NURSE PERCEPTIONS OF THEIR EDUCATIONAL PREPARATION AS PATIENT EDUCATOR

A THESIS

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DATE

To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a thesis written by Katherine Smith-Boswell, entitled "Nurse Perceptions of Their Educational Preparation as Patient Educator." I have examined the final copy of this thesis for form and content, and recommend that it be accepted in partial fulfillment of the requirements for the Degree of Master of Science, with a major in Health Sciences Instruction.

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DEDICATION

I would like to express my love and gratitude to the following individuals who contributed in so many ways to this accomplishment:

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ABSTRACT

COMPLETED RESEARCH IN HEALTH SCIENCES
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Patient Education is a responsibility of all levels of nursing. This study investigated perceptions of Licensed Vocational Nurses and Associate Degree Nurses as to their educational preparation for the nurse educator role as measured by the Boswell's Educational Preparation for Patient Education Questionnaire. All participants were licensed by the Texas Boards of Nursing, and were residing in one of five rural counties. A total of 69 usable responses to questionnaires were received. Descriptive statistics (frequency and percentage) were used to report the demographics (county of residence, educational preparation, age, primary employment, percentage of time doing patient education, graduation date) of Licensed Vocational Nurses and Associate Degree Registered Nurses. A *t* test was used to analyze the data obtained from the 12 item scale.

It was concluded that a significant difference was found.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

List of Tables

CHAPTER 1

THE PROBLEM AND ITS BACKGROUND

Nurses with various educational backgrounds and in a variety of health care settings are responsible for imparting information to patients. This information should be presented in such a manner that the patient will retain and be able to apply it in their lives.

A major portion of nursing activities involve patient education (Bille, 1981). Professional as well as legal responsibilities go along with the role of patient educator.

Teaching has been identified by the American Nurses Association as one of seven areas of nursing activity. Nurses are asked to teach and yet they frequently lack the knowledge and skills necessary to accomplish this task successfully.

Literature indicates that effective teaching-learning processes are based in the knowledge of learning theories and the learner and teaching strategies (Rankin and Duffy, 1983). Patient educators must be versed in these areas to facilitate the learning process.

Statement of the Problem

The problem of this study was to determine if there were differences in nurse perceptions of their educational preparation as patient educators between Licensed Vocational Nurses (LVNs) and Associate Degree Registered

Nurses (ADNs) in the state of Texas, as measured by the Boswell Educational Preparation for Patient Education Scale.

Purposes of the Study

The purposes of the study were:

1. To develop a questionnaire, Boswell's Educational Preparation for Patient Education (BEPPE).
2. To determine Content Validity of the Questionnaire.
3. To determine the LVN and ADN perceptions of their educational preparation.
4. To determine if there is a difference between LVN and ADN perceptions as to their educational preparation for the nurse patient educator role.
5. To determine ex post facto reliability of the BEPPE Questionnaire.
6. To profile the sample by, county of residence, educational preparation, sex, age, primary employment, percentage of time doing patient education, and graduation date.

Hypothesis

This study examined the following null hypothesis:

There is no significant difference between Licensed Vocational Nurses (LVNs) and Associate Degree Registered Nurses (ADNs) perceptions of their educational preparation for patient education, as measured by the BEPPE.

Definition of Terms

For the purpose of this study the following definitions were used:

1. Licensed Vocational Nurse (LVN). A nurse who has graduated from a 52 week or 12 month LVN educational program and is licensed and practicing nursing in Texas.

2. Associate Degree Nurse (ADN). A nurse who has graduated from a 2-year ADN educational program and is licensed and practicing nursing in Texas.

3. Perception. An individual's written or expressed opinion.

4. Patient Educator. A nurse who presents information to patients in a variety of health care settings, concerning some aspects of their care, health problems, or wellness.

5. Educational Preparation. Information and skills presented to undergraduate nursing students (LVN & ADN) in the nursing program curriculum.

6. Teaching-Learning Process. A means of structuring teaching and learning activities for both the teacher and learner to include individualized learning needs.

7. Learning Theories. Styles or methods of learning which are identified by and will vary according to the theorists.

Assumptions

It was assumed by the researcher that:

1. Perceptions can be measured.

2. Boswell's Educational Preparation for Patient Education (BEPPE) has content validity.

3. LVNs and ADNs will answer the questionnaire truthfully.

4. LVNs and ADNs are educating patients in all levels and types of health care settings.

5. All LVNs have similar educational backgrounds.

6. All ADNs have similar educational backgrounds.

Limitations

The limitations of this study were:

1. Findings apply to Texas Nurses in selected counties.

2. The mail-out process using the questionnaire strategy yields small returns.

Significance of the Study

The significance of this study was that it:

1. May impact patient education delivery in health care settings.

2. May impact course content in nursing programs at the LVN and ADN level.

3. May impact continuing education in the area of patient education.

4. May impact teaching methodology utilized in nursing programs at the LVN and ADN levels of nursing.

5. May impact inservice education training for nursing.

CHAPTER 2

REVIEW OF THE LITERATURE

A limited number of studies that investigated nurse perceptions of their educational preparation as patient educators was found. Most studies of the patient educator dealt with the need for patient education and its relationship to the nursing process and knowledge of learning theories. A few studies addressed the need for educational preparation of the nurse as an educator.

Patient Education

The American Nurses Association (ANA) Statement of Functions identifies teaching as one of the seven areas of professional nursing activity (Creighton, 1985). This responsibility is also delegated to the technical level nurse (LVN and ADN).

"The usefulness of patient teaching as a tool for nursing practice has been approved for years. Yet, patient teaching continues to be ineffective, inadequate, or completely absent" (Bille, 1981, p. 4). This is not considered to be a purposeful act, but a lack of knowledge to do the job and do it well (Magill, Williams, and Caspi, 1986).

Patients are not informed about their health needs in a manner which they can utilize. The reason may be that the nurses lack the knowledge and skills necessary to teach (Magill, Williams, and Caspi, 1986, p. 45).

Nurses are told that it is important and mandatory to teach patients. However, patients are not taught. Patients are not informed about their health needs in a manner which they can utilize. The reason may be that the nurses lack the knowledge and skills necessary to teach (Magill, Williams, and Caspi, 1986, p. 45).

