became apparent that many faculty felt unsupported or isolated, and sometimes undermined when trying to develop, revise, or evaluate courses. The environment was not always friendly for asking questions, and some initial discomfort with the academic culture was mentioned. For example, educator 13 recalled “It’s simple but intimidating when you’re the novice faculty coming in. And you ask so many questions anyway that you don’t want to, you know it’s almost like you. I think some people think coming in that you just, it’s like you’ve done it. They’ve been there so long that it’s very second nature and it’s just expected that it’s second nature of you so you almost feel like you’re asking too many questions, so you don’t want to ask anymore.”

Others mentioned hostile resistance, particularly if buy-in was not obtained, and “very little peer support.”

This is reminiscent of the new nurse coming onto the acute care floor that does not want to ask too many questions or the floor nurses will consider them bothersome, or question their competence, and the nurse does not want to put their job at risk. It may be that new educators must prove themselves and deal with attitudes similar to hazing historically experienced by novice nurses. Organizations and nurse leaders may not be ensuring that a supportive environment is created in academia. Incivility directed toward nurse educators from students, and from educators to students has been documented (Clark & Springer, 2007), but there is minimal research on incivility toward novice educators from other faculty. Clark, Olender, Kenski and Cardoni’s (2013) research
findings exposed that faculty incivility is flourishing in stressful academic environments, and faculty workload can be a contributing factor, with fear of reporting a concern related to peer review.

Faculty feeling “Lost at sea”, “without any guidance at all” learning “trial by fire”, or noting the lack of “trust and respect” and “effective communication” demonstrate that positive communication and support is lacking in academia. As well as from other faculty, it was clear that positive direction from administrators or leaders with experience in academia and curriculum, would be helpful. Rather than communication being on an improvement trend, it seems that more faculty lately may be “tossed to the wolves” according to some of the educators.

**Theme 3: The majority of novice educators lack knowledge related to curriculum alignment with course outcomes.** Eleven out of 15 faculty (73.3%) did not believe they saw the big picture or understood how their course fit with the curriculum when they developed their first course. Novice faculty may be inadequately prepared to evaluate or develop curriculum for accreditation. Knowledge was initially lacking related to curriculum alignment to outcomes, and for many the academic culture was threatening. Critically thinking faculty drew from their nursing experiences and what they could find on the internet, books, webinars, or from other instructors to create courses when they had no training in writing objectives. Nearly three quarters did not understand how their course fit with the curriculum when they developed their first course. Understanding of how to integrate the curriculum, and how accreditation standards must be met was insufficient. By the time the instructor begins to implement new practices, needs changed, leaving them feeling behind. Institutional processes were sometimes a barrier.
Theme 4: Mentorship is needed. All faculty interviewed agree that mentors are helpful in learning how to develop, revise and evaluate curriculum. It was the most frequent strategy recommended to increase competence. Mentoring faculty in their areas of responsibility is also recommended by accreditors such as ACEN (2013) in Standard 2.8. The finding confirmed Moore and Cagle’s (2012) recommendation that novices need mentoring to become competent professionals that feel prepared to practice. It also confirmed Weidman’s (2013) finding that faculty who were mentored had an easier transition to their role when they did not have a nursing education background. Weidman (2013) found mentoring to be enormously important for novice educators, yet the study findings intimate that many who need mentors are without them. Mentoring is desired by senior faculty as well as novices in the area of curriculum development, evaluation and revision. The NLN (2008) found mentorship to be so important a position statement stressing the need for mentorship was created noting mentorship was relevant across the career continuum of an educator, and the Healthful Work Environment Task Group created a mentoring tool kit to assist in operationalizing a mentorship plan in education. The need for mentoring is clear, but actualizing the implementation of mentoring across faculty has encountered impediments.

Theme 5: Faculty development and education is needed to aid knowledge. Faculty were inconsistently prepared and many had significant development requirements, not understanding how courses fit into curriculum, or how objectives needed to be integrated. Nearly 30% had no courses at all that related to curriculum development, evaluation, or revision. Sixty percent had 0-3 courses related to curriculum. Several experienced educators admitted lack of understanding in the area of
developing curriculum. All faculty agreed that faculty development would be helpful to learn the educator role related to curriculum, and that it was needed, particularly when a new faculty member was hired as they could be a novice at education despite being a clinical expert. Yet experienced faculty felt that they could also use development, as curriculum skills became rusty. Practice was considered to be a useful way to gain expertise in curriculum development, evaluation, and revision.

The study confirms Rich and Nugent’s (2010) finding that faculty may enter academia with inadequate preparation to teach and that the skills of an educator are not necessarily those of a practitioner. It is clear that adequate preparation for many educators still does not occur. McDermid, Peters, Jackson, and Daly’s (2012) finding that nurse academics are from clinical backgrounds with potentially little preparation for the faculty role seems to be increasingly prevalent. The study also confirmed Zungolo’s (2008) findings that transition from clinician to faculty could be challenging, and that a clinician may be an expert clinician but may not possess needed skills in education.

Weidman’s (2013) finding of transitioning faculty feeling stressed in their new role related to not having educational theory was confirmed and the lighter teaching load suggested would likely benefit new educators. Furthermore, as curriculum is not revised frequently in many organizations, sometimes only when accreditation is imminent, educators likely need to have their knowledge refreshed. Not all faculty were involved with developing, evaluating, and revising curriculum and coursework in previous studies. The findings of Krisman-Scott, Kershbaumer, and Thompson (1998) that clinically skilled experts did not have the knowledge and skills required for the higher education role, the current study revealed as still true, particularly in the area of curriculum
development, evaluation, and revision; furthermore, the acceptance of a faculty position without clear understanding of the faculty role was clearly supported by the majority of faculty being initially unaware that curriculum development, evaluation, and revision was part of their role. Some faculty also mentioned they might teach as they were taught. Several specifically mentioned that they did not have a grasp on what nursing education entailed or that curriculum development was out of their skill set entirely. This also confirmed the Penn, Wilson, and Rosseter (2008) study that many clinically expert nurses have only a vague idea of what the faculty educator role involves, and Fitzpatrick’s (2014) observation that expert clinicians enter educator roles with minimal understanding of the expected skill set.

Other faculty became overwhelmed with the process. Practice, not just formal education was very often recommended, or the opportunity for application. Yet, practicing without knowing what you are doing is inadvisable. So, an excellent course of action could be similar to what educator ten suggested: first course work in it, mentoring, then doing it- Education, mentoring, and practice.

**Theme 6: overloaded and inadequate time.** The majority of faculty complained of inadequate time to be able to develop, revise, or evaluate courses and curriculum. They felt workload was excessive, faculty in short supply, and time inadequate, which added to the stress felt when curriculum must be assessed in addition to other responsibilities. Two subthemes were heavy workload and feelings of stress or being overwhelmed, and the faculty shortage was mentioned. Faculty have inadequate time for curriculum revision due to workload.
The study confirmed findings that teaching loads were very demanding and that nurse educators salaries were comparatively low as compared to acute care nurse clinicians receiving higher salaries, another frustration for educators after needing to take out a loan for education, accompanied by multiple increasing dissatisfiers in the educator role realized by NACNEP (2010) as well as AACN’s (2005) finding of faculty feeling frustration due to inadequate time to complete work. I was familiar with the feeling of inadequate time to review curriculum due to other faculty expectations, and at her organization faculty had shared how meetings held outside of work hours in addition to other committee assignments increased stress due to inadequate time to fulfill student and regular course preparation needs and grading assignments. In addition to preparation time, committee and work assignments, faculty must take time to maintain expertise in their clinical area. For example, an essential element under Standard Two: Faculty, required for ACEN accreditation in the *Guidelines for the Preparation of the Self-Study Report* lists “Evidence of maintenance of faculty expertise in both academic and clinical settings” (ACEN, 2013). CCNE also requires specialty courses, or other preparation, as seen in Appendix C. This typically means either education outside of the work setting, or working another job. It is not surprising faculty report exhaustion and inadequate time. For some the extra money may help to compensate for the decrease in salary when becoming an educator, but it does not compensate for family time. Many colleges cannot afford to subsidize the cost of faculty coursework, and often faculty are in considerable debt. Consider the comment of educator three “I still have an enormous debt. It’s always about and I don’t want to sound negative, but the thing is when you’re an educator in a college, all right go to school, get your PhD, okay fine, but how are you going to pay for
it? And the reality of the situation is if I already have $135,000 worth of debt, what’s going to happen eventually, is that mountain of debt is going to come back. It’s already haunting me. And the honest truth is this: I stay in school because I don’t want to pay that.”

Educator five shared, “finances is a huge barrier. My program, my doctorate was fairly reasonable and it cost me $80,000…”

The average age of doctoral prepared faculty is over 53 (AACN, 2014). AACN (2014, p. 2) from 2013-2014 Salaries of Instructional and Administrative Nursing Faculty in Baccalaureate and Graduate Programs in Nursing reported that the average ages of nurse faculty with doctorates “holding the ranks of professor, associate professor, and assistant professor were 61.3, 57.7, and 51.5 years, respectively. For master's degree-prepared nurse faculty, the average ages for professors, associate professors, and assistant professors were 57.2, 56.8, and 51.2 years.” Furthermore, the average age that nurse faculty plan to retire is 62.5 years (AACN, 2014). Loans could negatively affect the ability for faculty to retire, or the willingness for some to become faculty. The ability to recoup though salary what is spent on education when an educator is already over 50 is improbable. Continuing education at a younger age could increase the odds of recovering the investment.

**Theme 7: suggested strategies.** There were many strategies suggested by faculty, so these were divided into categories: areas to comprehend, strategies to enable the educator to learn, and learning environment needs. Additionally, suggestions for administrators were offered. Using strategies was how the challenges encountered were met. Figure nine provides a visual of the overlap in categories. The overlap includes
needs for educators that overlap with needs for administrators, and that are needed for each strategy success such as environmental needs that enable learning for educators and administrators. These include: safe environment, respect, and communication.

Figure 12. The strategy categories with overlap.

**Areas for the educator to comprehend:** The educator needs to understand the structure of the curriculum, and the bigger picture. The educator should know why courses are placed where they are, and know yearly expectations so he or she can keep sight of the larger goals, not just one course. Educators need to know the program goals as well as the course goals, and must make sure course objectives, and even the topic objectives are aligned with overall student learning outcomes. Educators need to observe where the learning outcomes are covered by a variety of courses. Sometimes it helps to
start with the end point in mind when courses and curriculum are created. What are the learning outcomes that the educator is working towards? When creating a course, consider the top three things the educator wants the students to actually learn from the course and write it down. The educator should create student centered courses and curriculum. The educator must understand how to make objectives and outcomes measurable. Furthermore, they should remember to use Blooms taxonomy.

The educator needs to learn about accreditation, their standards, and how they affect curriculum. The standards are available online. Educators should practice writing outcomes to meet accreditation requirements. It benefits educators to create interpersonal relationships, and to learn the culture of academia. Another set of eyes can be useful.

Strategies to enable the educator to learn.

Educators should

• participate in online webinars such as Evolve webinars that are available at any time.
• participate in meetings monthly about curriculum to share what is new and helpful.
• apply and practice their skills; do curriculum development, evaluation, and revision.
  o Do it repeatedly until you realize what is done well, and what is not done well.
• find or be assigned a mentor. This is especially important for all new faculty.
• have guest speakers or consultants experienced in the development of curriculum visit.
• have collaborative discussions with faculty, other departments, and with other faculty across the state.
• use a leader in academia that can guide you through processes and help you keep current with standards developing curriculum and maintaining curriculum.
• encourage nursing organizations and/or accreditors to become more involved and supply a person on the phone who an educator could ask - am I on the right course?
• talk with experts, and senior faculty who can help new faculty fit into the organization and provide knowledge, expertise and the bigger picture, like a preceptor
• get feedback from other educators
• share “stuff” and ask for help.
• beware of curricular drift.
• be a part of the larger community of academia.
• be organized. Specifically, the educator should
  o be well-prepared ahead of time.
  o be persistent and organized.
  o break items down into subsections using ADDIE format and sticky notes.
  o map each course with outcome, learning activity, and how it is evaluated.
  o use sophisticated measurement techniques and curriculum mapping technology.
  o use organization and accurate saving files.
• continue their education and engage in faculty development;
  o Read professional journals, and books by Mary McDonald, and Billings.
• keep current, and this includes getting feedback from stakeholders.
• use surveys, student, and program evaluation feedback to improve courses and curriculum.
• be as creative as possible, to keep the art in the science of nursing and to make sure that that art is also in the curriculum.
• have a conceptual framework that is elegant.
• go through the accreditation process.
• cross teach with other faculty
go to meetings and conferences where you are immersed with people with different ideas.
not only revise but analyze your courses and curriculum when you review them.
use “Bloom’s Taxonomy to write objectives at the correct level.
know your end goal, and devise your objectives as to what the components are to reach the goal. ATI has resources and check current YouTube videos and Google scholar.
have others review your objectives.

*Strategies suggested to administration.*

It would be helpful if administrators could

- allow time specifically to work on curriculum. Release time and possible funding would help faculty.
- provide education, classes, in-services,…and more tuition reimbursement please.
- send faculty to conferences.
- have no expectation of a first year educator developing curriculum or courses the first year
- supply more resources.
- provide orientation about standards and a demonstration of what level objectives are and how they relate.
- support and provide continuing education and faculty development.
- provide consultants on call.
- ensure adequate staffing.
- have a meeting of leaders from multiple colleges and collaborate across the state.
- bring in individuals who have done things differently from our program and outside the program to help us all think about what other places have done that has gone well.
- be a site visitor of other programs, and share what they do.
- go outside to other places to see what they do.
• help with the financial burden so educators get more education because they need it.
• lessen the workload.
• provide a safe environment where faculty can disagree.
• factor in curriculum development as part of workload.
• provide the opportunity for application.
• keep current on the community and the process of curriculum evaluation, and the format.
• be proactive with the curriculum committee
• frequent the curriculum redesign, restructuring, on a delineated interval.
• understand curriculum design 100% and guide faculty through the process. The director needs to be an expert on curriculum development and designing outcomes. A background in academia is useful.
• self-educate regularly, maintaining current knowledge at the state and national level.

Learning environment needs: Educators need support and encouragement through contact. They need to feel heard. They also should be able to listen to others. Educators need to be provided a safe environment where people can professionally disagree. Faculty need to be able to create relationships and feel supported.

Being treated with kindness and respect by other faculty and administrators is important to faculty. All educators should be treated with professional respect. It would help if some curriculum meetings were less serious, and had a pleasant introduction. It is helpful for educators to have structure provided, attention and focus, as well as clear criteria guidelines available, so data and evidence can be created to demonstrate that educators teach what is intended.
Mentorship, more time, education, regular involvement with curriculum and use of a consultant were highly suggested by educators. Essentially, the educator needs to acquire knowledge about curriculum, which can be done through coursework or development, a mentor, and even books and webinars. Subsequently, the educator may practice developing, evaluating, or revising curriculum with a mentor and others, and receive feedback. After that more independent work can be done by the educator, but having another “set of eyes” to look at the course or curriculum work is recommended. The educator can keep current by visiting other colleges, attending conferences, or by arranging for consultants or guests to come visit, reading books, journals, visiting accréditor websites, and collaboration with other faculty.

**Theoretical Propositions**

Well-prepared faculty are one of eight components of the NLN (2006) Excellence in Nursing Education Model. Elements of well-prepared faculty include curriculum design, implementation, and evaluation, and skills with evaluation methods for programs and individual learners. The NLN Excellence in Nursing Education Model (2006) proposed that for nurse educators to be well prepared, they must be competent in curriculum design, implementation, and evaluation. The NLN (2013) define competence as the application of knowledge, making decisions, and using physical skills to perform the task or role. As nearly 75% of faculty in the study did not initially understand how their course fit with the curriculum when becoming an educator, or how to integrate courses into curriculum, excellence does not appear to be achieved by fundamental nurse graduate education. For nursing care to improve, and the gap between education and practice to decrease, nursing students require sound curriculum, and accreditors such as
ACEN (2013) state that curriculum must be developed by faculty, incorporating professional standards and competencies. If a potential faculty member is recruited with a master’s or doctoral degree and clinical expertise, but minimal or no curricular education, and weak skills in developing, evaluating, and revising curriculum, a pathway to becoming a well-prepared educator is needed. Otherwise, educators struggle to learn knowledge and skills on their own, and both students and public must tolerate the consequences of the inconsistent results.

