THE HOSPITAL-BASED NURSE EDUCATOR;
DEFINITIONS, TECHNIQUES, AND SELF-PERCEIVED ABILITIES
RELATED TO NEEDS ASSESSMENT

A Thesis
Presented in Partial Fulfillment of the Requirements for
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by
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* * * * *

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DEDICATION

To my parents
ACKNOWLEDGMENTS

I express sincere thanks to members of my Advisor, Dr. Stephen Wilson, for his guidance with this scholarly project. Special thanks to Dr. Sandra Cornett for her assistance and expertise in reviewing materials throughout my research. Thanks to Kay Wolf for her willingness to serve on my committee. I especially want to thank Jill Clutter for her assistance with statistical data and computer assistance, Regina Kengla for her assistance with editing, and the staff of Knox Community Hospital for their support. Most especially I would like to thank my husband, William, for his untiring support and belief in my abilities.
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FIELD OF STUDY

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CHAPTER 1
INTRODUCTION

The area of continuing education is under constant scrutiny by those within the nursing profession. Continuing education also has impact for others outside the profession. The nursing educator in staff development, the learner, the patient and family, the organization being served, and society all have a stake in concerns related to professional education. The purpose of this study is to examine aspects of the nurse educator role (techniques, self-perceived abilities, definitions utilized, resources) that impact on needs assessment and ultimately on program planning.

BACKGROUND

In 1970, the American Nurses Association (ANA) created the position of Coordinator of Continuing Education. In that same year, the first journal to deal with continuing education (CE) activities, The Journal of Continuing Education in Nursing, was published. In 1972, ANA formed the Council on Continuing Education.

State legislatures passed laws to make CE mandatory for relicensure, with Kansas and California being the first states to enact mandatory CE in 1978. Kristjanson and Scanlan (1992) point out that in this time of rapid technological and scientific change, CE is one means that nurses can utilize to maintain their competence to practice.
Oliver (1984) reminds us that participants in continuing education are expected to gain new knowledge and skill. The anticipation is that improved practice will ultimately improve health care for the public.

Salkalys and Carter (1986), in their study of a week-long program with nurses to improve their ability to assess and manage rheumatological disorders, found that CE did improve practice (Peden, Rose, and Smith, 1990). Waddell, using the technique of meta-analysis, found that CE does have a positive effect on practice. She states: "As a profession, nursing can be assured that implementation of continuing education programs is one way of meeting its social contract to ensure safe practitioners" (Waddell, 1991, p. 116).

The American Nurses Association (ANA) defines continuing education as a "planned, organized learning experience, designed to augment the knowledge, skills, and attitudes of nursing practice, education, administration, and research, to the end of improving health care for the public" (ANA, 1992, p. 4). In 1992, Roles and Responsibilities for Continuing Education and Staff Development Across All Settings was published, defining more clearly the role of the staff development educator. It is to be noted that patient outcomes, organizational outcomes, professional development outcomes, changing learner characteristics, knowledge explosion, changing delivery systems, and changing client demographics form the basis for learning needs within the nursing profession (1992). Nursing educators have attempted to meet these needs through continuing education programs.
Bachman, Kitchens, Halley, and Ellison (1992) suggest that continuing-
education educators have unmet learning needs. They observe that "this is reason
enough for continuing education planners to develop and offer programs to enable
nurses who assume teaching positions without adequate preparation to acquire
knowledge and skills to succeed" (p. 33).

STATEMENT OF THE PROBLEM

A review of the literature indicates that how to plan continuing education
offerings is a key concern for hospital educators. Evaluation is an integral part of this
process. Yet nurse educators utilize numerous definitions and techniques for
identification of learning needs, program planning, and evaluation. In a time when
nurses are required to maintain continuing education for relicensure in many states, a
clearer picture of how a hospital-based educator defines and conducts a needs
assessment, plans programs, and evaluates programs can improve strategies for cost-
effective, meaningful educational programs that should, in turn, improve clinical
practice and increase the nurses' sense of confidence and fulfillment.

The literature is replete with many confusing definitions of the term "needs
assessment." Kristjanson and Scanlan (1992) conducted an extensive literature review
showing that four different types of needs were identified: real need (objective
deficiencies), educational deficiency (can be satisfied by a learning experience), real
education need (specific understanding or attitude is lacking), or felt need (perceived
by the learner). Though ambiguous in nature, needs assessment provides the rationale
for the expenditure of millions of dollars to be utilized to plan and present educational programs for nurses.

The work of Banfield and others points out that analysis of patient charts, literature, job description observations, minutes of meetings, supervisor's ratings, and quality assurance techniques are possible sources to identify learning needs (Banfield, Brooks, Brown, Mason, Miller, Smith, and Wong, 1990). Wilson (1990) suggests that the use of market research tools can increase the power of needs assessment by demonstrating potential demand and refining offerings to better meet customer needs.

Urbano and Jahns (1988) postulate that motivational orientation is really a category of variables reflecting basic human needs, attitudes, values, expectations, and perceptions. They utilized motivational orientation as the independent variable in their complex model of participation in continuing education (dependent variable) (Quoted in Waddell, 1993). Waddell's meta-analysis of twenty-two studies supported the hypothesis of Urbano and Jahns that motivational orientation is the number one reason to participate in CE programs.

For this study, the aspect of the needs assessment definition, techniques used by nurse educators, and confidence level is examined. The nursing process, seen by Griffith and Christiansen (1982) as a dynamic, interactional feedback model, defines that assessment is the first step, followed by planning, analysis, implementation, and evaluation. It is logical to identify techniques and definitions of needs assessment utilized by the nurse educator.
OBJECTIVES OF THE STUDY

This study is conducted to answer the following questions:

1. What definition of the term "needs assessment" do nurse educators utilize most frequently?

2. In determining learning needs, what techniques does the nurse educator utilize?

3. What is the self-perceived confidence level of the nurse educator in fulfilling specific aspects of the needs assessment role?

4. How frequently are educational programs planned to meet special needs; i.e., outside regulatory agencies, needs of special groups, changing technology?

5. What human and financial resources does the nurse educator believe are available to fulfill their role?

DEFINITION OF TERMS

Continuing education — "those learning experiences intended to build on the educational and experiential basis for the professional nurse for the enhancement of practice, education, administration, research, or theory development, to the end of improving the health of the public" (ANA, 1992, p.4).

Nurse educator — a nurse who is responsible administratively for nursing staff development and continuing education activities.

Needs assessment — a measurable discrepancy between the current standard and the desirable standard.

Human resources - those individuals who have special skills and expertise that may be consulted as necessary.
Financial resources — adequate budgetary resources to carry out necessary research and program planning to fulfill the educator’s role.

LIMITATIONS

The study will be limited to nurse educators that are hospital based. Since the list of hospitals was the most current available and only one survey was initially mailed to each hospital, this reduces the chance of frame error. Non-response error was considered the greatest threat to validity by this researcher.
CHAPTER II

REVIEW OF LITERATURE

CONTINUING EDUCATION

The founding of the American Psychological Association for Adult Education in 1926 allowed adult education to be recognized as a delineated field in the United States (Knowles, 1980). Continuing education and staff development are recognized by the American Nurses Association as being "based on the use of theories and principles of adult education throughout assessment of learning needs, planning, implementation, and evaluation" (ANA, 1992, p.3).

Knowles makes the following statement regarding the mission of education:

We now know that in a world of the future we must define the mission of education as to produce competent people—people who are able to apply their knowledge under changing conditions; and we know that the foundational competence of all people must have is the competence to engage in lifelong, self-directed learning. We now know, also, that the way to produce competent people is to have them acquire their knowledge (and skills, understandings, attitudes, values, and interests) in the context of its application. (Knowles, 1980, pp. 18-19.)

Knowles sees several meanings of education as relevant. In the broad sense, it describes adults’ learning. In a more technical sense, it describes organized activities such as classes, study groups, lectures, etc. The third meaning combines the social
system of the individuals, institutions, and society in order to extend the opportunity for adults to learn and advance the level of our culture (Knowles, 1980, p. 25).

It was Knowles who brought to the forefront the concept of andragogical versus pedagogical learning. He perceives pedagogical learning in which the learner is a dependent personality rather than a resource to be built on. Pedagogical learning is subject oriented and motivates persons by external rewards and punishments (Knowles, 1986).

Andragogy differs in that adult learners have a self-concept of being responsible for their own lives and their need to know why they need to learn something before undertaking the learning. Adults are seen as life-centered in their learning orientation and have within themselves the richest resource for learning. While external motivators have some effect, the most potent motivators (desire for job satisfaction, self-esteem, quality of life) are internal. Knowles believes that the adult educator’s goal is to help adults discover and become interested in meeting their real needs, but in order to do this, their ‘felt needs’ must be addressed (Knowles, 1986).

Continuing education builds upon the educational and experiential basis of the nurse to enhance practice, education, administration, research or theory development to improve the public’s health. Staff development provides orientation, in-service education, and continuing education in order to promote professional development. Within an employment setting, staff development needs to be consistent with the goals and responsibilities of the employer.
NURSE EDUCATOR'S ROLE

It is important to examine aspects of the registered nurses's role as an educator in providing continuing education programs. In 1992 the American Nurses Association developed a document entitled Roles and Responsibilities for Nursing Continuing Education and Staff Development Across All Settings. This was done in order to better define and identify the parameters of continuing education and staff development.

In the section "Continuing Education Administration (ANA, 1992) of the Council of the continuing education report, several principles are defined: 1) the continuing education provider must have a clearly stated mission statement; 2) there must be appropriate human and financial resources to provide quality programs over an extended time; 3) advertising must provide disclosure of programs, services, and fees; 4) limited access to permanent records of attendance must be maintained; and 5) appropriate quality control must be in place within the organization.

The purpose of Continuing Education and Staff Development is said to be for the benefit of improved patient care and professional development. CE/SD educators are recognized for their contributions through certification.

ANA defines the educational preparation for the role of CE/SD to be at least a Bachelors of Science in Nursing and preferably a graduate degree in nursing or a related field. The CE/SD educator should demonstrate clinical expertise and an interest and ability to provide adult education to learners.
The formation of the American Society of Health Care Education and Training (ASHET), formed by the American Hospital Association in 1970, is open to all staff development professionals. Other organizations have provided continued growth for staff development/continuing education educators. Examples are the National Staff Development Organization (NSDO), Health Education Association (HEA), National Extension Association, and the American Society for Training and Development. Publications have also been a key resource for SD/CE educators.

Stein and Glazer (1994) conducted a survey of ASHET members to examine their characteristics of the ASHET member (educational background, salary, experience), the environment (name of department, delivery system, reporting level, full-time equivalent (FTE), major functions, budget), organizational characteristics (type of facility, bed size, location), and their perception of ASHET. A 46% response rate was returned from a frame composed of 696 names of members of ASHET.

The demographics profile provided by the study showed the typical ASHET member to be a female, age 40-49, who holds a Master's Degree with the first degree achieved being in nursing. Graduate degrees represented the areas of education, health administration, nursing, and nursing education. Typical earnings ranged from $40,000-44,999. Most educators had worked at his/her current role less than five years and worked most predominantly in a nonprofit, acute care organization of under 600 beds found in an urban location. Most functioned in a hospital-wide department of training and education and report to the vice-president level. Trends indicate
attempts to generate revenue through sale of education and training services, increases in funding for equipment, and decreases in travel and outside consultant fees.

These authors foresee the hospital educator becoming the coordinator of services rather than the provider. They state: "The health care educator will be a broker of learning experiences, seeking the required learning opportunities and brokering for the most cost-efficient delivery systems" (Stein and Glazer, 1994, p. 13).

COMPONENTS OF A CONTINUING EDUCATION PLAN

Brookfield's (1986) work examined program planning for adults, defining that the institutional model has been the primary focus for the last twenty years. The institutional model comprises five stages: identify needs, define objectives, identify learning experiences to meet these objectives, organize learning experiences into a plan with scope and sequence, and evaluate the program in terms of behavioral achievements (Brookfield, 1986).

