

Undergraduate Nursing Student Perceptions of Developing Confidence
Through Clinical Learning Experiences

by

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Abstract

The clinical learning environment (CLE) provides students with an opportunity to build confidence and competence in the provision of patient care (Benner, 2010). The aim of this qualitative descriptive research was to explore and describe student perceptions of developing confidence through their clinical learning experiences, discovering what features of the CLE support their learning and the development of confidence. Ten students were recruited through purposive sampling and participated in one-on-one semi-structured interviews. Self-efficacy theory (Bandura, 1997) was used as a theoretical framework to guide this research and for the interpretation of the content analysis. The analysis revealed five socio-structural themes that support student learning and development of confidence. These findings elaborate Bandura's (1997) theory. The most influential, through verbal persuasion was the clinical nursing instructor (CNI) followed by self, the buddy nurse, peers, and the staff/unit environment. Students perceived their development of confidence through a bi-directional interaction between their cognitive/affective processes, behaviour and the CLE. Understanding student perceptions of their confidence development, signals the need for informed pedagogical strategies to support student learning and development of confidence.

Dedication

In memory of my loving mom

Patricia Romas

September 28, 1947 – October 9, 2015

She gave me life,

She gave me love,

And she gave me the courage to move forward.

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This rich academic journey has touched me professionally and personally. I look forward to taking what I have learned through this experience into my future endeavors. I truly appreciate and value the many individuals who supported and encouraged me throughout this journey. A very special thanks to my thesis advisor Dr. Marlene Atleo, to my committee members, Dr. Richard Hechter (internal) and Dr. Wanda Chernomas (external) for attending to the details of my thesis work.

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Each and every one of you have touched me deeply,

An experience I will cherish for many years to come.

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Definition of Terms

Clinical learning environment (CLE) refers to a clinical practice setting that the student is engaged in situated learning through a real life experience of providing direct patient care, encompassing the nursing student, patient, health care team, peers, families, and the instructor (Gaberson & Oermann, 2010; Papp, Markkanen, & von Bonsdorff, 2003).

Clinical nursing instructor (CNI) refers to a nurse who works for a nursing educational institution that mentors and facilitates student learning in a practical setting to ensure that students have the knowledge, skill and attitude necessary for entry-level practice. Also known as, the clinical teacher, and/or the clinical education facilitator.

Confidence refers to “a feeling. . . .of one’s powers in her [his] ability to succeed” (Merriam-Webster’s Collegiate Dictionary, 2007, p. 261).

Culture “refers to patterns of learned values, beliefs, and behaviours that are shared from generation to generation within a group” (Jeffreys, 2012, p. 57).

Cultural congruence “refers to the degree of fit between the student’s values and beliefs and the values and beliefs of [his/her] surrounding environment” (Jeffreys, 2012, p. 57).

Entry-level nurse refers to “a registered nurse who has graduated from a basic nursing education program and is registering on the practicing register for the first time” (College of Registered Nurses of Manitoba, 2007, p. 1).

Human capital refers to an individual’s resources, such as knowledge, skill, and specific qualities (Fenwick, Nesbit, & Spencer, 2006).

Knowledge-based society refers to an individual’s knowledge and skill gained through a formal education that results in employment and contributes to society’s economy (Fenwick et al., 2006).

Nursing program within this context is considered an undergraduate baccalaureate-nursing degree.

Self-confidence refers to “a feeling of trust in one’s abilities, qualities, and judgement” (Oxford Online Dictionary, 2014, para 1).

Self-efficacy is “beliefs in one’s capabilities to organize and execute the course of action required to produce given attainments” (Bandura, 1997, p. 3).

Situated learning refers to “a change in mental models that happens through social interaction in a given context” (Goel, Johnson, Junglas, & Ives, 2010, p. 218).

Student refers to an individual in an undergraduate nursing program, unless otherwise stated.

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Chapter One: Introduction

Chapter one includes some background knowledge associated with the interrelatedness of student retention issues, student self-efficacy, and success in nursing education, as well as a contextual representation of the 21st century CLE. Additionally, the purpose of this research study, the research questions, and the significance of this research within the milieu of nursing education are expressed. The researcher's assumptions and beliefs about adult learning, specifically about learning in the CLE are articulated to gain an understanding of how the researcher is positioned. Finally, a brief preamble of Bandura's theoretical framework of self-efficacy theory guiding this research concludes chapter one, followed by a chapter summary.

Background

Human capital in the professions is a societal mandate of postsecondary education. This societal demand has had a dual effect on higher education. First, there is a significant increase in participation rates, especially with reference to baccalaureate programs, often related to a high demand for equal access, valuing a diverse student population in mainstream education. Secondly, there is an investment in postsecondary accelerated programs with a vision of being economically competitive internationally (Clark, Morgan, Skolnik, & Trick, 2009; Fenwick et al., 2006). This pivotal movement towards a knowledge-based society has definitely emerged into the realm of nursing education. With an existing and future nursing shortage looming in the Canadian health care system (Canadian Federation of Nurses Unions [CFNU], 2012), nursing programs across the country are dedicating time and resources into recruitment, retention, and completion strategies (Shelton, 2012).

The Nursing Sector Study in 2005 suggests that Canada would need to graduate about 12,000 registered nurses per year, in order to meet the growing demand of nurses required to address the potential nursing shortage in the near future. Increasing enrolment is one strategy to improve graduation numbers among students (CFNU, 2012). All the same, according to Shelton (2012), student retention strategies can create a more holistic approach to improving success rates. Student perseverance within a nursing program is of a dynamic nature, influenced by his/her background, external supports, or internal psychological processes. The clinical nursing instructors (CNI) cannot change a student's background but s/he can have some influence on a student's external supports and internal psychological processes (Shelton, 2012).

A student's internal psychological processes consist of his/her goals, values, beliefs, and self-efficacy. The student has developed these processes, set of learned values and beliefs about learning and education, over many years, through the influence of his/her environment (Shelton, 2012). Research suggests that student self-efficacy – a student's level of confidence in his/her nursing practice – engenders not only the student's level of persistence but also his/her motivation, academic performance, and success (Jeffreys, 2012). Further to this, a student's level of confidence in his/her nursing practice has an impact on his/her ability to acquire new knowledge to progress through the learning process, and to be successful at new skills (Chesser-Smyth, 2005; Lundberg, 2008). Researchers purport that types of clinical learning experiences are significant in generating and sustaining nurses (Pearcey & Elliot, 2004), and a nurse's confidence in his/her practical work environment has an effect on job fulfilment and retention (Meretoja, Leino-Kilpi, & Kaira, 2004), as well as patient outcomes (Foxman, 2004).

Students spend a significant amount of time learning in the clinical setting. This fundamental and practical component in nursing education provides students with an opportunity

to cultivate their confidence in a variety of skills – critical reasoning, psychomotor, relational, and organizational (Grealish & Carroll, 1998). A student's confidence in his/her skills influences a student's motivation to learn and ability to recognize that these skills are important aspects of performing a specific task, as well as providing good patient care. Additionally, a student's amount of effort, persistence, resilience, and ability to endure stress, often relates to a student's belief in his/her capability (Bandura, 1997). Despite the fact that students are eager to engage in clinical practice, these feelings of excitement are often occupied with feelings of anxiety, intimidation, and stress (Chernomas & Shapiro, 2013; Melincavage, 2011; Papastavrou et al., 2010).

The Clinical Learning Environment (CLE)

The intent of the CLE is to provide students with practical experiences of working with real patients, to give students an opportunity to develop their confidence and competence in nursing care. Over the years, there has been some documentation in the nursing literature as to what constitutes a CLE, which can assist stakeholders in understanding the various types of clinical learning experiences students may encounter. Stakeholders included individuals that interact with students through their learning process and have a vested interest in the student's success, such as nursing faculty involved with curriculum development or design, as well as staff in healthcare facilities working with students in clinical practice, clinical nursing instructors, unit managers and clinical course leaders. As these stakeholders understand students, they will be able to move forward to better serve students to improve their academic outcomes and influence patient care in a positive manner. The CLE is considered to be “the attributes of the clinical work setting which nurses perceive to influence their professional development” (Hart & Rotem, 1995, p. 3). It is “an interactive network of forces within the clinical setting [that] influence the

students' clinical learning outcomes" (Dunn & Burnett, 1995, p. 1167), allowing students to move between the context of theory, practical skills, and relational care. Both of these definitions recognize the *influential* capability that the CLE has upon a student's learning experience.

Unfortunately, the CLE is not always of a positive influence. Negative experiences within this practical setting exist and affect student confidence, influence student retention rates, and affect new nurse attrition rates (Algoos & Peters, 2012). Confidence in the CLE is not just about feeling confident in performing specific skills, but also feeling confident in providing overall holistic care for patients (Doane & Varcoe, 2005).

Historically, the traditional approach in nursing education was a hospital-based diploma nursing program in which student learning within the CLE consisted of performing specific delegated tasks or skills; however, these students had limited opportunity to gain confidence in the clinical reasoning or judgement component of patient care (Henderson, Cooke, Creedy, & Walker, 2012). Over time, the emphasis of learning within the clinical environment began to change its focus from a hospital-based approach, focusing primarily on performing specific skills, to a university-based baccalaureate degree program that encompassed a more knowledge-based approach, in order to prepare students for entry-level practice (Foxman, 2004). This reform to a knowledge-based approach, valuing evidence-informed practice, recognized the importance of the student's ability to critically reason, rather than just focusing on his/her ability to perform a task – a necessary entity for students to function in a more complex CLE, than in the past (Benner et al., 2010; Foxman, 2004).

The reform to a knowledge-based approach is necessary for students to feel confident in caring for patients into the 21st century (Foxman, 2004). Currently, nurses have more responsibility compared to the past, because patients are living longer with assorted chronic

illnesses and patients often have an elevated acuity level (Benner et al., 2010). Further to this, patient care often accompanies “diverse technological interventions [that require]. . . a high degree of skill and knowledge” (Benner et al., 2010, p. 21). Students, in a high stakes CLE, need to acquire an optimal level of confidence and competence in their ability to care for these complex patients, from *knowing* the information to *performing* the skills safely (Benner et al., 2010; Nolan, 1998). Moreover, students need to be confident in their clinical decision-making as they care for complex patients (Gillespie & Peterson, 2009; Kitson-Reynolds, 2009). This challenging environment has definitely changed the scope of nursing practice, influencing entry-level competencies within nursing standards (Foxman, 2004).