It was recognized that novice faculty struggled with their role, but it was not recognized that the majority of faculty, including extremely experienced educators, have low confidence when it came to assessing whether curriculum supports achievement of student learning outcomes, incorporating established professional standards, and competencies. Most nurse educators felt unsupported, and 60% did not expect to execute curriculum development. Nearly 30% had no courses that related to curriculum, and faculty had inadequate time to develop, revise, or evaluate curriculum. Developing, evaluating, and revising curriculum are not skills commonly used by nurses in clinical settings, from where potential faculty are often recruited. For excellence to be achieved, adequate education, then practice and support are needed.

Well-prepared faculty are expected to be academic leaders with a wide array of skills. An expected skill is the ability to design and evaluate curriculum. Excellent educators are more apt to build excellent curriculum that result in excellent nurses.

**Revisiting the framework.**

The NLN Excellence in Nursing Education Model (2006) was used, with particular attention to the component well-prepared faculty, one of eight core elements
required to sustain excellence in nursing education, which provided a framework that defined educator competence and preparedness. Well-prepared faculty are expected to be academic leaders, expert clinicians, and expert researchers (NLN, 2006). Well prepared academic faculty leaders, such as educators responsible for training the next generation of nurses, are expected to have an array of skills that include curriculum design, implementation and evaluation abilities as well as knowledge of evaluation methods (NLN, 2006). Accreditors expect curriculum to be developed by faculty (ACEN, 2014). Hence, an essential component of educator competence must include the ability to evaluate develop, and revise curriculum.

When the findings of the research question inquiring about the perceptions of nursing faculty regarding their preparedness and confidence for developing, evaluating, and revising curriculum are reviewed, the question relates well to the framework, and evaluates whether current faculty perceive themselves to be prepared and confident that they meet the expectations of the NLN Excellence Model in that component. As 87% of faculty interviewed did not feel confident about their abilities developing, evaluating, and revising curriculum, and recognizing whether it supports achievement of student learning outcomes, and nearly 75% did not understand how their course fit with the curriculum initially, most faculty are not well-prepared to fulfill their role without utilizing strategies to develop their potential. The second research question addressed the need for strategies by nursing leadership and education to benefit nurse educators who evaluate, develop, and revise nursing curriculum.

Prior to utilizing the NLN Excellence Model, other models were considered. Sawatzky, Enns, Ashcroft, Davis, and Harder (2009) discuss a Caring Framework for
Excellence in Nursing Education to teach excellence in nursing. The scholarship of teaching is described as inquiry producing knowledge that supports the transference of knowledge of the art and science of nursing from experts to novices, and the difficulty of evaluating excellence in teaching scholarship is mentioned (Sawatzky, Enns, Ashcroft, Davis, & Harder, 2009). However, there is little discussion of the preparation and knowledge needed for teachers to create effective curriculum, or even course outcomes. Education cannot be effective without skillfully crafted courses and activities that teach students what they need to learn to become critically thinking nurses. Just as researchers must be careful to accurately assess what they intend to measure is valid, education must accurately teach what it intends to teach, or graduates will be inadequately trained and not pass national examinations. A systematic way of keeping up with evolving healthcare and curriculum reform is needed. However, education in curriculum was not addressed, so the model was deemed inadequate for the study’s needs.

Benner’s (1984) Novice to Expert theory was considered. However, it became apparent that while educators became clinically expert according to Benner’s time stream, they often did not become expert in curriculum development, evaluation, and revision as this area was not practiced frequently. I saw the lack of expertise in curriculum development, evaluation, and revision in faculty who were expert in other roles in my own college as well as multiple other institutions, and reflected that most faculty were only involved with curriculum evaluation and revision through accreditation every eight years or so. That was the time greatest scrutiny occurred evaluating whether the student learning outcomes were met. Because colleges knew they would be scrutinized by national accreditors and peers, a closer look was taken at how the course
objectives lined up with the entire programs learning outcomes, and the fit of courses was considered in the program and curriculum evaluation. It was during this time that faculty were often introduced to the concepts of program evaluation and curriculum evaluation and revision. Until then, faculty may have been provided objectives written by another, and encouraged to become involved with committees in their spare time. However, participation became mandatory when accreditation was looming and a self-study must be completed as well as a systematic evaluation to remain accredited. When faculty wrote objectives for new courses, review by others was necessary; otherwise, the course objectives might not pertain to the student learning outcomes for the program. Faculty who were expert clinicians were often novices in developing, evaluating, and revising courses and curriculum. If skills are only rarely practiced, the skills tend to remain less proficient than other skills; hence Benner’s *Novice to Expert* model was insufficient for a framework.

Becoming faculty without practicing curriculum evaluation, development and revision is insufficient to develop expertise in these areas. Well prepared faculty leaders, require expertise and expert knowledge in curriculum design, implementation, development, revision, and evaluation abilities as well as evaluation methods. The NLN Excellence Framework addressed these areas thoughtfully; hence, was the best fit. The new model of understanding developed addresses these needs.

Strategies are needed to create a bridge from practice to education. Just as there is a knowledge gap for students moving from education to practice, there is also a knowledge gap for practitioners moving from practice to educational theory, as more than
expert clinical skills are needed. These gaps can be reduced. Experienced practicing faculty recommended strategies. Study findings are shared.

Findings

Study findings revealed that 87% of faculty have low confidence developing, evaluating, and revising curriculum and 93% experienced challenges in communication and support. The need for faculty support is palpable. All the faculty found mentors to be helpful, and mentorship and expert resources were desired by senior faculty as well as novices in curriculum development, evaluation, and revision. It is clear from the research that for faculty to become well-prepared excellent educators able to develop, evaluate, and revise curriculum, they are more likely to be successful if they have mentors available for curriculum work across the career continuum.

Knowledge was initially lacking related to curriculum alignment to outcomes for nearly 75% of faculty, and all faculty felt that faculty development related to curriculum would be helpful. More knowledge related to curricular alignment available through education first, then the opportunity and time to practice the skill is essential. The overload and inadequate time, lack of knowledge regarding curriculum, inadequate mentorship, poor communication and support, and low confidence, lead to faculty feeling challenged and overwhelmed in their role of educator. This phenomena is represented in the theory Challenged and Overwhelmed.
Description and Explanation of Theory:

Figure 13. is a graphic depiction of how the concepts: lack of confidence, overload and inadequate time, lack of knowledge and development, poor support and communication, and the need for mentorship are experienced by the educator who becomes challenged and overwhelmed. The theory Challenged and Overwhelmed: A Theory of Understanding How Faculty Challenges Lead to Becoming Overwhelmed with Curriculum Development, Evaluation and Revision is a descriptive middle range theory that emerged from the data and clarified understanding of what educators are facing in academia and the resulting sense of an onslaught of challenges that can become overwhelming. Faculty who have been expert nurses, struggle to achieve expectations they did not know existed when they were hired. Most progress from feeling confident
and expert in a clinician role, to experiencing low confidence and feeling like they are facing too many challenges and are floundering, feeling overwhelmed, particularly with curriculum development, evaluation and revision, despite high levels of knowledge in content areas, and years of experience in the clinical arena. There are five themes that emerged as challenges: lack of confidence, overload and inadequate time, lack of knowledge and development, poor support and communication, and the need for mentorship. Descriptors from educators provide evidence in each category:

*Lack of confidence.*

- I’m still climbing.
- Once you get confident it’s going to change again.
- The whole thing is really a huge challenge…a heavy weight on your shoulders…
- I don’t think I’ll ever be fully competent.
- It’s very difficult to know how it’s working.
- I don’t feel anywhere near competent or confident in my abilities….I think you feel like a fake your whole life.
- I don’t really have the scope or true sense of this.
- It’s always a challenge.

*Poor support and communication.*

- It’s very frustrating; it’s very time consuming….you can’t do both to have to do this and if we just had that ability to have the direction so we didn’t feel like we were floundering.
- There are more nurses that are kind of tossed to the wolves.
- I had very little peer support.
- It was kind of learn, trial by fire shall we speak….extremely difficult.
- You feel like you’re asking too many questions.
- There’s a lot of resistance.
- The greatest challenges are with your staff.
• I also felt some risk in terms of the administrative responsibilities….having responsibility in areas where you have no control, and having that in an environment where you didn’t feel trust and respect and you didn’t feel communication was effective.
• It was like spitting in the wind. You were just lost at sea.
• With each leadership change there has been a change in expectations.

Lack of knowledge and development.
• It’s been very difficult because I really don’t have the educational preparation, no preparation at all.
• Going for an accreditation, I was just a passenger.
• Institutional processes were a barrier, definitely a learning curve.
• It takes a long time to understand.
• I had absolutely no idea what I was doing.
• I don’t have a number of courses related to curriculum.
• You’re kind of thrown into it.
• I was more or less trying to put together classes and lectures and things that were very specifically focused on the topic and was not particularly worried about the big picture.
• A lot of it coming in was just being overwhelmed
• We all need to be developed farther so we can give quality education to our students.

Need for mentorship.
• _____ (mentor) was a tremendous help
• She took me under her wings and really helped me start off my education instructor experience.
• A mentor made it easier.
• It would be incredible help to have that kind of support or if there were mentors
• I had all I could do to get my feet on the ground.
• It depended a lot on your personal collegial relationships with people.
• It’s not easy as a brand new faculty coming in.
• Right now I would not have a clue

**Overload and inadequate time.**

• It’s very difficult, I think because I think it’s so time consuming and you no sooner feel that you have developed something that’s going to meet the needs of the now and by the time you’re able to begin to implement it those needs have already changed
• A challenge I face is the work load in academia. I’ve been a nurse for many decades and I’m used to working hard, but I think for me the balance of working in the community as a nurse and as a nurse educator was very challenging. I think just physical exhaustion…. stressful.
• We really don’t know how effective this is because we really haven’t had enough time to truly look at it. So, that’s extremely challenging. We haven’t had enough time.
• Oh my God! Workload….Workload is very subjective.
• You’re working all evening or you’re working all Saturday or you’re working all Sunday and you’re not getting any rest
• Sunday I’d be starting from scratch trying to make a lecture for Monday and you never really got ahead, so it was, that’s what made it more difficult was I just didn’t have time.

It is apparent that each of these five areas where critical needs are lacking, separately are difficult and can cause distress, but the combination of all five factors leads to an educator becoming more likely to be overwhelmed by the multitude of challenges. The themes are connected because low confidence increases the likelihood of feeling overwhelmed. Poor communication and changing expectation leaves the educator guessing if they are on the right track, as reading minds is an impossible challenge, and
the educator does not know if expectations from their supervisor or the needs of students are fully being met. The inadequate time does not allow for recovery from fatigue, or adequate time to prepare quality work. Educators are working late, and some work all weekend to keep up, when they may have family, other jobs, courses and additional responsibilities and financial burdens. This challenge adds to the educator feeling overwhelmed. The lack of a mentor leaves the educator struggling to find solutions on their own. They may have inadequate knowledge in the area of developing, evaluating, and revising curriculum, so this adds to the stressful burden, for they must figure out how it is done, and make sure their course is in compliance. The lack of knowledge related to curriculum development, evaluation and revision is another challenge that takes up teaching time, and knowledge is needed for quality work to result. It is clear from the comments that many educators do not have adequate knowledge to perform curriculum development, evaluation or revision. Figure 13. depicts a graphic representation of the theory and how the five areas: lack of confidence, overload and inadequate time, lack of knowledge and development, poor support and communication, and the need for mentorship assault educators and result in the educators feeling challenged and overwhelmed in their role.

**Incorporating Strategic Solutions**

During the interviews, not only were the themes discovered that resulted in the educator becoming challenged and overwhelmed, but collaboration with faculty occurred to discuss strategies and solutions to assist with the challenges faced by educators. Faculty suggested strategies specifically aimed at educators and administrators, and tips
for educators. For each area, specific strategies were suggested as well as other tips to remember for educators who develop, evaluate, and revise curriculum.

First the area of knowledge and development is addressed. Education and development related to curriculum is needed as nearly 30% had no education that related to curriculum development, evaluation, or revision. Sixty percent had 0-3 courses related to curriculum and nearly 75% did not initially understand how their course fit with the curriculum. All the educators felt that ongoing faculty development or education was needed. Continuing education at a younger age increases the likelihood of recouping the cost of education, and adds to the expertise of the profession. Education is available in many forms and will vary with the organization. Some recommended strategies included participation in online webinars and participation in meetings monthly about curriculum and having guest speakers or consultants with expertise in curriculum visit. Educators having collaborative discussions with faculty, other departments, and with other faculty across the state and taking with experts and senior faculty were suggested. Another suggestion was to encourage nursing organizations and accreditors to become more involved. Topic ideas for future meetings are often requested, and curriculum development, evaluation and revision are topics organizations could support. Tuition reimbursement was clearly a need. Annual in-service presentations might be more affordable to institutions unable to afford this service; but institutions should be aware that with academia offering a lower salary than acute care, tuition reimbursement is a useful recruiting tool. Engaging in faculty development offerings at colleges biannually, using on-line resources, and reading professional journals and recommended books were other suggestions.
The next area was low confidence. It was not clear that knowledge was the only thing needed to build confidence. As curriculum was constantly evolving, and needs of students and communities change, it was apparent that staying current on community and student needs was essential, and keeping up-to-date was a shared responsibility for faculty and administration, for collaboration and feedback was required to stay current. Going outside of the organization and talking to others to see what they have done that worked was suggested, via conferences or collaborative visits. Using a leader in academia that could guide one through processes and help the educator stay current with standards, developing curriculum, and maintaining curriculum was suggested. If the educator has no time to attend conferences that will update them on latest best practice, they must depend on others bringing information into the institution and sharing that information. Hence, another strategy was to get information from others and use surveys, student, and program evaluation feedback to improve courses and curriculum as well as feedback from stakeholders.

Time was the third area of concern. Educators need additional time to develop, revise, and evaluate courses and curriculum and there were strong recommendations that curriculum work be considered part of the workload. The importance of organization was addressed and many tips offered. However, it was clear that workload was an issue, and most educators did not have enough time. There were multiple suggestions to administrators related to time, such as release time for curriculum development, factoring in curriculum work as part of the workload, decreasing workload, and specific time where faculty worked with administrators. Provision of time for curriculum revision by adjusting workload rather than increasing it, and having experts assist, could increase
productivity, and increase the potential for innovative, creative curriculum.

Another area was that of communication and support. Educators recommended collaborating with other educators, getting feedback from other educators, sharing “stuff” and going to meetings and conferences where you are immersed with people with different ideas. Cross-teaching was recommended by another educator. Cross teaching would allow coverage if one of the teachers needed release time to work on curriculum. Some shared that kindness, respect, and a safe environment as well as positive support needed to be provided. Incivility should not be tolerated, and consequences though clear policy should be in place. Recognition is a positive communication, and excellent work could be recognized at annual and monthly meetings.

Mentorship was the most frequent strategy recommended to increase competence. The practice of mentorship is encouraged by many accreditation agencies, including ACEN, NLN, and CCNE. Educators need to have a person with whom to brainstorm or trial ideas, or to verify if they are on the correct tract. Clearly, mentors improve the academic experience for educators.

Another recommended strategy by many educators was for faculty to practice; practice collaboratively and repetitively, developing, and revising curriculum as well as evaluating courses and curriculum. This could be done in monthly meetings where a different educator or guest presents each time on their work, then further collaboration after meetings could occur. Participating in the accreditation process, and involvement in committees, and ongoing revision facilitates understanding of the big picture. Educators recommended that other educators apply and practice their curriculum skills, doing curriculum development, evaluation and revision. Educators suggested that other
educators do curriculum and objective writing skills repeatedly until they realize what they do well, and what they do not do well.

