RN-BSN Curricula: Designed for Transition, Not Repetition

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Combined efforts of professional mandates, employer preferences for increased educational levels of staff registered nurses (RNs), Magnet’s higher environmental ratings, the Institute of Medicine report, and Aiken’s (2003, 2008, & 2011) clinical research outcomes have spawned renewed attention for RN-baccalaureate degree of science in nursing (BSN) education. Yet, nationally, only 21.6% of associate degree nurses are continuing their education (Health Resources and Services Administration, 2010). Designing programs with the student as the center, where student/faculty engagement is the goal, has enabled one school of nursing to develop a quality on-line RN-to-BSN program. Core values of the program reveal a faculty who is committed to development of education to transition the associate degree and/or diploma graduate to professional nursing practice without repetition of content and learning activities. (Index words: RN/BSN education; On-line education; ADN or diploma completion education) J Prof Nurs 29:e37–e42, 2013. © 2013 Elsevier Inc. All rights reserved.

O UR PROFESSION HAS been engulfed with controversy over the relative merits of the diploma (DPL), associate degree (ADN) and baccalaureate degree of science in nursing (BSN)-educated providers for a long time, with little or no consensus! In fact, one author returned to school almost 50 years ago following the explosive 1965 American Nurses’ Association (ANA) Position Paper on Nursing Education publication projecting a mandate of the BSN as entry into the profession (ANA, 1965). By 1986, it seemed evident that it would become a reality when 94% of the ANA state constituents adopted the educational proposal (Zusy). The primary focus for this entry change was the DPL-prepared nurse, which at that time was approximately 70% of the work force (National League for Nursing (NLN), 1984); now, their national numbers are around 14% (United States Department of Health and Human Services, 2010).

Currently, the educational focus is on the ADN level. From a meager start of seven pilot schools in 1952, this type of nursing education has demonstrated phenomenal growth. In 1965, there were 172 ADN programs, in 1975, there were 608 programs, and by 1982, the number had risen to 771 (NLN, 1984; Zusy, 1986); now, the latest count 30 years later is over 1,000 (NLN, 2011). For 10 states (AK, AZ, CA, KY, NM, NC, OR, TX, WA, WY), mainly in the southern and western regions of the nation, there are twice as many ADN programs than BSN programs; in 7 other states (AL, AR, CO, FL, MI, MS, VA), the production of ADN graduates is close (NLN, 2011). Thus, it becomes obvious that with the current national picture of a majority of registered nurses (RNs) still holding an ADN, educators need to work closer with community and/or junior college nursing faculty and students rather than thinking that their picture will eventually be similar to the DPL.

In addition, recent surveys by Maneval and Teeter (2010) and Sportsman & Allen (2011) have validated the enrollment growth seen in many RN-to-BSN programs today with a reported 86% of ADN respondents hoping to obtain a BSN (Health Resources and Services Administration, 2010). Nurses in both surveys saw themselves returning to school within the first 5 years after graduation (Institute for Social Research and California State University, 1997).

Seizing the Opportunities

Several events have culminated. Over the past 15 years, more nursing professional organizations besides the early ANA Position Paper have continued to make strong
recommendations to increasingly support the need for BSN entry education (American Association of Colleges of Nursing (AACN), 2011). Importantly, a dyad of support from the clinical arena has drawn more attention to the issue, including employer preferences for increased educational levels of RNs and clinical research outcomes (AACN, 2011; Goode, Pinkerton, McCausland, Southard, Graham, & Krsek, 2001). Seminal and ongoing research continues to document the need for a different educational mix of staff RNs in hospitals to lower patient mortality and increase failure-to-rescue rates (Aiken, Clarke, Cheung, Sloane, & Silber, 2003): these findings have been confirmed (Aiken, Clarke, Sloane, Lake, and Cheney, 2008). Along with patient care, better work environments have been documented in Magnet-designated hospitals and facilities that traditionally hire and retain larger numbers of BSN (59% vs. 34% at other hospitals) and higher educated nurses (AACN, 2011; Aiken et al., 2008).

And now, the Institute of Medicine (IOM) released the *Future of Nursing: Leading Change, Advancing Health*. This report, along with the Action Coalition work from the Robert Wood Johnson Foundation, is providing an enthusiastic momentum to “matriculate an additional 760,000 nurses with a BSN by 2020” (Hassmiller, 2011, p.479). Thus, more than ever, RN-BSN education will be essential to assist the professional mantra of 80:20 BSN-to-ADN ratio of nurses by 2020 or “80 by 20.” In the future, higher proportions of BSN-prepared nurses might actually get to the patient’s bedside.

