

PERCEPTIONS OF THE BSN: WHAT NURSES THINK AND THE FACTORS THAT
INFLUENCE THOSE PERCEPTIONS

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ABSTRACT

The Institute of Medicine (IOM) has set a goal that 80% of nurses will be educated at the baccalaureate level or higher by the year 2020. Currently, only about 50% of nurses are educated at that level. To achieve that goal, significant work must be done to encourage nurses to return to school. Understanding the attitudes that nurses hold toward the baccalaureate degree, together with the factors that influence those perceptions, may lay the foundation for nursing leaders and educators to develop approaches that may be more effective in encouraging nurses to return to school. This study was designed, using a qualitative approach, to explore the perceptions and attitudes that nurses hold toward the BSN and the factors that influence those perceptions. The study found that non-BSN nurses generally view the BSN from the perspective of nurses' performance at the bedside. BSN-prepared nurses are perceived as lacking the requisite technical skills of a good nurse. Factors that influence these perceptions, beyond the focus on skills, include a general view that "a nurse is a nurse is a nurse." Other factors include the way in which the profession and employers fail to adequately differentiate nursing practice by educational level. The advanced recommendations to help address those perceptions and to act on the factors influencing those perceptions.

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CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGMENTS	iii
LIST OF TABLES	ix
LIST OF FIGURES	x
CHAPTER 1: INTRODUCTION.....	1
History.....	3
Differentiating the Degrees.....	6
The Push for the BSN	8
Problem Statement.....	12
Purpose of the Study and Research Questions.....	12
Significance.....	13
Assumptions.....	14
Summary of the Methodology	15
Definition of Terms.....	15
CHAPTER 2: REVIEW OF THE LITERATURE.....	18
Motivations and Barriers.....	18
Attitude Toward Continued Education and Intent to Continue.....	21
Attitude Versus Perception.....	23
Attitude	24
Perception	24

Perceptions and Attitudes.....	25
Theoretical Foundations: The Theory of Planned Behavior.....	26
Behavioral Beliefs.....	28
Normative Beliefs.....	28
Control Beliefs.....	29
Intentions.....	29
Taking Action.....	30
Conclusion.....	32
CHAPTER 3: METHODS AND PROCEDURES.....	34
Purpose of the Study.....	34
Research Design.....	35
The Qualitative Interview.....	38
Thematic Analysis.....	39
Ethical Considerations.....	41
Sample Population and Recruitment.....	43
Recruitment.....	43
Interview Protocol.....	45
Data Validation.....	46
Data Collection.....	46
Individual Interviews.....	47
Data Analysis.....	47
Reflexivity and Acknowledgment of Personal Bias.....	50
Conclusion.....	53

CHAPTER 4: RESULTS OF DATA ANALYSIS	54
Nurses’ Stories	54
Darla.....	54
Grace.....	58
Katie.....	61
Leila	65
Susan.....	68
Patty	73
Paige.....	76
Thematic Analysis.....	81
Perceptions of the BSN.....	82
Theme One: Skills Define a “Good Nurse”	83
Theme Two: Bedside Experience is Vital to Good Nursing	87
Theme Three: The BSN is not Needed	91
Summary of Perceptions	97
Influencing Factors	98
Theme Four: The Generic Nurse	99
Theme Five: Challenges to Professional Identity	107
Summary of Influencing Factors	112
Returning to School	114
Theme Six: Returning With Purpose	114
Theme Seven: There is a Difference.....	118
Theme Eight: Required Entry to Practice	122

Summary of Returning to School	125
CHAPTER 5: DISCUSSION, IMPLICATIONS FOR PRACTICE, LIMITATIONS AND SUMMARY	127
Discussion.....	127
Research Question One.....	127
Summary of Research Question One.....	133
Research Question Two	134
The Generic Nurse	135
Challenges to Professional Identity	140
Summary of Research Question Two.....	141
Research Question Three	143
Returning With a Purpose	143
There is a Difference.....	145
BSN Should be the Required Entry Level to Practice	148
Summary of Returning to School	149
Relevance to Theoretical Framework	150
Implications for Practice	152
Perceptions.....	152
Influencing Factors	154
Limitations	158
Identification of Additional Research Opportunities	159
Summary of the Study	160
Final Thoughts	160
REFERENCES	161

APPENDIX A IRB APPROVAL	169
APPENDIX B INFORMED CONSENT	171
APPENDIX C INTERVIEW PROTOCOL	177

LIST OF TABLES

1. List of Participants45

LIST OF FIGURES

1. Graphic of the Theory of Planned Behavior (adapted from Ajzen, 1991).....	31
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CHAPTER 1: INTRODUCTION

For a child born and raised in the Amazonian Rainforest, the extent of the world is contained within the limits of the forest in which he lives. Beyond the boundaries of his forest lies the unknown and unknowable. For him, communication is limited to the reach of his shouted voice, travel to the distance his feet can carry him over a few days' journey. His knowledge is of the physical world that surrounds him and of the skills needed to survive and prosper in that world. He does not know, and indeed cannot know, that there exists any other world. This child's view of the world is created through the lens of experiences, beliefs, and values with which he was raised. He can see it no other way. He does not know that there exist whole other civilizations and does not know that he does not know this.

His confidence in the world as he knows it is challenged when one day a mysterious vision appears. A White man, wearing a costume that hides his body, wanders into the tribe's circle. He speaks in strange tongues and shows many amazing and frightening things: sticks that flare into fire simply by striking them, a torch to light the night that contains no fire and that can be controlled at will, a box from which images of his friends and family emerge. Over time, the man learns to communicate with the tribesmen and begins to tell tales of strange, faraway lands, of traveling through many forests in a day, of talking in a normal tone of voice with others located far, far away. How can this be? Surely this man is possessed of evil spirits to conjure up such tales! Surely his magic firesticks and picture boxes are products of those evil spirits. The tribe's leaders become increasingly suspect of this visitor and begin to resist his stories, to refute them lest the tribe should become infected with the same evil that clearly has infected this man.

His tales and, indeed, his very presence, challenge the view of the world with which they have lived for many generations. That challenge poses a threat to their future.

By this point, the reader may be wondering how this discussion of an Amazonian tribe might be related to nursing. For 35 years I have worked in healthcare. For 32 of those years I have carried in my pocket a card that says that I am a “Registered Professional Nurse.” This same title, or a very similar one, appears on the license carried by every nurse who wears the title of “RN” regardless of their educational preparation. The majority of these nurses are prepared at the associate degree level and, like that Amazonian child, possess a view of nursing that suggests that what they know of nursing is all that is to be known; there is no other world of nursing. These nurses carry with them a view of the world of nursing that says that they are complete. They believe that they are highly qualified, professional nurses and that no difference between them and those prepared at the baccalaureate level truly exists. In talking to some of these nurses, you might hear them suggest that they are, in fact, superior to the baccalaureate nurse. Suggestions that these beliefs may not be quite true are resisted in the same way that the Amazonian tribe resists the tales of other worlds told by their visitor.

Goethe tells us that “we know accurately only when we know little; doubt grows with knowledge” (Goethe, n.d.). It is we who do not know who are content in the truth of our knowledge, for we do not know what we do not know. As new knowledge is gained, we become more aware of the many possibilities that may exist to challenge a single view. Our confidence is challenged as we become aware that we do, indeed, not know that which we do not know. This is where nursing is today. Many nurses prepared at the associate degree level believe themselves to be fully prepared to function as professional nurses. This belief is being challenged by increased

education and, like the Amazonian tribe, many of these nurses may be resistant to those calls. Their belief that they are professionals is being challenged.

History

While most professions have a single educational path for entry into professional practice, nursing has multiple educational paths including hospital-based diploma programs (DIP), associate degree programs (ADN), baccalaureate programs (BSN), and, more recently, the master's level entry programs (MSN). While each of these paths offers widely different educational experiences, each takes the same licensing examination that leads to precisely the same designation as a Registered Nurse (RN). How these multiple paths came to be plays an important role in the attitudes that today's nurse holds toward continued education.

The first formal training programs for nurses in the United States were established in the 1870s. These programs were hospital-based and followed either the Nightingale model, in which nursing school administration was separate from hospital administration, or the United States model in which the school was considered a part of the hospital and, thus, fell under the control of the hospital's administration ("Historical overview," n.d.). In contrast to the Nightingale model, the US system provided very little formal classroom or book-based, education, relying, instead, on an apprenticeship model of hands-on learning. The students were often exploited as free labor for the hospital (Cherry & Jacobs, 2017).

The first university-based school of nursing was established at the University of Minnesota in 1909. The original program was 3 years in length and did not lead to a baccalaureate degree. That degree would come 10 years later when the school established a 5-year program leading to the bachelor's degree ("Historical overview," n.d.). At the time there were just over 1100 nursing programs in the US, all of them hospital based ("Historical

overview,” n.d.). While baccalaureate programs continued to develop, the hospital-based model dominated nursing education until the mid-20th century when circumstances led to the development of the first associate degree programs.

In the late 1940s and early 1950s, a number of factors came together to create a nursing shortage that would lead to the development of the ADN. In post-war America, military nurses left their practices to become wives and mothers rather than continuing into civilian practice. This, together with a decline in enrollment in diploma-based programs as women increasingly abandoned the apprenticeship system in preference to college-based education, led to fewer nurses in practice. Meanwhile, the introduction of antibiotics, improvements in surgical techniques, and the creation of many new hospitals under the Hill-Burton Act increased the demand for hospital-based care (Orsolini-Hain & Waters, 2009). The overall effect of these changes was an increased demand for nurses. This increased demand called for an approach that could rapidly increase the nursing workforce; the extant programs could not meet that need.

To address that need, the National League of Nursing (NLN) leadership began exploring the possibility of using the 2-year community colleges that were expanding under the Truman administration to train nurses. At about the same time, the faculty of the Teachers College at Columbia University began exploring options for nursing education. They proposed two levels of practitioner, defined by two levels of education. The “Technical Nurse” would receive 2 years of training and would be prepared to carry out the technical aspects of nursing care. The “Professional Nurse” would receive 4 years of training at the baccalaureate level, and would provide oversight of the Technical Nurse. The 2-year technical nurse was a good fit for the community colleges and soon associate degree nursing program were being rapidly developed within the community college network (Orsolini-Hain & Waters, 2009)

Nursing shortages demanded large numbers of new nurses and, as a result, the 2-year associate degree nursing programs grew rapidly. By 2009 they represented 59% of all undergraduate nursing programs, producing 63% of new graduates (Health Resources and Services Administration, 2010). Early on, the quality of the ADN graduate was deemed to be as good as, or better than, graduates of other programs. In a study conducted by Montag (1959, as cited in Orsolini-Hain & Waters, 2009), 77% of nursing administrators rated the ADN graduate to be as good as, or better than, other graduates; 85% rated them as meeting or exceeding the administrator's standards for their staff. Additionally, about 90% of AD nurses successfully passed their licensing exam on the first attempt. The high quality of the ADN graduate, coupled with an increasing shortage of nurses, led nursing administrators to hire and place ADN graduates in increasingly responsible roles (Orsolini-Hain & Waters, 2009). Never intended to take on leadership roles, the ADN-prepared nurses nonetheless met the challenge and in response the ADN curriculum was adjusted to include leadership and management, topics normally within the scope of the baccalaureate nurse (Orsolini-Hain & Waters, 2009). This shift made differentiating the levels of nursing more difficult which, in turn, made the need for further education a questionable proposition. Despite attempts to differentiate the ADN from the BSN nurse, there was, in fact, very little to distinguish the two levels of nursing in practice. Given that attempts to define differences were unsuccessful, that the graduates of the two programs were identically licensed, and that both performed similarly in the workplace, administrators were hard-pressed to support any distinctions (Orsolini-Hain & Waters, 2009). These same factors made it difficult for the nurses, themselves, to see significant differences. Holmes (1992), in fact, expresses exactly this challenge in noting that with little difference in pay and responsibilities participants in her study found no need to pursue further education.

Differentiating the Degrees

As noted above, differentiating the degrees, particularly in the workplace, is challenging. The differences in educational preparation are not clearly visible in that environment. What, then, differentiates the two degrees? The primary differences in the educational preparation of the two degrees lie in the additional coursework in the humanities and the social and physical sciences, as well as specific courses in nursing research, community health, and nursing management the BSN student receives (American Association of Colleges of Nursing, 2017). This additional coursework, according to The American Association of Colleges of Nursing (AACN), prepares the BSN nurse for a broader scope of practice, providing the nurse with a better understanding of how the patient's political, social, cultural, and economic environments impact the patient's health and access to healthcare (AACN, 2017). These differences, according to the AACN, allow the BSN graduate to practice in more diverse settings and prepare them to function in expanded roles that leverage their educational preparation. The BSN nurse may be called on to design and coordinate a comprehensive plan of care that encompasses not only the patient's inpatient stay but may extend to their post-discharge care within the community. The BSN graduate's education provides them the foundational knowledge and skills necessary for considering the patient's overall circumstances and assessing the appropriateness of the available resources pertinent to the patient's needs. Associate degree education lacks the courses that could best prepare the AD nurse to function in that such an expanded role and in diverse environments. The AD graduate is prepared primarily to function at the hospital bedside (AACN, 2000).

The National League for Nursing (NLN) described associate degree education as providing the AD graduate with the skills to "practice in structured care settings, including hospitals, long-term care facilities, clinics, and offices" (NLN, 2010, p. 38). Like the AACN, the

NLN notes that BSN education includes experiences related to community and population-focused care, research, and leadership and management in addition to the foundational courses found in the AD programs. The NLN also differentiated the two degrees in terms of the competencies expected of the graduates of the two programs. While the competencies are similar within a domain, the differentiation is found in the depth and breadth of the competency.

As an example, the NLN competency for Nursing Judgment for the AD nurse states, “Makes judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality care and promote the health of patients within a family and community context” (NLN, 2010, p. 38). The related competency for the BSN graduate states, “Makes judgments in practice, substantiated with evidence, that synthesize nursing science and knowledge from other disciplines in the provision of safe, quality care and promote the health of patients, families, and communities” (NLN, 2010, p. 39). Two significant differences are found in these two competencies. First, while the AD graduate integrates nursing science in their practice judgments, the BS graduate incorporates nursing science with knowledge from outside the realm of nursing to expand their judgment. Second, the AD nurse is concerned with promoting the health of the single patient within the context of their family and community whereas the BS graduate is concerned with promoting the health not only of the patient but of the patient’s family and community. These differences reflect the influence of expanded exposure to the humanities, and community and population health, on the BS nurse’s perspective in caring for the patient.

While the differences between the two degrees may be difficult to discern in the workplace, the literature does provide evidence that differences do exist. Beyond the differences cited by the AACN and NLN, various studies have shown that there are substantive differences

in patient outcomes in hospitals that have larger percentages of BSN-prepared nurses. These studies highlighted decreased rates of failure to rescue, decreased surgical mortality, and overall improved patient outcomes as the percentage of BSN-prepared staff increased within a facility. (Kutney-Lee, Sloane, & Aiken, 2013; McHugh et al., 2013). Kutney-Lee et al. (2013), for example, projected that a 10-point increase in the percentage of BSN prepared staff could result in 2.12 fewer deaths per 1000 surgical patients.

The Push for the BSN

The last 15 years have seen an increased effort to encourage the Registered Nurse (RN), whose initial education is at the associate degree (ADN) or diploma (DIP) level, to return to school for a bachelor's (BSN) or higher degree in nursing. Several factors have combined to create this emphasis. First is the research, noted above, demonstrating positive correlations between the educational level of nursing staff and patient outcomes, failure to rescue, and other care-related outcomes. These studies provided support for the second factor: The Institute of Medicine (IOM) recommendation that 80% of the nursing workforce be prepared at the baccalaureate level by 2020 (IOM, 2011). This recommendation is one of several made by the IOM that are aimed at increasing the scope of practice, professional stature, and supply of nurses in the domain of healthcare. Central to the IOM goals, however, is a more fully educated nursing workforce.

The third factor is the Magnet[®] Recognition Program promoted by the American Nurse Credentialing Center (ANCC) (Abraham, Jerome-D'Emilia, & Begun, 2013). Many hospitals seek Magnet recognition as evidence of the quality of care they provide. As increasing numbers of hospitals seek recognition as Magnet facilities, many nurses, prepared at the associate degree or diploma level, face employer mandates to continue their education. These employer

expectations are rooted in the requirements for designation as a Magnet facility (AACN, 2015) which, while not mandating a bachelor's degree in Nursing (BSN) for all staff, does require that the applicant facility have a plan to increase its pool of Registered Nurses (RN) prepared at the BSN level or higher to at least 80% (American Nurses Credentialing Center, 2014).

In response to these factors, many hospitals have increased their emphasis on higher education and have set goals for their nurses to work toward the BSN. To this end, these hospitals are seeking ways to encourage nurses to return to school. Warren and Mills (2009) focused on AD and diploma-prepared nurses to identify the organizational incentives and rewards that might motivate the nurse to return to school. Of the 1800 nurses who were randomly selected from the Maryland Board of Nursing licensing database to receive the survey, 255 met the eligibility criteria and were included in the study. The study found that 19.4% of respondents intended to return to school for their bachelor's degree. Interestingly, those who reported no plans to return, however, did suggest that the right combinations of rewards and incentives might entice the nurse who is undecided on returning to school to elect to do so. Making continued education a job requirement was listed among the incentives identified in this study. On the other hand, the study also noted that nurses who were satisfied with their careers were unlikely to return to school, even in the face of rewards (Warren & Mills, 2009). Career satisfaction as a determinant of educational intent was also identified by Holmes (1992) who noted that nurses who were content with their current educational level and their current careers saw little need to continue their education.

While many organizations are making the BSN a job requirement in their pursuit of Magnet status, some states are moving toward making the BSN a requirement for continued licensure. Often known as the "BSN in 10," states such as New Jersey and New York have

proposed legislation that, while allowing initial licensure for the associate degree nurse, would require the nurse to complete a baccalaureate degree within 10 years of initial licensure (Maneval & Teeter, 2010). In fact, in December 2017, New York signed into law a requirement that nurses earn a BSN within 10 years of initial licensure. (Mensik, 2017).

Although BSN in 10 legislation was not being considered in Pennsylvania at the time of their study, Maneval and Teeter (2010) surveyed students in 28 Pennsylvania diploma and associate degree nursing programs with respect to their future educational goals and their opinions on the proposed BSN in 10 requirements. Over 4300 surveys were returned. The study revealed that 86.3% of respondents planned to continue on to obtain their bachelor's degree in nursing with most, 94.8%, hoping to do so within 4 years. The high number of respondents expressing an intent to continue their education is at odds with other studies. The authors of the study note that the manner in which the surveys were distributed may have created a bias in the results. While all schools in the state were offered the opportunity to participate, participation was voluntary. Consequently, schools that viewed the degree more positively may have been more likely to participate. Similarly, students who viewed the degree more positively may have been more likely to participate (Maneval & Teeter, 2010). Other potential explanations for such a high result, such as the possible idealism of those still in school, or a social desirability bias in which the respondent provides the response that is believed to be the "correct" or favorable one is given, were not provided.

Patient outcomes and complication rates have impacts on both the hospital's ratings and its bottom line. Medicare, for example, links reimbursement to several factors related to quality of care issues, including reduced readmission rates (Centers for Medicare and Medicaid Services, n.d.) while another program, the Hospital Consumer Assessment of Healthcare Providers and

Systems (HCAHPS) survey connects the patient experience—essentially patient satisfaction with care—with reimbursement (Letourneau, 2014). Factors that positively impact patient outcomes and other measures of quality of care provide clear benefits for the organization. The studies by Kutney-Lee et al. (2006) and McHugh and others (2013) provided evidence that increasing the number of BSN prepared nurses holds potential for improving the quality of care measures. In this context, setting goals to increase the number of BSN-prepared nurses on staff is a prudent course of action for hospitals to take.

But what do Registered Nurses think about returning to school? In what ways does earning a BSN benefit the nurse? According to the National Sample Survey of Registered Nurses (NSSRN), enrollment in RN to BSN programs has increased in each of the past 12 years, with an increase from 2013-2014 of 10.4% (AACN, 2015). Moreover, the NSSRN reported that nurses whose initial nursing education was at the associate or diploma level represent 32% of nurses holding a bachelor's or higher degree, though not necessarily in nursing or a related field. This suggests that nurses are, in fact, interested in continuing their education. However, in 2008, the most recent year for which data are available, only 12.1% of nurses initially educated at the associate degree level had completed a BS and only 13.1% of nurses whose initial education was at the diploma level had done so (Health Resources and Services Administration, 2010). Thus, while the numbers of nurses pursuing a BSN are increasing, there remains a significant population of nurses who have not chosen to pursue additional nursing education.

Given the pressure to increase the number of nurses prepared at the BSN level, steps must be taken to create an environment that encourages them to return to school. To create such an environment we must first understand the factors that influence that decision. We must identify the attitudes, beliefs, and values that these nurses hold toward the Baccalaureate Degree in

Nursing. That is, we must understand how the nurse perceives the degree. Then we must seek to understand the factors that influence those perceptions, if we are to effect changes in those perceptions.

Problem Statement

The increased emphasis on baccalaureate education in nursing is motivated by the benefits to the organization. Little attention has been paid to the ways in which nurses benefit from the degree. While many nurses do seek to complete their bachelor's degree, many more do not. The literature identified many factors, both internal and external, that influence the decision to return to school. Perhaps the biggest impediments to encouraging nurses to return to school are their own perceptions of the degree. Ajzen (1991) suggested that the perceived value of an action plays a significant role in the decision to act. Perceptions play a role in the development of the attitudes that ultimately influence action. Understanding how nurses perceive the degree and its benefits to them, as well as the factors that influence their perceptions, provides a foundation for nursing educators and administrators to promote the baccalaureate degree in a way that includes the nurse's needs and wants. Understanding how nurses' perceptions of the baccalaureate degree have changed as a result of their educational experiences may provide evidence that there is personal and professional benefit to the nurse.

Purpose of the Study and Research Questions

The purpose of this study was to examine the perceptions and subsequent attitudes that Registered Nurses, initially educated at the AD and diploma levels, hold toward the BSN and the factors that influence those perceptions with the aim of informing activities designed to support and encourage nurses in returning to school.

The research questions are derived from that purpose:

1. What perceptions do nurses hold toward the BSN?
2. What factors influence the perceptions the nurses hold?
3. Among nurses who return to school, in what ways, if any, do those perceptions change?

Significance

The old adage “perception is reality” defines the significance of this study. For nurses, the perceptions they hold toward the degree may reflect their reality. In turn, that reality determines their motivation to return to school. As noted earlier, Ajzen (1991) asserted that the perceived value and benefits of a course of action drive much of our decision-making. The IOM (2011) has set a goal of having 80% of the nursing workforce prepared at the baccalaureate level by 2020. As of 2008, the last year for which data are available, just under 50% of all nurses held a bachelor’s degree in nursing (Health Resources and Services Administration, 2010). To achieve the IOM goal, the number of nursing students graduating with a BSN will need to be significantly increased. Moreover, the majority of practicing nurses are prepared at the Associate Degree level. Thus, to achieve the IOM goals, nurses must be motivated to act to pursue further education. That motivation comes, in part, from the benefit they believe the degree will provide. By providing insight into the perceptions that nurses hold toward the BSN and the factors that influence those perceptions, this study provides nursing leaders with an understanding of how nurses perceive the degree and its benefits to them. By including the factors that influence those perceptions, the results of the study may provide nursing leaders with insights into how nurses’ perceptions arose and help them to identify factors that may be manipulated to effect change in the nurses’ perceptions. Finally, the literature suggested that nurses who continue their education experience changes in how they perceive the degree. All of the nurses in this study who continued their education shared ways that their perceptions were changed through the BSN

experience. Their stories provide nursing leaders with evidence to counter the belief that the degree is “not worth it.”

Assumptions

The basic assumption underlying this study was that the current healthcare environment has created a need for nurses to return to school to earn their BSN. The literature (AACN, 2017; Conner & Thielemann, 2013; Drenkard, 2010; IOM, 2001, 2011) has provided a foundation for this assumption. Because there is evidence that the expectation that nurses should earn their degree is gaining widespread support through projects such as the Magnet[®] Recognition program, this study began with the assumption that nurses should be encouraged to return. Along with this basic assumption was the assumption that efforts to identify factors that influence the decision to return to school are of value in achieving that goal.

A second assumption was that nurses are able to identify and describe their perceptions of the degree and to identify factors that have influenced their perceptions with some degree of accuracy despite the passage of time. Some nurses in this study related perceptions they held 20 to 30 years ago. I assumed that their recollections are mostly accurate despite the passage of time.

A third assumption was that the nurses participating in this study are presenting their perceptions in a way that accurately reflects their beliefs rather than what they believe I wanted or expected to hear. Social desirability bias, in which the respondent provides the response that is believed to be the “correct” or favorable one, is a valid concern in qualitative studies (Ferrari, Bristow, & Cowman, 2005; Neuman, 2012).

Summary of the Methodology

To answer the research questions, I used a qualitative research design that incorporated a semantic approach to thematic analysis to describe the ways that Registered Nurses perceived the BSN and to identify the factors that influence those perceptions. The data were collected using a semi-structured interview format that was adapted, as needed, as nurse's responses identified new topics for consideration.

Qualitative research is about understanding the perceptions and beliefs of individuals and the meanings they ascribe to those perceptions and experiences. Meaning flows from context. Qualitative research allows the researcher to situate participants' responses within their unique set of circumstances so that the researcher can better understand the participants' perspectives. In this study, I wanted to understand how the nurses perceived the BSN. Those perceptions, however, did not develop in a vacuum, but did so within the context of family, friends, colleagues, and personal experiences. By using a qualitative approach, I hoped to gain greater insight into what the nurses thought about the BSN and the factors that provided the foundations for those thoughts.

Definition of Terms

Attitude: A mindset or tendency to act in a particular way as a result of the individual's temperament and experience. Attitudes reflect the interaction of how we feel about something as well as how we act toward it. Attitude is the result of the interaction of our beliefs, values, motivations, and personality with respect to some object (Pickens, 2005).

Associate Degree in Nursing (abbreviated AD, ADN, or ASN for Associate of Science in Nursing): a 2- or 3-year program of study, usually provided at the junior college or community college level, that prepares an individual to take the licensing examination, known as the

NCLEX[®] exam, to become a Registered Nurse. An AD program generally focuses on the technical skills of nursing and includes classroom instruction, as well as clinical instruction in local hospitals and healthcare facilities.

Baccalaureate Degree in Nursing (abbreviated BSN for Bachelor of Science in Nursing): A 4-year program of study, usually provided at a senior college or university that prepares the individual to take the NCLEX[®] exam for licensing as a Registered Nurse. The BSN program of study includes all of the content taught in the AD programs, with additional education in the social sciences, management, research, and community health. The BSN is designed to broaden the scope of practice and enhance the professional development of the nurse (AACN, 2017).

NCLEX[®] (National Council Licensure EXamination): A criterion-referenced national examination administered to graduates of accredited nursing programs used to determine that the candidate has the required skills and knowledge for safe and effective practice in nursing. Passing the NCLEX[®] exam is required for licensure as a Registered Nurse in the United States and Canada. The NCLEX[®] for Registered Nurses is referred to as the NCLEX-RN[®]. In addition to being criterion-referenced, which refers to measuring student performance against a defined standard, the NCLEX-RN[®] uses a process known as Computer Adapted Testing (CAT) which tailors the exam questions to the examinee. This process adapts questions based on the examinee's responses to prior questions.

Magnet Recognition[®] Program: A program designed and administered by the American Nurses Credentialing Center (ANCC) that recognized hospitals and other healthcare organizations for nursing excellence. Facilities receiving Magnet Recognition[®] promote quality through support of professional clinical practice, identify excellence in delivery of nursing care,

and provide means for disseminating best practices in nursing services. There is evidence to show that organizations receiving Magnet Recognition have a generally more satisfied nursing staff, lower RN turnover, and improved patient outcomes and patient satisfaction (Drenkard, 2010).

Perception: A mental image resulting from one's interpretation of the physical experiences in the environment. Perception reflects an individual's understanding of some thing (Pickens, 2005).

CHAPTER 2: REVIEW OF THE LITERATURE

As noted in the first chapter, a shortage of nurses has existed, and grown, since the mid-1940s, and continues to grow today. This shortage created a need to get as many nurses as possible into the workforce as quickly as possible. The 2-year associate degree nursing programs could fill that need more quickly than could the 4-year baccalaureate nursing programs, which explains much of the former's proliferation. The demand for nurses also increased the demand for nursing leaders—managers and administrators. The associate degree programs, recognizing that need, adapted their programs to meet that growing need, as well. Healthcare, however, is constantly evolving. Evidence was beginning to mount that the skills and knowledge needed to provide care at the bedside—the care taught by AD programs—was insufficient to meet the growing need to provide continuity of care across healthcare systems. This gap was particularly visible in the care needs of a growing population of chronically ill individuals whose care was provided more often in a community setting rather than an acute care hospital (Fairman & Okoye, 2011). The Robert Wood Johnson Foundation (RWJF) partnered with the IOM in 2008 to consider the future of nursing and to make recommendations to ensure that nursing met the challenges of a changing healthcare environment. That study led to the *Future of Nursing* report of 2010. It was in this report that the IOM recommended that 80% of nurses should be educated at the BSN level by 2020. That recommendation was made based on the committee's belief that “the public needed better congruence of its health care needs with nurses' skills and knowledge; leadership, knowledge of systems, public health, community-based care, mental health, and end-

of-life care were competencies found in baccalaureate programs” (Fairman & Okoye, 2011, p. 310).

The committee noted, too, that these skills and competencies would be critical for all nurses as new models of healthcare emerge. This report, together with research that showed that hospitals with higher percentages of BSN-prepared nurses had better outcomes provided the impetus for the current efforts to promote the BSN degree.

In the wake of the IOM report, and with increasing efforts to attain Magnet[®] designation, hospitals have increased their emphasis on higher education and have set goals for their nurses to work toward the BSN. To this end, hospitals are seeking ways to encourage nurses to return to school. The literature reflects these efforts, though two observations of the literature are worth noting. First, the literature generally began from the assumption that the BSN is a worthwhile goal and is, therefore, aimed at providing support and guidance in realizing that goal. Second, while literature was found that defended the validity of the AD nurse, no literature was found that argued against increasing the numbers of BSN prepared nurses in the workforce.

The literature appeared to take for granted that nurses should return for their BSN. Consequently, the studies found in the literature were aimed at finding the means for encouraging more nurses to return to school. The Warren and Mills (2009) study presented in the first chapter, for example, focused on the organizational incentives and rewards that might motivate the AND- and diploma-prepared nurse to return to school. Other studies focused on the motivations and barriers beyond the organization that influenced the nurses’ decisions about returning (Cooper, 2005; Holmes, 1992; Romp et al., 2014; Root, 1991). Still others looked at related factors such as the financial effects of returning (Graf, 2005; Spetz, 2002; Spetz & Bates, 2013).

Motivations and Barriers

Many studies have sought to explain why nurses do, or do not, return to school by looking at the motivations and barriers to returning. These studies have identified a range of internal and external motivating factors. Some of the more common reasons given for returning to school include a desire for graduate study or to assume roles in advanced practice (Jezuit & Luna, 2013; Maneval & Teeter, 2010; Romp et al., 2014; Zuzelo, 2001), increased promotional opportunities and job mobility (Altmann, 2011; Delaney & Piscopo, 2004; Megginson, 2008), increased professional credibility (Megginson, 2008), and personal factors such as personal accomplishment, satisfaction, and growth (Altmann, 2012; Delaney & Piscopo, 2004; Megginson, 2008; Zuzelo, 2001).

For many students, the decision to return to school is predicated on the perceived “payback” of their investment of time and money (Blegen, Spetz, Goode, Park, & Vaughn, 2013; Duffy et al., 2014; Graf, 2005; Megginson, 2008; Schwarz & Leibold, 2014; Sportsman & Allen, 2011). Studies that have looked at the financial rate of return on investment in continued nursing education have provided support for the nurses’ notion that the BSN is a financially questionable investment (Graf, 2005; Spetz, 2002; Spetz & Bates, 2013) with Graf noting that “on average, and for more than half of ADN graduates, the cost of investing in advanced education outweighed the economic benefits” (2005, p. 138). While payback is one consideration, the mere costs associated with going back to school also factored heavily in the decision to return to school. Multiple studies reported that students expressed concern about their ability to pay for schooling, an unwillingness to take out student loans to continue schooling, and a lack of financial support from their employer (Delaney & Piscopo, 2004; Graf, 2005; Megginson, 2008; Sportsman & Allen, 2011; Zuzelo, 2001). Underscoring the influence of financial concerns,

Maneval and Teeter (2010) found that when financial considerations were removed, 9.5% more participants reported that they would return to school.