Nursing programs are competency-based driven to ensure students provide safe, competent, and ethical care in a variety of clinical settings; additionally, these competencies guide curriculum development and the formation of clinical evaluation tools (CRNM, 2007). Competencies represent specialized knowledge, skill, and attitude within a particular domain of practice, but there is value in exploring the function of students’ thoughts, beliefs, and values about their ability to fulfill these competencies and be successful within a nursing program (van Dinther, Dochy, & Segers, 2011). “Competence requires appropriate learning experiences; it does not emerge spontaneously. Hence, [individuals] develop different patterns of competencies and deploy them selectively depending on the match of efficacy beliefs to environmental demands and on anticipated outcomes” (Bandura, 1997, p. 15). Often, “there is an assumption [within nursing education that students’] . . . self-confidence [(self-efficacy)] develops independently and spontaneously” over time (Chesser-Smyth & Long, 2013, p. 145).

There are various types of CLEs – hospital facilities, community agencies, or long-term care facilities that demand competence of different skills and knowledge. Some students can

excel in one CLE, but may require more assistance to feel confident and competent in another differently structured and organized CLE. Regardless, nursing programs need to prepare students for the demands of the current health care system (Leigh, 2008). Further discussion in chapter two will address the uniqueness of a variety of CLE and provide an additional layer of context related to learning experiences and student challenges within this environment.

Purpose of the Research

The aim of this qualitative descriptive research is to explore and describe nursing student perceptions of developing confidence through clinical learning experiences, as well as discover what features of the CLE support learning and the development of confidence.

Being a CNI and clinical course leader in nursing education for many years, I have experienced firsthand the concerns related to student confidence from performing nursing technical skills, to critical thinking, decision-making, communicating with patients, and collaborating with the multidisciplinary team. This experience has provided me with the ambition to extend my nursing practice by learning about and using a qualitative research method to understand how clinical learning experiences influence a student's development of confidence in his/her nursing practice, and to recognize what features of the CLE support learning and the development of confidence.

Research Questions

- 1) How do students perceive developing confidence through their clinical learning experiences?
- 2) What features of the CLE support learning and the development of confidence?

The aforementioned research questions are influenced by several components, such as the researcher's experience as a clinical course leader and CNI; the goal of the research; how the

research will inform nursing education; the limited research on student confidence in the CLE; Bandura's theory of self-efficacy, learning, and success, and the research contribution of Lofmark and Wikbald (2001) and Townsend (2012).

Lofmark and Wikbald (2001) link student confidence in the CLE to the amount of responsibility and independence the student had on the unit, as well as the opportunity to practice a variety of skills and receive constructive feedback. Townsend (2012) claims that the level of confidence and learning that students experienced in the clinical environment were primarily influenced by the CNI's approach, particularly through verbal persuasion. This finding is contradictory to Bandura's (1997) premise, that mastery of experience is the most influential information source for a student's confidence in their capability.

Significance of the Research

This research makes a contribution to the limited body of knowledge related to understanding student perceptions of developing confidence through clinical learning experiences. This research provides nursing education with important insights into understanding a student's development of confidence and learning in the CLE. Understanding the features of the CLE that influence student confidence and learning contributes to a knowledge base of confidence-building pedagogical teaching strategies for those working with students in the CLE, especially CNIs. Ultimately, cultivating a student's confidence offers him/her the best possible opportunity to be successful (Bandura, 1997).

Much of the research related to student perceptions of their clinical learning experiences has been primarily of a quantitative nature, with the focus on general clinical experience (Skaalvik, Normann, & Henriksen, 2011; Warne et al., 2010), supports (Gidman, McIntosh, Melling, & Smith, 2011), skill development (Stayt & Merriman, 2013), and supervision

(Lofmark, Thorkildsen, Raholm, & Natvig, 2012; Saarikoski & Leino-Kilpi, 2002; Skaalvik et al., 2011; Warne et al., 2010). In much of this research, students refer to the positive and negative aspects of the CLE with some psychosocial undertones, and students perceive this learning environment as significant in acquiring the knowledge, skill, and attitude necessary to function as a competent nurse.

In addition to the aforementioned research, Chan (2001) developed a CLE Inventory that measured students' perceptions of various psychosocial characteristics of their actual CLE and preferred CLE with a vision of creating the most effective clinical learning environment (Bernsten & Bjork, 2010; Chan & Ip, 2007; Henderson, Twentyman, Heel, & Lyoyd, 2006; Ip & Chan, 2005; Midgely, 2006; Papathanasiou, Tsaras, & Sarafis, 2014; Perli & Brugnolli, 2009; Smedley & Morey, 2010). The majority of the research that utilized Chan's instrument occurred in Italy, Norway, Australia, Hong Kong, England, and Greece. Interestingly, a variety of common themes were noted among these various studies. Some of this research demonstrated a gap between student perceptions of what experiences they were having in the CLE, and what experiences they preferred to have in the CLE (Chan & Ip, 2007; Ip & Chan, 2005; Midgely, 2006). Importantly, the context in which these studies took place varied; however, students had similar perceptions. Further to this, in many of the studies, personalization was perceived by students to be the most meaningful and prominent feature of CLE for learning (Bernsten & Bjork, 2010; Chan & Ip, 2007; Ip & Chan, 2005; Midgely, 2006; Papathanasiou et al., 2014; Perli & Brugnolli, 2009; Smedley & Morey, 2010). Personalization was the "emphasis on opportunities for individual students to interact with clinical teacher/clinician and on concern for student's personal welfare" (Chan, 2001, p. 629).

Deepening our knowledge about the CLE, qualitative researchers began to explore “the stories [through student perceptions] behind the numbers” (Mayan, 2009, p. 10); including, students experience of their first clinical rotation (Jonsen, Melender, & Hilli, 2013), the clinical instructor’s role (Lambert & Glacken, 2006), clinical supervision (Sundler et al., 2013), students general clinical experience (Papp, Markkananen, & von Bonsdorf, 2003; Pearcey & Elliott, 2004), students lived clinical experience (Chessner-Smyth, 2005; Nabolsi, Zumot, Wardam, FaAthieh, & Abu-moghli, 2012), students clinical challenges (Killiam & Heerschap, 2013), students support (Gidman et al., 2011) and facilitating and obstructing features of the CLE (Lofmark & Wikblad, 2001). These qualitative research findings elicit knowledge related to the positive and negative aspects of the CLE influencing students learning.

Some of the aforementioned research (Gidman et al., 2011; Jonsen et al., 2012; Lofmark & Wikblad, 2001; Nabolsi et al., 2012) referred to the development of student confidence, but the depiction of confidence within these studies lacked the kind of depth needed to gain insight for pedagogical strategies that can support student learning and the development of confidence in the context of the CLE. This in part, because the research questions and data collection tools driving the research were not specifically intended to elicit a comprehensive focus on student perceptions of developing confidence through clinical learning experiences. Nonetheless, the influence of the student’s clinical learning experience upon his/her development of confidence surfaced in the following research through an assortment of experiences from the culture of the clinical environment (Gidman et al., 2011), the type of independence felt by the student (Nabolsi et al., 2012), and the student’s opportunity to be involved in patient care to master skills (Chessner-Smyth, 2005; Lofmark & Wikblad, 2001).

Although research related to student perceptions of developing confidence in his/her nursing practice through clinical learning experiences is limited within the literature, the recent research completed by Rowbotham and Owen (2015), Chesser-Smyth and Long (2013), Townsend's (2012) and Kukulu, Korukcu, Ozdemir, Bezci, and Calik (2012) have explored student confidence within clinical practice through a range of different approaches identifying a variety of features of the CLE that hinder or enhance student learning and confidence.

Rowbotham and Owen (2015) explored the effects of the CNI on student self-efficacy through a descriptive study, examining the relationship between perceived instructor effectiveness and student self-efficacy. There was a statistically significant difference between students with high and low self-efficacy. In other words, students with high self-efficacy received an evaluation from their CNI that influenced their self-efficacy in a positive manner. These CNIs identified "strengths and weaknesses, observed frequently, communicated expectations, and corrected without belittling" (p. 565). The evaluative feedback that these students received influence their belief about their ability to perform and be successful. Evaluation is pivotal in the student learning process, so they are able grow into confident and competent nurses (Rowbotham & Owen, 2015).

Chessier-Smyth and Long (2013) mixed methods study of Irish nursing students in their first year of an undergraduate nursing program explored the development of student confidence and found that the aspects of clinical learning experiences that enhanced student confidence consisted of opportunities for the student to take responsibility for patient care, the familiarity of the CLE, being a part of the team, recognition for their performance, and feedback. In addition, as the student developed confidence in his/her practice, the student's motivation towards academic achievement improved.

Townsend's (2012) qualitative research focused on aspects of clinical learning that effect student confidence, from a student perspective, and found that the approach of the CNI was the most significant influence upon student confidence. Verbal persuasion was a strong source of self-efficacy development and for student learning. Students expressed that when they felt supported, and were given encouragement and constructive feedback, their confidence grew through those experiences.

Kukulu et al. (2012) explored self-confidence, gender, and academic achievement of undergraduate nursing students through the collection of data using a Self-confidence Scale questionnaire. The findings indicate that females had lower self-confidence than their male counterpart, probably due to the context of the patriarchal society structure in Turkey. There was no difference in student self-confidence related to student position in the nursing program, that being first or last year of the program. However, academic achievement was higher for students with high self-confidence.