Figure 14. Strategic solutions

Figure 14 is a graphic representation of the strategic solutions suggested by educators. The general areas of the solutions are represented. The first area practice was recommended once education of how to develop, revise, and evaluate curriculum was received, as curriculum skills needs to be practiced more frequently than every eight years, when preparing for accreditation to develop proficient skill. Education and continued development strategies are used to address the lack of knowledge found in the majority of educators. Mentorship improves the academic experience for educators and was the most frequent strategy recommended to improve competence. Time release, time specifically designated to work on curriculum, preferably reimbursed time that is factored into workload would address the overload and inadequate time area. The final area is collaboration and feedback. This area includes collaborating with other educators, getting
feedback from other educators, including consistent feedback from administrators, and a safe environment to disagree, where one is treated with respect and kindness.

Faculty are required to undertake more education than acute care staff nurses, yet are paid less than acute care nurses and work more hours outside of their job. Nurse practitioners and clinicians recruited to academia often take a pay cut when they want to teach and give back to the profession. It should be expected that if nurse faculty are not better supported, the faculty shortage will continue or worsen. The study findings confirm that nursing programs are requiring a heavy workload, potentially exhausting their supply of excellent experienced faculty. If faculty are allowed to flounder, the nurse faculty shortage may become critical. This study has shown that new educators may have the required degrees, but the majority have only had a few courses or no training in curriculum or course development. Hence, a model of how to support faculty that includes strategies to address the five areas was needed to support educators, and reduce the likelihood of educators feeling challenged and overwhelmed.

**Supported and Empowered: A Model of Understanding**

Together the understanding gained from faculty descriptors and the recommended strategies faculty provided to support educators were used to develop a model of understanding. Figure 15. provides a graphic representation of *Supported and Empowered: A Model of Understanding to Support Faculty’s Growth and Competence in Curriculum Development, Evaluation and Revision*. The model depicts how the five strategy areas noted at the bottom of the model: education, mentoring, practice, time, and
collaboration and feedback act to fortify the five themes affecting the educator.

Figure 15. Supported and Empowered: Model of Understanding to Support Faculty’s Growth and Competence in Curriculum Development, Evaluation and Revision.

These strategic solutions have transformed the five deficient areas noted in the theory *Challenged and Overwhelmed*, to become positive influences: collaborative support and communication, knowledge related to curriculum, paired mentoring, designated time, and increasing confidence.

Release time for curriculum development, factoring in curriculum work as part of the workload, decreasing workload, and specified time for curriculum work will transform the area of inadequate time to designated time. The provision of time specified for curriculum revision by adjusting workload will allow educators to work
collaboratively to create innovative curriculum. Instead of inadequate time, the educator now has designated time to work on curriculum that is factored into the workload, and release time can be used. Alternatively, mentors and mentees could co-teach part of their workload, enabling each to alternate attending developmental activities. Rather than a lack of knowledge, the educator acquires knowledge related to curriculum. Educational opportunities can be used to inform practice. Education can be attained through formal education, or it can be biannual faculty development provided by the employer, or a nursing organization. Education can be faculty presentations at meetings, conferences, or a webinar at a convenient time for the educator. Knowledge will transform the area of inadequate knowledge related to curriculum. Collaborative, supportive communication will instill a higher sense of community, and teamwork, where educators encourage and strengthen one another rather than eating their young. The positive communication and support transforms poor communication and support into collaborative support and communication, where a nurturing safe environment creates an optimal learning environment for the educator. This modeling of positive behavior will inform practice for the student population, who will observe their practicing educators nurturing other young educators, rather than suppressing or hazing them.

Monthly meetings would be something to look forward to if positive recognition and encouragement as well as sharing of knowledge became the expectation. Mentors can become lifelong friends if a supportive, safe environment is sustained, and people enjoy meeting with friends who care about them and practice alongside them. Confidence that what is expected from leaders is being fulfilled will result if educators know they are on track and are recognized as successful. The positive environment may also reduce
turnover, and attrition is costly. A ripple effect of positive mentoring could result as well as improvement of the learning environment.

Figure 16. Deficiencies that lead to becoming overwhelmed transformed into positive influences

Figure 16 is a graphic representation of the five deficient areas: communication, knowledge, mentoring, confidence, and time, which can become positive areas that can support and empower the educator. Instead of poor inadequate communication, or feelings of isolation, a community where collaboration and encouragement results due to the implementation of positive communication strategies. Instead of inadequate knowledge pertaining to curriculum, the educator becomes well informed due to education strategies and practicing the skills. Available mentors or trained preceptors will facilitate understanding of the academic culture and procedures as well as curriculum, with mentorship becoming a positive influence. The capability of having a mentor to call on when needed may also relieve stress. The combination of positive feedback that the
educator is on-track, available support, adequate time and increased knowledge will aid confidence, transforming the low confidence into a positive force, increased confidence. The end result will be educators feeling supported and becoming empowered in their role.

**Assumptions and Limitations Reviewed**

The sample included educators from three colleges and a university as well as the perspective of myself from a fifth college. The first assumption was that faculty would answer truthfully and feel safe enough to share their challenges and frustrations, and that the sample was representative of the nurse educator population in Vermont. It is necessary for the truth to be told if the research is to be valid, and if participants are afraid to be honest sharing information and feelings, it could invalidate the study. To facilitate honest truth-telling, identities of participants were concealed and confidentiality was preserved. Participants were also told there were no right or wrong answers and interviewer body language as well as responses were kept neutral. Nodding the head positively was used to encourage further response, which could be taken as agreement or neutral. Faculty shared their frustrations and challenges freely; therefore, the assumption that faculty would answer truthfully and share feelings was true.

Another assumption was that the participants responding had the experience they claimed to have, a year of experience developing, evaluating, or revising curriculum and had interest in the subject matter. It was essential for participants to have the required expertise to answer the questions accurately. The interview questions revealed the participants had the needed expertise to answer, as they referred to terms such as curriculum guidelines, learning outcomes, and standards and guidelines addressing undergraduate nursing competencies as well as demographics; hence, it was clear early in
the interview that participants had the needed expertise. Additionally, it was not difficult to verify a year of experience, as the community was not large, and group email lists are used in many organizations. Interest also became apparent during the interview process, and multiple faculty mentioned their interest in the study results. Their interest motivated them to answer thoughtfully. The second assumption appears to be true.

A third assumption was that the information that was researched in the literature review was reliable. The information was useful to know what new information was obtained for the study, versus confirmed or contradictory information discovered. The attempt was made to confirm findings via other literature, multiple resources when possible, and to use reputable sources, such as peer reviewed journals and government and college sources. This resulted in hundreds of references. Some historical findings were confirmed by the current study. As provided earlier in Chapter 5, themes two, four, five, and six were confirmed by multiple studies. Additionally, a search for disconfirming evidence was performed on the themes. The assumption that information in the literature review was reliable was confirmed.

Last, constructivist grounded theory approach rejects the existence of an objective reality, instead viewing data and analysis as created from shared experiences with participants in their time, place and culture. This assumption was met when individual participants did not have the same view, but had individual interpretations that stemmed from their life experiences. Data from interviews validated the existence of multiple realities rather than one objective reality.

Regarding limitations, one educator worked for an online university 20 years as well as in Vermont, and another had worked for two of the colleges; however, the sample
size was small, 15 people. The majority of participants were female (87%) with only two being male (13%); yet the percentage of males in nursing is only 8.1% (U.S. Census Bureau, 2013), so the sample is representative of the U.S. nursing population in regards to gender. All those who volunteered to be interviewed were Caucasian, but there was a cultural mix of French, Irish, British, Italian, Polish, American, and one participant considered her race to be native Vermonter. In Vermont this indicates your grandparents were born in Vermont as well as you.

Faculty had to take time out of busy schedules to be interviewed. The study was performed in a limited geographic region in the northeastern United States, within driving distance of the researcher. The sample was a purposive sample, as educators with experience developing, evaluating, and revising, curriculum were needed. Only Vermont colleges were used, so the study can be generalized to nurse educators in Vermont, or similar colleges, particularly in the Northeast, but Vermont is more rural than many states, so may differ from an urban population. Some generalizations may be possible to faculty that adhere to similar standards, particularly in similar community types, but confirming research is recommended. At the colleges, interviews to all who qualified were offered, some more than once, but only three or four of the faculty educators responded from each location. This could mean that the subject matter or research and education was more important to these faculty.

**Strengths and weaknesses.**

Qualitative research such as grounded theory has strengths and weaknesses. Causality may not be identified, yet rich descriptive interviews can provide increased understanding. Ensuring that participants are represented accurately is essential.
A weakness was the minimal use of triangulation. The expert researcher who offered to review data and provide investigator triangulation became unavailable, though the study was reviewed by a dissertation committee. Only minimal data triangulation was available to verify participant interview data. The researcher is an educator in Vermont who was interested to discover if experiences noted at one college were experienced elsewhere, or if the challenges experienced at each college were different. The interpretation of data occurred through a nurse educator who was connected to the subject matter. As a nurse over 25 years, and an educator for 12, I have sufficient understanding of the subject matter to interpret data accurately; some expertise is required in nursing education and terminology. Kolb (2012) notes that researchers themselves can be a threat to validity, and to minimize researcher bias, reflexivity is encouraged. Therefore, reflection was used to explore, and examine relationships during research, and a journal was used to record impressions.

Participants were from a limited geographic area, Vermont. Expertise was needed, so a purposeful sample was used rather than random selection. The sample was also small, so the study has limited representativeness to the general population of nurse educators. Transferability is a weakness of qualitative studies (Marshall & Rossman, 2006). Using the purposeful sample provided information from more experienced educators, who had better understanding of the subject matter. Detailed information was provided, and demographics were included to allow for comparison of participant characteristics. The study could be replicated in another state or region to compare findings using the same protocol. Results from a qualitative study cannot be generalized to other dissimilar populations; however transferability judges the degree that the results
can apply beyond the current research. Though the small sample size and qualitative style of research means the findings cannot be generalized to a larger population, they may be transferable to a different setting (Anderson, 2010). Readers can make associations if given sufficient information; hence, adequate description was supplied. The interview protocol, participant requirements, demographic data, study limitations, with the location of the research are supplied. A new study of adult educators with a minimum of a year of experience developing, evaluating, or revising curriculum could be done. Either nurse educators or another population of educators could be studied, in the United States or abroad, and findings compared.

A strength of the study would be that more meaning and rich detail may be provided from semi-structured interviews. Anderson (2010) noted that data founded on human experience is powerful and frequently more compelling than quantitative data. Participants from more than one college were used, so 15 perspectives from four different colleges provided more data sources than one college would have provided. A clear description of methodology is present.

A search for disconfirming evidence was done, which Antin, Constantine, and Hunt (2015) found to be a valuable strategy to assess qualitative research validity and credibility. Discussion of negative cases and disconfirming evidence is in the following section. Additionally, participants reviewed their transcripts for accuracy. Interviews were recorded on two devices to preserve data integrity. Using the interview protocol listed in Appendix G enhanced validity by ensuring that consistent methodology was used.

Faculty at the researcher’s college were not interviewed, which reduced bias, as participants were not friends or co-employees from the same college. Instead participants
responded to an email invitation after permission to reach out to all nursing educators at their college was approved. Whether a public college, private college or university, many challenges were similar. The sample represents faculty views from all colleges with BSN programs in Vermont, if my perspective is included.

**Disconfirming Evidence, Counter-examples, and Alternative Interpretations**

To demonstrate the intellectual integrity and lend credibility, negative cases and disconfirming evidence should be sought (Quality Research Network, 2006). Alternative themes, explanations, and disconfirming evidence were explored and summarized in the following section. Antin, Constantine, and Hunt’s (2015) discussion of conflicting discourses in qualitative research, and the search for divergent data noted that the search for negative cases and disconfirming evidence is a valuable strategy when assessing qualitative research validity or credibility. Furthermore, in qualitative research additional steps can be taken to challenge bias that include using a self-reflexive journal, and having participants review data. Searches were made for disconfirming evidence, participants reviewed their transcripts for accuracy, and a journal was used that included reflections.

In the study by Antin, Constantine, and Hunt (2015), ambivalence between interviews, and conflicts within narratives were noted in the area of body confidence, acceptance, satisfaction, and the way consumption of food categories was reported. Exploration of these divergences revealed tension, resulting in inconsistencies, not dishonesty, which was a useful finding that revealed greater understanding of body image. In the current study, for the first theme, faculty with low confidence, though 87% lacked confidence, two educators (13%) did feel confident and expert assessing whether
curriculum supported the achievement of student outcomes. When the majority of experienced nurse educators did not express confidence, I was particularly curious what was different for these two. The first one mentioned that working with a consultant for six months, then having the support of a knowledgeable administrator increased her confidence. This was a strategy recommended by other faculty to increase confidence.

The second participant mentioned that most educators do not believe their internal experts, and that becoming an expert occurred as a process where “things come easier and then more people come to you and say how do you do this, how do you do that and you realize oh, I guess I do know what I’m doing.” This very experienced educator had more opportunity to practice her curriculum skills, and had experienced more than one accreditation. Enough practice to facilitate expertise may increase confidence. She seemed confident in general, in her skills and personhood. Confidence could be an innate trait; however, Zamanzadeh, Roshangar, Fathi-Azar, Valizadeh, and Kirkwood (2014) completed a study that improved self-confidence in new graduates, first noting that low self-confidence is associated with limited experience and knowledge, then increasing the participants knowledge through simulation education. Their findings confirmed results of the study Blum, Borglund and Parcells (2010) completed, that resulted in improved student confidence after simulation. Hence, it is likely that confidence can be increased.

Both of the participants with confidence had more curriculum education, and practice with other educators working on curriculum. Regular practice developing, evaluating, or revising curriculum did not seem to be a common practice for the majority of faculty. Practice and education may improve confidence, although curriculum evolves to address societal needs.
Looking for conflict within narratives revealed tension, when one educator defended how she “felt confident in my ability to practice as a nurse” and “expert in my field as a clinical instructor, but I’m a novice in this” when referring to curriculum. She expressed that she expected to become more confident, but that “it’s going to take a little while for me”. It was as if she needed to justify that she was still a nurse expert, and that a nurse could be an expert clinically, but still a novice in another area. In reviewing the data, it was noted that many educators felt knowledgeable in their clinical area, but not in the area of curriculum. This disclosure reveals how there are different areas of nursing expertise to develop, and these areas can develop at different speeds, depending on practice, education, and mentorship.

Benner’s (1984) From Novice to Expert theory, so pertinent and applicable for most areas of nursing, was ruled out as the study framework as many experienced faculty are not expert developing, evaluating, or revising curriculum. Becoming an expert takes years of practice, and many educators did not practice developing, evaluating, or revising curriculum unless accreditation was looming, which occurred every eight years or so. Without adequate practice, despite years as an educator, expertise may not develop in curriculum development, evaluation and revision. If educators practiced developing, evaluating, and revising curriculum frequently, the expertise regarding curriculum might follow a similar timeline to nurse clinical practice areas with confidence of educators increasing in the area of developing, evaluating, and revising curriculum.

The three educators with the most longevity with their employer were preparing to retire, and two of them could not express confidence. The third found it challenging but fun. There was not a correlation with confidence and longevity at the organization, or
years teaching. The next two most experienced educators had eight or nine years in at the same location, but the rest of the educators had only been with their current employer seven years or less. Many of these educators may not have been through their first accreditation, with the majority (60%) having zero to three courses related to curriculum; hence they are potentially less prepared to evaluate curriculum. A search of faculty confidence, curriculum and research, provided no disconfirming evidence about faculty, but instead found a report by the National Council of State Boards of Nursing (NCSBN) Faculty Qualifications Committee stating that novice faculty have low confidence, may become overwhelmed, feel unprepared, and that similar problems are seen globally; Furthermore, the Faculty Qualifications Committee noted Halstead, previous NLN president and current NLN CNEA executive director, and Dr. Patricia Benner, world renowned nurse theorist, had similar findings (Jackson, et al., 2008). The workload they found was higher than expected, and preceptors felt unprepared to precept. There was no information found about the experienced educator’s confidence level. The focus was on the novice, Ongoing development, mentoring, and engagement with the curriculum were some of the recommendations (Jackson, et al., 2008).

