The effect of nursing staff on student learning in the clinical setting


Abstract

**Aim** To explore baccalaureate nursing students’ perspectives of the influence of nursing staff on their learning and experience in the clinical setting.

**Method** A qualitative description approach was used. Thirty nursing students were interviewed individually or in focus groups. Data were analysed using content analysis. Four researchers analysed the data separately and agreed on the themes.

**Findings** Nursing staff had positive (enabling) and negative (hindering) effects on students’ clinical learning and socialisation to nursing. Nursing staff may encourage and excite students when they behave as positive mentors, facilitators and motivators. However, their actions may also have a negative effect on students, decreasing their confidence, learning and desire to continue in the profession.

**Conclusion** Nursing staff influence student learning. Their actions, attitude and willingness to teach are influential factors. The findings have implications for patient safety, nurse retention and recruitment, and preparing students for professional practice.

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Keywords

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Literature review


Horizontal, or lateral, violence represents negative nurse-to-nurse interactions involving any form of bullying, abuse, harassment or unwanted behaviour that may cause the recipient to feel intimidated, threatened or upset (Brunt 2011). It is a persistent theme in nursing literature (Johnston et al 2009). Vertical violence refers to bullying between levels of hierarchy, such as nursing staff and nursing students (Thomas and Burk 2009).
Decker and Shellenbarger 2012). This may be overt, such as name calling, or covert, for example refusing to work with or ignoring an individual. These forms of violence are prevalent in healthcare settings worldwide and are recognised as a health priority by the World Health Organization, the International Council of Nurses, and Public Services International (Hinchberger 2009). Toxic work environments may have detrimental effects on patients, staff and nursing students (Thomas 2010). Nursing students are vulnerable to experiencing violence (Ferns and Meerabeau 2008). Since nurses are role models for nursing students in the clinical environment, it is essential that they implement a zero tolerance policy (Hinchberger 2009).

Negative experiences with nursing staff in the clinical setting may affect students’ decisions to remain in the profession, or they may adopt such negative behaviours in their future practice (Longo 2007, Registered Nurses’ Association of Ontario 2008). Negative clinical environments may affect learning, professional socialisation, experiencing violence (Ferns and Meerabeau 2008). Since nurses are role models for nursing students in the clinical environment, it is essential that they implement a zero tolerance policy (Hinchberger 2009).

Fewer nursing graduates are interested in continuing to work in nursing, and many nursing staff discourage students from joining the profession (Boychuk Duchschier 2016). Nursing staff can have a profound effect on students’ stress levels, anxiety and sense of belonging; these feelings are perpetuated as new graduates enter the workforce (Mahat 1998, Levett-Jones et al 2007, Levett-Jones and Lathlean 2009, Moscaritolo 2009, Thomas and Burk 2009).

Student engagement in the clinical setting is crucial for education; a concept developed by theorists Jean Lave and Etienne Wenger who suggested that learning is embedded in activity, interaction and engagement in a community (Smith 2003). New learners should be accepted into the culture, and transition from observers to participants to acquire knowledge. These communities of practice rely on relationships between members (Smith 2003). Positive relationships with nursing staff, along with acceptance and engagement in the nursing culture are essential for effective student learning.

It is vital to understand how best to support and prepare baccalaureate (BSc or BA) students for professional practice, given nursing shortages.

Cultural context
This study was based at a Canadian university, and data were collected between September 2011 and February 2012. A cluster model for clinical education is used in years two and three as students enter the clinical setting in groups of eight, accompanied by clinical instructors. Instructors are licensed registered nurses hired and paid for by the university to instruct students in the clinical setting. The instructor is responsible for all students, allocating each a patient assignment for the clinical day. The student provides nursing care based on their educational level. Students depend on other nursing staff for guidance, because of the logistical difficulties of one clinical instructor supervising and facilitating learning for eight students simultaneously (Croxon and Maginnis 2009).

Nursing staff are responsible for patients and are expected to collaborate with the students, based on their skill and knowledge level. These nurses are not evaluated by students or university faculty staff, nor do they evaluate the students, but they may provide performance feedback. University faculty staff include clinical instructors and university employees who co-ordinate clinical placement agreements. In the cluster model, student evaluation is conducted by the clinical instructor.

Clinical instructors do not have a preceptor role for second and third-year students where clinical education is provided via the cluster model. In contrast, a preceptor model for clinical education is used in the fourth year, where each student works alongside the same assigned preceptor.