"Patient Education has become an important component of health care in the hospital, outpatient, and community settings. It is the general consensus from the nursing literature that nurses do and should continue to assume major leadership roles in patient education programs" (Caffarella, 1984, p. 222).

Nurses today are described as the primary teachers of patients, as leaders or members of a multidisciplinary patient education team and as chief administrators of all patient education programs (Caffarella, 1984). Professional responsibilities as well as legal ones go along with the role of patient educator.

The nurse has the most extensive contact with the patient. The nurse is also responsible for planning and implementing appropriate formal and informal patient teaching activities to meet the learning needs of each individual patient. This activity will be more meaningful if it is based upon identified patient needs (Harper, 1976, p. 2).

It is understandable that nursing is progressing in the area of patient education. Over 50% of health care professionals in most settings are comprised of nurses (Magill, Williams, and Caspi, 1986, p. 44). Also, nurses are with patients 24 hours a day.

> They are in an ideal position to anticipate patient teaching needs and readiness to learn as well as coordinate and reinforce teaching done by other disciplines. Since nurses are always with patients, they can most readily spot learning impediments (i.e., deficits in hearing, speech, sight, and mental capacity) and develop strategies for coping with them (Magill, Williams, and Caspi, 1986, p. 44).

Nurses are taught to assess, plan, implement and evaluate their daily care of patients. The teaching-learning process requires the same careful steps (Rieser, 1976, p. 34). The concept of patient education is composed of the teaching-learning process. Nurses often speak of patient teaching, but often times, the learning part of the process is overlooked. Patient education is not going to exist unless teaching and learning occur (Harper, 1976, p. 2).

Basic nursing education may or may not provide the graduate nurse for the teaching role; however, he or she will be expected to demonstrate these qualities in all areas and levels of health care. Basic education as we know it today provides facts and problem-solving knowledge but what about the skills of the teaching-learning facilitator?

The following questions will play an important part in the future of the nurse educator role: Do nurses perceive themselves as educators or teachers without the basic knowledge or the teaching-learning process, teaching strategies, learning theories, and knowledge of the adult and child learning needs ?

Are nursing education programs providing this information to prepare the nurse to meet the challenge of the patient educator role? And finally, are nurses ready to further develop their teaching skills to provide better patient education?

Teaching-Learning Process and Theories

"The teaching-learning process is interactive: it depends on feedback from both the teacher and the learner for optimal results to occur" (Magill, Williams, and Caspi, 1986, p. 44). The human element of caring, empathy, encouragement, and patience are important aspects of the teaching-learning process, and may help a patient to learn more than all the available information and teaching aids (Magill, Williams, and Caspi, 1986).

Not only is the human element important but also the knowledge of learning theories, the adult and child learning needs, and teaching strategies. It is in these areas that educational preparation of the nurse falls short (Magill, Williams, and Caspi, 1986).

According to Rankin and Duffy (1983) :

> . . . many nurses teach patients and their families in the way they were taught as children. The learner, inmost cases, assumes a passive role and the nurse lectures and demonstrates to the learner, as his or her teacher did in the grammar school setting. If the nurse tries to imagine himself or herself as an adult student seated in a fifth-grade classroom, she will understand why the adult patient needs a different environment (p. 143).

Patient educators must be well versed in the learning theories used to guide their teaching strategies, research, and evaluation. A thorough understanding of the nature of the learning process and its basic tenets will facilitate freedom to experiment and initiate improved methods and evaluations of teaching (Hoffman, 1987, p. 159).

"The relationship between learning theories and the educational process of a patient educator is the same as that between any science and its application" (Hoffman, 1987, p. 162). Everything an educator does is colored by learning theories as well as intervening variables such as the time demands of the patient setting, resources available, and external demands (Hoffman, 1987, p. 162).

The patient educator also needs to be aware of teaching strategies related to the child learner. It is important to realize that children learn best independently, not in groups; that they learn out of interest and curiosity, not to be accepted by the adult in power. They should be in control of their own learning, deciding what and how they want to learn. When a child understands they feel satisfaction and relief (Sedlacek, 1981, p. 274).

Children in different developmental age groups perceive the world in different ways. The patient educator should adjust teaching strategies according to the child's level of biophysical and psychosocial development. Where it is impossible to prepare an infant for an injection with reason and facts, a school age child needs reasons and facts, because the fear of the unknown makes him or her anxious (Sedlacek, p. 274).

A knowledge of growth and development is necessary for effective teaching and learning to occur with the child learner. Maturational readiness, as well as illness and hospitalization can affect and should suggest teaching strategies that might be successful.

"Knowles contributes four reasonable assumptions about the adult learners that distinguishes them from children" (Rankin and Duffy, 1983, p. 143). As a person matures: (a) his or her self concept moves from dependency to self direction. He or she sees himself or herself as capable of making his or her own decisions, taking responsibility for the consequences, and managing his or her own life; (b) he or she accumulates life experiences that are an increasing resource for learning; (c) his or her readiness to learn is increasingly oriented to his or her developmental tasks and social roles; and (d) his or her time perspective changes and his or her orientation to learning shifts. He or she needs immediate application of knowledge and his or her learning is problem-centered rather than subject-centered (Rankin and Duffy, 1983).

It is the above mentioned assumptions on which the nurse should base his or her teaching-learning process. Without this prior knowledge of the adult learner, it may be difficult to facilitate the learning process.

> Some selected populations may be able to benefit from self-care teaching packets, particularly if there is an evaluation component and the learner is literate enough to use the tool and benefit from the evaluation. However, many patients in crisis, even though literate and familiar with self-learning packets, may not be able to benefit from this type of learning" (Magill, Williams, and Caspi, 1986, p. 44).

The nurse always has to use his or her own discretion concerning the relevance of a particular teaching aid or strategy for an individual patient (Magill, Williams, and Caspi, 1986).

Another area in which the nurse may be weak is in knowledge of learning theories. Knowledge and theory could have an impact on the quality of the patient education program (Rankin and Duffy, 1983).

Teaching Strategies

The third area in which the nurse may be lacking in knowledge is in teaching strategies. Various methodologies should be utilized during the teaching-learning process, to be assured that you are meeting the patient's educational needs in a way he or she can comprehend.

The process should begin with an assessment of the learner and his or her capabilities. A program should be individually designed to meet the particular needs of the learner (Narrow, 1979).