In general, the motivations and barriers are presented as relatively consistent among respondents. No distinction is made between the factors that influence the returning student versus the non-returning student. This is, in part, likely due to the persistent use of enrolled RN to BSN students as study participants. Two studies did seek to identify the differences between those who did and those who did not return. One study (Root, 1991), using a sample comprised of both nurses who were currently enrolled in, or had recently taken BSN courses, as well as nurses who had not taken courses beyond licensure, identified several differences between the two groups. Notably, in identifying barriers, those who returned to school identified program-related factors such as inability to get credit for prior coursework, inconvenient scheduling or location of courses, and redundancy in the material presented. In contrast, those who chose not to return to school identified personal factors such as costs, childcare issues, and lack of time as primary barriers (Root, 1991). This differentiation is interesting in that it suggests that those who return seem to look for ways to “make it happen” more expeditiously while those who do not return appear to look for justifications for their decision. While these factors have been identified by other studies (Graf, 2005; Megginson, 2008; Spetz, 2014), none have specifically noted the differences between those who returned and those who did not. Moreover, Duffy and colleagues (2014) found no significant differences between the those who returned and those who did not, noting that both groups identified a mix of program and personal factors that acted as barriers.

Attitude Toward Continued Education and Intent to Continue

Several studies have looked at the attitudes that nurses hold toward the baccalaureate degree. These studies have identified relationships between attitude toward BSN education and

participation in continued education. Altmann (2012), for example, using the Attitude Toward BSN Education (ATBSNE) scale developed by Roche (1990), surveyed over 1300 nurses in three states, all educated at less than the BSN, on several factors related to continued education, including their attitude toward the degree. Not surprisingly, this study found a significant difference between the attitudes held by nurses who returned to school and those who did not, with the returning group holding more positive views. These findings supported Roche's (1990) earlier findings in comparing those who returned with those who did not. Altmann (2012) noted, however, that while both groups were positively inclined toward the BSN, the responses for both groups were barely above neutral, suggesting that there is significant room for improvement in all nurses' attitudes toward the degree.

Both Altmann (2012) and Roche (1990) identified the need for further exploration of the attitudes of both associate degree and diploma nurses toward continued education. Altmann (2012) pointed out that understanding the attitudes of nurses toward the baccalaureate degree is a necessary step in developing approaches to encourage continued educational efforts. Lillibridge and Fox (2005) went further, pointing out both the need to explore RN to BSN attitudes toward the degree and the potential for these attitudes to explain the differences among Registered Nurses who completed the degree but felt that the degree had added little or nothing to their professional skills and knowledge. That this latter suggestion reflects a belief expressed by respondents in multiple studies (for example, Altmann, 2012; Duffy et al., 2014; Megginson, 2008) suggests that attitude is, indeed, worthy of additional study.

Two other interesting perspectives were provided by Bahn (2007), who noted that nurses in her qualitative study of nurses' attitudes toward continuing education expressed concern over potentially losing sight of traditional nursing care though, as Bahn pointed out, the participants

were unable to identify exactly what they meant by this. Perhaps related to this fear, nurses in this study also expressed concern that nurses who were more “academic” were less caring, an anecdotal claim that nurses in the study who experienced continued education found to be baseless. Bahn observed that “[i]t is interesting that they had only changed their mind after taking part in academic study and that they had exercised subjective judgement without factual knowledge” (p. 729).

Attitude Versus Perception

Throughout this paper, two terms arise with some frequency: attitude and perceptions. The meanings of these two terms, and how they differ, are somewhat muddled. To ensure understanding, it is necessary to more clearly define these two terms. Brief definitions were given in Chapter 1, but additional discussion is warranted.

Many variations of the phrase “perceptions and attitudes” are found within the literature (see for example, Altmann, 2011; Doering, 2012; Melnyk, 2005; Rebar, 2010). A brief search of the literature for the phrase “perceptions and attitudes” revealed that nearly 16,000 articles, not limited to nursing, included the phrase in their titles in the years 2012 through 2017. Clearly, there is significant interest in the perceptions and attitudes of various groups on a wide range of topics. While there is significant interest in perceptions and attitude, there seems to be little clarity on exactly what these terms mean. Because these two terms appear together so frequently, there appears to be a consensus that the two concepts are “two sides of the same coin.” Attitude and perception are closely related, but different, concepts. While the frequency with which they are used together suggests that they are different, in general practice, the two terms tend to be used somewhat interchangeably. They are different.

Attitude

Allport (1935) noted that the term “attitude” is a highly abstract term that has “come to signify many things to many writers” (p. 798). Webster defined attitude as a “feeling or emotion toward a fact or state” (attitude, n.d.). Stating the case more simply, Pickens (2005) explained that an attitude is a “mindset or a tendency to act in a particular way due to both an individual’s experience and temperament” (p. 44). Attitudes reflect both how we see a situation and how we act toward it. Building on this basic definition, he noted that what we understand as “attitude” is the interaction of beliefs, values, motivations, and personality. Attitude may include not only what we think about a topic (our point of view), but our feelings toward that topic (the emotions we attribute to the topic), and the actions we take relative to the topic (our behavior) (Pickens, 2005). But the concept of “attitude” has changed over the years. Allport defined attitude as a “mental and neural readiness, organized through experience, exerting a directive and dynamic influence upon the individual’s response to all objects and situations with which it is related” (p. 810). Bohner and Schwarz (2001) traced the evolution of the term from Allport’s encompassing definition of attitude as both a mental process and a behavioral response to Bem’s definition of attitudes as “likes and dislikes” (as cited in Bohner & Schwarz, 2001). Bem’s definition speaks only to the evaluative aspect of attitude without the corresponding responsive behavior, a view shared by Eagly and Chaiken (as cited in Bohner & Schwarz, 2001).

Perception

Perception is generally associated with the senses. That is, we perceive the environment through the senses of sight, sound, touch, taste, and smell. But more than simply sensing, we interpret those sensory experiences; we give them meaning. We experience a thermal sense as hot or cold, pressure sense as hard or soft, rough or soft, and so forth. Pickens (2005) explained

that how a sensory input is interpreted depends on one's prior experiences. This, he notes, may result in the individual ascribing a meaning to an input that is significantly different than its reality. He further pointed out, basing his assertion on the work of Sherif and Cantril (1945), that one's receptiveness to a given stimuli is selective and is rooted in beliefs, values, motivations, attitude, and personality. That is, processing external stimuli is limited by beliefs, experiences, and attitudes. Various definitions of the term allow for the inclusion of external stimuli that lie outside of the physical senses.

The Merriam-Webster Dictionary provides several definitions for perception that are useful here. The dictionary defined the term as an "awareness of the elements of the environment through physical sensation" ("Perception," n.d.b). This definition supports the assertion that perception is of the senses but in using the phrase "elements of the environment" leaves open the possibility of including non-sensory inputs such as experiences and beliefs. Another dictionary definition is that it is the "physical sensation interpreted in the light of experience" ("Perception," n.d.b) This brings us closer to the notion that it is not merely the receipt of sensory stimuli that defines perception, it is its interpretation. Yet, again, it is defined as "a mental image" ("Perception," n.d.b). The Oxford dictionary online defined perception as a "way of regarding, understanding, or interpreting something; a mental impression" (Perception, n.d.a). Taken together, perception, when used in the context of "perceptions and attitudes," might be understood as a mental image, resulting from the interpretation of one's experiences in the environment, that reflects the individual's understanding of something.

Perceptions and Attitudes

In differentiating these two terms, one might say that perception is how we see, interpret, or give meaning to something while attitude is how we feel about it and act toward it based on

our perception of it. Thus, perceptions are among the antecedents to attitudes. If we understand how a thing is perceived, we may gain insight into the attitudes attendant to it. Within the context of this study, how nurses perceive the BSN contributed to their attitude toward the degree.

Theoretical Foundations: The Theory of Planned Behavior

To achieve the “80 by 20” goal, increasing the number of RNs returning to school is imperative. While many studies have identified motivations and barriers to returning, these studies have failed to explain why a large portion of nurses choose not to return, nor do they satisfactorily explain why some nurses do return to school while others, often facing the same motivations and barriers, do not. I believe that the answer lies not in the expressed motivations or barriers related to continuing, but in the beliefs, attitudes, and values that the nurse holds toward the BSN.

Returning to school is an intentional act. The student makes a conscious decision to both return to, and remain in, school. This intention to act, according to the Theory of Planned Behavior (TPB), is the result of a combination of the individual’s attitude toward the act, their estimation of the value of the act to their significant others, and their perceived control of the act (Ajzen, 1991). In general, the nurse is more likely to return to school if they hold a positive attitude toward the degree; the people important to them, such as family and friends, express value in the degree; and they feel that they have at least partial control over the outcome.

The Theory of Planned Behavior grew out of Fishbein and Ajzen’s earlier Theory of Reasoned Action (TRA) which, in turn, is grounded in the work of social psychologists such as Bandura’s concepts of Self Efficacy (Fishbein & Ajzen, 1975). The Theory of Reasoned Action, proposed by Fishbein and Ajzen in 1975, provided a model for understanding and predicting behavioral intent. The TRA proposed that one’s actions could be predicted based on one’s

intention to act. The stronger the intention, the greater the likelihood of action (Ajzen, 1991). Critics of the TRA, however, noted that the intent to act did not necessarily predict actual behaviors, limiting the utility of the TRA for predicting actual behavior (Ajzen, 1991). Specifically, the TRA failed to account for a strong intention to act limited by factors over which the individual may have little or no volitional control. To compensate for this, Fishbein and Ajzen developed the Theory of Planned Behavior which took in to account the amount of volitional control the individual can exert over the decision to act.

The TPB has provided the theoretical basis for hundreds of studies ranging from exercise behaviors (for example, Hagger & Armitage, 2004), to nursing student attitudes toward continuing education (for example, Altmann, 2012). As noted earlier, how nurses perceive the BSN plays a role in the attitudes they hold toward the degree. The TPB helps explain how those attitudes, in turn, influence the decision to return to school.

The TPB suggested that attitudes “develop reasonably from the beliefs people hold about the object of the attitude” (Ajzen, 1991, p. 191). These beliefs, in turn, are rooted in the group of characteristics, other objects, experiences, and outcomes with which the object is associated. According to Ajzen (1991), while people might hold many beliefs about a behavior, they can only attend to a small number at any point in time. Ajzen (1991) referred to this limited belief set as *salient beliefs*, noting that these salient beliefs are the primary determinants of intention and action. Ajzen (1991) identified three categories of salient beliefs: behavioral beliefs which influence attitude toward a behavior, normative beliefs which underlie the subjective norm, and control beliefs which are the foundation for how one perceives control over an action.

Behavioral Beliefs

Within the Theory of Planned Behavior, behavioral beliefs are based on the Fishbein and Ajzen's Expectancy-Value model of attitudes (Ajzen, 1991). This model posited that attitudes are based on associations drawn between the object of that attitude and certain attributes, such as other objects, characteristics, or events related to that object about which we already hold some belief. Associating a behavior, for example, with previously valued attributes or characteristics automatically bestows that behavior with the values, beliefs, and attitudes we hold toward those previously valued attributes. Through this process, Ajzen says, "we learn to favor behaviors we believe have largely desirable consequences and we form unfavorable attitudes toward behaviors we associate with mostly undesirable consequences" (1991, p. 191). If, for example, a nurse already holds the belief that her nursing knowledge is adequate to the task at hand, her attitude toward additional training on that task is likely to be negative. She does not believe that the training will be of benefit (a negative association), thus her attitude toward the training will be negative and she is less likely to pursue that training.

Normative Beliefs

Normative beliefs, the second set of beliefs that influence the intention to act, situate the intention to act within the social sphere. Normative beliefs are concerned with the likelihood that people or groups who are important to the individual will approve or disapprove of a particular behavior. These beliefs give rise to the subjective norm which is the individual's perception of how positively or negatively the significant others in his or her life values the object (Fishbein & Ajzen, 1975). The TPB asserted that when an individual believes that the important people in his life view a particular action in a positive light, he is more likely to take the action. Alternately, he is less likely to act when he believes that the important people view the action negatively. In a

sense, this could be conceived as a form of peer pressure as the individual seeks to act in a way that would be viewed positively by those whom he or she values.

Control Beliefs

The third factor of behavioral intention is what the TPB referred to as control beliefs (Ajzen, 1991). These beliefs reflect the degree to which the individual perceives an ability to express volitional control of the situation. These beliefs include factors such as the availability of necessary resources and opportunities, as well as the individual's sense of how successful they will be in their efforts (Ajzen, 1991), what Bandura (1978) would call self-efficacy. Past experience with an action, for example, prior educational experiences, exerts an influence on control beliefs. So, too, does second-hand information from others, such as friends or family members, who share their own experiences with the action. Ajzen (1991) also noted that control beliefs include the influence of non-specified factors that may increase or decrease the perceived difficulty of carrying out a specific action. Control beliefs lead to what is termed Perceived Behavioral Control—the degree to which individuals believe they control the situation.

Intentions

The TPB assumed that intentions capture the motivational factors that influence action, including the degree to which the individual is willing to try the behavior and how much effort they plan to give in performing the behavior. The TPB noted that “as a general rule, the stronger the intention to engage in a behavior, the more likely should be its performance” (Ajzen, 1991, p. 191). Intentions are combined with perceived behavioral control to predict the likelihood that an individual will engage in a particular behavior.

Taking Action

The TPB asserted that taking some action is the result of a combination of intentions and perceived behavioral control. These factors have been described above. An additional factor must also be considered: actual control. As its name implies, perceived behavioral control is rooted in the beliefs that the individual holds with respect to controlling or influencing the factors attendant to a behavior. The more an individual believes he can control the situation the stronger will be his perceived behavioral control for that action. Yet, perceived control and actual control may not be consonant. The person may believe they have more, or less, control than they actually do. Actual control represents the non-motivational factors that impact an action. These factors include the availability of resources such as time and money, the cooperation of others, or possession of the requisite skills, as well as the opportunity to act. Thus, in the absence of opportunity or the money necessary to act, the individual may be unable to act despite a strong intention and positive level of perceived behavioral control. As Ajzen noted, though, “[t]o the extent that a person has the required opportunities and resources, and intends to perform the behavior, he or she should succeed in doing so” (1991, p. 182).

The Theory of Planned Behavior is concerned with predicting behavior by examining the interaction of the antecedents to that behavior. Although this study was concerned with identifying the perceptions that nurses hold toward the bachelor’s degree in nursing and the factors that influence those perceptions, the need to identify those perceptions and factors is rooted in the need to encourage nurses to return to school. This study was designed to provide insight into the antecedents to the nurse’s decision to return to school by examining the nurse’s perceptions of and resulting attitudes toward the degree. This insight, in turn, might be used by nursing leaders to design interventions aimed at addressing those perceptions and attitudes.

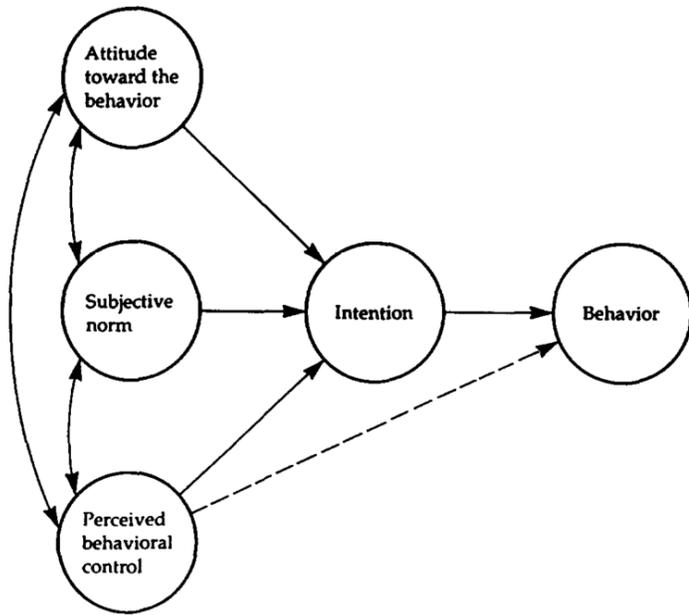


Figure 1. Graphic of the Theory of Planned Behavior (adapted from Ajzen, 1991).

The TPB provided an explanation of the factors that influence behavior—in this case, the behavior of returning to school; one of those factors is how the behavior is perceived. In choosing the TPB as the theoretical basis for this study I was acknowledging that understanding the antecedents to a behavior is necessary in order to influence that behavior. The three beliefs reflected in the Theory of Planned behavior provided the guiding framework for developing both the research questions and the questions used in the interview protocol. Behavioral beliefs, for example, provided the foundation for the first research question, exploring the perceptions that the nurses held toward the BSN. These beliefs also drove several of the interview questions that were aimed at exploring the perceptions that the nurse held of the BSN, and, if they had completed their BSN, in what ways, if any, that view changed once they had completed their degree.

Normative beliefs provided the foundation for the second research question, exploring the factors that influenced the nurses’ perceptions. While external factors such as job opportunities,

financial, and familial considerations were expected and encountered, I was also hoping for responses that showed how the nurses' perceptions were influenced by how others, such as family members, friends, and colleagues, saw the degree. With this in mind, questions that explored whether the nurse was aware of any particular attitudes their significant others held toward the degree and whether these individuals encouraged a particular educational path were included in the interview questions.

Control beliefs were not directly addressed in the research questions, though these were indirectly addressed by asking of those nurses who returned to school, what they expected from the experience. Failing to directly address this factor was, in hindsight, an omission on my part. My primary interest in this study was in how the nurses perceived the degree and the factors that influenced those perceptions. Although I did not directly address this factor, the influence of control beliefs was evident in the nurses' stories. For example, in their stories, several of the participants described how the lack of access to baccalaureate education influenced their decision to attend an AD program. Others explained that they delayed pursuing their BSN owing to financial concerns. And, of the nurses who returned to school, none expressed ever harboring doubts about their ability to complete their degree. All of these are identified as contributing factors to control beliefs, according to the TPB.

Conclusion

Various researchers (for example, Altmann, 2012; Duffy et al., 2014; Lillibridge & Fox, 2005; Megginson, 2008) have identified the need for further exploration of nurses' attitudes toward the BSN in order to better understand, and to provide a more complete picture, of the motivations nurses have for returning to school. The Theory of Planned Behavior is well suited as a theoretical framework to guide this study as it suggested that in order to understand the

nurse's intent to return to school it is necessary to identify and understand the antecedents to that intent—the attitudes, subjective norms, and perceived behavioral control relative to returning to school.

CHAPTER 3: METHODS AND PROCEDURES

This chapter presents the methodology used in conducting this study. Included in this chapter is a review of the purpose of the study, a discussion of the research design, a description of the desired sample population and procedures used to recruit participants, a description of the procedures used to conduct the interviews and analyze the data, ethical considerations, acknowledgement of personal biases, and concludes with a general description of how the findings are presented.

Purpose of the Study

The purpose of this study was to explore nurses' perceptions of the BSN and the factors that influence those perceptions with the aim of informing activities designed to support and encourage nurses in returning to school. Lewin's Force Field Analysis theory suggests that people only change when they feel the need for change (Coghlan & Jacobs, 2005). Expectancy-Value theory (Wigfield & Eccles, 2000), a pre-cursor to the Theory of Planned Behavior, identifies utility value as the way in which an action fits into the individual's future plans, providing motivation for achieving some extrinsic goal. These two concepts suggested that so long as the nurse perceives no benefit to pursuing further education, they are unlikely to do so. Conversely, the more strongly the nurse perceives a benefit to further education, the more likely they are to return. The influence of attitude toward an action, such as returning to school, is one of several factors that Fishbein and Ajzen (1975) have identified as instrumental in the decision to act. Thus, exploring nurses' perceptions of the degree provides insight into to how the benefits, or lack of benefits, are perceived and may influence the nurse's decision to return to

school. This insight is important as nurse leaders strive to find ways to encourage nurses to return to school. When nursing leaders are aware of these perceptions and their resulting attitudes, new ways of promoting continued education that focus on the needs of the nurses, rather than those of the organization, may be developed.

Perceptions do not develop in a vacuum but are the products of one's beliefs, values, and experiences. Understanding the beliefs, values, and experiences that influence the perceptions nurses have of the BSN provides insight into how those perceptions might be changed. This understanding, as with the understanding of the perceptions themselves, may identify opportunities to promote the pursuit of further education that had not previously been considered.

Research Design

A qualitative research design that incorporated a semantic approach to thematic analysis of data collected using a semi-structured qualitative interview was used to describe the ways in which Registered Nurses perceived the BSN degree and to identify the factors that influenced those perceptions. While the literature has presented numerous studies purporting to explore nurses' attitudes toward further education, and specifically toward the BSN degree, these studies have generally only identified the direction in which these attitudes move, they have not described the actual attitudes and perceptions that nurses hold toward the degree, nor have they identified the underlying factors that drive those attitudes. Knowing the direction of movement is not enough if we are to effect change; we must understand what brings about that movement. The qualitative interview was designed to elicit the perceptions that nurses hold and to expose, to the extent possible, the factors that the nurses believe influenced those perceptions.

Qualitative research is about understanding the perceptions and experiences of individuals and the meanings they ascribe to those perceptions and experiences. But more than

that, qualitative research is about situating those perceptions and experiences within the individual's unique set of circumstances (Creswell, 2014; Munhall, 2012a; Stake, 2010).

Munhall (2012a) asserted that the qualitative researcher wants to understand the totality of an individual's experience: what happened in an event, how they experienced that event, how they felt about the event, what that experience means to the individual, and what they want. Stake (2010) offered a similar description of qualitative research noting that it focuses on the meanings of human events from different points of view, that it acknowledges the contextual uniqueness that surrounds those events, and that it seeks out the uniqueness of the experience. These descriptions of qualitative research fit well into the goals I had for the study.

Qualitative research is also seen as a way of thinking (Creswell, 2014; Munhall, 2012a; Stake, 2010). It is not a fixed way of thinking, but "a grand collection of ways" (Stake, 2010, p. 31). Those ways of thinking are "interpretive, experience based, situational, and personalistic" (Stake, 2010, p. 31). Stake noted that each researcher will conduct qualitative research differently, though always striving to present each participant as an individual, and to capture the complexity of the participants' backgrounds, all while finding the common threads between them.

A third characteristic of qualitative research is that it is evolutionary. Virtually all aspects of the study are subject to change as the study unfolds, new data are gathered, and new ways of understanding the research questions emerge as the data are considered. Creswell (2014) referred to this as the emergent nature of qualitative research. Whatever else about the study may change, the desire to learn about the issue being investigated through the eyes of the participants remains. This evolutionary process was evident in this study. At the heart of this study was the desire to identify ways to encourage nurses to return to obtain their BSN. The study began with the notion

of exploring the attitudes, beliefs, and values that nurses held toward the BSN. That general focus did not change. The desired population did change as the study progressed, from those who chose not to return to a more general population of nurses whose initial education was at the AD level, regardless of subsequent education. This population was adapted again as a nurse whose initial preparation at the BS level showed enthusiasm for the project and was interviewed. Her interview led to changes in the interview process that allowed me to dig more deeply into perspectives she provided that I had not anticipated.

Taken together, these descriptions suggest that there is no “right way” to do qualitative research. Each researcher will conduct his/her research differently, initially based on the goals the researcher sets for the study and the researcher’s way of thinking, then adapted to meet the fluid nature of the data the research exposes. While Holloway and Todres (2003) noted that approaches to qualitative research are imprecisely defined and the lines between them often blurred, Stake (2010) noted the goal of qualitative research is always to capture the individual behind the data and all of the complexities that individual represents even while striving to find the threads of commonality between each study participant.

While the study was driven by the research questions which were, in turn, derived from the conceptual framework, I recognized that the most efficient way of understanding the responses to the questions was to understand the context surrounding those responses. For that reason, I allowed the interviews to proceed according to the participant’s preferences, with occasional redirection from me to keep the interview moving forward. This allowed the participant to provide more background or context around their answers than I might otherwise have been able to obtain.

From a qualitative perspective, individual nurses have a unique experience of their nursing education and practice. How they perceive the education and practice of nursing is influenced by a multitude of personal, social, and experiential factors. To begin to understand how nurses perceive the BSN, and to understand the influences on those perceptions, I recognized that I would need to understand not just what they thought, but the circumstances, experiences, and beliefs that created that nurse's situation. That is, it was necessary to hear their stories in their words. Every nurse's motivation for entering the practice of nursing is unique. Every nurse's reason for pursuing further nursing education is different. This is their truth. As Munhall (2012a) pointed out, "[o]nce we understand the interior (subjective) world of the individual or culture, we have accomplished the first step of knowing the truth, the meaning, and the interpretation from the source" (p. 21). That source is the individual, for only they know their truth. I chose a qualitative approach to the research questions because I wanted to hear, in their words, their thoughts and ideas. I wanted to hear, in their words, their understanding of the factors that influenced those thoughts and to draw from their stories the common threads that contributed to their view of the BSN.

The Qualitative Interview

Data for this study were collected using a qualitative interview process that consisted of a series of semi-structured questions. The semi-structured interview is one in which the participants are asked to speak to a specific set of open-ended questions (Jamshed, 2014). Rubin and Rubin (2005) emphasized that the qualitative interview is a conversation, albeit a focused one. During the interview process, the interviewer sets the initial direction, the interviewee determines the specific path the conversation follows. The qualitative interview allows the participant to provide a richly detailed accounting of their perceptions and the meanings they

ascribe to those perceptions. Thus, the use of open-ended, semi-structured questions allowed the participant the freedom to fully express their thoughts, while allowing the interviewer to maintain the focus of the conversation on the purpose of the interview. The depth of detail provided by these accounts allowed me to develop a more complete picture of what these nurses think about the BSN.

Thematic Analysis

Thematic analysis is a process for “identifying, analyzing, and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 83). Braun and Clarke (2006) laid out a six-step process for conducting thematic analysis: familiarize yourself with the data, generate initial codes, search for themes, review themes for “fit,” define and name themes, and produce the report (Braun & Clarke, 2006). Each of these steps will be more fully explained below. Given the range of approaches to qualitative research, Braun and Clarke (2006) suggested that thematic analysis should be the method that forms the foundation for qualitative analysis. “It is the first qualitative method of analysis that researchers should learn, as it provides core skills that will be useful for conducting many other forms of qualitative analysis” (Braun & Clarke, 2006, p. 81). Considering the steps outlined above, the processes described by Rubin and Rubin (2005) and by Miles, Huberman, and Saldaña (2014) appear to fall into the category of thematic analysis, each describing similar approaches to data analysis, though neither specifically described their processes as such.

Conducting thematic analysis, as laid out by Braun and Clarke (2006), involves six steps:

1. Familiarizing yourself with the data. This step may begin with transcription of the audio recordings. Wuest (2012) and Braun and Clarke (2006) recommended transcribing the recordings yourself, as this brings you closer to the data and allows you to begin the process of

analyzing and interpreting the data. Once transcribed, the data should be read through several times so that the data are familiar to you. Braun and Clarke urged reading in an “active way.” That is, while reading you are searching for meanings and patterns.

2. Generating initial codes. Coding is based, in part, on the initial set of ideas about what is in the data and begins the initial process of organizing the data. How data are coded depends on whether the researcher chooses to approach themes from a theory-driven or data-driven perspective. Data-driven approaches simply identify and create codes as they arise in the data. Theory-driven approaches generally code around specific questions that the researcher has in mind.

3. Searching for themes. This step involves organizing the codes, and their corresponding extracts, into potential themes. During this phase you begin the process of analyzing your codes, considering whether codes may combine into overarching themes. Creating a map of the relationships of the codes is suggested here.

4. Reviewing themes. Once an initial set of themes has been developed, further refinement is needed. During this step, the extracts for each theme are read to determine if they form a coherent pattern. During this process, some themes may be abandoned, merged into another theme, new themes created, or a problematic theme may be reworked. This step also involves evaluating the themes within the context of the entire data set. Re-reading the data set at this point is necessary to ensure that the identified themes accurately reflect the overall data set. Additionally, new themes may be identified in the re-reading for which additional coding is needed. The process of coding and theming is an iterative process with no clearly defined endpoints. The process should only continue so long as the process continues to add substance.

5. Defining and naming themes. Defining themes, according to Braun and Clarke (2006), involves identifying the core concept within the theme. That is, what the theme is all about and what facet of the data is being represented by the theme. Detailed analysis is conducted for each theme. This analysis should include the story the theme tells, together with an explanation of how the theme fits into the overall story about the data, and how it fits into the research questions. The end result of this stage is a set of themes that can be easily described in a sentence or two (Braun & Clarke, 2006).

6. Producing the report. This final step in the process represents the final analysis of the data. Writing up the analysis should be done in a clear, logical, interesting way that demonstrates to the reader the value and validity of the study.

The Theory of Planned Behavior provided the foundation for coding the interview data. The characteristics of each of the three salient beliefs were used to develop the initial set of codes. This approach allowed me to begin the process of grouping the codes in a way that permitted me to consider the data within the context of the TPB. Once the data were coded, I was able to interpret the nurses' responses within the context of the three beliefs.

Ethical Considerations

Prior to initiating the study, approval from the Institutional Review Board (IRB) of the University was obtained (Appendix A). All participants were required to provide informed consent prior to participating in the study. The informed consent document included an explanation of the participant's role in the research and of the rights they have with respect to the study (Appendix B). At the beginning of the interview, they were reminded that participation was voluntary and that they could choose to end the interview, or withdraw from the study, at any time. No vulnerable populations were identified for this study.

Mindful that my behavior during the interview reflected on the university, I maintained a relaxed, but professional, demeanor in all interactions with participants. My goal was to leave each participant with a positive impression of the university and of the study. During the interview process, participants were asked to share their ideas, thoughts, beliefs, values, and experiences related to their continued education and perceptions of the BSN. All interviews were recorded to facilitate transcription. Several steps were taken to protect the privacy of all participants. Participants were reminded that the recordings, and any transcriptions of those recordings, would be held in strictest confidence.

Original recordings of the interviews and the digital transcripts of those recordings were stored in a password-protected folder on my desktop computer. A backup copy was created and kept in a separate password-protected folder on another computer owned and accessible only by me. Printed transcripts were stored in a locked safe. Neither the recording nor the transcripts will be shared with anyone other than the researchers. These files will be retained for 7 years, after which they will be physically destroyed.

Although participants were asked to share their perspectives, beliefs, and experiences related to continued nursing education, the focus of the study lacked the level of personal exposure that might lead to physical or psychological harm. Moreover, what was shared was ultimately determined by the participant. Thus, no untoward effects were anticipated with this study.

Participants were assured that no personal information will be published. Alternate names were assigned to all interviewees to further protect participant privacy. Participants were sent a copy of the transcription to validate that their privacy was protected and that the transcriptions were correct.

Sample Population and Recruitment

The population of interest in this study was English-speaking Registered Nurses practicing in the United States whose initial nursing education was at the Associate Degree level. In addition, to avoid potential cultural differences in how education is perceived, nurses whose initial education was obtained outside the US were excluded. To gain insight into how BSN education may have altered the perception of the degree, nurses who were either currently in school to complete their BSN or had already completed their BSN were included.

Recruitment

The initial inclusion criteria had limited the study population to non-BSN nurses who did not intend to return to school. This population proved problematic, as I was unable to recruit participants. Outreach to six local hospitals relied on cooperation from intermediaries, in the form of hospital-based nursing administrators and educators, to approve recruitment efforts within their facility and to disseminate recruitment materials within the facilities. Where nursing administrators were not supportive or indifferent to the study, recruitment was stymied. Where administrators were supportive, I was still limited to the numbers of staff within that facility.

A second approach involved mailing recruitment postcards to nurses' home addresses, a process that was both costly and poorly aimed. The information provided by the State Board of Nursing in Georgia did not include educational preparation, which meant that I was unable to filter out nurses whose initial educational preparation would exclude them from the study. In considering the lack of response to these efforts, I suspect that they failed because those nurses who are not interested in returning to school are also not interested in discussing their decisions or in contributing to research aimed at encouraging nurses to return.