Sork and Buskey have developed a framework for analyzing program planning models that examines the planning context, level of program emphasized, client system orientation, sophistication necessary to use the model, theoretical framework, and comprehensiveness of steps in the planning process (Sork and Buskey, 1986). Sork points out that "a need becomes an overtly expressed statement that a program planner can utilize to justify and focus program planning activities" (Sork, Yellow Brick Road or Great Dismal Swamp: Pathways to Objectives in Program Planning, p. 262).
Within continuing education in the nursing profession, the institutional model components are evident. Cervero (1988) notes that Sork addresses the discrepancy between textbook frameworks with what actually happens in real-world settings.

COMPONENTS--NEEDS ASSESSMENT

Sork and Carafella (1990) point out that the very term "needs assessment" is so confusing that some authors have suggested that the term be purged. Sork suggests that there are alternatives that justify and focus program planning. These include interest inventory, the market test, the compelling mandate, trend analysis, problem analysis, and ideas generated by an individual programmer.

Kristjanson and Scanlan (1992) state that if nursing administrators are asked to identify need, the concern is usually on identifying gaps or problem areas of performance. This may involve observation of work performance, formal or informal interviews, analysis of records and reports, and monitoring of changes within and without the agency. They state, "A learning need may not exist simply because of a discrepancy between the employer's expectations and the nurse's performance" (Kristjanson and Scanlan, 1992, p. 159).

Wise (1992) points out that "the process of identifying learning needs is time consuming, multidimensional, and complex . . . it is important to reiterate that using multiple sources to identify needs yields more accurate information about needs and priorities than does one source" (p. 189).
COMPONENTS-PROGRAM PLANNING

Once a learning need is determined, elements of program planning can begin in earnest. Knowles’ (1980) work indicates that program planning include defining purposes and objectives, selecting a format, recruiting and training leaders, providing facilities, public relations/advertising, budgeting and financing, and evaluation.

Leroux (1992) defines curriculum within staff development as "a systematic group of courses, sequence of subjects, and planned experiences" (p.203). She feels the Tyler curriculum model addresses four areas: philosophy, conceptual framework, objectives, and curriculum threads. Adult learning theories undergird all curriculum development.

Within nursing continuing education, the institutional model components are evident. Programs must define behavioral objectives, content, time-frames, how the educational materials will be presented, and evaluation methods. Steps in the process are outlined in the Ohio Nurses Association Continuing Education Manual (1991).

Examination of frameworks for program planning within the profession raises questions as to the reality of what happens in the real-world situation. Is the program based on a needs assessment and, if so, how was the needs assessment conducted? Or is it the idea of the nurse educator or one being presented to meet mandatory requirements? Is an education committee or advisory committee involved in the planning process? Is the community involved in any way? What are the budgetary constraints and resources available? Will an expert be brought in to do the program? How will marketing of the program take place? What about choice of the facilities to
be utilized? What will determine fees or tuition? Will a sponsoring agency underwrite costs and, if so, to what extent?

These are serious questions that are justified for examination in a time when costs are escalating, nurses are required to maintain CE for relicensure, competition is keen within marketing of programs, and nurses must make choices about how to expend both their time and money to gain knowledge that will be beneficial to their careers as well as providing personal satisfaction. Needs assessment is the first step in the process of educational planning and demands closer examination for these very reasons.

**COMPONENTS-EVALUATION**

Evaluation is important in the dynamic feedback mechanism of the nursing process. Puettz (1985) states that evaluation is important to meet accreditation/approval requirements, account for funds, respond to requests for information, make administrative decisions, and assist in program development. Cox and Baker (1981) stressed the need for evaluation as being reflective of accountability for CE offerings. However, in contrast, Cervero (1988) states that it is a myth to try to "prove" that continuing education makes a difference in professional practice and client outcomes. He sees evaluation as deeply intertwined with program development.

Day and Baskett (1982) believe that focusing on achievement of predetermined objectives does not allow for spontaneous learning and leads to the educator viewing all learning as demonstrable behavior. These authors cite the work of Pratt (1979), Knox (1979), and Sjogran (1979) to point out that factors such as the work climate,
organizational structure, and motivation have a significant effect on program planning and that these are not under the educator's control.

Lavern Forest (1976) sees program evaluation literature and practice as being paradoxical. Pressure mounts for accountability and systematic evaluations based on educational objectives, yet these are not utilized for decision making in the real world.

Forrest suggests that programs must be accountable to ourselves and others, that those related to the program cannot be excluded from the evaluation process, informal evaluations are going on continuously, naturally, and informally. She feels it is important to make obvious to participants the importance of their informal evaluations for revising program content.

Waddell (1991), utilizing the technique of meta-analysis to review 34 studies, found that those who received CE (treatment group) performed on the dependent variable as well or better than 76.3% of the control group or than they did prior to the CE activity. She concludes, "From a practical standpoint we can now say that CNE (Continuing Nursing Education) is likely to result in improving nursing practice for more that three-fourths of the participants" (Waddell, 1991, p. 115).

Lauffer (1979) suggests that continuing education educators use the following techniques for evaluation purposes: 1) use of nonobtrusive measures, which examines the number of workshops, facilities, cost, number attending, staff time spent on programs, and demographics of participants; 2) hip pocket evaluation, which asks participants if they enjoyed a workshop and plan to return; 3) subjective satisfaction measures that examine such factors as transportation, timing, and location; 4)
standardized tests to examine changes in ability and skills; 5) experimental designs, which are rarely used in CE; and 6) case studies, which can identify problems in the program operation.

It is important to examine the "when, how, and for whom" of evaluation that may be required by funding bodies or outside regulatory agencies. Lauffer (1979) states, "It is important for the evaluator to know not only what questions to ask but also who the major consumers of the findings will be . . . for findings to be useful in program planning, their implication for action should be clearly spelled out" (p. 186).

Evaluations take many forms, ranging from the summative evaluation taking place at the end of an educational offering to the formative (assessing strengths and weaknesses during the program process) evaluation. Wise and Cox state, "Learner satisfaction is far more important to continuing education programs than to almost any other program because of the transient flow of 'enrolled' students" (Wise and Cox, 1984, p. 117).

The literature review suggests that primarily summative evaluations are utilized and yet there are many modalities that can be utilized. These include simulations, case studies, proficiency examinations, chart reviews, and observation of job performance, just to name a few. There does not seem to be sound data as to what techniques are utilized by continuing education and staff development practitioners other than summative evaluation.

Waddell (1993) describes the process utilized by Georgia Nurses Association (GNA) to develop a reliable and valid evaluation instrument for CNE. Review of the
literature indicates that the learner is the best judge of the success of a CNE offering and that there is validity in assessing learners opinions rather than measuring a change in knowledge, skill, or attitude. "Based on the literature review, the decision was made to limit the scope of the new GNA evaluation instrument to learner satisfaction with the following program elements: content, instructional method, setting, faculty effectiveness, and self-report of achievement of offering and personal objectives" (Waddell, 1993, p. 185).

Puettz (1985) stresses that "the recognition that human and material resources are not limitless also has fostered a need for evaluation, which can lead to allocation of scarce resources to those programs that have demonstrated to be most effective or beneficial" (p.2). It is important to evaluate the nurse educator's perception of the availability of both human and financial resources to carry out programming that is based on needs assessment techniques.

In summary, there are conflicting/contrasting views on the effectiveness of evaluation techniques and there is not a wealth of information available on nurse educators' perceptions of resources available (both human and financial). That a summative evaluation takes place at the end of an educational offering is very evident. More research needs to be done as to what techniques are used for evaluation purposes.

**NEEDS ASSESSMENT-DEFINITION**

Monette (1977), in a review of selected literature, discusses the concept of educational need. The purpose of this literature review was to highlight the term need
in order to assess the usefulness for practitioners and to clarify issues that remain to be debated by researchers and practitioners. He found the definition of need to include four categories 1) basic human need, a tension state that causes gratification-seeking behavior, 2) felt need, suggesting an ultimate goal limited by the perception of individuals and can be initiated by the individual without really being need, 3) normative need, indicating a deficiency state or gap between a desired standard and the standard that exists, and 4) comparative need, measured by comparing characteristics of those in receipt of a service with those who do not.

Monette points out that needs assessments are learning needs, implying that needs assessment can be satisfied by a learning experience providing appropriate knowledge, skill, and attitudes. When applied to the individual, need is used to describe a "felt need". "Real need" is used when there is a gap in knowledge, attitude, or skill measures according to objective criteria.

Knowles makes evident that there is a debate as to who can assess the needs of the adult learner. The learner must see the need to provide motivation to close the gap. Others believe that the most pressing needs are recognized by others.

Monette states:

The question of who can best determine an individual's needs does not require an either/or answer. . . . Because learning is an internal process, only learners themselves can, in the end, decide to learn and act upon their learning. Persons other than the adult learner (program planners, experts) can, in some cases, specify objective standards to which individuals can compare themselves in order to determine the nature and magnitude of their need. (Monette, 1977, p. 121.)
Monette points out that needs assessment should be continuous during a program. He feels the adult educator is asked to assess the "needs of systems" to improve system performance through educational programs.

Atwood and Ellis (1971) point out that values are inextricably involved with needs and that attention to them is required. "It becomes apparent that the concept of need has no meaning without a set of norms and that it is therefore impossible to identify needs without them" (Monette, 1977, p. 123).

Monette concludes that both the terms "felt needs" and "real need" are inadequate for defining educational objectives. He points out that various needs approaches are value laden.

Kristjanson and Scanlan (1992), in a literature review conducted to identify methodological, conceptual, and instrumentation considerations important in conducting needs assessment, identified four themes: 1) the importance of clarifying and defining the construct "need" when defining a needs assessment, 2) variables that influence participation in continuing education programs, 3) means of conducting a needs assessment, and 4) marketing continuing education programs. Their literature review pointed out the fact that there is danger in which the continuing education planner imposes his/her own values on a set of data. They point out that a critical issue involves differentiating perceived needs (felt needs) and the normative (when a gap exists between a desirable standard and a standard that actually exists).
Knowles views an educational need as the gap between a present competency and a higher level required for effective performance as defined by the learner, their organization, or society (Knowles, 1986). He defines three sources of needs and interest that must be considered in adult education program planning: 1) those of the individual to be served, 2) those of the sponsoring organization or institution, and 3) those of the society or community at large.

Knowles suggests that research, judgement of experts, task analysis, and group interaction can develop competency models. He suggests that different kinds of assessment procedures are needed for different kinds of performance. He believes that a self-diagnostic model "is for individuals to assess the gaps that exist between their models of desired behaviors and their present level of performance" (Knowles, 1986, p. 232).

Cannon and Waters (1993) conducted a study to determine educational needs of licensed nurses when mandatory CE for relicensure was implemented. Their review of the literature reveal "a confusing assortment of terms related to needs--educational need . . . 'real' educational needs . . . learner needs . . . 'felt' needs . . . described needs" (Cannon and Waters, 1993, p.148). This again emphasizes the lack of congruence related to the term "need" related to educational offerings. Knowles definition "the expressed preferences among possible activities perceived as potentially satisfying educational needs" (quoted from Knowles, 1980) was utilized in their study.
In its purest form, Sork (1986) states:

Following, then, is a proposed working definition of need for those who engage in the study and practice of program planning: **Need** is a statement (oral or written) which contains the following **two** essential elements: 1) A verifiable description of a performance, capability, or outcome which is thought to exist. 2) A hypothetical description of, or specifications for, a parallel performance, capability, or outcome which **might** exist in the future and which is considered more desirable than (1). Given this definition, a need becomes an overtly expressed statement that a program planner can use to justify and focus program planning activities (p. 262).

NEEDS ASSESSMENTS—TECHNIQUES

Pennington (1980) found that "most needs assessments involve some systematic collecting of data from persons who can affect or are affected by the problem being examined" (Quoted in Kristjansen and Scanlan, 1992, p. 159). Methods vary widely and include questionnaires, Delphi studies, and telephone surveys. Informal methods may be utilized such as nursing advisory committees and key practice experts in specific areas.

