Nursing is at a crossroad. The current nursing shortage, characterized by numerous supply and demand variables, has provided an opportunity to radically redefine all areas of nursing, including the educational system that produces our newest professionals. This article presents one baccalaureate nursing program's journey to redefine itself in the face of mounting odds. Just as practice often informs policy, and change in practice often precedes legislation, our department embraced a curriculum model that is, to the best of our knowledge, unique among nursing programs in the United States.

Calls to the Profession and Its Educators Recent calls by the National League for Nursing for innovation in nursing education have not been adequately answered. Most responses to the NLN position statement, “Innovation in Nursing Education: A Call to Reform,” have taken the form of changes to curricular content rather than substantive redesign of underlying curricular delivery mechanisms and philosophy (1).

As a profession, nursing has been prescriptive in terms of curricular standards. Perhaps it is in our very nature as nurses to be thorough, organized, detail-oriented, and consistent. These values carry over into the prescriptive nature of our governing and credentialing bodies, as anyone who has gone through this process can attest. However, an untoward consequence of wide-ranging standardization of curricular content is stagnation. The energy of educators is spent complying with demands, guidelines, and rules, as opposed to being encouraged to dream, to hope, and to innovate.

Recently, the Robert Wood Johnson Foundation (RWJF) conducted a comprehensive analysis of the nursing shortage — why...
it has evolved, why it is persistent, and what strategies may help alleviate it. In addition to recommending systemic changes in both the supply and demand portions of the nursing shortage equation, RWJF recommended that the supply of nurses be increased “through expanded educational capacity and opportunity” (2, p. 26). Specifically, RWJF recommended increasing school and faculty capacity, forging community partnerships, and ensuring that educators and professionals are accountable for preparing students for today’s health care environment and enhancing the quality of the work environment.

Encouraging nursing education organizations to “enhance collaboration between education and practice” (2, p. 33), the RWJF report calls for the development of a national forum to advance nursing in several key areas. In the area of nursing education, the report states that “to attract and retain a new generation of nurses, and to ensure that the new nursing workforce represents the ethnic and racial diversity of the United States, the Forum would focus efforts on reinventing nursing education and work environments to address the needs and values of these new workers. It would foster the creation of new training/educational models and new community-based roles that utilize nurses’ unique skills, while fostering satisfaction and competence” (2, p. 58).

The American Nurses Association, with funding from the American Nurses Foundation, brought together 60 professional nursing organizations as part of the Call to the Nursing Profession Summit. What emerged was “Nursing’s Agenda for the Future,” a comprehensive strategic plan that outlines the shared future vision of nursing and the pathway for attaining this vision. In the area of education, it was agreed that stakeholders “will focus on reexamining and reshaping nursing education to improve nursing practice, enhance nursing’s image and better meet patient care needs” (3, p. 16). A vision statement for education includes “highly qualified faculty [engaged] in innovative teaching, clinical practice and research that lead to learning and work environments that are conducive to the creativity of faculty and students and promote education that is evidence-based and result in safe, quality care” (3, p. 16).

Implicit in recent calls for educational reform is the need to establish evidence-based underpinnings to the nursing curricula. As stated in the NLN position statement, “Building a science that accompanies [educational] innovation and reform will provide the foundation for creating and maintaining partnerships between nursing education and service” (1). Just as we would not expect any less for patient care, we must develop a rational basis for curricular design, methods, and outcomes.

### Responding to the Call for Innovation

Like many other nursing education programs, the School of Nursing at the University of Delaware has engaged in periodic extensive efforts to reformulate its baccalaureate nursing program and achieve quality change. The department was in the midst of one curricular transition when it became apparent that the planned new curriculum was costly, labor intensive, and somewhat unwieldy. During this time, the demand for seats in the nursing major was increasing significantly, and public and political pressures to expand enrollments — with no corresponding increase in resources — were immense.

Various intrinsic and extrinsic forces had led to awareness of the need for change in the program, away from the traditional format in which didactics were delivered alongside clinical experiences and students participated in two one-day specialty areas each week. For example, clinical instructors often found themselves providing impromptu lectures on disease processes in the hallways of hospitals to students who had not yet learned about particular phenomena in class. An organization, already tired, was asked to go back to the drawing board and develop a bold and radical curricula in line with the core components of the Essentials of Baccalaureate Education for Professional Nursing Practice (4).