To cast a wider net and to increase my chances of success in recruiting participants, I reconsidered my goals for the study. Because I was interested in how nurses perceived the degree, I recognized that all non-BSN prepared nurses, including those who did return, would hold some perceptions and that their early perceptions might be instructive. Consequently, I revised my criteria to include AD- and diploma-prepared nurses, regardless of other educational preparation. Recruitment then aimed for a target population consisting of a convenience sample of 5 to 12 Registered Nurses, recruited from a variety of sources, including the alumni of a national online university, outreach to the alumni of on-ground schools of nursing, and recommendations from colleagues. Interestingly, local hospitals expressed little interest in the study and I had difficulty getting return calls from several of them. One hospital was quite supportive in communicating the study to their nurses, but no responses were obtained from that effort.

I altered my recruitment efforts to include social media. Primary recruitment outreach was accomplished using posts on several Facebook groups announcing the study. The posts were short and pointed interested persons to a webpage that provided a copy of the informed consent that described the study, my contact information for further information, and a means for signing up to participate in the study. The Facebook posts were shared by multiple people, extending the outreach of the study and exposing the recruitment notice to a far wider audience, increasing the numbers of potential candidates.

The recruitment announcement on social media sent interested people to a webpage that outlined the study and described the criteria for participation. This allowed the individual to self-select for the study. If they believed they fit the criteria, they completed a brief sign-up form that notified me of their interest. I followed up with a copy of the consent form which I asked them to

sign and return via email. I also included the inclusion criteria again to ensure that the participant identified themselves as appropriate for the study.

All nurses who met the inclusion criteria were offered the opportunity to participate. Eleven individuals showed initial interest. Of those, seven completed the sign-up process and actually participated in the study.

Table 1

List of Participants

<i>Name</i>	<i>Age</i>	<i>BSN</i>	<i>Initial Education</i>	<i>Other Education</i>	<i>Sex</i>	<i>Years of Practice</i>
<i>Darla</i>	58	No	AD	No	F	34
<i>Grace</i>	73	Yes	AD	BS/MS Hospice	F	33
<i>Katie</i>	45	Yes	AD	AS equine management	F	22
<i>Leila</i>	56	Yes	Diploma	No	F	33
<i>Paige</i>	62	Yes	AD	MEd	F	38
<i>Patty</i>	39	No	AD	No	F	18
<i>Susan</i>	33	Yes	BSN	No	F	10

Interview Protocol

The study used an interview protocol to guide the interview process. The protocol provided a general framework for the interview, though participants were encouraged to expand on their responses. Throughout the interview process brief, hand-written field notes were maintained to highlight areas that needed further elaboration or follow-up, or to note themes that emerged during the interview. The full interview protocol is presented in Appendix C. The protocol was adapted to explore topics that I believed required further study based on participant responses. In addition, a personal journal noting my thoughts and reactions to the interview responses was maintained to protect against the influence of the researcher’s personal values and beliefs on the interviewee’s responses. These field notes also provided additional content to be considered in the coding and interpretation of the data.

Data Validation

Following each interview, I transcribed the recording, verbatim. The transcription was then proofread while listening to the recording to ensure accuracy. A copy of the interview transcript was sent to the participant for validation to ensure that the transcript accurately captured what the participant said, or intended to say, during the interview. None of the participants indicated the need to revise the transcripts. One participant did provide additional information via email.

A summary of each transcript was created that edited out discussions that were unrelated to the research topics. These contributed to the analysis of the data, allowing easier comparison of ideas, concepts, and themes across studies. These summaries were also shared with the participants to validate that their main thoughts were captured appropriately.

Data Collection

Interviews were conducted between December 16, 2017 and January 16, 2018. The recruitment materials remained active until January 25. At that time, there had been no activity on the website for 1 month and the recruitment website was shutdown.

In all, 11 individuals showed interest in the study and were sent a response email that included a copy of the consent form and a link to a booking site that would allow the participant to set a time and date for their interview. Instructions for signing and returning the consent form were included in the email. Seven participants returned the signed consents and booked interview appointments. Although the target population for this study was nurses whose initial education was at the diploma or associate degree level, one individual, Susan, whose initial education was at the BSN level was included. The decision to include Susan was based on her level of enthusiasm for the project and because I recognized that having the perspective from the “other

side” might provide more insight into factors influencing how the BSN is perceived. As it turned out, this decision was fortuitous as she exposed a factor that I had not considered and was not otherwise expressed. The interview protocol was adjusted to include a question on what differences the nurse saw between BSN education and AD education. The responses were enlightening.

Individual Interviews

Participants were geographically dispersed with two originating in Nebraska, two in New Jersey, one in Georgia, one in Florida, and one in Kentucky. Given their geographic dispersion, all interviews were conducted via telephone from my private home office. The participants joined from the location of their choice. All interviews were recorded using two digital voice recorders to protect against accidental loss or technical failure. Once transferred to the password-protected folder on my desktop computer and to the password-protected folder of the backup computer, the digital files were deleted from both recording devices.

Data Analysis

Following Miles et al.’s (2014) recommendation that data collection and data analysis occur concurrently, I took several steps to analyze the data during the data collection period. During the interview process, I listened for the meaning behind the speaker’s words and often asked for clarification or for validation of my understanding of their meaning. This approach also provided me an opportunity to follow new lines of questioning that I felt might be fruitful in digging more deeply into their thoughts. An example of this is the adjustment made to include a question on the nurse’s understanding of how the programs differed in their academic offerings, a result of the interview with Susan, the BSN-prepared nurse.

Following each interview, I transcribed the recording myself. Wuest (2012) suggested that transcribing interviews yourself brings you closer to your data. I found this to be true, as the process of transcribing forced me to carefully think about what the participant was saying. This allowed me to see several concepts that I had not noted while the interview was in progress. Following the transcription, a summary of the interview was created that allowed me to focus on the key elements that each participant identified.

As an ongoing process, I read through the summaries of prior interviews as recommended by Rubin and Rubin (2005) prior to the next interview in order to keep fresh in my mind what others had said so that I could follow up, where needed, on the ideas they identified. In keeping with Braun and Clarke's (2006) first step of thematic analysis, once the interviews were completed, I read through them as a group to develop more coherent descriptions and to begin to develop themes that answered the research questions. The transcripts were read multiple times as I continued to identify concepts and themes that were common to most of the interviews.

Step 2 in the thematic analysis of the data began once all of the interviews were transcribed and read through. In this step, coding of the data was initiated. Rubin and Rubin (2005) suggested that the codes used should match the research purpose, analogous to Braun and Clarke's (2006) theory-driven approach. Field notes made as I read and re-read the interviews allowed me to identify specific topics which were appropriate for coding. A coding schema, structured around the research questions and reflecting a hierarchy of concepts appropriate to the content, was developed. Each interview was then coded using this schema, with additional codes created when necessary. Because the initial research questions were derived from the three aspects of the Theory of Planned Behavior, the development of the initial coding schema necessarily took into account these factors.

Coding was initiated in the software program, NVIVO 11, which is designed to aid in the management and manipulation of qualitative data. The learning curve for NVIVO is steep. Consequently, I decided to move the data into an Excel spreadsheet where I could more easily visualize and sort the data. This also allowed me to organize the data into multiple levels that represented specific concepts that made up the themes and subthemes within the data.

Step 3 moved the analysis away from the relatively granular level of coding to the broader level of themes. The codes were sorted into potential themes together with the relevant coded extracts. The potential themes were organized using manual mind-mapping on a dry-erase board. Analysis at this stage required that I consider the relationships between the codes and between the potential themes. During this phase, I began to consider which codes, or groups of codes, represented appropriate themes. On completion of this stage, I had identified six themes and four subthemes.

Step 4 involved reviewing the extracted data for each theme to evaluate its “fit” for that theme. During this step, the themes were revised and refined to ensure that each theme reflected the data associated with it. Two criteria were considered here. Did the data for each theme provide coherent and meaningful support for the theme? And, were the themes clearly distinct from each other? During this step, I identified themes that did not appear to work well. As a result, I returned to the data, reviewed the coding for each of the interviews, and coded additional material with an eye on the themes I had identified. Additionally, I identified one new theme. Throughout the process, the mind-map I used to organize the themes was revised and re-written multiple times as I combined related themes and reconsidered others. In the end, I identified eight themes and no subthemes.

Step 5 involved defining the themes with short descriptions of what each of the themes was about and considering what each theme captures about the data. Three important aspects of this step were to establish the relevance of each of the themes to the research questions, to consider both how the data supported, and were supported by, the conceptual framework, and to consider the relationships that existed between the themes. For this study, the research questions considered first, the perceptions that nurses held toward the BSN, and then the factors that influenced those perceptions. The scope of the themes identified was broad, yet each of them was clearly related to the research questions. As noted previously, the research questions were rooted in, and reflected, the salient factors of the TPB. As a result, the process of considering the data within the context of the research questions also led to the consideration of the data from the perspective of the TPB. The identified themes corresponded closely to the concepts of attitude beliefs and normative beliefs as described in the TPB. The influence of control beliefs, such as availability, financial concerns, and their perceived ability to be successful in their educational pursuits, were evident in their stories, providing support to the notion that perceived control beliefs influence the intention to return, as described in the TPB. Finally, there was considerable interaction between the themes, particularly where themes represented factors that influenced perceptions of the degree. This posed a significant challenge in clearly delineating the themes in ways that ensure that the themes represented the data in distinct and coherent ways. By the end of this step I had clearly defined and named themes.

Reflexivity and Acknowledgment of Personal Bias

Cutcliffe (2003) noted that it is “widely accepted that qualitative research is a reflexive process in that the researcher has an effect on the research and vice versa” (p. 136). That is, qualitative researchers are not simply channeling the “voice” of the participant but are active

partners in interpreting the participant's meaning (Braun & Clarke, 2006). How the research study was developed, the questions that were asked, and the meanings ascribed to the coding and theming of extracts are all products of the researcher's experiences, values, and perspectives (Creswell, 2014; Wolf, 2012). Reflexivity requires that the researcher examine their own values, thoughts, and perspectives on the research subject and to acknowledge the role these factors play in how the study is designed, interpreted, and reported (Wolf, 2012). Reflexivity brings credibility to the research not by mitigating the effects of the researcher's role in giving meaning to the data, but by acknowledging that role in a way that allows the reader to understand the researcher's influence on the results of the study by providing the background that contributed to the judgment calls the researcher made as the study progressed (Cutcliffe, 2003).

This research was initiated in response to anecdotal experiences I have had in a long history of working alongside AD- and diploma-prepared nurses and in working with RN to BSN students who shared their thoughts and frustrations with me. This long history of interaction with the subject matter necessarily influenced how I see the topic and the beliefs and values I brought to the study. These, in turn, influenced how I framed the research questions and the subsequent interpretation of participant responses. The choice of the Theory of Planned Behavior as the theoretical framework, which guided how I framed the questions and influenced how I interpreted the nurses' responses, was influenced by my experiences with the subject matter. The concept that attitudes toward the degree would influence their decision to return to school resonated with my prior experience with other nurses. I used reflexivity as a means for guiding the development and execution of the study. By providing the reader with background knowledge of my own experiences and perspectives, I can provide the reader with a means for determining the validity of the work.

As a practicing nurse, I understand the practical context within which nurses operate. I understand the importance of sound clinical skills in the practice setting. I am, in this respect, an insider to the process with knowledge that would be difficult for an outsider to access and appreciate. This intimate familiarity with the experience of nursing significantly influences my interpretation of the participants' responses, allowing me to "read between the lines" to infer meaning where no explicit statement was made.

My perspectives of how the BSN is perceived by non-BSN nurses is rooted in 35 years of experience working alongside these nurses and hearing their perspectives on the degree. They are rooted, too, in the many dozens of interactions I have had with RN to BSN students who voiced, sometimes vehemently, their belief that the degree was not needed. Consequently, I developed a view that many AD and diploma nurses did not see the BSN as important to their practice. Because they were already licensed and practicing Registered Nurses, I believed that they saw little benefit to returning to school. That is, my experience had taught me that they believed that they were already good nurses and did not see how the additional education would make them better nurses. Many of the nurses I had worked with also believed that there was no financial benefit accruing from their investment, making pursuit of the BSN unattractive from a financial perspective. That these points of view would be reflected in the data collected in this study was not surprising, given the many years of anecdotal evidence on which my own perspectives were based. I must also acknowledge that the risk of confirmation bias—looking for information from the participant that confirmed my preconceived beliefs—was real. With this in mind, I was careful to pose questions that allowed the participant to answer in their own words, without conveying an expected response. While the questions on the interview protocol were based in these assumptions, I aimed to ensure that the questions were not leading the participant to desired

responses. I deliberately used open-ended questions that allowed the nurses to provide their own stories.

In the end, the results of this study are the products of my own interpretation of the nurses' stories. My interpretation was guided by the theoretical framework of the Theory of Planned Behavior and influenced by my own background and experiences. My history of working with nurses and with RN to BSN students provided a context for situating participant responses. In turn, this context provided me a broader understanding of the perceptions nurses hold toward the degree than might have been drawn from the data alone.

Conclusion

This research study used a semantic approach to thematic analysis (Braun & Clarke, 2006) to explore and describe the perceptions and attitudes that nurses hold toward the BSN and the factors that influence those perceptions and attitudes. Data were collected using one-on-one interviews with a convenience population of seven nurses. Reflexivity provided a means for situating and interpreting the collected data leading to a coherent report of the study and its findings. Throughout the process, steps were taken to protect the participant's rights and to ensure that participant anonymity and confidentiality.

CHAPTER 4: RESULTS OF DATA ANALYSIS

This chapter presents the analysis and interpretation of the collected data. As part of the analysis of the data, each nurse's interview was condensed into a story that situated their perceptions of the BSN degree and the factors that influenced their perceptions of the degree within their own background and experiences. These stories provide insight into their experiences and help the reader to appreciate how their perceptions evolved. These stories are followed by the thematic analysis of the data. Although not fully intentional, the eight themes were organized into three groups that roughly correspond with the research questions and provide a framework for understanding how the nurses see the degree and how various factors influenced those perceptions.

Nurses' Stories

Darla

Darla is a 58-year-old nurse currently out on disability but whose normal employment, for the last several years, has been in case management. Her initial nursing education was at the AD level and she has been in nursing practice for 36 years. Though she has taken classes toward her BSN, she has not completed her studies and has no plans to continue. Her most recent classes were about 4 years ago. She has never considered any other field except nursing as a career.

When asked about how she saw the BSN, Darla related that her early perceptions of the BSN were not positive:

In my early days, I did not have a very high opinion of the baccalaureate program, or nurses. I found them to be just book smart. That was not what I was looking for personally. So, that's why I didn't do it in my early career. Then, later on, when I started

growing in my jobs, in like, education, I wanted to . . . I thought that by going back for my bachelor's it would make me better at what I was doing.

In response to her comment about the bachelor's making her better at what she was doing, I asked if she now felt that the BSN was a better nurse.

No, I didn't see it as a better nurse. But where I thought it would help me was more in my communication skills, in my writing skills, in dealing with difficult families and patients, and all that. Like, how could I do that better and more effectively? That's kind of how I looked at it.

From a clinical perspective, Darla felt that the BSN nurse lacked the skills necessary to be a "good nurse." In contrast, she held the diploma-prepared nurse in high esteem.

When I worked with them on the floor in my early career, I found that they couldn't perform and take care of patients. Because I worked in med-surg and all that. I worked with patient care then and I found that they [BSN nurses] could not perform better than—I hate to say this—the diploma nurses. I found them [diploma nurses] to be exceptional.

I was jealous that I didn't go to a diploma program because I envied those nurses. I thought that they were phenomenal. And then the next step up was the associate's nurse, who had the knowledge base behind what they were doing, which I was very comfortable in. And, I did not, I had very little respect—I hate to say that—for the bachelor's nurse. I found them just to be book smart; they couldn't perform. To me, go to management, get off the floor.

Her comments regarding the abilities of the diploma nurse suggested that she was measuring performance in terms of physical skills. "I think the diploma nurse had the skills—excellent skills—and developed the knowledge later on." She clarified that the knowledge the diploma nurse added was achieved through their work experience. She did not believe that the reverse was true, that the BSN nurse had the knowledge and later developed the skills:

Interviewer:

Would you say that the reverse is true? That the baccalaureate nurse came in with the knowledge and was able to add the skills? Or, do you feel like they didn't?

Darla:

Not in my early days, no.

Interviewer:

So you don't feel they ever really picked up the skills?

Darla:

No. To be honest, no. Not in any of the [state] based baccalaureate programs.

Darla was not totally disparaging of the BSN nurse, noting that BSN education appeared to have improved, but also suggesting that the combination of skills and knowledge obtained by the AD nurse who returned to school was worthy of admiration.

Then, over time, I think they changed the bachelor program a little bit, they must have, because they started producing better nurses. Although, the ones that had an associate's first and then went on for their bachelor's, I admired them more so than the one that went straight to a bachelor program.

Darla did add the caveat to her discussion that she did not work with many BSN-prepared nurses early in her career, stating, "Not a lot, but enough to base that opinion."

As noted earlier, Darla did return to school for her BSN. She shared that she "thought that by going back for my bachelor's it would make me better at what I was doing." She also voiced admiration for a colleague who had continued her education. She stated that she admired her colleague's ability to "put things together, and so easily." She also saw that her knowledge base was lacking in ways that prevented her from doing her best in the roles she held and from obtaining additional roles she sought.

At the time, education for example. I worked in education, I taught IVs; I wanted to be the Emergency Room Educator. That was kind of my goal. I couldn't do that with the knowledge base that I had. I wanted to, I wanted to learn more; I wanted to grow. I wanted to grow into the position. How could I—I'm really good at motivating people, but I lack some of the skills to teach because I didn't have that knowledge base behind me. Back then I couldn't even do a PowerPoint, yet [another nurse educator] would fly them out like they were nothing. And, I used to look at that and go, "I want to do that. I want to be that. I want to be able to put something together and have someone else benefit from it." I couldn't do that with where I was.

In exploring her experiences in the BSN program and her reasons for not continuing, Darla was very clear about her dislike for the BSN educational process.

Well, I took a couple of classes. I wanted to try an on-line one. I did one through University of _____; it was extremely hard, yet it was so basic I could have done it . . . I could have taken that class without opening the book. The only thing that I learned from it was that stupid way of writing. To me, it's a waste of time. It was such—I don't even remember the name of the course, but it was so—I could have taken that class with my eyes closed, but their demands were so intense, it ate up my life. I had no time to even

cook Thanksgiving dinner. I mean, I thought that was ridiculous for the class that I took. Then I took another one, what was it? Medical terminology . . . no, something stupid . . . uh . . . public speaking. I could have did [*sic*] that one with my eyes closed. Same thing. Same demands. You have to write something and support it with this and that and whatever. It was stupid. I learned nothing other than that stupid way of writing.

Then I said, alright, I'm going to try _____ University. I went to _____ University, took a class there. I forget what their first class is, but another waste of time. But the demands! All they do is teach you time management. That's all I learned: time management. Nothing from the class. And the instructor, of course she was a doctor, and she was, "Oh, you know, anybody below you is worth nothing. " She just put down the people that worked under you, including the associate's nurse and the LPNs and the aides. And I thought, "I don't want to hear this! No place can run without them." I don't know. It really turned me off, and to think that I was paying all that money to learn nothing. I learned nothing!

Darla's perceptions of the BSN appeared to be based on her experiences in working with BSN-prepared nurses in the work place along with her negative experiences in efforts to expand her educational foundations. Other than her admiration for the one colleague, who had continued her education, Darla did not express any particular influences by her colleagues, friends, or family.

In closing, Darla was asked to share any other thoughts that she felt were important to be captured. She reiterated some of her earlier comments:

When I think about the nurses that I work with, I just find the ones that have their associate's, or even . . . there's not many diploma nurses left—so I have to use the associate's when they have gone on to get their bachelor's. I just find that they make a much better nurse. Most of your associate's have bedside experience and I think that is more important than learning anything from a book. I think the bedside experience is really what helps somebody. Those that I see that go directly for their bachelor's—they're lacking something. They're really, they're lacking something. And I think the baccalaureate programs, they don't teach enough at the bedside. They don't have enough clinicals. That's my opinion, just working with these people, and I've been working in hospitals my entire career. Those that went straight to a baccalaureate program, I think they make not very good bedside nurses, so to me, the baccalaureate programs are missing something. They're too into the books. They need to do more at the bedside. That's kind of putting it in simple terms.

Grace

Grace is now 73 years old and has practiced nursing for 33 years. She is currently retired. Her initial education was at the AD level and she has since earned her BSN, as well as a BS and an MS in Hospice. Grace described herself as a late bloomer, having not started her nursing career until her late 30s. She had always wanted to be a nurse but familial obligations intervened, delaying her studies. Once her children were in their teens she returned to school, receiving an AD in nursing in 1984. She reported that she quickly became disillusioned with nursing.

I had the AD degree and I was thrilled to get that, but I hated it because it seemed like I was just doing task nursing. I mean, you know, it took me a little while to figure out, you know, God, I wanted to do this for so long, why am I hating it? But it was because I was doing tasks. I didn't know any of the 'why's' behind what I was doing. Or, if I did, it hadn't been taught to me. I had learned it because I had been an aide and different things like that and you have your own, you know, experiences.

I couldn't wrap my head around why I wasn't enjoying being a nurse until I finally realized that you don't know enough. You're safe and you're doing these things as long as you're following these rules and stuff, but why are you doing what you're doing?

Grace did not recall ever really thinking about the differences between the AD and BS nurse. In her early career she noted, "I don't think I really worked with that many [BSN nurses] when I first began nursing. So, I don't remember ever comparing or thinking about it." While she did not recall thinking about the BSN-prepared nurse during her early years, she did recall with respect her work with LPNs and diploma-prepared nurses.

I was actually working with more diploma nurses. And, we had team nursing, so there were a couple of LPNs that just staggered me. They were just amazing. You know, and things of that nature, so I thought, "why am I . . . you know, I feel so backward with them." I mean, not just doing the tasks, but you know, they were older, and they had learned. And, again, the diploma nurses had it all over everybody, I thought at the time.

When asked to clarify on what she was basing her assessment that the "diploma nurse had it over everyone," she replied,

Their competence. You know, I found that if I had a question, or something like that, I would go to Pearl rather than maybe a colleague. I don't know. They just took more time

and explained things and I just felt confident in their answers. It didn't seem like they used—they learned everything by rote like a lot of my nursing [AD prepared] colleagues at the time.

Grace reported that her family, in the form of her husband, was very supportive of her educational pursuits. Familial support took the form of encouraging her to achieve her goals, without a specific educational goal in mind.

I started a family sooner than I had anticipated and put everything on hold. When my youngest got to be 12 my husband said, 'okay, now you can go to nursing school.' I was like, "really?" And, he was just terrific. He . . . , yes, like when he said, "why don't you go take the testing and see." And then, 2 weeks later I was in nursing school. [H]e was sorry he ever did that because I never stopped going!

Grace also reported that her early efforts to continue her education were prompted by several factors, including her own desire to know more, and the support of her colleagues.

And, you know when I went for my first job, I worked at a rehab unit and they said, "okay, now here we follow the Dorothy Orem theory" and I said, "Who? What?" I had no idea what they were even talking about. And that's where they said, "okay, we need to get you for more schooling because you're interested." But, why they hired me . . . I think they hired me because I was older. But, anyway, that's what kind of put me up with this.

While her employer and colleagues in that first job were supportive, she reported that others were less supportive. When asked if her friends or colleagues encouraged her, she responded, "Absolutely not. I would explain things, or something, but no, they were . . . a nurse is a nurse is a nurse to most people." She continued,

Yeah. They didn't understand why you were putting more effort into it. I mean, I even had a colleague that already had a bachelor's in nursing and she was my manager for a while in hospice. And, when I had gone back for my masters in hospice she said, "why are you going for a degree when you're already working in it?" And I thought, "wow, that's archaic" but she was a diploma nurse. And I really admired her, but I remember her opening that discussion with me.

In exploring her expectations of the BSN educational experience, she expressed a desire to gain more knowledge.

I wanted all the different ramifications of nursing because that's something I still say to people: you can specialize, just like a doctor, you can specialize in something that you

really find that you like. Like, I knew right away that I didn't want OB or pediatrics or things like that, I thought, "okay." Didn't do well in psych. I couldn't grasp that. I just wanted everybody to get over it. I really . . . that was the hardest one for me to grasp, was psych. But it was so interesting to me, you know, getting a ballpark figure, you know a little bit of knowledge about each thing and then, when we went and had to put it into practice and did our field work, that was fascinating, so . . . yeah.

Beyond her expectation to be exposed to the different aspects of nursing, Grace noted that she did not come to the experience expecting it to be a repeat of her prior nursing education. She attributed this to a program at the university she attended that provided a clear view of what the program was all about. She noted that this helped her to both see the benefits of the BSN and to set appropriate expectations.

But I did go to an introduction. U of M held them 2 or 3 times a year. where you could go to an auditorium where "is the bachelor's degree for you?" or "whopat do you expect?" It was about an hour and they kind of went over all the different courses. I can remember the one nurse, she was describing doing dressings and she was saying the difference is we're not going to just teach you how to do the dressing, but why you have to do it this way. You know, and I thought, "That's what I want!"

Grace validated my observation that she went into the BSN experience expecting to learn more.

I realized that I didn't know everything, and I wanted to know a whole lot more. I didn't want to be in a situation where I didn't know what to do or, you know . . . At least recognize it, you know.

Although she began her career as an AD-prepared nurse, Grace holds a dim view of the AD nurse, expressing a clear view that the AD nurse should be eliminated.

I was really frustrated as an associate degree nurse and I really feel they should do away with them. I think it muddies everything up because I still get annoyed when . . . you know and I know that they sat for the RN test and everything, and it's nothing personal, but I really hate being an RN on the same plane when I spent so much time learning theory and all that sort of stuff.

I wouldn't mind if they did an associate degree and you got an associate degree, but you couldn't sit for your RN. You could get your associate degree and apply it to another school to go on for a BSN and RN.

Again, I think that everything else should be done away with and just have the baccalaureate. Or, like I said, you have to have a baccalaureate to sit for the RN. Just because of what I've seen and, you know, and . . . I think that you wouldn't have frustrated nurses that either act out because they don't know what they're doing and they haven't been able to identify that. Or, go above what they've learned and try to . . . try to . . . what am I trying to say . . . They lie their way through something rather than admit that they haven't a clue. Because they're an RN and they're expected to know these things. It's just . . . I just think . . . I don't know why they've continued with associate degrees. I really don't. Other than like, I get it, as far as the training. Like I say, I just don't think that you should sit for the same RN test as the bachelor's prepared.

Katie

Katie is a 45-year-old nurse who began her nursing career in 1995. She attended her AD program using scholarships from her employer, a university hospital. Her employer also offered scholarships for continuing her education and she had planned to go on to her BSN after completing her AD.

So, I went ahead and got a scholarship that was basically that the university would give me a stipend for the semesters I was in school and, you know, contributed to my books, uniforms, and all that. And, that was in exchange for my agreeing to work for them for I think one to two years when I graduated. So, all through nursing school I was working at this university medical center. And, I can honestly say during my nursing school time, I really, genuinely did love just about everything. One, because I was excited to be in the program and, two, in the back of my mind I thought, "well, I don't know where the university is going to need me, you know. If they need me in ER, well, that's fine, I'm going to do ER. If they need me in OB, that fine, I liked my OB rotation." I was very unattached to my specialty when I was in nursing school because I thought I was going to be working full-time there.

And, I was optimistic, especially when I got the scholarship from the university medical center, I was also kind of optimistic that if I needed higher degrees, that I would be empowered to do that without going into massive debt, you know, because I would be in a system and I was entering a profession that kind of valued that.

However, as she neared completion of her AD the market shifted, and her employer chose not to hire her as an AD-prepared RN. This experience had a lasting impact on her.

Well, about a week before graduation, I and the other scholarship recipients got letters in the mail, this would have been in '95. And the letters were very short and sweet and basically said, "The good news is you won't owe us any money. But the other news is, we're not hiring new grads." And, that was kind of a blow. I recognize, in reflecting back, that there was a piece of that, when I got that letter, there was a piece of that that was a

big letdown. I had not looked at other jobs, I had not applied anywhere else because, you know, in the back of my mind, you know, I'm committed to the university. So, the . . . what comes up for me even now all these years later is they didn't want me. They didn't want new nurses. So, I guess what I'm saying is, there's still a little raw spot for me around the traditional academic institution.

She had expected to continue her education with her employer, the university hospital, subsidizing her costs. Since she was unable to enter nursing practice at the university hospital in which she had worked while in school, she also no longer had an option for employer-based tuition support in continuing her education. Further, if she chose to continue her education at that time, she would be attending the university which, she felt, had betrayed her. She acknowledged feeling a bit rebellious about returning to school—particularly, that school—at that point:

But the way I saw my nursing career play out when I was in school was, "Okay, wow! I'm going to start working at my local university hospital, I'm going to get all this great experience. I don't know what specialty I'm going to be in but I'm going to be . . . and then I can probably go back to school because, being an academic hospital, you know, they're big on, you know, degree help. So, I was a bit of a rebel when I found out I wasn't going to work there, or at any other area hospitals.

She noted that this experience may have played into her perception of the BSN degree. She also noted other influences on her early perceptions of the degree. For example, she described how she and her classmates perceived how the BSN students with whom they interacted saw the AD nurse.

And I still kind of remember talking to my peers at the time and talking to other students in the bachelor's program and there is something about where we sat, the two-year nurses sat for the same boards, as the four-year nurses. So, my impression of the bachelor's at that time, and has probably colored over the years a similar one, that the bachelor's degree, and I don't want to say fluff in a way that it is perceived that I think it's fluff now, but I think even back when I was in the two-year program, there was a little bit of a disconnect. I and some of my peers kind of perceived that nurses who were in the bachelor's program thought, and of course this is pure projection, conjecture, that they thought they were better than we were because they were in a, quote, longer degree.

A theme that ran through her discussion was the desire to avoid excessive debt in obtaining her education. Noting that all nurses, regardless of educational preparation, took the

same licensing exam, she felt that the idea that a 4-year degree was “better” than a 2-year degree made no sense. They were both pathways to the same goal, with the choices having to do with the individual’s needs and circumstances. Achieving what she perceived as the same outcome while minimizing her costs made the AD an attractive option.

And I think myself and many of my peers, we kind of identified, or I kind of identified, as someone who was very motivated and driven and wanting to do well, wanting to be a really good nurse. But, kind of focusing on the bedside and kind of focusing on, you know, not being weighed down with a lot of debt. I was also in a class with a lot of non-traditional students, students who had other degrees—they were teachers, or social workers, or—and most them entered the two-year program for similar reasons. You know, they, too, had families to raise, they didn't have the money to be in a four-year program.

They too—and I’m not saying we were in it for the money, I think you understand that—I’m just saying we were in it with a sense of pride that, okay, we, I didn't have the money to be in school four years, but by golly I could do two and I was going to sit for the same boards and answer the same questions as the nurses that were in school two years longer were. And, then I was going to get the job experience and the work experience and then I would kind of get the other degrees in my own way and in my own time.

Katie did return for her BSN through an online program, completing it in 2017. She had reached a point where she felt the BSN was inevitable. She had been working per diem at a local Veterans Administration Hospital (VA) with fairly regular hours and opportunities to work.

So, what that gave to me was a fairly steady income and yet, as an agency nurse, it kind of allowed me to stay above the fray and keep a little bit more control over my schedule. You know, I basically worked for them when my availability met their need. But if my availability didn't intersect with their need, it was no big deal.

So, that worked really well up until 2016. In early 2016, one of my previous contracts at the VA had expired, or actually had been cut early because they ran out of that bucket of money. And so, I went for several months where I was hired on with the new agency, the agency that had the new contract, and for the first time my phone never rang for shifts. I take that back. I think I worked two shifts in about three and half months. So during that time I was really torn because I thought, "Wow! The VA has usually been pretty consistent. You know usually I had been able to work as much or as little as I wanted." Well, in early 2016 I wanted to work at least 3-4 days a week and yet that just wasn't happening. And I was on the fence. There was part of me that thought, "wow, maybe I need to go out and look for other jobs!" Well, every single thing I saw that was remotely aligned with my interests or specialty or area of experience. Twelve hour shifts. Most of them were 12 hour nights. And I realized . . . and keep in mind, too, that I also had a heads up . . . that this private duty job—the job that I’m currently in, I had a heads up that

something local was potentially coming open and available. So . . . and I didn't know when that was going to start. So, let's just say that in early 2016 I was really in limbo. And then I realized that at some point that, "Wow. I have all this time on my hands. It doesn't seem prudent for me to just go knocking on the nearest HR door and get a job just to get a job, maybe this is the universe's way of telling me that I need to use this time to go ahead and get my bachelor's." Oh, let me also say twelve hour shifts and I was seeing almost all the jobs saying bachelor's degree preferred.