RN-BSN education is important because these graduates “develop strong professional-level skills...demonstrating higher competency in nursing practice, communication, leadership, professional integration, and research/evaluation” (AACN, 2011 p.5; Phillips, Palmer, Zimmerman, and Mayfield, 2002). The purpose of this article is to (a) challenge present thoughts about this alternative path to BSN education, (b) reduce entry hindrances, (c) incorporate methodologies that transition the student, and (d) incorporate learning strategies that ultimately unleashes the ADN’s potential while (e) promoting self-efficacy toward advanced nursing education. RN-to-BSN programs build on previous education obtained in nursing in ADN or DPL education to prepare graduates for a broader scope of practice (AACN, 2011).

**Obstacles Linger for RN-BSN Trajectory**

Although there has been limited fluctuation of ADN numbers (58–60%) over the past 10 years (NLN, 2010), the big problem is the small amount of current ADN graduates continuing their education. With 634 RN-BSN programs available nationwide, including more than 400 offered at least partially, or totally on-line, only slightly more than one in five (21.6%) obtain their BSN (AACN, 2011).

A rich source of RN-BSN literature was produced in the late 20th century (Goode et al., 2001; Lynn, 1989; Phillips, 2002; Sullivan, 1984; Wooley, 1978; Zsusy, 1986), yet the recent literature still tells us that, from their perspective, the path to educational mobility of BSN education continues to be fraught with obstacles. In PA, 96% of DPL and ADN nurses said that they would return for BSN education if money was not an obstacle (Maneval and Teeter, 2010). Other hindering factors cited from an administrative qualitative investigation include “(1) time, (2) fear, (3) lack of recognition for past educational and life accomplishments, 4) equal treatment of BSN, ADN, and DPL RNs [in the workplace], and (5) negative ADN or DPL school experience” (Meggison, 2008, p 47). One good note is that Web-based RN-BSN nursing programs seem to have reduced some historical frequently mentioned barriers such as inconvenient scheduling and geographic inaccessibility (NLN, 2011).

**Striving for Seamless Transition**

“Seamless education” is a concept used consistently when faculty speaks about RN/BSN education. However, with each university and community college requiring a variance in general education requirements, seamless transition from the community college to the university becomes very challenging for the ADN graduate particularly if they change state residence. Seamless education requires dialog among community college and university administrators to achieve consensus on needed prerequisite courses; perhaps, even a “preferred partner” status can be negotiated. Dialog, articulation agreements, and belief by both schools are needed for seamless transition to occur. In addition to community college and university articulation agreements, there are several states that have state-wide agreements for student transition. The states with statewide articulation plans include the following: Florida, Connecticut, Arkansas, Texas, Iowa, Maryland, South Carolina, Idaho, Alabama, and Nevada (AACN, 2011). The authors have found that whatever it takes to create a process for ease in enrollment is important because turning potential RN students away often produces frustration and loss of worth, with no further admission attempts.

**Relevant Transitional Curricula**

Designing relevant curricula to transition the ADN or DPL graduate to BSN education and beyond is challenging for both faculty and school of nursing administrators. To overcome these current and perceived barriers and facilitate a professional and customer-centered curriculum, nursing faculty will need to continually rethink course and program outcomes, examine environmental trends, and investigate ways to build on what the ADN and DPL already posses.

**Learner-Centered Curricula Infused With Adult Learning Principles**

Different from traditional educational models, which may be teacher centered, relevant transitional curricula for the RN-to-BSN student should be learner centered and faculty facilitated, with a targeted outcome of student engagement. Moving to a model of facilitated learning that engages the learner can require faculty to rethink
many, if not all, of the teaching methodologies employed with the RN-to-BSN student.

Reviewing the characteristics of the adult learner will encourage faculty to “rethink” learning activities as they are very apparent in this student population. Although traditional BSN and RN students are getting the same academic degree, what has been known for a long time is that RNs need a different journey; they are different students at entry, during enrollment, and upon completion (Sullivan, 1984; Lillbridge and Fox, 2005). Often, seasoned educators identify the similarities in the characteristics of the RN-to-BSN student to the master’s degree student in graduate nursing studies. The RN student is self-directed, uses previous experience and new knowledge to find solutions to real life problems, and enjoys connection and support from peers and faculty (Knowles, 1984). These characteristics, seen in both graduate and RN-to-BSN students, allow many graduate faculties to easily transition to teaching within RN-to-BSN programs.

Although many RNs come to this educational program with a wealth of experiences and knowledge, historically, RN-BSN programs have attempted substitute measures to provide BSN education. These past efforts have proven very ineffective for the student. One common method has been preassessing or validating their knowledge. Unfortunately, this validation of prior learning is costly, time consuming and, most importantly, a source of resentment, often stifling RNs from even considering further education. In addition, RN-BSN education does not mean patching a new curriculum track by identifying courses for completion from the prelicensure/traditional track. With both of these approaches to curriculum design, RN-to-BSN students can experience repetitive content and content gaps.