For the second theme, poor support and communication, only one educator did not have concerns and problems that related, yet even she admitted, “a lot of administrators have not a clue” regarding curriculum. A search for faculty communication that was positive, rather than negative, instead revealed articles such as one from Inside Higher Ed by Woodhouse (2015) that discussed the tension and disconnect between faculty and administration, and their “simmering level of mistrust.”
Communication issues between administration and faculty is clearly not a problem exclusive to nursing.

The next theme was about faculty feeling adequately prepared for their role. I considered combining the categories lack of knowledge related to curriculum with faculty development and education is needed to aid knowledge, but there was a distinction. While the first category related to lack of knowledge, particularly in the area of curriculum when becoming a nurse educator, the other category was about the need for ongoing faculty development, though they both related to education. All the faculty supported the concept of faculty development.

The few faculty that did feel prepared had a strong educational background or mentor that helped them understand their role. All of the faculty felt a mentor would be a great resource. It was the most frequent strategy recommended, and the literature has a huge amount of literature that supports mentorship. An internet search on poor mentorship unearthed how mentorship can go bad due to reasons such as deceit, harassment and manipulation. Chandler and McManus (2010) shared how difference in personality styles, neglect of protégés due to heavy workload, competitive manipulation, inappropriate delegation, or even malicious sabotage can occur. Another article mentioned a criticism of nurses becoming too overqualified and posh, though the author noted the accusation was rejected by the Willis Commission who acknowledged that a theory-practice gap exists and lamented a lack of consistency in mentors (Triggle, 2012). The article noted that some nurses who mentor may not have enough time, so rush through things so quickly it decreases the benefit to their students. Mentorship requires careful selection and follow up, or problems can occur.
Lack of time related to workload was a problem experienced by all the faculty, but one dealt with it differently. Educator 14 shared “I don’t take work home on nights and weekends because it drives me crazy. I need a separation between work and home. I work much better at work if I don’t also do it at home. Even with the online classes. I don’t work at it after dinner. Sorry, and they know it, because I tell them. I’m, there early in the morning. I’m a morning person, so I’ll be on line fairly early, but night? You know you could let it rule your life if you let it. I don’t. Too many other things in this world to do. No one laid on their deathbed and said God, I wished I’d worked more.” Setting appropriate work boundaries, particularly for online faculty, was an important point.

Time and workload issues was confirmed as a problem for faculty by a multitude of studies as mentioned earlier in this chapter. An additional search only provided further confirmation of high workload of full-time educators in non-administrative positions, displaying a 56-hour average work week, with more than 62% percent of faculty picking up work outside of their institution (NLN, 2014). Nearly half were unhappy with their workload, and 25% mentioned it was likely they would leave their current job, citing workload as the cause when 35% more faculty are needed by 2022 (NLN, 2014). In the current study more than half complained about time and workload. One faculty member mentioned plans to leave their job, but that was not the focus of the research, so there was no question about plans to leave their work place. Setting boundaries with time, and separating work from home, particularly if work is on-line, may be difficult for many faculty.
Implications

The findings of the study have important implications for nurse education, administrators, and educators. The NLN (2006) Excellence Model demonstrates the need for educators to be well prepared in the area of curriculum design, implementation and evaluation. It is concerning that experienced faculty are struggling and lack confidence in an area that is critically important for being an excellent educator and academic leader. Strategies to support all educators in curriculum development, evaluation, and revision, not just novices, need to be implemented to fashion excellent academic educators and academic leaders. Resources to support faculty education, mentoring, practice, and methods to allow adequate time for curriculum work need to be implemented, with barriers addressed. The study not only provides strategies, but also includes a theory, and a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision.

Previous research such as Anderson’s (2009) study of expert clinicians transitioning to education, or Duffy’s (2012) nurse to educator study, have shown that novice nurse educators struggle in their role, but it was not recognized how difficult it was for all faculty, including experienced educators when it came to developing, evaluating, and revising curriculum, when practice in these skills may occur only infrequently. Student needs may take priority until reaccreditation is approaching. In the pre-semester rush, when faculty review syllabi, and update articles for their courses, the bigger picture of how a course fits in with the program may be neglected, and curriculum mapping overlooked. Faculty may be unaware what knowledge needs to occur at each level of a program or may not know the student learning outcomes that need to be
achieved in their courses as they focus on what content to teach. As a multitude of challenges arise, feelings of inadequacy may occur if collaboration between faculty members and mentorship does not occur. Instead of experiencing collaboration and mentorship, most faculty felt “tossed to the wolves”, “lost at sea” “floundering’ with “little peer support”, when developing, evaluating and revising curriculum.

Staying current with changing community needs, accreditation standard changes, and the feedback from employees who hire graduates not only takes time and effort outside of class time and preparation, but administrators must be willing to include faculty in committee meetings where community or accreditor feedback is received, and to involve them in curriculum reform and systematic evaluation. Objectives with a syllabus may be offered to busy faculty with little time to prepare with the best of intentions. A clinical expert may not know how to write weekly objectives that address cognitive, affective, and psychomotor domains and relate to program student learning outcomes. If faculty come from a clinical background, curriculum mapping may seem a foreign language they need to learn. Faculty development strategies are needed.

Additionally, colleges have policies that require committee approval for any course changes that may take many weeks and knowledge of the college culture to facilitate. Though faculty strive to stay current, curriculum change may not be approved if not skillfully and collaboratively presented, yet student graduates must be prepared to practice safely, using new technologies in a multitude of acute and community settings that evolve continually. Education must evolve with healthcare needs by collaborative efforts with other health professionals to reduce shortcomings in healthcare beginning with effective preparation of nurses, or the gap between education and practice will grow.
The majority of educators were unaware that developing, evaluating, or revising curriculum would be part of their role when hired. Better communication and distribution of educator role responsibilities and the best way to prepare for these responsibilities should be widespread. Curriculum responsibilities need to be discussed when educators are employed. The administrator overseeing the hiring needs to be capable of providing support through sharing knowledge as needed, so must also be equipped with adequate knowledge, and paired with a mentor or consultant if a knowledge deficit exists. Communicating clear expectations is the first step towards effective leadership.

Education of the educators must be evaluated to ensure that graduate level education addresses education about curriculum design, implementation, and evaluation, because the majority of educators had zero to three courses, and felt inadequate. The DNP was intended as a clinical path into advanced clinical practice (Bartels, 2007; Donley & Flaherty, 2008). Hence, their focus will be more clinically based. Preparation of the educators in the study was inconsistent, but the PhD prepared educator averaged more courses related to curriculum than the DNP. Identifying if gaps are present is the first step to addressing them. Review of graduate and post graduate curriculum education can be done by nurse directors and deans, but findings may need to be evaluated by a national organization, such as the ANA NCSBN, or NLN.

Nearly seventy-five percent of faculty did not believe they saw the big picture or understood how their course fit with the curriculum when they first developed courses. Most felt initially inadequately prepared, and all faculty believed faculty development would be beneficial. Evaluation of post-graduate education knowledge of curriculum
development, evaluation, and revision is needed. Fortunately, practice was considered to be a useful way to gain expertise, when mentorship is available.

It is also clear that the majority of educators feel overloaded, and that communication and peer support can be less than positive in their workplace. This does not bode well for retention rates. Inadequate time to develop, revise, or evaluate courses and curriculum may result in less effective or moldy curriculum. Hence evaluation of the academic culture, and reasonable expectations of faculty are needed.

The study findings confirmed that a faculty shortage is occurring, but a critical shortage of faculty could be imminent if these needs are not addressed, and faculty better supported. Colleges are struggling to recruit qualified faculty. Ingeno (2013) reported that an entire cohort of nursing faculty will retire at nearly the same time, leaving nursing education in crisis, and cited several examples of institutions in danger of losing accreditation because faculty have inadequate qualifications, and colleges have difficulty recruiting qualified faculty despite national and international searches. Universities and colleges must compete with hospitals, corporations and the military, who offer nurses with higher degrees, far higher salaries, and if a nurse practitioner is making $125,000 per year with a hospital, and is told they would have to go back to school, then receive half the salary to become faculty, people say, “why would I do that” (Ingeno, 2013, para. 12). Add to the problem that the transition from clinician to educator is difficult, workload heavy, roles are unclear, communication problematic, and new skills in curriculum development, evaluation, and revision must be learned; as a result a worse faculty shortage should be expected unless changes are made. Recruiters, often nursing directors or faculty, used to be able to attract staff by the incentive that tuition
reimbursement would help to pay for education, but with economics being tight, this is often no longer the case. Without qualified faculty, colleges will not be able to maintain their accreditation, or standards will be lowered, and the potential result of this crisis would be seen in inferior student training for new nurses and substandard teachers, an increasing nurse shortage, and a decrease in public health quality that could result in higher mortality rates.

Collaborative suggestions of educators are shared and interpreted to recommend how the needs of faculty who develop, revise and evaluate curriculum may be met. Thoughtful mentoring, improved communication strategies, faculty development, fastidious attention to workload that incorporates mentoring and curriculum work release time in the same way that release time is given to chairs, or board members, should be considered.

**Significance of the Study**

There was a lack of knowledge regarding the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum and a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision was needed. The majority of faculty were initially unprepared to evaluate, develop or revise curriculum, and educational preparation was inconsistent. Strategies were needed to benefit nurse educators who evaluate, develop, and revise nursing curriculum.

The study has demonstrated that there are five areas that critically affect educators, or they may become challenged and overwhelmed in their role. The five areas are: lack of confidence, lack of knowledge and development, poor support and
communication, the need for mentorship, and overload and inadequate time. Depletion in these five areas leads to educators feeling challenged and overwhelmed. The theory, *Challenged and Overwhelmed: A Theory of Understanding How Faculty Challenges Lead to Becoming Overwhelmed with Curriculum Development Evaluation, and Revision* emerged and describes this experience.

The majority of educators (87%), even those who are very experienced, feel low confidence assessing curriculum, and recognizing whether it supports achievement of student learning outcomes (SLOs). It was not previously recognized that the majority of experienced faculty were having difficulty with their confidence assessing whether curriculum supports achievement of SLOs. Yamazaki’s (2012) study of 914 Asian employees revealed that confidence greatly increases job satisfaction. As there is a relationship between confidence and job satisfaction, lack of confidence may result in less job satisfaction, resulting in lower job retention rates and reduced faculty numbers. It will also be more difficult for seasoned faculty role to model for less experienced faculty if current faculty feel inadequate to role model with confidence. Confidence in the role is needed.

Educators noted that each class of students was different, with different learning styles, and learning needs and traits. Curriculum was constantly evolving and needed to be modified to adjust to student needs. Unlike many professions, nursing practice continually changes as new evidence provides better strategies and tools for healthcare, that improve patient outcomes, and educators must stay abreast of changes and translate these into needed student outcomes. Accreditation requirements also change, affecting
educator and administrator strategies, and curriculum requirements. Developing curriculum was perceived as tough, difficult, stressful and a huge challenge.

Some educators felt it was “a weight on their shoulders to make sure all criteria were met”. It took years to understand the concepts and definitions, and begin to see the big picture, for until then most educators were still learning how to use technology and teaching methods. High NCLEX pass rates helped to boost faculty self-esteem for some, if pass rates were high, but NCLEX testing does not occur until the students graduate, so that performance feedback would not occur until late, so those who saw pass rates as a measure of their curriculum and teaching effectiveness did not know how effective they were during the teaching process, particularly if poor communication was an issue.

Poor support and communication was another critical area, and, 93% of faculty experienced challenges in communication and support. Instead of feeling supported, educators felt they had to learn through “trial by fire”, worried about “asking too many questions” and felt “expectations kept changing”. Changes in administration created turmoil and stress for faculty as well. Faculty looked to administration to share what was effective, but instead found themselves feeling “lost at sea”, or worse, in danger from nurses who “eat their young”. Administrators need to share knowledge regularly.

Improved communication from mentors, administration, and even other departments were recommended faculty strategies, and these strategies appeared helpful to increase faculty feelings that they were accurately performing the role of developing, evaluating, and revising curriculum. Hence, better communication could also aid confidence. All the faculty felt mentors were helpful in learning how to develop, revise and evaluate curriculum. The majority of faculty (73.3%) did not feel that they had the
big picture, and were unsure how to align their courses with the curriculum and program student learning outcomes when becoming an educator. Learning about curriculum alignment was perceived as a challenge faced by faculty. The amount of information about standards, accreditation requirements, how objectives from the courses needed to meet course outcomes and how these must align with program learning outcomes, types of objectives and formative and summative feedback needed can be overwhelming on top of preparing to teach, and learning about learning strategies. Resolving the knowledge deficit was particularly critical for those who were clinicians and became novice educators. Curriculum development, evaluation, and revision are not learned in a clinical setting, so when nurses are recruited from acute care who have not been trained in education, they are novice educators. Faculty were inconsistently prepared, and had many learning needs related to curriculum, and nearly 30% had no education that related to curriculum development, evaluation, or revision. Sixty percent had 0-3 courses related to curriculum. All the educators felt that ongoing faculty development or education was needed; therefore education and development was considered to be another critical area. All the faculty talked about being extremely busy, and most complained of inadequate time to be able to develop, revise, or evaluate courses and curriculum.

Problems in any of the five areas separately are difficult and can cause distress, but the combination of all five factors leads to an educator feeling overwhelmed by the multitude of challenges. Too many critical needs are lacking. The NLN states that for a nurse to be a well-prepared educator in academia, he or she must have competence in:

- Evidence based teaching
- Advancing the profession
Citizens of the academy

Curriculum design, implementation, and evaluation

Providing leadership to transform and re-vision nursing education

Mentoring neophyte educators

Building the science of nursing education

Teaching skills for diverse groups of learners

Advisement and counseling skills

(NLN, 2006)

Study findings revealed that nearly 75% of faculty did not initially understand how their course fit with the curriculum when becoming an educator; hence, adequate knowledge to be a well-prepared educator in the area of curriculum design, implementation, and evaluation is lacking. Faculty recruited from the clinical arena must develop new skills to become a well prepared educator, such as developing, evaluating, and revising curriculum that were not used in previous nurse roles. The study findings provide greater understanding of faculty, and their feelings and strategies surrounding the development, evaluation, and revision of curriculum.

Experienced educators shared strategies that enabled them to learn their role, and provided tips for other educators. The strategies revealed can assist faculty’s growth and competence in curriculum development, evaluation and revision. The understanding gained from faculty constructions, and the recommended strategies faculty provided to support educators were combined, and a model of understanding emerged. Supported and Empowered: A Model of Understanding to Support Faculty’s Growth and


*Competence in Curriculum Development, Evaluation, and Revision* where five areas conjoin to produce a supported empowered educator.

The five strategy areas, education, mentoring, practice, time, and collaboration and feedback have transformed the five themes negatively affecting the educator in the theory: low confidence, poor communication, overload and inadequate time, lack of knowledge related to curriculum, and the need for mentorship, into their opposites. The strategic solutions transform the five deficient areas to become positive influences: collaborative support and communication, knowledge related to curriculum, paired mentoring, designated time, and increasing confidence. The knowledge can be used to strengthen graduate nurse curriculum to better prepare nurse educators to develop, revise, and evaluate curriculum that will result in higher-quality nurse educators that will be able to design better curriculum, resulting in high quality student results and healthier communities.

**Recommendations**

Those who are expert clinicians who want to become educators need a bridge to become well-prepared faculty. The five areas found to be critical factors in the theory must be addressed, or the educator will feel challenged and overwhelmed. The area of communication can start to be addressed at the hiring interview. Initially, upon hire, a thorough interview should ascertain if the educator has experience in developing, evaluating, and revising curriculum, and the expectations of the educator role should be clear.

The interview process could include having the potential educator develop a brief teaching plan that includes goals, objectives, and outcomes that relate to program
outcomes. In this way, the employer will have an idea what training may be needed to
develop the new educator’s capabilities. A short questionnaire could also be used to
evaluate the ability to tell goals from objectives, and relate course outcomes to overall
program student outcomes. Developing a valid questionnaire to assess a new educator’s
current skill level that includes the ability to tell goals from objectives, and relate course
outcomes to overall program student outcomes as well as discern behavioral objectives
from the cognitive, affective, and psychomotor domain would be useful.