So, what I realized at that point was, "okay, I've probably squeezed about every drop of serviceability from my two-year degree, it's probably time to go back." I knew I didn't have the means or desire to be in debt and it also didn't . . . I knew that I would be basically paying everything out of pocket. That's why I went back. I kind of realized that if I was to stay in nursing it was reaching a point where I would have to. And I was no longer willing, as I had in years past, to just go out and find something that I could do.

Katie found the BSN educational experience fulfilling and that it had altered her perception of the degree. It also led, as she noted, to what she referred to as a "reframing" of her identity:

I have really enjoyed the bachelor curriculum and I definitely do see value in it. And, I'll acknowledge the closer I got to getting that bachelor's, I did have a . . . there was a little . . . sadness isn't quite the right word. There was a (pause) reframing of my identity. There was almost a sense of sadness because I didn't want to lose my connection to the nurses that have two-year degrees. Because I think I, at some level, at some different times, have kind of thought that nurses that had their bachelor's degree when I didn't, that there was this sort of sense of "better than." I'm a better nurse because I have my bachelor's, and that's why I'm in this role, and you're in that role. And, I certainly see a similar thing with LPNs. I think a lot of my friends who are LPNs have really had a lot of identity crises, you know, because they're trying to figure out where they fit in.

When asked what she had expected from her BSN, Katie noted,

My perception of the bachelor's program is that it would help me identify the areas that I am strongest in and it would give me an opportunity to strengthen or bridge knowledge gaps that I may or may not have known I had, and ultimately, of course, the expectation is that with my bachelor's, it would open, open up the number of available jobs that are more closely aligned with what I need now for my family life.

She was clear that the experience not only met her expectations but exceeded them. The BSN experience led to her decision to continue on for her master's degree.

I really kind of thought when I entered the BSN program, I wasn't really sure what kind of job I would have next with my bachelor's, other than I was hoping it could be an on-line environment. I actually was not originally looking at the bridge program [offered by

her online university] and I was actually not originally thinking of a job in an academic setting. I was thinking more maybe patient education, or online case management, or something to where I would be—you know triage—something along those lines.

In her closing discussion, Katie expressed an interesting concern about her future plans.

She was concerned that her educational journey may never end.

I will share one more thing. And this is not a strong fear because I do believe in things working out and even the way, you know, stories that I might be sharing that I'm acknowledging a little bit of sadness around, or whatever, I fully acknowledge that every piece of my story has brought me to where I am now and I am in an exciting place in my professional career because of going back to school and specifically because of [university]. But I'll also say that this sense of quote-unquote not being enough or what if what is enough now might not be enough when I get the next thing is still kind of in the back of my mind. You know, I'm really keen on applying for a student mentor position when I get my master's. And, I have been very regularly checking the job boards and there is a sense of like "Oh my goodness, what if I get my master's and that coincides with when the new minimal educational standard becomes a PhD?" Holy crap, you know . . .

Leila

Leila, 56, began her nursing career in 1984, graduating from a diploma school. Nursing is the only career she has held and has no other educational preparation. She completed her BSN in 2017. She noted that obtaining her bachelor's degree was something that she always wanted to do. She noted that her nursing school was developing a BSN program while she was a student there. This program was implemented the year following her graduation. The school had encouraged her to continue, but financial considerations prevented her from going at that time.

You know, the bad thing with my school, I graduated in '84. In '85 they had a baccalaureate program. So, they changed it the year after I graduated. You know, they encouraged a lot of us to stay another year. It was a three-year program, stay another year and get that, but just with loans and living on my own and scraping by, you know, from paycheck to paycheck, I just couldn't financially do it. There was no money there. So, I decided to postpone it. And that was . . . I kind of always regretted that.

I asked Leila to share her perceptions of the BSN in the early years of her career.

You know, I'm thinking back to when I first graduated. There were not a lot of BSN nurses back then. There were diploma programs and associate degree programs. You didn't hear about very many people that went on to get their BSN. So, I didn't think

anything of it at the time, but it became, like I said, as I've gotten older and more nurses, you that was getting to be more of the norm, then I just saw it as something that I didn't really know what I was missing. I just always kind of assumed, well, I have three years, I think I had everything that I should have had. I don't really know what this is going to give me but, if it will look better.

I asked her to elaborate on her comment that she did not really know what she was missing. Her answer reflected what she has now recognized as the differences in the two curricula, having completed her BSN.

I mean there were definitely things that I learned in these two and a half years that I took at the College of _____ that I didn't know anything about, [such as] nursing research. We did nothing with research at my diploma school, so nothing about research. And they did, you know we did that whole great big capstone for my senior project which was a lot of research and there were three of us that worked on it all together. I mean just the depth of what we looked into and putting it all together. Let's see, what else. I had a community class with this, when I went back to school, which I had a community class once upon a time, but you know that's been a long time ago, and I did home care for a long time, so a lot of that was pretty similar but there were things that I took away from that. I was at a high school with a nurse at the high school and, what was the other thing? I was with a teacher as a nurse at an elementary school. There were definitely different things that they were doing that I don't really think I had much experience with in my diploma program.

I'm trying to think back to what specific nursing classes I had. You know I guess the research was a big part of that because I had no experience in that, whatsoever. So that whole looking at certain databases, and how to—I mean, I can remember asking how do I get peer reviewed, I mean I was totally naïve. I knew nothing about that. So, that was a big thing that I think I took away from this.

Much of Leila's perception of the degree was rooted in the belief that she already possessed the knowledge she needed to be a successful nurse. As she began her BSN education, however, she realized that her assumption was incorrect.

I think I kind of went into it thinking I'm probably going to know everything. This isn't really going to be that difficult. One of my first nursing classes I had to take, because they wanted you to have an assessment class within five years, well, it had been 30 years since I had had an assessment class. And, I'm telling you, that was really a tough class. It was like, "Okay, I never learned . . ." I mean, you know very specific tests that I was looking up on the internet, okay, how do you do this test? And like specific hearing tests. I mean, even from when I took that class, I'm like, "oh, this is really in depth," so I think they have a really good program and you're very well rounded and I think a lot of, I don't know.

The views of family, friends, and colleagues toward the degree appear not to have exerted any influence on her perceptions. She did not explicitly deny their influence, but neither did she identify any specific influences when asked. She did identify experiences that influenced her perception and desire to return. One was the requirement of a desired job coupled with a desire for personal achievement.

Until I took this job that I'm currently doing right now and that was something that they talked with me about at the job interview. That they would encourage it. I was actually grandfathered in; I don't have to have it, but they are kind of wanting more of the nurses . . . if you were . . . let's see I was born in '61, so it must have been '62 and—1962 and older that they want them to have their BSN by 2020, but I was actually grandfathered in. But, like I said, it was something that I always wanted to do and with this job that I have right now they were really pro that because there were a couple of semesters where I had to be in school all day on Wednesdays. They just let me work four ten-hour days rather than, "well, you know, that's not gonna work for us, you're going to have to do something else."

Another influence was in how she felt that others saw her as a diploma nurse.

It wasn't, didn't used to be, such a big deal but you know, I can remember somebody from like Human Resources, like he totally didn't even understand what a diploma nurse was. Seriously, like he didn't even know what that meant. And so, yeah, kind of—I don't know—kind of made me feel, you know, well, they don't really care what experience I have, they just care about this BSN. I kind of, I don't know, it kind of made me want it more because I didn't want anybody to just assume that because I didn't have that I wasn't as good as somebody that just graduated that had a BSN.

I turned the discussion to what her perception of the BSN was now that she had completed her degree and whether she saw any differences between her initial education and the BSN.

So, I don't think it's just a piece of paper. Now I have BSN after my name. I think there is a lot of validation with that. And that you're, you know, I'm more prepared to take care of patients than I was with my diploma program and have some more critical thinking skills and theory behind what I'm doing rather than it was always done this way and this is how we do it. And, could use that to, you know, "this is why I think we should do this because of this reason," or "I'm going to research this because I don't really know if I agree with how we're doing this."

Asked to build on the statement that she is more prepared to take care of patients, she replied,

I think there is more theory than what I got at my diploma program. I think I've learned more theory behind things and not just "we do it because this is how we've always done it" because that was kind of my diploma program. But, we're doing this because the nursing research shows this. So I think that's a big thing I've taken from it.

Leila currently works in case management, so she noted that much of the hands-on skills, such as a full assessment, that she learned through the BSN are not applicable to her current work. However, she did express the belief that the degree was useful to her.

So, it's great that I learned all that but in my current job—which I really love—I'm not using that. I'm still using my critical thinking skills and, you know, the research behind—how to phrase that—you know, the nursing theory. But I don't really do, as far as like assessments, I don't touch people any more.

She agreed with my observation that she seemed to see value in the degree. "Oh, yes. Very much so." I also observed that the value she saw came from improved critical thinking skills, better understanding of research, . . . and she added "wider knowledgebase."

Susan

Susan is a 34-year-old nurse whose initial nursing education is at the BSN level. She has been in practice 10 years and is currently working on her MS in Health and Wellness Coaching. Because Susan's initial nursing education is at the BSN level, she did not meet the inclusion criteria for the study. However, her enthusiasm for participating encouraged me to interview her anyway, more as practice than with any intent of including her data. However, as the interview unfolded, she provided several significant insights which I felt needed to be considered in painting a picture of how the BSN is perceived.

Susan entered nursing somewhat naively. She had set her sights on being in the medical field since the 5th grade, although she had limited knowledge of her options within the field.

I actually got into nursing . . . I was going to be a doctor and when I was about a sophomore in high school I talked to a friend of mine who was a senior, who was getting ready to graduate. And she was like, "I'm going to be a nurse practitioner." And, I'd never heard of a nurse practitioner before. And she was explaining to me what a nurse practitioner was, I was like, "Well, that's basically a doctor with fewer years of school. I'm gonna do that!" Literally, that is why I started looking at nursing programs. The funny thing is the longer I was in nursing school, the less I wanted to even go to medical school. It was like I was always meant to be a nurse and it was divine intervention. And I just knew more, and more, every single year, you know the four years I was in nursing school, that this was what I was meant to do. And, it's been great. I wouldn't look back. I still answer that question, "would you back to nursing school?" and I'm like, "yes, in a heartbeat", so . . .

Susan's decision to enter a bachelor's program was based both on a worldview that made the BS the only real option, and a lack of knowledge of her alternatives. Her parents, as well as all of her siblings, have earned bachelor's degrees. While she noted that there was no particular pressure to pursue the bachelor's degree, the environment in which she grew up made the degree a logical choice.

I decided that if I was going to be a nurse I was going to get a bachelor's degree. And my line of thought was that if I was going to do anything else, like any other career I would get a four-year degree, so why not just get the four-year degree? To be honest, I didn't even know the two-year degree existed until I was in school and looking at the different nursing schools in the area. There are six or seven of them in Omaha, between bachelor's prepared programs and RN and LPN. I didn't even know the two-year program existed and for probably even the first year before I realized there were diploma schools still available. Not in my area, and they were certainly few and far between, but I didn't know that diploma schools existed either, until that kind of intro into the nursing world. Because, literally, I didn't know anything about being a nurse before I set foot on campus.

I observed that she really went into this career blindly.

Absolutely. I mean I have two aunts who are nurses and everybody else in my family is an engineer. And that skill completely eluded me and so, it's like, "can't do the engineering thing, don't care. Want to go into medicine." And both of them actively tried to talk me out of nursing, which I thought was ironic because they're both still working as nurses. But, yeah, the three of us are literally the only medical professionals on either side of my extended family for probably two generations. So, I picked nursing, like I said, so I didn't have to go to med school and it literally was one of those things that I kind of fell into. It had to be divine intervention.

Entering the field without any real knowledge of the field, or of her options, meant that she really had no idea of what to expect as she entered the field. I asked her if it was a fair statement that she went into the experience with no perception of what she should expect.

Yeah, that is a very true statement. Sometimes I'm like, "am I glad I didn't know how much of a bitch nursing school was going to be?" Because if I'd known how difficult it was going to be I'd probably have done something else (laughing).

Susan expressed an interesting, and unexpected, perspective on general baccalaureate education, and baccalaureate nursing, in particular.

I will say that my opinion of the baccalaureate degree has changed over the last decade. I will say that when I was a freshman in college, and I don't know if this was because it was my plan to get a baccalaureate degree, so obviously it was the best plan, right? Or, if there were faultiness in preparation for the two-year degree or three-year degrees. But from when I was a freshman in college I would say, hands down, you should get a baccalaureate degree. And, I felt like most of the companies were changing to require the BSN that I was right in line with this is the way to go, this is what you need to do. We're the best prepared, blah-blah-blah-blah blah, you know, drinking the Kool-Aid or whatever. But what I've come to realize since working, is that you don't really learn anything in school (laughing), I mean, you do but you don't realize it, you don't access any of that knowledge until you are out, on the floor, doing it. And these people who were trained as RNs, who were trained in diploma schools but, who . . . even the people who are LPNs, just blew my mind with their amount of knowledge in their ability to do their job, simply from having practical experience. And, if you look at it now—and I still advocate for a bachelor's degree. And the reason why is because we've set ourselves up as a society, that seems to be, the bachelor's degree seems to be, the new high school diploma. You know, from maybe 80 years ago, you know, the bachelor's degree is the new high school diploma. You know, it seems like everybody has got to have one, right? But what I've come to realize is that, you can do your job, you can get the knowledge—even in nursing—you can get the knowledge you need in a two-year degree and become a good nurse as long as you have good mentors along the way and you have a good effort on your part to learn what you need to learn. I'm not so sure that all the humanities classes are necessary to be a good nurse. You know what I mean? Which is my understanding is the difference between a bachelor's degree and, you know, your RN degree . . . Just getting your RN.

Susan attended a Jesuit university and discussed the principles that are a part of the Jesuit education that correspond with the caring approach of nursing. So, while she says that she does not feel that the humanities are necessary to be a good nurse, she also notes that the humanities courses pave the way for the development of ethics that were an integral part of her education at

the Jesuit college. And, she concedes that her perspective may be the result of the integration of ethics throughout her university experience.

So, [University] is a Jesuit school, a Catholic Jesuit school and Jesuits are known for two things: service and education, right, so it wouldn't have mattered if I'd gotten a nursing degree or—my sister went to [the same university], as well, for a finance degree, as she did. And we're still going to be taught service and respect for other people. I mean there are six Jesuit ideals. One of them is known as *cura personalis*, which means care of the whole person, so this is the formation that I got as a bachelor's prepared student, that I likely wouldn't have got if I had went to a non-Jesuit school. But you know what I mean, like the ethics. That stuff was ingrained in my formation from my welcome week classes until the time I graduated, and certainly is being, you know, is the focus of my master's program, as well. So, you know, for me I don't know that the humanities were necessary because of the type of education that I received. Now, I'm sure that that's different from public university, state university, but you know, I don't know because I have no experience.

Susan pointed out the importance of developing the physical skills of nursing in the development of the nurse. She went so far as to suggest that nursing students should be required to go through a Certified Nursing Assistant (CNA) course before beginning their nursing classes.

I think that it's important that we at least try to get nurses on the floor in practical situations or, using simulation labs sooner. I just think it's super important. And, another thing: if you're going to do simulation, you have to make it as real as possible. You can't have students going in there with the attitude of, like, 'well, it doesn't really matter what I know, or what I don't know. It's just a dummy'. You know what I mean? You foster that type of an attitude because, again, I think that nursing is more practical application, not that you can just walk in off the street and be a nurse. You need to have the background in the sciences and the math and understand the pathophysiology, but I do think that there's more of a practical application than, say, if you were going to be an accountant or researcher, or something. You know what I mean? So, I think that it's important that whether you're getting a two-year degree, a one-year degree as an LPN or a four-year degree as a BSN, that you're on the floor learning basic things. I also think that it should be required that anybody in nursing school should get a CNA license and go through the class before they can get into nursing school.

Because Susan began her career as a BS-prepared nurse, she was unable to provide a perception of the BSN as seen through the eyes of an AD nurse. She was, however, able to provide the alternate view: how the BSN perceived the AD nurse. As I talked with her I began to understand that this alternate perspective was also instructive.

I think associate degree nurses, and I think, even like LPNs—LVNs—kind of thing . . . they have to work with a chip on their shoulder. At least in my experience, I feel like they walk into a job thinking that people think that they're not as well prepared or they're not as smart. Especially, the newer associate degree nurses. I think most of the ones that have been in the career field you know, for twenty years, thirty years, forty years in some cases don't have that perception. They know their crap and they know they know their crap and they will put you in your place when you try to tell them they're not a good nurse. But the newer ones, I think, come in with a chip on their shoulders like, "I've got something to prove. I'm just as good as, you know, these smart nurses."

Susan also called nursing the "Great Equalizer."

The only difference that I would say, because again, I also feel like nursing is one of those careers it's like a great equalizer. You know, it doesn't matter—I guess I shouldn't say it doesn't matter, because it does to some extent—there is [*sic*] certainly differences between bachelor's prepared nurses and I think there's more academic rigor in a bachelor's degree program than in an associate's program. And I think that you can see that in the way that people start their careers, you know.

I wanted to make sure that I understood what she meant by the great equalizer.

Interviewer:

You said that the bachelor's degree, coming out, let's see if I can remember exactly how you said this, that there's a big difference between the bachelor's degree at least when they start into their career. So early on it sounds like you're saying the baccalaureate nurse kind of comes in it a little better, a little stronger but then things begin to equal out. Is that what you were saying?

Susan:

Yeah, that's it's exactly what I mean. Like I said, a lot of it harkens back to my belief that you do most of your learning in nursing on the job. And, I think that bachelor's programs, with their higher academic rigor, are better prepared to start. They're better prepared from the, at least again this is limited to my experience which is, of course, limited to just my community, but they have more academic rigor and are better prepared to start out. They're more confident in themselves, I guess. And, I think that, like I said, nursing is a great equalizer, you come in . . . I'll never forget. I'm a bachelor's prepared nurse and I sent a patient into a coma two weeks into my career. And I'll never forget the face of the person—my preceptor—who was like, "you're on your own! Call the med team." Like, sorry, you're a nurse now!

Like I said, as a baccalaureate nurse I'm not immune from making mistakes, you know, and I'm not saying that nurses that are associate degrees are going to make more mistakes, either. I'm just saying that nursing is one of those ones where mistakes happen to anybody, you know, and you learn from that experience and, so, I think that more of nursing comes from the practical experience than comes from the two years you're in school or the four years you're in school and the

longer you're in the role the better of a nurse you'll become if you'll allow yourself to learn and to grow. I guess that's what I mean by nursing being a great equalizer.

In my current role, I often hear nurses say, “I don’t want this degree [BSN]; I’m doing this to keep my job.” I asked Susan to comment on that statement and to consider how we might shift that thinking.

I almost agree with that now. I would have said the exact opposite when I started. When I first came out with a bachelor’s degree I would have been the one that said, "I'm better than you because I have four years of a degree and you only have two." I would have been that person. But I'm saying that, now, and especially like the people who unfortunately have been a nurse for 20 years and how the company is saying you have to get a bachelor’s degree. I understand their frustration because I'm really not sure that there's something that a standard bachelor’s prepared program can teach them that they don't already know from 20 years’ experience, you know what I mean?

I reminded Susan that the bachelor’s program includes courses in community health, quality improvement, and research that are not generally included in AD education. Her response surprised me and exposed an important factor in how nurses perceive the BSN:

I guess being a sole bachelor's prepared nurse, I didn't know what I didn't know. And I didn't know that. I assumed that the two years of what is taught in a bachelor's degree program was taught in the two years of an associate’s degree program. I also benefit from working for a company that is huge on quality. And I realize now—I did quality improvement in my first job—and I'm realizing that there is not a push within healthcare systems to be quality. Because it's all about bottom line and stuff.

In closing, I asked Susan if there were any other observations she wanted to share.

Critical thinking remains a big focus: “I did notice, as a bachelor's prepared nurse that I could critically think better than the associate’s prepared nurses when I was working on the floor with them. Still to this day. “

Patty

Patty, age 39, followed her sister into nursing. Patty’s initial nursing education was at the Associate Degree level and she has not aspired to pursue further education. She has been in

practice for 18 years and has worked in a variety of environments, including doctors' offices and schools. She is currently employed as a school nurse where she has practiced for the last 7 years.

Patty's entry into nursing was the result, she said, of not really knowing what she wanted to do.

My sister was in nursing school when I started college and, you know, I guess seeing her go through it just kind of appealed to me and, honestly, I didn't really have an idea of what I wanted to do and I thought, well, I'll go ahead and put my name on the list and if I get in, I get in. And, I did. It just kind of fell into place. It was never a life-long goal to be a nurse, or anything like that.

She also shared that part of the motivation was the clarity of what was required of nursing.

And really, honestly, besides being a teacher, I thought, okay, I could go, I could get a business degree, I could do this, I could do that. But, I guess I'm not creative enough to think, "what am I going to do with this degree?" And so, that's why nursing appealed to me, because I thought, "Okay, if I have a nursing degree I will be a nurse. And that is a specific . . . I mean, honestly, I thought that when I graduate I will be a nurse and I'll know what I need to do and what I need to be (laughing). You know what I mean? I couldn't think of other things that I could do with a less specific degree, is what I'm saying.

Patty chose the AD in nursing because there were few other options. Asked if she had considered the BSN, she acknowledged that there was a BSN bridge program that she could have entered after she completed her AD, but no option to get her initial nursing education at the BSN level.

When I joined the nursing program I went to, there was not, per se, a bachelor's degree program that was available. You could . . . the associate degree was basically all they offered and then they kind of offered a kind of a bridge program after that. And now, I think, they've changed to offer only a bachelor's program. I'm not sure that they even offer an associate's program. At my point in time, that was really was the only option.

After verifying that she had had the opportunity to work with BSN nurses, I asked her about her thoughts on the BSN.

My sister has recently completed her BSN because she wanted more of a management position, and just from her feedback from what she had to do to get her BSN, it doesn't

seem like there was a whole lot more . . . it doesn't seem a whole lot more in-depth than what I did. You know what I mean? It seemed like hoops she had to jump through more than anything. I don't really feel like she thinks she gained a whole lot of knowledge or a whole lot of anything other than just having that behind her name, now. You know what I'm saying?

Beyond the influence her sister had on her decision to enter nursing, she denied that her family exercised any influence in her educational pursuits. She also hinted that her friends and colleagues did not seem concerned about the type of degree she sought.

So far as family, it was kind of the thing, "You're going to be an RN and that's kind of what really matters." So that was, it wasn't really the degree that was it as much as the training I got in order to be an RN and things like that. My sister had gone through the associate's degree program so there really wasn't any pressure to do what she had done and, you know, I mean, it was not big deal. And, really, I mean, I didn't feel any kind of . . . it was more about being an RN as opposed to being an LPN or medical assistant, or something like that, that seemed more important to the people around me, I guess, than the associate's or bachelor's degree.

Her colleagues did have an early influence on her perceptions, however, beginning from her time in nursing school. This was particularly true with respect to the nurses with whom she interacted during her clinical experiences while in school.

And, honestly, it really felt like the whole time we were going through it, that it was kind of like it was told to us that it didn't matter that much. As far as like, when you get into the workforce, if you have your bachelor's as opposed to your associate's, it's going to be 50 cents an hour. It's just a minimal upgrade as far as what you're going to make. And, not by our instructors, but by basically by, kind of, all the people that we were around and things like that. It didn't seem like there was that much of a benefit to it, so I didn't really feel like I was making a bad decision by not searching out a BSN program as opposed to the associate's, so I just went with that.

I sought to clarify that it was not her instructors that were conveying this message, but others in the clinical environment.

No, it was more in the clinical areas and stuff like that, where we were working. It seemed like the only people who had bachelor's degrees at that time were in management positions and teaching positions, not like staff nurses and things like that, so, you know.

The notion that the BSN leads to management also seemed to be an influence on her. Her sister had pursued her BSN because it was a requirement for the management position she sought. Patty was adamant that she did not want a management position.

I think her getting her BSN allowed her to pursue the position that she wanted to. And in management, because if she had only had an associate's she would not been able to pursue that because it was a specific BSN requirement. So, in that light, I feel like she has seen benefit as far as being able to get that position. [But] I don't want a management position in nursing. I don't want to go back and work in hospital that requires a bachelor's in nursing. I don't want . . . I wouldn't want to teach nursing or anything like that. None of that is anything, really, like, would appeal to me. I feel like, as a nurse, I've probably gone just about as far as I want to go.

Another factor that may have influenced her perception is the job market. In her view, she has never had a problem getting a job with her AD, so there is no need to obtain the BSN.

My associate's has served me perfectly well. I've gotten every job I've ever wanted to have, I feel like I was qualified for every job and perhaps even overqualified for several of them. So, I've never felt like having an associate's has held me back in any way. Because I've never said, "oh, I wish I could have that job if I only had my bachelor's." You know, it's never, as of yet, that's never happened to me. So, I don't see any kind of plus side to me having it. You know, if I had gone on.

Paige

Paige, 60, followed in her mother's footsteps, first by becoming a nurse, then later becoming a school nurse. She has been in practice for 38 years. Nursing is the only career she has had or has ever wanted to have. She attended a somewhat unique nursing program in which she attended classes for an associate's degree at a community college while receiving her nursing training from the hospital. She noted that she graduated from the community college. In addition to her ADN, Paige also holds a BSN in nursing, a Master's in Education (M.Ed.), and now a Doctorate in Education (EdD).

Paige was asked if she could recall, as an AD nurse, her thoughts on the baccalaureate degree.

I absolutely do. I can give you an earful! I thought it was a waste of time. That it was not necessary. And the reason why is that I worked with bachelor's prepared nurses and they had no clinical experience coming out of school. So, yes, they had initials after their name, but I had the skillset to be able to run the floor—because I worked in a hospital—and they didn't even have, like . . . this one girl came out and was like, "I've never done a catheter before." And I was like, "What? How'd you get out of school?" Our teacher would say either you find somebody to do it on, or your friends are doing it on you. Or, you're doing it on them. They weren't very kind back then. (laughing). But, no. I thought it was a waste of time—a total waste of time.

Paige noted that her mother had attended the same nursing school she had attended, so there was no initial pressure to go in a different direction. However, when she decided to go back for her BSN, she reports that her parents were behind her, "100%." I asked if her parents had pressed her to pursue her BS or whether they took a "do what you want to do" approach.

It was a do what you want to do. My mother was a graduate of the same nursing program I was at and, she went back when she was in her 30s and she got a Bachelor of Arts degree. She was also a school nurse. I literally followed in her footsteps. Literally. God bless her. So, she went back and that helped her, and they saw the value of that, so they were supportive. Nobody I was going to . . . this was back before I was school nurse . . . nobody thought I was going to go into school nursing. I was going to be a hospital nurse. But they saw the benefit of having a bachelor's degree, so they supported it.

Paige returned for her BSN 14 years after she received her initial nursing education because her new job as a school nurse required it of her. She noted that the BSN had been on her radar from early on, as she had initially returned for her BSN the year following her graduation from her nursing program. After a short stint in school, however, she dropped out.

When I got out of nursing school, I went back to get my bachelor's from a four-year college in New York, but shortly after that I met my husband and got married and dropped out. So, I had maybe a year in for my bachelor's in 1980. And then I dropped out. So, I'd say, yes, it had been on my radar but then family came and it got put on the back burner.

Asked what her motivation had been for her initial return to school in 1980, Paige pointed to the proposed changes to the education requirements for entry into practice.

Because all through my three years, the two-year program was really a three-year program. All through that time they kept telling us that the entry level position was going to be a bachelor's, so go back now. So, I did.

When she initially returned to school in 1980, her former classmates were not supportive, though her coworkers were.

The people I went to school with who graduated with me thought I was crazy. The people that I worked with on the floor, because it was myself, that other nurse from Seton Hall which is a four-year university, and then I had two LPNS. They supported me going back.

Based on prior interviews and other cues within the interview with Paige, I asked if she thought the support from her coworkers was a bit rare.

Yeah, I do. It was helpful. It was helpful that they supported me because my friends who were not nurses did not support me. They were kind of like, "man, you just got done with school. What are you doing now? Don't you ever wanna go and have fun?" (laughing).

No, my associate degree friends who I went to school with were not supportive. It was the people I worked with, who were not the people I graduated with. They supported me.

I asked Paige if she had any thoughts on why her classmates were not supportive. She noted two major factors: disbelief in the proposed changes to the entry level in nursing and they were not having trouble getting jobs. This was, as she notes, during a shortage, so there was a high demand for nurses.

They didn't . . . there was a lot of disbelief when the board of nursing said the entry level was going to be bachelor's degree, our instructors would say, "oh, that's crap. They've been saying that for years, blah blah blah." And that was kind of the general tone of the school of nursing.

They also had jobs. We all had no problems getting hired. You know, there was a nursing shortage. You know, I got the job I wanted.

Paige finally returned for, and completed, her BSN in the mid-1990s. She attended a distance learning program and shared the challenges of that experience, along with her perceptions of it.

But then I went back for the bachelor's and I did it through a distance education program and this was pre-computer, so I hooked up with a local hospital and had to start working there per diem. I actually worked there every Friday from 7p-11p and that qualified for my per diem hours, so I could go to school there at the University of _____. So, they would send me the entire course on videotapes. So, I got this huge box every semester and I would watch the tapes and then I would go the hospital and take my tests, proctored

by the mentor that agreed to mentor me. So, I would try to do them at night and I would wake up to that blue screen. And, by that time I had four children, by the way, they ranged in age from 7 to 2, as my youngest, so what I started to do was get up at five in the morning, watch my tapes for 2 hours then get them all up and ready for school then go to work with them because I worked in the school that they went to school in. And so that . . . And, I'll be honest, when I graduated in '97—it took me four years to get through—I really felt like I learned something. I kind of impressed myself like, "wow, this was worth it. There is stuff I don't know. How bout that! Damn! Education works" (laughing).

She admitted that she had not known what to expect from her BSN program but expressed satisfaction with what she had learned.

I don't think I knew what to expect. It was a program that you had to go down twice a semester to the college, they put you up overnight in the dorms. It was a Friday-Saturday and we would go to classes all day Friday and all day Saturday. And, I learned about research which totally piqued my interest. I knew right then I wanted to be a researcher. And the professor I had happened to be Larry Purcell, who happens to be the guru for community nursing and that whole . . . I'm trying to think of the woman's name, the theorist who incorporates all kinds cultures, cultural nursing. So, he's a big cultural nursing person. And he says to me, "well, there's a lot more to it than just going to the library." And I'm like, "no, you don't get it. I understand that. I want to learn the steps." What I learned there was leadership and ethics, particularly. From my weekends there. And health assessment. Like a full health assessment. It was very interesting because I never had to do that. We always did it in steps but not putting it all together.

I noted that I was unaware that the AD nurse is not taught a holistic assessment; they are taught focused assessments. She confirmed this.

All focused assessment, so putting it all together was the new part. I could listen to any system, I could assess any system, but when I had to do a head-to-toe [assessment] and videotape it, I was blown away.

Paige noted that her perception of the BSN had improved significantly and she now believes that the BSN should be the entry level for practice.

It has greatly improved. I believe that it is the entry level for nursing because I think that everything that is covered through a bachelor's degree is what is necessary for the working nurse. That the physical skills that they're teaching in an RN diploma or associate degree, whichever, is not enough to keep up with the demands of what is needed by nursing today. There's no, like I said before, there's no leadership, there's no ethics built in. I'm not saying that they're unethical; I'm saying that they don't know what they don't know. I don't think they're very strong in delegation.

I noted that delegation is part of the Leadership/Management piece of the BSN education.

Right. And I think that's huge. And, I think there's a lot less . . . I mean, they're doing more physical skills. There's more. But I think they lack a little more in time management because they need to, you know, when you're overseeing a team of people, you need to figure out not just what you need to do, but what everybody else needs to do and that's the leadership/management piece that I don't think they get. I never got it in diploma school, at all. I took care of myself and I was a one-person entity. Even though we did all types of nursing. We did primary and team nursing, but it was really more . . . you never really looked outside that frame.

