

A student's journey: Examining the efficacy of the academic preparation of BSN students and readiness to enter practice

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Abstract

Background: The nursing profession is under more pressure than ever to hire clinicians that exhibit critical thinking (CT) skills. A review of the literature has identified a divide between bedside clinicians and nursing faculty resulting in the separation of academic educators from current clinical practices [1]. New graduates enter the clinical setting inadequately prepared to meet the clinical needs and demands of today's hospitalized patients [2].

Method: A generic qualitative approach sought to explore the lived experience of BSN graduate nurses transition into clinical practice and to gain insight into how successful the nursing profession is training nursing students to meet the clinical demands of today's hospitalized patients.

Results: The results identified four themes: clinical rotation; didactic content and academia; transition to practice; and simulation. **Conclusion:** A theory-practice gap continues to exist in nursing education.

Introduction

Background

The concept of critical thinking (CT) is not new and has perplexed employers and researchers in the field of nursing for decades. Conferences, publications, and programs in higher education have been conducted to learn and understand the constructs that make up critical thinking skills [3]. Conversations of critical thinking in education dates back 2,500 years ago to Socrates [4]. The debate continues today among researchers and academics between how to teach the skills for critical thinking and how to apply these skills to clinical settings [5].

The term critical thinking (CT) has acquired many definitions that adds to the confusion [6]. Brookfield and Merriam (2005) defined CT as "a productive and positive activity . . . process, not an outcome . . . triggered by positive as well as negative events . . . emotive as well as rational" [7]. Scriven and Paul (2003) defined CT as "an intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing and evaluating information" [8]. Moreover, Toulmin, Rieke, and Janik, (1984) defined it as "a rational response to questions that cannot be answered definitively and for which all relevant information may not be available" [9].

Although there is a paucity of current literature, Bloom (1956), Jenkins (1998), Dalal (1994), and Guillemette (1991) developed a classification system making up six levels of cognitive thinking that encompasses CT skills, which are still compared today in both the academic and professional realms [10-13]. The system begins with

the basic level of CT, in which knowledge is the foundation and works its way up to the very top level of evaluation [5]. Scriven and Paul's (2003) description of CT includes several learning objectives from what is popularly referred to as "Bloom's taxonomy" [6].

Benjamin Bloom (1956) developed a classification system that identifies progressive levels of learning [10]. The foundation of Bloom's taxonomy is knowledge, which the nursing process depends upon. A disposition towards critical thinking requires one to reconsider others' opinions when making decisions [14]. There is a structured approach to patient problems and care rendered. Because they are part of a multidisciplinary team, nurses must accept others' perspectives and interpretations in order to provide safe and effective patient care, especially when the perspectives and interpretations are supported with evidence [6].

Critical thinking is a mandated outcome requirement upon graduation, creating pressure for hospitals to hire clinicians who exhibit these skills [15]. How to assess, teach, and determine if a nurse possesses these skills remains unclear [16]. Nurses must have the ability for critical thought and implement quick interventions to ensure safe patient care [4]. The profession of nursing is fast-paced, and it is assumed that nurse competency assures patient safety. Nursing is highly complex and exists in a rapidly changing environment [17]. Healthcare settings are elaborate and demand for new graduates to possess high levels of critical thinking (CT) to ensure patient safety and provide quality care [18].

Among all levels of nursing exists much debate and discussion about

the best ways to address the issues in critical thinking education [14]. Currently, nursing education consists of content learning and skill acquisition [19]. Assessment of a student's ability to think is related to the student's ability to memorize, recall, and apply content learned to clinical situations. Nursing education exists under the assumption that students who can memorize will have knowledge readily available when clinical situations demand it [20]. Memorization assures the ability for recall but does not prove a student has the ability for CT or the ability to transfer content into practice [6].

A critical thinker displays a core set of cognitive skills when evaluating a clinical situation [14]. Critical thinking is an active and continual process [4]. CT begins with a triggering event, resulting in an individual questioning his or her thought process or way of doing things [21]. Self-examination of assumptions leads to further exploration for new ways of thinking and acting [22]. As a discipline, nursing continues to struggle with determining the best tool to use for assessing CT [23]. Experts debate the importance of teaching strategies, evaluation methods, emphasis on clinical practice versus academic work, and individual learning needs as teaching priorities in order to minimize new graduates entering the clinical setting ill prepared [24].

Travale (2007) noted that, more than 57% of healthcare facilities currently hire inexperienced nurses into high acuity and critical care areas [2]. Nursing leaders watch inexperienced nurses struggle at the bedside, spend months in orientation only to result in high levels of dissatisfaction, absenteeism, and turnover rates that negatively impact the quality and delivery of care patients receive [2]. Meanwhile, Fero et al. (2010) reported that 28.5% of new graduates and 21% of experienced nurses do not perform to the clinical level expected by hospital leaders [25]. Fero et al., (2009), noted a gap exists between what is being taught, expectations of the clinical setting, and evaluation methods currently used to ensure safe and quality care rendered [23, 26].