Although the philosophies of nursing leaders include teaching as a part of nursing, and although patients need and want to know about their illnesses, the quality of patient teaching done by various professionals often leaves much to be desired. Organized teaching plans, aimed at increasing the efficiency and effectiveness of the teaching-learning process are often inadequate or non-existent (Bille, 1981, p. 3-4).

Perceptions

"Perceptions are concerned with how we sense and know the rich and varied world of things and people that surrounds us" (Hochberg, 1964). Individual sensory organs contribute greatly to our perception of the world. These sensory organs must function properly in order for perception to occur; however, there are certain characteristic differences between the physical world and the perceived world (Hochberg, p. 2).

Redman (1993), defined attitudes or perceptions as a learned, emotionally toned predisposition to react in a particular way toward an object, idea, or a person. These feelings are expressions of how individuals believe an object or relationship affects them. Perceptions or attitudes pervade all spheres of learning.

Pohl (1978), described perception as a process involving three steps. The first being that the sense organs recieve a stimulus. Secondly, the afferent nervous system transfers this impulse to a sensory area in the brain. Thirdly, the brain interprets it as a sensation of sight, sound, taste, odor, or touch. These are the only pathways through which we recieve messages from the world around us. Pohl (1978), further stated that problems in perception occur because of individual differences and misinterpretations of these perceptions by the person involved.

Zimbardo (1970), defined perceptions or attitudes as either mental readiness or implicit predisposition which exert some general and consistent influences on a fairly large class of evaluative responses. These responses are usually directed toward some object, person, or group.

In addition, attitudes or perceptions are seen as enduring predisposition, but ones which are learned rather than innate. Thus, even though attitudes or perceptions are not momentarily transient, they are susceptible to change.

Perceptions depend upon a multitude of factors which include past experiences and present knowledge. Other factors include such things as physical properties of the stimului, individual family background, general social milieu, and the capacity of the perceiver to interpret and respond to what is happening to him or her (Ujhely, 1968). The manner in which a nurse perceives his or her environment can be a deciding factor in determining his or her behavior.

According to Bartlett (1990), nurse educators played a primary role in socializing nursing students into the role of teacher. They can have a significant impact on the performance of patient teaching. It is during the nursing school experience that patient education skills should be developed and practiced.

In Bartlett's (1990) study, nurses reported that patients left the hospital not knowing all that was needed regarding their condition. He also found that only 25% of nurses surved in a single institution reported that patients were adequately taught before being discharged, with 90% believeing that ther was not enough time to educate patients. This study indicated nurses do not perceive that patient education is being delivered effectively.

Perceptions of preparation for the patient educator role are directly related to the nursing program design. Evaluation of program design can give insight into the development of these perceptions.

Four levels of evaluation are of concern in a program evaluation. The first being that of process evaluation. It involves the participant's general feelings of the benefits of the learning experience. The method of choice for an evaluation of this type would be a Likert Scale (Holly, 1989).

The second level is content evaluation which refers to changes in knowledge, affect, and skill immediately following the learning experience. A method to evaluate content might be to ask the learner qualitatively what was learned and what can be done with the knowledge.

Outcome evaluation, the third level of program evaluation hierarchy, involves change in behavior that continues after the initial learning experience. Outcomes can be measured by nonparticipant observation of practice.

The fourth and final level is impact evaluation. This measures improvement in the system and is the most difficult, time-consuming, and costly of all. An example of this type of evaluation is a retrospective audit. This is the most valuable of all the levels. It provides the best information about the effectiveness of the program.

Nurses perceptions of educational preparation are accomplished through impact evaluation of their nursing programs. However, impact evaluation results should use data that have been collected both during and after the program and should include all the information collected from process, content, and outcome evaluations as well as interviews, performance appraisals, and opinion or attitude scales.

Perceptions of nurses as to their educational preparation for the nurse educator role vary according to their physical and perceived surroundings. These perceptions impact the teaching-learning process. According to Ali (1993), unless nurses perceive they have acquired the skills needed to provide effective patient education, they may lack the confidence patients require of their patient educator. Rankin and Stallings (1990), however, did emphasize that patient education cannot be learned on the job, rather it is a skill to be learned in nursing school.

Measurement of Perceptions

Measurement is the quantifying of any phenomenon (Leedy, p.18). It can be either mathematical or numerical. Measurement can also be defined as the process of obtaining a numerical description of the degree to which an individual possesses a particular characteristic (Gronlund, p. 4).

It is assumed that attitudes or perceptions can be measured by a quantitative technique so that each person's opinion can be reported by some numerical score. A Likert Scale of Summated Rating is a technique used to accomplish this measurement. It is assumed that a particular test item has the same meaning for all respondents, and thus a given response will be scored identically for everyone making it (Zimbardo and Ebbesen, 1970).

Measurement can further be defined as either substantial or insubstantial. Substantial measurement is the measurement of things, insubstantial measurement, measures those things that exist only as concepts

or ideas. Therefore, perceptions can be measured by using insubstantial measurement (Leedy, 1985).

Summary

In summary, nurses realize the importance of their role as patient educators. Frequently, however, the nurse lacks the knowledge and skills needed to teach.

Knowledge of learning theories, the adult and child learning needs, and teaching strategies are necessary for patient education to be successful. Nurses must use this information in planning individualized patient education programs.

CHAPTER 3

METHODOLOGY

This was a descriptive study using an investigator-developed Likert-type instrument (Boswell's Educational Preparation for Patient Education Scale) to determine the differences in perceptions of nurses as to their educational preparation for the patient educator role. The Likert scale, also referred to as the summated rating scale, employs choices expressing different degrees of agreement or disagreement. Perceptual differences are measured along a single dimension. Each individual's score, places them along a continuum of favorableness or unfavorableness toward a homogeneously defined attitude (Gronlund, 1985).

Population and Sample

The populations studied were Texas Licensed Vocational Nurses and Associate Degree Nurses who resided within one of five rural counties. These counties were Palo Pinto, Parker, Hood, Wise, and Jack. All participants surveyed had to be presently employed in nursing. The sample consisted of 38 Licensed Vocational Nurses and 33 Associate Degree Nurses.

Licensed Vocational Nurses were selected by the use of a random table. All Associate Degree Nurses who qualified were used due to the small sample size.