The findings of this thesis research provide further insights related to learning and student confidence in the CLE, which appends to the limited existing body of knowledge and extends the aforementioned research beyond what students prefer, how students describe the actual CLE, and the negative or positive aspects of the CLE (Streubert & Carpenter, 2011). This qualitative descriptive research offers "rich narrative descriptions of phenomena that [will] enhance [the] understanding" of student perceptions of developing confidence through their clinical learning experiences (McMillian, 2012, p. 18). Providing students with an opportunity to share their viewpoint about how they perceive various clinical learning experiences in relation to developing confidence in their nursing practice maintains a discourse, between the student, the researcher, and CNIs. If the disciplinary goal in nursing education is to foster student retention, then this

research is essential to inform nursing education's pedagogical practice and recognize that self-efficacy and success has been rooted in other domains of practice (Bandura, 1997).

Meaningfully, this thesis research adds value to student learning and success, designing curriculum, client outcomes, as well as, an opportunity to compare findings to the theoretical framework of Bandura's sources of self-efficacy.

Researcher's Assumptions and Beliefs

Reflexivity is an investigative tool that qualitative researchers often utilize to explore their assumptions and beliefs related to a phenomenon of interest, so these assumptions and beliefs can be bracketed. Bracketing entails a "cognitive process of putting aside one's own beliefs, not making judgements about what one has observed or heard, and remaining open to data as they are revealed" (Streubert & Carpenter, 2011, p. 27). This process assists the researcher to avoid making judgements when formulating questions, and during the creation and interpretation of the data (Polit & Beck, 2012). This exercise of self-awareness is especially important in qualitative descriptive research, to allow student descriptions of their experiences to be respected and to dominate the data, in order to gain a deeper understanding of the development of confidence through their clinical learning experiences. This reflexive exercise will acknowledge my work experience related to the CLE, my reflection on student learning in the clinical environment, my opinion of a preferred CLE for students, and my frustrations related to health care professionals working with students in the CLE.

Student learning is situated in a variety of different environments, so I believe that it is important to consider the contextual influence of both the learning environment and the student, in order for the student to be successful within a nursing program. From my work experience as a CNI and clinical course leader in the undergraduate nursing programs at the University of

Manitoba and Red River College, I believe that the quality of the CLE influences student learning outcomes. This unique practical learning environment should be of a positive nature with a nurturing and challenging element to provide students with an opportunity to learn and gain confidence in their nursing practice, narrowing the gap between theory and practice. From my experience with students, learning is more likely to transpire when the social atmosphere of the CLE consists of respect, inclusion, and support, thereby reducing the level of stress and anxiety a student may experience.

From my aforementioned work experience, there is a perception from students that their CNI or nursing staff in the CLE can *make or break* the student's clinical experience. I have observed that an unfamiliar and potentially unfavourable learning environment can be a difficult endeavour for students to apply their knowledge, perform skills, and openly communicate with others. An assumption may be that all nursing instructors and nursing staff are highly motivated mentors, facilitators, and teachers within the clinical environment, creating every effort to construct an environment that is conducive for learning, confidence building, and cultivating motivation. However, without a solid understanding of the student – CLE interaction, it may not be the premise adopted by those working with students in the CLE.

I believe that students should be valued as individuals with integrity working in a socio-technical context, such as the CLE. Each student has a unique approach to learning and his/her cultural imprint will reflect the student's belief about learning. As adult learners, students arrive in post-secondary education with a variety of past experiences that can hinder or contribute to their learning experience. Perhaps some students have uncertainties about their ability to be successful, in light of their personal history. Providing students with an opportunity to discuss these past experiences, personal, academic or work related, with their CNI can promote self-

directed learning through mutual goal setting, resulting in an opportunity for the student to demonstrate academic and personal growth. I believe this approach is pivotal in assisting students to acquire the necessary disciplinary knowledge, in which students need to begin thinking like a nurse through the utilization of problem-solving and critical reasoning skills. Moreover, ongoing constructive feedback in the CLE becomes a salient component to provide students an opportunity to reflect upon his/her clinical experience and demonstrate growth, confidence, and competence in further clinical experiences. This sort of approach values learning as a process and social construct. I believe that the social component of the environment superimposes upon the cognitive component of the student. This social feature within the CLE may influence the student's ability to learn, the student's perception about his/her capability to progress into a confident and competent nurse, and the student's ability to retrieve the knowledge necessary to perform various skills.

Additionally, I am aware that students do not easily share negative experiences that occur within the CLE, because they fear that speaking out may place them in jeopardy, academically. There is great value in moving forward with this research study, a safe environment, to allow students to describe their development of confidence in their nursing practice through their clinical learning experiences. The knowledge gained from this research will create a meaningful discussion juncture for all stakeholders involved in students' clinical learning experiences and will perhaps assist in achieving cultural congruence between stakeholders and students.

Theoretical Framework: Bandura's Self-efficacy Theory

Theories, such as Bandura's self-efficacy theory, consist of interrelated concepts that serve as conceptual guideposts with which to think about behaviour-focused practice, such as the

practice of nursing. These conceptual guides provide researchers with ways to think about what is happening within a particular context, such as the CLE and in turn explain an individual's behaviour or a phenomenon, providing the researcher with some conceptual direction in creating research questions, moving forward with a literature review, and developing methodology (Polit & Beck, 2008). "The value of a theory is ultimately judged by the power of the methods it yields to effect changes. Self-efficacy theory provides explicit guidelines on how to enable [individuals] to exercise some influence over how they live their lives" (Bandura, 1997, p. 10). It has a practical nuance and an application in a variety of different contexts.

The development of the self-efficacy concept evolved through various theoretical layers, originally emerging from a large theoretical frame developed by Dr. Albert Bandura, known as *social learning theory* in the 70's from his work in psychoanalysis related to phobias. In the 1980's Bandura (1997) renamed the theory, *social cognitive theory*, as he recognized that individuals could influence their life experiences through their thoughts and beliefs (Bandura, 1997). Individuals engage in tasks that they believe they will be successful and renounce tasks that they feel they will be unsuccessful (van der Bijl & Shortridge-Baggett, 2002). The more confident the individual is in his/her capability, the more likely they will persevere, exert more energy to do a task, and often succeed; the main premise of *Bandura's self-efficacy theory* (Bandura, 1997). This logical development towards the emergence of the self-efficacy theory generates theoretical value.

Bandura (1997) maintained the recognition of the key concepts from his social cognitive theory – human agency, collective agency, reciprocal causation, outcome expectancies, and the sources of self-efficacy judgements, as he moved forward with his theory of self-efficacy. Self-efficacy, the cardinal concept situated within self-efficacy theory affects an individual's

behaviour, such as learning, adaptation, and perseverance (Bandura, 1997; Schunk & Pajares, 2002). Self-efficacy is defined as “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments”; it is an individual’s level of confidence in his/her ability to perform successfully (Bandura, 1997, p. 3). Although, this thought process affects an individual’s motivation and performance, this belief exists in a *triadic reciprocal causation*; an individual’s internal personal factors (his/her thoughts and beliefs), behaviour, and environment interact in a reciprocal manner (Bandura, 1997). However, Bandura (1997) purports in his writing of *Self-efficacy: The Exercise of Control* that there is a *collective efficacy*, to consider, that is mutually agreed upon beliefs of a collective group to achieve a particular outcome; individuals exist within a larger community context, whether this context is a work, education or family community. Shared efficacy beliefs among these community members can improve experiences as the group interacts and collaborates (Bandura, 1997).

Moreover, another concept embedded within self-efficacy theory is *outcome expectancy*. Outcome expectancy is an individual’s belief about the expected consequence of his/her successful behaviour (Bandura, 1997; Resnick, 2013; Schunk & Pajares, 2002). Bandura (1997) makes it clear that an individual’s self-efficacy expectation can differ from his/her outcome expectation. Nevertheless, an individual makes judgements about his/her self-efficacy from four sources of information: *mastery of experience*, *vicarious experience*, *verbal persuasion* (previously, known as *social persuasion*) and *physical and emotional states* (Bandura, 1986, 1997). In the CLE, these forms of information are valuable considerations to enhance student self-efficacy, motivation, learning, and success.

Bandura’s theory of self-efficacy is most appropriate to guide this research. If CNIs and nursing staff are to provide clinical learning experiences and support student success, then it is

important to understand that this theoretical framework draws our attention to the role of student thoughts and beliefs that are mediating in their clinical learning experiences. Student thoughts and behaviour can influence the CLE, as well, the CLE can influence student thoughts, beliefs, and behaviour. It is about understanding how determinants of student behaviour operate together to explain their actions. This theory demonstrates the complexity of human nature and the CLE that can influence student self-efficacy, by being grounded in the assumption that there is an interaction between student thoughts, behaviours and their environment and that how a student thinks, feels, or believes about his/her capability will influence his/her performance (Bandura, 1997). Utilizing Bandura's self-efficacy theory as a solid underpinning of rich theoretical knowledge for this qualitative research, will provide rigor and strength through its "explanatory and predictive power" related to student academic development (Bandura, 1997, p. viii).

Summary

Chapter one consisted of background information from a global perspective related to retention and success within nursing programs, in order to address a potential nursing shortage, by viewing the internal psychological process of a student, such as student self-efficacy, since student self-efficacy can affect the amount of effort s/he may place in program completion. A brief synopsis of the CLE in the 21st century demonstrated challenges students face in this environment to prepare them to be confident and competent future nurses. The formulated research questions were presented and the development of these questions discussed. The significance of this research study was established through the limited research completed on this phenomenon in the CLE and the contribution it will make towards pedagogical teaching strategies in the CLE. Furthermore, the researcher situated herself through her beliefs and assumptions about the CLE and student learning. Finally, a brief preamble of Bandura's self-

efficacy theory demonstrated the strength of utilizing this theoretical framework as a foundation for this research. This framework will provide a platform for the literature review in Chapter two entailing a conceptualization of the CLE and self-efficacy, the four information sources of self-efficacy, the features of the CLE that contribute to student self-efficacy, and self-efficacy in a variety of other contexts.

Chapter Two: Literature Review

The purpose of a literature review is to review the knowledge known about the topic of interest, specifically the research questions (Machi & McEvoy, 2009). Often in qualitative research, there are a variety of views about when and how much of a literature review to complete based on the idea that the review may influence the interpretation of the phenomenon of interest (Polit & Beck, 2012). For the purpose of this research, a literature review was completed prior to the research, in order to synthesize of the theoretical and empirical literature related to a student's development of confidence in his/her nursing practice through clinical learning experiences, as well as explore features of the CLE that support student learning and the development of confidence.