Patricia Wise Yoder (1992) sees that timing, marketing, priorities, and data form crucial elements within planning of educational activities. Techniques outlined by Wise as needs assessments strategies that are useful are advisory groups, anecdotal notes, brainstorming, checklists, critical incident technique, Delphi technique, focus groups, interviews, literature analysis, nominal group process, observations, position analysis, process recording, professional standards, questionnaires and opinionnaires, rating scales, records and reports, services/institutional changes, slip technique, testing, telephone surveys, and prospective versus retrospective assessments.
The following is an explanation of needs assessment techniques that Wise outlines given in brief detail:

**Advisory groups** - composed of eight or nine people, both internal & external to the organization, who act as a sounding board for programming. Made up of experts, they may help identify needs, resources, speakers, and content.

**Anecdotal notes** - a succinct note on individuals, units, or clinical concern that can reveal performance discrepancies.

**Brainstorming** - allows a convening group to be open and free about discrepancies in their clinical area that can lead to program design to meet learning needs identified.

**Critical incident technique** - includes recording the date, "classification" of the critical incident, who was observed, what was said and done, and where the incident occurred. A series of these recordings can reveal specific performance discrepancies.

**Delphi technique** - Utilized to obtain consensus & priority, this includes a series of questionnaires; the first one is mailed, responses summarized, and a new version is mailed to attempt to reach consensus about needs.

**Focus groups** - Consists of a group of 5-9 people who meet for up to 1 1/2 hrs. to discuss questions planned by a leader. Allows for consumer input and allows "grass roots" input to plan for the future or correct past inadequacies.

**Interviews** - Structured, or unstructured, these allow individuals to share in-depth views & expand on identified areas of concern.

**Literature analysis** - Allows the educator to identify trends and project learning needs for future programs.
Nominal group process - Designed to create consensus through individual ranking of items & pooling of scores. Requires a convened group. Helpful to identify an emerging need.

Observations - Involves direct observation of work performance; it is important to use standards to determine the adequacy of performance and allow for interrater reliability.

Process recordings - Consists of a verbatim report of what is said. Are especially helpful in identifying needs related to communication.

Professional standards - Standards arise from a variety of professional associations and must be monitored by the educator to provide needed learning experiences for mandated change.

Questionnaires and opinionnaires - surveys that focus on the respondent's opinions as opposed to their actual knowledge or skill. May be open-ended, closed-ended, or sentence completion format.

Rating scales - Usually consist of a Likert-type scale or a semantic differential scale. Are excellent for assessing attitudes.

Records and reports - Reports provide a rich source of data that is based on actual practice and can be analyzed to reveal problem areas. Examples: incident reports, quality assurance reports, infection control reports, annual reports, marketing reports, patient surveys, minutes of meetings.

Service and institutional changes - Changes in services of an institution may provide indicators of learning needs.
Slip technique - The respondent is asked to respond to a question or problem, writing as many short answers as possible in a specified length of time. The answers are then separated into categories. Answers are written on cards or slips of paper.

Testing - Includes use of both pretests and posttests. Must be analyzed carefully to not be mistaken for errors in test taking.

Prospective versus retrospective assessments - The prospective audit focuses on preventing problems and is future oriented; retrospective assessments are oriented to problem solving.

Banfield, Brooks, Brown, Mason, Miller, Smith, and Wong (1990) note that many types of learning needs assessment techniques may be utilized, but it is the learner who can best assess his/her educational needs. These authors point out that many needs assessment techniques can be time consuming and expensive for the organization. They stress the need to look at the technique in terms of time and money available for the task, client involvement, communication with the client, the data collected, desired results, preference for a particular technique data for plan implementation, and types of needs to be uncovered.

NEEDS ASSESSMENT-NURSE EDUCATORS NEEDS ASSESSMENT ABILITIES

Utilizing a descriptive study, Bachman, Kitchens, Halley, and Ellison (1992) conducted a study to determine self-reported learning needs of nurse educators in a southern state. This was identified as important due to the lack of Master's Degree programs in nursing that provide nursing education as an area of study. The work of Fitzpatrick and Heller (1980), Kelley (1985), and Kitchens (1986) points out that
administrators of nursing education programs have no choice but to employ clinicians in teaching positions and that they may lack knowledge and skills necessary to the educator role.

Using a tool "Questionnaire for Nurses" developed by Kitchens in a previous study that identified knowledge and skills common to nurse educators, mailings were sent to all nurses identified as "instructors" or employed by "schools of nursing" in the frame provided by the Board of Nursing. In the current study a Likert-type scale was utilized to identify the extent that those studied were interested in acquiring knowledge of twenty-four content areas. With a response rate of 41.4% (n=866), 62.7% of respondents held a Masters degree, 17.6% a Ph.D., 16.2% a B.S.N., and 2.5% a diploma or A.D. 79.4% worked in schools of nursing, 9.2% in staff development, and 11.4% in other areas such as patient education and allied health.

The variables of academic credentials and employment setting accounted for marked differences in degree of interest in content areas. Those educators with Ph.D.'s are more interested in nursing research than those holding a B.S.N. or Master's degree. Setting of employment affected level of interest in content area. Those employed in staff development had a higher interest in curriculum development and clinical evaluation tools than those employed in other settings. The authors suggest that results of data analysis indicate that the nurse educator role is in need of "programs designed to enable nurses who assume teaching positions without adequate preparation to acquire knowledge and skills to succeed" (p. 33).
Eason and Corbett (1991) studied evaluations from 113 programs involving 2,877 participants to further define effective teacher characteristics and to examine these characteristics as either personal or professional. Frequency statements were utilized to identify 20 attributes that were found desirable. Four major categories were identified: organization of content, knowledge of content, individual attributes, and teacher strategies. Ten nurse educators were asked whether the four categories should be classified as personal or professional. They were then asked to place the 20 attributes into one of the four major categories.

The following is a list of characteristics identified in this study: **Professional characteristics** - answering questions, informative, and knowledgeable; **organization of content** - clear, concise realistic content, well-prepared, organized; **teacher strategies** - audiovisuals, handouts, examples, case studies share their experience, used language all understood; **personal characteristics** - dynamic easy to listen to, energetic, entertaining, enthusiastic, fascinating, helpful, interesting, maintained attention, and a sense of humor. Out of this study, a tool was developed to allow the faculty to design and evaluate CE offerings according to identified characteristics that are valued by adult learners. A "Be Prepared to Teach Checklist" was developed out if this study.

Peterson (1983) described the development of how fourteen principles of adult education were used to provide the conceptual framework for performance competencies in a large, acute care hospital. Competencies were written at three levels, with the first level being minimum competency. This is similar to a nursing career ladder utilized by many facilities. Advantages of identifying these
competencies are: 1) encourage self-direction necessary for professional autonomy and countability, 2) structuring peer review as an integral part of the instructor's job, 3) providing a tool for on-going self evaluation by the instructor, 4) enabling the inservice director to evaluate instructors in a criteria referenced basis rather than a normative basis, 5) providing a scale for average, above-average, and excellent ratings for performance reviews, and 6) ensuring that unit rounds are utilized to promote instructor visibility and accessibility.

Development of the competencies was based on work done by members of the department. All members of the department read selected material and then listed five important principles. Through consensus, fifteen principles were phrased to include a functional end result. Principles were further clarified with three levels identified for each principle.

Three themes were identified in the competencies: 1) peer review (sharing expertise and assisting peers with identifying strengths and areas of growth) is always present at the third stage, even if not explicitly stated, 2) the focus of the competencies is first with orientation and then with CE, and 3) competencies indicate how instructors can accomplish meaningful rounds, providing accessibility and role identity competence. Sequence of the competencies begins with the teaching-learning process, then moves to the instructor's professional practice and relationships within the department and the hospital, and finally examines consultant function.
Highlights of the competencies are:

- Accept the learner as a person with feelings and ideas
- Establish and maintain communication with learners regarding job responsibilities
- Develop educational offerings with realistic behavioral objectives
- Utilize a variety of learning opportunities for individuals and groups
- Utilize appropriate hospital and community resources
- Continuously evaluate the learner’s progress and the effectiveness of the facilitator
- Establish appropriate physical conditions
- Maintain current knowledge, skills, and attitudes in nursing and education
- Foster communication within the department
- Establish and maintain an effective working relationship with orientees
- Keep informed of changes in hospital policies and procedures
- Assist the learner to identify the effects of stress on his/her job performance
- Serve as consultants to supervisory staff
- Serve as consultants to hospital personnel regarding educational resources

These competencies guide the incorporation of adult educational principles into professional practice. This further strengthens the role of the nurse educator.

The literature demonstrates that to some extent the nurse educator may not be well versed in many of the techniques of needs assessments. The better educated nurse may have had exposure to techniques that are research based or more highly
refined than just the basic tool that is termed a "needs assessment" but is really a list of desired programs by the individual. Literature review did not clearly reveal the extent to which the nurse educator feels confident of his/her own knowledge and skills of determining programming needs based on use of multiple needs assessment tools.

Since the nursing process views assessment as the first step in the dynamic feedback mechanism, it is imperative that validation of nurse educator's skills, comfort level, and abilities to use multiple needs assessment techniques be established. This is crucial, since needs assessment is the basis for program development within the profession.

It is the perception of this individual that more highly educated and experienced nurse educators will verbalize their own comfort with utilizing different techniques and demonstrate that, in fact, multiple needs assessment strategies are utilized as the basis of program planning.

**SUMMARY**

The literature review has outlined the principles of adult education examining the work of Knowles and Monette as well as others. The areas of needs assessment was closely examined. Discussion of different definitions of the term "need" was further defined, showing that there is no one clearly understood definition of the term "need." This points out the necessity to identify what the educator is utilizing as his/her definition in program planning. The role of the nurse as educator is examined in depth. Learning needs of nurse educators are looked at and development of levels of competencies as nurse educators are explored.
Multiple needs assessment techniques have been identified in the literature, as well as the discrepancies as to whether the effect of continuing education programs effects can indeed be "proved." It remains to be seen whether the more highly educated and experienced nurse educator utilizes various techniques to determine programming needs, what resources the educator perceives are available, how the nurse views their own ability to determine needs assessment, and what impact outside regulatory agencies have upon the nurse educator role.
CHAPTER III
DESCRIPTION OF THE STUDY

INTRODUCTION

Literature within the field of needs assessment suggest that there is a wide diversity to "the scope, focus, and methodology" used in needs assessment (Stufflebaum, McCormick, Brinkerhoff, & Nelson, 1985, p.5). Patricia Wise Yoder (1992) identifies the use of the discrepancy concept identified by Pipe and Mager to be the concept most utilized by nurse educators. To state this concept as simply as possible "discrepancy . . . is a difference, a lack of balance between the actual and the desired Yoder, 1992, p. 184)."

Stufflebaum (1985) identifies four general views of needs assessments:

1) discrepancy view, which reveals a discrepancy between the desired performance and the observed or predicted performances,

2) democratic view, where need is a change desired by a reference group,

3) analytic view, where need is a predicted area of improvement based on the current state, and

4) diagnostic view, in which need whose absence is harmful.
He furthermore states that needs assessment involves examining current performance, means to achieve the desired performance, and cost and viability related to recommended actions (p. 9).

Stufflebaum also believes that needs assessment and evaluation involve the same measurement and evaluation techniques, involving identification of problems, ranking priorities, and examining effectiveness of programs designed to address problems. Witkin (1984) sees needs assessment as "the systematic approach to setting priorities for future actions (p. ix)."

The responsibility of the CE/SD educator as defined by the ANA (1992) involves the designing and implementing of CE/SD activities based on data gathered through needs assessments. Yet review of many broad-based literature sources reveals that nurse educators utilize a great variety of definitions and techniques that they term "needs assessment."