After the gaps in educator skills are assessed upon hiring, an experienced educator
or preceptor can be assigned to mentor the new faculty member so the novice can ask “is
this correctly done” types of questions without repercussions or negative evaluation
impact. All faculty even experienced educators could benefit from a mentor, and faculty
could be paired. However, the selection of a mentor should be thoughtfully done to assist
a better match, for personalities can clash, for an unethical mentee or mentor could
manipulate, sabotage, neglect or take advantage of their mentor or their mentee.
Therefore, a evaluation of the mentoring from both mentee and mentor should be a part
of the process, and the capability of changing the mentor/mentee should be possible, if
training to improve the relationship and improve communication is not sufficient.

Additionally a mentor can introduce new faculty to the culture and assist their
knowledge of the policies, procedures, standards and how curriculum is developed,
revised and evaluated at the organization. The mentor should have experience or training
on how the mentorship should occur and have available resources to assist their
mentoring that are updated annually. A faculty handbook and some basic training on the
technology used at the organization should be as part of orientation. A mentor hotline
could be used for those who only need an occasional mentor, when there are difficulties, or where incivility might be an issue. There could be an on-call mentor. NLN’s Healthful Work Environment Task Group mentoring tool kit could be used to assist mentors.

Preceptors or mentors for new faculty are needed to teach the academic role expectation, familiarize novices with the culture, and to provide feedback on development, evaluation, and revision of courses and curriculum as well as assistance for teaching strategies, similar to an internship or nurse residency. There is not less information for an educator to learn than in acute care. The faculty who teach nursing, and create courses and curriculum not only have to know the information they teach at an expert level, but they need to be able to translate that information into measurable objectives in the cognitive, affective, and psychomotor domain. The objectives must line up with the course outcomes that line up with the student learning outcomes for the program. Feedback on progress could be received from mentor preceptors rather than supervisors responsible for annual faculty evaluations, allowing for better communication. Education on how to precept or mentor a new faculty member would be advisable for those who mentor. Administrators can provide additional feedback.

Mentors or preceptors can be specifically assigned in the area of curriculum development, evaluation, and revision. After an initial precepted time required for new educators, on-call mentors, or consultants could be used. Areas for the mentor/preceptor to address would include those listed under areas for the educator to comprehend (Theme 7, Figure 12), such as how to align program goals and course goals, and make sure course objectives, and even the topic objectives are aligned with overall student learning
outcomes. Recognition of time spent should be considered in workload. The mentor would assist in connecting their mentee to available strategies to enable learning. To award the mentor for these additional responsibilities, the mentors would have supportive meetings with administration to allow leadership mentoring, and recognition of their role.

Mentorship and supportive relationships are recommended by faculty to assist in overcoming challenges, such as developing, evaluating, and revising curriculum. Just as a new nurse in a hospital setting needs a preceptor, in similar fashion a faculty member needs someone to show them the ropes, learn the new academic culture, and give feedback on objectives and questions. A faculty member with minimal experience in academia should undergo a period of acclimation to the new culture with a preceptor mentor. However, the research findings suggest that experienced faculty also wanted the opportunity to have a mentor, particularly in areas where they had little confidence.

As faculty look to administrators for support, administrators need to have excellent communication skills and current knowledge about curriculum development, evaluation, and revision. Development in curriculum for administrators should be available as well as training on ways to improve communication and support faculty. Nurse leader job descriptions should include the need for adept knowledge in these areas. Administrators need to contribute when faculty develop, revise, and evaluate curriculum and help faculty to see the big picture.

Faculty should not feel disconnected from support, and need to be able to get questions answered without negative repercussions. Regular contact from administrators at a time that works well for faculty, not just the administrator, can reduce anxiety and clarify expectations or concerns, and even quell rumors that could create a negative
environment. If faculty receive feedback that they are performing well, confidence, and job satisfaction may improve. Time for faculty to collaborate should be encouraged.

A faculty member can develop a plan to be educated in areas where testing shows weakness or an area they believe is weak or have low confidence. Faculty want to know how to be successful. All of the faculty interviewed felt faculty development was needed and important. This can be done using online modules, in-services, consultants, conferences, or course work. Another method would be to work with a proficient professor collaboratively the first year who could be trained as a preceptor for others. Mandatory participation in course reviews, could be done via a curriculum committee.

Ongoing communication via faculty meetings can occur and a number to report incivility should be available for faculty, whether it comes from students, administrators, or other faculty. Policy on expectations of treating others with respect should be part of overall academic policies across colleges and clear upon hiring. A safe environment is mandatory. Time release to work on curriculum could be allowed, and monthly or quarterly meeting time should be set aside by the administrator for faculty to work on curriculum collaboratively.

Practice at developing, evaluating, and revising curriculum is needed. Unlike acute care where a skill is practiced regularly and the nurse can become proficient in a few years, accreditation may only occur every eight years. Skills get rusty when they are not used frequently. Both mentor and mentee reviewing curriculum and coursework together can practice the needed skill, and collaborative meetings allow for greater group communication and sharing of what is being practiced, with recognition of excellent
work by the administrator and other faculty. As systematic evaluation time is required by accreditors, practice time could be designated at the faculty meetings.

Not all faculty felt adequately involved with developing, evaluating, and revising curriculum and coursework. More practice was recommended because as educator seven shared, “it doesn’t happen every year with that whole accreditation process or the curriculum design” and application of the knowledge assists in learning the process. Collaborative curriculum review involving all faculty should be done routinely within each organization. Additionally, it would be helpful for educators to see how other institutions organize to develop, revise, or evaluate curriculum. Organizations such as the State Nursing Association, or Vermont Organization of Nurse Leaders (VONL) as well as national organizations such as NLN, could include in annual conferences, break-out session time for different groups. Educators would be one group, and other groups could include acute care specialties, administrators, and community nurses as well as others. Educating groups that are non-nursing that encourage quality education can also be used to assist development, such as Quality Matters, or combined state college conferences.

Accreditors update standards, technology evolves, and research provides evidence to improve practice; therefore, the plan from eight years ago will be insufficient for today. Hence, courses and curriculum must be reviewed every year to review what is working, outdated or ineffective. Accreditors already require faculty to be involved with developing curriculum, but not that they be good at it. Acquiring a graduate degree, did not ensure adequate training in curriculum development, evaluation and revision has occurred as 60% of the research sample had three or less courses in curriculum development, with 27% having no courses in it at all. Yet most faculty learned their role
regarding curriculum with the help of a mentor and other strategies, such as consultants and education.

Faculty development may need to become part of the systematic evaluation plan that accreditors require. Practice and review of courses should be done a minimum of annually, but preferable at quarterly face to face meetings with alternating faculty presenting. Curriculum practice and participation in continuing development should be part of the professional growth expected for achieving tenure. Collaborations with neighboring colleges should be encouraged in order that educators can become aware of what is effective and current best practice. Rather than competition, colleges should attempt collaborative projects and mentoring across campuses. Innovative opportunities to aid communities when and where disasters strike, or to improve sustainability and transform the community and planet into a more healthy environment should motivate educators to join forces. Modeling positive behavior will eliminate negative hazing, and if nurses work together, even the planet might be healed.

The knowledge and skills required for the higher education role may be acquired during the first year if workload is not prohibitive, but yearly updates and practice are needed. Education can be offered through consultants, webinars, inner-organization teams, formal education, or faculty presentations. Certification for Nurse Educators should be encouraged, and it would benefit the nursing profession if colleges paid certified educators even a small stipend more. Supporting educator competency may improve student outcomes, and reduce attrition rates, another potential area of study. Encouraging students to achieve their BSN within ten years, and continue lifelong learning will improve the skills of nurses in the community, public health, and the quality
of curriculum as well as increase the likelihood that the financial encumbrance encountered in education will be recouped. Tax breaks for institutions that provide tuition reimbursement should be considered. Institutions could make it easier for overloaded faculty to find scholarships, and assist with legitimate application processes, as faculty struggling to complete work, school, and family needs may have no time to search for loans, and scams exist. Financial support and fund raising personal can assist student faculty as well as students.

Educators do not have enough time to adequately develop, review and revise courses or curriculum prior to beginning their coursework. As educator 15 put it, “innovation is just the ability to pull your head out of the muck and be creative, and sometimes being stuck in the muck is what helps you to be creative because you have to come up with something. But excellence, I believe the desire for excellence must come from within yourself.” If educators come in prior to the start of the semester, the time will not be paid, and the time may be needed for them to work another job to demonstrate their expertise. Additionally, online educators may feel isolated from those who teach face-to-face. Release time to work on curriculum is a possible solution, even for institutions with limited resources. Curriculum work needs to be factored in with workload. Time could also be set aside at annual retreats to discuss innovative education. Faculty should not be required to work overload hours every semester, and criteria for what constitutes an overload schedule needs to be clearly defined at a national level.

Inadequate numbers of faculty necessitates other educators must do more, or that less students are admitted during a nursing shortage, potentially increasing the shortage. Ensuring there are adequate qualified faculty in academia is a concern that must be
addressed. Directors and deans could collaborate to have rotating luncheons quarterly, or biannually, with the host group sharing an education topic, or engaging in peer review. Effective local resources could be shared via a state web site such as Vermont Nurses in Partnership (VNIP), Vermont State Nurses Association, or Vermont Organization of Nurse Leaders (VONL) that might be persuaded to expand current resource pages to include educator teaching resources and link to further national resources such as NLN. VNIP could develop a preceptor training directed specifically at educators lacking the skills listed by NLN for a well prepared educator. Finding the most effective strategies to address faculty preparation requires continued collaboration of well-prepared educators as curriculum evolves.

**Future research recommendations.** The first recommendation is an interventional study, where some of the strategies faculty suggested are tested to see if the strategies worked, or which one worked. For example, utilizing a trained preceptor mentor with specific curriculum education tools, workshops webinars, and practice sessions where faculty review course objectives and outcomes, and check alignment with overall program student learning outcomes. Faculty teaching a course could take turns presenting to other faculty how their class learning activities fulfill weekly objectives and thence course outcomes, and how the course outcomes fit into the curriculum and fulfill program student learning outcomes. In this way knowledge of how everything ties in, examples of effective measurable objectives, and sharing of best strategies and best practice could occur to aid less experienced faculty in understanding the big picture, or to provide inspiration and sharing of innovative ideas. Feedback on program outcomes, such
as employer feedback, or attrition rates could also be shared, or available interested
stakeholders or alumni invited to improve employer of graduates feedback and input.

The time it takes for a novice faculty member coming from the clinical setting to
acclimate to the new culture of academia with a preceptor mentor needs to be evaluated.
The optimal preceptor or mentor training also needs to be researched regarding new
educators with minimal coursework learning how to develop, revise and evaluate
curriculum and course work. There is minimal research on incivility toward novice
educators from other faculty, and enough was shared to raise that novice faculty may not
feel welcomed, but instead feel that their inadequacies are noted and they may be treated
unkindly. Stokowski (2010) noted that bullies do not necessarily see themselves as
bullies, but instead have a self-perception of being smarter, or more skilled than others,
with an exaggerated concept of their own importance, so making someone else look bad
makes them feel like they look more competent. As novice faculty feel less competent,
this could be an issue as novices in the workplace often become targets for the
aggressive. Early research findings suggest faculty-to-faculty incivility is a severe to
moderate problem for 68% of educators (Clark, Olender, Kenski & Cardoni, 2013).
Hence, research on how novice educators are impacted and how mentorship improves
faculty relationships, potentially increasing retention could be useful. Negative
communication trends in academia could have other causes as well, such as increased
technology communication rather than face to face communication, or related to stress,
high workload and inadequate time.

Another area for research is the hidden curriculum. Though it was not a strong
enough area for a theme, numerous faculty mentioned a hidden curriculum, what faculty
are really held accountable to and model, though faculty are still harassed for high NCLEX pass rates. The idea that faculty are responsible for providing student graduates that are able to practice safely, and think critically; a person that faculty would feel comfortable having care for their parent, child or self, or work with without concern, rather than just preparing nurses who meet the organizational student learning outcomes and pass the NCLEX. Another part mentioned was the empathy, caring and moral character a student should possess, and the responsibility to the public.

It was mentioned that faculty may be less able to retire if they are still paying off loans rather than saving for retirement. Rivers (2015) notes that nurses graduating currently have an average debt burden of over $35,000. Educators are expected to continue education, but will need help with this burden. High debt in nurse faculty may preclude their ability to retire. Older nurses may have more difficulty, such as becoming fatigued earlier, which could lead to increased errors, and yet there should be no discrimination of older experienced nurses with expertise that may require higher pay. The long-term effect of stress resulting from time pressure could affect health. Life balance is difficult when a faculty member must juggle work and either an additional job or classwork on top of family needs. During a nurse shortage, nurses may take less vacation or rest annually. Dickey (2015) notes that other countries encourage vacation time, but in America, our lack of time off may be affecting our professionals negatively. Research on how inadequate time pertains to categories such as nursing doctoral education, and workload affecting family relationships and health would be useful and perhaps encourage better management of life balance. Nurse faculty need to be supported.
in their role when transitioning to academia in order to feel prepared and confident to develop, evaluate, and revise curriculum.

**Summary**

Seven main themes were created from the constructions of educators. The first theme discovered was that the majority of educators interviewed did not feel confident about developing, evaluating or revising curriculum and even those who are very experienced feel low confidence assessing curriculum, and recognizing whether it supports achievement of student learning outcomes. In spite of an average of over 29 years as a nurse, and an average of 13 as an educator, 87% of faculty could not express confidence in the curriculum development, evaluation, and revision. Only two out of 15 felt confident.

The second theme was that most faculty (93%), experienced challenges in communication and support. Faculty did not have an easy or positive transition to academia from clinical practice. Most faculty feel unsupported developing, evaluating, or evaluating curriculum. When hired, 60% did not expect that curriculum development would be part of their role. They expected to be teaching, and some expected materials to be provided for them, not having to create courses or objectives.

The third theme was that knowledge was initially lacking related to curriculum alignment to outcomes. For some the academic culture was threatening. Eleven out of 15 faculty (73.3%) did not see the big picture or understand how their course fit with the curriculum when they developed their first course.

The forth theme was that all faculty interviewed found that mentors are helpful in learning `how to develop, revise and evaluate curriculum. It was the most frequent
strategy recommended to increase competence. The NLN’s (2008) position statement stressed the need for mentorship stating it was relevant across the career continuum of an educator. Faculty who were interviewed considered mentorship to be important, even for those nearing retirement. Even having someone to call and ask was considered “incredibly helpful.”

The fifth theme was that faculty were inconsistently prepared and many had inadequate knowledge and lack of understanding in the area of developing curriculum, hence education and faculty development was needed. Nearly 30% had no courses at all that related to curriculum development, evaluation, or revision. Sixty percent had 0-3 courses related to curriculum. All faculty agreed that faculty development would be helpful to learn the educator role related to curriculum. Experienced faculty felt that they could use development, as curriculum skills became rusty. Practice was considered to be beneficial to gain expertise in curriculum development, evaluation and revision.

The sixth theme was that most educators complained of inadequate time to be able to develop, revise, or evaluate courses and curriculum. They felt workload was excessive, faculty in short supply, and more strained and time pressed when curriculum had to be assessed in addition to other responsibilities. Faculty stated they had inadequate time for curriculum revision due to workload.

The seventh theme was strategies useful to other educators and effective tactics used. There were many strategies suggested by faculty, so these were divided into categories: areas to comprehend, strategies to enable the educator to learn, and learning environment needs. Some areas included discussion of mentorship, continuing education and faculty development.
development, the need for practice, release time or time allocated specifically for curriculum, and collaboration and feedback. Suggestions for administrators were also offered.

A theory emerged from the themes: lack of confidence, overload and inadequate time, lack of knowledge and development, poor support and communication, and the need for mentorship that depicted how the educator becomes challenged and overwhelmed. The theory *Challenged and Overwhelmed: A Theory of Understanding How Faculty Challenges Lead to Becoming Overwhelmed with Curriculum Development, Evaluation, and Revision* is a descriptive middle range theory that was created to clarify understanding of what educators are facing in academia when they are besieged by challenges that can become overwhelming.