A fundamental shift in the philosophy that formed the basis of the curricula was needed. Concerned about deeply embedded aspects of nursing, in both practice and education, faculty considered the problem of disempowerment and nursing’s history as a profession for women. These were seen as central to the profession’s failure to be represented at the highest levels of decision making (5). Parallels were drawn to social-psychology theory suggesting that oppressed groups tend to reenact victimizer-victim roles, developing in their own groups internal stratification and turmoil as means of mastery, or modeling of the oppression (5). In nursing, it was thought, such tendencies are played out in our own treatment of young professionals and in the use of dominance and subservience by some nurse educators who encourage blind deference to perceived authority (6). It became apparent that an active embrace of collegiality would be necessary to produce empowered, spirited nurses who will forge critical leadership roles at all levels of organizations and society (7).

In a 2001 article, Porter-O’Grady described a model for nursing education where “the classroom, teacher-driven learning model no longer predominates, and the accountability for ensuring learning occurs is shifting to the student” (8, p. 184). In such an environment, it is “the obligation of the learner to give evidence that learning has occurred and...results in sustainable action” (8, p. 184). Porter-O’Grady speaks of nursing education
programs as having two basic functions: content provision and certification of learning.

The Nurse Residency Model developed by faculty at the University of Delaware School of Nursing embraces the philosophical shift espoused by Porter-O'Grady. After three years of content provision (coursework, lab/simulation practice, and field experiences), the final year is dedicated to certification of learning in the form of clinical immersion. Students present to the clinical immersion year prepared to perform as well as to learn.

The First Three Years The design of the nurse residency curriculum is based on the premise that students progressively gain knowledge and demonstrate competence. As students are admitted directly into the nursing major, specific nursing courses, as well as courses in general science and the liberal arts, are provided from the beginning. During both semesters of the freshman year, required coursework focuses on a variety of nursing concerns including professional behaviors, nursing roles, the history and philosophy of nursing, and basic clinical skills.

The sophomore year expands on this foundation. There is a continued exploration of the liberal arts along with an examination of the sciences undergirding nursing care, such as pathophysiology, pharmacology, clinical decision making, health assessment, and research concepts. Two newly developed courses, Care of Vulnerable Populations and Health Promotion Across the Lifespan, were designed to introduce nursing students to local, national, and global health and wellness issues.

In previous curricular formulations, students studied research in the first semester of the senior year; later, the course was moved to the second semester of the junior year. Because we strongly believe that evidence-based practice requires the tools to be critical consumers of research, we moved the course earlier in the program. Students take the nursing research course during the junior year as they already have sufficient nursing knowledge to understand the relevance and importance of evidence-based practice.

As students progress to the junior year, the nursing courses focus on specialty content, including nursing care of adults, psychosocial nursing, care of children and families, care of women, and communities and health policy. These courses provide a comprehensive view of each nursing specialty and a thorough knowledge base in each didactic nursing subject.

These three years provide the foundation for the clinical immersion of the senior year. Much like the student teaching model, students demonstrate mastery of all content areas prior to learning the experiential craft of nursing. In clinical areas where patient acuity has increased, this educational model ensures the presence of students who are able to integrate previous knowledge and continue their development as professional nurses.

Senior Year Clinical Immersion The senior year clinical immersion is an intensive experience designed to enable graduates to transition readily to nursing practice. Students are immersed in each of six clinical areas three days per week for four weeks. The six areas include two clinicals in medical-surgical nursing; one each in maternal-child, psychosocial, and community nursing; and a final capstone experience. The capstone, a preceptorship in the student’s chosen area, involves independent learning and real-world experience.

During this transition to practice experience, students are held accountable for a high level of clinical preparation. Meeting three days in a row allows instructors time to evaluate student learning and whether or not course objectives are being met. All clinical courses are pass/fail, with well-defined clinical behaviors and competencies. Students are expected to function independently and develop their clinical skills and knowledge without the constant struggle for higher grades.