I asked Paige if there was anything else she felt was important that we had not touched on. She reiterated her belief that the BSN should be the entry level to practice. She also alluded to the differences between the two degrees in terms of focus and skills.

I think that the associate degree programs should be revised to LPN programs and not RN programs. I don't think they're learning enough in the associate's degree. I think the baccalaureate as the entry level is important and, see in [State], they're trying to allow the associate degree programs to offer a bachelor's degree, which I'm not for. I think they need the full time to get all the curriculum in. I've taught in all of them: the associate degree, the RN to BSN, the accelerated baccalaureate where they come with a different degree and then fast track in, and all the way up to grad school. And, I see the differences. And the difference is, the nurses that we make from the baccalaureate program are better prepared and more grounded than the associate's. Because the associate's seems to be only worrying about "am I doing this skill right?" Where the critical thinking is stronger in the baccalaureate. That's what's missing is the critical thinking.

I paraphrased her comments, noting that she was describing the differentiation between the "technical" nurse and the "professional" nurse that has been proposed since the 1950s. The associate degree nurse is the technical nurse, focused on skills, while the baccalaureate nurse is the professional nurse with a broader perspective and broader scope of practice.

Yeah. That sums it up well. In the state of [state], our Registered Nurse License is called a Registered Professional Nurse. And it does not take into account whether it's an associate or a baccalaureate.

To clarify her meaning, I noted that I had heard the argument that, "What's the difference? We're taking the same test" and I understand that. If they are taking the same test and the license is the same, then the state is saying they are the same.

Right, but then you can have an associate degree say, "why should I go back?" And, it would really be kind of interesting to do an item analysis on the ones [test questions] that

covered the curriculum that doesn't fall into the associate program [and the questions] that do fall into the baccalaureate and see how the associate [degree nurse] did on the baccalaureate questions. That would be very interesting to me.

Thematic Analysis

Following the methods of thematic analysis as laid out by Braun and Clarke (2006) , eight themes were identified from the data. Specific themes related to the perceptions that nurses hold toward the BSN and the factors that influence those perceptions were identified. Identification of these themes was guided by the concepts of the Theory of Planned Behavior and by the research questions. Braun and Clarke (2006) identified two approaches to thematic analysis. A semantic approach is essentially descriptive. Themes are derived from the explicit meaning of the words used by the participant, with little effort to go beyond what the participant says. In this approach, the data are organized to describe patterns found within the data and those patterns are then summarized. The data may be interpreted within the context of the literature in an effort to establish the significance of the patterns and to provide them with broader meaning. Latent analysis, in contrast, is an effort to identify the underlying ideas and assumptions that are believed to influence the semantic content. Latent analysis involves a degree of theorizing the significance of the data. As Braun and Clarke (2006) stated, “Thus, for latent analysis, the development of the themes themselves involves interpretive work, and the analysis that is produced is not just description, but is already theorized” (p. 84).

In this study, my primary focus was on the identification and description of the perceptions that nurses hold toward the BSN and of the factors that influence those perceptions. Thus, I chose semantic analysis as my primary approach. To facilitate understanding of the themes and their relationship to the research questions, the themes were organized into three groups. The first group, consisting of three themes, speaks to the perceptions the nurses hold. The two themes comprising the second group reflect the factors that influence the nurses’

perceptions. The third group, consisting of three themes, describes the nurses' experiences surrounding their return to school.

As the Theory of Planned Behavior suggested, the decision to act is rooted in the attitudes one holds. Those attitudes are rooted in the values and beliefs that the individual holds, as well as the perceived values and beliefs relative to the action, held by significant others. With this in mind, the themes related to perceptions are presented first, as they are the core area of interest in the study. These are followed by the themes related to the factors that influence those perceptions. Finally, the themes related to the nurses who returned to school are presented.

Perceptions of the BSN

Early in the interview process I realized that the nurses talked about BSN education by referencing the BSN nurses with whom they had worked. This made sense to me. After all, the most tangible—and, perhaps, only—frame of reference these nurses had for forming an opinion about BSN education was their experiences with the product of that education: the BSN nurse. Recognizing this, I adjusted my interview process to explore the nurses' perceptions about the BSN nurse as something of a proxy for their perceptions of the degree, allowing them to explain their perceptions of the degree by discussing their perceptions of the BSN-prepared nurse. The nurses framed their responses within the context of clinical practice; this was the only frame of reference they had. Clinical experience and skills were important to them and, as discussed below, formed their definition of a good nurse. Thus, responding from the perspective of clinical experience allowed them to, as Ajzen said, “form unfavorable attitudes toward behaviors we associate with mostly unfavorable consequences” (Ajzen, 1991, p. 191) of the BSN nurse. As suggested by the Theory of Planned Behavior, the nurses' experiences in working with BSN-

prepared nurses helped to define their attitudes toward the degree which then influenced their decisions regarding returning to school.

Theme One: Skills Define a “Good Nurse”

Central to how BSN-prepared nurses were perceived was how the nurses defined “good nursing.” When asked for their thoughts about the BSN, they almost always couched their responses in terms of the performance the BSN-prepared nurse in the clinical setting. All of the nurses interviewed, including one nurse whose initial education was at the BSN level, described nursing in terms of nursing skills and clinical experience. This definition of nursing was never explicitly stated but was clearly evident as the nurses described their views of the BSN nurse.

The defining characteristic of a “good nurse,” according to these nurses, is their mastery of the clinical skills needed to perform in the clinical setting. Performance in this environment means providing safe and appropriate care to the patient while demonstrating a mastery of the required technical skills. These nurses shared the opinion that the BSN-prepared nurse did not meet this characteristic because they lacked those necessary clinical skills.

Darla was, perhaps, the most vocal in her feelings toward the BSN nurse. She explained her perception of the BSN and her reasons for not choosing, at least early on, to pursue her degree. For her, the BSN-prepared nurse was not a good nurse. Part of her assessment was based on her conception of nursing as skills-based. As a result, even though she acknowledged that they were “book smart,” she did not feel that they possessed the technical skills appropriate to a nurse.

In my early days, I did not have a very high opinion of the baccalaureate program, or nurses. I found them to be just book smart. That was not what I was looking for personally. So, that's why I didn't do it in my early career.

Because they did not represent the skills that she felt were important to a nurse, she saw no need to pursue the degree. What she saw in the BSN-prepared nurse was not what she wanted for her own practice.

In considering the levels of nursing education, Darla created a mental hierarchy of nurses, based on their clinical skills. In that hierarchy, the baccalaureate nurse does not fare well. Her reverence of clinical skills and the ability to perform well in the clinical environment was a common theme throughout her interview.

When I worked with them [BSN nurses] on the floor in my early career, I found that they couldn't perform and take care of patients. Because I worked in med-surg and all that. I worked with patient care then and I found that they could not perform better than—I hate to say this—the diploma nurses. I found them [diploma nurses] to be exceptional. I was jealous that I didn't go to a diploma program because I envied those nurses. I thought that they were phenomenal. And then the next step up was the associate's nurse, who had the knowledge base behind what they were doing, which I was very comfortable in. And, I did not, I had very little respect—I hate to say that—for the bachelor's nurse. I found them just to be book smart; they couldn't perform. To me, go to management, get off the floor.

At various points throughout the interview she returned to the idea that the BSN nurse lacked the skills for safe clinical practice. In doing so, she was emphasizing that the BSN nurses' apparent lack of clinical skills played a significant role in the attitudes that she developed toward the degree. When combined with her observation that what she saw in the BSN-prepared nurse was not what she was looking for in her own practice, Darla's early attitude toward the BSN is not surprising. She has, as the TPB holds, drawn connections between her experiences and the BSN degree that then influenced her attitudes toward the degree. Her experiences with the BSN-prepared nurse were negative and, in consequence, she developed a negative perception of the degree.

Darla presented an interesting contrast between the BSN and diploma nurse, noting that the latter had the skills but was able to gain the knowledge, while the BSN had the knowledge

but, in her estimation, never gained the skills. She was unable to explain why she thought the two were different in this respect. This may, perhaps, be explained by Ross, Lepper, and Hubbard (1975), who observed that impressions, once formed, are remarkably difficult to alter, even in the presence of evidence contrary to those impressions. Having developed an early impression of the BSN nurse as lacking skills, she continued that belief, not allowing herself to acknowledge any evidence to the contrary.

Although Darla saw the BSN-prepared nurse as lacking the skills needed to be a good nurse, effectively rendering the nurse as “not a good nurse,” she was somewhat less dismissive of BSN education, overall. Of the AD nurse who returned for their BSN, she observed that, “Although, the ones that had an associate’s first and then went on for their bachelor’s, I admired them more so than the one that went straight to a bachelor’s program.” Her admiration for the nurse that returned was apparently based on her belief that, having developed the skills needed to be a good nurse, the additional knowledge gained by the returning nurse contributed to their effectiveness in practice.

Similarly, Paige wondered how a BSN-prepared nurse with whom she worked had managed to graduate nursing school because the nurse lacked what Paige considered a basic clinical skill.

I worked with bachelor’s prepared nurses and they had no clinical experience coming out of school. So, yes, they had initials after their name, but I had the skill set to be able to run the floor—because I worked in a hospital—and they didn't even have, like . . . this one girl came out and was like, "I've never done a catheter before." And I was like, "What? How'd you get out of school?"

Grace, whose initial education was at the Associate Degree level, also suggested that those with good clinical skills and practical experience were “better” nurses based on their skills. Speaking of the diploma nurses with whom she had worked early in her career, Grace had this to say about why she held those beliefs:

I was actually working with more diploma nurses. And, we had team nursing, so there were a couple of LPNs that just staggered me. They were just amazing. You know, and things of that nature, so I thought, "why am I . . . you know, I feel so backward with them." I mean, not just doing the tasks, but you know, they were older, and they had learned. And, again, the diploma nurses had it all over everybody, I thought at the time.

Asked to explain why she felt that the “diploma nurse had it all over everybody”, she responded,

Their competence. You know, I found that if I had a question, or something like that, I would go to Pearl [a diploma-prepared nurse] rather than maybe a colleague. I don't know. they just took more time and explained things and I just felt confident in their answers.

In contrast to her sense of confidence in the diploma nurses' competence which she felt stemmed from their skill set, Grace provided a sobering account of a BSN-prepared nurse whose lack of clinical skills had devastating results.

I have a colleague. She was sent to an ICU and it was a small hospital. She was sent to an ICU as a new grad and, I can't remember exactly what happened, but the patient ended up dying. The trach had come out and she didn't know that you could just put it back in. You know, I mean that's a prime example. We were taught how to clean them and stuff like that and I mean she never went on to become a nurse. I mean a practicing nurse after that. I've never forgotten that. Too, and she had insurance paid through as a student. And she was just out and had sat for her RN but didn't know if she'd passed. So, the hospital turned around and sued her. It was not pretty. So . . . Yeah, she didn't know enough, there's a hole in somebody's throat, so what do you do? he didn't know.

Both Grace and Paige described events that highlighted the clinical skills that they perceived the BSN-prepared nurse lacked and of the potentially negative consequences that could result from the lack of skills. In both cases, too, the attitudes they formed with respect to the BSN degree were rooted in their experiences in working with BSN-prepared nurses. They valued quality patient care, which they generally defined in terms of technical skills. Their behavioral beliefs, one of the salient beliefs within the TPB, drew on the associations they made between the quality of care and technical skills and compared those to the associations they drew between the BSN-prepared nurse and BSN education. Because the BSN did not meet the values they held, the nurses perceived the BSN negatively.

Susan, whose initial preparation was at the baccalaureate degree level, provided a surprising perspective on the importance of skills in nursing. Her words clearly convey that a “good nurse” had strong clinical skills.

And these people who were trained as RNs, who were trained in diploma schools but, who . . . even the people who are LPNs, just blew my mind with their amount of knowledge in their ability to do their job, simply from having practical experience.

From the perspective of these nurses, the skills necessary for appropriate performance in the clinical setting is the defining characteristic of a “good nurse.” Moreover, from their perspective, the BSN-prepared nurse lacked the requisite clinical skills and, therefore, were “not very good nurses.”

The Theory of Planned Behavior posits that attitudes are reasonably derived from the beliefs that people hold toward an object. Those beliefs are founded on the characteristics, experiences, and outcomes with which the object is associated. The attitudes that these nurses described were rooted in their valuation of the experiences they had in working with BSN-prepared nurses and of the perceived outcomes of BSN education. The nurses created two sets of associations that influenced the development of their attitudes toward the degree. First, they associated the BSN degree with the product of that degree, the BSN-prepared nurse. Second, they associated the concept of a “good nurse” with a specific subset of nursing skills—technical skills—which they felt were vital to safe and effective nursing practice. Their attitudes derived from comparing those two sets of associations and evaluating their differences.

Theme Two: Bedside Experience is Vital to Good Nursing

Skills require practice. The nurses noted that the BSN-prepared nurse lacked the clinical skills needed to be a good nurse and attributed that to their lack of clinical experience. In their critiques of BSN education, the perceived lack of clinical training in the BSN curriculum was a central theme.

Darla, while referring to the nurse as the product of the educational experience, compared the clinical experiences of the AD programs to the BSN programs. Her observation is echoed by the other nurses in the study.

Most of your associates have bedside experience and I think that is more important than learning anything from a book. I think the bedside experience is really what helps somebody. Those that I see that go directly for their bachelor's—they're lacking something. They're really, they're lacking something. And I think the baccalaureate programs, they don't teach enough at the bedside. They don't have enough clinicals.

While Darla was explicit in her identification of what was lacking in the BSN curriculum with respect to clinical skills, others emphasized the importance of clinical experience in the learning process. Susan, for example, repeatedly noted the importance of practical clinical experience in the education of nurses.

But what I've come to realize is that, you can do your job, you can get the knowledge—even in nursing—you can get the knowledge you need in a two-year degree and become a good nurse as long as you have good mentors along the way and you have a good effort on your part to learn what you need to learn. I'm not so sure that all the humanities classes are necessary to be a good nurse.

Having started her nursing career with her BSN, Susan's perspective regarding clinical skills in BSN education is even more surprising. She spoke to “drinking the Kool-Aid” that the BSN is a better nurse, noting the significance of clinical practice in leveraging the knowledge she gained in the classroom in becoming an effective nurse.

But from when I was a freshman in college I would say, hands down, you should get a baccalaureate degree. And, I felt like most of the companies were changing to require the BSN that I was right in line with this is the way to go, this is what you need to do. We're the best prepared, blah-blah-blah-blah blah, you know, drinking the Kool-Aid or whatever. But what I've come to realize since working, is that you don't really learn anything in school (laughing), I mean, you do but you don't realize it, you don't access any of that knowledge until you are out, on the floor, doing it.

Susan believed that the BSN was important but her thinking regarding its significance has evolved. She recognized the importance of developing clinical competence—technical competence—in addition to didactic knowledge in developing a well-rounded nurse. She even

advocated for requiring that student nurses earn a Certified Nursing Assistant (CNA) license prior to beginning nursing school so that the fledgling student has some foundational skills and knowledge.

So, I think that it's important that whether you're getting a two-year degree, a one-year degree as an LPN or a four-year degree as a BSN, that you're on the floor learning basic things. I also think that it should be required that anybody in nursing school should get a CNA license and go through the class before they can get into nursing school.

Susan also pointed to experience as being “the great equalizer” in which the clinical experience tends to smooth out the differences over time. She described an experience that served as a learning experience for her that classroom instruction could not have prepared her for.

I think that, like I said nursing is a great equalizer, you come in . . . I'll never forget. I'm a bachelor's prepared nurse and I sent a patient into a coma two weeks into my career. And I'll never forget the face of the person—my preceptor—who was like, "you're on your own! Call the med team " Like, sorry you're a nurse now!

Like I said, as a baccalaureate nurse I'm not immune from making mistakes, you know, and I'm not saying that nurses that are associate degrees are going to make more mistakes either. I'm just saying that nursing is one of those ones where mistakes happen to anybody, you know, and you learn from that experience and, so, I think that more of nursing comes from the practical experience than comes from the two years you're in school or the four years you're in school and the longer you're in the role the better of a nurse you'll become if you'll allow yourself to learn and to grow. I guess that's what I mean by nursing being a great equalizer.

As she pointed out, practical experience gives the nurse an opportunity to make and to learn from mistakes. She acknowledged, though, that to learn from those mistakes, the nurse must be open to learning from them. Benner pointed to the role of experience in developing the expert nurse (Benner, 2004, 2011; Downs, 1992) and Susan's observation that “more of nursing comes from practical experience than from the two years you're in school” serves as support for the concept that the nurse develops expertise at the bedside.

While the nurses talked about the importance of clinical skills to the new nurse, several of the nurses spoke to how their years of clinical experience influenced their perception of their BSN educational experiences. Typical of this view was Darla. In describing her experience in a BSN program, she shared both a frustration in her studies, as well as her interpretation of that frustration.

So, what they're teaching is repetitive or boring to me because I think of my experience and my knowledge level. I would hope that as you get further into the program that it's hopefully, new, and you can gain something from it. But in the beginning, I just thought it was some way for the school to make money. That's my honest opinion.

For Darla, work experience served to undermine her educational experience. The knowledge and skills she brought into the educational environment defined how she experienced the classroom. She felt that what she was learning duplicated her prior knowledge and, for her, that was a negative experience. Like the experiences in working with BSN-prepared nurses, the perception that the classroom was duplicating her knowledge base set a negative impression on her view of the degree, providing further support for her attitude that the degree was not needed.

In contrast, Grace pointed to work experience as a source of knowledge when she was just beginning her nursing career and noted that her work experiences as a nursing assistant had, in some ways, filled some of the gaps in her knowledge. She was working as a nurse but was often plagued with uncertainty about why she was doing what she was doing.

But it was because I was doing tasks. I didn't know any of the "why's" behind what I was doing. Or, if I did, it hadn't been taught to me. I had learned it because I had been an aide and different things like that and you have your own, you know, experiences.

Unlike Darla's expressed belief that the classroom experience duplicated her knowledge from clinical experience, Grace recognized that her clinical experiences were inadequate. She acknowledged that her AD preparation was inadequate and that at least some of her knowledge gaps were filled through work experiences. In contrast to Darla, whose perception of the BSN

was negative, Grace's experiences led her to believe that the BSN was necessary. From the perspective of behavioral beliefs, both of these nurses relied on the characteristics of their experience in forming their opinions and attitudes toward the BSN, though each came to different conclusions.

Viewed through the lens of the TPB, the nurses' concerns with clinical experience provide a foundation both for their behavioral beliefs and their control beliefs. As noted in the first theme, the nurses associated quality care with technical proficiency. Their emphasis on bedside experience underscores that behavioral belief, further supporting their beliefs regarding the BSN. Control beliefs are related to the nurses' sense of control over their environment. Darla described a sense of lack of control in describing her BSN educational experience. She did not feel that she had control over the outcome in that environment. Grace contrasted that view by noting that she felt that she had less control over her practice as an AD nurse. Both of these nurses developed their attitudes regarding the degree based on how they perceived their control over their environments, even though their beliefs represented opposing perceptions of the degree.

Ultimately, nursing is about caring for others. The ability to provide safe and effective care is dependent, according to these nurses, on the skills nurses possess. To learn to be a good nurse requires that students gain as much practical experience as possible.

Theme Three: The BSN is not Needed

The attitudes and perceptions the nurses held toward the BSN were based, in part, on their definition of a good nurse. In their view, the BSN-prepared nurse was not a good nurse because the nurse lacked the clinical skills needed to provide safe, effective bedside care. Two other perceptions about the degree were expressed by the nurses. Whereas the discussion of the

lack of skills among BSN nurses focused on what constitutes a good nurse, the nurses also focused on the degree itself and its relevance to their own practices. Their views on the BSN were relatively consistent and reflected a generally negative view of the degree and, by extension, the nurses whose initial preparation was at the BSN level.

The nurses presented a general view that the BSN nurse was not prepared for bedside practice but, instead, was intended for management. Darla exemplified that thought as she shared her perspective on the BSN-prepared nurses' performance on the nursing unit.

I had very little respect—I hate to say that—for the bachelor's nurse. I found them just to be book smart; they couldn't perform. They couldn't—you know, you've been a nurse long enough, can you remember back then? To me, go to management, get off the floor.

Patty echoed this view noting that her experience, early in her career, was that BSN nurses were destined for management. "It seemed like the only people who had bachelor's degrees at that time were in management positions and teaching positions, not like staff nurses and things like that, so, you know." She related that her sister, who is also a nurse, returned to school to get her BSN specifically because she wanted a management position. But, while Patty said the degree did qualify her sister for the position she was seeking, Patty was not sure that it provided what her sister was looking for in terms of preparing her for the management role.

My sister has recently completed her BSN because she wanted more of a management position, and just from her feedback from what she had to do to get her BSN, it doesn't seem like there was a whole lot more . . . it doesn't seem a whole lot more in-depth than what I did.

I think her getting her BSN allowed her to pursue the position that she wanted to. And in management because if she had only had an associate's she would not have been able to pursue that because it was a specific BSN requirement.

And now that she's a manager she does a lot less of the actual hands-on nursing and I don't know that the BSN part of her training prepared her for her management role as much as she thought it was going to. You know, even maybe as much as business management might have done.

Preparing the student for positions in leadership and management is part of the BSN curriculum so it is not surprising that BSN nurses would more likely be found in management positions. And, as Patty noted, the management position her sister sought required a baccalaureate. Today this is a common expectation. Relating her own view on the BSN, she noted that the reason she would not pursue the degree is that “[b]asically, I don't want a management position in nursing.”

While the nurses were dismissive of the BSN nurse at the bedside, they presented something of a confused view of the educational preparation for the degree. On the one hand, their view of the BSN nurse's questionable preparation for bedside nursing clearly conveyed a message that they felt the BSN nurses' preparation was inferior to their own. On the other hand, they expressed the belief that, but for the lack of clinical experience, there was little difference between AD programs and BSN programs. They believed that they would “probably know everything,” should they return to school. This sentiment is reflected in their belief that it was a waste of time that provided no benefit to them, a view that aligned with their perception that the educational preparation was inferior. Paige pulled no punches when asked of her view of the BSN:

I thought it was a waste of time. That is was not necessary. And the reason why is that I worked with bachelor's prepared nurses and they had no clinical experience coming out of school. So, yes, they had initials after their name, but I had the skill set to be able to run the floor—because I worked in a hospital—and they didn't even have, like . . . this one girl came out and was like, "I've never done a catheter before." And I was like, "What? How'd you get out of school?" I thought it was a waste of time—a total waste of time.

The idea that that the BSN was unnecessary is reflected in the nurses' experiences in the workplace. Beyond their perceived clinical competence, the nurses noted that their nursing preparation had, generally, not limited them; they were still able to get jobs, for example. Patty

pointed out that her decision to pursue an AD rather than a BSN when she was beginning her nursing career was rooted in the belief that there was little difference.

It didn't seem like there was that much of a benefit to it, so I didn't really feel like I was making a bad decision by not searching out a BSN program as opposed to the associate's, so I just went with that.

She also noted that her AD had served her well, making the need for a BSN less important.

My associate's has served me perfectly well. I've gotten every job I've ever wanted to have, I feel like I was qualified for every job and perhaps even over qualified for several of them. So, I've never felt like having an associate's has held me back in any way. Because I've never said, "oh, I wish I could have that job if I only had my bachelor's." You know, it's never, as of yet, that's never happened to me. So, I don't see any kind of plus side to me having it. You know, if I had gone on.

There was also the sense among those nurses who returned to school that the classes would be repetitive. That is, they believed that they already had the knowledge they needed and that their BSN curriculum was simply going to repeat what they already knew. Leila provided a good example of this view.

I think I kind of went into it thinking I'm probably going to know everything. This isn't really going to be that difficult. I just always kind of assumed, well, I have three years, I think I had everything that I should have had. I don't really know what this is going to give me but, if it will look better.

Susan, whose initial preparation was at the BSN level, also shared her perspective that the BSN curriculum may be repetitive and acknowledged the AD nurse's concerns.

I understand their frustration because I'm really not sure that there's something that a standard bachelor's prepared program can teach them that they don't already know from 20 years' experience, you know what I mean?

Darla, who did return to school for a time, described her frustration with what she perceived as the repetitive nature of the BSN curriculum.

So, what they're teaching is repetitive or boring to me because I think of my experience and my knowledge level. I would hope that as you get further into the program that it's

hopefully, new, and you can gain something from it. But in the beginning, I just thought it was some way for the school to make money. That's my honest opinion.

Susan also brought to light a perspective that may explain why nurses might believe that the education would be repetitive. In sharing with me her experiences and frustrations in mentoring nursing students in the clinical setting, Susan expressed the assumption that the AD curriculum mirrored the last 2 years of BSN nursing. I shared with her some of the curricular differences between the two programs.

I guess being a sole bachelor's prepared nurse, I didn't know what I didn't know. And I didn't know that. I assumed that the two years of what is taught in a bachelor's degree program was taught in the 2 years of an associate's degree program.

Her belief that the nursing curricula would be essentially the same led me to ask the other nurses their understanding of the differences. All of them admitted that they had been unable to identify differences between the two programs prior to returning to school. This suggests that one of the reasons why nurses see the BSN as a waste of time is that they believe the two programs are teaching the same nursing content, the only difference being the humanities. Clearly the curricula of the two programs did not include clear discussions of how the two educational levels differed.

While these nurses were basing their evaluation of the BSN on their experiences in working with BSN nurses, or vicariously through the input of family who had pursued their degree, Darla based her perceptions on her personal experiences with BSN education. She did return to school but came away from the experience with a similarly negative view. After trying two different schools, she noted that she found nothing in the curriculum that she felt was worthy of the time invested. As she stated, "I learned nothing."

Throughout her interview, Darla expressed a desire to know more, to grow, and to become a better person—and a better nurse—by extending her education. Given that context, her

responses to the educational experiences she related were surprising; it seems she would have approached the educational experience with an openness to learning. Seen through the lens of the TPB, however, those early perceptions she formed about the BSN nurse appear to have influenced her experience of the BSN classroom. Early on she stated she saw the BSN nurse as “book smart” but lacking in clinical skills and that this was not what she was looking for. That is, she expected to learn little of value, and those expectations were fulfilled. She acknowledged this potential, expressing the view that her work experience may have contributed to her dissatisfaction with the educational experience, noting that early on the material was boring and expressed hope that she would gain something new later into the program. Whether her expressed hope would be realized is unknown; Darla terminated her pursuit of the BSN.

In contrast to the other nurses in the study, Grace was more dismissive of the AD preparation she had received, acknowledging that she was much happier once she had completed her BSN. She felt that the AD had not adequately prepared her to act in her full capacity as a Registered Nurse. She noted that she was focused on tasks, and was competent in performing those tasks, but lacked an understanding of the “why” behind her work.

I had the AD degree and I was thrilled to get that, but I hated it because it seemed like I was just doing task nursing. I mean, you know, it took me a little while to figure out, you know, God, I wanted to do this for so long, why am I hating it? But it was because I was doing tasks. I didn't know any of the “why's” behind what I was doing.

Of note, Grace is the only one of the nurses in the study to start her nursing career later in life. While the other nurses entered their AD program straight out of high school, Grace did not enter her AD program until her late 30s. It is possible that her dissatisfaction with her preparation was an expression of her life experiences rather than any inherent fault in her nursing program. Adult learning theory asserts that adults tend to want to know the “why” behind their activities

and how what they are learning is relevant to their lives (Knowles, 1978). Grace clearly expressed a need to understand the “why” behind what she was doing.

Summary of Perceptions

The nurses expressed general agreement that, early in their careers, their perception of the BSN was that it was an unnecessary waste of time and added nothing to their clinical practice. They based their perceptions on their experiences in working alongside BSN-prepared nurses whom they judged lacked the clinical skills needed for safe and effective practice. The nurses also suggested that the lack of clinical skills was a consequence of a failure of the BSN curriculum to include adequate clinical time.

The perceptions and attitudes the nurses held toward the BSN are explained by the Theory of Planned Behavior. Behavioral beliefs, as defined in the TPB, form the foundation for the attitudes that an individual holds toward an object, such as a BSN degree. The individual associates the object of the attitude with certain characteristics, experiences, outcomes, and even other objects. The value the individual places on those characteristics, experiences, outcomes, and other objects influences how the individual values the primary object. For these nurses, the ability to perform technical skills is a key characteristic of functioning as a good nurse. Consequently, they attached significant value to skills performance. Because the nurses viewed the technical skills of the BSN in a negative light, their valuation of the BSN and subsequently their attitudes toward the degree, was similarly negative.

Despite their insistence that the degree was unnecessary and represented inferior training, the nurses also suggested that there was little differentiation between the two groups. That is, they believed that if they returned to school, they would “already know everything.” Control beliefs, another salient belief found within the TPB, describes the degree to which the individual

believes they would be successful in some action. For these nurses, this speaks to their sense that they would be successful in their attempts to complete their degree. While they did not directly address this specific belief, the assertion that they will already know everything does imply that the material would be redundant and they, therefore, would be successful in continuing their education. The TPB does not directly address the influence that control beliefs have on attitude. However, because the nurses' responses to the question of how they perceived the degree pointed to the perceived repetitive nature of the content in the BSN program, it seems that those beliefs did have an influence on their attitudes and perceptions of the degree.

The themes identified in this research question provided evidence to support the influence of both attitudes toward the behavior and perceived control beliefs, as described in the TPB. The TPB asserts that the intention to act is based, in part, on the influence of an individual's attitude toward the behavior. The nurses in this study expressed clearly negative attitudes toward the degree and identified that, at least early on, they did not intend to return to school. The TPB would have correctly predicted this outcome based on the nurses' expressed attitudes toward the degree.

Influencing Factors

Perceptions do not develop in a vacuum. Rather, they are formed through the individual's interactions with others in combination with their own values, beliefs, and experiences both directly related and indirectly related to the object of that perception. Gaining a clear understanding of an individual's perceptions, as with attitudes, is challenging. The literature suggested that context plays a significant role in how a thing is perceived. Schwarz and Bohner (2001) suggested that attitudes are "evaluative judgments that the respondents construct at the time they are asked, based on whatever information happens to be accessible" (p. 3). Thus, to

understand the perceptions that nurses hold it is necessary to understand the contexts within which they developed.

In this section, I examine the contexts within which the perceptions expressed by the nurses were developed. The nurses identified and explained, as best they could, the factors that influenced their view of the BSN degree. Although not identified as an influencing factor, per se, I acknowledge the roles of confirmation bias and the self-perpetuating nature of attitude in influencing the nurses' perceptions of the BSN. That is, because the nurses see the BSN in a certain way, they tend to interpret everything related to the BSN through that lens; they see what they expect to see.

Theme Four: The Generic Nurse

“A nurse is a nurse is a nurse to most people” is how Grace described the lack of support she received from her friends and colleagues as she began her pursuit of the BSN. Looking beyond the support of others, that phrase suggests that there is no difference between nurses. Any nurse can, and should, be able to practice in any setting; all nurses are essentially the same. From an anecdotal perspective, I have worked in hospitals where this view of nurses was prevalent, even among nursing leadership. If all nurses are the same, why, then, would a nurse be motivated to return to school? And, how does that perspective of the generic nurse influence the nurses' view of the BSN?

In this theme, the influence of both normative beliefs and control beliefs can be found. Normative beliefs, according to the Theory of Planned Behavior, speaks to the influence that others have on the attitudes one holds toward an object. That is, how others see the BSN, and nursing in general, exerts an influence on how the nurse perceives the degree. Control beliefs

describe both the level of control the individual believes they have regarding their education and the availability or accessibility of the resources needed to achieve their educational outcomes.

The nurses discussed how they chose nursing and why they chose to pursue the AD rather than the BSN. Patty came to nursing somewhat by default, Paige followed in her mother's footsteps, and for Grace, nursing had been a long-time goal. Most chose the AD route out of expediency and lack of other opportunities. Patty's experience reflects the experiences shared by several of the other participants.

When I joined the nursing program I went to, there was not, per se, a bachelor's degree program that was available. You could . . . the associate's degree was basically all they offered and then they kind of offered a kind of a bridge program after that.

Darla shared a similar experience noting that there were few opportunities to attend a BSN program, and little incentive to do so, when she began her nursing career. Knowing she wanted to be a Registered Nurse, the AD was her only option.

Well, I did not want my LPN and the associate's, back in 1978 was . . . there weren't a whole lot of choices to go for your bachelor's. And the associate's was the thing to do if you wanted to be a nurse.