Aim
The aim was to explore baccalaureate nursing students’ perspectives of the influence of nursing staff on their learning and experience in the clinical setting, with a view to understanding how nursing staff affect students’ experience, learning and socialisation to nursing.

Method
A qualitative description approach was used, letting participants provide a summary of an event or experience in everyday, personal terms (Sandelowski 2000, 2010). Qualitative description was considered most appropriate to answer questions such as ‘What are students’ experiences with nursing staff?’ and ‘How do students perceive nursing staff have affected their clinical learning?’

Research setting and participant recruitment
All participants were registered at one university in Canada in the Bachelor of Science in Nursing (BScN) programme, and had clinical experiences that used the cluster model. Recruitment for the study sample took place on campus. Study information was shared during third and fourth-year nursing programme orientations (induction sessions) in September 2011, and advertised on the nursing programme website. Interested students were able to seek
Further information and to register online for focus group or individual interviews. Researcher contact information was provided, and voluntary informed consent obtained from all participants. The research team comprised two faculty staff experienced in qualitative and educational research, one newly graduated nurse and two senior BScN students.

**Sampling**

Purposive sampling is the preferred approach for qualitative research to ensure an information-rich group of participants who share experience of the phenomenon of interest (Patton 2002). Maximum variation sampling and criterion sampling were also used (Patton 2002). Maximum variation sampling allowed researchers to recruit a range of participants; varied ages, backgrounds, clinical specialties and hospitals. Criterion sampling required all participants to be registered BScN university students, and to have completed at least one clinical placement using the cluster model.

Three focus groups and individual interviews were held on campus engaging 30 participants (Table 1), all from the purposeful sample of 500 BScN students in their third or fourth year.

**Data collection**

Focus groups and individual interviews were audiotaped. All participants took part in individual interviews or in-depth focus groups, using open-ended questions in a semi-structured reflexive format. Interviews were conducted by three student research partners; two being fourth-year BScN students and one a newly-graduated nurse. Two faculty staff with experience in qualitative research mentored the process and trained the partners to conduct focus groups, interviews and data analysis. Using students to facilitate the focus groups and interviews reduced the potential for imbalanced power relationships during data collection, enabling candid, honest sharing of experiences, resulting in rich data.

**Data analysis**

Three research team members transcribed data verbatim, with transcripts reviewed with original audiotapes for accuracy. Data were analysed using qualitative content analysis. Concurrent data collection and analysis took place. Codes were identified, systematically clustered, continuously organised and reduced into a smaller number of codes and categories representative of the original data. This resulted in a descriptive, interpretive summary of the data with answers to the research questions (Sandelowski 2000, 2010).

Numbers were used instead of names during transcription. Transcripts were read and re-read to gain a sense of the complete student experience. Prevalent themes, codes and categories were identified and organised broadly under positive (enabling) and negative (hindering) experiences. Data were clustered and reclustered into broader, more encompassing categories. Four research team members discussed the analysis and collaborated to reach a mutual agreement on the final categories and representative participant quotations.

**Ethical considerations**

Research ethics board approval was granted from three university-specific committees. Voluntary informed consent was obtained before conducting the focus groups and interviews. Participants were given a detailed explanation of their ability to withdraw from the study at any time, and of confidentiality rules. No names or identifiers were used. Study documents and recordings were kept in a locked office.

**Rigour**

Several strategies were included in the research process to augment rigour (Shenton 2004). Triangulation of data was accomplished by use of focus groups and interviews engaging a wide range of participants. Information was confirmed at the end of each focus group or interview to clarify

| TABLE 1 |
|-----------------|-----------------|
| **Participant demographics (n=30)** | **Number of participants (%)** |
| **Gender** | **** |
| Male | 3 (10) |
| Female | 27 (90) |
| **Age (years)** | **** |
| 18-20 | 8 (27) |
| 21-25 | 13 (43) |
| 26-30 | 4 (13) |
| > 30 | 5 (17) |
| **Marital status** | **** |
| Single | 23 (77) |
| Married | 2 (7) |
| Separated | 1 (3) |
| Divorced | 0 (0) |
| Common law | 2 (7) |
| Prefer not to say | 2 (7) |
| **Current level in BScN programme** | **** |
| Third year (level 3) | 23 (77) |
| Fourth year (level 4) | 7 (23) |
| **Previous healthcare experience** | **** |
| Previous experience | 11 (37) |
| No experience | 12 (40) |
| No response | 7 (23) |
accuracy. Student researchers collaborated regularly with faculty advisers who were experienced qualitative researchers. The research was also scrutinised by peers at national and international nursing conferences. Transferability was enhanced through sharing and recording in-depth information on the context and research process. Dependability was supported by describing each stage of the process to allow other researchers to conduct similar studies. Reflexivity was used to improve confirmability. Furthermore, four researchers (faculty and student researchers) reviewed data individually, discussing and collaborating to ensure findings represented participant experiences (Shenton 2004).