Lists totaling 728 Licensed Vocational Nurses and 112 Associate Degree Nurses were acquired from the Boards of Nurse Examiners.

Protection of Human Subjects

The return of the questionnaire indicated consent to participate in the study. For follow-up purposes a coding strategy was developed. A three digit code was arbitrarily assigned to each subject. The first digit assigned was one (a) indicating Licensed Vocational Nurse (LVN), and two (b) indicating Associate Degree Nurse (ADN). The additional two digits were arbitrarily assigned. This procedure assured confidentiality. No names were used and only group data were reported. Return of the questionnaire indicated consent.

Instrument

The Boswell's Educational Preparation for Patient Education Scale is a two-part Likert-type investigator-developed instrument. Part I was composed of a demographic profile. The subjects were profiled as to county of residence, sex, age, educational preparation, employment, percentage of time doing patient education, and date of graduation.

Part II of the instrument consisted of 12 items total which the participants were instructed to answer based on a 5-point scale: strongly agree (5), agree (4), undecided (3), disagree (2), and strongly disagree (1). Of the 12 items, 6 were stated favorably (items 1, 3, 5, 7, 9, and 11) and 6 unfavorably (items 2, 4, 6, 8, 10, and 12). The value given to the unfavorable statements were: strongly agree (1), agree (2), undecided (3), disagree (4), and strongly disagree (5).

Thus, for all unfavorable statements, reverse scoring was used. Four educational catagories were assessed by the evaluation scale (nursing education, learning theories, teaching strategies, patient education). Three items on the scale dealt with each of the four categories. Items 1, 4, and 12 dealt with nursing education. Items 2, 7, and 9 dealt with learning theories. Items 3, 10, and 11 dealt with teaching strategies. Items 5, 6, and 8, dealt with patient teaching.

Content Validity and Reliability

The Boswell's Educational Preparation for Patient Education Scale was distributed to six experts in patient education to determine the content validity of the instrument. The experts consisted of 3 Licensed Vocational Nurses and 3 Associate Degree Nurses. The 6 experts were not participants in the actual study. An evaluation form with a cover page was prepared for the experts to evaluate the content of the Boswell's Educational Preparation for Patient Education Scale (see Appendix A). The forms were distributed by hand to the experts. They were given a stamped, preaddressed envelope to return the form to the investigator. All experts were telephoned within one week to remind them to complete the instrument and to return them. If four experts disagreed upon any one statement, a change was made or the item deleted. No modifications were made. An ex post facto item analysis was conducted on the instrument to determine reliability. The alpha coefficient was .9206.

Scoring

A summative score for each participant was determined by using the 5-point scoring scale mentioned previously. The value given both favorable and unfavorable items was determined and a summative score was calculated. Scores ranged between 60 and 23.

Collection of Data

A Likert-type questionnaire, Bosewell's Educational Preparation for Patient Education Scale, a cover letter and a preaddressed, stamped envelope were mailed to all selected participants (see Appendix A). The participants were instructed to return the questionnaire in the preaddressed stamped envelope, within two weeks. A follow-up letter was sent when less than 50% of each group of participant questionnaires were returned. The letter included as before a questionnaire, a second cover letter (see Appendix A), and a preaddressed, stamped envelope. The participants were again instructed to return the questionnaire within two weeks. The individuals who did not reply after the second letter were omitted from the study.

Treatment of Data

A profile of demographics of the participants (Licensed Vocational Nurses and Associate Degree Nurses) was done. Nominal data were used to arrive at the frequencies and percentages. The responses of LVNs and ADNs to each of the 12 items on the Boswell's Educational Preparation for Patient Education Scale by frequency and percentage were profiled.

Inferential statistics were also utilized. The statistical treatment applied was a t - test. The level of significance was set at .05.

CHAPTER 4

FINDINGS

This chapter describes the participants (Licensed Vocational Nurses and Associate Degree Nurses) by demographic characteristics: county of residence, sex, age, educational preparation, employment, percentage of time doing of patient education, and graduation date. The responses of all participants to the Boswell's Educational Preparation for Patient Education Scale are presented as the data relates to the hypothesis of the study. Ex post facto reliability of the Boswell's Educational Preparation for Patient Education Scale is also discussed.

Description of Participants.

The subjects of the study initially consisted of 112 Licensed Vocational Nurses and 112 Registered Nurses. It was not known how many of the Registered Nurses were Associate Degree Nurses. Of the 38 LVN responses received, 2 were eliminated from the study because they had retired many years ago. Thirty-three Associate Degree Nurses responded. Three participants had Bachelor of Science Degrees in Nursing (BSNs), and were disqualified. In addition, 30 of the Licensed Vocational Nurse and 20 of the Associate Degree Nurse instruments were returned due to incorrect addresses.

It was noted that many of the addresses acquired from the Boards of Nursing were incorrect, resulting in a large number of returned, undeliverable instruments. Forty-six Licensed Vocational Nurses and 55 Associate Degree Nurses did not respond. The findings of this study were based on, 36 LVNs and 33 ADNs. The return rate for the Licensed Vocational Nurses was 32% and 29% for the Associate Degree Nurses.

Licensed Vocational Nurses

Of the 36 LVNs, all were licensed in the state of Texas. Twenty practiced in Palo Pinto County, 12 in Parker County, 2 in Jack County, 1 in Wise County, and 1 in Hood County. Four of the participants were males and 32 were females (see Table 1). Participants ranged in age from 26 to 65 years. Eight participants were between 26 and 35, 11 were between the ages of 36 and 45, 10 were between 46 and 55, and 7 were between 56 and 65 years of age. Thirty participants reported that they worked in hospitals, with 2 reported working in nursing homes, 2 working in rehabilitation centers, 1 working at a physician's office, and 1 reported working as an LVN instructor. Graduation dates from nursing school ranged from 1953 to 1988 with the mean year being 1975.

Table 1

Participant Demographic Profile

Demographic Categories	LVNs f	LVNs %	ADNs f	ADNs %
Licensed & Practicing in Texas	36		33	
County in which Practicing				
Palo Pinto	20	55.6	22	66.6
Parker	12	33.3	5	15.2
Jack	2	5.6	3	9.1
Wise	1	2.8	1	3.0
Hood	0	0.0	2	6.1
Other	1	2.8	0	0.0
Sex				
Male	4	11.1	4	12.1
Female	32	88.9	28	84.8
Unreported	0	0.0	1	3.0
Primary Employment				
Hospital	30	83.3	26	78.8
Nursing Home	2	5.6	3	9.1
Home Health	0	0.0	4	12.1
Rehabilitation Center	2	5.6	0	0.0
Psychiatric Facility	0	0.0	0	0.0
Physician's Office	1	2.8	0	0.0
Other (LVN Instructor)	1	2.8	0	0.0

Table 1 contd.