These two nurses' comments reflect the influence of control beliefs on their choice in nursing education. Their choices were limited by the programs available to them. Because the AD programs were the only ones available to them at the time they began their schooling, they had no other options for achieving their goal of becoming a nurse.

Both Darla and Patty noted that their schools of nursing either added or converted to a BSN program in the year or two following their graduation. Paige described a similar transition in her school shortly after she graduated. All three nurses reflected that their schools had encouraged them to continue on for the BSN, though they chose not to. Their reasons for not doing so were varied, but generally revolved around competing priorities and finances.

How these nurses and others saw the role of the nurse contributed to their notion that the nurse is a generic entity. Few nurses enter the field knowing that they want to practice in a specific area, or even that practice specialization was possible. Katie provided a good example of this lack of specialization as she discussed her plans for her nursing career following the completion of her education.

But the way I saw my nursing career play out when I was in school was, "Okay, wow! I'm going to start working at my local university hospital, I'm going to get all this great experience. I don't know what specialty I'm going to be in but . . ."

And, I can honestly say during my nursing school time, I really, genuinely did love just about everything. One, because I was excited to be in the program and, two, in the back of my mind I thought, "well, I don't know where the university is going to need me, you know. If they need me in ER, well, that's fine, I'm going to do ER. If they need me in OB, that's fine, I liked my OB rotation." I was very unattached to my specialty when I was in nursing school because I thought I was going to be working full-time there.

Katie's openness to whatever options her employer provided her speaks to the perception that a nurse is a nurse is a nurse as well as the reality that basic nursing education is, after all, aimed at general preparation for practice. While her comments suggested that she felt that she could be successful in any practice environment, a central concept in control beliefs, she was at the same time ceding some control of her future to the needs of others.

Patty provided a different perspective as she described her decision to attend nursing school. She noted that she came to nursing as something of a default option. She had a very naïve view of nursing and, having no other definitive plans, followed in her sister's footsteps.

My sister was in nursing school when I started college and, you know, I guess seeing her go through it just kind of appealed to me and, honestly, I didn't really have an idea of what I wanted to do and I thought, well, I'll go ahead and put my name on the list and if I get in I get in. And, I did. It just kind of fell into place. It was never a life-long goal to be a nurse, or anything like that.

And really, honestly, besides being a teacher, I thought, okay, I could go, I could get a business degree, I could do this, I could do that. But, I guess I'm not creative enough to think, "what am I going to do with this degree?" And so, that's why nursing appealed to me, because I thought, "Okay, if I have a nursing degree I will be a nurse. And that is a

specific . . . I mean, honestly, I thought that when I graduate I will be a nurse and I'll know what I need to do and what I need to be (laughing).

Patty's comments are interesting on several levels. From the perspective of normative beliefs, her decision to pursue nursing was validated by her sister having chosen nursing school. She was assured that her decision would be found acceptable by those most significant in her life. From the perspective of control beliefs, however, her comment that "I will know what I need to do and what I need to be" led me to believe that she was not confident in her ability to succeed in other fields. That comment also pointed back to a naïve, monolithic view of nursing: A nurse is a nurse is a nurse. I identified this as a naïve view of nursing because it reflects a lack of understanding of the wide range of practice options available to nurses and of the complexity of the knowledge required to practice nursing. This is not, perhaps, unexpected, given that she would have made these assessments while in her late teens, with no real exposure to practicing nurses, and lacking any real experience in the workforce. That perception, however, appears to be widespread in the greater community, as well, based, for example, on the quote from Grace's friends that a "nurse is a nurse is a nurse."

Patty also shared her family's view of nursing with respect to the BSN. In their view, the training that led to licensing as an RN was more significant than a specific degree.

So far as family, it was kind of the thing, "You're going to be an RN and that's kind of what really matters," so that was, it wasn't really the degree that was it as much as the training I got in order to be an RN and things like that.

That comment demonstrates the influence that normative beliefs—how others see the degree—may have on how the nurse perceives the degree. Her family conveyed the message that the degree was less important than the outcome of being a nurse. Thus, for her, the degree lacked significance.

Following in her mother's footsteps, Paige began her career attending a hybrid program in which she received her nursing training through a diploma program and her didactics through the community college. Upon graduation she possessed both a diploma and an AD in nursing. For her, the choice of schools was based on her mother's experience. She noted that her family was supportive of her choices regardless of the degree. In discussing familial support for her baccalaureate, Paige noted that,

It was a do what you want to do. My mother was a graduate of the same nursing program I was at. And, she went back when she was in her 30s and she got a Bachelor of Arts degree. She was also a school nurse. I literally followed in her footsteps. Literally. God bless her. So, she went back and that helped her and they saw the value of that so they were supportive.

Familial support is clearly important in how the nurse perceives the degree. In talking about her return to school, Grace noted that her colleagues were not always supportive. In her case, she was referring to continuing her education with a Master's in Hospice, but the sentiment she described here, she also noted, applied to her pursuit of the BSN.

Yeah. They didn't understand why you were putting more effort into it. I mean, I even had a colleague that already had a bachelor's in Nursing and she was my manager for a while in hospice. And, when I had gone back for my Master's in Hospice she said, "why are you going for a degree when you're already working in it?"

Paige described a similar experience when she initially returned to school, explaining that her AD colleagues thought she was crazy.

The people I went to school with who graduated with me thought I was crazy. No, my associate degree friends who I went to school with were not supportive. They were kind of like, "man, you just got done with school. What are you doing now? Don't you ever wanna go and have fun?"

The attitude that these colleagues expressed toward continuing nursing education provides further insight into how both the study participants and their colleagues perceived the degree, and into the influence that those perceptions may have had on the participant's own perceptions. The perceptions expressed by their colleagues may well have served to reinforce

their own perceptions of the degree.

Professional factors, how the profession itself views the nurse, also played a role in the perceptions that nurses had toward the degree. The nurses shared how the experiences they had with other nurses, particularly during their time in school, shaped their view of the degree. These nurses often diminished the degree and the efforts to promote the degree as the entry level for nursing. Patty described the feedback she got from nurses on the floor during her clinical experiences while in school.

[H]onestly, it really felt like the whole time we were going through it [her AD program], that it was kind of like it was told to us that it didn't matter that much. As far as like, when you get into the workforce, if you have your bachelor's as opposed to your associate's, it's going to be 50 cents an hour. It's just a minimal upgrade as far as what you're going to make. And, not by our instructors, but by basically by all the people that we were around and things like that. It didn't seem like there was that much of a benefit to it, so I didn't really feel like I was making a bad decision by not searching out a BSN program as opposed to the associate's, so I just went with that.

Paige shared a similar experience when describing the lack of support she got from her colleagues in pursuing the BSN. She noted that their lack of support was rooted in feedback they received from their nursing instructors at the time, rather than from nurses on the unit.

There was a lot of disbelief when the board of nursing said the entry level was going to be bachelor's degree, our instructors would say, "Oh, that's crap. They've been saying that for years, blah blah blah." And that was kind of the general tone of the school of nursing.

While the feedback from other nurses exerted some influence on the nurses' perceptions of the degree, structural factors related to employment and licensing also played a significant role. The nurses talked about the availability of jobs regardless of their educational preparation. Paige described the lack of support she received from her colleagues when she returned to school, noting that while there was disbelief when the board of nursing said the entry level for nursing would be the baccalaureate degree. She also noted that her colleagues had jobs. To clarify her comments, I observed that her colleagues were reflecting what they had been told.

“Yes. They also had jobs. We all had no problems getting hired. You know, there was a nursing shortage. You know, I got the job I wanted.”

Patty shared a similar perspective on her ability to get a job as an AD-prepared nurse, noting that the lack of a BSN had not impaired her ability to obtain the jobs she wanted.

My associate’s has served me perfectly well. I’ve gotten every job I’ve ever wanted to have, I feel like I was qualified for every job and perhaps even overqualified for several of them. So, I’ve never felt like having an associate’s has held me back in any way.

Employer mandates are often the impetus for nurses to return to school. Given this, a reasonable expectation is that the employer’s actions would reflect their commitment to this mandate. It is reasonable that employers’ practices around hiring and pay would reflect this and that the employer would take steps to recognize those nurses who had achieved their BSN. This may not be the case, however, if Leila’s experience is representative.

I would add that my work . . . does not let you change your name badge to BSN after receiving this. I guess they feel that is not important. This is a bit discouraging. They also do not pay their BSN nurses any more than AD or diploma nurses, depends on years of service and your performance. These are reasons why other nurses do not feel it is important to go back to school and get their BSN. If your organization does not back it with money or even let you change your name badge, what is the point except for your own accomplishment?

From her view, Leila’s observation that “I guess they feel that it is not important” suggests that the organization’s actions fail to reflect their stated desire that nurses to return to school. Grace also noted a lack of employer support in continuing her education. In describing the contrast between her current employer who was very supportive of her returning to school and some of her prior employers, Grace noted that, “. . . and a lot of my jobs that I had, they weren’t really friendly with, as far as working around a schedule to go back to school.” She noted that her current employer allowed her to alter her schedule to accommodate her school schedule. Their message was, “Well, you know, that’s not gonna work for us, you’re going to have to do

something else." That nurses have little reason to return to school if employers are not going to acknowledge the accomplishment seems to be a valid concern.

The profession, itself, appears to be somewhat confused about the value of the BSN. The nurses noted that the process for licensing nurses does not differentiate educational level. As several nurses asked, how is the BSN different, if they are all taking the same exam? Katie pointed out that disconnect which her fellow students were aware of early on in their AD education.

And I still kind of remember talking to my peers at the time and talking to other students in the bachelor's program and there something about where we sat, the two-year nurses sat for the same boards as the four-year nurses. So, my impression of the bachelor's at that time, and has probably colored over the years a similar one. That the bachelor's degree, and I don't want to say fluff in a way that it is perceived that I think it's fluff now, but I think even back when I was in the two-year program, there was a little bit of a disconnect.

Paige spoke of the lack of differentiation not just in the licensing exam, but in the titling of the license. Historically, those who have championed the BSN as an entry level for nursing did so by differentiating the practice levels of the two degrees. The 2-year associate degree nurse was considered a "technical nurse" whereas the 4-year baccalaureate degree nurse was considered the "professional nurse." As Paige pointed out, however, no such distinction is made between the two educational levels on her nursing license. "Our Registered Nurse License is called a Registered Professional Nurse. And it does not take into account whether it's an associate or a baccalaureate." I will note here that I know the same is true in Georgia and most likely many other states, as well.

Taken together, these factors create the normative and control beliefs that influence the nurses' attitudes and perceptions of the degree. Among the significant normative beliefs are how the families and colleagues view the degree. Because families, in particular, value the status of an RN more than any particular degree, the nurse interprets the BSN as being less important.

When the nurse perceives that others within the field see the degrees similarly, that belief is reinforced. Other less obvious normative factors include the way in which employers and other nursing organizations appear to value the degree. Control beliefs, particularly in terms of licensing practices and employer actions that tend to minimize the nurses' educational accomplishments, further support the nurses' perceptions that the degree is "not worth it." The nurse who sees the lack of differentiation at the professional level through state licensing, at the local level through their employers' perspectives of the nurse, and through the eyes of their friends and family, has little reason to see the BSN as anything other than unnecessary and a waste of time.

Theme Five: Challenges to Professional Identify

Nurses are professionals. Their license says so. So, too, does much of the professional literature they consume, the practice acts under which they operate, and the general presentation of the profession of nursing within the public sphere. Even the foregoing statement that referenced "the profession of nursing" implies that nurses are professionals. It is not surprising that suggestions that in some way AD-prepared nurses are not professionals would be met with resistance. None of the nurses in this study specifically spoke to the ways in which the efforts to promote the BSN or to encourage current Registered Nurses to complete their degree challenge their professional identity, but the sentiment is there within their responses. This section looks at how the nurses expressed their perceptions that they might not be "good enough." Like the generic nurse in Theme Four, challenges to professional identify are reflections of the normative beliefs that influence the nurses' perceptions of the degree. Normative beliefs relate to how we perceive that significant others value an object. Coworkers may well fall into that category of

significant others, thus, how the nurse perceives their coworker's valuation of the degree has importance to the nurse.

Several of the nurses shared their experiences with BSN-prepared nurses who communicated either directly or indirectly that they were better nurses than the AD owing to the additional time they had spent in school. Katie exemplified that attitude in sharing experiences as an AD student interacting with BSN students.

. . . That the bachelor's degree, and I don't want to say fluff in a way that it is perceived that I think it's fluff now, but I think even back when I was in the two-year program, there was a little bit of a disconnect. I and some of my peers kind of perceived that nurses who were in the bachelor's program thought, and of course this is pure projection, conjecture, that they thought they were better than we were because they were in a, quote, longer degree.

As Katie noted, it was not merely that the BSN student saw herself as better, but that the AD students perceived that attitude and, to some extent, may have internalized that view. This is most evident as she told of her concerns when she did return to school for her BSN some years later. She described her concerns about how achieving her BSN might impact her relationship with her AD-prepared colleagues.

I'll acknowledge the closer I got to getting that bachelor's, . . . there was a little . . . sadness isn't quite the right word. There was a (pause) reframing of my identity. There was almost a sense of sadness because I didn't want to lose my connection to the nurses that have two-year degrees. Because I think I, at some level, at some different times, have kind of thought that nurses that had their bachelor's degree when I didn't, that there was this sort of sense of "better than." I'm a better nurse because I have my bachelor's, and that's why I'm in this role, and you're in that role. And, I certainly see a similar thing with LPNs. I think a lot of my friends who are LPNs have really had a lot of identity crises, you know, because they're trying to figure out where they fit in.

Normative beliefs are rooted in the value that we place on the views of others. They are socially driven. For Katie, this meant being concerned about how her BSN would impact her relationship with her AD-prepared friends and colleagues. Her reference to reframing her identity around her BSN and its effect on her relationship with her colleagues reflects the ways in which

she internalized the perceptions of the BSN she formed while working with those earlier BSN students. Not only was she concerned that she might see herself differently from her colleagues, but she feared that they might see her differently, as well.

The concept of the BSN nurse seeing herself as superior, or “better than,” the AD nurse was reflected, as well, by Susan, whose initial education was at the BSN level. She provided a bit of a twist on the concept, though, as she acknowledged that perhaps the additional education does not make one a better nurse.

When I first came out with a bachelor’s degree I would have been the one that said, "I'm better than you because I have four years of a degree and you only have two." I would have been that person. But I'm saying that, now, and especially like the people who unfortunately have been a nurse for 20 years and how the company is saying you have to get a bachelor’s degree. I understand their frustration because I'm really not sure that there's something that a standard bachelor’s prepared program can teach them that they don't already know from 20 years’ experience, you know what I mean?

But from when I was a freshman in college I would say, hands down, you should get a baccalaureate degree. And, I felt like most of the companies were changing to require the BSN that I was right in line with this is the way to go, this is what you need to do. We're the best prepared, blah-blah-blah-blah blah, you know, drinking the Kool-Aid or whatever.

She noted that her belief that as a BSN-prepared nurse she was “better” than the AD nurse was established early in her educational career. She implied through her phrase “drinking the Kool-Aid” that this view of the BSN was part of her educational experience. Socialization of the nurse to the professional role is part of the educational process and BSN programs promote this attitude among their students as part of the nurse’s education. It is the experience I had over 35 years ago and is one that others have shared with me anecdotally ever since.

Susan also pointed out that from her perspective as a BSN-prepared nurse, that the AD nurse, particularly the newer ones, come into the clinical setting “with a chip on their shoulder.”

At least in my experience, I feel like they walk into a job thinking that people think that they're not as well prepared or they're not as smart. Especially, the newer associate degree nurses.

She noted that the older, more experienced nurses

. . . know their crap and they know they know their crap and they will put you in place when you try to tell them they're not a good nurse. But the newer ones, I think, come in with a chip on their shoulders like, "I've got something to prove. I'm just as good as, you know, these smart areas."

Susan's comments echo Katie's earlier observations and reflect the influence of normative beliefs on the nurses' attitudes. Susan and Katie's comments suggest that the AD nurse may internalize the attitude, which may be communicated through social interactions with other nurses, that the BSN nurse is somehow "better" than the AD nurse.

Coupled with the pressure that many employers put on nurses to return to school, the suggestion that the BSN nurse is better than the AD or diploma nurse implies that the non-BSN nurse is incomplete. That, as Darla noted, "They are missing something. They are really missing something." The nurses who returned to school quantified that "something missing" and this will be discussed in more detail in the next theme. As an influence on the nurses' perception of the BSN and of their decision to return, or not return to school, the idea that they are somehow incomplete is a significant one. How can one be a professional if they are incomplete?

Leila expressed this sense of being incomplete as she related her experience with a person from the human resources department in which she was seeking a job. He did not know what a diploma nurse was. His lack of knowledge challenged her professional identify.

It wasn't, didn't used to be such a big deal but you know, I can remember somebody from like Human Resources, like he totally didn't even understand what a diploma nurse was. Seriously, like he didn't even know what that meant. And so, yeah, kind of—I don't know—kind of made me feel, you know, well, they don't really care what experience I have, they just care about this BSN. I kind of, I don't know, it kind of made me want it more because I didn't want anybody to just assume that because I didn't have it that I wasn't as good as somebody that just graduated that had a BSN.

Leila perceived the HR person's lack of knowledge of her preparation as an affront to her validity as a nurse. What we believe about how others perceive us is part of our normative

beliefs. Her statement that she did not want anyone to assume that she was not as good a recently graduated BSN student reflected the influence of social factors on her perception of the degree.

Grace presented another view of how her professional identity was challenged by a sense of being incomplete. She related her experience in her first job and the inadequacy of her preparation for that role.

You know when I went for my first job, I worked at a rehab unit and they said "okay, now here we follow the Dorothy Orem theory" and I said, "Who? What?" I had no idea what they were even talking about.

Like Leila, Grace was concerned with how she was perceived by others. Her lack of knowledge of Orem's theory created a social environment in which she felt inferior. In subsequent comments, she communicated that her desire to fill the gaps in her knowledge led to her return to school.

Control beliefs surrounding her ability to perform as a nurse were often reflected in Grace's comments. Control beliefs include factors that influence the perceived difficulty of carrying out a specific action. Having earned her AD, Grace expressed a great deal of frustration with her preparation because she felt that she lacked the knowledge needed to fully understand and fulfill her role as a nurse. She did not understand the "why" behind what she was doing and felt inadequate to answer patient questions.

I had the AD degree and I was thrilled to get that, but I hated it because it seemed like I was just doing task nursing. I mean, you know, it took me a little while to figure out, you know, God, I wanted to do this for so long, why am I hating it? But it was because I was doing tasks. I didn't know any of the "why's" behind what I was doing.

I couldn't wrap my head around why I wasn't enjoying being a nurse until I finally realized that you don't know enough. You're safe and you're doing these things as long as you're following these rules and stuff, but why are you doing what you're doing?

And patients, would ask you things and I wouldn't know the answer! You know, I could give the answer as far as what I knew, or I'd say, you know, "let me find out for you and I'll get back to you as to exactly. Or, did you ask the doctor?" I just felt like I didn't have a grip on my practice. It was very upsetting.

These comments reflect Grace's sense that she was not in control of her practice. Unlike the other nurses, though, for Grace her control beliefs influenced her to reach for the BSN rather than to inhibit her educational efforts. While her stories supported why she returned to school, she also offered an observation that perhaps her experience was not unique and that this feeling of inadequacy to the role was behind some of the turnover and clinical errors that occur in nursing.

Just because of what I've seen and, you know, and . . . I think that you wouldn't have frustrated nurses that either act out because they don't know what they're doing, and they haven't been able to identify that. Or, go above what they've learned and try to . . . try to . . . what am I trying to say . . . They lie their way through something rather than admit that they haven't a clue. Because they're an RN and they're expected to know these things.

From the perspective of control beliefs, her observation is enlightening. She suggested that it is the nurse's sense that they are not in control of their practice that leads to increased frustration and "acting out." Because as nurses they should know certain information or possess certain skills, their sense that they lack that knowledge creates a situation in which they are not truly in control.

Summary of Influencing Factors

The nurses all described a variety of factors that influenced their perceptions of the degree. Beginning in nursing school, nurses are taught that they are professionals and have the skills and knowledge needed to carry out their roles. Once established, this belief is difficult to unseat. As psychologists Lee Ross, Mark R. Lepper, and Michael Hubbard noted, ". . . once formed, impressions are remarkably perseverant and unresponsive to new input, even when such input logically negates the original basis for the impressions" (1975, p. 880). Thus, even as the profession challenges it, the AD-prepared nurse holds to the belief that they are fully qualified nurses, a belief that negates the need for further education.

Beyond nursing school, the nurses identified several other factors that influenced their perceptions. Chief among those factors was the perspectives of the nurses with whom they worked both during their nursing school clinical experiences and in their professional workplace. Not surprisingly, nursing students would look to those already in the professional workforce for insight into the profession. Who better to model professional behaviors and attitudes than those who are working in the field? When those role models suggest that the degree is of little value, as Katie reported, the nursing student is likely to listen and adopt a similar belief. Similarly, when those role models dismiss the notion that the BSN would one day become required for entry into the profession, the nursing student would take note of that, as well. Viewed through the lens of the TPB, the nurses' attitudes regarding the BSN developed from the normative deriving from the experiences, observations, and attitudes demonstrated by the people the nurses looked to as models of professional comportment.

As working nurses, the participants noted the dissonance between their employers' words and actions. Despite encouraging their nurses to continue their education, many nurses found that they had no difficulty getting a job, despite their lack of a BSN. Surely, if the employer was serious in their desire for a BSN staff, they would alter their hiring practices to reflect this. Further, while employers give voice to the desire for their nurses to pursue the degree, failing to give the nurse time to attend classes or to acknowledge the accomplishment with additional pay, or even the simple acknowledgement of the nurse's academic credential on her name tag, all contradict the organizations' stated desires and communicates to the nurse that, as Leila noted, "I guess they feel that it is not important." It is not surprising that she would find the simple refusal to add "BSN" to her name badge as "a bit discouraging."

As noted earlier, control beliefs are the beliefs the individual holds regarding the sense of control the individual has over an action or the availability of opportunity and resources to achieve the desired outcome. According to the TPB, control beliefs are one of the three pillars on which attitudes are built. If the nurse perceives that she has little control over the outcomes of her actions, or of the resources needed to achieve the desired outcome, she is more likely to develop a negative attitude toward that action. These nurses perceived the disconnect between the employers' words and actions as evidence that they had little control over the results of achieving the BSN. That is, there was no benefit to them. And, in the absence of perceived benefit, they demonstrated a negative view of the degree.

Returning to School

In this section, I will examine the factors that motivated these nurses to return to school, the level of support and encouragement they received from friends and colleagues, and how their perceptions changed as a result of their BSN educational experience. While the general perception among the nurses, early in their career, was that the degree was unnecessary, a waste of time, and repeated what they had already learned, the nurses who subsequently returned for the BSN tell a different story. For them, the BSN provided clear benefits and, far from being repetitive, added to their knowledge base making them, in their view, better prepared to provide safe and effective care to their patients. They could clearly identify how the curricula differed. All saw value in the degree and they all echoed the same view that the BSN should be the entry level for Registered Nurses.

Theme Six: Returning With Purpose

All but one of the nurses in this study noted that their early, and often long-standing, perceptions of the BSN were negative; yet four of the seven participants did ultimately return.

Their reasons for returning were personal and unrelated to the expectations of their employer. Instead, they chose to return to meet their own needs and interests. While many employers are requiring their nurses to go back to school or risk losing their jobs, Paige, whose early view of the BSN was that she “thought it was a waste of time. That it was not necessary,” returned in order to qualify for, and pursue, a job in which she was interested.

At the prompting of her nursing school faculty, Paige had initially returned for her BSN shortly following her graduation from nursing school. She stopped, however, when she met her husband and got married. She finally did return to school roughly 24 years later, “[b]ecause I got a job as school nurse and they required a bachelor's degree.”

Job opportunities also prompted Katie to return. After working regularly with a nursing staffing agency for several years, she began to experience a decrease in the opportunities available to her for work. A new agency had taken over the management of temporary nurses at the VA hospital at which she had been working. That agency demonstrated a preference for BSN-prepared nurses, limiting the hours available for Katie. In response she began to look about for other job opportunities only to realize that they required a BSN and often were for shifts that were not desirable to her. She realized that she would need to evolve if she wanted to continue to work in nursing.

So, what I realized at that point was, "okay, I've probably squeezed about every drop of serviceability from my two-year degree, it's probably time to go back." That's why I went back. I kind of realized that if I was to stay in nursing it was reaching a point where I would have to. And I was no longer willing, as I had in years past, to just go out and find something that I could do.

Her decision to return to school was initiated by a control belief that she could no longer control her work situation. She could, however, influence it by returning to school, an action that was within her control. While Katie had anticipated continuing her education while in her AD program, her plans had been thwarted by changes in her employment status that were also

beyond her control. Both the initial event that scuttled her earlier plans and this more recent set of events that spurred her return were control beliefs that influenced her attitude toward the degree. In the former case, she adopted a more negative attitude toward the degree in response to the unexpected loss of the job she felt she had been promised by the university she attended and in which she worked. In the latter case, she shifted her attitude in a more positive direction in recognizing that she could achieve more by completing her degree, an action she felt was within her control.

For Leila, a job played a role in her return, but was not the motivation for it. In fact, she was not required to return to school by her employer but chose to both to fulfill her own personal goals and to help meet the organization's goals. She noted, though that most of her prior employers were not supportive of returning to school.

Until I took this job that I'm currently doing right now and that was something that they talked with me about at the job interview. That they would encourage it. I was actually grandfathered in; I don't have to have it, but they are kind of wanting more of the nurses [to have the degree].

Earlier, I described an encounter Leila had with a Human Resources person who did not know what a diploma nurse (Leila's initial nursing education) was. Referring to that experience and noting that it felt like the organization was more concerned with the degree than with the experience she brought to the table, she noted that she did not want to be seen as lacking in some way.

I kind of, I don't know, it kind of made me want it more because I didn't want anybody to just assume that because I didn't have that I wasn't as good as somebody that just graduated that had a BSN.

The Theory of Planned Behavior describes intentions as the degree to which an individual is willing to try a behavior and the amount of effort they give in carrying out that behavior (Ajzen, 1991). Leila's return to school represents an intention to return to school based on her

behavioral beliefs that the degree itself, or more accurately the knowledge gained from the degree, had value. Her decision was also influenced by normative factors surrounding how she perceived that others saw her. She was concerned, as she noted, that others saw her as lacking something without the BSN. These two factors combined to generate within Leila an intention to return to school.

Grace came into the BSN program from a very different perspective. She chose to return to school as a personal goal but also because she felt that her AD had failed to provide her the level of knowledge she felt she needed to be safe and successful in nursing. She had wanted to be a nurse long before she was able to realize that dream. As she noted, she started a family sooner than she had planned. When her youngest child turned 14 she applied to, and was accepted by, an AD program. She was thrilled. Soon after obtaining her license and entering practice, however, she found herself very frustrated. A combination of control beliefs surrounding her nursing practice and normative beliefs built around the concerns she had about how others might see her worked to motivate her return. She described her sense of confusion and frustration in her practice because she knew what she was doing, but not the reasons why. She felt a strong lack of control over her practice. Similarly, she described concerns that the patients with whom she interacted would consider her inadequate if she was unable to answer their questions. These factors combined to create a motivation and intention to return to school to complete here degree.

Returning to school, as I noted in Chapter 2, is an intentional act. The TPB assumes that intentions capture the motivations for an action, including the degree to which the person is willing to attempt the action and the amount of effort they are willing to invest in the action. Those motivations are driven by the attitudes the individual holds toward the action. In deciding to return to school, these nurses first had to reconsider their earlier attitudes toward the degree.

For each of these nurses, that process involved determining that the effort of returning to school offered some benefit that they found valuable. For them, that benefit took the form of fulfilling personal goals or positioning themselves to obtain a desired job.

Theme Seven: There is a Difference

The nurses who returned for their BSN all found value in the degree beyond the fulfillment of their own goals or in positioning themselves for a desired job. They recognized the differences between the two degrees and how the additional knowledge provided by their BSN education allowed them to expand and deepen their practice. These nurses valued the provision of safe, effective, high-quality care to their patients. Behavioral beliefs within the Theory of Planned Behavior are based, in part, on the associations drawn between an object of an attitude and other related objects about which we already hold some belief. In identifying ways that the additional education aided their ability to provide that high quality care, the nurses drew a connection between the benefits of the BSN and their beliefs regarding the provision of care. Because they saw the positive effect of that education on their practice, the nurses were able to shift their attitudes toward the degree.

The nurses returned to school with expectations of growth, both personally and professionally. That these expectations were met may explain why they all felt that the experience was worth the effort. Leila expressed her expectations of the degree noting that she did not know what she was missing.

I just saw it as something that I didn't really know what I was missing. I just always kind of assumed, well, I have three years, I think I had everything that I should have had.

Grace provided another example, setting up her experience as one of wanting to know more.

Well, again, I was really, and I know it sounds goofy, but I really just wanted the knowledge. I wanted all the different ramifications of nursing because that's something I

still say to people: you can specialize, just like a doctor, you can specialize in something that you really find that you like.

Katie reported a similar expectation, noting that she “. . . did go in with an exceptionally . . . an openness and receptivity that undoubtedly played into why I was entering the program to begin with.” More specifically, she noted that

[M]y perception of the bachelor's program is that it would help me identify the areas that I am strongest in and it would give me an opportunity to strengthen or bridge knowledge gaps that I may or may not have known I had, and ultimately, of course, the expectation is that with my bachelor's, it would open, open up the number of available jobs that are more closely aligned with what I need now for my family life.

Once they completed the degree, the nurses noted the differences between the curricula and how those differences positively impacted their practice. Subject areas such as nursing research and leadership were new areas for them and they generally found them interesting and useful. Other topics such as health assessment were a surprise to them. As AD nurses they had been taught to do a focused assessment. This is a process of systematically inspecting and assessing the patient focusing on specific body systems. The primary goal of a focused assessment is to document and report any abnormalities. In contrast, a health assessment, as taught at the BSN level, is a more comprehensive process that includes inspection and assessment, within the context of the patient's past medical history, family history, current health issues, current living environment, and other factors that may influence the patient's overall health. It also involves, as Paige said, “putting it all together,” interpreting the findings to gain a better understanding of the patient's overall health. Paige described her reactions to learning to do a full health assessment, something she had never previous learned or done.

And health assessment. Like a full health assessment. It was very interesting because I never had to do that. We always did it in steps but not putting it all together. [Previously she had learned and conducted] All focused assessment, so putting it all together was the new part. I could listen to any system, I could assess any system, but when I had to do a head-to-toe and videotape it, I was blown away.

Leila expected her prior education and experience to carry her through her BSN; she was soon disabused of that notion.

I think I kind of went into it thinking I'm probably going to know everything. This isn't really going to be that difficult. One of my first nursing classes I had to take, because they wanted you to have an assessment class within 5 years, well, it had been 30 years since I had had an assessment class. And, I'm telling you, that was really a tough class. It was like, "Okay, I never learned . . ." I mean, you know very specific tests that I was looking up on the internet, okay, how do you do this test? And like specific hearing tests. I mean, even from when I took that class, I'm like, "oh, this is really in depth."

And, like I said, "Assessment? That's so silly. Why would I have to take assessment?" But it was very in-depth and a very good class.

Leila's comments reflected the behavioral beliefs she held toward the expectations of the degree. While she saw value in the assessment process, she came into the experience believing that she already possessed appropriate skills in assessing patients. As she experienced the assessment class, however, she realized that there was more to know. Thus, while her initial beliefs would have supported her earlier negative attitude toward the degree, her subsequent exposure to the more in-depth assessment taught at the BSN level disrupted that thinking and helped to move her attitude toward a more positive view because she valued the quality of care that the more in-depth assessment allowed her to provide her patients.

The nurses also described how their understanding of nursing research, a topic not included in their prior education, had enhanced their practice. Leila's experience with nursing research exemplified that view.

You know I guess the research was a big part of that because I had no experience in that, whatsoever. So that whole looking at certain databases, and how to—I mean, I can remember asking how do I get peer reviewed, I mean I was totally naive. I knew nothing about that. So, that was a big thing that I think I took away from this . . . And, could use that to, you know, this is why I think we should do this because of this reason, or I'm going to research this because I don't really know if I agree with how we're doing this.

Grace found nursing theory to be both interesting and valuable to her.