Findings

Nursing staff had an influence on student participants in their clinical practice. Their actions, attitude and willingness to teach has positive and negative effects on nursing students’ learning and socialisation to nursing. Some nursing staff hindered nursing student learning and confidence. However, others enabled student learning and created an environment of support and encouragement. The students’ experiences identified in the data analysis are summarised in Box 1.

Nursing staff hindering nursing students in their development

Participants explained that nursing staff often made them feel unwanted, undervalued, unsupported and bullied. Participants described how they felt in these negative clinical learning environments, and how the nursing staff behaved towards them (Box 1).

Feeling unwanted, unsupported and ‘in the way’

Many students felt unwanted in the clinical setting, annoyed staff and burdened them with additional work. Some heard staff state that they did not want to teach students. Many described feeling nervous and intimidated, and observed that it limited their learning and confidence:

‘I’ll be nervous to ask for help because sometimes they act like they’re so busy and I feel like I am just an extra job for them, like an extra burden... I don’t want to ask them [a question] because I don’t want them to be annoyed by me’ (Participant 13).

Many participants described difficulty obtaining assistance and that they did not receive encouragement or sufficient mentoring. They described some nursing staff as unavailable, causing students to feel overwhelmed and alone:

‘I was paired up with a nurse who does not like being with students and I did feel as though there was some distance between us for the entire day. I felt like, because of that distance, I wasn’t learning anything’ (Participant 1).

Participants perceived that nursing staff behaviour was symptomatic of organisational issues affecting nursing staff:

‘There is nursing burnout, there is job dissatisfaction, it’s “you’re giving me another thing... to do during this day and that is teaching another student”... there are a lot of issues around fatigue in the workplace... they’re just frustrated I think’ (Participant 6).

Feeling mistrusted and undervalued

Several participants felt that nursing staff did not trust their clinical competency. They were not delegated

<table>
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<th>BOX 1</th>
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<td>Summary of nursing students’ experiences of nursing staff in clinical settings</td>
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<th>Hindering experiences</th>
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<td>Feeling mistrusted and undervalued.</td>
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<td>Feeling bullied and treated unprofessionally.</td>
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<td>Students’ responses to hindering experiences</td>
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<tr>
<td>Decreased confidence in nursing abilities and nursing as a career choice.</td>
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<td>Feeling fearful.</td>
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<tr>
<td>Reluctance to ask questions or seek assistance.</td>
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<td>Missing desired and valuable learning opportunities.</td>
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<td>Feeling unprepared for next steps.</td>
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<td>Considering abandoning their nursing career.</td>
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<td>Concerned that they will follow role model and become ‘one of those mean nurses’.</td>
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<tr>
<td>Motivated to never become ‘a nurse like her’.</td>
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<td>Deciding to never apply to work in a clinical setting where students have hindering experiences with nursing staff.</td>
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<th>Enabling experiences</th>
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<td>Being able to engage in learning opportunities.</td>
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<td>Feeling supported, respected and trusted.</td>
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<td>Experiencing patient and non-judgemental support.</td>
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<td>Students’ responses to enabling experiences</td>
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<tr>
<td>Increased confidence in nursing abilities and nursing as a career choice.</td>
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<tr>
<td>Feeling comfortable asking questions.</td>
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<td>Feeling comfortable seeking assistance.</td>
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<tr>
<td>Improved learning – engaging in desired and valuable learning opportunities.</td>
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<tr>
<td>Motivated, excited and prepared to continue nursing education and join the profession.</td>
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<tr>
<td>Wanting to work in a clinical setting where students have enabling experiences with nursing staff.</td>
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the appropriate tasks to challenge and broaden their learning:

‘She did not want me to touch anything... she was probably concerned about how it would be on her if something [bad] happened... It just made me feel really stupid because you have to prepare for [the clinical shift] ... and then you don’t even get to do anything’ (Participant 8).