Angel et al., (2000) asserted that nursing education is a "fact loading process" [27]. Mathews (2003) argued that educators who teach in the school setting are not equipped with the tools for teaching students CT skills [23, 28]. In addition, nursing educators in academic settings have been and remain segregated from educators in the clinical setting. As a result, new graduates enter the clinical setting unable to meet the clinical demands of today's hospitalized patients, often times resulting in patient harm [29].

Benner (1984) argued that new graduates need strategies that provide for safe patient care while meeting their level of clinical competency as a novice practitioner [30]. While Fero et al. (2010), noted that new graduates must start their nursing careers with the knowledge, skills, and attitudes that achieve delivery of competent care to their patients. Hospital personnel falsely assume that the knowledge taught in a school setting prepares new graduates for the actions demanded by real-life clinical situations [25, 31]. Middleton et al., (2014), argued for student training to be a shared responsibility between academia and clinical practice in order to meet the learning needs of students and must not be ignored [32].

The discussion around a theory-practice gap in nursing has been ongoing since 1943 [33]. Historically, nursing education has focused on testing theories instead of focusing on outcomes [34]. However,

currently, nursing education consists of content learning and skill acquisition [27]. Ferguson and Jinks (1994) maintained that nurses have traditionally learned to become nurses while "on the job" [14, 35]. McCaugherty (1991) identified two reasons for the theory-practice gap [36]. Textbooks provide knowledge only and fail to replicate real clinical experience. Textbooks are unable to capture the psychological and social dimensions affecting patients in the clinical setting. Therefore, students' experiences of real patients do not reflect what was learned from the textbook. In addition, McCaugherty (1991) argued that classroom lectures fail to provide firsthand patient-care issues and hands-on experience for students that result in true learning and understanding on how to care for hospitalized patients [23, 36].

Bendall (1976) noted, "what is taught in school is not practiced on the wards and vice versa" [37]. A disparity exists between the values taught in school, which includes autonomy and individualized care, with the realities of practice to get the work done and a task-centered approach towards patient care have furthered the gap [34]. Fero et al. (2010) stated, nursing education consists of content learning and skills demonstration. Academic evaluations to determine critical thinking is grounded upon memorization, recall, and the ability to apply content learned into clinical situations [25]. Ironside (2005) noted that memorization only displays the ability for recall and does not equate to critical thinking or the ability to transfer content learned into practice [38].

Academic and practice educators do not value one another's role and contribution to nursing education, further widening the perceived gap. MacPhee et al. (2009) stated that each group possess a different focus, which influenced a students' perception regarding the expertise of classroom and clinical educators [39]. Corlett (2000) identified this phenomenon as decontextualized teaching practices leading to high levels of frustration [40]. Academic educators focus on students' needs and clinical placements while practice educators are mainly concerned with the needs and issues of the clinical staff [39]. Decontextualized teaching strategies have resulted in new graduates lacking confidence and heightened awareness that they do not possess the skills for critical thinking that are required in today's clinical settings [41]. MacPhee et al. (2009) argued that academic and clinical educators need to collaborate in order to minimize student confusion therefore meeting learning needs [39].

Method

Scientific knowledge is the foundation of knowledge in nursing, and application of that knowledge to practice (skills) is considered secondary knowledge [42]. Currently, a gap exists between the professional knowledge of nursing and the demands of real-life practices [31]. To gain a better understanding of the practice-in-action theory, attention to the specifics of the event is required. Nursing experts organize their knowledge differently compared to their counterparts and have the ability to forward reason [30]. Forward reasoning is the result of working through many examples that serves as a source of analogies utilized for problem solving [43].

A generic qualitative study of nursing education with a focus on its efficacy in preparing new graduates of baccalaureate degree nursing programs to meet the demands inherent in the profession was conducted. Generic qualitative research is the process of "seek[ing] to discover and understand a phenomenon, a process, or the perspectives and world views of the people involved" [44].

Generic qualitative research strives for understanding and experience of an event, resulting in knowledge development [45].

This study looked to explore the lived experience of new BSN graduate nurses' transition into clinical practice and to gain insight into how successful the nursing profession is training nursing students of BSN programs to meet the clinical demands and expectations of today's hospitalized patients. The purpose of the study was to explore the experience of a new graduate BSN and their transition into clinical practice. The researcher was mainly interested in how a student's educational experience prepared them for their first clinical job and what their lived experience was during the adjustment period. It is hoped that this study can offer critical insight into and extensive understanding of the perceived gap between the clinical demands placed on registered nurses and the training goals of the nursing profession.