The purpose of this study is to survey the definitions and techniques utilized by the nurse educator that is hospital based. The data obtained from this study could offer insight into the nurse educators own learning needs for future programs related to techniques and resources for determining needs assessments.

Results could also shed light on why programming is done and the resources (both human and financial) the nurse educator believes are available for reference. While studies have been done as recently as 1994 to look at the health care educator role, this does not focus on just the nurse educator role in CE/SD. This knowledge
could help further determine programming needs to fill the nurse educator role that
might not have been addressed in the educational setting of the individual.

POPULATION AND SAMPLE

The target population of this study consists of hospital-based nurse educators
within the state of Ohio. The frame was made up of participating hospitals within the
Ohio Hospital Association; this consists of 226 hospitals. Surveys were addressed to
the attention of the Nurse Educator, Staff Development/Continuing Education.

Because this researcher used a non-randomized convenience sample, the results
cannot be generalized to the entire target population. However, since the list of
hospitals was the most current available and only one survey was initially mailed to
each hospital, this did reduce the chances of frame error. Non-response error was
considered the greatest threat to validity by this researcher.

INSTRUMENTATION

Literature review suggested definitions of needs assessment that nurse educators
might use as a basis for their own definition. The work of Yoder (1992) succinctly
defines techniques that are utilized by nurse educators in needs assessment. The
questionnaire "Feedback for Professional Development" (1979) developed by the
American Society for Training and Development was a resource for developing the
self-assessed ability section of the questionnaire, along with consultation with several
content experts within the field of Staff Development/Continuing Education. (Sandra
Cornett, Ph.D., The Ohio State University Medical Center, Columbus, Ohio; Zandra
Ohri, M.S., Ohio Nurses’ Association, Columbus, Ohio)
Definitions used in the survey tool itself were gleaned from an extensive literature search. A Likert-type scale was used to allow respondents to give feedback in the sections of the survey instrument Needs Assessment Techniques and Program Source Determination. Ary, Jacobs, and Razaviéh (1990) point out that this type scale can be assigned points and that measures of central tendency, variability, and correlation can be calculated. Scaled items were utilized in the section of the survey instrument Self-Assessed Ability.

The demographics section was developed by the researcher to address the areas of education, experience, responsibility, resources available to the educator, and the source of program planning ideas. The survey tool was field tested and reviewed by a panel of five experts identified through the Staff Development/Continuing Education Committee of the Ohio Nurses’ Association. These experts field tested the survey tool for content validity and reliability as well as readability. The content experts were asked to make any suggestions they thought were appropriate to decrease chances of measurement error. A survey instrument critique tool was included with the survey instrument, addressing the areas of readability, clarity of instructions, and comprehensiveness. Ary, Jacobs, and Razaviéh (1990) point out that pretesting in such a manner allows inadequacies, ambiguities, and misunderstandings to be identified. Revisions to the original survey tool were made in response to feedback received in this field test.
DATA COLLECTION

Human subject approval was not required, based on the guidelines set forth by The Ohio State University. It was indicated in the cover letter that confidentiality of the individual respondents would be maintained. Verbal arrangements by telephone were made in June, 1994 to utilize the mailing list of the Ohio Hospital Association.

Following approval of the researcher's Masters Examination Committee, the survey tool was mailed to five content experts and revisions on the original survey tool were made in response to their suggestions.

On February 21, 1995, a pre-card was mailed to the Nurse Educators at each of the identified hospitals. This announced that they would receive a forthcoming questionnaire providing the opportunity to share how they, as nurse educators, view and carry out needs assessments. It also stressed that results were confidential and encouraged their cooperation.

On February 24, 1995, the survey was mailed to the nurse educators in a legal-size envelope, along with a cover letter, self-addressed, stamped envelope, and a flavored tea bag as an incentive to participate. The cover letter explained that if they would like feedback on the survey results, they should include a self-addressed, stamped envelope. A decorative commemorative stamp was used on the return envelope. Identification codes were utilized on the survey for follow-up mailing purposes only. Participants were assured of the confidentiality of information received.
On March 8, 1995, a postcard reminder was sent to the nurse educators to thank them for their participation and remind them of the importance of returning the surveys. Three weeks later, a complete packet was mailed to non-respondents, again encouraging them to participate.

Late respondents were those identified as requiring a second survey mailing. Non-respondents were compared to respondents by conducting phone interviews with a small percentage of non-respondents chosen by random sample, utilizing a selected group of questions from the survey instrument. This allowed the two groups to be compared for significant differences to ascertain that respondents represent an unbiased sample of those that received the questionnaire (Ary, Jacobs, and Razavieh, 1990).

RESULTS:

DESCRIPTION OF THE SAMPLE

Data was analyzed using the Statistical Package for Social Services (SPSS-x) on the main frame at The Ohio State University. A total of 226 surveys were mailed to nurse educators and 154 usable surveys were returned. Data analysis includes percentages and means. These were then displayed visually and appear in the text for review.
CHAPTER FOUR
ANALYSIS OF RESULTS

This chapter will report results of the survey conducted. The nurse educator sample will first be described, followed by examination of institutions that participated in the survey. Following this, analysis of data will fall into five categories:

- definition of "needs assessment" utilized by nurse educators
- techniques utilized by nurse educators
- self-perceived confidence level of the nurse educator related to the needs assessment role
- program source determinations
- human and financial resources believed to be available to the nurse educator in his/her role.

DESCRIPTION OF THE SAMPLE

The study included nurse educators located within 226 hospitals within the state of Ohio that are members of the Ohio Hospital Association. An overall return rate of 73% was obtained; however, three hospitals had been closed, reducing the frame to 223 hospitals. Six hospitals (2%) returned the survey, saying that they had no nurse educator. One-hundred fifty-four (69%) usable surveys were returned with complete data; 1% were excluded due to incomplete data.

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Non-respondents were made up of 79 hospitals. Ary, Jacobs, and Razavieh (1990) suggest that unless a researcher has achieved above a 75% response rate, it is wise to randomly survey approximately 10% by phone to see if non-respondents differ from respondents. In this case, 10% of the non-respondents (eight educators) were randomly selected for telephone interviews. Demographic characteristics, their definition of needs assessment most frequently utilized, and their confidence level related to needs assessment were factors that were elicited in the interviews.

Based on comparison of certain demographic factors and response to selected questions (definitions of needs assessment, confidence level), actual respondents may not be reflective of the entire population. Differences in number of males represented (25% of the phone interviews with non-respondents were male) and level of highest education (60% had less than a BSN) indicates this. Also reported by several of the educators interviewed by phone was that with downsizing many nurse educators are filling multiple roles (Director of Nursing, Infection Control Nurse). Also important to note is that smaller hospitals were represented in the randomly chosen hospitals. Only one hospital randomly selected was over 200 beds and had a Nurse Educator with a BSN. Others held an A.D. or were diploma prepared.

Analysis of demographic data shows that 96% of the nurses responding are female. The mean age is 49 with a range of 26-66 years of age. Ninety-one percent are employed full-time and the mean length of employment is 8.7 years. Approximately 38% reported less than five years experience as a nurse educator.
This study asked the respondents to report their highest level of education. One-third of the educators hold a BSN as the highest level of education; another one-third hold an MSN as the highest level of education. Nearly one-half of the nurse educators hold a degree above a Bachelor’s.

**TABLE 1**

**LEVELS OF EDUCATION**

<table>
<thead>
<tr>
<th>DEGREE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Diploma</td>
<td>14</td>
<td>9.2</td>
</tr>
<tr>
<td>BSN</td>
<td>51</td>
<td>33.3</td>
</tr>
<tr>
<td>B.S. (Non-nurse)</td>
<td>8</td>
<td>5.2</td>
</tr>
<tr>
<td>M.S. (Non-nurse)</td>
<td>21</td>
<td>13.7</td>
</tr>
<tr>
<td>MSN</td>
<td>49</td>
<td>32</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>4</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Fifty-five percent of those responding state they had course work in the educational process during their advanced degree work, with 72% attending course work on the educational process in the last year. Ninety-seven percent report that program planning is part of their job.

Respondents were asked how much self-study they do per week (e.g., journal reading, etc.). On the average, one-third reported 1-2 hours of self-study per week.
with the maximum being 10-20 hours of self-study. Many indicated that this was dependent on many factors in their lives, such as job and personal responsibilities.

TABLE 2

HOURS OF SELF STUDY

<table>
<thead>
<tr>
<th>HOURS OF SELF STUDY</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>48</td>
<td>31.8</td>
</tr>
<tr>
<td>3-5</td>
<td>45</td>
<td>35.1</td>
</tr>
<tr>
<td>6-10</td>
<td>37</td>
<td>23.9</td>
</tr>
<tr>
<td>10-20</td>
<td>13</td>
<td>8.5</td>
</tr>
</tbody>
</table>

The hospitals surveyed showed a wide range of bed capacity, with 27% being under 100 beds, 29% between 101-200 beds, and 33% between 201-500 beds. The mean size of the hospital represented was 248 beds. Forty-five percent of the hospitals reported that they were teaching hospitals.

ANALYSIS OF RESEARCH QUESTIONS

What definitions of the terms needs assessment does the nurse educator utilize most frequently?

The nurse educators were asked to choose one of the three definitions provided on the questionnaire. These include "real education need" (a specific understanding, skill, or attitude is lacking and can be satisfied by a learning experience to obtain a more desirable condition; may not be recognized by the person involved), "felt need"
(regarded as necessary by the person concerned), and "normative need" (a gap between the desirable standard and the standard that actually exists).

Of the 144 respondents to this question, seventy percent of the nurse educators indicated that they utilize real need most frequently, 17% chose normative need, and only 12% chose felt need. Two respondents took the time to write on the survey that they did not make a choice because they utilize all three definitions at times in combination.

In determining learning needs, what techniques does the nurse educator utilize?

Nurse educators were asked to indicate how frequently they use various needs assessment techniques that were suggested by the literature review. This section of the questionnaire utilized a Likert-type scale.

Analysis of this data per frequency and percentile shows that there are possibly four natural groupings of very high use, high use, moderate use, and low use. The very high use category includes services and institutions and records and reports. High use includes professional standards, supervisor's evaluations and suggestions, direct observation, questionnaires and opinionnaires, and then critical incidents, advisory groups, and brainstorming. Moderate use included rating scales, testing, literature references, focus groups, interviews, anecdotal notes, and nominal group process. Low use were techniques such as prospective assessment, process recordings, Delphi technique, telephone surveys, and the slip technique. See Table 3 for detail.
**SCALE**
1 = Never  
2 = Rarely  
3 = Sometimes  
4 = Frequently  
5 = Very Frequently  
6 = Unfamiliar with Technique