The literature review follows a specific sequential course. Firstly, the literature review includes how various CLE's are organized, and how adult learning provides a way of thinking about learning in the clinical environment. Secondly, conceptualizing self-efficacy through various concept analyses is necessary to gain an understanding of this abstract concept in order to maintain the quality of this research. Thirdly, Bandura's theory of self-efficacy encompassing the constructs of reciprocal determinism, human and collective agency, cognitive process, affective process, motivation process, as well as outcome expectations are discussed in greater depth, in order to understand how a student's level of confidence in his/her nursing practice can affect student behaviour and how the CLE can affect student cognition or behaviour. Bandura's four sources of self-efficacy information are explored by considering features of the CLE, including signature pedagogies, to gain an appreciation of how students understand this CLE in relation to their self-efficacy. Fourthly and finally, viewing one's self-efficacy in a variety of different contexts, other than nursing education provides a well-rounded viewpoint of

confidence, performance, learning, and success. This sequential approach to the literature review situates and justifies this research study and provides other scholars with an opportunity to comprehend the structure and function of self-efficacy within their own realm of practice.

A variety of databases – Academic Search Complete, CINAHL, ERIC, EBSCOhost, PUBMED, and PsycINFO, as well as, an array of research and nursing textbooks, ebooks, and dictionaries from the University of Manitoba library – were utilized for the literature review, encompassing diverse disciplines, such as education, nursing, and psychology. At the same time, reference lists of salient articles were searched to obtain a more robust exploration of the literature.

Various Clinical Practice Models

There are various clinical practice models used in nursing education globally; however, regardless the model utilized within a nursing program, these clinical practice models “. . . . [occur within a] dynamic and complex setting”, and graduate nurses need to be prepared to manage these various environments (Killiam & Heerschap, 2013, p. 684). This preparation begins within nursing education programs by preparing students to feel confident and competent in caring for the physical and psychological needs of their patients in acute and chronic care settings, as well as in promoting health and preventing illness in a community health setting (Foxman, 2004). In creating a clinical practice model for students, consideration must center on the uniqueness of the student population.

Many of the clinical practice models that exist in nursing programs consider the principles of adult learning to assist students to reach their highest potential. According to Knowles, Holton III, and Swanson (2005), it is important for the adult learner to understand *why* they are learning something before they engage in learning and the realism of the clinical setting,

representing a high-stakes learning environment, can impress upon the student the importance of *knowing* before *doing*. More importantly, the CNI functioning as a facilitator can raise students' awareness of the *need to know* and assist students to realize the necessary academic and personal growth required to function as a confident and competent nurse (Knowles, Holton III, & Swanson, 2005).

Further to this, Knowles et al. (2005) purport that adult learners have a desire to take responsibility for their academic and personal life and want others to view them as being self-directed. Often, adult learners bring with them past experiences that demonstrate the uniqueness of each student within their learning, necessitating individualized teaching and learning strategies. These past experiences are not always a positive contributor to student confidence and learning, so it is important for the CNI to explore with students their past learning experiences, in order for students to move forward and be successful in their future learning (Knowles et al., 2005).

Finally, Knowles et al. (2005) vow that adult learners value an experiential form of learning. An epitome of this type of learning can occur through peer-to-peer learning, simulation experiences, or group discussions, often seen in various clinical practice models. These clinical experiences provide real-life situations for students to learn, and adult learners need these experiences to induce a sense of readiness to learn and perhaps the motivation necessary to learn. This motivation for adult learners can be related to internal motivators (self-esteem, life satisfaction, self-efficacy), as well as external motivators (rewards of a good job). However, their learning environment and the level of respect for the principles of adult learning that exist within that particular environment can affect the growth of an adult learner's motivation (Knowles et al., 2005).

The Canadian Association of Schools of Nursing [CASN] (2003) review of the literature recognizes that various clinical practice models exist in nursing education across North America and Australia. Each model embodies innovative strategies for clinical practice, including principles of adult learning, in order for students to attain program success and clinical competence. The models are as follows: clinical teaching associate model, dedicated education unit model, collaborative learning unit model, direct faculty-supervised model, preceptorship model, a dual assignment model, as well as, a work-study model (CASN, 2003).

According to CASN (2003), the clinical teaching associate model is based on practice principles of “reciprocity and collaboration” as the staff nurse in the facility, known as a nurse associate of the agency, supervises three to four students and is mentored by a faculty member, known as the “lead teacher” (p. 7). The faculty member is also responsible for educating staff, implementing research, completing student evaluations, and assisting students to narrow the theory-practice gap (CASN, 2003).

The dedicated education unit model, primarily seen in Australia’s nursing education system, is devoted to academia and patient care, representing the primary purpose of the unit (CASN, 2003). An experienced nurse clinician on the unit supervises students and collaborates with faculty in order to ensure that student experiences address the required competencies necessary for their clinical success and assists in the completion of student evaluations. Additionally, this model recognizes the significance of peer-to-peer learning and supports mentoring of junior students by senior students (CASN, 2003).

Collaborative learning unit model is a modification of the dedicated education unit model utilized at the University of Victoria in British Columbia; the variation exists, because all the nurses on the unit collectively engage in the teaching and learning experience of students,

providing students with an opportunity to learn from a number of different nurses. The experience is student-centred because it encourages students to share with the nurses their practical goals and learning needs, in order to obtain the best patient care assignment for their ability (CASN, 2003).

Dual assignment model is a unique model for beginning students; two students care for one patient with each acquiring specific responsibilities for the patient's care, while being supervised by a faculty member. The premise is that peer-to-peer learning can reduce student anxiety and enhance student learning in the CLE. Students begin to recognize the importance of the co-operative and collaborative skills necessary in caring for patients (CASN, 2003).

Work-study model, seen at the University of Texas, allows students to work on the units and achieve academic credit; students need to acquire 24 hours of clinical work in one month, in addition to attending seminars (CASN, 2003). A faculty member and a staff nurse (unit manager) organize this work and academic experience. The unit manager evaluates the student's clinical performance and can terminate students at any time, if they do not meet the standards of the facility or have academic difficulty. The faculty member maintains the responsibility of evaluating the student's academic requirements (CASN, 2003).

The primary practice models at Red River College, as well as many Canadian nursing programs, consist of the direct faculty supervision model, and a preceptorship model. The preceptorship model, utilized in the student's last clinical experience, known as a consolidated clinical practicum consists of about 450 hours of practice at the student's preferred clinical setting. The student typically aligns with one staff nurse on the unit for his/her experience, with the objective of the student gradually transitioning into the nurse role.

The direct faculty supervision model, year one to year three of the student's clinical experience at Red River College, includes a CNI who works for the educational institution and takes a group of students, consisting of six to ten students depending on the facility or clinical practice course, into a CLE of the CNI's expertise. The CNI, a "facilitator, coach, role model, and evaluator", supervises the students in the CLE and is responsible for teaching, formulating patient assignments, as well as, completing student evaluations (CASN, 2003, p. 5). Overall, regardless of which model is utilized for a particular nursing program, the ultimate goal is to provide students with clinical experiences that allow them to progress from a non-complex to complex experience, in order for them to gain a gradual level of confidence in caring for a variety of patients (CASN, 2003).

The CNI role can be a challenging endeavour, not only are CNIs mentoring and facilitating student learning but also they are contending with patients and staff on the unit, as well (Hart & Rotem, 1995). So, a student who lacks confidence and requires some additional attention to invigorate his/her confidence to be successful within clinical practice can be demanding for a CNI.

For the student, this CLE has the potential to create higher stress levels than learning in a classroom setting (Smedley & Morey, 2010). These high stress levels can result in feelings of anxiety and contribute to a student's lack of confidence in his/her clinical capability (Melincavage, 2011), influencing a student's ability to make the connection between theory and practice, critically reason, and perform psychomotor skills competently (Dunn & Hansford, 1997). "Student nurses need a rich opportunity to continue to learn, develop their practice, and articulate it both as individual nurses and members of a health care team" (Benner et al., 2010, p. 30). Students need to believe that they are capable of functioning and coping in the health care

environment of high-acuity, ever-changing technologies, and managing patients and families with high-quality relational skills (Benner et al., 2010). A CLE that is conducive to learning and contributes to student confidence in their capability, consists of an environment that allows students to take responsibility for patient care; ask questions safely; practice skills; supervise their own peers; feel respected and trusted by staff and the CNI (Lofmark & Wilkblad, 2001). The concept of self-efficacy, a central concept in Bandura's self-efficacy theory, consists of various attributes that are relevant to students learning and clinical performance, such as *confidence*. Conceptualizing the term self-efficacy within its context of usage, such as the CLE, allows the attributes of self-efficacy to become apparent to others.

Conceptualizing Self-efficacy

Research that explores the phenomenon of confidence often utilizes Bandura's theory of self-efficacy as a guiding framework. Confidence, self-confidence, and self-efficacy are often seen in the nursing literature as surrogate terms and are used interchangeably (Lundberg, 2008; Perry, 2011). However, Perry (2011) vows that "self-confidence informs self-efficacy, which influences learning, which further influences confidence, learning, and affective domains" (p. 219). According to Bandura (1997), confidence is related to "the strength of a belief" and self-efficacy is related to the level of confidence and the "affirmation of the capability level" (p. 382). In this research, self-efficacy and the statement, one's level of confidence in their clinical capability to perform or in their nursing practice, will be surrogate terms and used interchangeably. Confidence then becomes an attribute of self-efficacy. Additionally, the terms self-efficacy, perceived self-efficacy, self-efficacy judgement, self-efficacy expectation, self-efficacy expectancies, and personal efficacy are all synonymous terms and will be used interchangeably within this thesis work.