Feeling bullied and treated unprofessionally
Experiences of being yelled at, belittled and bullied by nursing staff were frequently shared:

‘[The environment] becomes claustrophobic for me, you feel like you’re trapped... you’re almost scared to go out of the [patient’s] room because... when you’re in with the patient, [the nurses] have to be nice. They have to be nice when they’re in there. As soon as you leave the room, it’s over’ (Participant 3).

‘There’s always a part of you that’s nervous... am I going to have a good nurse today or am I going to have a bad nurse? Is this nurse going to pick on me or not pick on me?’ (Participant 12).

Students’ responses to hindering experiences by nursing staff
Participants perceived that nursing staff can and do hinder nursing students in their personal and professional development. Participants explained that nursing staff could decrease students’ confidence, create anxiety, block desired learning and even discourage them from continuing in the nursing profession. Students did not feel comfortable or safe asking these nurses for assistance.

Students also spoke of missing valuable learning opportunities:

‘I wasn’t gaining the knowledge that I could get with a nurse who was willing to show me things and make me participate’ (Participant 3).

Some described a desire to abandon their nursing career in response to negative experiences with nursing staff:

‘I’m afraid, and now I feel too scared and intimidated to work in the nursing field’ (Participant 13).

Others feared that negative behaviours could be adopted and incorporated into their own practice:

‘And then you become one of those nurses who is mean to students later on’ (Participant 2).

Some felt nervous and lacked confidence to return to clinical areas or repeat clinical skills where they had a bad experience:

‘If you get negative reinforcement when you’re trying to learn a new skill, it makes you more afraid to do it... if you’ve been almost chastised and looked down upon, and you’ve lost your confidence in something... it doesn’t allow you to grow and to positively learn from the experience. The nurses have... a big role to play because your [faculty] tutor cannot be there all the time’ (Participant 15).

Other students described using negative experiences as motivation for self-improvement, or to strive to behave differently from the nurse in their example:

‘It has definitely let me know what I don’t want to be as a nurse when I go into the hospital. I can say distinctly that I do not want to be like her’ (Participant 24).

Participants asserted that after graduating they would not want to work in the areas where they had encountered negative experiences with nursing staff:

‘There are some units that I would never want to work in, [that I] will never apply to because of the staff’ (Participant 17).

Nursing staff enabling nursing students in their development
Nursing staff also functioned as positive mentors and motivators for students. These nurses engaged students in learning opportunities, were patient and non-judgemental, offered constructive feedback, and made students feel supported and valued. This promoted their comfort and confidence in clinical roles (Box 1).

Being able to engage in learning opportunities
Learning experiences were enabled where students were delegated appropriate tasks for their skill level, received supervision and instruction, or were invited to observe an unfamiliar procedure. They appreciated engaging in a variety of experiences, as well as gaining practice competence:

‘The nurses were absolutely phenomenal. They would get you for whatever was going on, as long as it was appropriate for you to be there... and they were great at saying: “Come to team
Acknowledged strengths and identified areas requiring further skill. A student explained:

“She gave me a lot of positive reinforcement... I learned a lot” (Participant 15).

Students’ responses to enabling experiences with nursing staff

Students felt encouraged and excited to join the healthcare team when they had positive experiences working with nursing staff:

“I would not still be in this programme if I hadn’t had good experiences” (Participant 1).

They were more confident in their nursing skills and career choice since they were learning what they needed to develop as professional nurses:

“I felt confident in what I was able to do, and I felt comfortable asking questions” (Participant 8).

This motivated them to continue their education and join the profession. They expressed a desire to work in the clinical practice areas where they had positive experiences with nursing staff:

“The staff worked as a team, it had a positive energy. I would love to be able to work there after I graduate” (Participant 6).

Limitations

This research incorporated the views of 30 nursing students enrolled at one university with clinical placements in one large geographical region. Additional research using a larger sample size at multiple universities would be advantageous to augment transferability of the findings.

Although 30 participants is considered a fairly large sample size, the students in this study represented almost 500 third and fourth-year students in the total student population. It is possible that students who were exposed to extreme clinical experiences were more likely to share their stories through focus groups and interview participation. In addition, students who experienced negative influences on clinical learning from nursing staff may have been more likely to share experiences than those who had positive experiences.

This study focused on student perspectives, and does not provide insight into nursing staff perspectives. In some situations, such as missed learning opportunities, it is possible the nurse may have deemed the student unsafe or unfit to perform the tasks. In these cases, the nurse’s actions may
have ensured patient safety and safe student learning rather than hindering learning.