Demographic Categories	LVNs f	LVNs %	ADNs f	ADNs %
% Time Devoted to Patient Education				
0	1	2.8	0	0.0
5	1	2.8	2	6.1
10	4	11.1	2	6.1
15	3	8.3	0	0.0
20	1	2.8	5	15.2
25	4	11.1	4	12.1
30	3	8.3	4	12.1
35	0	0.0	2	6.1
40	4	11.1	0	0.0
45	1	2.8	2	6.1
50	8	22.2	6	18.2
55	0	0.0	1	3.0
60	0	0.0	1	3.0
65	0	0.0	0	0.0
70	1	2.8	0	0.0
75	5	13.9	3	9.1
80	0	0.0	1	3.0
Graduation Date				
1953	1	2.8	0	0.0
1958	1	2.8	0	0.0
1959	1	2.8	0	0.0
1966	1	2.8	0	0.0
1967	1	2.8	1	3.0
1968	0	0.0	1	3.0
1969	3	8.3	1	3.0
1970	2	5.6	1	3.0
1971	1	2.8	1	3.0
1972	2	5.6	0	0.0
1973	1	2.8	0	0.0
1975	1	2.8	2	6.1
1976	4	11.1	3	9.1
1977	3	8.3	3	9.1
1978	1	2.8	0	0.0
1980	0	0.0	3	9.1
1981	2	5.6	0	0.0

Table 1 contd.

Demographic Categories	LVNs		ADNs	
	f	%	f	%
1982	4	11.1	3	9.1
1983	2	5.6	0	0.0
1984	1	2.8	1	3.0
1985	2	5.6	1	3.0
1987	1	2.8	0	0.0
1988	1	2.8	0	0.0
1989	0	0.0	3	9.1
1990	0	0.0	6	18.2
1991	0	0.0	3	9.1

Note: Some percentages do not add up to 100 because of rounding off numbers.

These Licensed Vocational Nurse participants reported that from 0% to 75% of their time was spent in patient education, with 37.5% being the mean (see Table 2).

Table 2

Percentage of Time Spent in Patient Education

Group	Range (Low-High)	M	SD	SEM
LVN	75 (0-75)	37.50	22.38	3.73
ADN	75 (5-80)	37.27	20.85	3.63

Note: The number of LVN subjects equaled 36; ADN subjects equaled 33.

Associate Degree Registered Nurses

Of the 33 ADNs, all were licensed in the state of Texas. Twenty-two practiced in Palo Pinto County, 5 in Parker County, 3 in Jack County, 1 in Wise County, and 2 in Hood County. Four of the participants were males, 28 were females, and 1 did not report gender. Participants ranged from age 26 to 55 years.

As indicated in Table 1, 11 were between 26 and 35, 17 were between 36 and 45 and 5 were between 46 and 55 years of age. Twenty-six participants reported working in hospitals, with 3 working in nursing homes and 4 working in home health agencies. Graduation dates from nursing school ranged from 1967 to 1991. These Associate Degree Nurse participants reported that from 5% to 80% of their time was spent in patient education with 37.27% being the mean (see Table 2).

Finding by Evaluation Categories

Responses to each item, on the Boswell's Educational Preparation for Patient Education Scale, of Licensed Vocational Nurses and Associate Degree Registered Nurses were reported by frequency and percentage (see Tables 3 and 4). Each of the 4 educational categories, identified by the Boswell's Educational Preparation for Patient Education Scale, were analyzed separately as they related to the Licensed Vocational Nurse and the Associate Degree Registered Nurse. The following briefly describes the findings in each of the 4 categories:

1. In the area of nursing education (Item 1, 4, 12), the majority (55.5%) of the LVNs believed that their nursing program did not prepare them to be a patient educator whereas, 94.0% of the ADNs believed they were not prepared. Both groups perceived, (LVNs reported 50.6% and ADNs reported 84.9%), that their nursing program curriculum did not include basic knowledge of the needs of the adult learner. Both groups again perceived with a majority of LVNs (61.0%) and ADNs (93.9%), that they were not prepared to provide effective patient education.

2. In the area of learning theories (Items 2, 7, 9), 72.4% of the LVNs and 69.7% of the ADNs perceived that they were not prepared to base patient educational programs on appropriate learning theory. However, the majority (55.6%) of the LVNs perceived that their nursing program prepared them to meet the learning needs of children, but 78.8% of the ADNs had the opposite perception. Both groups perceived, that they were not instructed that a basic knowledge of learning theories was needed to deliver effective patient education; 72.3 % of the LVNs and 84.9 % of the ADNs reported this perception.

Table 3

LVN Attitudes Toward Educational Preparation

by Item, Frequency, and Percentage

Statements	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree	
	f	%	f	%	f	%	f	%	f	%
1.	0	0.0	14	38.9	2	5.6	17	47.2	3	8.3
2.	1	2.8	16	44.4	7	19.4	12	33.3	0	0.0
3.	0	0.0	14	38.9	2	5.6	20	55.6	0	0.0
4.	2	5.6	16	44.4	6	16.7	12	33.3	0	0.0
5.	2	5.6	9	25.0	5	13.9	19	52.8	1	2.8
6.	5	13.9	22	61.1	5	13.9	4	11.1	0	0.0
7.	2	5.6	18	50.0	5	13.9	10	27.8	1	2.8
8.	4	11.1	13	36.1	4	11.1	13	36.1	2	5.6
9.	0	0.0	5	13.9	5	13.9	20	55.6	6	16.7
10.	1	2.8	16	44.4	5	13.9	11	30.6	3	8.3
11.	2	5.6	14	38.9	7	19.4	13	36.1	0	0.0
12.	6	16.7	16	44.4	5	13.9	7	19.4	2	5.6

Note: See Appendix B for statement of items.
Statements are on pages 45 - 46.