The study sought to answer the following question: How successful is the profession of nursing in training students of BSN programs to meet the clinical demands of today's hospitalized patients without resulting in patient harm? The study was also guided by the following interview sub-questions:

1. What do you think are the key criteria for effective teaching and learning methods to prepare you to practice in your current clinical setting?
2. How well did your nursing school prepare you to begin clinical practice in the hospital setting?
3. Describe how your educational experience was relevant and appropriate to meet the demands of your current role and responsibilities on your clinical unit.
4. How well did your clinical experience prepare you to work in your current clinical setting?
5. To what extent do you feel confident in transitioning from school into clinical practice?

Open-ended questioning was used and coded into recurrent themes for data collection. Once the data failed to produce a new or different theme, this researcher assumed that data collection had reached saturation.

A purposive convenience sampling of 10 BSN graduate nurse volunteers currently practicing at the bedside were chosen for the study. Purposeful sampling was sought from participants who could provide meaningful information regarding the subject matter of interest [46]. Participants had recently graduated from a Baccalaureate nursing program and successfully completed their National Council Licensure Examination (NCLEX). They were asked to describe in detail their academic clinical training and how successfully the profession of nursing trained them to meet the clinical demands of today's hospitalized patients at the time of hospital employment.

Participants were recruited from a hospital's nurse residency program in a medical teaching facility located in New York City. The 12-month "Program," helps facilitate the transition process for new graduate nurses during their transition from student to registered professional nurse. The participants were recruited on a voluntary basis and were free to withdraw from the study at any time. Snowball sampling is a non-probability technique used to identify potential subjects in studies where the participants share like circumstances [47]. The sampling method served as a chain referral. Participants

of the study were part of the recruitment process. Consequently, snowball sampling was utilized as a recruitment technique to obtain the number of participants identified.

IRB approval was obtained through Capella University and the medical teaching facility in New York City. Informed consent was discussed with each potential participant addressing all questions and concerns regarding study participation and obtained prior to study participation. Participants were asked to answer an open-ended question utilizing guided questions as needed during an audiotaped conversational interview. Storytelling was considered an acceptable means used to answer the open-ended questions. All interviews were audio recorded during face-to-face or phone interviews. Once an interview was obtained, transcription of the audio recording was conducted for data analysis, identification of common themes, and coding. Data analysis was shared with each interviewee to provide an opportunity for verification of the data interpreted and make necessary additions or corrections, which helped to ensure the validity and rigor of the study. Data continued to be collected until saturation was reached [45].

Utilization of the computer program NVivo was used for data analysis. NVivo is a computer software program specifically designed to assist with coding and theme identification of qualitative research. For this study, the narrative for each interview was transcribed verbatim and downloaded into the program. NVivo 10 allowed the researcher to color code all themes identified to aid with data analysis [48]. Additionally, the data ascertained from the NVivo program allowed the researcher to quantify differences noted between new graduates of traditional and accelerated nursing programs.

Minimal identifiable information was collected for the study. Demographics including age and gender were obtained from each study participant. All identifiers were removed, and each participant was assigned an alias that only the researcher had access. Participants ranged in age from 22-50, and all were female. Eight of the participants were from the medical teaching facility at which the study was conducted; two were from outside facilities. Four of the participants previously held positions in other fields prior to working as a registered nurse.

All the participants expressed excitement in participating in the research study and all were willing to express themselves during the interviews. Participants spoke freely about their clinical and classroom experiences as well as their transition from student to new graduate. Inclusion criteria included:

1. New graduate BSN hired for their first job.
2. A willingness to share lived experiences of academic and clinical training.
3. Participants have no less than three months clinical experience.
4. Successfully passed nursing orientation.
5. Participants have not worked more than 12 months in total.

Exclusion criteria included:

1. Independent clinical experience of 12 months or more,
2. Part-time or per diem status,
3. Previous experience as a licensed practical nurse (LPN), a nursing assistant (NA), or possesses an Associate degree in Nursing and has previous work experience as an RN,
4. Failure to successfully pass the NCLEX-RN examination, and

5. Non-English speaking.

All interviews began once informed consents were obtained from Capella University and the medical teaching facility. IRBs, along with consent for recording the interview. Interview lengths varied from 45 to 83 minutes total. To protect the privacy and confidentiality of each participant, an alias was assigned.

Detailed Analysis

The information obtained from the sub-questions provided answers to the fundamental research question.

SQ1. What do you think are the key criteria for effective teaching and learning methods to prepare you to practice in your current clinical setting?

Students felt the need for self-direction as a key factor to obtain the learning experiences they wanted. Students attributed their success in school as directly related to self-direction. All participants interviewed agreed that classroom teachings were ineffective learning modalities because most educators “taught at” (“Kim”) instead of taught to students in the class.