### TABLE 3

**NEEDS ASSESSMENT TECHNIQUES**

<table>
<thead>
<tr>
<th></th>
<th>Means (Stan. Dev.)</th>
<th>1 Freq. (%)</th>
<th>2 Freq. (%)</th>
<th>3 Freq. (%)</th>
<th>4 Freq. (%)</th>
<th>5 Freq. (%)</th>
<th>6 Freq. (%)</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and Institutional Changes</td>
<td>4.349 (.725)</td>
<td>2 (1.3)</td>
<td>16 (10.7)</td>
<td>59 (39.6)</td>
<td>72 (48.3)</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records and Reports</td>
<td>4.342 (.738)</td>
<td>2 (1.3)</td>
<td>18 (11.8)</td>
<td>58 (38.2)</td>
<td>74 (48.7)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Standards</td>
<td>3.993 (.873)</td>
<td>2 (1.3)</td>
<td>3 (2.0)</td>
<td>37 (24.3)</td>
<td>62 (40.8)</td>
<td>48 (31.6)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Supervisor's Evaluations &amp; Suggestions</td>
<td>3.993 (.839)</td>
<td>2 (1.3)</td>
<td>5 (3.3)</td>
<td>39 (25.5)</td>
<td>61 (39.9)</td>
<td>48 (31.4)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Critical Incident</td>
<td>3.882 (.976)</td>
<td>1 (1.3)</td>
<td>10 (6.6)</td>
<td>46 (30.3)</td>
<td>44 (28.9)</td>
<td>51 (33.6)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Questionnaires &amp; Opinionnaires</td>
<td>3.778 (1.027)</td>
<td>3 (2.0)</td>
<td>14 (9.2)</td>
<td>41 (26.8)</td>
<td>51 (33.3)</td>
<td>44 (28.8)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Direct Observation</td>
<td>3.664 (1.003)</td>
<td>2 (2.6)</td>
<td>15 (11.8)</td>
<td>53 (34.9)</td>
<td>44 (28.9)</td>
<td>38 (25.0)</td>
<td>- 2</td>
<td></td>
</tr>
<tr>
<td>Advisory Committee</td>
<td>3.579 (.987)</td>
<td>4 (2.6)</td>
<td>18 (11.8)</td>
<td>41 (27.0)</td>
<td>64 (42.1)</td>
<td>25 (16.4)</td>
<td>- 2</td>
<td></td>
</tr>
<tr>
<td>Brainstorming</td>
<td>3.490 (1.020)</td>
<td>3 (2.0)</td>
<td>23 (15.0)</td>
<td>51 (33.3)</td>
<td>48 (31.4)</td>
<td>28 (18.3)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Rating Scales</td>
<td>3.042 (1.310)</td>
<td>22 (15.4)</td>
<td>29 (20.3)</td>
<td>37 (25.9)</td>
<td>31 (21.7)</td>
<td>24 (16.8)</td>
<td>10 1</td>
<td></td>
</tr>
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</table>
Table 3 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Means (St. Dev.)</th>
<th>1 Freq. (%)</th>
<th>2 Freq. (%)</th>
<th>3 Freq. (%)</th>
<th>4 Freq. (%)</th>
<th>5 Freq. (%)</th>
<th>6 Freq. (%)</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
<td>3.033 (1.146)</td>
<td>15 (9.9)</td>
<td>38 (25.2)</td>
<td>38 (25.2)</td>
<td>47 (31.1)</td>
<td>13 (8.6)</td>
<td>2 (1)</td>
<td></td>
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<tr>
<td>Literature References</td>
<td>3.026 (1.019)</td>
<td>10 (6.5)</td>
<td>32 (20.9)</td>
<td>70 (45.8)</td>
<td>26 (17.0)</td>
<td>15 (9.8)</td>
<td>1 (-)</td>
<td></td>
</tr>
<tr>
<td>Focus Groups</td>
<td>2.974 (0.970)</td>
<td>9 (5.8)</td>
<td>36 (23.4)</td>
<td>70 (45.5)</td>
<td>28 (18.2)</td>
<td>11 (7.1)</td>
<td>(-)</td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>2.935 (1.074)</td>
<td>14 (9.2)</td>
<td>39 (25.5)</td>
<td>55 (35.9)</td>
<td>33 (21.6)</td>
<td>12 (7.8)</td>
<td>1 (-)</td>
<td></td>
</tr>
<tr>
<td>Anecdotal Notes</td>
<td>2.765 (0.958)</td>
<td>17 (11.1)</td>
<td>37 (24.2)</td>
<td>68 (44.4)</td>
<td>27 (17.6)</td>
<td>4 (2.6)</td>
<td>1 (-)</td>
<td></td>
</tr>
<tr>
<td>Nominal Group Process</td>
<td>2.604 (1.004)</td>
<td>18 (12.9)</td>
<td>48 (34.5)</td>
<td>50 (36.0)</td>
<td>17 (12.2)</td>
<td>6 (4.3)</td>
<td>13 (2)</td>
<td></td>
</tr>
<tr>
<td>Prospective Assessment</td>
<td>2.299 (0.974)</td>
<td>33 (24.6)</td>
<td>43 (32.1)</td>
<td>44 (32.8)</td>
<td>13 (9.7)</td>
<td>1 (0.7)</td>
<td>17 (3)</td>
<td></td>
</tr>
<tr>
<td>Process Recordings</td>
<td>2.095 (0.946)</td>
<td>45 (32.8)</td>
<td>44 (32.1)</td>
<td>38 (27.7)</td>
<td>10 (7.3)</td>
<td>(-)</td>
<td>15 (2)</td>
<td></td>
</tr>
<tr>
<td>Delphi Technique</td>
<td>1.93 (0.946)</td>
<td>42 (38.5)</td>
<td>40 (36.7)</td>
<td>21 (19.3)</td>
<td>4 (3.7)</td>
<td>2 (1.8)</td>
<td>8 (-)</td>
<td></td>
</tr>
<tr>
<td>Telephone Surveys</td>
<td>1.623 (0.846)</td>
<td>84 (55.6)</td>
<td>48 (31.8)</td>
<td>12 (7.9)</td>
<td>6 (4.0)</td>
<td>1 (0.7)</td>
<td>3 (-)</td>
<td></td>
</tr>
<tr>
<td>Slip Technique</td>
<td>1.594 (0.830)</td>
<td>38 (59.4)</td>
<td>16 (25.0)</td>
<td>8 (12.5)</td>
<td>2 (3.1)</td>
<td>(-)</td>
<td>81 (9)</td>
<td></td>
</tr>
</tbody>
</table>

*How frequently are educational programs planned to meet special needs; i.e., outside regulatory agencies, needs of special groups, changing technology?*
Respondents were asked to indicate how frequently educational programs were planned to meet special needs by indicating this with the use of a Likert-type scale.

Mean frequency showed ranges between 4.06-3.7. Results are shown in Table 4.

**SCALE**
1 = Never
2 = Rarely
3 = Sometimes
4 = Frequently
5 = Very Frequently

**TABLE 4**

**PROGRAM SOURCE DETERMINATION**

<table>
<thead>
<tr>
<th>Source of Education</th>
<th>Mean</th>
<th>1 Freq. (%)</th>
<th>2 Freq. (%)</th>
<th>3 Freq. (%)</th>
<th>4 Freq. (%)</th>
<th>5 Freq. (%)</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs identified by the organization</td>
<td>4.065</td>
<td>--</td>
<td>--</td>
<td>28 (18.3)</td>
<td>87 (56.9)</td>
<td>38 (24.8)</td>
<td>1</td>
</tr>
<tr>
<td>Keeping abreast with changes in nursing due to technology</td>
<td>4</td>
<td>--</td>
<td>3 (2.0)</td>
<td>26 (17.0)</td>
<td>92 (60.1)</td>
<td>32 (20.9)</td>
<td>1</td>
</tr>
<tr>
<td>Meeting outside regulatory requirements</td>
<td>3.974</td>
<td>--</td>
<td>7 (4.5)</td>
<td>40 (26.1)</td>
<td>56 (36.1)</td>
<td>50 (32.7)</td>
<td>1</td>
</tr>
<tr>
<td>Program/educational topics requested by staff nurses</td>
<td>3.895</td>
<td>--</td>
<td>3 (2.0)</td>
<td>37 (24.2)</td>
<td>86 (56.2)</td>
<td>27 (17.6)</td>
<td>1</td>
</tr>
<tr>
<td>Needs identified through quality assurance studies</td>
<td>3.876</td>
<td>--</td>
<td>2 (1.3)</td>
<td>50 (32.7)</td>
<td>66 (43.1)</td>
<td>35 (22.9)</td>
<td>1</td>
</tr>
<tr>
<td>Needs identified by incidents related to clinical practice</td>
<td>3.869</td>
<td>--</td>
<td>4 (2.6)</td>
<td>51 (33.3)</td>
<td>59 (38.6)</td>
<td>39 (25.5)</td>
<td>1</td>
</tr>
<tr>
<td>Meeting the needs of supervisors &amp; administrators</td>
<td>3.693</td>
<td>--</td>
<td>5 (3.3)</td>
<td>60 (39.2)</td>
<td>65 (42.5)</td>
<td>23 (15.0)</td>
<td>1</td>
</tr>
</tbody>
</table>
What is the self-perceived confidence level of the nurse educator in fulfilling the needs assessment role?

In 1979 the American Society of Training and Development published a pamphlet "Feedback for Professional Development", designed to assist both the educator and their supervisor identify the requirements for their job and their personal development needs. In addressing the area of confidence in one's own job, the original questionnaire was designed as a resource tool. No data is available on results of the original research.

Most of the respondents in this survey felt confident in their ability to identify program needs and set priorities, develop questionnaires for program evaluation, and to develop content outlines and objectives. Sixteen percent felt a lack of confidence in their ability to evaluate stated need and system planning (management, discipline, etc.).
**SCALE**
L = Confidece in own abilities
SC = Confidence in own abilities, but would like to learn more
LC = Lacks confidence

**TABLE 5**

<table>
<thead>
<tr>
<th>Self Assessed Ability</th>
<th>Missing</th>
<th>C Freq. (%)</th>
<th>SC Freq. (%)</th>
<th>LC Freq. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing content outlines and objectives</td>
<td>--</td>
<td>138 (89.6)</td>
<td>15 (9.7)</td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>Developing questionnaire for program evaluation</td>
<td>--</td>
<td>131 (85.2)</td>
<td>18 (11.7)</td>
<td>5 (1.3)</td>
</tr>
<tr>
<td>Identifying program needs to set program priorities</td>
<td>2</td>
<td>118 (77.7)</td>
<td>32 (21.1)</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>Identifying organizational needs that impact on programming</td>
<td>--</td>
<td>98 (63.6)</td>
<td>53 (34.4)</td>
<td>3 (1.8)</td>
</tr>
<tr>
<td>(equipment unavailable, lack of follow-through by manager, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing tools to evaluate knowledge before and after</td>
<td>--</td>
<td>91 (59.1)</td>
<td>58 (37.2)</td>
<td>5 (3.2)</td>
</tr>
<tr>
<td>educational offerings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing questionnaires for analyzing learning needs</td>
<td>--</td>
<td>94 (61.0)</td>
<td>51 (33.1)</td>
<td>9 (5.8)</td>
</tr>
<tr>
<td>Developing learning needs through clinical simulations</td>
<td>--</td>
<td>91 (59.1)</td>
<td>51 (33.1)</td>
<td>12 (7.8)</td>
</tr>
<tr>
<td>Developing competency based assessment</td>
<td>--</td>
<td>84 (54.5)</td>
<td>58 (37.7)</td>
<td>12 (7.8)</td>
</tr>
<tr>
<td>Evaluating stated need &amp; system planning such as</td>
<td>--</td>
<td>50 (33.6)</td>
<td>75 (50.3)</td>
<td>24 (16.1)</td>
</tr>
<tr>
<td>management, discipline, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What human and financial resources does the nurse educator believe are available to their role?

Demographics revealed that 60% of the educators believe that educational experts are available in their work setting. Several took the time to write in that they, in fact, were the expert! Twenty-three percent state that experts are available as outside consultants, 52% believe an expert is available by phone, And 1% indicated an expert was available by fax. Twenty-four percent believe that experts are available utilizing outside consultants, phone, and fax. (See Fig. 1)
There is an even split when it comes to determining if there are adequate human resources to meet programming needs. This is an area that may relate to the hospital size and budget.

Sixty-two of respondents report that there are adequate monies available through the budget after the planning process is completed. Most indicate that educational expenses are met through the annual budget, fees charged for programs, and some through a hospital-based foundation. Sharing of resources across departmental budgets was handwritten in on several questionnaires as a means of extending economic resources.

Written in on questionnaires were comments such as "I am an administrator by experience, an educator by happenstance . . . there is no one else . . ." and "I’m the infection control nurse who inherited the staff development job." At least five of the questionnaires returned included a comment that the educator held another position as well as that of the nurse educator. Several respondents indicated that the education department had been pared to one "one man" department and that inadequate secretarial help was available. Many took the time to write that they were on a very tight budget and that programming required great creativity.