Table 4

ADN Attitudes Toward Educational Preparation by Item, Frequency, and Percentage

Statements	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree	
	f	%	f	%	f	%	f	%	f	%
1.	0	0.0	2	6.1	0	0.0	19	57.6	12	36.4
2.	3	9.1	20	60.6	0	0.0	10	30.3	0	0.0
3.	0	0.0	4	12.1	0	0.0	27	81.8	2	6.1
4.	6	18.2	22	66.7	2	6.1	2	6.1	1	3.0
5.	0	0.0	1	3.0	0	0.0	21	63.6	11	33.3
6.	20	60.6	11	33.3	0	0.0	2	6.1	0	0.0
7.	0	0.0	5	15.2	2	6.1	23	69.7	3	9.1
8.	5	15.2	26	78.8	0	0.0	2	6.1	0	0.0
9.	0	0.0	5	15.2	0	0.0	16	48.5	12	36.4
10.	3	9.1	22	66.7	0	0.0	7	21.2	1	3.0
11.	0	0.0	8	24.2	2	6.1	20	60.6	3	9.1
12.	7	21.2	24	72.7	0	0.0	2	6.1	0	0.0

Note: See Appendix B for statement of items.
Statements are on pages 45 - 46.

3. In the area of teaching strategies (Items 3,10,11), the majority of LVNs (55.6%) and an overwhelming number of ADNs (87.9%) reported that they were not prepared to use a variety of teaching strategies to deliver effective patient education. Both groups reported that they were not prepared to use audiovisual or media instruction (LVNs 47.2%, ADNs 75.8%). LVNs perceived (45.5%) that their nursing program curriculum prepared them to use role play as a teaching method, while 69.7% of the ADNs perceived that they were not prepared to use role play.

4. In the area of patient teaching (Items 5, 6, 8), the majority of both groups (LVNs 55.6%, ADNs 96.9%) perceived that as a student nurse they were not allowed to do patient teaching. Both groups perceived overwhelmingly (LVNs 75%, ADNs 93.9%) that they had no patient education preparation as a student. Again, both groups perceived that they did not feel that they were adequately prepared as a patient educator in their nursing program, (LVNS 47.2 %, ADNS 94%).

Findings by Hypothesis

The hypothesis of this study stated: "There is no significant difference between Licensed Vocational Nurses (LVNs) and Associate Degree Registered Nurses (ADNs) perceptions as to their educational preparation for patient education, as measured by the Boswell's Educational Preparation for Patient Education Scale."

The raw scores of the Licensed Vocational Nurses and Associate Degree Registered Nurses is found in Table 5 (see Appendix C). Using a *t*-test, no significant difference (t= -4.58, p <.0001) was found at the .05 level; thus the null hypothesis was rejected (see Table 6).

Table 6

Total Independent t-Test of BEPPE

Group	M	t	p
LVN	38.75		
		-4.58	<.0001
ADN	47.24		

Summary

Table 7 illustrates the disposition of the hypothesis. No statistical difference in perceptions of educational preparation for patient education was found.

Table 7

Disposition of Hypothesis

Hypothesis	Disposition
1. There is no significant difference between Licensed Vocational Nurses (LVNs) and Associate Degree Registered Nurses (ADNs) perceptions as to their educational preparation for patient education.	Rejected

CHAPTER 5

SUMMARY, CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

Summary

This study determined if there was difference between LVN and ADN perceptions as to their educational preparation for the patient educator role. The subjects of the study from the LVN group were selected by random sampling from a list of names acquired from the Texas Board of Vocational Nurse Examiners. All of the subjects from the ADN group, acquired from the Texas Board of Nurse Examiners, were used due to the small sample size. The investigator-made instrument consisted of two parts (a demographic profile and the Boswell's Educational Preparation for Patient Education Scale). The instrument, along with a cover letter, was mailed out to the sample. If there was no response within two weeks, a second instrument and cover letter were sent. The first part was a demographic profile (county of residence, sex, age, area of employment, educational preparation, percentage of time doing patient education, and graduation year), analyzed using descriptive statistics (frequency and percentages). The second part was the Boswell's Educational Preparation for Patient Education Scale which consisted of 12 items, each with a possible response to strongly agree, agree, undecided, disagree, or strongly disagree. The mean scores of the two groups were analyzed using a *t*-test. Ex post facto reliability (.9206) of the instrument was established using Cronbach Alpha.

Conclusions

The following conclusions were made based upon the results of the study:

1. The Boswell Educational Preparation for the Patient Educator Scale was determined to be a reliable instrument (r = .9206).

2. The perceptions of Licensed Vocational Nurses and Associate Degree Registered Nurses as to their educational preparation for the patient educator role were similar.

3. Other conclusions were:

   a. LVNs and ADNs did not feel that their nursing program prepared them as a nurse patient educators.

   b. LVNs felt that they were prepared to meet the learning needs of children, whereas ADNs felt that they were not prepared.

   c. LVNs and ADNs felt that they were not instructed that basic knowledge of learning theories is needed to deliver effective patient education.

   d. LVNs and ADNs felt that they were not prepared to use a variety of teaching strategies to deliver effective patient education.

   e. LVNs felt that their nursing program curriculum prepared them to use role play as a teaching method, whereas ADNs felt that their nursing program curriculum did not.

   f. The majority of LVNs and ADNs felt that as students they were not allowed to do patient education.

Discussion

Patient education is provided by all levels of nursing personnel in a variety of settings. It is identified as a legal responsibility and yet prior to this study no documentation was found as to how prepared nurses feel they are for this role. This study explored the differences in perceptions between two different levels of nursing as to their educational preparation for the patient educator role.

The sample used in this study contained 69 participants, 36 Licensed Vocational Nurses and 33 Associate Degree Registered Nurses. The mailout strategy yielded a small sample size. This may have rendered less reliable statistical findings. The results of this study may vary if more Texas counties were included.

The teaching/learning process involved in patient education is a very complex process. Several internal and external variables could have impacted the study. The following is representative of the possible variables.

The nurse may not view patient education as a critical aspect of their particular job. For example, a nurse who works in a physcians office and doubles as a receptionist may not consider patient education as part of the job responsibilities or an important aspect of the job. Time could also be a factor.

The personality of the nurse may have impacted how they perceived themselves as patient educators. Individuals who are reserved and lack confidence, may find patient teaching as a threatening process. Those who are more outgoing and confident may enjoy the challenge and accept the role readily.