Conceptualizing the term self-efficacy is necessary, in order for researchers to reduce the ambiguity of the abstract concept and to understand what is being researched (Rodgers, 1989). Self-efficacy, the all-encompassing concept, does not exist in many dictionaries. However, one can find the definition of *self* and the definition of *efficacy* to create the unified term, self-efficacy. Yet, not always can the solo word, *efficacy*, be located in a dictionary. Nevertheless, dictionaries from a variety of disciplines define the all-encompassing term, self-efficacy. The Taber's Cyclopedic Medical Dictionary (2009), similar to Bandura's claim, states that self-efficacy "pertains to one's belief in his or her ability to perform a given task or behaviour" (para 1), and this will be the definition utilized for this research. Similarly, the Cambridge Dictionary of Psychology (2009) defines self-efficacy as *perceived* self-efficacy being "concerned with people's beliefs in their ability to influence events that affect their lives. This core belief is a foundation of human motivation, performance accomplishments, and emotional well-being" (p. 469).

Zulkosky (2009) states that the terms *self-efficacy* and *perceived self-efficacy* noted in the aforementioned definition and in the research done by Bandura, Schunk, and Lenz and Shortridge are used synonymously. Zulkosky (2009) posits that the word *perceived* is inferred within the definition of self-efficacy. According to Merriam-Webster's Collegiate Dictionary (2007), *perceive* is defined as "to attain awareness or understanding of [or] become aware of through the senses" (p. 918). Zulkosky (2009) defines self-efficacy as "a person's own judgement of capabilities to perform a certain activity in order to attain a certain outcome" (p. 95). This judgement is achieved through an individual's senses, which is intrinsic to perception, seeming redundant.

Interestingly, Mosby Dictionary of Complementary and Alternative Medicine (2005) defines self-efficacy as a “positive subjective assessment of one’s ability to cope with a given situation; senses of personal power” (para 1). The usage of the word *positive* implies that self-efficacy maintains a favourable meaning of one’s ability to cope; however, not all individuals have the same level of efficacy. This definition is not a replication of Bandura’s definition of self-efficacy, since it misconstrues self-efficacy as being consistently positive, when in fact one’s efficacy can be low.

In order to gain a deeper understanding of the concept self-efficacy, it is important to understand that the manifestation of the concept occurs through a discursive assortment of terms or attributes. These attributes become a part of the definition and analyzing this concept through its attributes has the potential to create transparency in defining and using the concept in research (Rodger, 1989).

Attributes of self-efficacy. Concept analysis is a meaningful and rigorous approach to explore the structures and functions of a concept, especially an abstract concept, such as self-efficacy (Walker & Avant, 2011). According to Townsend and Scanlan (2011) concept analysis, the concept of self-efficacy within the CLE demonstrates specific attributes, which include “effectiveness, capability, persistence, performance ability, motivation, and confidence” (p. 6). All these attributes contribute to the meaning of self-efficacy and no one term exclusively describes self-efficacy (Townsend & Scanlan, 2011).

Mowat and Laschinger’s (1994) concept analysis of self-efficacy suggests:

Human beings with high self-efficacy have the following characteristics in common (a) a firm personal belief that they can master a particular task, (b) the ability to carry out the required behaviour, (c) the ability to maintain the behaviour over time, (d) the ability

to cope effectively with stress and other phenomena requiring great personal effort.

These descriptions of the defining attributes of self-efficacy may be summarized as (a) confidence, (b) capability, (c) persistence, and (d) strength (p. 1108).

Zulkosky (2009) concept analysis of self-efficacy suggests that the attributes of self-efficacy relate to cognitive and affective processes, as well as locus of control. In relation to cognitive processes, individuals set goals based on their belief in their capability to be successful. Efficacious individuals will set goals that are more challenging and persevere at goals to be successful. These individuals will even have positive thoughts about their capability in achieving a goal. Additionally, an individual's affective processes, such as anxiety or depression, will influence the individual's ability to cope and will affect the individual's belief of whether they are capable in performing a task. Further to this, locus of control plays a role in an individual's perception about how much control they have over their success. Efficacious individuals believe that they have the ability to control outcomes based on internal forces, such as their cognitive practices and emotional well-being. That is, outcomes are not a matter external forces, such as luck or chance (Zulkosky, 2009).

Overall, these concept analyses attach meaning to the concept of self-efficacy and support the fact that self-efficacy plays a pivotal role in how an individual thinks, feels, and acts, as well as how motivated, how much effort and how persistent an individual will be when facing challenges (Bandura, 1997). The concept of self-efficacy is important for nursing instructors to consider when working with students, since 21st century students are faced with many challenges related to the complexity of patient care, difficulties within the workload of nursing education, as well as their own financial and personal challenges. Aspects of the CLE, such as health care providers working with students, may unknowingly contribute to student self-efficacy belief

during clinical learning experiences, so it is important to recognize how social and cognitive processes, as seen in Bandura's self-efficacy theory influence students' self-efficacy.

The concept of self-efficacy, around for decades, was embedded in the social cognitive theory, and most recently situated as a core concept in Bandura's self-efficacy theory (van der Biji & Shortridge-Baggett, 2002). Originally, the popularity of self-efficacy was rooted in clinical psychology research through treatment success, which was the focal point of human behaviour relating to anxiety disorders and phobias (Williams, 1995), depression (Maddux & Meir, 1995), health (Maddux, Brawley, & Boykin, 1995), and childhood aggression (Roeckelein, 1998).

Over the years, the concept of self-efficacy surfaced into the educational context, recognizing that self-efficacy acts as a vital role in students level of motivation, learning, and achievement (Schunk, 2003). The development of student self-efficacy is multifaceted through their level of confidence in their capability, knowledge, and previous success (Bandura, 1997; Schunk & Pajares, 2002). Self-efficacy forms a part of student cognition, through their thoughts and feelings, in a fashion that affects their behaviour (Bandura, 1997). Students with a high level of self-efficacy will have the confidence to perform successfully, place a significant amount of effort into the task, and persevere in spite of challenges; moreover, a student's thought process will evolve around positive self-talking and feelings of confidence in their ability to succeed (Bandura, 1977b, 1997). Further to this, according to Bandura (1977a, 1986, 1997) student self-efficacy judgement occurs on three dimensions that affect performance: *magnitude, strength, and generality*.

Self-efficacy judgements. The judgement of *magnitude* is based upon the degree of difficulty, through a levelling process, such as a step-by-step assessment of the amount of

difficulty within the task that the student is capable of performing (Bandura, 1977a, 1986, 1997). For example, a student may feel confident in his/her capability of completing a foley catheter insertion in a simulation situation or on a stable patient. However, if the situation in the CLE is stressful with the CNI observing or the situation is of an emergent nature in which the foley catheter needs to be inserted quickly and efficiently, the student may lack the confidence in his/her capability to insert the foley catheter based on the *magnitude* of the situation.

Strength refers to a student's determination, certainty, or confidence that he/she can perform the task necessary to be successful, despite obstacles (Bandura, 1977a, 1986, 1997). Therefore, based on the magnitude of the situation in the above scenario, the student who demonstrates a quality of persistence and determination represents the *strength* of his/her confidence in completing the task.

Generality refers to successes or failures of a student's particular experience that influences his/her level of confidence in a different context or similar task (Bandura, 1977a, 1986, 1997). For instance, in the above scenario, if the student was successful at inserting a foley catheter in an emergent situation, then his/her level of confidence may have been enhanced by the student's success. Therefore, the student may transfer these feelings of success to another context like completing an IV insertion in an emergent situation.

Judgements of self-efficacy are usually represented by the three constructs of *magnitude*, *strength*, and *generality*, but most researchers focus on the *strength* dimension (Maddux, 1995). Even with the numerous reviews of the self-efficacy definition, an inherent quality of the definition is the *strength* dimension. Self-efficacy is a pivotal function in a student's academic success and there is considerable value in exploring how education can facilitate the development of a student's self-efficacy (van Dinther, Dochy, & Segers, 2011). However, "self-

efficacy is not the only type of self-belief”; our thoughts and beliefs can be influenced through our level of self-esteem and self-concept, but these concepts are different (van Dinther, Dochy, & Segers, 2011, p. 96).

Differentiating other self-beliefs. The term self-efficacy utilized by nursing instructors in the academic environment, often does not represent an accurate definition of the term. From personal experience, nursing instructors use the terms, self-esteem, self-concept, and self-efficacy, synonymously. Researchers do not conceptualize these concepts in a comparable fashion (Pajares, 1996). It is important to differentiate between the aforementioned self-belief terms to avoid confusion in the academic and research realm.

Self-concept is how an individual views oneself or one’s attitude about himself or herself that forms through a particular experience or other individuals (Bandura, 1986, 1997). Correspondingly, Taber’s Cyclopedic Medical Dictionary (2009) defines self-concept as “an individual’s perception of self in relation to others and the environment” (para 1). Self-concept judgements are of a global nature and not linked so much into a particular context (Bandura, 1997; Pajares, 1996). For instance, a student may state, as a self-concept judgment – I am a good communicator. The question of self-efficacy judgement becomes – how confident is the student in communicating with the family who just lost their love one. This demonstrates how self-efficacy is context and task specific (Maddux, 1995; Pajares, 1996). Pajares (1996) and Bandura (1986) claim that the terms, self-concept and self-efficacy, do not necessarily co-occur in a similar context. For example, a student may feel highly confident in their communication skills but may not recognize the value of this skill and does not feel any sense of self-worth related to the skill.

However, according to Hughes, Gilbraith, and White (2011), self-efficacy and self-concept are not completely different from each other; a common element of both self-beliefs is their *perceived competence*. Self-efficacy relates to the cognitive perception of competence – Can I do an IV start? And self-concept relates to the affective perception of competence – I am very good at doing IV starts? Nonetheless, Bandura (1986, 1997) asserts that an individual's self-concept does not have any predicting power of behaviour under different circumstances, but rather self-concept is measured through individuals describing attributes of themselves in a more global aspect by a general judgement of their competence and self-worth. For example, a student A student may self-assess their academic life globally (self-concept) by stating – I perform overall well in my academic life; however, the student may judge his/her level of self-efficacy as high in communication courses and low in the anatomy and physiology courses.