The strategies were reviewed and faculty’s constructions were used to develop a model of understanding to support faculty’s growth and competence in curriculum development, evaluation and revision. The model *Supported and Empowered. Model of Understanding to Support Faculty’s Growth and Competence in Curriculum Development, Evaluation, and Revision* was created and demonstrates that there the five areas that negatively affected educators can be transformed into positive influences; hence, educators no longer need to feel challenged and overwhelmed in their role. Overload and inadequate time, low confidence, the need for mentoring, and lack of knowledge related to curriculum, and poor support and communication can become collaborative support and communication, knowledge related to curriculum, paired mentoring, designated time, and increasing confidence when recommended strategies are applied.
It was not previously recognized how difficult it was for all faculty, including experienced educators when it came to developing, evaluating, and revising curriculum. The majority of faculty were not even aware it was part of their role when hired. Educators feel besieged by the multitude of challenges and can be overwhelmed when tasked with curriculum development, evaluation, and revision, in addition to other all their other responsibilities. Inadequate time due to workload, poor communication and changing expectations, no one to advise them, and lack of knowledge and confidence in the area lead to many educators feeling challenged and overwhelmed. Strategies to address each area are recommended.

Strategies to support educators in curriculum development, evaluation, and revision must be implemented for faculty to become supported and empowered. Negative impediments such as incivility practices and expectation of continual overload in work hours for minimal salary must be removed. Graduate level education should include curriculum design, implementation, and evaluation. The model Supported and Empowered: A Model of Understanding to Support Faculty’s Growth and Competence in Curriculum Development, Evaluation, and Revision can be used to enhance, support, and empower educators. By incorporating the five strategy areas, education, mentoring, practice, time, and collaboration into education the current areas of low confidence, poor communication, overload and inadequate time, lack of knowledge related to curriculum, and the need for mentorship, that leave faculty feeling overwhelmed and challenged can be transformed into positive forces. The strategic solutions transform the five deficient areas to become positive influences: collaborative support and communication, knowledge related to curriculum, paired mentoring, designated time, and increasing
confidence. Nurse educators should not be left struggling, feeling overwhelmed and challenged, when they can become supported and empowered. The five strategies will transform nursing education and practice.
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Appendix A
The Essentials of Baccalaureate Education

Essential I: Liberal Education for Baccalaureate Generalist Nursing Practice

A solid base in liberal education provides the cornerstone for the practice and education of nurses.

- Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety
  Knowledge and skills in leadership, quality improvement, and patient safety are necessary to provide high quality health care.

- Essential III: Scholarship for Evidence Based Practice
  Professional nursing practice is grounded in the translation of current evidence into practice.

- Essential IV: Information Management and Application of Patient Care Technology
  Knowledge and skills in information management and patient care technology are critical in the delivery of quality patient care.

- Essential V: Healthcare Policy, Finance, and Regulatory Environments
  Healthcare policies, including financial and regulatory, directly and indirectly influence the nature and functioning of the healthcare system and thereby are important considerations in professional nursing practice.

- Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes
  Communication and collaboration among healthcare professionals are critical to delivering high quality and safe patient care.

- Essential VII: Clinical Prevention and Population Health
  Health promotion and disease prevention at the individual and population level are necessary to improve population health and are important components of baccalaureate generalist nursing practice.

- Essential VIII: Professionalism and Professional Values
  Professionalism and the inherent values of altruism, autonomy, human dignity, integrity, and social justice are fundamental to nursing.

- Essential IX: Baccalaureate Generalist Nursing Practice
  The baccalaureate-graduate nurse is prepared to practice with patients, including individuals, families, groups, communities, and populations across the lifespan and across the continuum of healthcare environments.

(AACN, 2009)
Appendix B
ACEN Standard 4: Curriculum

STANDARD 4

Curriculum
The curriculum prepares students to achieve the outcomes of the nursing education unit, including safe practice in contemporary health care environments.

4.1 The curriculum incorporates established professional standards, guidelines, and competencies, and has clearly articulated student learning and program outcomes.

4.2 The curriculum is developed by the faculty and regularly reviewed for rigor and currency.

4.3 The student learning outcomes are used to organize the curriculum, guide the delivery of instruction, direct learning activities, and evaluate student progress.

4.4 The curriculum includes cultural, ethnic, and socially diverse concepts and may also include experiences from regional, national, or global perspectives.

4.5 Evaluation methodologies are varied, reflect established professional and practice competencies, and measure the achievement of student learning and program outcomes.

4.6 The curriculum and instructional processes reflect educational theory, interdisciplinary collaboration, research, and best practice standards while allowing for innovation, flexibility, and technological advances.

4.7 Program length is congruent with the attainment of identified outcomes and consistent with the policies of the governing organization, state and national standards, and best practices.

4.8 Practice learning environments are appropriate for student learning and support the achievement of student learning and program outcomes; current written agreements specify expectations for all parties and ensure the protection of students.

4.8.1 Student clinical experiences reflect current best practices and nationally established patient health and safety goals.

*For nursing education units engaged in distance education, the additional criterion is applicable:*

4.9 Learning activities, instructional materials, and evaluation methods are appropriate for the delivery format and consistent with student learning outcomes.

(ACEN, 2013)
Appendix C

CCNE Standards for Accreditation of Baccalaureate and Graduate Degree Programs

STANDARD I

PROGRAM QUALITY: MISSION AND GOVERNANCE

The mission, goals, and expected program outcomes are congruent with those of the parent institution, reflect professional nursing standards and guidelines, and consider the needs and expectations of the community of interest. Policies of the parent institution and nursing program clearly support the program’s mission, goals, and expected outcomes. The faculty and students of the program are involved in the governance of the program and in the ongoing efforts to improve program quality.

KEY ELEMENTS

I-A. The mission, goals, and expected program outcomes are:

- congruent with those of the parent institution; and
- consistent with relevant professional nursing standards and guidelines for the preparation of nursing professionals.

Elaboration: The program’s mission statement, goals, and expected program outcomes are written and accessible to current and prospective students, faculty, and other constituents. Program outcomes include student outcomes, faculty outcomes, and other outcomes identified by the program. A mission statement may relate to all nursing programs offered by the nursing unit or specific programs may have separate mission statements. Program goals are clearly differentiated by level when multiple degree/certificate programs exist. Student outcomes may be expressed as competencies, objectives, benchmarks, or other terminology congruent with institutional and program norms.

The program identifies the professional nursing standards and guidelines it uses. CCNE requires, as appropriate, the following professional nursing standards and guidelines:

- The Essentials of Baccalaureate Education for Professional Nursing Practice [American Association of Colleges of Nursing (AACN), 2008];
- The Essentials of Master’s Education in Nursing (AACN, 2011);
- The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006); and
- Criteria for Evaluation of Nurse Practitioner Programs [National Task Force on Quality Nurse Practitioner Education (NTF), 2012].

A program may select additional standards and guidelines.

A program preparing students for certification incorporates professional standards and guidelines appropriate to the role/area of education.

An APRN education program (degree or certificate) prepares students for one of the four APRN roles and at least one population focus, in accordance with the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (July 2008).

I-B. The mission, goals, and expected student outcomes are reviewed periodically and revised, as appropriate, to reflect:

- professional nursing standards and guidelines; and
- the needs and expectations of the community of interest.

Elaboration: There is a defined process for periodic review and revision of program mission, goals, and expected student outcomes. The review process has been implemented and resultant action reflects professional nursing standards and guidelines. The community of interest is defined by the nursing unit. The needs and expectations of the community of interest are reflected in the mission, goals, and expected student outcomes. Input from the community of interest is used to foster program improvement.
I-C. Expected faculty outcomes are clearly identified by the nursing unit, are written and communicated to the faculty, and are congruent with institutional expectations.

Elaboration: The nursing unit identifies expectations for faculty, whether in teaching, scholarship, service, practice, or other areas. Expected faculty outcomes are congruent with those of the parent institution.

I-D. Faculty and students participate in program governance.

Elaboration: Roles of the faculty and students in the governance of the program, including those involved in distance education, are clearly defined and promote participation. Nursing faculty are involved in the development, review, and revision of academic program policies.

I-E. Documents and publications are accurate. A process is used to notify constituents about changes in documents and publications.

Elaboration: References to the program’s offerings, outcomes, accreditation/approval status, academic calendar, recruitment and admission policies, grading policies, degree/certificate completion requirements, tuition, and fees are accurate. Information regarding licensure and/or certification examinations for which graduates will be eligible is accurate. For APRN education programs, transcripts or other official documentation specify the APRN role and population focus of the graduate.

If a program chooses to publicly disclose its CCNE accreditation status, the program uses either of the following statements:

“The (baccalaureate degree in nursing/master’s degree in nursing/Doctor of Nursing Practice and/or postgraduate APRN certificate) at (institution) is accredited by the Commission on Collegiate Nursing Education, One Dupont Circle, NW, Suite 530, Washington, DC 20036, 202-887-6791.”

“The (baccalaureate degree in nursing/master’s degree in nursing/Doctor of Nursing Practice and/or postgraduate APRN certificate) at (institution) is accredited by the Commission on Collegiate Nursing Education (http://www.aacn.nche.edu/ccne-accreditation).”

1 Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (July 2008).


I-F. Academic policies of the parent institution and the nursing program are congruent and support achievement of the mission, goals, and expected student outcomes. These policies are:

• fair and equitable;
• published and accessible; and
• reviewed and revised as necessary to foster program improvement.

Elaboration: Academic policies include, but are not limited to, those related to student recruitment, admission, retention, and progression. Policies are written and communicated to relevant constituencies. Policies are implemented consistently. Differences between the nursing program policies and those of the parent institution are identified and support achievement of the program’s mission, goals, and expected student outcomes. A defined process exists by which policies are regularly reviewed. Policy review occurs and revisions are made as needed.

SUPPORTING DOCUMENTATION FOR STANDARD I

1. Mission, goals, and expected program outcomes.

2. Copies of all professional nursing standards and guidelines used by the program. CCNE requires the following professional nursing standards and guidelines:

• Baccalaureate degree programs: The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008).
• Master’s degree programs: *The Essentials of Master’s Education in Nursing* (AACN, 2011).
• Doctor of Nursing Practice programs: *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006).
• Graduate degree (master’s or DNP) or certificate programs preparing nurse practitioners: *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2012).
• Post-baccalaureate entry programs: *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) and other relevant standards based on the degree outcome (e.g., *The Essentials of Master’s Education in Nursing* for master’s programs, *The Essentials of Doctoral Education for Advanced Nursing Practice* for DNP programs, and *Criteria for Evaluation of Nurse Practitioner Programs* for nurse practitioner programs).
• All programs: Any additional relevant professional nursing standards and guidelines used by the program.

3. For APRN education programs (degrees/certificates), evidence that transcripts or other official documentation specify the APRN role and population focus of the graduate.
4. Appointment, promotion, and tenure policies or other documents defining faculty expectations.
5. Major institutional and nursing unit reports and records for the past three years, such as strategic planning documents and annual reports.
6. Reports submitted to and official correspondence received from applicable accrediting and regulatory agencies since the last accreditation review of the nursing program.
7. Catalogs, student handbooks, faculty handbooks, personnel manuals, or equivalent information, including (among other things) academic calendar, recruitment and admission policies, grading policies, and degree/post-graduate APRN certificate program completion requirements.
8. Program advertising and promotional materials directed at prospective students.
9. Documents that reflect decision-making (e.g., minutes, memoranda, reports) related to program mission and governance.

STANDARD II

PROGRAM QUALITY: INSTITUTIONAL COMMITMENT AND RESOURCES

The parent institution demonstrates ongoing commitment to and support for the nursing program. The institution makes resources available to enable the program to achieve its mission, goals, and expected outcomes. The faculty, as a resource of the program, enable the achievement of the mission, goals, and expected program outcomes.

KEY ELEMENTS

II-A. Fiscal and physical resources are sufficient to enable the program to fulfill its mission, goals, and expected outcomes. Adequacy of resources is reviewed periodically and resources are modified as needed.

*Elaboration: The budget enables achievement of the program’s mission, goals, and expected outcomes. The budget also supports the development, implementation, and evaluation of the program. Compensation of nursing unit personnel supports recruitment and retention of qualified faculty and staff. Physical space is sufficient and configured in ways that enable the program to achieve its mission, goals, and expected outcomes. Equipment and supplies (e.g., computing, laboratory, and teaching-learning) are sufficient to achieve the program’s mission, goals, and expected outcomes. A defined process is used for regular review of the adequacy of the program’s fiscal and physical resources. Review of fiscal and physical resources occurs and improvements are made as appropriate.*

II-B. Academic support services are sufficient to ensure quality and are evaluated on a regular basis to meet program and student needs.
Elaboration: Academic support services (e.g., library, technology, distance education support, research support, admission, and advising services) are adequate for students and faculty to meet program requirements and to achieve the mission, goals, and expected program outcomes. There is a defined process for regular review of the adequacy of the program’s academic support services. Review of academic support services occurs and improvements are made as appropriate.

II-C. The chief nurse administrator:
• is a registered nurse (RN);
• holds a graduate degree in nursing;
• holds a doctoral degree if the nursing unit offers a graduate program in nursing;
• is academically and experientially qualified to accomplish the mission, goals, and expected program outcomes;
• is vested with the administrative authority to accomplish the mission, goals, and expected program outcomes; and
• provides effective leadership to the nursing unit in achieving its mission, goals, and expected program outcomes.

Elaboration: The administrative authority of the chief nurse administrator is comparable to that of chief administrators of similar units in the institution. He or she consults, as appropriate, with faculty and other communities of interest to make decisions to accomplish the mission, goals, and expected program outcomes. The chief nurse administrator is perceived by the communities of interest to be an effective leader of the nursing unit. The program provides a rationale and a plan to come into compliance if the chief nurse administrator does not hold a graduate degree in nursing and a doctoral degree (if applicable).

II-D. Faculty are:
• sufficient in number to accomplish the mission, goals, and expected program outcomes;
• academically prepared for the areas in which they teach; and
• experientially prepared for the areas in which they teach.

Elaboration: The full-time equivalency (FTE) of faculty involved in each program is clearly delineated, and the program provides to CCNE its formula for calculating FTEs. The overall faculty (whether full-time or part-time) is sufficient in number and qualifications to achieve the mission, goals, and expected program outcomes. Faculty-to-student ratios ensure adequate supervision and evaluation and meet or exceed the requirements of regulatory agencies and professional nursing standards and guidelines.

Faculty are academically prepared for the areas in which they teach. Academic preparation of faculty includes degree specialization, specialty coursework, or other preparation sufficient to address the major concepts included in courses they teach. Faculty teaching in the nursing program have a graduate degree. The program provides a rationale for the use of any faculty who do not have a graduate degree.

Faculty who are nurses hold current RN licensure. Faculty teaching in clinical/practicum courses are experienced in the clinical area of the course and maintain clinical expertise. Clinical expertise may be maintained through clinical practice or other avenues. Faculty teaching in advanced practice clinical courses meet certification and practice requirements as specified by the relevant regulatory and specialty bodies. Advanced practice nursing tracks are directly overseen by faculty who are nationally certified in that same population-focused area of practice in roles for which national certification is available.

II-E. Preceptors, when used by the program as an extension of faculty, are academically and experientially qualified for their role in assisting in the achievement of the mission, goals, and expected student outcomes.
Elaboration: The roles of preceptors with respect to teaching, supervision, and student evaluation are:

- clearly defined;
- congruent with the mission, goals, and expected student outcomes; and
- congruent with relevant professional nursing standards and guidelines.

Preceptors have the expertise to support student achievement of expected outcomes. Preceptor performance expectations are clearly communicated to preceptors and are reviewed periodically. The program ensures preceptor performance meets expectations.

II-F. The parent institution and program provide and support an environment that encourages faculty teaching, scholarship, service, and practice in keeping with the mission, goals, and expected faculty outcomes.

Elaboration: Institutional support is available to promote faculty outcomes congruent with defined expectations of the faculty role and in support of the mission, goals, and expected faculty outcomes. For example:

- Faculty have opportunities for ongoing development in the scholarship of teaching.
- If scholarship is an expected faculty outcome, the institution provides resources to support faculty scholarship.
- If practice is an expected faculty outcome, opportunities are provided for faculty to maintain practice competence, and institutional support ensures that currency in clinical practice is maintained for faculty in roles that require it.
- If service is an expected faculty outcome, expected service is clearly defined and supported.