The senior year also provides opportunities to examine selected topics in nursing and health care delivery, such as cross-cultural women’s health, death and dying, adolescent decision making, oncology nursing, and aspects of critical care. Clinical integration seminars span the immersion year and provide for discussion of leadership, professionalism, decision making, and issues essential to nursing practice. An emphasis on NCLEX preparation and career planning enables graduating seniors to transition to the world of work and/or graduate school.

Unique Aspects of the Nurse Residency Model Just as change can be exhilarating and inspiring, it also stirs up feelings of anxiety and fear. We were certain that a radical change to the curriculum would evoke such reactions among our peers and within the larger community. The most prevalent questions concerned the clinical immersion in the senior year and the resulting decrease in traditional clinical hours. Other concerns related to the impact of curricular change on students who learn best when practice is integrated with didactic knowledge acquisition. Three interventions — experience in a simulation resource laboratory, field experiences, and a work requirement — were designed specifically to address those issues.

Simulation Resource Laboratory The simulation resource laboratory provides the environment and tools needed to
THE DEPARTMENT was in the midst of one CURRICULAR TRANSITION when it became apparent that the PLANNED NEW CURRICULUM was costly, labor intensive, and somewhat unwieldy. During this time, the DEMAND FOR SEATS in the nursing major was INCREASING SIGNIFICANTLY, and public and political pressures to expand enrollments — WITH NO CORRESPONDING INCREASE IN RESOURCES — were immense.

allow students to pursue independent psychomotor and cognitive learning. A full-time, baccalaureate-prepared lab coordinator staffs the lab daily and is largely responsible for its success. In addition, an extensive network of undergraduate teaching assistants (TAs) provides additional support and extended evening hours. State-of-the-art simulation equipment, set up in the fashion of a health care facility, complete with a nurse's station and high-tech computer learning stations, has been assembled. Students sign up for lab practice and demonstrations or drop by the lab to use computer facilities.

A unique requirement is that students enter the lab in full nursing student uniform. Our belief is that for the lab to offer true simulation, students must be professional in all of their behaviors, including dress. Students have expressed a surprising level of satisfaction with this policy. They report taking the lab simulation practice seriously, and most importantly, they report that they more closely embrace the true role of a professional nurse.

Student preparation is also required for lab practice. It is clearly articulated in the lab rules that the staff will provide guidance and oversight but will not teach skills from scratch. Maintaining a consistent philosophy of student-centered learning is crucial to making the lab feasible. Readings, student-purchased skills CDs, and lab equipment purchases are key.

Students entering the senior year clinical immersion demonstrate competency in prior learned skills via simulation case studies and virtual clinical experiences. Students are presented case studies, asked to perform skills and assessments on the simulation manikins, and answer questions related to clinical decision making. These case studies, both instructor-developed and commercially available virtual clinical experiences, ensure competence and confidence when entering the clinical arena.

An active TA program, in which senior and junior nursing students are awarded independent study credits for mentoring other students, has provided numerous benefits to all parties. First, TAs benefit the simulation center by providing additional staffing during day and evening hours. Second, they benefit the students they mentor, supporting peers in their exploration of lab content, providing basic demonstrations of lab skills, and assisting in skills checklist completion. Since many of these TAs also support didactic courses, a peer teaching and leadership atmosphere pervades the simulation laboratory and spills over to the entire nursing curriculum. Third, TAs develop leadership skills, strengthen their own clinical expertise, and experience the role of educator.

FIELD EXPERIENCES Most nursing courses during the first three years of the program have an identified set of one to five clinical field experiences ranging from one to six hours each. These are used to meet course objectives and operationalize class content. Field experiences are set up by faculty and are required of students, but they are completed like homework — outside scheduled class time. They are remotely supervised by faculty and directly supervised by designees of the clinical agencies (e.g., staff nurses).

The transition to remotely supervised field experiences was a difficult leap for some faculty and for some agencies. The need for strict control exists; however, a shift of the responsibility for completing field experiences to the student has been a successful one, sparing many precious faculty hours. To address the concerns of faculty about the added burden of coordinating and monitoring the field experiences, workload credit was given to each course in its initial offering. On an ongoing basis, TAs track student completion of field experience requirements.