Students felt that simulations provided them with an opportunity to care for patients and make mistakes in a safe environment without actually causing harm. If a mistake was made during simulation, approximately half the students felt their instructors provided constructive criticism. “Marie,” a med-surg nurse, noted that the simulations were the “most valuable learning experience . . . real helpful . . . needed more.”

SQ2. How well did your nursing school prepare you to begin clinical practice in the hospital setting?

Answers to this sub-question indicated that most new graduates did not feel they were prepared to begin their first nursing job. “Kim” noted, “I feel insanely inadequate right now.” Many felt not enough time was spent on the units during clinical rotations or actual time spent with and caring for patients. “Karen,” a telemetry nurse, felt that nursing school did not prepare students for “the real world of nursing.” Classroom sizes are varied. The larger the classroom, the more difficult it was for an instructor to teach the content required for a particular course. Students described lectures as “disorganized.” Lack of clear expectations by instructors resulted in confusion among students. “Jean,” a new graduate working in geriatrics stated, “We spent much time trying to figure things out.” “Kate” felt students received experience with seeing things “in the textbook,” but when it came to actual patient experiences, the opposite occurred. Students noted that an existing disconnection between classroom teachings and clinical experiences caused feelings of being ill prepared to work as a new graduate.

SQ3. Describe how your educational experience was relevant and appropriate to meet the demands of your current role and responsibilities on your clinical unit.

Students described their overall educational experience as “mixed.” Some students felt they were continually challenged to think about why and what they were doing. Some classroom instructors were described as “engaging” (“Kate”), while others were defined as “boring” (“Karen”) or “disinterested” (“Jean”). Students felt that

class time was spent fact-loading by educators who do not spend time in the clinical setting. “Patty” noted, “There was a lot of busy work in school . . .” and “Kim” stated, “Can’t possibly learn it all.” The general feelings among the students were that individual schools rushed classroom educators to teach the content mandated by the state. “Kate” described instructors telling students, “You will just learn that on the unit once you get a job.” Lack of preparedness resulted in high levels of stress and anxiety felt during the transition phase of new graduate nurses.

SQ4. How well did your clinical experience prepare you to work in your current clinical setting?

Most new graduates felt their clinical experiences did not prepare them for their first nursing job. “Kim” stated, “We would get a nurse to follow . . . you watched how she did things,” “Kim” stated, “As a student we were allowed to do very, very little.” The hours spent in the clinical setting varied between 6 to 16 per week and depended upon the number of students and facilities available. Many students were unable to connect what was taught in the classroom with the clinical setting. Students felt as if their clinical experiences failed to meet their needs for learning.

SQ5. To what extent do you feel confident in transitioning from school into clinical practice?

A high sense of anxiety and stress is related to transitioning from student to nurse. This was clearly displayed by “Mary,” “First three months of orientation was overwhelming . . . most stressful time in my life.” The new graduates attributed multiple demands placed upon them, time management, and delegation as reasons for increased stress and anxiety. “I would not think about it on my own . . . preceptor has to explain to me (Mary).” New graduates constantly grapple with delegation. “Mary” stated, “I would try to do everything myself.” “Kate” described the transition from student to new graduate as “It depends on the day how I feel.” Some new graduates attributed their co-workers and clinical managers as the main reasons for their success with their transition. New graduates discussed the expectations their peers and clinical nurse managers had of them. The new graduates were expected to know all there is to know in order to successfully function in their new role. Most times, this was not the case. “Amy” stated, “She didn’t explain how she got to a decision. . . .” the inability of experienced clinicians to share their knowledge with the novice nurses, further increased already elevated anxiety levels.

The main themes that emerged were compared between traditional students and those of accelerated nursing programs, which are presented in below.

Clinical Rotations

Most participants interviewed believed they did not spend enough time in the clinical setting. Participants felt they would have benefited more if they were given more time during clinical rotations.

We did not have the ability to practice skills learned in class during clinical rotations. More time is needed on med-surg unit. (“Beth”) Disjointed . . . not able to connect what was taught in class with the clinical rotation. (“Kate”)

Clinical phase absolutely horrendous . . . felt as if we were running in circles. (“Karen”)

Study participants noted the time spent in any clinical unit was not maximized. Many felt their time on the units could have been put to better use. Did not learn time management. Much down time during clinical rotations was a waste of time . . . we babysat patients or washed them. (“Karen”)

Half the time was spent on the unit the other half discussion. (“Jean”)
Always released ahead of time . . . four-five hours was spent on the unit. (“Mary”)

As a student, we were allowed to do very, very little . . . we were told how to do it . . . no opportunity to practice it. (“Kim”)

While many participants believed their experiences did not match what they expected, several felt that overall, their school gave students the correct amount of time during clinical rotations and entered clinical rotations at the right moment in their program.