SUPPORTING DOCUMENTATION FOR STANDARD II

1. Nursing unit budget for the current and previous two fiscal years.
2. Name, title, educational degrees with area of specialization, certification, relevant work experience, and teaching responsibilities of each faculty member and administrative officer associated with the nursing unit.
3. Current curricula vitae of the chief nurse administrator and faculty.
5. Current collective bargaining agreement, if applicable.
6. Policies regarding faculty workload.
7. Documents that reflect decision-making (e.g., minutes, memoranda, reports) related to institutional commitment and resources.

STANDARD III

PROGRAM QUALITY: CURRICULUM AND TEACHING-LEARNING PRACTICES

The curriculum is developed in accordance with the program’s mission, goals, and expected student outcomes. The curriculum reflects professional nursing standards and guidelines and the needs and expectations of the community of interest. Teaching-learning practices are congruent with expected student outcomes. The environment for teaching-learning fosters achievement of expected student outcomes.

KEY ELEMENTS

III-A. The curriculum is developed, implemented, and revised to reflect clear statements of expected student outcomes that are congruent with the program’s mission and goals, and with the roles for which the program is preparing its graduates.
Elaboration: Curricular objectives (e.g., course, unit, and/or level objectives or competencies as identified by the program) provide clear statements of expected learning that relate to student outcomes. Expected outcomes relate to the roles for which students are being prepared.

III-B. Curricula are developed, implemented, and revised to reflect relevant professional nursing standards and guidelines, which are clearly evident within the curriculum and within the expected student outcomes (individual and aggregate).

• Baccalaureate program curricula incorporate *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008).

• Master’s program curricula incorporate professional standards and guidelines as appropriate.

  a. All master’s degree programs incorporate *The Essentials of Master’s Education in Nursing* (AACN, 2011) and additional relevant professional standards and guidelines as identified by the program.

  b. All master’s degree programs that prepare nurse practitioners incorporate *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2012).

• Graduate-entry program curricula incorporate *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) and appropriate graduate program standards and guidelines.

• DNP program curricula incorporate professional standards and guidelines as appropriate.

  a. All DNP programs incorporate *The Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006) and additional relevant professional standards and guidelines if identified by the program.

  b. All DNP programs that prepare nurse practitioners incorporate *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2012).

• Post-graduate APRN certificate programs that prepare nurse practitioners incorporate *Criteria for Evaluation of Nurse Practitioner Programs* (NTF, 2012).

Elaboration: Each degree/certificate program incorporates professional nursing standards and guidelines relevant to that program, area, role, population focus, or specialty. The program clearly demonstrates where and how content, knowledge, and skills required by identified sets of standards are incorporated into the curriculum.

APRN education programs (degree and certificate) (i.e., Clinical Nurse Specialist, Nurse Anesthesia, Nurse Midwife, and Nurse Practitioner) incorporate separate comprehensive graduate level courses to address the APRN core, defined as follows:

• Advanced physiology/pathophysiology, including general principles that apply across the lifespan;

• Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and

• Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents.

Additional APRN core content specific to the role and population is integrated throughout the other role and population-focused didactic and clinical courses.

Separate courses in advanced physiology/pathophysiology, advanced health assessment, and advanced pharmacology are not required for students enrolled in post-master’s DNP programs who hold current national certification as advanced practice nurses, unless the program has deemed this necessary.
Master’s programs that have a direct care focus but are not APRN education programs (e.g., nursing education and Clinical Nurse Leader), incorporate graduate level content addressing the APRN core. They are not required to offer this content as three separate courses.

III-C. The curriculum is logically structured to achieve expected student outcomes.

- Baccalaureate curricula build upon a foundation of the arts, sciences, and humanities.
- Master’s curricula build on a foundation comparable to baccalaureate level nursing knowledge.
- DNP curricula build on a baccalaureate and/or master’s foundation, depending on the level of entry of the student.
- Post-graduate APRN certificate programs build on graduate level nursing competencies and knowledge base.

Elaboration: Baccalaureate program faculty and students articulate how knowledge from courses in the arts, sciences, and humanities is incorporated into nursing practice. Post-baccalaureate entry programs in nursing incorporate the generalist knowledge common to baccalaureate nursing education as delineated in The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) as well as advanced course work.

Graduate curricula are clearly based on a foundation comparable to a baccalaureate degree in nursing. Graduate programs delineate how students who do not have a baccalaureate degree in nursing acquire the knowledge and competencies comparable to baccalaureate education in nursing as a foundation for advanced nursing education. Accelerated programs that move students from basic nursing preparation (e.g., associate degree or diploma education) to a graduate degree demonstrate how these students acquire baccalaureate level knowledge and competencies delineated in The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008), even if they do not award a baccalaureate degree in nursing in addition to the graduate degree.

DNP programs, whether post-baccalaureate or post-master’s, demonstrate how students acquire doctoral-level competencies delineated in The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006). The program provides a rationale for the sequence of the curriculum for each program.

III-D. Teaching-learning practices and environments support the achievement of expected student outcomes.

Elaboration: Teaching-learning practices and environments (classroom, clinical, laboratory, simulation, distance education) support achievement of expected individual student outcomes identified in course, unit, and/or level objectives.

III-E. The curriculum includes planned clinical practice experiences that:

- enable students to integrate new knowledge and demonstrate attainment of program outcomes; and
- are evaluated by faculty.

Elaboration: To prepare students for a practice profession, each track in each degree program and post-graduate APRN certificate program affords students the opportunity to develop professional competencies in practice settings aligned to the educational preparation. Clinical practice experiences are provided for students in all programs, including those with distance education offerings. Clinical practice experiences involve activities that are designed to ensure students are competent to enter nursing practice at the level indicated by the degree/certificate program. The design, implementation, and evaluation of clinical practice experiences are aligned to student and program outcomes.

III-F. The curriculum and teaching-learning practices consider the needs and expectations of the identified community of interest.
Elaboration: The curriculum and teaching-learning practices (e.g., use of distance technology, didactic activities, and simulation) are appropriate to the student population (e.g., adult learners, second language students, students in a post-graduate APRN certificate program) and consider the needs of the program-identified community of interest.

III-G. Individual student performance is evaluated by the faculty and reflects achievement of expected student outcomes. Evaluation policies and procedures for individual student performance are defined and consistently applied.

Elaboration: Evaluation of student performance is consistent with expected student outcomes. Grading criteria are clearly defined for each course, communicated to students, and applied consistently. Processes exist by which the evaluation of individual student performance is communicated to students. In instances where preceptors facilitate students’ clinical learning experiences, faculty may seek input from preceptors regarding student performance, but ultimately faculty are responsible for evaluation of individual student outcomes. The requirement for evaluation of student clinical performance by qualified faculty applies to all students in all programs. Faculty evaluation of student clinical performance may be accomplished through a variety of mechanisms.

III-H. Curriculum and teaching-learning practices are evaluated at regularly scheduled intervals to foster ongoing improvement.

Elaboration: Faculty use data from faculty and student evaluation of teaching-learning practices to inform decisions that facilitate the achievement of student outcomes. Such evaluation activities may be formal or informal, formative or summative. Curriculum is regularly evaluated by faculty and other communities of interest as appropriate. Data from the evaluation of curriculum and teaching-learning practices are used to foster program improvement.

SUPPORTING DOCUMENTATION FOR STANDARD III

1. Course syllabi.
2. Examples of student work reflecting student learning outcomes (both didactic and clinical).
3. Student performance evaluations (both didactic and clinical).
4. Course/faculty evaluations.
5. Current affiliation agreements with institutions at which student instruction occurs.
6. Student and faculty evaluations of clinical sites.
7. Documents (e.g., minutes, memoranda, reports) that reflect decision-making or improvements related to curriculum and teaching-learning practices.
8. Examples of assignments and/or course content reflecting incorporation of professional nursing standards and guidelines in curriculum.

STANDARD IV

PROGRAM EFFECTIVENESS: ASSESSMENT AND ACHIEVEMENT OF PROGRAM OUTCOMES

The program is effective in fulfilling its mission and goals as evidenced by achieving expected program outcomes. Program outcomes include student outcomes, faculty outcomes, and other outcomes identified by the program. Data on program effectiveness are used to foster ongoing program improvement.

KEY ELEMENTS

IV-A. A systematic process is used to determine program effectiveness.

Elaboration: The program uses a systematic process to obtain relevant data to determine program effectiveness. The process:

• is written, ongoing, and exists to determine achievement of program outcomes;
• is comprehensive (i.e., includes completion, licensure, certification, and employment rates, as required by the U.S. Department of Education; and other program outcomes);
identifies which quantitative and/or qualitative data are collected to assess achievement of the program outcomes;
• includes timelines for collection, review of expected and actual outcomes, and analysis; and
• is periodically reviewed and revised as appropriate.

IV-B. Program completion rates demonstrate program effectiveness.

Elaboration: The program demonstrates achievement of required program outcomes regarding completion. For each degree program (baccalaureate, master’s, and DNP) and post-graduate APRN certificate program:
• The completion rate for each of the three most recent calendar years is provided.
• The program specifies the entry point and defines the time period to completion.
• The program describes the formula it uses to calculate the completion rate.
• The completion rate for the most recent calendar year is 70% or higher. However, if the completion rate for the most recent calendar year is less than 70%, (1) the completion rate is 70% or higher when the annual completion rates for the three most recent calendar years are averaged or (2) the completion rate is 70% or higher when excluding students who have identified factors such as family obligations, relocation, financial barriers, and decisions to change major or to transfer to another institution of higher education.

A program with a completion rate less than 70% for the most recent calendar year provides a written explanation/analysis with documentation for the variance. This key element is not applicable to a new degree or certificate program that does not yet have individuals who have completed the program.

IV-C. Licensure and certification pass rates demonstrate program effectiveness.

Elaboration: The pre-licensure program demonstrates achievement of required program outcomes regarding licensure.
• The NCLEX-RN® pass rate for each campus/site and track is provided for each of the three most recent calendar years.
• The NCLEX-RN® pass rate for each campus/site and track is 80% or higher for first-time takers for the most recent calendar year. However, if the NCLEX-RN® pass rate for any campus/site and track is less than 80% for first-time takers for the most recent calendar year, (1) the pass rate for that campus/site or track is 80% or higher for all takers (first-time and repeat) for the most recent calendar year, (2) the pass rate for that campus/site or track is 80% or higher for first-time takers when the annual pass rates for the three most recent calendar years are averaged, or (3) the pass rate for that campus/site or track is 80% or higher for all takers (first-time and repeat) when the annual pass rates for the three most recent calendar years are averaged.

A campus/site or track with an NCLEX-RN® pass rate of less than 80% for first-time takers for the most recent calendar year provides a written explanation/analysis with documentation for the variance and a plan to meet the 80% NCLEX-RN® pass rate for first-time takers. The explanation may include trend data, information about numbers of test takers, data relative to specific campuses/sites or tracks, and data on repeat takers.

The graduate program demonstrates achievement of required program outcomes regarding certification. Certification results are obtained and reported in the aggregate for those graduates taking each examination, even when national certification is not required to practice in a particular state.
• Data are provided regarding the number of graduates and the number of graduates taking each certification examination.
• The certification pass rate for each examination for which the program prepares graduates is provided for each of the three most recent calendar years.
• The certification pass rate for each examination is 80% or higher for first-time takers for the most recent calendar year. However, if the pass rate for any certification examination is less than 80% for first-time takers for the most recent calendar year, (1) the pass rate for that certification examination is 80% or higher for all takers (first-time and repeat) for the most recent calendar year, (2) the pass rate for that certification examination is 80% or higher for first-time takers when the annual pass rates for the three most recent calendar years are averaged, or (3) the pass rate for that certification examination is 80% or higher for all takers (first-time and repeat) when the annual pass rates for the three most recent calendar years are averaged.

A program with a pass rate of less than 80% for any certification examination for the most recent calendar year provides a written explanation/analysis for the variance and a plan to meet the 80% certification pass rate for first-time takers. The explanation may include trend data, information about numbers of test takers, and data on repeat takers.

This key element is not applicable to a new degree or certificate program that does not yet have individuals who have taken licensure or certification examinations.

**IV-D. Employment rates demonstrate program effectiveness.**

**Elaboration:** The program demonstrates achievement of required outcomes regarding employment rates.

• The employment rate is collected separately for each degree program (baccalaureate, master’s, and DNP) and post-graduate APRN certificate program.
• Data are collected within 12 months of program completion. For example, employment data may be collected at the time of program completion or at any time within 12 months of program completion.
• The employment rate is 70% or higher. However, if the employment rate is less than 70%, the employment rate is 70% or higher when excluding graduates who have elected not to be employed.

Any program with an employment rate less than 70% provides a written explanation/analysis with documentation for the variance.

This key element is not applicable to a new degree or certificate program that does not yet have individuals who have completed the program.

**IV-E. Program outcomes demonstrate program effectiveness.**

**Elaboration:** The program demonstrates achievement of outcomes other than those related to completion rates (Key Element IV-B), licensure and certification pass rates (Key Element IV-C), and employment rates (Key Element IV-D); and those related to faculty (Key Element IV-F).

Program outcomes are defined by the program and incorporate expected levels of achievement. Program outcomes are appropriate and relevant to the degree and certificate programs offered and may include (but are not limited to) student learning outcomes; student and alumni achievement; and student, alumni, and employer satisfaction data.

Analysis of the data demonstrates that, in the aggregate, the program is achieving its outcomes. Any program with outcomes lower than expected provides a written explanation/analysis for the variance.
IV-F. Faculty outcomes, individually and in the aggregate, demonstrate program effectiveness.

Elaboration: The program demonstrates achievement of expected faculty outcomes. Expected faculty outcomes:
• are identified for the faculty as a group;
• incorporate expected levels of achievement;
• reflect expectations of faculty in their roles and evaluation of faculty performance;
• are consistent with and contribute to achievement of the program’s mission and goals; and
• are congruent with institution and program expectations.

Actual faculty outcomes are presented in the aggregate for the faculty as a group, analyzed, and compared to expected outcomes.

IV-G. The program defines and reviews formal complaints according to established policies.

Elaboration: The program defines what constitutes a formal complaint and maintains a record of formal complaints received. The program’s definition of formal complaints includes, at a minimum, student complaints. The program’s definition of formal complaints and the procedures for filing a complaint are communicated to relevant constituencies.

IV-H. Data analysis is used to foster ongoing program improvement.

Elaboration: The program uses outcome data for improvement. Data regarding completion, licensure, certification, and employment rates; other program outcomes; and formal complaints are used as indicated to foster program improvement.
• Data regarding actual outcomes are compared to expected outcomes.
• Discrepancies between actual and expected outcomes inform areas for improvement.
• Changes to the program to foster improvement and achievement of program outcomes are deliberate, ongoing, and analyzed for effectiveness.
• Faculty are engaged in the program improvement process.

SUPPORTING DOCUMENTATION FOR STANDARD IV

1. Aggregate student outcome data (not applicable to new programs without graduates), including:
   • Completion rates for each degree and post-master’s APRN certificate program
   • NCLEX-RN® pass rates
   • Certification pass rates by APRN role, population focus, and/or specialty
   • Certification pass rates for any other roles/areas for which the program prepares graduates
   • Employment rates for each degree/certificate program
   • Other aggregate data, as appropriate

2. Summary of aggregate faculty outcomes for the past three years with an analysis of aggregate faculty outcomes in relation to expected faculty outcomes.