Basically, the bottom line is one of using sound adult education principles. Garnered belief that RNs already have a basic body of knowledge and those other nonbaccalaureate schools of nursing can also provide quality basic nursing education. From the author’s combined 50-year experiential base with RN-BSN education, operationalizing this philosophy has produced applicable, accessible, interactive programs; stimulated a diverse minority RN population with 47% of the students from diverse ethnicities; and increased enrollments, retention, and graduating over 600 yearly. Interesting to note, this program has achieved a rate of almost 60% of these BSN graduates continuing on with graduate nursing education. Other details of our program include (a) 55 semester hours (SH) of general education requirements, primarily set by the state’s university and higher education board, and expected to be completed before entry into the RN-BSN program; 35 SH of advanced placement awarded for their basic nursing program; an on-site orientation to initially meet faculty, fellow students, and student service personnel face to face; and university enrollment for 30 SH of Web-based delivery education over two semesters, for a total 120 SH degree. Almost all the RN students are enrolled full-time, while also working full time. In another demonstration of the adult learning theory, depending on where they achieve their general education requirements, the RN can literally transfer into the university 90 SH from a community/junior college.

Reflect on the Program Outcomes

Relevant transitional curriculum design requires program administrators, BSN faculty, nursing practice administrators, and ADN faculty to dialog about the student educational needs in transition education. To avoid repetition and build a value-added curriculum, meeting with key stakeholders before curriculum design begins is essential to building in relevant content and activities and key to designing a seamless pathway to the BSN education in your region. Once the dialog and partnership with key stakeholders has occurred, then the faculty can begin curriculum design by first reflecting upon the program outcomes.

Our school of nursing program outcomes are the IOM (2003) core competencies, plus one. Reflecting on the terminal outcomes for competence in (a) patient safety, (b) evidence-based practice, (c) patient-centered care, (d) quality improvement, (e) interdisciplinary teams, and (f) informatics allow the faculty to build a curriculum reflecting these needed competencies and avoid repetition of previous basic nursing education. The five competencies for health professionals plus an additional outcome focusing on safety have been leveled to each type of degree and serve as student learning outcomes for both graduate and undergraduate nursing education. For our RN-BSN curricula, the 30 SH of Web-based education are designed to enhance skills to practice at the level recommended by the IOM for all health care providers.

Build Curricula by Beginning at the End

First, create the last course, with the end product in mind; in our curriculum, it was the capstone course. This course was designed to facilitate opportunities for the student to bring together the competencies gained throughout the curriculum and reflect on new skills obtained from this transition education. An example of a capstone activity may be the opportunity for the student to use the six core competencies obtained through previous coursework to design a comprehensive plan of care for individuals or a population of interest.

The curriculum design for the RN-to-BSN student requires an awareness of where to begin with the RN student who has basic knowledge and skills for safe practice and intentional opportunities. All courses are designed with competencies and standards of accreditation at the forefront. This is best accomplished through the use of a curriculum matrix that may crosswalk the student learning outcomes with AACN baccalaureate essentials (2010) and in Texas State Board of Nursing (2011), with course descriptions, course objectives, sample learning activities, and course outcomes. Some examples are to build on basic patient-centered care skills to population-centered care skills and from basic
knowledge of evidence-based practice to a more in-depth exploration of research and information management skills and the incorporation of evidence-based practices skills. Application of informatics skills in patient risk assessment transitions the student from basic practice knowledge and skills to the use of enhanced knowledge and skills for professional nursing practice while opening the door to future graduate study.

Quality and Rigor

RN students are adult learners that can be new graduates directly from their basic nursing program, or someone with a few years of knowledge and experience, to the more than 15-year veteran. To stimulate this vast range of ADN- (and DPL-) prepared nurses toward further education and while designing the relevant transitional curricula, be sure to include the “elephant in the room” faculty discussions about quality and rigor because these two elements differ. Don not shy away from this topic because everyone (including faculty) is a victim of their educational past, and this dialog is healthy, proactive, and necessary.

Effective curriculum is not carved in stone but an ongoing process, a frequent moving target, with the many health care changes, knowledge, and informatics explosion. Rigor is defined as demanding, rigid, and challenging (Hechinger Publications, 2011), whereas quality is defined as the ongoing process of building and sustaining relationships by assessing, anticipating, and fulfilling stated and implied needs. Remember, through a comprehensive system of checks and balances, a quality curriculum in RN-to-BSN education can be established and maintained. Quality goals are obtained by (a) scanning the practice environment and current literature and aligning courses with essentials, (b) faculty connectedness and prevention of “curriculum drift,” (c) evaluation feedback by students and faculty, (d) external advisory committee members of practice and education experts, (e) evaluation feedback from graduates at 6 months and 1 year from graduation, and (f) valuing accreditation visits (Allen and Boswell, 2012).