Slow transition into clinical settings. Learned a skill and then had opportunity to practice new skill in clinical setting. (“Marie”)

I do feel I got a good nursing education. School did prepare me well. (“Patty”)

I would say I had the best experience in med-surg . . . compared to my classmates. (“Beth”)

Simulation

Participant experiences with simulation widely varied as well as their feelings of its usefulness in skills training. Some students treated simulation scenarios as a real-life situation, while others saw it as unrealistic, therefore not taking the experience seriously. Unfortunately, several students were not afforded simulation opportunities at all.

Simulation exercises are always so nerve-wracking; it’s you and another student . . . people are watching, and the instructor is behind a curtain like a Wizard of Oz type of thing. (“Amy”)

Impractical experience. Unable to represent the true look and feel of what an actual patient might experience. (“Sue”)

Really great simulation experiences in school. I loved it. What’s better than actually getting that practice knowing you’re not going to hurt anyone. (“Patty”)

Not well planned or thought out by educators. . . . I did not appreciate the simulations at all. (“Kate”)

No simulation experiences at all. (“Jean”)

Disorganized . . . always something didn’t work...did not feel scenarios were realistic. (“Mary”)

Not enough. Usually offered once per semester . . . one of the best experiences we could have had. (“Marie”)

Valuable . . . wished for more experiences. (“Kim”)

Classroom Instruction and Instructors

All of new graduates questioned for this study reported their classroom experiences as “fact-loaded” (“Amy”). Students believed that their time in the classroom setting was spent doing “a lot of busy work” (“Patty”).

Experienced instructors made teachings realistic . . . made it stick in your mind. (“Karen” and “Jean”)

Provided foundation . . . professors were very good. (“Sue”)

Felt like the more paperwork you produced, the more you’ve done kind of thing. (“Patty”)

Instructors piled on teachings . . . amount of information taught was overwhelming. (“Kate”)

Too much too fast . . . unable to retain material later on. (“Mary”)

Classroom lectures were recounted as “passive” (“Kate”).

Classroom instructors read directly from their Power Point presentations. Memorization was encouraged as the desired way for content learning. There was little to no time spent reviewing case studies or care planning as teaching modalities.

Boring . . . students left during class. (“Beth”)

Hire people who are familiar with the subject. (“Jean”)

Professors forget what it’s like to be a student. (“Karen”)

Some instructors engaged students more than others during lecture. (“Mary”)

One hundred ninety slides that I could read myself. . . . I don’t learn from a slide (“Kim”)

Classroom educators were Ph.D.-prepared who taught classroom courses and did not go into the clinical setting. Students noticed what was taught in the classroom many times did not carry over into their clinical rotations. Many reported communication among the two groups was severely lacking resulting in confusion among the students.

Does not coincide with clinical goals and objectives. (“Amy”)

Limited or outdated clinical experience. (“Patty”)

Some educators had difficulty teaching in a way that students could understand. (“Kate”)

They had the wrong people teaching the wrong things. (“Karen”)

Classroom instructors expected us to learn skills during clinicals. (“Jean”)

Ability to Transition

No matter what students experienced in school, one theme remained consistent throughout all interviews: new graduate nurses struggled throughout their first year of transition into practice. Time management and delegation challenged some, while others created ways to deal with their lack of knowledge or skills training, and some floundered with relating to their colleagues and members of the healthcare team.

Terrified. I could read a chart and understand what was going on. Hard skills, no way... Never saw pressure ulcer...Saw a lot of pictures. (“Amy”)

Seek out the nicer nurses to ask for help who don’t eat their young. (“Sue”)

Humbling experience in terms of having someone watch everything you do . . . I feel more prepared now. (“Patty”)

Going really well. My preceptor is very supportive of me. I would have been completely lost. (“Beth”)

My preceptor was great, she was very helpful, patient, relatable, willing to educate . . . a great model to emulate . . . I learned so

much. (“Karen”)
First three months of orientation was extremely overwhelming . . . most stressful time in my life. I felt stupid most of the time. (“Mary”)
I left work in tears. I felt like such a burden . . . you’re treated inadequate. (“Kim”)

Although the main themes identified in this study were clinical rotation, simulation, ability to transition, and classroom instruction and instructor, several unanticipated sub-themes were identified during the data analysis. Participants identified the following sub-themes during personal interviews that are worth discussing.

Lack of Skills Training

The profession of nursing is much more than task completion and ensuring doctors’ orders are carried out. Nursing requires skills training, particularly in the clinical setting, where scaffolding is crucial. Failure to provide study participants opportunities to move towards stronger understanding and independence in their learning lead students to question the quality of the experiences they were provided.