3. Program policies related to formal complaints.

4. Record of formal complaints, if any, for the past three years, and any action(s) taken to foster program improvement.

5. Documents that reflect decision-making (e.g., minutes, memoranda, reports) related to assessment of program outcomes.

6. Examples of use of aggregate data to foster program improvement when indicated.

(Commission on Collegiate Nursing Education, 2013).
Appendix D
NLN Core Competency IV

Competency 4: Participate in Curriculum Design and Evaluation of Program Outcomes

Nurse educators are responsible for formulating program outcomes and designing curricula that reflect contemporary health care trends and prepare graduates to function effectively in the health care environment. To participate effectively in curriculum design and evaluation of program outcomes, the nurse educator:

• Ensures that the curriculum reflects institutional philosophy and mission, current nursing and health care trends, and community and societal needs so as to prepare graduates for practice in a complex, dynamic, multicultural health care environment
• Demonstrates knowledge of curriculum development including identifying program outcomes, developing competency statements, writing learning objectives, and selecting appropriate learning activities and evaluation strategies
• Bases curriculum design and implementation decisions on sound educational principles, theory, and research
• Revises the curriculum based on assessment of program outcomes, learner needs, and societal and health care trends
• Implements curricular revisions using appropriate change theories and strategies
• Creates and maintains community and clinical partnerships that support educational goals
• Collaborates with external constituencies throughout the process of curriculum revision
• Designs and implements program assessment models that promote continuous quality improvement of all aspects of the program (NLN, 2005).
Appendix E: Initial Request for Permission

Dear <name of dean, director of nursing, education director, or department chair>,

My name is Meredith Roberts and I am a doctoral candidate with the University of Phoenix. I am contacting you about my dissertation research involving nursing education. The problem addressed in the research is the lack of research concerning the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum. The purpose of this study is to discover perceptions of faculty related to their preparedness and confidence in evaluating, developing, and revising nursing curriculum and to use the information to develop a model of understanding that will support faculty’s growth and competence, and discover strategies to benefit nurse educators.

In order to gain rich data to answer the research questions, one-on-one semi-structured interviews will be conducted on nursing faculty members from nursing programs in Vermont. I would like to interview four nursing faculty members from your organization. The faculty members need to be nursing faculty with a minimum of one year as an educator who has evaluated, developed, or revised curriculum in a BSN program.

If you have any questions about the research, or what I am looking for in potential participants, please contact me at Information Redacted Information. I will be contacting you within a few days to see if you agree to my using your facility as a site for my research. If you agree, I will ask you to sign the attached “permission to use premises” form. I will contact you to obtain the names of potential faculty participants. I greatly appreciate your time and support in the completion of my doctoral journey.
Appendix F: Premises

UNIVERSITY OF PHOENIX

Permission to Use Premises, Name, and/or Subjects
(Facility, Organization, University, Institution, or Association)

Name of Facility, Organization, University, Institution, or Association

Check any that apply:

☐ I HEREBY AUTHORIZE MEREDITH ROBERTS, STUDENT OF UNIVERSITY OF PHOENIX, TO USE THE PREMISES (FACILITY IDENTIFIED BELOW) TO CONDUCT A STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING AND REVISING BSN CURRICULUM

☐ I HEREBY AUTHORIZE MEREDITH ROBERTS, DOCTORAL CANDIDATE AT THE UNIVERSITY OF PHOENIX, TO RECRUIT SUBJECTS FOR PARTICIPATION TO CONDUCT A CONSTRUCTIVIST GROUNDED STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING, AND REVISING BSN CURRICULUM

____________________________________  ______
SIGNATURE  DATE

____________________________________  __________
NAME  TITLE

FACILITY AND ADDRESS
UNIVERSITY OF PHOENIX
Permission to Use Premises, Name, and/or Subjects
(Norwich University)
Name of Facility: Norwich University

Check any that apply:

☒ I HEREBY AUTHORIZE MEREDITH ROBERTS, STUDENT OF UNIVERSITY OF
PHOENIX, TO USE THE PREMISES (FACILITY IDENTIFIED BELOW) TO CONDUCT A
STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING
EVALUATING AND REVISION BSN CURRICULUM

☒ I HEREBY AUTHORIZE MEREDITH ROBERTS, DOCTORAL CANDIDATE AT
THE UNIVERSITY OF PHOENIX, TO RECRUIT SUBJECTS FOR PARTICIPATION TO
CONDUCT A CONSTRUCTIONIST GROUNDED STUDY ENTITLED: PERCEPTIONS OF
FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING, AND REVISION BSN CURRICULUM

Signature Redacted

SIGNATURE

Signature Redacted

NAME

FACILITY AND ADDRESS

NORWICH UNIVERSITY School of Nursing

159 HARMON DRIVE
NORTHFIELD, VT 05663-1035
T 802.485.1600
F 802.485.2607
srichie@norwich.edu
www.norwich.edu

SHARON I RICHIE PhD, MSN
Director and Associate Professor
School of Nursing

3-18-14

DATE

Director, School of Nursing

TITLE
UNIVERSITY OF PHOENIX
Permission to Use Premises, Name, and/or Subjects
(The University of Vermont)
Name of Facility: The University of Vermont

Check any that apply:
☐ I HEREBY AUTHORIZE MEREDITH ROBERTS, STUDENT OF UNIVERSITY OF PHOENIX, TO USE THE PREMISES (FACILITY IDENTIFIED BELOW) TO CONDUCT A STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING AND EVALUATING BSN CURRICULUM

☒ I HEREBY AUTHORIZE MEREDITH ROBERTS, DOCTORAL CANDIDATE AT THE UNIVERSITY OF PHOENIX, TO RECRUIT SUBJECTS FOR PARTICIPATION TO CONDUCT A CONSTRUCTIVIST GROUNDED STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING AND EVALUATING BSN CURRICULUM

Signature Redacted
SIGNATURE
Signature Redacted
NAME

University of Vermont
Burlington, VT
FACILITY AND ADDRESS

3/1/2014
DATE
Dr. Redacted
TITLE
UNIVERSITY OF PHOENIX

Permission to Use Premises, Name, and/or Subjects
(Castleton State College)

Name of Facility: Castleton State College

Check any that apply:

I HEREBY AUTHORIZE MEREDITH ROBERTS, STUDENT OF UNIVERSITY OF
PHOENIX, TO USE THE PREMISES (FACILITY IDENTIFIED BELOW) TO CONDUCT A
STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING,
EVALUATING, AND REVISING BSN CURRICULUM

I HEREBY AUTHORIZE MEREDITH ROBERTS, DOCTORAL CANDIDATE AT
THE UNIVERSITY OF PHOENIX, TO RECRUIT SUBJECTS FOR PARTICIPATION TO
CONDUCT A CONSTRUCTIVIST GROUNDED STUDY ENTITLED: PERCEPTIONS OF
FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING, AND REVISIBG BSN
CURRICULUM

Signature Redacted

----------------------------------
Signature

March 18, 2014
DATE

----------------------------------
Ellen Capretelli, RN, MS
NAME

Director of Nursing Education
TITLE

Castleton State College 251 South Street Castleton VT 05735
FACILITY AND ADDRESS
UNIVERSITY OF PHOENIX
Permission to Use Premises, Name, and/or Subjects
(Southern Vermont College)
Name of Facility: Southern Vermont College

Check any that apply:

☐ I HEREBY AUTHORIZE MEREDITH ROBERTS, STUDENT OF UNIVERSITY OF PHOENIX, TO USE THE PREMISES (FACILITY IDENTIFIED BELOW) TO CONDUCT A STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING AND REVISING BSN CURRICULUM

☐ I HEREBY AUTHORIZE MEREDITH ROBERTS, DOCTORAL CANDIDATE AT THE UNIVERSITY OF PHOENIX, TO RECRUIT SUBJECTS FOR PARTICIPATION TO CONDUCT A CONSTRUCTIVIST GROUNDED STUDY ENTITLED: PERCEPTIONS OF FACULTY PREPAREDNESS FOR DEVELOPING, EVALUATING, AND REVISING BSN CURRICULUM

Signature
Redacted

Signature
Redacted

NAME

DIVISION OR DEPARTMENT

ADDRESS

FACILITY AND ADDRESS

4/30/14

DATE

PERSONAL SIGNATURE

TITLE


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Appendix G: Interview Protocol

1. The researcher contacts a potential participant by email or phone after the permission to use premises and subjects form is signed. The researcher introduces herself and states the problem and purpose of the research. The researcher explains the role of the participant. If the potential participant agrees to continue with the interview process, the researcher explains that she will e-mail the informed consent to the participant and confirms their preferred e-mail address. The researcher plans a time and place to meet with the participant.

2. The researcher meets with the participant on the planned date at the time and place specified above. The researcher will bring a paper copy of the informed consent form, the interview questions, binder-folder, memo pad, and pen, and a recording device.

3. The researcher will review the research with the participant and provide them with the informed consent form. The researcher provides the participant a paper copy of the informed consent form and offers an opportunity for the participant to ask questions, and states they can withdraw at any time.

4. After the participant’s questions have been answered, if he or she still desires to participate, the researcher will have the participant sign the informed consent form.

5. After the consent form has been signed, the researcher will turn on the recording device.

6. The researcher will ask the participant the first question.

7. The researcher will ask the remaining questions one at a time. The researcher may take brief notes or memos, but will not attempt to transcribe the interview.

8. The researcher will ask the open-ended interview questions unless the participant does not provide a complete answer. The researcher will then prompt the participant to provide further information about the response. If the researcher feels that a superficial response has been provided to a question, the researcher may ask the participant to expound upon their answer.

9. At the conclusion of the interview, the research will ask the participant if they have any further comments, questions, or if there is a question she should have asked. Any questions will be answered. The participant will be retold that if they wish to withdraw from the study, to notify the researcher as soon as possible, that there are no penalties, and they will be given phone and email contact information. The researcher will also request that the participant write a brief reflection of a challenging experience they remember when developing, evaluating, or revising curriculum. The participant will receive a transcript of the interview within a month to review for errors and to see if the transcript captured the participant’s perceptions. The reflection can be picked up during the transcript review meeting, or can be emailed to the researcher address containing a firewall if the client prefers. The researcher will thank the participant for taking part in the research and will depart.
Appendix H: Informed Consent

INFORMED CONSENT: PARTICIPANTS 18 YEARS OF AGE AND OLDER

Dear Educator,

My name is Meredith Roberts and I am a student at the University of Phoenix working on a PhD in Nursing degree. I am doing a research study entitled:

Perceptions of Faculty Preparedness for Developing, Evaluating and Revising BSN Curriculum

The problem I am addressing in this research study is lack of knowledge regarding the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum. The purpose of this study is to discover the perceptions of faculty related to their preparedness and confidence in evaluating, developing, and revising nursing curriculum and to use the information to develop a model of understanding that will support faculty’s growth and competence in curriculum development, evaluation and revision. It is also hoped that strategies will be revealed to assist faculty’s growth and competence in curriculum development, evaluation and revision

Your participation will involve an interviewer performing a face to face interview that could take 30 to 60 minutes. A brief reflection (approximately 300 words or less) in writing is requested that will require a brief second meeting with the interviewer that allows the participant to share any further thoughts and review previous information. Recording the interview is requested. 12-20 participants will be interviewed. You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any penalty or loss of benefits. The results of the research study may be published but your identity will remain confidential and your name will not be made known to any outside party.

In this research, there are no foreseeable risks to you.
Although there may be no direct benefit to you, a possible benefit from your being part of this study is improvement of nursing curriculum, a model to support faculty’s growth and competence in curriculum development, evaluation and revision, and new strategies to assist faculty, resulting in better nurse preparation. There are no costs for participating.

If you have any questions about the research study, please call me at (xxx)xxx-xxxx (office), (xxx)xxx-xxxx (cell) or contact me at mroberts@vtc.vsc.edu. For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. Meredith Roberts, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. If interviews are done, they may be recorded. If they are recorded, you must give permission for the researcher, Meredith Roberts, to record the interviews. You understand that the information from the recorded interviews may be transcribed. The researcher will develop a way to code the data to assure that your name is protected.
5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study may be published.

“By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here.”

(□) I accept the above terms.  (□) I do not accept the above terms. (CHECK ONE)

Signature of the interviewee ________________________________ Date _____________

Signature of the researcher ________________________________ Date ___________
Appendix I
Permission to use NLN Excellence Model

Dear National League for Nursing Leaders,

I hope your organization is thriving. I am a doctoral candidate at the University of Phoenix. My dissertation work discusses faculty preparedness in developing, evaluating and revising curriculum. I would like to share components of your excellence model in my dissertation.

The model components in your 2006 Excellence Model presents a visual model of excellence in nursing education. I am particularly interested in the aspect describing well-prepared faculty; therefore, I am respectfully requesting permission to use two slides: the overall model pictured, and the close-up of the branch entitled well-prepared faculty. I have attached both slides to avoid confusion. The website mentions that the citation should read:


I plan to cite as requested. Thank you for your thoughtful consideration.

Your sincere ambassador,

Meredith L. Roberts
RISC Director

Sent: Mon 3/17/2014 11:25 AM

To: Meredith<br>cc: Linda Christensen


From: Carrie O'Reilly -noreply@ln.org>

Thank you for contacting the National League for Nursing. As long as you cite the NLN appropriately you may use the citation in your research. If you plan to make changes to the model or modify it in any fashion you will need to request approval from our Chief Administrative Officer, Linda Christensen (lchristensen@ln.org).

I wish you the very best on your doctoral journey!

Carrie O'Reilly, Ph.D., MSN, RN | Manager, Professional Development National League for Nursing | www.nln.org | coreilly@ln.org (202) 989-2322 | 2000 Virginia Avenue, NW | Washington, DC 20037

nln.org - The Voice for Nursing Education
Appendix J: Invitation to Faculty

Date, 2014

Dear Faculty,

My name is Meredith Roberts and I am a doctoral candidate with the University of Phoenix as well as an educator. I invite you to participate in my dissertation research involving nursing education. The problem addressed in the research is the lack of research concerning the perceptions of faculty related to their preparedness and confidence in developing, evaluating, and revising nursing curriculum. The purpose of this constructivist grounded theory study is to discover perceptions of faculty related to their preparedness and confidence in evaluating, developing, and revising nursing curriculum and to use the information to develop a model of understanding that will support faculty’s growth and competence, and discover strategies to benefit nurse educators.

In order to gain rich data to answer the research questions, a one-on-one semi-structured interview will be conducted on faculty members of nursing programs in Vermont, and a brief (less than 300 word) reflection requested. You will have a chance to review your information and make corrections if needed. Faculty members need to be nursing faculty with a minimum of one year as an educator who has evaluated, developed, or revised curriculum. If you have any questions about the research, or what I am looking for in potential participants, please contact me at mroberts@vtc.edu or call me at 802-324-XXXX.

Final participants chosen will not be disclosed and will be coded data.

I greatly appreciate your support in my doctoral journey.
Appendix K: Initial Interview Questions

Demographic Data:

1. What is your age?
2. What is your gender?
3. What is your ethnicity?
4. How many years have you been a nurse?
5. How many years have you been a nurse educator?
6. What is your education preparation level?
7. Please list the number of formal education courses you have taken related to curriculum development, evaluation, or revision, or zero if none.

Questions Pertaining to Research Questions:

8. Tell me what it is like for you to develop, evaluate, and revise curriculum?
   a. What was your expectation when you were hired?
   b. Please give me an example of a challenge you faced in this area.
9. What guidelines do you consider when assessing curriculum and learning outcomes?
10. There are a multitude of standards and guidelines that address undergraduate nursing competencies. What are you comfortable using?

Think back to the first time you had to create a course, or course outcomes.

11. How did your education prepare you to develop your course outcomes and align with the program curriculum?
    How well prepared were you by your education?(sub-question)
12. How else did you learn to evaluate your nursing (course and program) student learning outcomes and curriculum?
13. What did you need to learn to evaluate your course outcomes and how it fit into your program’s curriculum that you would share with novice faculty?
14. To create your first course outcomes, how did you prepare for the task?
15. Who helped make it easier for you, if anyone, and how? Please use role rather than name.
16. What was the most effective tactic you used to develop curriculum?
17. How is curriculum usually developed by the faculty where you work?
18. How do you ensure student learning outcomes organize the curriculum?
19. How long (if ever) does it take for a nurse educator to be confident and effective assessing whether curriculum supports achievement of student learning outcomes, incorporating established professional standards, and competencies? Where are you on the spectrum?
20. What adequately prepares faculty to develop curriculum and write outcomes that meet accreditation requirements confidently?
21. What would help you more effectively develop curriculum and outcomes?
22. What would have made it easier for you to evaluate courses, and program curriculum?
23. What action(s) could a nurse leader or administrator take that would benefit nurse educators who evaluate, develop, and revise nursing curriculum?
24. How could education be offered or changed to help faculty who evaluate, develop, and revise nursing curriculum?