Clinical Experiences

The issue of clinical for the RN-to-BSN student is always troublesome. What does it look like, where does clinical belong, and how many clinical hours should the student need to complete are all common questions voiced by faculty. This is another area for frank faculty dialog, but before initiation, know what requirements are present with your current accreditation and state board of nursing standards. When designing a postlicensure program, state board of nursing standards may or may not be incorporated in the curriculum because postlicensure education may not require board of nursing approval in your state.

The actual and important dialog should focus on two aspects: (a) what the clinical experience will provide for the student in terms of learning enhancement with a faculty awareness of clinical experiences previously completed in the basic nursing education programs and (b) recognition by the faculty of a licensed learner who is an adult with characteristics and learning needs similar to those of the graduate student. For our school, the clinical for the RN-to-BSN student resembles the clinical for the graduate student in terms of supervision of a licensed professional and a focus on activity outcomes, rather than time on task. We provided a template of the clinical assignment and then the student designs their clinical (with faculty review) according to their individual nursing interest, issues, or even future professional plans to accommodate the various types of RN learners that are present in any one semester.

Clinical experiences in RN-to-BSN education are usually focused in two courses, leadership and population health, and a field experience approach is utilized, which may or may not require direct patient contact. Beyond the focus on outcomes, field experiences are designed as opportunities for the RN student to venture into unknown environments for the purposes of broadening their world view of nursing and expanding student skills in accessing patient and/or community resources and agency services. For example, a field experience in population health may require the student to interview a member of a selected population and stakeholder in this population for defining the population health strengths and needs. An example of a population health field experience that is not appropriate for the RN student would be an activity requiring the student to venture downstairs in his or her facility to the wound care office. This is not a community activity but rather an exploration of institutional resources. The student knowledge of population health needs is not broadened by this limited opportunity where the student does not venture beyond his or her own institution into the community at large.

Professional Socialization

RN students make many arrangements such as financial aid, home care, and time management when they return to school, but few think about the impact of further education to their role, so during RN-BSN orientation, there seems to be interesting dichotomy. The RN student sits with folder arms wondering what RN-BSN faculty have to offer because they already are effective bedside practitioners, whereas the faculty's perspective is different. Wooley (1978, p. 103) describes this dichotomy well, “the change we are encouraging our RN students to make is not simply in the amount of knowledge and credits they can gain; instead it is a whole behavioral [transformation] in their attitudes, roles, and function.” To produce better practice, the authors talk to RN students about “unleashing their potential.”

“Professional socialization (PS) refers to the learning of social roles—a process that continues throughout one’s life” (Lynn, McCain, and Boss, 1989, p. 232); here, the word process is meaningful. Traditionally, PS is thought to come with modeling, discussion, and role play, elements most likely started during their basic nursing
program. Yet, the use of individualized clinical assignments, webinars/asynchronous chats, collegial student/faculty interaction and, yes, even the telephone calls, sometimes within Web-based programs, can further enhance the individual process of self-discovery, critical thinking, and professional growth. By the first semester, faculty sense student struggles with acquisition of new attitudes, concepts, and roles; RN students even talk about losing some of their bedside colleagues because they begin to give up familiar practice assumptions. Each time the RN returns to school can trigger more socialization and role transition, so the process of assuming professional values, attitudes, and goals will continue to grow because they internalize further skills, knowledge, and behavior (Lynn et al., 1989).

Graduate Education Progression

Aiken’s (2011) research documents that ADN are unlikely to progress beyond one level higher than their basic nursing education, so qualitatively, out of the 72,000 U.S. nurses that return to school, only 4,000 are likely to pursue graduate education or higher. In our experience, promoting self-efficacy toward advanced nursing education is very important during RN-BSN education. During RN-BSN orientation, graduate education is discussed, pathways illustrated, and resources for further information promoted at our school or others. In addition, encouraging our seasoned graduate faculty to teach the RN-to-BSN student has both enhanced the program quality, and we believe in encouraging the student to move on to graduate education after RN-BSN program completion, whether it is direct transition or enrollment after “taking a small break” after graduation.

Summary

The RN-BSN model should build on concepts from current ADN and DPL programming to (a) avoid any repetition, (b) build a collegial faculty–student relationship, and (c) infuse the momentum for them to move onward with higher education. In addition, it can (d) build further partnerships and collegial relationships between community/junior college faculty and BSN faculty while meeting regularly to review and update RN-BSN curricula.

This important ADN journey to BSN, and beyond, should be student centered and faculty facilitated. The BSN program should capitalize on (a) the adult education principles of self-direction and pragmatism, (b) blend in the students’ previous experiences, (c) engage students through relevant assignments, (d) interact with environmental trends, and (e) incorporate evidence-based practice resources, to facilitate student to create new meaning, from new knowledge.

References


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