More focus is needed on skills that are actually done in the hospital. (“Sue”)

I did not learn skills in my clinical I only learned during my practicum. (“Patty”)

You have to really do it to know how to do it . . . we were told how to perform skills but never provided an opportunity to practice in the clinical setting. (“Kim”)

You will just learn that on the unit once you get a job . . . employers surprised at all the skills we did not learn in school. (“Kate”)

The only way we learned how to draw blood was to be willing to practice on each other. (“Mary”)

Clinical Instructor

Clinical instructor experiences during the student’s clinical rotations were variable. Most clinical instructors served as adjunct educators who were Master’s-prepared and whose primary job was not teaching. Adjunct instructors are chosen by the schools for their “field experts” (“Amy”) notoriety when compared to classroom instructors.

Minimal. Dependent upon individual instructor and her ability to teach or previous clinical experience. (“Amy”)

Our instructor was the primary go-to person for us. At the end of our day she would review with us the occurrences that happened throughout the day. (“Patty”)

Our instructor was absent. (“Beth”)

Depending on who the instructor was determined if our experience was positive or negative. (“Mary”)

I had good instructors for the most part . . . very hands-on during clinical rotations. (“Marie”)

I had some fantastic teachers. (“Kim”)

Students credited a lack of loyalty exhibited by adjunct instructors in direct relationship to the low salaries received. Students felt that independent nursing schools “are at the mercy of adjunct professors” (“Sue”), leading to the wide gap noted between a good or bad instructor.

They like to keep who they can keep . . . don’t always have instructors

do what they are supposed to do. (“Sue”)
Very poor communication . . . disjointed and frustrating experience. (“Beth”)
Others taught outdated practices . . . failure to adjust to the times. (“Kate”)
Some were lazy . . . this is easy pay. (“Karen” and “Jean”)

We had no guidance during clinicals . . . not a good experience. (“Mary”)

It was clear to all the students, the more engaged a clinical instructor was during clinical rotations, the better the student’s clinical experience.

Instructors gave us our patient assignments. They were very hands-on at the beginning of the program and backed away as our knowledge base widened . . . very appropriate. (“Amy”)

Clinical instructors made the clinical assignments, worked in the area hospital as a staff nurse or clinical nurse manager that we went to, instructed the group . . . made for a better clinical experience for students. (“Karen”)

The instructors stayed with us on the unit . . . constantly running from room to room with people giving meds . . . not a lot of time for in-depth instruction. (“Patty”)

The clinical instructors knew exactly what to focus on during clinical rotations. (“Marie”)

Preceptor Program

Study participants interviewed, attributed their learning how to be a nurse as the direct result of the nurse preceptor program participation.

It was the best learning experience of my life. (“Patty”)

I highly recommend. (“Kim”)

The nurse was very valuable . . . I learned a lot. (“Sue”)

Ability for autonomy . . . you had to do everything. (“Patty”)

I felt safe working under the guidance of a clinical nurse . . . the clinical nurse would step in when needed. (“Karen”)

Limitations of the Research Design

The sample size chosen for the current study cannot be generalized to the whole population of new graduate nurses in every institution in the United States. Also, study participants were purposefully chosen for participation and part of a convenience sample. Only participants who met the inclusion criteria were chosen for study participation, further limiting the generalizability of this study to all new graduate nurses. Although there was no intent to engage only one gender, the participants in this study were all female. Consequently, the findings cannot be generalized to their male counterparts. It should also be noted that the participant pool represented one hospital in New York City. Therefore, the data cannot be generalized to nurses in other healthcare institutions in New York or to those in any other state in the United States.

All data gathered were self-reported by the participants and caution is recommended when linking what was reported as own actual experiences lived with those of other nursing students in a particular nursing program. While it is believed that participants well represented the different types of nursing schools available, the programs offered, and the varying types and sizes of hospitals of an urban community, the current study was limited to one geographic

area. Thus, it is recommended that future studies replicate the current study utilizing a larger sample size of varying geographic areas both in and out of the United States for generalization.

Recommendations for Future Research

It is recommended that future studies look more closely at and compare the differences in preparation between traditional and accelerated nursing programs. Studies need to look more closely at the potential influence of possessing an associate degree in nursing on the educational experiences and preparedness of students who are returning for BSN degrees. Consideration for studies comparing BSN students with and without previous work experience as a nursing assistant or patient care technician on educational experiences or preparedness. Do second career students possess similar or different experiences when returning for a BSN? Finally, qualitative studies consisting of a larger sample size, male and female participants, and quantitative and mixed methods studies also need to be considered for generalization and continued discussion of the theory-practice gap that exists in nursing.

Conclusion

The current study indicated a need for collaboration between nursing schools and hospitals to facilitate the growth and development of new graduate nurses. Benner (1984) clearly defined the constructs that make up each stage of a professional nurse, from novice to expert [30]. Hospitals must be held accountable for continuing the learning process of new graduates [34]. Hospitals onboard new graduates expecting them to begin their careers with certain concepts and skills already in place [49]. However, this is not the case. Hospital educators and nurse preceptors carry the burden of having to teach new graduates basic skill sets [29]. As a result, new graduates lose time during their transition period learning basic skills instead of enhancing critical thinking and application skills.