Another contributing factor could be that nurses may only utilize styles and methods of teaching which lend a greater level of comfort. These may be the methods that were used during their educational experience.

If urban rather than rural counties were used, would the differences between the groups be greater? In urban areas there are greater nursing role differentiations. Thus, selected nurses might be assigned the role of patient educator. For example, a particular nurse may be responsible for all diabetic teaching. Rural areas tend to promote eclectic responsibilities which would involve all nurses to be participating in some form of patient education. Also, subjects may be practicing in a rural setting but living in an urban location which may impact their view of patient education. With these factors in mind a greater difference might have been observed.

Licensed Vocational Nurses and Associate Degree Registered Nurses have similar education within their own levels of training. The length of time in practice, however, may make a difference in their perceptions. The focus on patient education in nursing curricula has been a more recent phenomena. Thus, the more recent graduates may view the educator role from a different perspective than the earlier graduates.

Another factor which could impact the study might be the level of the nurse's enthusiasm in providing patient education. Some may view it as an integral part of their job, while others view it as a problem and time consuming. This also may impact the effectiveness of patient education.

Questions which might also impact this study evolve around the issue of effectiveness. Are nurses who feel they are prepared as patient educators actually effective? Are they evaluating whether or not their patients have learned and can actually apply the information they have imparted. The answers to these questions were not measured in this study.

Nurses work in a variety of health care settings. The nature of the work related to place of employment could vary the responses. Perhaps it would be best to study this topic in only one type of health care facility (ie. hospitals).

What do the nurses perceive as patient education activities? This is another area of potential influence. Some may perceive day to day care and information exchange with patients as patient education. Others may view patient education as a formal session with handouts.

Another factor which might have impacted the study could be that LVNs are not doing as much patient education as the ADNs. If this is a factor, LVNs may not feel as strongly about educational preparation for patient education or patient education in general.

Concerns maybe that ADNs are functioning on the same level as the BSNs in the area of patient education. ADNs overwhelmingly agreed that they were not prepared to be patient educators. If this was so, how was the knowledge for effective patient education acquired? Did they acquire this knowledge on their own? Just because they are nurses does not make them educators.

Recommendations

Several recommendations are suggested by this research:

1. To replicate the study using a larger random sample size.
2. To use a different methodology besides the mailout strategy.
3. To replicate the study using Bachelor and Master level Registered Nurses.
4. To review the items in the four specific categories evaluated by the Boswell's Educational Preparation for Patient Education Scale.

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APPENDICES

Appendix A

Cover Letter, Follow-up Cover Letter
and
Boswell's Educational Preparation
for Patient Education Scale

Dear Participant:

Nurses in all areas of health care delivery are held responsible in part, if not totally, for various aspects of patient education. With this responsibility it is critical that nurses be prepared to meet this challenge with adequate educational preparation and training.

You have been selected from a group of Texas Licensed Vocational Nurses and Associate Degree Nurses to give your opinion on how you perceive your educational preparation for the patient educator role. Your name was drawn from a sample of five rural counties. In order for the results to be truly representative of your level of nursing, it is important for you to complete the questionnaire and return it within two weeks.

You may be assured of complete confidentiality. No names will be utilized and group data will be reported. If you wish not to participate, please return the contents in the preaddressed, stamped envelope.

The results of this research will be made available to you upon request. If you would like a copy of the findings of this study, please check the appropriate line on the last page of the questionnaire. Your cooperation would be appreciated.

I would be happy to answer any questions you might have. Please call or write. The telephone number during working hours is (817) 594-5471.

Thank you for your assistance.

Sincerely,

Katherine Boswell R.N., B.S.
Director, Vocational Nursing Program
Weatherford College

Dear Participant:

About three weeks ago I wrote you seeking your opinion on the educational preparation for the role of the patient educator among Licensed Vocational Nurses and Associate Degree Nurses. As of today, I have not received your completed questionnaire.

I have undertaken this research project because I believe the nurse should be prepared to assume the responsibility of educating patients. The levels and types of patient education varies with the health care setting and are critical in promoting health and disease prevention.

I am writing you again because of the significance each questionnaire has to the usefulness of the study. Your name was selected from Texas Licensed Vocational Nurses and Associate Degree Nurses. In order for the results of this study to be truly representative of the opinions of Texas nurses, practicing in rural counties, it is essential that each person return their questionnaire. In the event your questionnaire has been misplaced, a replacement is enclosed. If you wish not to participate, please return the contents in the preaddressed, stamped envelope.

You may be assured of complete confidentiality. Thus, no names will be utilized and group data will be reported.

The results of this research will be made available to you upon request. If you would like a copy of the findings of this study, please check the appropriate line on the last page of the questionnaire.

I would be happy to answer any questions you might have. Please call or write. The telephone number during working hours is (817) 594-5471.

Your cooperation is greatly appreciated.

Sincerely,

Katherine Boswell R.N., B.S.
Director, Vocational Nursing Program
Weatherford College

BOSWELL'S EDUCATIONAL PREPARATION FOR PATIENT EDUCATION

(BEPPE)

PART I: DEMOGRAPHIC PROFILE

Directions: Please complete by placing an "X" in the appropriate blanks.

1. Are you licensed and practicing nursing in the State of Texas?

   Yes _____ No _____

   If no, stop here and return this questionnaire in the preaddressed, stamped envelope.

2. If yes, indicate in which county you are practicing.

   Palo Pinto _____ Jack _____
   Parker _____ Wise _____
   Other _____ Hood _____

   If other, stop here and return this questionnaire in the preaddressed, stamped envelope.

3. Indicate highest level of education preparation:

   LVN _____ ADN _____

   If BSN or MSN, stop here and return this questionnaire in the preaddressed, stamped envelope. If you are a licensed and practicing ADN or LVN please continue.

---

4. Sex

   Male _____ Female _____

5. Age

18-25	_____	46-55	_____	76 & above	_____
26-35	_____	56-65	_____		
36-45	_____	66-75	_____		

6. Primary employment

Hospital	_____	Rehabilitation Center	_____
Nursing Home	_____	Psychiatric Facility	_____
Home Health	_____	Physician's Office	_____
Other	_____	Please indicate:	_____

7. What percent of your time is devoted to patient education at your current place of employment?

_____ %

8. Date of Graduation

_____

PART II: QUESTIONNAIRE

The following is a list of statements to which you might have any of five (5) reactions. You might strongly agree (SA), agree (A), be undecided (UN), disagree (D), or strongly disagree (SD). There are no right or wrong answers. Please read the statements and circle the answer that best describes your opinion. All answers are confidential.