Several educators indicated that they network with other educators and departments, but as a result of "downsizing," meeting education needs for employees was very difficult. One stressed the need to coordinate technology and budgeting on organizational goals and objectives.
A number of respondents pointed out that lack of administrative support created both space allocation and budgetary problems. One hospital stated that they eliminated food and beverages with programs to contain costs.

Space allocation was noted by at least 25 respondents as a problem with one comment made that more education is occurring on the nursing unit and less in the classroom. Allowing employees to be relieved to attend classes was also listed as problematic. One respondent stated succinctly: "We do the best with what we have."

This statement was reflective of many of the nurse educators surveyed.

**SUMMARY**

The areas of definitions utilized by nurse educators for the term needs assessment, techniques utilized in determining learning needs, self-perceived confidence level of the nurse educator in various aspects of his/her role, program planning determinants, and human and financial resources have been examined through this survey. Chapter Five will discuss implications of this survey and suggestions for future research.
CHAPTER V

SUMMARY, DISCUSSION, LIMITATIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

The final chapter will include discussion of the findings of this descriptive study and limitations of the study. It will also suggest areas of future research that emerged after examination of the data found in this study.

SUMMARY

ANA (1992) proposes that nurses must continue to maintain and increase their competence in the changing environment of health care. CE/SD offerings form the basis for lifelong learning to meet these needs within the nursing profession. ANA points out that CE/SD educational offerings should be based on principles of adult learning determined through use of assessment of learning needs, planning, implementation, and evaluation (nursing process).

This descriptive study was designed to examine the following questions:

1. What definition of the term needs assessment does the nurse educator utilize most frequently?

2. In determining learning needs, what techniques does the nurse educator utilize?
3. What is the self-perceived confidence level of the nurse educator in fulfilling the needs assessment role?

4. How frequently are educational programs planned to meet special needs: i.e., outside regulatory agencies, needs of special groups, changing technology?

5. What human and financial resources does the nurse educator believe are available to their role?

A questionnaire was designed by the researcher based on review of the literature and reviewed by five content experts who are members of the Ohio Nurses Association Continuing Education Committee. This was done to determine readability, content ease, and that the survey tool was accurate, inclusive, and appropriate. Changes were made to the original survey tool based on feedback received from these experts.

Two hundred and twenty-six (226) hospitals in the state of Ohio identified by membership in the Ohio Hospital Association provided the frame for the research. A pre-card announcing the survey was sent on February 21, 1995, encouraging participation of the nurse educator. On February 24, a cover letter and questionnaire addressed to the Director of Staff Development was mailed to each hospital. Surveys were coded to identify the responding hospitals.

On March 8, 1995, a reminder card was sent to the hospitals that had not responded to the questionnaire. A second questionnaire was mailed on March 29, 1995 to non-respondents.
Information was received that three hospitals had closed, reducing the frame to 223 hospitals. An overall return rate of 73% was achieved, with 154 (69%) usable surveys with complete data received. Data was analyzed using the Statistical Package for Social Services (SPSS-x). Results are reported using means, percentages, and frequencies and are displayed in graphs and tables.

Non-respondents were randomly surveyed by phone on selected questions and demographics. Analysis shows non-respondents to be from smaller hospitals, reflective of less educational preparation than respondents, and fulfilling in cases multiple roles within their hospital (Director of Nursing/Nursing Education, Infection Control/Nursing Education). Therefore, results cannot be generalized based on differences between the sampling of respondents and non-respondents.

DISCUSSION

The average nurse educator represented in the survey is a full-time employee, female, aged forty-nine, employed approximately eight years as an educator, and educated in most cases above the level of a BSN. She reports attending course work in the educational process in the last year and sees program planning as part of the educator role.

These findings are similar to those of Stein and Glazer (1994) in age and sex of the educator. They report that in 1992 the health educator (not defined as a nurse necessarily) was a 46 year old female. Length of employment as an educator differed slightly in that Stein and Glazer found that 52% of the health educators had less than
five years experience in this role. Average length of experience as a nursing educator in the current study was 8.7 years.

The fact that several surveys were returned from hospitals that indicate they have no nurse educator and that random telephone surveys of non-respondents indicate that the nurse educator in smaller hospitals is fulfilling multiple roles indicates that changes in health care structure and management is impacting significantly on nursing education. The nurse educator role may suffer fragmentation and loss of time that impacts significantly on programming due to the multiplicity of jobs of the nurse educator.

DEFINITION OF NEEDS ASSESSMENT

It becomes obvious as one reviews adult education literature that there are a myriad of definitions for the term "needs assessment." Cannon and Waters (1993) have pointed out that there "a confusing assortment of terms related to needs" (Cannon & Waters, 1993, p. 148). Monette (1977) looks at basic human needs, felt needs, normative needs, and comparative needs. Knowles (1986) identifies that the needs of the learner, the organization, and society are all sources of need. Kristjansan and Scanlan(1992) identify the use of real need (objective deficiencies), real education need (specific understanding or attitude is lacking), educational deficiency (can be satisfied by a learning experience), or felt need (perceived by the learner). Sork (1986), after extensive discussion regarding multiple definitions of needs assessment, narrows his working definition to an overtly expressed statement that one can use to justify program planning.
The highest percentage (70%) of nurse educators utilized "real education need." This supports the writings of Monette (1977) who states that learning needs can be satisfied by a learning experience providing appropriate knowledge, skills, and attitudes. He points out that "'real' apparently indicates that some outside observer is utilizing some criteria which are not necessarily the individual's" (Monette, 1977, p. 121).

Seventeen percent of the educators chose "normative need," defined by Monette (1977) as a gap between the desirable standard and the standard that actually exists. Kristjanson and Scanlan (1992) have emphasized the importance of differentiating between "felt need" and "normative need" so that the continuing education planner does not impose his/her own values on data.

Implied in the definition of "real education need" is the ability to obtain a more desirable standard by participating in a learning experience. This raises questions of behavioral objectives that can be measured and criterion referenced standards. The debate by proponents and opponents of this viewpoint can be identified within much of adult education. Monette points out that use of behavioral objectives sets serious limitations on the possibility of ongoing assessments of needs. He states that "a more dynamic, change-oriented definition of needs and goals may be required" (Monette, 1977, p. 122).

Within nursing continuing education, granting of contact hours is dependent upon use of written behavioral objectives. Participation in a formative evaluation process that modifies the educational program while it is occurring is an unlikely
occurrence due to the somewhat inflexible structure that is provided for nursing continuing education.

At the same time, use of consistency in program applications ensures that certain standards that have been time-honored and are based on sound adult education principles are maintained. It is clearly defined by the Ohio Nurses' Association that providership for continuing education status clarifies that behavioral objectives are stated before the educational offering occurs. Hopefully, participants in the process of defining the behavioral objectives will be reflective of the target audience so that the learners will be adequately represented in the formulation of these objectives.

Analysis of the data has raised the question in the mind of the researcher as to whether different disciplines view needs assessment from a different viewpoint. While the nurse educator is, in the majority of cases, using the definition "real education need" as a basis for program planning, the adult education area is more obscure and diverse in the definition of needs assessment.

This in turn raises the question as to whether the nurse educator is forced to narrow the scope of their personal view of needs assessment to meet the requirements imposed by outside regulatory agencies that control the granting of continuing education status. That different philosophies within nursing education and adult education exist seems a very real possibility. Nurse educators must follow the institutional model as laid out by Ralph Tyler, which defines programs in behavioral objectives with definitive content outlines and evaluation methods.
Stufflebaum, McCormick, Brinkerhoff, and Nelson (1985) point out that needs are the outcomes of human judgements, values, and interactions within a given context. Emphasized by these authors is that the definition used by the needs assessor will have significant impact for how a study is conducted and that a working definition is basic to a needs assessment study.

NEEDS ASSESSMENT TECHNIQUES UTILIZED

Stufflebaum, McCormick, Brinkerhoff, and Nelson (1985) state that a random sample of needs assessments would show diversity in scope, focus, and methodology. Yoder (1992) sees assessing learning needs as the most crucial step in staff development activities and one that results in meeting both the institution's and learner's needs if done effectively.

Yoder (1992) uses a framework for identifying learning needs based on individual and organizational needs to form the basis for goal setting and priority determinants. She highlights the fact that records and reports reflect organizational and not necessarily individual needs. It is not surprising that institutional needs are identified as a high priority. Yoder points out that changes in technology, such as the use of computerized medical records and focused services, create learning needs for nurses.

Changes in technology and computerization as well as redesign of hospitals are examples of things that result in learning needs. Within the health care arena, this requires that the staff development director be in a position to foresee the needs for learning experiences brought on by institutional changes. Quality assurance reports
are most useful because they are based on actual practice and suggest areas in which deficiencies exist. Incident reports and infection control reports show deviation from acceptable practice (Yoder, 1992).

That the Delphi studies and the slip technique are among those techniques used least is not surprising. Eighty respondents stated that they were unfamiliar with the slip technique. Use of Delphi requires a longer time commitment than some other techniques due to successive mailings to a target audience. Prospective assessments rely on trends in the health care delivery system but are more futuristically oriented. Telephone surveys have been used effectively in some instances, but are not a typical strategy in staff development (Yoder, 1992).

Response showing lack of familiarity with some needs assessment techniques (slip technique, process recording, prospective assessments) suggests that there may be a need to provide educational programs for nurse educators in a number of these areas. Future research might focus on exploring the nurse educator’s knowledge of how and when to use a wider variety of needs assessment techniques. As an example, 68% of those responding indicate that they are unfamiliar with the slip technique.

Two reasons may explain the more frequent and less frequent use of certain needs assessment techniques. The first is that the size of a hospital, reflective of resources (both material and human), may impact significantly on the ability to utilize a wider variety of needs assessment techniques. The second aspect is that analysis of data or future research might reveal a relationship between needs assessment techniques utilized by the educator and the educational preparation of the particular
nurse educator. This could confirm or rule out a relationship between two variables and is suggestive of relational research.

PROGRAM SOURCE DETERMINATION

In light of the fact that the needs of the organization and keeping abreast with changes in technology are ranked highest by respondents as needs for programming, Monette's viewpoints seem to reflect these findings. He states: "... the adult educator is sometimes called upon to assess the 'needs of the system' as such in order to improve system performance through some educational program... systems have problems as well as ends to which they are ordered, however, and this is what needs-talk masks, systems as such cannot be educated... If the performance of a system is to improve, the individuals within the system must act upon themselves and upon their system" (Monette, 1977, p. 122).

Brookfield (1986) states that the criteria for determining program priorities is the providing agencies' institutional statement. ANA (1992) points out that the change in demographic characteristics of the health care consumer, advances in the health care delivery system, technology, local, state, national, and international legislative changes influence learning need priorities.

Knowles (1986) emphasizes that the organization is a living element and has a need for survival, safety, belonging, esteem, and self-actualization (Maslow's hierarchy of needs). Institutional management typically thinks of training needs that will further efficient operation and mission accomplishment.
Leroux (1992) reminds us that the philosophy of the nursing department and staff development are the basis for program determination. Stufflebaum's (1971) model of Context, Input, Process, and Product (CIPP) looks at the interested party, community and professional standards, and means to accomplish these goals to make program determination decisions.

Mazmanian (1980) suggests that mandatory participation in CE for relicensure and certification, contractual obligations to funding agencies, provision of CE by rival sponsors, requests for cosponsorship from other professional organizations, and requests from formal & informal groups are social structural forces that come into play within the area of continuing medical education.

Pillar (1991) suggests that the introduction of new technology, whether a new procedure, drug, device or service, causes significant disruption for the nursing staff. Monette (1977) feels that educational need can be defined from the viewpoint of both individual learner or an objectively determined deficiency in knowledge, skill, or attitude.

Analysis of the data indicates very little variance in sources of program determination. While needs identified by the organization are supported by the ANA (1992) statements and the writings of Knowles, Brookfield, and Leroux, technology changes are almost equally as much of a determining factor.