The need for critical thinking is not a new concept in nursing. Hospital settings are complex and diverse. Patients are acute and clinical practice settings are fast-paced and high tech [18]. The demands placed on today's bedside clinicians leads to high anxiety levels and frustration for new graduate nurses, potentiating risks to patient safety [21]. Oermann et al. (2010) argued that new graduates require proper preparation upon entering the nursing profession to minimize anxiety levels and frustration experienced during the transition, in addition to promoting retention rates [50].

The disconnection between what is taught in the classroom setting and the reality of clinical practice continues to be apparent [19]. Opportunities for nursing students to practice the necessary skills that ensure patient safety are limited during academic experiences [51]. Collaboration between academia and hospital settings must focus on shared responsibilities to meet the learning needs of new graduates [34]. CAPSTONE courses, nurse residency programs, and extended orientations have proven effective in supporting new graduate nurses during their transition into practice [29]. A call for collaboration between schools of nursing and facilities that employ new graduate nurses must occur in order to bridge the theory-practice gap, nursing has no choice.

References

1. Maben J, Latter S & Clark JM (2006) The theory-practice gap: impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing* 55: 465-477.

2. Travale IL (2007) Computer assisted instruction for novice nurses in critical care. *The Journal of Continuing Education in Nursing* 38: 132-138.
3. Robert RR & Petersen S (2013) Critical thinking at the bedside: Providing safe passage to patients. *MEDSURG Nursing* 22: 85-93.
4. Von Colln-Appling C & Giuliano D (2017) A concept analysis of critical thinking: A guide for nurse educators. *Nurse Education Today* 49: 106-109.
5. Page D & Mukherjee A (2007) Promoting critical-thinking skills by using negotiation exercises. *Journal of Education for Business* 82: 251-257.
6. Andreou C, Papastavrou E & Merkouris A (2014) Learning styles and critical thinking relationship in baccalaureate nursing education: A systematic review. *Nurse Education Today* 34: 362-371.
7. Brookfield SD & Merriam SB (2005) *Critical thinking in adult education*. Hoboken, NJ: John Wiley & Sons.
8. Scriven M & Paul R (2003) *Defining critical thinking*. Retrieved from <http://www.criticalthinking.org/aboutCT/definingCT.shtml>
9. Toulmin S, Rieke R & Janik A (1984) *An introduction to reasoning* (2nd ed.). New York, NY: Macmillan.
10. Bloom BS (1956) *Taxonomy of educational objectives: The classification of education goals. Handbook 1: Cognitive domain*. New York, NY: McKay.
11. Jenkins EK (1998) The significant role of critical thinking in predicting auditing students' performance. *Journal of Education for Business* 73: 274-279.
12. Dalal NP (1994) Higher order thinking in MIS. *Journal of Computer Information Systems* 34: 26-30.
13. Guillemette RA (1991) Domains of educational objectives: An information systems perspective. *Journal of Computer Information Systems* 31: 18-25.
14. Nelson AE (2017) *Methods Faculty Use to Facilitate Nursing Students' Critical Thinking*. *Teaching and Learning in Nursing* 12: 62-66.
15. Hunter S, Pitt V, Croce N, Roche J (2014) Critical thinking skills of undergraduate nursing students: Description and demographic predictors. *Nurse Education Today* 34: 809-814.
16. Staib S (2003) Teaching and measuring critical thinking. *Journal of Nursing Education*, 42: 498-508.
17. Rogal SM & Young J (2008) Exploring critical thinking in critical care nursing education: A pilot study. *The Journal of Continuing Education in Nursing* 39: 28-33.
18. Dadgarn I, Parvizy S & Peyrovi H (2012) A global issue in nursing students' clinical learning: The theory-practice gap. *Social and Behavioral Sciences* 47: 1713-1718.
19. Papatthanasious IV, Tsaras K & Sarafis P (2014) Views and perceptions of nursing students on their clinical learning environment: Teaching and learning. *Nurse Education Today* 34: 57-60.
20. Lee W, Chiang CH, Liao IC, Lee ML, Chen SL, et al. (2013) The longitudinal effect of concept map teaching on critical thinking of nursing students. *Nurse Education Today* 33: 1219-1223.
21. Chan ZCY (2013) A systematic review of critical thinking in nursing education. *Nurse Education Today* 33: 236-240.
22. Hatlevik IK (2012) The theory-practice relationship: Reflective skills and theoretical knowledge as key factors in bridging the gap between theory and practice in initial nursing education. *Journal of Advanced Nursing* 68: 868-877.