Of the 25 field experiences currently in the curriculum, some were borrowed from previous clinical courses that included alternate off-unit experiences, and several are new. Short written assignments promote reflective learning and document comple-
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The following examples reflect a small portion of the field experiences offered:

- In the vulnerable populations course, students conduct a wheelchair survey of the campus and spend time in shelters for homeless populations.
- Students in both pharmacology and health assessment attend a three-hour clinical observation in a local rehabilitation center where they have the opportunity to witness medication administration and health assessment as integral components of client care.
- Observations in labor and delivery, the operating room, the postanesthesia care unit, and with hospital specialty nurses provide real-life contact with patients and the ability to observe and model professional nursing behaviors.
- Experiences with school nurses, with bedside nurses, in home and hospice care, at self-help meetings, and in community settings are planned to provide a glimpse of the nurse’s role and reinforce class-related concepts.

WORK REQUIREMENT The work requirement for junior-year students consists of two pass/fail courses that provide one credit each for 80 hours worked in a health care setting. The courses provide patient contact, workplace familiarity, and insight into the workings of health care facilities. To ensure their integrity and value, several guidelines were put in place and specific parameters were adopted. All settings need to be preapproved by faculty. In addition, students sign a contract that reinforces professional behaviors, confidentiality, and work responsibility. Finally, students are carefully monitored to ensure that all requirements are completed.

Extensive networking and marketing of the curriculum yielded the development of a unique program by one local area hospital to assist students in meeting the work requirement. The hospital coordinated an unpaid Student Nurse Extern Program, which provides 80 hours of clinical orientation and shadowing, thereby both awarding a credit for this course and orienting new employees for unlicensed assistive personnel positions. Students and the setting determine the fit of the student in specific areas prior to official employment.

The most unique aspect of the clinical immersion model of education is a philosophical expansion of the definition of clinical education. In addition to the traditional resource-laden, instructor-supervised inpatient hospital clinical rotations, we also consider simulation laboratory experiences, independent field experiences, and the work requirement components of clinical education. It is our belief that students extract value and meaning and synthesize content and professional role behaviors from all of these experiences. When all of these non-didactic components are considered, total “clinical” time (using the newly expanded definition) is actually greater in the new curriculum than the old, even though the resource burden has decreased. (See Table 1.)

### Table 1. Comparison of Clinical Education Hours Across Curriculum Models

<table>
<thead>
<tr>
<th></th>
<th>Old Model</th>
<th>Residency Model</th>
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</thead>
<tbody>
<tr>
<td>Traditional Clinical</td>
<td>*</td>
<td>504</td>
</tr>
<tr>
<td>Field Experiences</td>
<td>0</td>
<td>58</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Varied by instructor</td>
<td>50+ **</td>
</tr>
<tr>
<td>Work Requirement</td>
<td>0</td>
<td>160</td>
</tr>
<tr>
<td>Total Clinical Hours</td>
<td>704</td>
<td>772</td>
</tr>
</tbody>
</table>

*Observational experiences subsumed within traditional clinical rotation. Students sent off unit to observe.

**Students may use simulation laboratory at higher rates depending on individual needs.
**Nurse Residency Philosophy** The core philosophical components of the Nurse Residency Model include enhanced socialization, improved transition to practice, and increased student accountability. At its foundation, the model is rooted in a spirit of collegiality that we aim to instill in our nurses. We are attempting to inculcate a lifelong passion and pursuit of learning and engagement in mentoring relationships as both mentee and mentor.

**Enhanced Socialization** Admitting students directly to the nursing major is central to socialization. Because of a demonstrated commitment on the part of both the student and the program, nursing coursework begins in the very first semester. Socialization continues as students begin field experiences and laboratory simulation practice in the second half of the freshman year, continuing throughout the junior year. Moreover, the junior-year work requirement acquaints students with the reality and complexity of nursing in health care delivery.

In the clinical immersion year, socialization is enhanced as students spend a total of 24 hours per week during three days in clinical settings. As such, clinicals are concentrated, as opposed to diluted experiences, and students gain greater appreciation for the nursing role in fast-paced, ever-changing health care environments.

A unique feature of the Nurse Residency Model is the existence of integration seminars that span the residency clinical immersion year. These seminars serve to link research to practice, theory to clinical, and past practice to present performance. By focusing on multiple system levels, the seminars cover issues of relevance to individual students, to the organizations for which they work, and to the nursing profession as a whole.