Smith and Elbert (1986) suggest that changes in nursing roles are driven by the need to "do more with less" (resources), maintain high quality care while lowering costs, and expand knowledge and technology. The Joint Commission on Accreditation
of Hospitals (JCAH) requires continuous training and education in areas such as infection control, hazardous waste, cardiopulmonary resuscitation, fire, safety, and disaster.

The ranking of needs of supervisors and administrators as the lowest priority may have been due to unclear wording of the statement, causing it to be confused with needs identified by the organization. A statement concerning lack of clarity regarding this statement was handwritten on at least five surveys. There is not enough difference in the mean of these program source determinants to show any significant trends. Meeting the needs of supervisors and administrators was ranked as the lowest priority.

Perhaps the use of front-end analysis (Rodriguez, 1988) in which all possible causes of performance problems allows one to pursue the appropriate solution bears closer examination. Front-end analysis focuses on internal organizational processes, not on results. Examination of such features as personnel selection criteria, improving supervision, redesigning jobs, modifying working conditions, or improving information exchange may bear examination.

**SELF-PERCEIVED CONFIDENCE LEVEL IN THE NEEDS ASSESSMENT ROLE**

Traditional roles of education such as developing content outlines and objectives, developing questionnaires for program evaluation, and identifying program priorities indicate that nurse educators are confident in these roles. Areas such as developing competency based assessment shows slightly more than a 50% confidence level.
Peterson (1983) believes that application of education principles helps one feel proud and confident of the role as both a nurse and an educator. Competencies found to be important in the nurse educator role were: 1) utilize a variety of learning opportunities for individuals and groups; 2) continuously evaluate the learner's progress and effectiveness as a facilitator; 3) maintain current knowledge, skill, and attitudes in nursing and education; 4) keep informed on hospital policies and procedures; and 5) serve as consultant to supervisory staff and serve as a consultant to hospital personnel regarding educational resources.

This is suggestive of the fact that areas involved in stated need and system planning such as management and discipline are areas in which the nurse educator may benefit from continuing education programs. Bachman, Kitchens, Halley, and Ellison (1992) found that nurse educators were interested in classes related to computer applications, classroom and clinical learning, and strategies to maintain clinical proficiency. The more traditional role of the nurse educator is expanding as human and financial resources become less and the nurse educator takes on a less traditional role.

Bachman, Kitchens, Halley, and Ellison (1992) suggest that less than half of NLN-accredited Master's programs offer nursing education as an area of study. They raise the problem that nurse educators may have needs to fulfill the educator role that can best be fulfilled by continuing education programs. They warn against assuming "an educator is an educator is an educator" (Bachman, Kitchens, Halley, & Ellison, 1992, p. 33).
Eason and Corbett (1991) looked at the characteristics of an effective adult educator and found that knowledge of content, organization of content, and teacher strategies were highly valued by program participants. Fong (1990) emphasized the need to decrease job demands and increase administrative support for the nurse educator to diminish the possibility of burnout and role overload.

Mason, Costello-Nickitas, Scanlan, & Magnuson (1991) point out that a positive and potent self-esteem, developing self-efficacy with skills needed to attain personal and collective goals, and consciousness raising related to political and social realities within one's life circumstances are aspects of empowerment. They state, "Empowerment requires an acknowledgement and appreciation of one's own abilities and strengths and a sharing of these with others" (Mason, Costello-Nickitas, Scanlan, & Magnuson, 1991, p. 6).

**HUMAN AND FINANCIAL RESOURCES**

Gundlach (1994) suggests that it is imperative for staff development to restructure and realign roles within staff development. She believes that structural rigidity prevents collaboration, flexibility, and responsiveness to learning needs. The role of initiator, collaborator, and facilitator of the organizational learning role are seen as critical. She suggests use of action learning described by Revans in 1980, which is based on doing and learning from project-focused learning on nursing units, as a model for change. This involves a staff development specialist working with four to six nurses over a six to nine month period to work on real-life problems within the nursing unit.
Puetz (1985) stressed the need for accountability for services and funds spent. She believes that scarce resources should be allocated for programs proven to be effective.

As indicated by both the respondents and non-respondents (per phone interviews), nurse educators are facing a critical time within health care. With the "downsizing" and "rightsizing" of hospitals, human and financial resources have been eliminated and in all probability will not be replaced. The literature available in nursing education is sparse due to the recent evolution of this phenomenon. Consultation by phone with the National Staff Development Organization in Pensacola, Florida did not reveal any additional written resources on this topic.

Many hospitals are going through the process known as redesign or reengineering. Gardener states that reengineering "has the potential to drive organizations to improve quality and customer responsiveness, reduce costs, and streamline operations" (Gardener, 1994, p. 13). Reengineering brings people, technology, and infrastructure together to break down barriers that limit change. The multidisciplinary approach integrates solutions to achieve radical change. This is a phased approach and requires 18-24 months to implement; the goal is to establish a culture of learning and continuous improvement.

Stewart believes that reengineering "starts from the future and works backward, as if unconstrained by existing methods, people, or departments" (Stewart, 1993, p. 41). Strasen (1994) believes that health care organizations can reorganize in less than twelve months with improvement to quality, service, and financial outcomes.
What effect does "downsizing" and "rightsizing" have on the nurse educator?

First of all, both human and financial resources are scarce. These resources are being carefully scrutinized, and in many cases being diminished or eliminated.

One respondent stated that there is now one nurse educator in a department that previously had six educators. Smith and Elbert (1986) point out that changes in the nursing role involve doing more for less, maintaining high quality while lowering costs, teaching and educating others, helping hospitals spot high-expense and low-revenue sources, and team approaches. Cross-training and nurse-extenders are terms heard frequently within hospitals today, creating a more austere climate. Yet rising medical costs necessitate these measures.

Tracking and trending in budgeting and personnel as health care settings "downsize" and "rightsize" will bear a close watching in the future to determine the impact on educational programming. The fact that nursing educators are being asked to assume multiple responsibilities and roles could impact negatively on the ability to carry out responsibilities that are part of the educator's role. While the nurse educator may be able to continue to present educational programs, areas such as researching, carrying out quality assurance studies on programming, and acting in a consultant role may be neglected.

RECOMMENDATIONS FOR FUTURE RESEARCH

Previous research has identified demographics regarding hospital educators, but the current research focused on nurse educators only. In the face of changes occurring within hospitals such as "downsizing" and "rightsizing", a suggestion for
future research is to replicate the study to determine the impact of budgeting constraints on the perception of space, money for programming, and human resources available to the educator.

Another area of future research might be to examine other roles the nurse educator must assume. This again raises the question of fragmentation and the ability to fulfill multiple roles without loss of subtle elements in programming. Roles defined by the ANA(1992) of the nurse educator are educator, manager, consultant, and researcher. It would seem likely the role of consultant and researcher might be negatively impacted by these multiple role expectations.

The nurse educator's knowledge of how and when to use a wide variety of needs assessment techniques to determine programming priorities might be investigated in future research. While the nurse educator expresses confidence in traditional roles, educational preparation of the nurse educator for the more expanded role that impacts on needs assessment (advancements in technology, organization and management needs, use of competency based techniques, clinical simulations) may require further education for the educator role.

Relational research examining the size of hospitals and educational preparation of the educator related to budgetary constraints and perceptions of resources available for programming is strongly suggested. This has particular merit in a time when hospitals are going through redesign.
RECOMMENDATIONS FOR PRACTICE

Perhaps the reason non-respondents did not return their surveys was based on the multiplicity of roles and time constraints engendered as changes within redesign of hospitals occurs. Close attention must be given to the possibility of fragmentation of efforts by nurse educators, diminishing the effectiveness of the nurse educator role. This is especially likely for small hospitals as indicated by telephone conversations with those interviewed as non-respondents.

Nurse educators need to take the initiative to assess their own skill levels and knowledge base of a wide variety of needs assessment techniques. As individual educators, they might set goals to become familiar with techniques that they do not utilize through literature, networking with peers, and perhaps advanced study in needs assessment techniques and program planning.

From an administrative perspective, several areas bear examination. Is there a clearly defined framework from which the nurse educator is expected to operate? What kind of input from staff nurses, administration, and peers in staff development does the nurse educator receive? Is the educator role seen as a collaborative effort?

The work of Bachman, Kitchen, Halley, and Ellison (1992) suggests that there is a need for programs for the nurse educator who assumes a teaching role without adequate knowledge and skills to succeed. A probationary and annual performance review of the nurse educator should evaluate competencies of the nurse educator. This is an ideal time to include self-assessment, peer assessment, and supervisory assessment to allow the opportunity for goal setting on ways to increase the individual
educator's competencies. Regular follow-up on whether these goals have been achieved should then follow. This supports the work of Peterson (1983) and incorporates implementation of suggestions found in the literature.

At least annually, the nurse educator should review his/her own resources in the educational role. A review of adequate library resources (access to literature search base, Internet capability, satellite programs) and adequate technological equipment (is it up-to-date, available, in good working order) is essential on a regular basis. Are there adequate human resources to carry out needs assessment techniques? For instance, in any institution it is easy to neglect certain elements of the educator role that may not be evident at first but over a period of time will lead to ineffective programming.

And, perhaps lastly, does the nurse educator have adequate budgetary support for programming? Needs assessment can result in an initial outlay of resources, but if the resulting needs that emerge are effectively addressed, this will be money well spent!

It is certainly necessary in the competitive arena of nursing education for both the educator and the organization to make careful use of the resources that are available. Needs assessment is at the forefront of the dynamic process that requires the individual educator to be ever abreast with developments with Staff Development and Continuing Education. Lifelong learning is also important to the nurse educator and includes the aspects of activities related to clinical nursing practice, theories of learning, teaching strategies, and adult education principles (ANA, 1992).
APPENDIX A

LETTER TO EDUCATION EXPERTS

3303 Simmons Church Road
Centerburg, Ohio 43011

Jan. 31, 1995

Ms. Zandra Ohri
Ohio Nurses Association
4000 East Main St.
Columbus, Ohio

Dear Zandra:

As a Master’s Candidate from The Ohio State University School of Allied Medicine, I am conducting survey research entitled "Needs Assessment: Techniques and Self-Perceived Abilities of the Hospital-Based Nurse Educator Related to Nursing Continuing Education/Staff Development Activities." In order to field test the survey instrument, your name has been suggested as a content expert within the area of Continuing Education in nursing.

I would request that you take the time to review the enclosed survey instrument for readability and content ease. I will then make modifications on the survey tool based on the feedback received from five content experts. There is an enclosed response tool which will help you evaluate the survey. Feel free to make additional comments on the tool itself.

I will then mail it to Nurse Educators within the state of Ohio identified by a mailing list of the Ohio Hospital Association.

The intent of my research is to identify techniques utilized by the nurse educator related to needs assessments, examine self-assessed ability to determine needs assessment, identify how frequently programs are designed to meet the needs of outside regulatory requirements or needs of special groups, and describe the nurse educator’s perception of resources (human and financial) in their employment setting.

This could help clarify programming needs that the nurse educator feels have been unmet in their own educational preparation for their current role. It might also shed light on some of the factors that would enhance the role of the nurse educator.
I have enclosed a flavored tea bag for you to enjoy while you make any suggestions or comments on the survey instrument. Please return the survey and critique within one (1) week in the enclosed self-addressed, stamped envelope. At the conclusion of my survey, I will be glad to share the results for your own information. Please enclose a self-addressed, stamped envelope if you would like to receive a copy. Feel free to call me at 614-625-5188 if you have any questions.

Sincerely,

Judith Mailloux,
Graduate Student, The Ohio State University
APPENDIX B

SURVEY INSTRUMENT CRITIQUE TOOL

Please use this tool to critique the enclosed Needs Assessment Survey Questionnaire. Check the appropriate box and make any additional comments that come to mind.