Well, for example, I really liked learning about the nursing theorists. I thought this was a cool thing to do. And, it impressed me that these nurses would spend all this time doing the research and figuring out the why of nursing versus the medical field and doctors. I really liked that.

These nurses' experiences in learning about nursing research and how it could benefit their practice allowed them to perceive greater control over their practice. Grace's observation, for example, that the research helped to "figure out the why of nursing versus the medical field" contributed to her understanding of her practice and how it differed from other fields, but also provided a foundation for better understanding what she was doing within her practice. Having a sense of control over one's success in an activity, what the TPB calls control beliefs, is an essential contributor to the attitudes that an individual holds toward that activity.

Health assessment and research are topics that came up several times in discussing how the educational experiences differed. These courses represent measurable differences that can be established from side-by-side comparisons of the programs. Less easily measured, but clearly experienced by these nurses, was a sense that they were better prepared to care for patients due to the improved critical thinking skills that resulted from their BSN education. Paige provided a broader, more encompassing view of the effect of BSN education on critical thinking.

And, I see the differences. And the difference is, the nurses that we make from the baccalaureate program are better prepared and more grounded than the associate's. Because the associate's seems to be only worrying about "Am I doing this skill right?" Where the critical thinking is stronger in the baccalaureate. That's what's missing is the critical thinking.

Leila attributed her improved critical thinking skills to having developed her skills in conducting and understanding research and in realizing its utility to her practice.

I'm more prepared to take care of patients than I was with my diploma program and have some more critical thinking skills and theory behind what I'm doing rather than it was always done this way and this is how we do it. And, could use that to, you know, this is why I think we should do this because of this reason, or I'm going to research this because I don't really know if I agree with how we're doing this.

In noting the differences between the levels of nursing education, these nurses described how their behavioral beliefs were altered by the experience. They valued quality of care. In their initial attitudes toward the degree, they equated that quality of care with the ability to carry out tasks. As they expanded their knowledge with the BSN, they became aware of the positive impact that the additional education had on their practices. Recognizing the differences in levels of education would lead to new attitudes toward the degree and ultimately to the belief that the BSN should be the required educational level for entry into practice as discussed in Theme Eight.

Theme Eight: Required Entry to Practice

All of the nurses who returned to school stated, somewhat emphatically, that they believed that the BSN should be the required educational level for entry into professional practice. They supported their position by acknowledging the curricular differences between the two programs and the effect that those differences had on their practice. They also pointed to other factors, as well. Grace, for example, noted that having multiple entry points just “muddies things up.”

I was really frustrated as an associate degree [nurse] and I really feel that they should do away with them, personally. But . . . I think it muddies everything up because I still get annoyed when . . . you know and I know that they sat for the RN test and everything . . .

I wouldn't mind if they did an associate degree and you got an associate degree, but you couldn't sit for your RN. You could get your associate degree and apply it to another school to go on for a BSN and RN. [But] like I said, you have to have a baccalaureate to sit for the RN.

Control beliefs are the beliefs the individual holds regarding their perceived ability to be successful. In addition, control beliefs are related to the availability of resources and opportunities to be successful. In Grace's view, her AD education had not prepared her adequately to be successful in her chosen field. Thus, the control beliefs she held influenced her perception not of the BSN so much as of the associate degree. Having completed her BSN, she

recognized the difference in her sense of control over her practice and, in response, determined that the AD degree failed to provide the level of preparation she needed. As a result, she held that the BSN should be the entry level for all nurses.

Paige also asserted that the BSN should be required for practice as an RN. She noted that the AD programs needed to be revised, recognizing that the focus of the AD program simply did not adequately prepare the student to work as a Registered Nurse in today's environment.

I think that the associate degree programs should be revised to LPN programs and not RN programs. I don't think they're learning enough in the associate's degree . . . I think that everything that is covered through a bachelor's degree is what is necessary for the working nurse. That the physical skills that they're teaching an RN diploma or associate degree, whichever, is not enough to keep up with the demands of what is needed by nursing today. There's no, like I said before, there's no leadership, there's no ethics built in. I'm not saying that they're unethical; I'm saying that they don't know what they don't know.

Paige has clearly identified the factors that she feels differentiates the AD from the BSN prepared nurse. She values the quality of care that nurses provide and recognizes the importance of what is taught at the BSN level in providing that care. The TPB explains this as the influence of behavioral beliefs on attitudes. Her attitude shifted from one that said the BSN was a "waste of time. A total waste of time" to one that believed the BSN should be the entry level as a result of the association she had drawn between the impact of BSN education that she saw on her practice and the value that she placed on quality patient care.

Earlier I quoted Paige as noting that the AD nurse tended to focus on physical skills and that they lacked critical thinking skills. She also noted that their ability to lead and manage teams was inadequate, as well. Leadership and management are parts of the BSN curriculum, but not of the AD curriculum. She felt these skills are critical in today's nursing environment. Referencing her own BSN experience, she noted, "What I learned there was leadership and ethics, particularly." Paige considered leadership and management as essential elements of nursing

practice today and provided this as further evidence that the BSN should be the entry level to practice.

I don't think they're very strong in delegation. And I think that's huge. And, I think there's a lot less . . . I mean, they're doing more physical skills, there's more. But I think they lack a little more in time management because they need to, you know, when you're overseeing a team of people, you need to figure out not just what you need to do, but what everybody else needs to do and that's the leadership/management piece that I don't think they get.

Echoing Paige's observation that ethics was not "built in" to the AD curriculum, Susan pointed out how important ethics is to the practice of nursing. She noted that nurses have been viewed as the most ethical profession for many years (Brenan, 2017).

We are professionals and people don't view us as professionals, although they do view us as ethical. If you look at the Gallup results for, like the last 16 years or something in a row, nurses are the most ethical position of any job field anywhere.

Susan attended a Jesuit university that included ethics as an integral part of all of its classes. As she noted, she would have gotten the same ethics training regardless of her collegiate major. Thus, while the views she expressed regarding ethics are valid, her foundation in ethics is likely much stronger than that of most BSN nurses, owing to the integration of ethics into all of her college courses.

Before entering their BSN programs, these nurses were unaware of the differences between the two curricula. They thought that the only real difference was in the humanities and other non-nursing courses that made up the first 2 years of a 4-year degree. They believed that the actual nursing content presented in both programs was the same. After completing their BSN, they realized not only that the curricula were different, but how significant those additional courses were to their nursing practice. They observed how their BSN education led to differences in how they saw and implemented their nursing practice. They drew associations between the effect of BSN education on their practices and the value they placed on quality patient care.

Armed with this knowledge, the nurses experienced a shift in their behavioral beliefs, as they all supported the notion that the BSN should be the entry level for professional Registered Nursing.

Summary of Returning to School

The nurses returned to school for a variety of reasons, including a desire for more knowledge, personal growth and accomplishment, or to expand their career opportunities. None identified employer mandates as a catalyst for their return. While they returned for different reasons, their decision to return required that they let go of their earlier perceptions of the value of the degree and acknowledge that the degree provided additional value to them. All but one of the nurses noted that they found the BSN curriculum to add to their knowledge base in unexpected ways. For example, Paige reported that she was “blown away” by her experience in health assessment which, as Leila noted, seemed “so silly” to her. Why, she asked, did she need to take another assessment course? Yet, Leila found, as did Paige, that the health assessment at the BSN level provided her the skills to understand the patient’s health status in a much deeper and more comprehensive way. The one dissenting nurse did not complete her BSN, in part because her educational experience did not meet her expectations. She continued to feel that the BSN was a waste of time.

While the nurses noted that they had been previously unaware of how the curricula differed between the AD and BSN nurse, they all were able to clearly describe the differences and had come to realize that the BSN was, in fact, quite different from their AD preparation. This realization, coupled with the positive impact the BSN education had on their professional practice, led them to declare that the BSN should be the entry level for nursing practice.

Viewed from the perspective of the Theory of Planned Behavior, these nurses experienced shifts in both their behavioral beliefs and control beliefs. They saw the positive

impact that their BSN education had on the quality of care they provided. Because they valued providing quality care, anything that improves the quality of care they provide will be seen in a positive light. Similarly, the additional education provided them with additional insights into the “why” behind their practices to help them understand both the reasons for their actions and how their actions differed from those of other medical professionals. This provided them with an increased sense of control over their practice. In providing them a greater sense of control over their practice, the BSN education led to a more positive attitude toward the degree.

CHAPTER 5: DISCUSSION, IMPLICATIONS FOR PRACTICE, LIMITATIONS, AND SUMMARY

The aim of this study was to describe the perceptions that nurses hold toward the BSN, the factors that influenced those perceptions, and the ways in which those perceptions may have changed as a result of completing BSN education. Using a semantic approach, thematic analysis of the data presented by the nurses resulted in the identification of a total of eight themes: three related to perceptions of the BSN, two related to factors that influence those perceptions, and three related to returning to complete the degree. In addition, three subthemes of the Generic Nurse were identified.

This chapter provides a discussion of the themes and subthemes within the context of the literature and relevant theory, presents conclusions, addresses limitations of the study, and summarizes the study. Discussion findings are presented in terms of the research questions.

Discussion

Research Question One

What perceptions do nurses hold toward the BSN? Responses to this research question tended to inter-relate the concepts of the BSN-prepared nurse with BSN education. The nurses generally perceived the BSN nurse, and by extension the BSN degree, in a negative light. They perceived the BSN-prepared nurse to be ill-equipped to care for patients at the bedside, suggesting that they may be better suited for work in administration than for work in bedside care. The nurses also expressed the view that the degree was not necessary and a waste of time.

Nursing is defined by technical skills. The nurses' perceptions of the degree were rooted in how they defined nursing. In considering their early assessment of the BSN, all of the nurses defined nursing in terms of clinical skills and the ability to perform in the clinical setting. Skills, as generally used within the nursing literature, represent a range of physical, cognitive, and emotional abilities. Commonly identified nursing skills included the technical skills needed to carry out the tasks of nursing, as well as leadership and management, communication, decision making, critical thinking, organization, and information gathering (Candela & Bowles, 2008). These nurses' responses suggest that they were defining nursing based only on the technical skills needed to carry out the tasks of nursing care. Although unlikely to be intentional, these nurses' definition of nursing aligns well with the concept of the technical nurse as defined by Montag in the model of nursing she proposed in the 1950s (Matthias, 2010).

A review of the literature failed to identify any studies that specifically addressed how AD nurses perceive nursing, although there are hints within the literature to suggest that the definition used by the nurses in this study is not uncommon. Zuzelo (2001), for example, noted that some RN to BSN nurses expressed the sense that the degree had no real influence on the direct care they provided to patients. Similarly, Delaney and Piscopo (2007) quoted an RN to BSN nurse who observed that "I used to be very task oriented. I would think we need to get this and that done, wait 2 hours, and do it again" (p. 172). These examples do suggest that the AD nurse tends to focus more on the accomplishment of the tasks of direct bedside care rather on than the broader scope of the whole patient. Zuzelo noted that this move away from a task orientation was part of the transition to baccalaureate nursing. Kumm et al. (2014) noted that the AD nurse is "educated specifically to be the nurse that goes out into the working world and can 'hit the ground running'" (p. 218). This statement can be understood to mean that the nurse is

given the technical skills to safely function in the clinical setting. However, it may also be understood to mean that the AD nurse possesses the full set of skills needed to function effectively in the clinical environment. If this latter view is true, then the BSN would add little to the AD nurse's repertoire and the nurses' belief that the degree adds nothing to their practice would be validated. The literature strongly suggested, however, that RNs who have completed their degree do feel that their BSN experience added to their skill set (Delaney & Piscopo, 2004; Doering, 2012; Megginson, 2008; Zuzelo, 2001). This view was also expressed by the nurses in this study who completed their degree.

Bedside experience is vital to good nursing. No small part of the perception of nursing as based on clinical skills is the importance the nurses gave to practical clinical experience. The nurses all agreed that practical clinical experience was the bedrock of nursing practice. Susan, for example, observed that

I think that more of nursing comes from the practical experience than comes from the two years you're in school or the four years you're in school and the longer you're in the role the better of a nurse you'll become if you'll allow yourself to learn and to grow.

Candela and Bowles (2008), in a study of RN graduates' perceptions of their educational preparation, found that 77% of the nurses in that study did not believe that their nursing program provided a sufficient number of clinical hours. More interesting, perhaps, is that the AD graduates in that study were slightly more satisfied with their preparation than were BSN graduates, though the findings were not statistically significant ($p = 0.57$) and no specific reasons were provided for these findings. Gaberson and Oermann (2010), in discussing teaching in the clinical environment, pointed out that nursing is a practice discipline and, therefore, the ability to perform in the clinical environment is more important than classroom performance. Much of Patricia Benner's work on the development of expertise in nursing centered around clinical experience (Benner, 2004, 2011). In the Novice to Expert model, for example, expertise was

context dependent such that a nurse can rightfully be considered an expert in one clinical setting while a novice in another. The difference is in the clinical experience the nurse has in each of those settings.

Nursing is a practice discipline; it cannot be taught in a classroom. The fledgling nurse must have the clinical experiences of working with real patients in real clinical settings in order to develop effective clinical reasoning skills (Benner, Sutphen, Leonard, & Day, 2010). Susan suggested, as well, that it was “super important” to get students into a simulation lab, making that experience as real as possible. Simulation labs clearly do provide the student with a safe space in which to practice and develop their technical skills. Some lab scenarios may even provide the student an opportunity to hone their problem-solving skills in dealing with aberrant situations. Benner et al. argued, however, that simulation cannot replace the genuine interaction between student and patient that is essential to the student’s formation as a nurse. “The temptation is to reduce the notion of moral agency to a possession of skill and strategic capacities. However, strategic skillfulness and knowledge ignores the relational issues involved in good nursing care” (Benner et al., 2010, p. 180).

The BSN is not needed. The nurses presented a generally negative view of the BSN degree, noting that it was not needed in order to be a good nurse. They believed that it was a waste of time and believed that they would already know all that is taught in the BSN program. Their experiences in working with the BSN-prepared nurse, coupled with their tendency to evaluate nursing ability in terms of technical skills, formed the basis for this view of the degree. Paige provided an excellent example of this way of thinking.

I thought it was a waste of time. That is was not necessary. And the reason why is that I worked with bachelor’s prepared nurses and they had no clinical experience coming out of school. So, yes, they had initials after their name, but I had the skill set to be able to run the floor—because I worked in a hospital—and they didn't even have, like . . . this

one girl came out and was like, "I've never done a catheter before." And I was like, "What? How'd you get out of school?"

These nurses' view of the degree reflected their focus on the bedside nurse and were consistent with the findings reported by Carlson in her unpublished study on the relevance of psychosocial deterrents on the nonparticipation of nurses in BSN programs (as cited in Cooper, 2005). Carlson noted that "some nurses believed that the degree was only needed for the nurse in administrative positions, not for the bedside nurse" (Cooper, 2005, p. 26). Root (1991) provided some corroboration to the nurses' concerns that they would "already know it all" as she noted that some of the students in her study identified areas of overlap in the curricula of the AD and BSN programs. She also noted that participants in that study expressed the sense that having to repeat these courses was "insulting, time consuming, and expensive" (p. 73).

The notion that the degree was not needed is also consistent with findings by Zuzelo (2001) where nurses reported having a BSN education had not impacted their practice. A study by Weinberg, Cooney-Miner, Perloff, and Burgoin (2011) that explored the influence of educational preparation on hiring practices, provided further support for these nurses' views. That study found that nurse managers saw little meaningful difference in how nurses delivered care, noting that this suggested that nursing remains a technical, skills-based practice. In contrast, other studies suggested that BSN-prepared nurses have better clinical skills based on improved outcomes (McHugh et al., 2013). Kutney-Lee et al. (2013) found better overall patient outcomes and lower rates of failure-to-rescue in hospitals staffed with larger percentages of nurses prepared at the BSN level and higher. This would seem to contradict these nurses' perceptions that the BSN nurses were not good nurses. The phrase *clinical skills*, however, may carry multiple meanings such that the nurses in this study were referring to the physical or technical skills (e.g., catheter insertion) whereas the clinical skills implied by Kutney-Lee et al., McHugh

et al. (2013), and others may have referred to higher level cognitive skills rather than physical skills.

The nurses in this study pointed to a lack of clinical experience in BSN education to explain what they perceived as a disparity between the clinical skills of the BSN-prepared nurse and those of the AD nurse. The perceived difference in clinical educational experience was also reported by Zuzelo (2001). In that study, Zuzelo quoted one nurse who observed, “You had more clinical, which you don’t have in a college program and I don’t understand why they’re trying to get rid of nursing programs to tell you the truth. . .” (p. 60).

Whether this is, in fact, a valid assertion or the result of a lack of knowledge of what BSN education entails is unknown and may be worthy of additional study. Moreover, if the nurses’ perceptions regarding the lack of an adequate clinical component in BSN education is accurate, the BSN nurse could be reasonably expected to learn and hone those technical skills quickly once they are working in the clinical environment. The clinical environment would demand it of them.

While the general consensus was that the BSN was a waste of time, not everyone held that view. Grace pursued her BSN in the hopes that it would fill a void in her knowledge base. She was driven to return to school because she felt that she lacked the knowledge necessary to do well in her role. She did not feel that she had a handle on her practice because she did not understand the “why” behind what she was doing. While it does not appear that her perspective is common, neither is it an isolated perspective. Similar views were expressed by nurses in other studies (Delaney & Piscopo, 2007; Megginson, 2008; Zuzelo, 2001).

The notion that the BSN offered nothing original to the AD-prepared nurse, that they would already know it all, is an interesting one. It reflects a lack of knowledge of how the two

curricula differ. It also reflects the assumptions that may interfere with a more complete understanding of those differences. Cooper quoted from Carlson's unpublished dissertation that

[I]f registered nurses have not participated in a course or a program for a BSN degree, they do not have first-hand knowledge of the quality or relevance of credit courses. So, the negative impressions of credit courses held by registered nurses were formed, or at least influenced, by others. (2005, p. 27)

The AD nurses also reported that the only differences they saw were related to the humanities and other general education courses not directly related to nursing. This was an interesting and unexpected finding and one which appears to have not been addressed in the literature. This is an area that requires further study. Only those nurses who went on to complete their BSN were able to explain the differences in educational preparation between the two programs. Neither the AD nurse nor the BSN-only nurse was able to do so. It is reasonable to assume that professionals within a field should be able to identify and understand the differences in educational preparation within that field. That nurses appear to lack this understanding is concerning and clearly contributes to the confusion surrounding the degrees and how they are perceived.

Summary of Research Question One

The data relevant to the nurses' perceptions and attitudes of the BSN were organized into three themes. Each of the themes presented a perspective on the BSN nurse and, by extension, BSN education, that was rooted in the nurses' conception of what constituted a "good nurse." In general, the nurses held a negative view of the BSN nurse and of BSN education. The nurses described the BSN-prepared nurse as ill-prepared for bedside practice, noting that the BSN education lacked the amount of clinical instruction and experiences that the nurses felt was adequate to provide the BSN nurse with the requisite skills for safe practice. In keeping with their view that technical skills were at the center of safe practice, the nurses emphasized the

importance of clinical experience in developing the necessary skills. Extending this perspective, they asserted that BSN education was unnecessary, as it added nothing to their skillset.

Considered from the perspective of the Theory of Planned Behavior, the nurses' conception of the "good nurse" provided the foundation for determining the relative worth of the degree. In accordance with the concept of behavioral beliefs, as described by the TPB, they found that the characteristics they associated with the BSN nurse did not rise to the level of what constituted a good nurse and, as a result, formed unfavorable attitudes toward the degree.

Research Question 2

The second research question asked what factors influenced the perceptions the nurses held toward the BSN. The responses to this question were aggregated under the heading of Influencing Factors, with two themes and three subthemes identified. The Theory of Planned Behavior (TPB) plays a significant role in how these themes impacted the nurses' perceptions of the degree. The TPB posits that the attitudes one holds toward some action are strongly influenced by three factors: behavioral beliefs, normative beliefs, and control beliefs. Behavioral beliefs are the beliefs that the individual holds regarding the value of the object of that attitude. As Ajzen noted, "we learn to favor behaviors we believe have largely desirable consequences and we form unfavorable attitudes toward behaviors we associate with mostly undesirable consequences" (1991, p. 191). In this study, behavioral beliefs included how the nurses saw the value of the degree to their practice. Normative beliefs, the second factor that influences beliefs, represent how the individual believes the significant others in their lives views the behavior. For example, whether family and friends hold the BSN to be of value will influence the nurses' valuation of the degree. The final factor is control beliefs. Control beliefs are concerned with the degree to which the individual believes he or she can control the situation. This is also associated

with the degree to which they believe they will be successful in their efforts. In considering the factors that influence the nurses' views of the BSN, only the first two factors—behavioral beliefs, and normative beliefs—were well represented in the nurses' responses. The nurses were not asked to speculate on their ability to control their educational experiences, or to be successful in those endeavors. This was, in retrospect, a failure on my part in planning the interview process. However, given that several of the participants did complete their degree and others made a deliberate choice not to pursue their degree, it is unclear whether the participants would have been able to provide any meaningful responses to questions in this area. As Schwarz and Bohner noted, attitudes are “evaluative judgments that the respondents construct at the time they are asked . . .” (2001, p. 3).

The Generic Nurse

This theme suggests that a nurse is a nurse is a nurse. That is, there is little to no difference between nurses, regardless of their educational preparation. It also suggests that the RN license is more important than the pathway the nurse follows in obtaining that license. This theme is discussed within three specific contexts, which form the subthemes for this theme: family, friends, and colleagues; professional factors; and, structural factors.

Subtheme 1: Family, friends, and colleagues. How the nurse was perceived by family and friends seems to have an important impact on how the nurses perceived the degree. The nurses commonly reported that their friends and family tended to see the role of nurse in an undifferentiated way. As Grace noted, “a nurse is a nurse is a nurse to most people.” Patty noted that her family's perspective was that “you're going to be an RN and that's kind of what really matters.” Family and friends were supportive of their efforts to earn the RN license but were indifferent to the educational pathways followed in achieving that goal. This is not surprising.

The nurses' perceptions of the BSN degree reflected a lack of appreciation for the differences between the AD and BSN nurse. If these members of the profession failed to see significant differentiation, how would those outside the profession be aware the differences?

Even still, Susan pointed out that society has set up a situation in which the 4-year degree is almost required. If her assertion is accurate, it seems reasonable that families would encourage the student to pursue the baccalaureate degree, in keeping with current societal expectations.

[A]nd I still advocate for a bachelor's degree. And the reason why is because we've set ourselves up as a society, that seems to be, the bachelor's degree seems to be the new high school diploma. You know, from maybe 80 years ago, you know, the bachelor's degree is the new high school diploma. You know, it seems like everybody has got to have one, right?

One possible explanation is that nursing is seen more as a vocational track than a professional one. This view can be explained both as a holdover from nursing's history, in which "training" was based on an apprenticeship model, taking place in the hospital and by the long history of AD education occurring in community colleges which, "equated nursing education with vocational training at a time when professional status was being sought for nursing" (Donahue, as cited in Megginson, 2008, p. 48).

While family and friends may have been indifferent to the educational pathways the aspiring nurse took to achieve initial licensure, the same is not true, at least among friends and colleagues, for those who chose to return. Those who returned related their experiences with colleagues who did not understand why they would choose to return. Grace shared her experience with a colleague who asked, "Why are you going for a degree when you're already working in it?" Others reported that their friends thought they were "crazy" and were generally not supportive, although Paige and Grace both reported that at least some of their colleagues were supportive. These findings are supported by Lillibridge and Fox (2005) who noted that participants in their study reported a lack of peer support in returning to school. The findings are

also at least partially supported by Doering (2012), whose participants reported mixed support from their friends and colleagues. She noted that some participants reported support for their efforts, while others reported negative feedback from colleagues.

Subtheme 2: Professional factors. Professional factors in the form of how other nurses present the degree appeared to impact how nurses perceived the BSN. Efforts to promote the BSN as the entry level for professional nursing have been around for 60 years (Orsolini-Hain & Waters, 2009) and yet only recently have these efforts begun to gain traction. Because of the long history of these efforts, many nurses believe that the efforts will never be fruitful. As a result, nurses tend to downplay the importance of the BSN. Paige shared how the issue was presented to her: “There was a lot of disbelief when the board of nursing said the entry level was going to be the bachelor’s degree. Our instructors would say, “Oh, that’s crap! They’ve been saying that for years . . .” The attitude that the degree is not necessary was consistent with what others have found (Altmann, 2012; Megginson, 2008).

How the profession itself demonstrates the value for the degree also influences how nurses perceived it. Patty reported that nurses in the clinical setting reminded her that “. . . if you have your bachelor’s as opposed to your associate’s, it’s going to be 50 cents an hour,” implying that the BSN would not pay for itself. The literature does lend some support to this perspective. Sportsman and Allen (2011) reported that nurses reported finding no difference in pay. Spetz and Bates (2013) reported only small premiums for additional education, while Graf (2005) found that organizations do not consistently provide substantial pay differentials for additional education. Thus, even though organizations may prefer that nurses hold a BSN, they are unlikely to compensate nurses for their degree, implying that the degree is not highly valued.

Mixed messages from employers also contributed to the nurses' perceptions of the degree. On the one hand, many employers encourage, even mandate, that their nurses pursue the degree. On the other hand, they may not offer tuition assistance, additional pay, or even acknowledgement of the accomplishment in simple ways. Leila noted that "my work does not let you change your name badge to BSN after receiving the degree. I guess they feel it is not important." She noted that "if your organization does not back it with money or even let you change your name badge, what is the point except for your own accomplishment?" Grace noted that some of her employers were "not really friendly with, as far as working around a schedule to go to school." It is reasonable to believe that an organization committed to promoting the BSN would be open to alternative scheduling to accommodate the nurses' academic schedules.

Whether because of on-going nursing shortages that force the employer's hand, or a lack of commitment to promoting the BSN, employers' hiring practices may also play a role in how the nurse sees the BSN. Patty noted that her associate's degree had served her well and that she had gotten every job she had wanted. She did not feel that not having the BSN had held her back in any way. Paige also suggested that her colleagues had never had problems getting jobs which, she felt, explained their dismissive view of the BSN.

Subtheme 3: Structural factors. Structural factors are those factors that reflect the environmental context in which the nurse operates. While the curricula of the 2-year AD nursing programs are different from the curricula of the 4-year BSN programs, graduates of the two types of programs sit for the same licensing examination and are issued the same title of "Registered Nurse." In New Jersey, Georgia, and perhaps other states, the official license reads "Registered Professional Nurse" regardless of the educational qualifications of the licensee. One participant noted this as a factor in how the degree is perceived. This lack of differentiation in licensing

likely creates confusion among those who want to become nurses, making the decision to pursue an AD or a BSN less clear. If both paths lead to the same outcome, other factors, such as financial constraints and time commitment, would tend to favor the AD. In fact, several of the nurses noted that they chose the AD path to nursing practice based on a consideration of financial factors, as well as the fact that they sit for the same licensing exam. Once licensed, the nurse has little incentive to return to school. Katie noted,

I didn't have the money to be in school four years but, by golly, I could do two and I was going to sit for the same boards and answer the same questions as the nurses that were in school two years longer were.

As noted earlier, that there is little to no differentiation between the two levels in practice has been identified as a barrier to returning for the BSN (Megginson, 2008; Schwarz & Leibold, 2014) and should similarly influence how the BSN is perceived. The lack of differentiation was highlighted by Susan, who stated that she was under the impression that the AD curriculum was essentially the last 2 years of the BSN curriculum. She was unaware of any differences. This lack of awareness of the curricular differences was confirmed by the AD nurses who also were unable to identify differences, at least until they had completed their BSN. Earlier, I quoted Carlson's observation that unless the nurse had taken some courses at the BSN level, they would be unaware of the differences in the curricula. This is an interesting observation but raises the question of why nurses are not more fully apprised of the differences in the curricula. Regardless of their own level of preparation, members of a profession should be aware of the differences in the levels of educational preparation within the profession. This is a structural issue related to nursing education that could be easily rectified. The nursing textbooks generally provide only a generic explanation of the differences. More specific content on the differences in curricula would be both appropriate and helpful in clarifying the differences. Providing clarity in the

differences may also help the aspiring nurse to better determine the route needed to achieve their specific career goals.

Challenges to Professional Identity

None of the nurses explicitly identified this as a factor, though they conveyed this through their stories. The nurses believed themselves to be professionals. They believed that they have been given all the tools needed to perform their jobs well; their practice experiences would seem to confirm this. Several factors, however, challenged their view of themselves as a complete nurse. That nurses were being encouraged to “complete” their degree suggests that their current preparation was inadequate. Leila captured that sense of being incomplete. In describing an encounter with a Human Resources employee who was unfamiliar with diploma nursing, she noted that she felt that her experience was not important, only the degree was.

The pressure from employers to return to school may also play a role in this sense of inadequacy. Though this was not directly addressed by the nurses in this study, they noted that they were aware of these pressures. If hospitals are using the literature that shows that hospitals with higher BSN staffing levels have better outcomes as evidence to support their push for nurses to return to school, I do wonder to what extent that information is interpreted as an affront to the clinical efficacy of the AD nurse.

Another way in which the nurses’ professional identity is being challenged was through their interactions with BSN graduates. As Katie put it,

I and some of my peers kind of perceived that nurses who were in the bachelor’s program thought, and of course this is pure projection, conjecture, that they thought they were better than we were because they were in a quote longer degree.

Susan, whose initial preparation was at the BSN level, validated that this was a view that BSN nurses tend to hold.

When I first came out with a bachelor's degree I would have been the one that said, "I'm better than you because I have four years of a degree and you only have two." I would have been that person.

Similarly, Darla shared that she was incensed by the attitude expressed by an instructor in a BSN program she attended.

And the instructor, of course she was a doctor, and she was, "Oh, you know, anybody below you is worth nothing." She just put down the people that worked under you, including the associates nurse and the LPNs and the aides. And I thought, "I don't want to hear this! No place can run without them." I don't know. It really turned me off.

Reading these excerpts, it is easy to understand that the AD-prepared nurses may feel that their professional identity is being challenged. The literature suggested that issues of professional identity are tied to the idea of credibility. Megginson (2008) found that the participants in her study felt less credible, professionally, than their BSN counterparts. Matthias (2010), in exploring the concepts of "BSN in 10" legislation noted that "The 'BSN in 10' legislative proposals stimulate questions regarding the current identity and placement of associate degree nursing within nursing practice" (p. 42). With the increasing emphasis on degree completion, the professional identity of the AD nurse is being brought into question. This likely generates a degree of uncertainty in the nurse as to their future in the profession. And, just as likely, the AD nurse, in response to that uncertainty, may push back against the BSN. They believe they are already professionals, no additional degree needed.

Summary of Research Question Two

The data relevant to the factors that exerted influence on the attitudes and perceptions the nurses held of the BSN were organized into two themes. The nurses described factors that created the sense that the nurse is a generic entity that lacked internal differentiation. "A nurse is a nurse is a nurse to most people" was how one nurse explained it. This lack of differentiation extended into how other nurses presented the profession, noting that there was little difference in

how BSN and AD nurses were treated on the nursing unit. While the nurses saw little differentiation between the two educational levels, they reported that the BSN nurse presented an attitude that they were better the AD nurse, owing to their additional education. That the AD nurse reacted negatively to these perceived belittling behaviors is not surprising. Employers also appeared to contribute to this view by failing to acknowledge nurses' educational accomplishments with pay and other incentives, including the failure to include academic credentials on the nurse's name tag.

The responses to this question reflected the normative beliefs that contribute to the development of attitudes toward the BSN. According to the TPB, normative beliefs derive from the social factors that influence the individual and their attitude toward an object. In the context of the TPB, the individual's values tend to reflect the values that he/she perceives others hold toward an object. The nurses' stories, and the themes derived from those stories, support the notion that control beliefs influence the decision to return to school. In general, the nurses' normative beliefs were neutral or negative, depending on the social group involved. From the perspective of family, for example, the nurses described indifference to the degree whereas with professional colleagues, the message they received was often interpreted negatively. On the whole, then, the nurse tended to perceive that others saw the degree in a negative light. Consequently, they tended to see the degree similarly, as their previously described attitudes and perceptions of the degree affirmed. With a lack of positive support from their significant others, the nurses were more likely not to intend to return to school, as the TPB would predict.