**Improved Transition to Practice** The bulk of traditional nursing education relies on a paired classroom and supervised hospital clinical combination. Certainly this has fared well throughout the years and is still considered a basic method for knowledge and skill acquisition. However, it has been our experience that students often report a stark and harsh transition to practice, as they no longer have onsite clinical instructors by their side.

The Nurse Residency Model addresses this disjointed transition to practice by being grounded in a building-block, step-wise approach. Increasing responsibility, accountability, and competence are fostered with each progressive semester of the program. The structure of the immersion year serves to improve students' transition to practice by offering simulated and real-life experiences. We believe this to be more representative of actual professional practice.

An additional mechanism by which the model improves transition to practice is moving to a pass/fail grading system for clinical and field experiences. Superimposing academic measures of performance onto clinical practice is not consistent with the mechanism by which clinical competence is evaluated in professional nursing practice. By its very definition, clinical practice is expected to be, at the least, minimally competent. Rewards or incentives for practicing above minimal competence should be intrinsic; students should gain a sense of satisfaction, pride, confidence, and accomplishment. Moreover, motivation to provide optimal patient care is extrinsically supported by the receipt of praise, positive patient outcomes, and sharing of best practices. In place of getting a grade, students are encouraged to articulate and define the continuum from minimum competency to optimal patient care delivery and work to achieve it.

Ben-Zur, Yagil, and Spitzer foresee a future shift in nursing education models that focuses on “the cancellation of traditional student evaluation tools” (9, p. 1433). Although they do not expand on this point, the implementation of clinical practice evaluation that mirrors the reality of nursing practice is certainly a means by which socialization to the profession is improved.

**Increased Student Accountability** Ben-Zur, Yagil, and Spitzer describe innovative curricula as those that focus on “learners and the creation of a climate for life-long learning” (9, pp. 1432-1433). Often we see instructors complain about students who do not appear to be accountable, who need continual prompting and guidance, or who want knowledge to be explicitly stated. For many, it is easy to see the shortcomings of the student. However, as with any dyad, the lack of accountability is rooted in a relationship. Equally open to examination is the nurse educator who may be unwilling or unable to let go of the structure, routine, and control that are deeply embedded in the very fabric of nursing education.

The Nurse Residency Model encourages student accountability by providing non-senior-level clinical experiences in the form of self-directed, or minimally directed, field experiences. By shifting the attitude to one of “this is to my benefit to do” as opposed to “we think it is good for you to do,” internal motivation and locus of control are fostered.

At the beginning of the immersion year, students are provided with checklists of clinical behaviors and skills commonly associated with particular clinical rotations. Students are in charge of determining their competence with the various behaviors and skills to which they have been exposed in previous years. Instead of mandating faculty oversight to ensure competence prior to starting the rotation, students check off skills after taking whatever steps are needed to be prepared for the rotation. By using
The most unique aspect of the CLINICAL IMMERSION MODEL of education is a PHILOSOPHICAL EXPANSION of the DEFINITION of clinical education. In addition to the TRADITIONAL RESOURCE-LADEN, instructor-supervised inpatient hospital clinical rotations, we also consider simulation laboratory experiences, independent field experiences, and the work requirement components of CLINICAL EDUCATION.

available resources, including the simulation lab, students are in control of defining their level of competence. Certainly this mirrors professional nursing practice.

As an added benefit, an increase in student accountability likely results in improved patient safety. In the previous curriculum, students would learn technical skills during clinical hours caring for patients in acute, chronic, and long-term care agencies. Novice nursing students were at the bedside with faculty caring for clients with high-level needs. With the new curriculum, the clinical simulation laboratory provides simulation, skills-building, and remediation experiences for all students, from the freshman to the senior years. Practicing on simulators and manikins allows skills to be taught and developed in a safe, nonthreatening environment.

The Administrative Perspective  With the overwhelming nursing shortage, the public cry for increased student enrollments, and the growing shortage of faculty across the country, new models of nursing education are important to pursue. Just as the adage, “work harder, work smarter” has impacted industry, this same perspective should be applied to academia.

Historically, nursing education has limited its view of education to small-group clinical settings requiring more teaching hours than faculty are able to produce. With a finite number of clinical site placements and academic budgets stretched to accommodate increased enrollments, faculty workloads are overwhelming. In addition, increased pressure to produce external funding and demonstrate scholarship must be balanced alongside heavy teaching needs. Innovative, new models of educating entry-level nurses must be found to address this complex, multifaceted nursing shortage.