1. **Overall readability of the survey tool:**
   
   ___ ambiguous ___ unclearly stated ___ clearly stated

   **Comment on specific sections:**
   
   __________________________________________
   __________________________________________

2. **Definitions of needs assessments clearly stated:**
   
   ___ yes ___ no

   **Comment:**
   
   __________________________________________

3. **Needs assessment techniques list comprehensive:**
   
   ___ yes ___ no

   **Should any techniques be added or deleted?**
   
   **Comment:**
   
   __________________________________________
   __________________________________________

4. **Program source determination comprehensive:**
   
   ___ yes ___ no
Should any program source determination be added or deleted? ________________
Comment: ________________________________

5. **Self-Assessed ability processes comprehensive:**
   
   ____ yes
   ____ no

Should any self-assessed ability processes be added or deleted? ________________
Comment: ________________________________

6. **Demographics section:**

   A. Are questions clearly stated?
      
      ____ yes
      ____ no

   Comment: ________________________________

   B. Are questions regarding human resources comprehensive?
      
      ____ yes
      ____ no

   Comment: ________________________________

   C. Are questions regarding financial resources comprehensive?
      
      ____ yes
      ____ no

   Comment: ________________________________
D. Are there any important issues related to programming resources not identified?

____ yes
____ no

Comment: 


7. Clarity of survey tool:

____ poor     ____ fair     ____ good     ____ excellent

8. Are there areas of the questionnaire that need to be modified?
Please describe these briefly in your own words with any suggestions for revision:


APPENDIX C

ORIGINAL QUESTIONNAIRE

NEEDS ASSESSMENT

DEFINITIONS

Please place a check (✓) mark beside the definition of "needs assessment" that you utilize most frequently. Choose only one definition.

___ real need- an objective deficiency that actually exists and may or may not be recognized by the one who has the need.
___ education need- an educational deficiency that can be satisfied by a learning experience.
___ real education need- a specific understanding, skill, or attitude is lacking and can be satisfied by a learning experience to obtain a more desirable condition. (May not be recognized by the person involved.)
___ felt need- regarded as necessary by the person concerned.
___ normative need- a gap between the desirable standard and the standard that actually exists.
___ comparative need- measured by those in receipt of a service with those who do not receive this service.

NEEDS ASSESSMENT TECHNIQUES

Indicate how frequently you utilize the following needs assessment techniques utilizing the following frequency key:

1 = never
2 = rarely
3 = sometimes
4 = frequently
5 = very frequently

1 2 3 4 5 critical incidents
1 2 3 4 5 questionnaire and opinionnaire
1 2 3 4 5 advisory committees
1 2 3 4 5 direct observations
1 2 3 4 5 supervisors’ evaluations & suggestions
1 2 3 4 5 rating scales (semantic differential or Likert)
PROGRAM SOURCE DETERMINATION

Indicate how frequently the following sources determine needs for educational programs your department offers:

1. meeting outside regulatory requirements
2. meeting the needs of supervisors/administrators
3. keeping abreast with changes in nursing due to technology
4. program/educational topics requested by staff nurses

SELF-ASSESSED ABILITY

As a nursing educator, please indicate your self-assessed ability regarding needs assessment techniques. Please utilize the following letters:

(C) - confident of my own abilities
(SC) - somewhat confident, but would like to learn more
(LK) - lack knowledge

1. Developing questionnaires for analyzing learning needs
2. Identifying learning needs through clinical simulation
3. Developing tools to evaluate knowledge before & after educational offerings
4. Developing questionnaires for program evaluation
5. Identifying program needs to set program priorities
6. Developing competency based assessment
7. Evaluating stated need & system planning such as management, discipline, etc.
APPENDIX D

MODIFIED QUESTIONNAIRE
NEEDS ASSESSMENT:
TECHNIQUES AND SELF-PERCEIVED
ABILITIES OF HOSPITAL-BASED NURSE EDUCATORS
RELATED TO CONTINUING EDUCATION/STAFF DEVELOPMENT ACTIVITIES

Please return survey by
NEEDS ASSESSMENT

DEFINITIONS

Please check (x) the definition of "needs assessment" that you utilize most frequently. Choose only one definition.

_____ real education need- a specific understanding, skill, or attitude is lacking and can be satisfied by a learning experience to obtain a more desirable condition. (May not be recognized by the person involved)

_____ felt need-regarded as necessary by the person concerned

_____ normative need-a gap between the desirable standard and the standard that actually exists

NEEDS ASSESSMENT TECHNIQUES

Circle the number that indicates how frequently you utilize the following needs assessment techniques utilizing the following key:

1 = never
2 = rarely
3 = sometimes
4 = frequently
5 = very frequently
6 = unfamiliar with technique

Please circle only one number!

1 2 3 4 5 6 critical incidents

1 2 3 4 5 6 questionnaire and opinionnaire

1 2 3 4 5 6 advisory committees

1 2 3 4 5 6 direct observations

1 2 3 4 5 6 supervisors' evaluations & suggestions

1 2 3 4 5 6 rating scales (semantic differential or Likert)
literature references
anecdotal notes
brainstorming
Delphi technique
focus groups
interviews
nominal group process
process recordings
professional standards
records & reports (statistical reports, patient record, patient surveys, minutes of meetings, nursing audits & quality assurance reports, infection control reports, incident reports, employee records, annual reports, marketing reports)
services & institutional changes
slip technique
testing
telephone surveys
prospective assessments
PROGRAM SOURCE DETERMINATION

Circle the number that indicates how frequently the following sources determine needs for educational programs your department offers:

1 = never    4 = frequently
2 = rarely    5 = very frequently
3 = sometimes

Please circle only one number!

12345 meeting outside regulatory requirements
12345 meeting the needs of supervisors/administrators
12345 keeping abreast with changes in nursing due to technology
12345 program/educational topics requested by staff nurses
12345 needs identified by the organization
12345 needs identified through quality assurance studies
12345 needs identified by incidents related to clinical practice

SELF-ASSESSED ABILITY

As a nursing educator please indicate your self-assessed ability regarding needs assessment processes. Please utilize the following letters:

(C) - confident of my own abilities
(SC) - somewhat confident, but would like to learn more
(LC) - lack confidence

____ 1. Developing questionnaires for analyzing learning needs

____ 2. Identifying learning needs through clinical simulation

____ 3. Developing tools to evaluate knowledge before & after educational offerings

____ 4. Developing questionnaires for program evaluation

____ 5. Identifying program needs to set program priorities

____ 6. Developing competency based assessment

____ 7. Evaluating stated need & system planning such as management, discipline, etc.
______ 8. Identifying organizational needs that impact on programming (i.e., equipment not available, manager does not follow through with discipline, etc.)

______ 9. Developing content outlines and objectives

(Modified from Feedback for professional development, 1979, American Society for Training and Development)
DEMOGRAPHIC DATA

Please fill in or check the appropriate box.

1. Size of hospital: ______ beds

2. Is your institution: _____ teaching
   _____ non-teaching

3. Gender: _____ Male  _____ Female

4. Birth Year _____

5. Length of employment as a hospital-based educator: ______ yrs.

6. Employment status: ______ full-time  ______ part-time
   (less than 32 hours per week)

7. Highest level of education:
   _____ Associate degree
   _____ Diploma
   _____ Baccalaureate (Non-nursing)
   _____ Baccalaureate Degree in Nursing
   _____ Master's Degree (Non-nursing)
   _____ Master's Degree in Nursing
   _____ Ph.D. (Please indicate in what area

   _____ non-nurse

8. In your most advanced educational degree, did you take course work in the educational process?
   _____ yes  _____ no

9. If the answer to 8 was yes, at what level did this course work occur?
   ________________________________
   ________________________________

10. Have you attended continuing education programs focusing on the educational process in the last year?
    _____ yes  _____ no

11. If the answer to #10 was yes, what areas were highlighted in the continuing education programs you attended? Please give a brief explanation:
    ________________________________
    ________________________________
    ________________________________

12. Is program planning part of your job?
    _____ yes  _____ no

13. How much self-study (e.g., journal reading) do you do per week?
    _____ hrs./week
14. Are educational experts available to you in your work setting?  
   ____ yes  ____ no  

15. Is the educational expert available:  
   ____ brought in as an outside consultant  
   ____ by fax  
   ____ by phone  

16. Is an educational/advisory committee involved in program planning?  ____ yes  ____ no  

17. In your opinion, are there adequate monies available through your education budget to implement programs after the planning process has been completed?  
   ____ yes  ____ no  

18. How are education expenses met?  

19. Do you feel there are adequate human resources available to meet programming needs within the hospital and outside the hospital?  
   ____ yes  ____ no  

20. Is there adequate meeting space within the hospital to meet educational needs?  
   ____ yes  ____ no
APPENDIX E

LETTER TO HOSPITAL EDUCATORS

3303 Simmons Church Rd.
Centerburg, Ohio 43011
February 21, 1995

Dear Colleague:

As a Master's Candidate from The Ohio State University School of Allied Medical Professions, I am conducting survey research entitled "Needs Assessment: Techniques and Self-Perceived Abilities of Hospital-Based Nurse Educators Related to Continuing Nursing Education/Staff Development Activities." At the direction of my advisory committee, I am surveying nurse educators within the State of Ohio. A mailing list provided by the Ohio Hospital Association has identified your hospital as a participating member.

The intent of my research is to identify definitions and techniques utilized by the nurse educator related to needs assessments, examine self-assessed ability to determine needs assessment, identify how frequently programs are designed to meet outside regulatory requirements or needs of special groups, and describe the nurse educator's perception of resources (human and financial) available in their employment setting.

This could help clarify programming needs that the nurse educator feels have been unmet in their own educational preparation for their current role. It might also shed light on some of the factors that would enhance the role of the nurse educator in the needs assessment process.

The survey instrument has been reviewed by a panel of experts who serve on the Continuing Education Committee of the Ohio Nurses Association. Since you are the expert in these matters, it is extremely important to me that you take the time to fill out the enclosed questionnaire. To make this time a little more pleasant, I have enclosed a flavored tea bag so you can enjoy the few minutes taken to complete to complete this survey.

If you are interested in receiving a copy of the survey results, please include a self-addressed, stamped envelope. Feel free to call me if you have any questions. The telephone number is 614-625-5188.
Your cooperation is greatly appreciated. Surveys have been coded with a number to identify the facility responding. Results will remain confidential and participation is voluntary. I look forward to receiving your completed survey within the next 2 1/2 weeks.

Sincerely,

Judith Mailloux
Graduate Student, The Ohio State University
APPENDIX F

ANNOUNCEMENT CARD (PRE-)

COMING SOON:

The opportunity to share how you, as a nurse educator, view and carry out needs assessment!

Watch for the forthcoming questionnaire.

Judy Mailloux, Graduate Student
The Ohio State University
APPENDIX G

REMEMBER CARD

*Just a Reminder*

Recently you receive a survey on Needs Assessment. If you have not returned the survey yet, please take a few moments to complete it and mail it back in the self-addressed, stamped envelope that was enclosed. Please return it even if it is past the suggested date!!

Thanks,
Judith Mailloux, RN, BSN
Graduate Student, The Ohio State University
APPENDIX H

SECOND LETTER TO HOSPITAL EDUCATORS

3303 Simmons Church Road
Centerburg, Ohio 43011
March 26, 1995

Dear Colleague:

Within the last six weeks, your facility was mailed a survey entitled "Needs Assessment: Techniques and Self-Perceived Abilities of Hospital-Based Nurse Educators Related to Continuing Nursing Education/Staff development Activities." As of this date, I have not received the completed survey.

Knowing how busy schedules can become, perhaps it has been overlooked or misplaced (At least on my desk that could happen!). Your opinion is very important to me since you are the expert in these matters. Please take a few minutes of your time to complete the enclosed survey and return it in the enclosed envelope.

Surveys are coded with a number to identify the facility responding. Results will remain confidential. If you are interested in receiving a copy of the results of the survey, please include a self-addressed, stamped envelope.

I look forward to hearing from you within the next few weeks. Please feel free to call me at 614-625-5188 if you have any questions.

Sincerely,

Judith Mailloux
Graduate Student, The Ohio State University
REFERENCES


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