23. Paul SA (2014) Assessment of critical thinking: A Delphi study. *Nurse Education Today* 34: 1357-1360.
24. Bostrom E, Hornsten A, Persson C, Rising I & Fischer RS (2012) Clinical challenges and ongoing role changes for primary health-care nurses. *British Journal of Community Nursing* 17: 68-74.
25. Fero JJ, O'Donnell JM, Zullo TG, Dabbs AD, Kitutu J, et al. (2010) Critical thinking skills in nursing students: Comparison of simulation-based performance with metrics. *Journal of Advanced Nursing* 66: 2182-2193.
26. Fero LJ, Witsberger CM, Wesmiller SW, Zullo TG, Hoffman LA (2009) Critical thinking ability of new graduate and experienced nurses. *Journal of Advanced Nursing* 65: 139-148.
27. Angel BF, Duffey M, Belyea M (2000) An evidence-based project for evaluating strategies to improve knowledge acquisition and critical-thinking performance in nursing students. *Journal of Nursing Education* 39: 219-228.
28. Mathews MB (2003) Resourcing nursing education through collaboration. *The Journal of Continuing Education in Nursing* 34: 251-257.
29. Ajani K & Moez S (2011) Gap between knowledge and practice in nursing. *Social and Behavioral Sciences* 15: 3927-3931.
30. Benner P (1984) *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice-Hall Health.
31. Schon DA (1983) *The reflective practitioner: How professionals think in action*. London, UK: Ashgate.
32. Middleton L, Howard A, Dohrn J, Von Zinkernagel D, Parham, DH & Aranda-Naranjo B (2014) The Nursing Education Partnership Initiative (NEPI): Innovations in nursing and midwifery education. *Academic Medicine* 89: 24-28.
33. Higginson R (2004) The theory-practice gap still exists in nursing education. *British Journal of Nursing* 13: 1168.
34. Bvumbwe T (2016) Enhancing nursing education via academic-clinical partnership: An integrative review. *International Journal of Nursing Sciences* 3: 314-322.
35. Ferguson KE & Jinks AM (1994) Integrating what is taught with what is practiced in the nursing curriculum: A multi-dimensional model. *Journal of Advanced Nursing* 20: 687-695.
36. McCaugherty D (1991) The theory-practice gap in nurse education: Its causes and possible solutions. Findings from an action research study. *Journal of Advanced Nursing* 16: 1055-1061.
37. Bendall E (1976) Learning for reality. *Journal of Advanced Nursing* 1: 3-9.
38. Ironside PM (2005) Teaching thinking and reaching the limits of memorization: Enacting new pedagogies. *Journal of Nursing Education* 44: 441-449.
39. MacPhee M, Wejr P, Davis M, Semeniuk P & Scarborough K (2009) Practice and academic nurse educators: Finding common ground. *International Journal of Nursing Education Scholarship* 6: 1-18.
40. Corlett J (2000) The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education. *Nurse Education Today* 20: 499-505.
41. Seymour B, Kinn S, Sutherland N (2003) Valuing both critical and creative thinking in clinical practice: Narrowing the research-practice gap? *Journal of Advanced Nursing* 42: 288-296.
42. Burns P, Poster EC (2008) Competency development in new registered nurse graduates: Closing the gap between education and practice. *The Journal of Continuing Education in Nursing* 39: 67-73.
43. Norman G, Eva K, Brooks L & Hamstra S (2006) Expertise in medicine and surgery. *The Cambridge handbook of expertise and expert performance* (pp. 339-353). New York, NY: Cambridge University Press.
44. Merriam SB (1998) *Qualitative research and case study applications in education*. San Francisco, CA: Jossey-Bass.
45. Caelli K, Ray L & Mill J (2003) "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative methods* 2: 1-13.
46. Sandelowski M (2000) Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health* 23: 334-340.
47. O'Byrne P & Holmes D (2008) Researching marginalized populations: Ethical concerns about ethnography. *Canadian Journal of Nursing Research* 40: 144-159.
48. Hsu LL (2005) Analysis of clinical teacher behaviour in a nursing practicum in Taiwan. *Journal of Clinical Nursing* 15: 619-628.
49. Walker A, Earl C, Costa B, Cuddihy L (2013) Graduate nurses' transition and integration into the workplace: A qualitative comparison of graduate nurses' and Nurse Unit Managers' perspectives. *Nurse Education Today* 33: 291-296.
50. Oermann MH, Poole-Dawkins K, Alvarez M T, Foster BB, O'Sullivan R (2010) Managers' perspectives of new graduates of accelerated nursing programs: How do they compare with other graduates? *The Journal of Continuing Education in Nursing* 41: 394-400.
51. Scully NJ (2011) The theory-practice gap and skill acquisition: An issue for nursing education. *Collegian* 18: 93-98.

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