The Nurse Residency Model was designed to alleviate some of the stress felt by faculty and local agencies resulting from the presence of greater numbers of students. The clinical teaching workload of the traditional four-year program required 21.4 full-time equivalents (FTEs) of faculty teaching time. The new curriculum reduces annual teaching needs in clinical coursework by 34 percent. (See Table 2.) The overall needs in the new residency curriculum, however, increased the number of FTEs for classroom teaching from 3.5 to 5.3. Despite this increase, this teaching format is an easier need to fill from within tenure-track faculty. The overall teaching needs in the four-year residency curriculum were reduced by 22 percent.

Table 2. Annual Faculty Teaching Needs by Curriculum Reported in Full-Time Equivalents (FTE)

<table>
<thead>
<tr>
<th></th>
<th>Old Model</th>
<th>Residency Model</th>
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</thead>
<tbody>
<tr>
<td>Clinical Teaching</td>
<td>21.4</td>
<td>14.2*</td>
</tr>
<tr>
<td>Classroom Teaching</td>
<td>3.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Total Teaching Needs</td>
<td>24.9 FTE</td>
<td>19.5 FTE *</td>
</tr>
</tbody>
</table>

*Includes one FTE for new laboratory coordinator position.

With increased student enrollments, finding sufficient clinical placements continues to be difficult. The residency model has allowed some relief. In the former curriculum, all undergraduates had clinical coursework in local acute care agencies for four of their eight semesters. The residency model requires only two semesters of clinical placement in acute care agencies. It should be noted that simulation laboratory experiences, independent field experiences, and the work requirement are components of clinical education. It is our belief that students extract value and meaning and synthesize content and professional role behaviors from all of these experiences. When these components are considered, total “clinical” time is actually
greater in the new curriculum than the old, even though the resource burden has decreased.

Establishing an Evidence Base Through Outcomes Assessment

The use of evidence to support practice change is expected in the clinical area. The same degree of critical inquiry should apply to nursing curricula. To determine the effectiveness of the Nurse Residency Model, the following outcome indicators have or will be put in place.

- We will continue to gather data related to student satisfaction with the curriculum.
- A faculty satisfaction survey has been suggested as a means of anonymously tapping faculty sentiment. Presently, faculty are encouraged to voice opinions, suggestions, and complaints to members of the Curriculum Committee and other key players. Brown bag lunches and open faculty meetings devoted to curricular development take place as part of ongoing assessment and quality improvement.
- Agency surveys will continue to be conducted regarding satisfaction with students and faculty. Employer surveys will be used to identify degree of satisfaction with the quality of our graduates.
- Program retention rates and NCLEX pass rates will continue to be tracked.

Some faculty have suggested the use of focus groups to gain a more thorough appreciation for students’ experiences in, expectations of, and satisfaction with the Nurse Residency Model. The use of a consultant external to the nursing program was recommended in order to achieve the most accurate representation of the program.

The Ongoing Process of Implementation

Despite much planning and discussion, some glitches have arisen in the implementation of the residency model. Obtaining clinical sites for three days in a row for all clinical specialties, coordinating field experiences, maintaining standards and expectations for pass/fail experience completion, and communicating with agencies about the employability of our students while they are still enrolled in the program (e.g., summer externships) are issues with which we continue to grapple.

By creating the residency model, we have untangled the very important clinical experiences from other theoretical and didactic components, providing a similar number of clinical hours through clinical immersion and field experiences. Disseminating this message to prospective students, agencies, and other schools in the community has proven a challenge. Although one seasoned faculty member was heard to say, “We still teach nursing the same way they taught us 25 years ago,” the residency model offers a new way to teach nursing and an innovative means by which to meet the challenges facing the nursing profession. Rooted in a spirit of collegiality and life-long learning and supporting enhanced socialization, improved transition to practice, and increased student accountability, this curriculum will continue to evolve and respond to change. For today, it offers a new means to educate the nurses of tomorrow.

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Key Words

Baccalaureate Nursing Education – Curriculum Models – Clinical Education – Student Accountability – Transition to Practice

References


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