Self-esteem is a judgment about how an individual feels about themselves; that is, his/her self-worth (Bandura, 1986, 1997; van Dinther, Dochy, & Segers, 2011). According to the Taber's Cyclopedic Medical Dictionary (2009), self-esteem is defined as “one's personal evaluation or view of self, generally thought to influence feelings and behaviours. One's personal successes, expectations, and appraisals of the views others hold toward oneself are thought to influence this personal appraisal” (para 1). According to Bandura (1997), this self-belief originates in an individual's affective context, not his/her cognitive context. There is no relationship between an individual's belief about his/her capabilities and an individual's thought about his/her value as a person (Bandura, 1997). The fact that an individual likes him/herself does not imply or parallel his/her performance accomplishment. The individual needs to be confident to persist and succeed at a task, so personal efficacy may predict performance accomplishment; however, self-esteem does not necessarily influence an individual's

performance. Self-esteem can be domain specific, meaning that an individual can have a strong self-esteem in their academics, but a poor self-esteem as a parent. Further to this, self-esteem may emerge from self-evaluation, social evaluation, or cultural stereotyping (Bandura, 1997). For instance and from experience, when nursing staff devalue male students working in a maternity clinical environment, male students describe feelings of being out of place, or express that they feel they have nothing valuable to offer their patients. Because self-esteem sources are multifaceted, considerable effort is necessary to enhance self-esteem (Bandura, 1997).

Self-efficacy and self-esteem are not synonymous and do not necessarily co-occur. For instance, the fact that a student finds it difficult to care for sick children and does not feel confident about working on a pediatric unit (self-efficacy), does not mean that this student devalues themselves as a person (self-esteem). Self-beliefs are conceptually divergent, and do not necessarily have a direct influence on each other; when comparing self-beliefs it is salient to compare them at the same level of specificity, such as task specific or domain specific to recognize their distinct features (Pajares, 1996; Hughes, Galbraith, & White, 2011).

Understanding a student's self-efficacy judgment in a practical context and differentiating self-efficacy from other self-beliefs creates a basic understanding of the concept of self-efficacy. However, expanding the view on self-efficacy by exploring the function of self-efficacy in a broader context, such as a student's behaviour, cognition, and the CLE provides an opportunity to improve teaching and learning within nursing education (Peterson, 2013).

Triadic reciprocal causation. Human behaviour is a triadic reciprocal interaction between those internal personal factors (thought and beliefs), behaviour, and environment; these factors influence one another “bi-directionally. . . ., [representing] an interdependent and casual structure” (Bandura, 1997, p. 6). Accordingly, the cognitive effort that individuals exhibit

represents the agentic characteristic of individuals, also known as human agency, which demonstrates that individuals influence their behaviour, and contribute to their environment through thought processes, beliefs, and emotions (Bandura, 1997, 1986; Pajares, 1996; Resnick, 2013). For instance, a student who believes that administering blood to a patient to be a difficult task, more than it really is, may elicit an emotional reaction of anxiety and renounce the task by letting the staff nurse administer the blood product. Bandura (1986) claims that acquiring the knowledge or skill about administering blood products will not necessarily reflect the student's competence in completing the task successfully – the student will have certain level of confidence, feelings, and thoughts about his/her capability of completing this task, which will have a powerful influence on his/her behaviour. This exemplar demonstrates that there is a self-system to consider and work through, which influences a student's behaviour, demonstrating a bidirectional interdependence between a student's cognition, and behaviour (Bandura, 1997).

Human (personal) agency. “Agency refers to acts done intentionally” (Bandura, 1997, p. 3). Intentionality is an example of an individual being proactive and not just reactive to his/her environment and is representative of his/her future behaviour (Bandura, 1997, 2001). Personal efficacy belief regulates behaviour through an individual's *cognitive, motivational, affective, and selection processes* (Bandura, 1995).

Cognitive process. Personal efficacy beliefs from a cognitive perspective embody *forethought, intentionality, and self-reflectiveness*, key features of human agency (Bandura, 1995). According to Bandura (2001), an individual's behaviour is regulated by forethought that evolves from an individual setting goals with the thought of an anticipated outcome; however, these intentions and forethought alone are not enough for an action to occur because there must be a connection between the individual's thoughts and actions, such as motivation or level of

confidence in his/her ability. Individuals enter into a self-regulating domain, through their self-efficacy and expected outcome, in order for intentionality and forethought, such as goal setting, to be successful. Although forethought and intentionality have a future dimension, it does enter into the cognitive domain of an individual; these future happenings become the motivator and regulator of an individual's behaviour. If an individual's perceived self-efficacy encompasses a high level of confidence in managing complex situations/tasks, he/she will set more challenging goals and the individual is more likely to exert the effort and persevere in performing the task (Ferla, Valcke, & Schuyten, 2009; Komarraju & Nadler, 2013; Van der Bijl & Shortridge-Baggett, 2002). Further to this, individuals reflect on their performance or behaviour; this reflection evolves from the outcome of their performance, and the feedback they receive from others, in which they re-evaluate their initial motivation and perceived self-efficacy, affecting their future behaviour (Bandura, 1986).

Motivational process. “[Personal] efficacy beliefs play a key role in the self-regulation of [one's] motivation” (Bandura, 1995, p. 6), in affecting an individual's choice, effort, and persistence on a task (Bandura, 1997). According to Bandura (1995), motivation, a cognitively induced behaviour, evolves through *causal attributions, outcome expectancies, and cognized goals*.

Causal attributions. Personal efficacy beliefs are reflected in an individual's reaction to his/her failure or success known as, causal attributions. Efficacious individuals attribute their failures to their personal effort or other factors not directly related to their behaviour and inefficacious individuals will attribute their failure to their inability (Bandura, 1995). According to Maddux and Lewis (1995), not much research has been dedicated to causal attribution and self-efficacy, but there is probably a relationship between causal attributions and self-efficacy. In

psychological therapy, a therapist tries to have individuals recognize their control over an outcome, and that their success is a direct result of their effort placed forward and not a result of intangible factors.

Outcome expectations. Self-efficacy and *outcome expectations* are prominent features of Bandura's self-efficacy theory and are distinctly different concepts (Resnick, 2013). Self-efficacy expectancies are "judgements about personal ability to accomplish a given task" and outcome expectancies are "judgements about what will happen if a given task is successfully accomplished" (Resnick, 2013, p. 83). There is some controversy in the literature related to the relationship between self-efficacy and outcome expectations (Maddux, 1995; Pajares, 1996; Williams, 2010a).

Bandura (1986, 1997) states that the relationship between self-efficacy and outcome expectations is multifaceted and complex – an individual may understand that a particular kind of performance is necessary to produce a specific outcome, even if the individual may not have the confidence in his/her ability to perform at that particular level. For instance, a student recognizes that being engaged in preparation for clinical practice will probably produce more positive performance (a good grade) and outcome (self-satisfaction); however, a busy family life, employment responsibilities, or health issues may influence his/her belief that he/she is capable in investing the necessary preparatory time to obtain a positive outcome, such as a favourable clinical evaluation through positive comments from the CNI. Therefore, the student performs at the "C" level ("a marker of different levels of performance" (Bandura, 1997, p. 22)) with the outcome expectancy (the judgement of the likely consequence that the performance produces ie. "physical, social or self-evaluative" reaction (Bandura, 1997, p. 22)) of being satisfied with a passing grade (self-evaluative reaction). However, often the outcomes that individuals expect

will depend on how confident they are about their capability to perform the specific task (Bandura, 1997; Resnick, 2013). Highly efficacious students will most likely expect a positive outcome from their behaviour, such as positive feedback from the CNI (social reaction), so the premise emerges that “expected outcomes are dependent on self-efficacy judgements” (Resnick, 2013, p. 83). Nonetheless, Bandura (1997) recognizes that there may be no predictive or explanatory feature between the two constructs, self-efficacy expectation and outcomes expectations; meaning, that individuals may be highly efficacious – confident in their capability – but other factors, such as their environment, may influence their outcome expectancy – what an individual expects if they are successful. When expected outcomes are not completely affected by an individual’s performance because of other confounding factors, self-efficacy expectancies may not align with outcome expectancies; therefore, independently, outcomes expectancies do not become much of a predictive factor in behaviour (Bandura, 1997; Maddux, 1995).

An exemplar in which expected outcomes may have no connection to an individual’s self-efficacy expectations exists in cultural incongruence often seen in the CLE between the nursing staff on the unit and the student or student group. If students anticipate unwelcoming behaviour from nursing staff in the clinical setting based on information they received from previous student groups, then student outcome expectancy may be of a negative nature (the social reaction of the staff). Even if the student is confident in his/her capability of functioning in the clinical setting, the student may be unmotivated by the environment and feel it is not worth putting the effort into practice because his/her skills will not be valued. The outcome they may expect from the nursing staff will be that the staff will find something wrong with their performance, no matter how well they perform (social reaction). So, when self-efficacy and

outcomes expectations are indifferent, often the outcome expectancy is not connected to the quality of the performance (Bandura, 1997).

However, according to Resnick (2013), research demonstrates that there is strength within outcomes expectancy and self-efficacy judgements in influencing an individual's behaviour; however, the relationship between the two concepts may be reflected in the uniqueness of the circumstance. In health related research, outcome expectancy can have a significant impact on an individual's health behaviour. Maintaining an exercise regime in the elderly is more reflective of their outcome expectancy than their self-efficacy expectation. The older adult may exhibit efficaciousness in an exercise program, but if they do not recognize the outcome benefits of exercise, then they will not persevere within the exercise program (Resnick, 2013). In a similar vein, Williams (2010a) states that some researchers have demonstrated that outcome expectancies can influence an individual's self-efficacy, especially in self-regulated behaviours, such as smoking cessation or phobias. For instance, offering an incentive (outcome expectancy) can influence an individual's belief about their ability to perform a specific behaviour (Williams, 2010a).