SA = Strongly Agree
A = Agree
UN = Undecided
D = Disagree
SD = Strongly Disagree

1. My nursing program prepared me to be a patient educator.	SA	A	UN	D	SD
2. I was not prepared to base patient educational programs on appropriate learning theory.	SA	A	UN	D	SD
3. I was prepared to use a variety of teaching strategies to deliver effective patient education.	SA	A	UN	D	SD
4. My nursing program curriculum did not include basic knowledge of the needs of the adult learner.	SA	A	UN	D	SD
5. As a student nurse I was allowed to do patient teaching.	SA	A	UN	D	SD
6. As a student nurse I had no patient education preparation.	SA	A	UN	D	SD
7. My nursing program prepared me to meet the learning needs of children.	SA	A	UN	D	SD

8.	I do not feel I was adequately prepared as a patient educator in my nursing program.	SA	A	UN	D	SD
9.	I was instructed that a basic knowledge of learning theories is needed to deliver effective patient education.	SA	A	UN	D	SD
10.	I was not prepared to use audio visual/media instruction.	SA	A	UN	D	SD
11.	My nursing curriculum prepared me to use role play as a teaching method.	SA	A	UN	D	SD
12.	I was not prepared to provide effective patient teaching.	SA	A	UN	D	SD

Thank you for participating in this study.
Please mail the Questionnaire in the preaddressed, stamped envelope.

If you would like a copy of this study please indicate:

Yes _____ No _____

Appendix B

Cover Letter and Experts Evaluation

Dear Nurse Patient Educator,

I am conducting graduate research concerning the perceptions of LVNs and ADNs as to their educational preparation for patient education. I am asking for your assistance because of your educational background and patient education experience.

I am enclosing a sample questionnaire and a critique sheet on which I would like your comments and suggestions. The Likert-type questionnaire consists of favorable and unfavorable statements.

Your comments will be valuable in this study. All comments will be kept confidential. To assure confidentiality, please return your critique in the enclosed preaddressed, stamped envelope.

The results of this research will be made available to you upon request. If you would like a copy of the findings of this study, please contact me at (817) 594-5471 during working hours or (817) 325-3987.

I would be happy to answer any questions you might have. Please call the above phone numbers or write.

Thank you for your assistance.

Sincerely,

Katherine Boswell R.N., B.S.

NURSE PERCEPTIONS OF THEIR EDUCATIONAL PREPARATION AS PATIENT EDUCATOR

INVENTORY CRITIQUE

Please read each statement and place a mark (X) in the appropriate column. If you feel the statement needs to be changed, please indicate in the space provided a more appropriate manner in which to make the statement. If you think it should be deleted, or if you have any additional statements please indicate. The critique consists of six favorable statements and six unfavorable statements. Your comments are appreciated and valued.

		KEEP	CHANGE	DELETE
1.	My nursing program prepared me to be a patient educator.	_____	_____	_____

Indicate change: _____

_____

_____

2.	I was not prepared to base patient educational programs on appropriate learning theory.	_____	_____	_____

Indicate change: _____

_____

_____

3.	I was prepared to use a variety of teaching strategies to deliver effective patient education.	_____	_____	_____

Indicate change: _____

_____

_____

	KEEP	CHANGE	DELETE
4. My nursing program curriculum did not include basic knowledge of the needs of the adult learner.	_____	_____	_____

Indicate change: _____

_____

_____

5. As a student nurse I was allowed to do patient education.	_____	_____	_____

Indicate change: _____

_____

_____

6. As a student nurse I had no patient education preparation.	_____	_____	_____

Indicate change: _____

_____

_____

7. My nursing program prepared me to meet the learning needs of children.	_____	_____	_____

Indicate change: _____

_____

_____

	KEEP	CHANGE	DELETE
8. I do not feel I was adequately prepared as a patient educator in my nursing program.	_____	_____	_____
Indicate change: _____			
9. I was instructed that a basic knowledge of learning theories is needed to deliver effective patient education.	_____	_____	_____
Indicate change: _____			
10. I was not prepared to use audio visual/media instruction.	_____	_____	_____
Indicate change: _____			
11. My nursing curriculum prepared me to use role play as a teaching method.	_____	_____	_____
Indicate change: _____			

	KEEP	CHANGE	DELETE
12. I was not prepared to provide effective patient teaching.	_____	_____	_____

Indicate change: _____

_____

_____

13. Other Statements: _____

_____

_____

Appendix C

Raw Scores of Licensed Vocational Nurses and Associate Degree Registered Nurses

Table 5

Raw Scores of Licensed Vocational Nurses and Associate Degree Registered Nurses

Type of Nurse	Participant #	Raw Scores
Licensed Vocational Nurses	1	55
	2	33
	3	47
	4	23
	5	33
	6	42
	7	46
	8	27
	9	42
	10	45
	11	37
	12	49
	13	30
	14	52
	15	27
	16	39
	17	26
	18	42
	19	42
	20	50
	21	26
	22	26
	23	52
	24	32
	25	49
	26	34
	27	45
	28	40
	29	27
	30	46
	31	42

Table 5 contd.

Type of Nurse		Participant #	Raw Scores
		32	33
		33	23
		34	47
		35	31
		36	47
Total Study Group:			
Mean:	38.75		
Variance:	76.74		
Standard Deviation	8.76		
Associate Degree Registered Nurses		1	51
		2	46
		3	50
		4	46
		5	50
		6	51
		7	56
		8	47
		9	50
		10	42
		11	48
		12	56
		13	48
		14	48
		15	60
		16	44
		17	45
		18	48
		19	26
		20	48
		21	49
		22	48

Table 5 contd.

Type of Nurse		Participant #	Raw Scores
		23	49
		24	49
		25	44
		26	48
		27	26
		28	52
		29	50
		30	50
		31	46
		32	51
		33	44
Total Study Group:			
Mean	47.24		
Variance	43.29		
Standard Deviation	6.58		