Further research is required to explore the perceptions of nursing staff of their role in student learning in the clinical setting. For example, an exploration of the contextual factors of environments that optimally support student clinical learning and those that do not could contribute important insights. Ongoing conversations between nursing staff in clinical practice and staff in university education about the experiences of nursing students and nursing staff in clinical practice are required to create change. Collaboration between nursing staff, nurse managers, nurse educators and students is necessary to develop effective strategies to enable student learning in clinical settings. These strategies should then be articulated, trialled, evaluated and shared.

Two members of the research team were BScN students at the time of data collection, enrolled at the study university. This reduced potential researcher-participant power imbalances during data collection. However, it is possible some bias may have occurred while gathering data from fellow students. The student researchers collaborated with experienced faculty research team members and adhered closely to the rigour strategies described to ensure accurate results were obtained.

**Discussion**

The supervision and instruction of nursing students and the effects of nursing staff on student learning have implications for patient safety, patient experience, patient satisfaction and quality of care. Effective instruction has implications for recruitment and retention, nursing policy and nursing education. Patient safety may be compromised when nursing students are uncomfortable asking for guidance, lack confidence, or receive insufficient supervision from nursing staff.

The goal of nursing education is to create safe and competent nurses who provide excellent patient care (Chuan and Barnett 2012). With positive, supportive role models, students described providing safe, efficient care and a desire to continue doing so throughout their nursing careers. An understanding of how to recruit and retain nurses is essential, given nurse shortages and the costs of recruitment and retention.

More emphasis is required on providing clinical environments to enable student learning and on supporting nursing staff to enable students to learn since students are more inclined to apply to work in areas they have encountered positive enabling experiences. They may abandon nursing careers as a result of negative clinical experiences.

It is also essential to understand the degree of vertical non-physical violence that occurs between nurses and nursing students and the policies that have been implemented to prevent this. The Registered Nurses’ Association of Ontario (2008) created a position statement on zero tolerance for such violence. It is imperative to understand how to enforce this for people’s safety and to improve nurse retention and recruitment.

The nursing profession is undermined when staff are not held accountable for failing to contribute to student clinical learning. It is important to understand the reasons for perceived behaviours that hinder learning, the assistance required to optimally support and mentor students, and the best ways to uphold accountability. Exploration of team dynamics and the support available in the enabling clinical learning environments that students described in our research may offer insight and improve cultures that hinder learning. Decker and Shellenbarger (2012) recommend implementing anonymous student surveys to evaluate nursing staff and the clinical environment.

It is essential to recognise difficulties nurses may encounter when instructing students. In particular, it is important to know how nurses are prepared, supported, encouraged or rewarded to work with students; the role of the university in preparing nursing staff for their role with students, and the role of the organisation.

It may be beneficial to explore incentives or professional development opportunities that assist nurses to become more supportive of student learning. It is necessary for all students to engage in a self-directed learning process. Therefore, provision of an excellent nursing education is a collaborative effort. Melincavage (2011) recommends extensive student preparation before they enter the clinical environment, to give them the skills to solve common issues. While clinical education is the responsibility of nursing staff and students, faculty staff are the ‘teacher, guide, and supervisor’, responsible for preparing students for clinical education and ‘delivering safe patient care’ (Langan 2003). Open communication between students, nursing and faculty staff is essential for an effective learning environment (Decker and Shellenbarger 2012).

**Conclusion**

Nursing staff behaviour, attitude, and willingness to teach have an important influence. This research provides insight into nursing student perspectives, and ways nurses can create positive clinical learning environments to attain the highest level of professional preparation. It emphasises possible reasons for students abandoning their careers,
and ways nurses can provide support to avoid this and improve nurse recruitment and retention.

If students do not feel wanted, trusted, respected or supported, or feel bullied, intimidated or treated unprofessionally, the workplace culture causes them to lose confidence. This hinders growth, resulting in inadequate preparation for professional nursing practice. Some considered abandoning their nursing careers.

In other settings, nursing staff motivated students, encouraged them and increased their confidence. Students were inspired. Nurses who were patient and willing to teach, enabled students to feel comfortable asking questions and address their learning requirements. Confidence increased in settings where they felt supported, respected, trusted and part of the team. This reinforced their eagerness to learn and grow to become professional nurses prepared for the challenges of nursing practice. It is imperative that faculty, students and nursing staff work together and support each other to optimally prepare future nurses.

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