Yet, in the academic realm, the relationship between these two prominent concepts, self-efficacy and outcome expectations, embedded in Bandura's self-efficacy theory, are viewed differently. Just because an individual expects a particular outcome from a certain behaviour, it does not imply much predictability of an individual's behaviour, since skill, knowledge, and self-efficacy take part in an individual's academic success (Schunk & Pajares, 2002). Self-efficacy expectations become the deeper component of predictability of an individual's behaviour than outcome expectations (Bandura, 1986).

However, outcome expectations, can be a form of motivation or lack of motivation, as represented through *physical forms (feelings of joy or dissatisfaction)*, *social forms (praise or disapproval from others)*, and *self-evaluative reactions* – all that can be expressed in a positive or negative nature, as seen in the aforementioned exemplar of cultural incongruence (Bandura, 1997).

Goal setting. According to Bandura (1995), another way to self-influence an individual's motivation is through goal setting. Aforementioned, confidence in one's capability can influence their goal setting, since this belief reflects the type of goals the individual plans, his/her perseverance, and resilience in challenging endeavours. Individuals who are confident in their capability are going to set challenging goals, extend considerable effort into a task and are more likely to be successful (Bandura, 1995; Komarraju & Nadler, 2013). An individual's confidence in his/her coping skills will influence how stressed s/he feels in difficult situations, as well as his/her motivation to persevere in that situation, regulating the individual's affective process (Bandura, 1995).

Affective processes. According to Bandura (1995), an individual's perception of a stressful situation evolves from his/her efficacy belief – the stressful situation may be seen as a challenge or a danger to him/her; this belief will elicit feelings of anxiety in the dangerous situation or feelings of excitement in a challenging situation. An individual's perception of an environment as threatening may result in the individual evading the situation because he/she believes this circumstance surpasses the individual's ability to cope under those sorts of conditions. Based on the individual's perception, he/she begins to make selections that affect the situation, as seen in the aforementioned example of the student inserting a foley catheter in an emergency (Bandura, 1995).

Selection process. “[Individuals] are partly the product of their environment” (Bandura, 1995, p.10). Personal efficacy, how confident the individual is in their capability, influences the choices that individuals engage in and these choices begin to shape their circumstances. A study completed by Komarraju and Nadler (2013), that explored “why implicit beliefs, goals, and effort regulation matter” (p. 67) in relation to academic achievement of college students, found that efficacious students preferred challenging goals, higher grades, competing activities, and demonstrating their academic ability. According to Bandura (1995), an inefficacious student lacks commitment to his/her goals and withdraws from challenging situations; in addition, the inefficacious student begins to engage in a negative thought process of his/her inability and becomes stressed and anxious. “Self-efficacy beliefs are the product of a complex process of self-persuasion that rely on cognitive processing of diverse sources of efficacy information conveyed enactively (sic), vicariously, socially, and physiologically” (Bandura, 1995, p. 11).

Self-efficacy theory recognizes that society and the individual do not just coexist but are interacting elements, creating a more global view of agency (Bandura, 1997). A student’s learning is a mental process that occurs in a sociocultural context; that is, students exist in collective groups of individuals; for example, peers, nursing instructor, nursing staff, patients, and families. Just as human agency effects an individual’s adaptation to his/her environment, so does collective agency (Bandura, 1997).

Collective agency. The multifaceted influence on self-efficacy beliefs demonstrates the interdependence of social systems (Bandura, 1997). Collective efficacy is defined as “a group’s shared beliefs in its conjoint capabilities to organize and execute the course of action required to produce given levels of attainment” (Bandura, 1997, p. 477). Nurses work in collective forms, intraprofessionally and interprofessionally creating a multidisciplinary team, with the primary

goal of producing positive patient outcomes. Students have an opportunity to work as a part of these teams, as well as in peer teams. The performance of the team is how they perceive collective competence (Bandura, 1997). For example, two students are at a patient's bedside performing a dressing change. The student performing the task will consider the competence of the student assisting them and the assisting student will consider their belief in the student performing the task successfully. So, the collective efficacy is about the two student's perceived capability. Lent, Schmidt, and Schmidt (2005) and Bandura (1997) claim that collective efficacy beliefs are a stronger predictor of team performance than an individual team member's perception of his/her confidence in capability. This vicarious source of efficacy forms the direction of a student group choice and their motivation to perform (Bandura, 1986, 1997; Maddux, 1995).

Bandura's Four Sources of Self-efficacy Information

Researchers recognize that a student's level of confidence in his/her capability to perform (self-efficacy) influences motivation, performance, learning, and the amount of effort, persistence, and resilience the student exhibits; based on this premise, it is paramount to understand how nursing education can enhance the development of student self-efficacy (Bandura, 1997; Jeffreys, 2012; van Dinther, Dochy, & Segers, 2011; Zimmerman, 2000). Bandura (1997) suggests that there are four particular self-efficacy information sources that a CNI can use to develop student self-efficacy: *mastery of experience*, *vicarious experience*, *verbal persuasion*, and *physical and emotional states*. Moreover, enhancing student self-efficacy can occur through one or more of these information sources (Bandura, 1997).

Mastery of experience. Mastery of experience is about accomplishing a particular task or behaviour successfully, cultivating a student's confidence in his/her ability, which can

encourage him/her to persist in similar tasks or even more challenging tasks in the future (Bandura, 1997; Maddux, 1995; Zulkosky, 2009). Mastery of experience is the most powerful source of information to a student's level of confidence in their capability to perform (Bandura, 1997). For instance, a student, successful at administering blood in the CLE, will strengthen his/her level of confidence in completing that skill and his/her perception of failure related to that skill will subside in future situations. However, Bandura (1997) cautions researchers that using only performance to judge a student's capability would be erroneous because there are other salient factors to consider in a student's self-efficacy judgment through performance experiences – the difficulty of the task, the amount effort needed to be successful, the amount of assistance, the environment in which the task occurred, and how the experience is stored in the student's memory.

Vicarious experience. Vicarious experience, modeling, or observational learning, is similar to living through someone else's actions. Observing someone else succeed or not succeed at a task, may in fact influence an individual's thought about his or her capability of performing the same task (Bandura, 1997; Zulkosky, 2009), especially if the modeller and the observer have similar characteristics (Bandura, 1986, 1997). An exemplar of vicarious learning in the CLE often occurs through peer-to-peer learning. When students engage in peer-to-peer learning, they encounter similar challenges; the observing student may feel confident that they can perform the skill by recognizing what it takes to be successful from the student modeller's experience or challenges (Bandura, 1986). This observational learning is the next best experience to mastery of experience (Bandura, 1997).

Verbal persuasion. Verbal persuasion occurs when an individual persuades the student that they are capable of performing the task successfully; this sort of encouragement inspires the

student to strive and persevere for success (Bandura, 1997; Zulkosky, 2009). This source of self-efficacy is a weaker form of information from mastery of experience or vicarious experience, and is subject to the credibility and expertise of the individual providing the encouragement (Maddux, 1995). Moreover, Bandura (1997) claims that if the persuader verbally encourages the student to complete a task that is outside his/her skill set, seeming unachievable or unreal, than this sort of encouragement will not boost the student's confidence due to the unrealistic means. There is a significant disparity between the student's level of confidence in his/her capability and the verbal encouragement. Verbal persuasion is most effective when balanced with other strategies to enhance self-efficacy (Bandura, 1997). An exemplar of verbal persuasion in the CLE occurs when the student receives verbal encouragement from his/her CNI or staff nurse in completing a task, skill, or general nursing care that they are aware the student is realistically capable of performing. In order to provide valuable encouragement, the CNI may refer to the student's past experience, such as his/her previous newborn assessment that was done well the prior week in clinical practice. The student will feel that he/she had accomplished this task previously, and with the additional verbal encouragement/feedback from the CNI, the student can acquire the confidence necessary to complete the assessment on the newborn.

Physical and emotional states. The condition of a student's physical and emotional state can influence his/her decision-making regarding the level of confidence in his/her capability to perform at an acceptable level (Bandura, 1997). Being enrolled in a professional program, such as nursing, in combination with the demands of a student's personal life can elicit feelings of stress, anxiety, or depression. Further to this, stress related to clinical practice is identified not only in practice but also occurring before clinical practice by preparing the night before and after the clinical experience, as they reflect on errors or what could have been done differently

(Chernomas & Shapiro, 2013). Further to this, the actual CLE has the potential to be a stressful learning environment for students: the workload may be too heavy; the environment may be unfamiliar; the staff may be unwelcoming of students; the clinical instructor may have particular expectations of the student, and the evaluation process may elicit feelings of uncertainty (Shaban, Khater, & Akhu-Zaheya, 2012).

Learning in a clinical environment is coined situated cognition; this situated cognition experience can be anxiety provoking for a student and result in a student's inability to perform, due to the fact that anxiety blocks his/her cognitive capability to process information (Melincavage, 2011; Schmeiser & Yehle, 2001). Much of this anxiety emerges from the student's fear of making errors while performing a particular skill (Spengel & Job, 2004). This emotional state of anxiety can affect the student's level of confidence in his/her capability to perform in the CLE and this stress can also elicit a physiological response, such as, fatigue, aches, and pains (Bandura, 1997). A student who is very anxious and experiences gastrointestinal upset during pre-conference, utilizing the washroom facilities three to four times prior to clinical practice, may feel a lack of confidence in his/her capability to function in the clinical area that day.

The level of confidence a student has in his/her capability to perform influenced by the four aforementioned experiences, demonstrates that social and pedagogical influences of the CLE have a powerful influence on the outcome of student success in this environment. Students need to acquire knowledge and skill, but this information alone does not deem that a student will be successful within the nursing program. A student's thought process related to his/her level of confidence in his/her capability is an influential intermediary between a student's knowledge and skill (Bandura, 1997; Plaza, Drugalis, Retterer, & Herrier, 2002). Bandura's self-efficacy theory

is a practical theoretical framework to understand student confidence, learning, and success in the CLE. Importantly, attrition rates are lower among students with a high level of confidence in their capability; further to this, confident nurses are more likely to advance in their nursing career and practice the standards of care, having a positive influence on patient outcomes (Harvey & McMurray, 1994; Manojlovich, 2005). Perhaps, addressing the issue of confidence building in nursing education by exploring features of the CLE, including signature pedagogies, can have lifelong effects on student self-efficacy as students' progress through their nursing career.