There are likely a multitude of factors influencing how nurses perceive the BSN that were not captured in this small sampling of nurses. The consistency with which the nurses presented these factors suggests that they are common themes among all AD nurses.

Research Question Three

The third research question asked, of those who have returned to complete their degree, in what ways, if any, did their perceptions change. Four of the seven participants in this study returned to complete their degree. The responses of those four nurses to the questions related to this research question exposed three themes. The four nurses pointed to the positive benefits they perceived from the courses they took in their BSN program that differed from their initial nursing education. More interesting is that while all but one of the nurses reported negative views of the degree early in their careers, each had arrived at the conclusion that the benefits of the BSN were such that they now believed it should be the required educational level for entry into practice.

Returning With a Purpose

Attitude toward a desired outcome—how that outcome is perceived—is recognized as a driving force in the decision to pursue that outcome (Fishbein & Ajzen, 1975; Schein, 1996). If the outcome is perceived positively, one is more likely to act to achieve that outcome than if the outcome is perceived negatively. The four nurses who continued on to their BSN did so despite earlier views that the degree was unnecessary, or a waste of time. That is, they changed their perception of the degree. Their reasons for doing so were varied, but all revolved around personal goals rather than employer mandates. Paige and Katie both returned in order to meet the requirements for jobs in which they were interested. Katie's return was prompted by what she perceived as a changing job market. She had come to realize that, "I've probably squeezed about every drop of serviceability from my two-year degree; it's probably time to go back." She felt that the degree would open additional job opportunities for her. Others returned because of a desire to gain a 4-year degree or to gain additional knowledge. Darla, who ultimately did not complete her degree, returned because she wanted to know more. Grace provided a similar story,

though she returned, in part, because she felt that she was missing something in her practice. “I couldn’t wrap my head around why I wasn’t enjoying being a nurse until I finally realized that you don’t know enough,” she said. Even though she was not required to return by her employer, she chose to do so both because “it was always something that I wanted to do,” and because her employer was supportive. Personal achievement and the desire for knowledge as motivators for returning to school are well documented in the literature (Altmann, 2012; Delaney & Piscopo, 2004, 2007; Doering, 2012; Duffy et al., 2014).

While the personal factors the nurses identified influenced changes in the perception of the degree in a positive direction, the nurses’ responses suggested that personal factors may turn a generally positive view into a more negative view or may reinforce a negative view. One example is Darla, who wanted the knowledge afforded her by the BSN. However, her educational experiences in the BSN program turned her against the degree, leading her to proclaim that the degree was a waste of time. Darla’s experience underscored the influence that educational experiences can have on how continued education is perceived. Darla’s experience suggested a dissonance between her expectations and the reality she experienced. This phenomenon does not appear to be reflected elsewhere in the literature of RN to BSN studies which is not surprising, given the majority of such studies are conducted on students who are enrolled in, or recently completed, RN to BSN programs. Those who began but did not persist are not represented.

As they returned to school, the nurses had clear reasons for their decision to return, but were not sure what to expect from the experience itself. In terms of outcomes, some, like Grace, expected to add to their knowledgebase. Others expected the degree to provide increased job mobility. Others, like Paige, did not know what to expect. Delaney and Piscopo (2004) noted that

the participants in their study also expressed varied expectations from their BSN experience. This is somewhat different from the findings reported by Lillibridge and Fox (2005), who noted that the participants in that study all expressed clearly defined expectations of their education “including using it as a solution to burn out, the need to expand their knowledge base, and specific career goals” (p. 15). Like Lillibridge and Fox, Doering (2012) found that the participants in her study had clearly defined goals for their degree, even noting that for some, those goals and expectations were exceeded. Megginson (2008) identified both the belief that additional education would enhance job options and the desire for personal growth among the respondents in her study. Zuzelo (2001) noted preparing for a future that includes work and wanting a college degree as motivators among those in her study. The literature did not appear to clearly address the nurses’ expectations of the educational experience.

There is a Difference

As noted earlier, the nurses commonly felt that the BSN would not contribute significantly to their nursing practice because, as Leila put it, “I think I kind of went into it thinking I’m probably already going to know everything.” The three nurses in this study who completed their BSN all reported positive impacts on their personal and professional lives. Deepening their understanding of the processes of care. Knowing the “why” behind their actions was a common theme. As one nurse put it, “I think I’ve learned more theory behind things and not just ‘we do it because this is how we’ve always done it.’ But we’re doing it because the nursing research show this.” Nursing research figured prominently in their discussions as they described how learning how to read and understand the research helped them to better understand the “why” behind what they do.

They also identified how courses that were not part of their AD curriculum helped to broaden their knowledge base. They cited learning to conduct a more holistic assessment through the Health Assessment course, and how their leadership courses helped them learn time management and the leadership skills needed to manage teams as examples of how their professional practices have been positively influenced. Each of the nurses identified specific courses that they found particularly helpful in advancing their practice. Leila, for example, described how beneficial the courses in research were to her.

You know I guess the research was a big part of that because I had no experience in that, whatsoever. . . . I knew nothing about that. And, I could use that to, you know, this is why I think we should do this because of this reason, or I'm going to research this because I don't know if I really agree with how we're doing this.

Health assessment provided a similar benefit to Paige who noted that her prior training had not given her the skills to “put it all together.” She spoke about her experience with conducting a full health assessment.

And health assessment. Like, a full health assessment. It was interesting because I had never had to do that. We always did the steps but not putting it all together. I could listen to any system, I could assess any system, but when I had to do a head-to-toe and videotape it, I was blown away.

Leila's experience was similar: “Assessment? That's so silly. Why would I have to take assessment?” But, it was very in-depth and a very good class.”

While the nurses had acknowledged that they did not know the differences between the AD and BSN curricula prior to beginning their BSN education, they were all able to explain the differences in the curricula, along with how those additional courses aided in their professional development.

Stronger leadership skills were identified as an important aspect of the BSN curriculum. “When you're overseeing a team of people, you need to figure out not just what you need to do, but what everybody else needs to do . . .,” noted Paige. While the desire to move into a

leadership position drove some of the nurses to pursue their BSN, the benefits of learning the skills of leadership were acknowledged by all of those who completed the degree. The literature agreed with these nurses. Doering (2012) quoted one participant as noting that “I feel like they give you the tools to be a better leader” (p. 133). Delaney and Piscopo (2007) noted a student who acknowledged that the leadership class gave her the confidence to venture into new different committees, taking on more leadership responsibilities.

The nurses also identified improved critical thinking skills, resulting from their deeper understanding of the theory underlying their actions and research that supported the theory as evidence of the benefits of BSN education on their practices. Leila attributed her improved critical thinking skills the research skills she had developed.

I’m more prepared to take care of patients than I was with my diploma program and have some more critical thinking skills and theory behind what I’m doing rather than it was always done this way and this is how we do it.

They noted a shift away from a focus on skills to a focus on the *why*. “Because the associate’s seems to be only worrying about ‘am I doing this skill right?’ Where the critical thinking is stronger in the baccalaureate,” Paige opined. These echoed the findings of Duffy et al. (2014), as well as Zuzelo (2001), whose participants reported that they felt that they had increased their knowledge base and broadened their professional perspectives. “I think more critically” said one nurse in Delany and Piscopo’s study (2007, p. 171). Lillibridge and Fox (2005) also reported that nurses recognized a deeper knowledge base, bolstered by the ability to conduct and read research. The nurses in that study also recognized that they had developed a more global perspective that led them to look beyond their immediate circumstances.

The differences the nurses in this study identified supported the findings by multiple other researchers (Delaney & Piscopo, 2004; Doering, 2012; Lillibridge & Fox, 2005; Schwarz & Leibold, 2014; Zuzelo, 2001). Lillibridge and Fox (2005), for example, noted that the nurses

in that study reported that the benefits they received from their BSN education exceeded their expectations with a specific note that the degree had changed their perspective, allowing them to see the bigger picture or had enhanced their critical thinking skills.

BSN Should be the Required Entry Level to Practice

All of the nurses who completed their BSN were clear in their belief that the BSN should be the minimum educational level for entry into practice as a Registered Nurse. They pointed to the influence of the additional education in leadership, ethics, community health, and expanded education in skills such as health assessment to support their argument. Paige, for example, based her assertion on the observation that

I don't think they learn enough in the associates. I think the baccalaureate as the entry level is important. I believe that it [the BSN] is the entry level for nursing because I think everything that is covered through a bachelor's degree is what is necessary for the working nurse. That the physical skills that they're teaching an RN diploma or associate's degree is not enough to keep up with the demands of what is needed in nursing today.

Grace argued that the AD degree "just muddies things up." She clarified that "like I said, you have to have a baccalaureate to sit for the RN [exam]." She felt frustrated as an AD nurse and suggested that the frustration she felt came from not knowing the "why" behind what she was doing and from feeling inadequately prepared to answer patient questions. Nurses may, in her words, "act out" because they feel that they must answer patients' questions, even if they are uncertain of their answers.

Effectively managing teams is an essential element of clinical nursing practice. Paige observed that the AD nurse lacks strong skills in leadership, time management, and delegation. As she noted, "When you're overseeing a team of people, you need to figure out not just what you need to do, but what everybody else needs to do and that's the leadership/management piece that they [the AD nurses] don't get." She also noted that ethics is not built into the AD curriculum, though it is a vital part of nursing practice.

Susan echoed this view, noting that nurses have been recognized as the most ethical profession for many years. The most recent Gallup poll found that nursing is ranked as the number one most honest, ethical profession (Brenan, 2017). While Susan's assertion is correct, her observation raises an interesting contradiction. As Paige noted, ethics is not a significant part of the AD curriculum. Given that AD-prepared nurses still comprise the bulk of nurses, how do we explain the Gallup Poll findings? While the AD nurse may not receive specific courses in ethics, as with Susan's experience in the Jesuit university, the AD curriculum may teach ethics throughout the curriculum making it somewhat invisible, but effective in developing a sense of ethical comportment within the AD nursing student.

Summary of Returning to School

The data related to the experience of returning to school was organized into three themes: Returning with purpose, there is a difference, and the BSN should be the required entry to practice. The four nurses who returned to school for the BSN cited personal factors, in the form of desire for personal growth, achievement, or for a particular job, as factors that influenced them to alter their views of the degree. Statements such as "I wanted that personal accomplishment to make myself better" or "I just really wanted the knowledge" reflected this view. Another nurse noted that she did not feel that she had a sufficient understanding of the "why" behind what she was doing and sought additional education to fill that void. Personal achievement and the desire for knowledge as a motivator for returning to school were well documented in the literature (Altmann, 2012; Delaney & Piscopo, 2004, 2007; Doering, 2012; Duffy et al., 2014).

To effect the changes in attitude that these nurses experienced required an interaction of two of the three beliefs described in the Theory of Planned Behavior. From the perspective of behavior beliefs, quality of care is the characteristic of nursing that they valued most highly. To

change their attitude toward the degree required that they reassess the impact of their additional education on the quality of care they provide. The nurses identified the multiple ways that their BSN education had positively influenced their professional practice. Each of the nurses was clear in their belief that, in fact, their practices had been enhanced by the experience, leading to a change in their view of the degree. From the perspective of control beliefs, the nurses all expressed the belief that they were more in control of their practice, having a better understanding of the “why” behind their actions. They identified how specific courses within the BSN curriculum had impacted their personal and professional lives. And, having seen the impact on their own practices, how they now believed that the BSN should be the required educational level for entry into practice.

Relevance to the Theoretical Framework

The Theory of Planned Behavior (TPB) provided the theoretical foundations for this study, underlying the research questions and guiding the interpretation of the collected data. The TPB is both a predictive model which may be used to predict the likelihood that an individual will undertake a given behavior, and an explanatory model that helps to explain why an individual undertook a given behavior. In this study, the TPB was used as an explanatory model and the model served its purpose well. The three salient factors identified by the TPB—attitude toward the behavior, normative beliefs, and perceived control beliefs—were evident throughout the data. The TPB explains the intention to act as the interaction of these three salient beliefs. As the research questions were considered from the perspective of the TPB, I became increasingly aware that the attitude beliefs, as described by TPB, were seen, for example, in the nurses’ observations that the BSN was not needed, or in the nurses’ definition of nursing in terms of technical skills. The nurses clearly expressed a negative attitude toward the degree. Given that

negative attitude, the TPB would predict that the nurses would not be inclined to pursue the BSN and this was proven to be correct in most cases.

The factors associated with normative beliefs were most evident in the nurses' stories. The TPB presents the three salient factors of attitude toward the behavior, normative beliefs, and control beliefs as conceptually independent (Ajzen, 1991). However, the findings in this study suggest that attitudes toward the behavior and normative beliefs may be inter-related, at least in some situations. The factors associated with normative beliefs, such as the value that friends and colleagues place on the behavior, or the influence of professional factors, appeared to have an impact not only on the intention to act, but on how the nurse perceived the behavior. That is, the nurses' beliefs regarding the value of the degree—their attitudes toward it—reflected the influence of the social factors associated with normative beliefs. Regardless of whether attitudes and normative beliefs related to the degree are independent, or interdependent, concepts, the result of those two factors remain that the nurses in this study expressed a negative attitude toward the degree and a general intention not to return to school.

The third belief that influences the intention to act is that of perceived control. The findings in this study did reflect the influence of perceived control on the decision to return, or not to return, to school. The nurses identified a variety of factors, such as familial obligations, availability of BSN education, and financial concerns as factors that influenced both their initial decisions to attend an AD program rather than a BSN program. These factors were also cited as factors in the decision to continue on for additional education, or to return to school. Although not specifically identified as an influencing factor in their decision to return, for those that returned to school, perceived control was reflected in their belief that they would “already know everything,” suggesting that they were confident in their ability to be successful in their studies.

In all, the TPB proved useful in helping to guide the development of this study, and in interpreting the results. The concepts of the TPB provided explanations for how the nurses came to their decisions regarding nursing school. The TPB appears to provide an appropriate means for predicting which nurses are likely to return.

Implications for Practice

The purpose of this study was to describe the ways in which nurses perceived the BSN and the factors that influenced those perceptions, in order to provide nursing leaders with insights that may help in encouraging nurses to return for their BSN degree. The use of a convenience sample of seven nurses, however, limits the utility of the findings in understanding how nurses perceive the degree on a broader scale. Nonetheless, some general concepts have been identified that may be useful to the profession in encouraging nurses to return to school. Findings from the third research question, related to the changes in perceptions following completion of the BSN degree, have been incorporated into the discussion below.

Perceptions

The nurses' responses suggested that they construed the term "BSN" as referring both to the BSN nurse and BSN education. This makes some sense given that the BSN nurse is the product of BSN education. The nurses' perception of BSN education would likely be based on what they saw embodied in the performance of the BSN nurse. In essence, how the nurse saw the BSN degree is determined by how they saw the BSN-prepared nurse in relation to their definition of what constitutes a good nurse.

How the nurse perceived the BSN nurse, and subsequently BSN education, has implications for the profession in terms of its ability to promote BSN education and to encourage nurses to return to school. The intention to return to school is predicated on how the nurse

perceives the degree. The Theory of Planned Behavior identifies attitude toward a behavior as one of three major aspects in determining whether someone will take action. Given the poor perception that these nurses tended to express toward the BSN nurse, it is understandable that they would see BSN education as not necessary to enhance their practice. To address this, nursing leaders need to be aware that working nurses tend to define nursing in terms of technical skills and should take steps to emphasize the value of the cognitive skills, developed in BSN education, in providing high-quality care. It is important not to diminish the technical skills but, instead, to make clear that well-developed technical and cognitive skills are both necessary ingredients in providing quality nursing care. “Seeing is believing” and in this environment, communication of the importance of both technical skills and cognitive skills needs to be accomplished in concrete, visible terms and not just through rhetoric. Leveraging the experiences of bedside nurses who returned to school to complete their degree, highlighting the ways in which the experience has enhanced their practice is one way of accomplishing this.

Nursing educators will need to take steps to ensure that BSN-prepared nurses possess the technical skills expected in the workplace so that the BSN-prepared nurse is not seen as “lacking something” in providing good nursing care. The value of clinical experience during nursing school can not be overstated. Benner et al. (2010) argued that clinical experience is essential to developing sound clinical reasoning skills. As noted earlier, Gaberson and Oermann (2010), pointed out that nursing is a practice discipline and, as such, the ability to perform in the clinical setting is more important than classroom performance. With these two views in mind, nursing educators need to design clinical experiences that provide the student with multiple opportunities to develop, to practice, and, ultimately, to master basic nursing skills. These activities take time. Expanding the number of required clinical hours is one solution, though the realities of limited

space for clinical practice must be considered. Holding clinical experiences outside of normal school hours—such as evenings, or weekends—may not only increase the potential for clinical hours, but may expose the student to activities and priorities common to those work periods that the student may otherwise not encounter.

The nurses expressed the belief that the BSN nurse was more appropriate for management and this view was somewhat confirmed by those in this study, as well as elsewhere in the literature, who reported that they pursued the BSN in order to qualify for a position away from the bedside. As more nurses pursue the BSN, encouraging them to remain at the bedside is essential both to meet the needs for effective clinical care and to demonstrate the value of the BSN at the bedside. Encouraging BSN-prepared nurses to remain at the bedside may counter the belief that the BSN is only for those who aspire to management positions and would provide evidence that the BSN can enhance bedside practice. As noted, however, it is imperative that nurse educators ensure that the BSN nurse is provided the opportunity to master the technical skills of nursing to minimize the perception that they lack the requisite clinical skills.

Influencing Factors

Multiple factors were identified as influencing the nurses' perceptions of the BSN. The Theory of Planned Behavior identifies the individual's estimation of the value of the act to their significant others as a second aspect of influence on the intention to act. How the nurse believes family, friends, and colleagues see the BSN impacts how they are likely to perceive the degree and, thus, influences their decision to return. No specific familial support for the BSN, or baccalaureate education in general, was identified by the nurses in this study. Most reflected that "a nurse is a nurse is a nurse" in the eyes of their family and many of their friends, as well.

Generally, families valued the goal of becoming a Registered Nurse more than the degree that got them to that goal.

For the nurses in this study, friends and colleagues tended to represent the same groups. The influence of friends and colleagues was mixed, though the general tenor of their attitudes toward continued education was more negative. Nurses reported that many of their colleagues communicated that the degree was not important, or that it did not provide a financial benefit. Another noted that a colleague expressed confusion over why she would want additional education in field in which she was already working. Others found support and encouragement among their colleagues. Why one group would be supportive while another was dismissive of the degree is unclear. Differences in organizational cultures may account for some of the difference, but there was insufficient evidence regarding the organizational cultures from these nurses' stories to draw any conclusions.

Addressing implications related to the influence of family, friends, and colleagues is at best challenging. To address potential issues related to the organizational culture, nurse leaders will need to routinely assess the consistency of the messaging that the organization sends out. Messaging that is conflicting or inconsistent with respect to the value the organization places on the BSN degree will likely have a negative effect on how the degree is perceived.

A third major influence was related to the environmental context in which the nurse is operating. Several factors related to the education and licensing of nurses, career options, and professional identity exert influence on how the nurse perceives the degree. Nurses noted that despite differences in educational preparation nurses all take the same licensing exam and are issued the same nursing license. Nurses see this lack of differentiation in testing and licensing as a clear indication that the BSN is not important. They very reasonably deduce that if differences

did exist, the testing and licensing would differ between the two educational levels. Lack of differentiation in pay both supports the belief that there is no difference between the two levels and removes an incentive for investing in more education. Healthcare organizations, though they may express a preference for BSN-prepared nurses, appear to continue to hire large numbers of AD-prepared nurses. Nurses reported that their organizations did not identify the BSN nurse differently from the AD nurse to the public. As one nurse noted, “I guess it’s not important to them.” The failure of healthcare organizations to demonstrate a commitment to promoting the BSN through their hiring and pay practices, and even in acknowledging the accomplishment, provided further support to the nurses’ belief that the degree is not necessary.

Structural issues around licensing and how the profession presents itself both internally and externally appear to exert a significant influence on the attitudes held by the nurses in this study. They also provide the greatest opportunity for nursing leaders to act to change those beliefs. Nursing leaders and state boards of nursing need to define, through the nurse practice acts, how the practices of AD-prepared and BSN-prepared nurses differ. These differences need to be demonstrated through differentiated testing and licensing processes. The single RN license could be replaced with degree-specific licenses such as Registered Technical Nurse (RTN) or Registered Professional Nurse (RPN). Currently all nurses take the same license and, at least in some states, are issued the same Registered Professional Nurse license. Nursing leaders within healthcare organizations need to take steps to differentiate educational levels within their organizations through differentiated pay scales that might serve as an inducement to nurses to continue their education, through job ladders that describe different advancement opportunities based on educational preparation, and through public acknowledgement of educational accomplishment. The literature has demonstrated the importance of a more highly educated staff

(Friese, Lake, Aiken, Silber, & Sochalski, 2008; Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011; McHugh et al., 2013). Making the educational level of staff visible to everyone who enters the facility through a simple notation on a nametag would serve as reassurance to patients and would enhance the nurse's professional identity.

The final factor influencing the nurses' perception of the BSN is the lack of knowledge related to the differences in educational curricula. Only those nurses who had completed their BSN were able to identify differences in the curricula. Those nurses noted that prior to beginning their BSN studies they had not been aware of the differences. It is interesting and concerning that professionals would not be cognizant of the differences in educational preparation among practitioners within their field. It is understandable that nurses may perceive the BSN as unnecessary if they are unaware of the differences in education. For nurse educators, the implication is clear: curricula for both AD and BSN programs should include specific content on how the levels of education differ. This content should be incorporated throughout the curricula in way that opens the door for additional discussion. For example, in an AD program, while teaching about chronic conditions such as diabetes or kidney disease, a brief discussion may be included on community support. Currently, such discussions may be limited to acknowledging that community resources are available. The student may not recognize that nurses are involved in planning and providing these additional resources, or that additional training is available in that area. Taking an extra moment to remind students that a more thorough exploration of community nursing is part of the BSN curriculum allows the AD student to see that there are potential areas of expanded practice available to them through BSN education. Though this is a simple action, providing even brief reminders throughout the course materials helps the AD student to situate their own practice within the larger field of nursing and recognize that other

practice options are available to them with additional education. For the BSN nurse, this discussion might include reminders that the AD-prepared nurse may not be aware of the available community resources, thus requiring the BSN nurse to ensure follow up that the patient is receiving the services he or she needs. This is, admittedly, a challenging task. Presenting this information in a way that does not diminish the AD nurse is vital, but difficult to accomplish effectively.

A common theme in nursing is the concept of continuum of care. That is, quality patient care involves a variety of services, provided by an array of providers of various levels, depending on the patient's condition at a given point in time. Done properly, all of the providers of care for a given individual are cognizant of that individual's needs from multiple perspectives and are aware of the services provided by the various care givers. Using a similar approach, the nurse educator may find that presenting the various levels of nursing education as analogous to a continuum of care minimizes the likelihood of presenting the AD in a negative light by highlighting how each level of nursing education contributes to the continuum of care in nursing. This approach should be incorporated into all discussions regarding care so that the nursing student has an opportunity to internalize the concepts so that they may implement that approach when in practice.

Limitations

Several limitations were identified in this study.

1. This is a qualitative study. Munhall (2012b) noted that qualitative researchers "do not claim to generalize their findings" (p. 16). Given the small sample size and potential for self-selection bias, the findings of this study cannot be generalized, nor is it my intention that the findings be generalized.

2. Potential self-selection bias exists. The participants in this study volunteered in response to advertisements for participants. The likelihood exists that only those who hold specific views regarding the topic of this study chose to volunteer. Those holding alternate views may have specifically elected not to participate. This potential may impact the findings in significant, but unknown ways.

3. The majority of nurses in this study have been in practice for more than 30 years and presented their views of the BSN based on their early views of the degree. Whether their perceptions of the degree reflect how nurses with less experience see the degree is unclear.

Identification of Additional Research Opportunities

The findings in this study identified three topics that deserve additional study.

1. Further study on nurses' understanding of the differences in nursing educational preparation is warranted. This study identified that nurses' initial education may not provide them with an understanding of how nursing programs differ. Gaining a better understanding of this phenomenon may help guide nursing leaders and educators in filling what appears to be a gap in professional knowledge.

2. Repeated studies exploring the perceptions that nurses hold toward the BSN and BSN education are needed to build a better understanding of what nurses think and to provide guidance on how their perceptions may be altered.

3. Studies examining organizational cultures and their influence on how the BSN is perceived are needed. The responses from the nurses in this study suggested that mixed messages were common. Studies exploring how organizations message the importance of the BSN and the consistency of that messaging may provide insight into why nurses perceive that the organization does not value the degree.

Summary of the Study

This study used a qualitative research design, guided by the theoretical framework of the Theory of Planned Behavior, to identify the perceptions that nurses hold toward the BSN and the factors that influence those perceptions. Data were collected using a semi-structured interview process with questions designed to address the three research questions. The data were analyzed using a semantic approach to thematic analysis. The findings of this study identified the perceptions held by the nurses participating in the study, finding that non-BSN nurses generally hold a negative view of the degree. The study also identified that the factors that influenced their views. These factors reflected the three major determinants of the intention to act as presented by the Theory of Planned Behavior. Recommendations for addressing these factors were offered.

Final Thoughts

Although the findings of this study are not generalizable, they do provide some hints to the issues faced by the profession in encouraging nurses to pursue the BSN. If the profession of nursing is truly intent on increasing the numbers of baccalaureate-prepared nurses, nursing leaders and educators must act to validate these findings on a larger scale and to actively explore opportunities for addressing and correcting these concerns. How nurses perceive the degree and the value they ascribe to it is very likely a major determinant in their decision to seek further education. Managing the factors that lead to those perceptions is critical to the success of efforts to promote the BSN and meet the Institute of Medicine's goal of having 80% of nurses educated at the BSN or higher level by 2020.

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APPENDIX A
IRB APPROVAL



Office of the Vice President for
Research & Economic Development
Office for Research Compliance

November 28, 2017

John Sauls
ELPTS
College of Education
The University of Alabama
Box 870302

Re: IRB # 16-OR-325-R1-A "Saying No to the BSN: An Exploration of the Attitudes that Influence the Intent of RNs to Pursue BSN Education"

Dear Mr. Sauls:

The University of Alabama Institutional Review Board has reviewed the revision to your previously approved expedited protocol. The board has approved the change in your protocol.

Please remember that your protocol will expire on August 7, 2018.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.

Good luck with your research.

Sincerely,

Director & Research Compliance Officer
Office for Research Compliance

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

APPENDIX B
INFORMED CONSENT

UNIVERSITY OF ALABAMA

Informed Consent for a Non-Medical Study

Study title: Perceptions of the BSN: What Nurses Think and the Factors That Influence Those Perceptions

Investigators: Kevin Sauls, student
Douglas McKnight, PhD

You are being asked to take part in a research study.

This study is called "Perceptions of the BSN: What Nurses Think and the Factors That Influence Those Perceptions." The study is being done by Kevin Sauls who is a graduate student at the University of Alabama. Mr. Sauls is being supervised by Dr. Douglas McKnight, a professor of Education at The University of Alabama.

This study is not funded by outside sources. Neither Mr. Sauls nor Dr. McKnight are receiving additional payment for this work.

What is this study about?

This study is aimed at exploring how nurses perceive the BSN, the factors that may influence those perceptions, and how returning to school may influence those perceptions. Specifically, you will be asked about your attitudes toward the BSN, about the attitudes your family, friends, and colleagues express toward the degree, and about how your prior educational experiences may influence your view of the degree.

What will I be asked to do in this study?

If you meet the criteria and agree to be in this study, you will be asked to participate in a one-to-one interview that will explore your attitudes, thoughts, and beliefs regarding the BSN. This discussion will include exploration of the attitudes, beliefs, and values that you believe your family, friends, and colleagues hold toward the degree and the degree to which you believe their attitudes influence your decision. The interview will include exploring how your prior educational experiences might influence how you perceive the BSN degree.

To facilitate transcription, the interview will be audio and/or video recorded.

Why have I been asked to participate in this study?

You responded to an advertisement seeking nurses to participate in this study. You have told us that you are a Registered Nurse working in the US, that your initial nursing education was not at the BSN level, and you do not hold a bachelor's degree in any other field.

How much time will I spend being this study?

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 11-28-17
EXPIRATION DATE: 8-7-18

UNIVERSITY OF ALABAMA

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The interview should take 1 to 1.5 hours.

Will being in this study cost me anything?

The only cost to you from this study is the time involved in the interview process, as well as, a small amount of time reviewing the transcription of that interview to ensure its accuracy.

Will I be compensated for being in this study?

In consideration of your time, you will receive a \$25 Amazon gift card on completing the interview. This will be sent to you via email.

What are the risks (dangers or harms) to me if I am in this study?

There are minimal risks associated with this study. The interview will be conducted in way that will minimize the likelihood that any personal information will be made publically available. In addition, you can control the amount and type of information you choose to share. That is, you may always choose not to answer a question that is asked.

What are the benefits (good things) that may happen if I am in this study?

There are no direct benefits to you for participating in this study.

What are the benefits to science or society?

This study will help researchers to understand more about how the BSN is perceived by non-BSN nurses and about the factors that influence that perception.

How will my privacy be protected?

In general, you can protect your privacy by controlling the information you share in the interview. While the interview will be recorded, those recordings, along with the subsequent transcripts, will be kept in a secure location within the researcher's home office and only authorized researchers will have access.

How will my confidentiality be protected?

All video and audio recordings, and the associated transcripts, will be maintained in a locked cabinet of the researcher's private office for a period of six (6) years. Only authorized researchers will have access to these materials. At the end of that period, all transcripts and recording will be destroyed. While the original recordings may have your voice and image associated with your responses, the transcribed documents will assign random names to the responses. This will decouple your name from the responses, providing a level of protection for your confidential information.

What are the alternatives to being in this study? Do I have other choices?

The alternative to being in this study is not to participate. There are no untoward effects of choosing not to participate.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 11-28-17
EXPIRATION DATE: 8-7-18

What are my rights as a participant in this study?

Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect on your relations with the University of Alabama, your employer, or the researchers.

The University of Alabama Institutional Review Board (“the IRB”) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?

If you have questions, concerns, or complaints about the study right now, please ask them. If you have questions, concerns, or complaints about the study later on, please call the investigator Kevin Sauls at 706-669-8197. You may also email him at jksauls@crimson.ua.edu.

6

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email the Research Compliance office at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. I will receive a copy of this consent form to keep.

I understand that the interview will be audio and/or video recorded.

I may be contacted at:

Phone: _____

Email: _____

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 11-26-17
EXPIRATION DATE: 8-7-18

Signature of Research Participant

Date

Signature of Investigator

Date

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 11-26-17
EXPIRATION DATE: 6-7-18

APPENDIX C
INTERVIEW PROTOCOL

Demographic data:

Age

Gender

Initial Nursing education (Associate or diploma)

How long have you been in nursing practice?

Do you hold degrees in any other fields? If so, what fields? Were these obtained before or after entering nursing?

If prior to initiating nursing practice: How long, if ever, did you work in that field before entering nursing?

If subsequent to entering nursing practice: Have you worked in that field and, if so, for how long?

What prompted the move (or return) to nursing?

Questions for Interview Protocol IF RETURNED TO SCHOOL

Think back to the time before you returned to school for your BSN. How did you view the BSN? Explain.

On what, if anything, was this view based?

Do you recall that this view applied to all baccalaureate education, or just nursing? If just nursing, what differentiated your views?

Are you aware of any particular views that family, friends, or colleagues held toward the degree?

In what ways, if any, did your family, friends, or colleagues influence your view of the degree?

What prompted your return to school? Explain.

What did (do) you expect from your BSN education? What did (do) you expect to get out of it? Or, what did (do) you expect the experience to be like? Explain.

How closely did your expectations match your experience?

If the participant has completed their degree:

How has your view of the BSN changed as a result of your BSN experience?

What other thoughts do you have about the BSN that you feel are important to share that I've not touched on?

IF ADN ONLY

- Think about your experience with continuing education since you graduated. In what ways have those experiences been the same, or different?
- What role do you think that continuing education plays in profession practice?
- What responsibility, if any, does the professional nurse have with respect to continuing education?
- What do you believe your peers and family think about a baccalaureate degree?
- What are your thoughts on the BSN degree? What are the pros and cons you see with respect to the degree? How do you believe the BSN is different from the ADN? In what ways are they similar?
- If your peers were enthusiastic about the degree how might that change your own perception of the degree?
 - What have we not discussed that you feel is important?