Signature Pedagogies, Features of the CLE, and the Development of Student Self-efficacy

Efficacious students think, act and feel different from the students who are inefficacious – these efficacious students are more confident in their capabilities and persevere and scrutinize difficult tasks as challenging, engage in goal commitment, contribute unsuccessful endeavours to his/her own efforts, and present as highly motivated students – this sort of cognition effects the student's academic learning and success positively (Bandura, 1997). However, the challenge for CNIs evolves from the fact that not all students are highly efficacious. Pedagogical strategies utilized in nursing education can influence student self-efficacy, in order for students to feel confident in their nursing practice, and persevere at challenging tasks as a future nurse. This portion of the literature review will demonstrate how various pedagogical strategies used in the CLE, and features of the CLE attend to Bandura's sources of self-efficacy: mastery experiences, vicarious learning, verbal persuasion, and physiological response, but also how student performance is influenced by a triadic interaction between the cognition, behavioural, and environmental factors (Bandura, 1997). Simulation, peer-to-peer learning, debriefing, journaling, feedback, CNI approach, and sense of belonging are pedagogical strategies or features of the CLE that will be discussed.

Simulation. In order to overcome the challenges of high enrolment in nursing education and the limited clinical placements in health care facilities, simulation has become a popular teaching and learning strategy in nursing education (Jefferies, 2005; Opton, Clark, Wilkinson, & Davenport, 2014). Further to this, at times, CNIs often find it challenging to allocate patient assignments of higher acuity for students to develop their critical thinking skills, without jeopardizing patient care, due to larger clinical groups and a shortage of nursing staff on the unit (Howard, Englert, Kameg, & Perozzi, 2011). So, a simulation environment provides an opportunity for student learning that mimics the reality of a clinical environment with the absence of risk, in order for students to increase their confidence and competence in nursing practice (Bambini, Washburn, & Perkins, 2009; Broussard, 2008; Christian & Krumweibe, 2013; Jefferies, 2005).

Simulation can present itself through a variety of different contexts, such as high fidelity, using interactive technical mannequins or low fidelity, by utilizing a case study or role-playing with students, through the facilitation of the nursing instructor (Jefferies, 2005; Torterud, Hedelin, & Hall-Lord, 2013). Research demonstrates that this innovative pedagogy of simulation has many gains in student learning and success, including an increase in self-confidence or perception of self-efficacy after a simulation experience (Akhu-Zaheya, Gharaibeh, & Alostaz, 2013; Bambini et al., 2009; Bantz, Dancer, Hodson-Carlton, & Van Hove, 2007; Cardoza & Hood, 2012; Christian & Krumwiede, 2013; Goldenberg, Andrusyszyn, & Iwasiw, 2005; Kameg, Howard, Clochesy, Mitchell, & Suresky, 2010; McConville & Lane, 2006; Pike & O'Donnell, 2010; Reilly & Spratt, 2007; Richards, Simpson, Aaltonen, Krebs, & Davis, 2010; Sinclair & Ferguson, 2009; Smith & Roehrs, 2009; Sohn, Ahn, Lee, Park, & Kang, 2013;

Thomas & Mackey, 2012; van Schaik, Plant, Diane, Tsnag, & O'Sullivan, 2011; Wagner, Bear, & Sander, 2009).

Simulation is a teaching strategy that can address all four sources of student self-efficacy judgement – mastery of experience, vicarious experience, verbal persuasion, and physical/emotional states (Bandura, 1997; Sinclair & Ferguson, 2009). After a simulation experience, students believe that their confidence increases in their capability to care for their patient in a real clinical environment, especially their technical skills, because simulation provides an opportunity for mastery of experience through prior experience and success (Kuznar, 2007; Reilly & Spratt, 2007). This safe learning environment allows students to develop critical thinking skills, enhance teamwork skills, improve communication skills, and develop psychomotor skills (Moule, 2011). Students provided with an opportunity to practice these skills and apply prior knowledge in a safe environment allow them to obtain some feedback from the CNI or their peers (Benner et al., 2010), supporting Bandura's self-efficacy judgement through verbal persuasion. During the simulation exercise, vicarious learning is evident; since, students are often congregating, observing and learning from each other's performance, and the emotional response of anxiety begins to subside and student confidence levels rise (Sinclair & Ferguson, 2009).

CNI approach. In Tang, Chou, and Chiang (2005) study of student perceptions of an effective CNI, a CNI's demeanour has a significant effect on students' level of anxiety and stress in the CLE. In fact, students prefer a nursing instructor with good relational skills and a positive attitude toward students, creating a clinical environment conducive to learning; this positive attitude of the nursing instructor is more favourable than the nursing instructor's clinical ability or skill. This attitude and support of the CNI is salient to being an effective clinical instructor and alleviating student anxiety (Tang, Chou, & Chiang, 2005). In a similar vein, Townsend (2012)

demonstrates through qualitative research that the CNI is the most salient influence in a student's ability to learn and develop confidence in the CLE. Some of the comments from students in regards to how a CNI made them feel confident in their learning relates to the nursing instructor's demeanour: "setting a positive tone, make me feel welcome, clear expectations, and build me up – don't shut me down" (Townsend, 2012, pp. 51-63). Additionally, according to Chernomas and Shapiro (2013), students related their level of stress and anxiety in relation to the clinical instructor/staff approach with the students; one student claimed that "clinical is extremely stressful especially if you have a clinical teacher that is not very helpful or other nurses that you can tell are annoyed by students" (p. 262).

In addition, researchers have explored student perceptions of the psychosocial aspects of their CLE utilizing a Clinical Learning Environment Inventory; these psychosocial aspects included individualization, innovation, involvement, personalization, task orientation, and satisfaction (Chan, 2001). Interestingly, the personalization factor achieved the highest score in Berntsen and Bjork (2010), and Smedley and Morey (2010) studies. Personalization referred to the fact that nursing instructors had a genuine interest in students and that students had an opportunity to interface with the instructor (Chan, 2001). CNIs have the potential to build student confidence by being caring, competent, and committed to students; making a connection with students permits a transformative space for learning and knowledge creation (Gillespie, 2005).

This aforementioned research demonstrates two sources of Bandura's self-efficacy judgement: first, students value verbal persuasion from the CNI, through words of encouragement, interest, and a positive approach. This verbal persuasion strengthens students' belief that they are capable in this challenging environment, guiding students to do their best (Bandura, 1997). Secondly, this positive learning environment with an approachable CNI has

the potential to reduce student anxiety. If a student's level of anxiety and stress are not high, then the student's vulnerability will subside and s/he will have more confidence in their capabilities (Bandura, 1997). Although these aspects of verbal persuasion from the CNI, such as encouragement, genuine interest, and a positive approach seem like common sense, often CNIs are not experienced or trained in teaching students and may not recognize the favourable qualities of a CNI to support student learning and confidence. Additionally, it is possible that CNIs do not feel confident themselves in performing certain tasks, so s/he may not verbally encourage students to perform.

Sense of belonging. Maintaining the assertion that the CLE is a complex social environment with the interweaving of a variety of social interactions, nursing staff and student interactions in the CLE affects a student's clinical experience, learning, and success in a nursing program (Henderson et al., 2010; Pearcey & Elliot, 2004). These interactions can include cliques among nursing staff on the units that can influence a student's formation of his/her own nursing identity. The inter-generational factor between staff nurses and student nurses creates cliques on the unit that influence student learning experiences, sense of competence, and retention rates (Newton, Billett, & Ockerby, 2009).

According to Nolan (1998), it is important for students in the CLE to "fit in" with nursing staff, since this sense of belonging affects their psychological well-being and confidence in developing their nursing skills. Further to this, this research demonstrates that when nursing staff value students' knowledge and allow students to demonstrate their skills and capabilities in nursing care, this approach becomes a form of acceptance and students feel a sense of belonging, which assists students in developing their confidence. In fact, "until students feel accepted, learning cannot proceed, as fitting-in takes up most of their time and energy" (p. 626). However,

Nolan (1998) cautions the validity of this premise, because if students fit in on the unit too well, their confidence may begin to diminish, due to the fact that, they begin to make decisions based on potential reactions from the nursing staff. Students may feel pressured from nursing staff to practice in a particular manner that may not represent safe, competent, and ethical care (Nolan, 1998). Further to this, students in the study claim that their confidence diminishes when nursing staff or the nursing instructor scrutinize their activities, creating a stressful learning environment, even if students are quite capable in performing the task. Students want the nursing staff and the CNI to trust them and provide them with opportunities to be responsible for patient care, since this sort of behaviour boosts their confidence (Chesser-Symth & Long, 2013; Koontz, Mallory, Burns, & Chapman, 2010). Students need a “space to grow”, such as a CLE that involves the collaboration between the student, nursing staff, and the instructor, in regards to planning learning experiences and communicating with each other to ensure patient safety (Gillespie, 2005, p. 216).

Additionally, students feel more confidence in their capability to perform nursing care when they are able to *do* the task, rather than *observe* the staff nurse (Lofmark & Wikblad, 2001; Nolan, 1998). “Learning by doing is the crux of clinical placement, as problems are placed within context and critical thinking can be developed” and when students contribute to nursing care on the unit, they feel more confident in their nursing skills (Nolan, 1998, p. 626). Further to this, Bradbury-Jones, Sambrook, and Irvine (2011) state that when students obtain a sense of empowerment – that is, being valued as a team member on the unit; being valued as a learner and being valued as an individual, they feel confident in their ability to learn.

Lofmark & Wikblad (2001) demonstrate that when others in the clinical environment, such as nursing staff provide students with responsibility and a sense of autonomy, this dynamic

increases their confidence and success in clinical practice. Being responsible for the whole client provides them with some confidence in making decisions regarding client care. Additionally, verbal persuasion, such as being accepted and receiving constructive feedback from the staff, patients or instructor, contributes to an increase in student confidence (Lofmark & Wikblad, 2001). Furthermore, students deem a positive learning environment as one in which they feel a sense of community or belonging among the staff on the unit; that is, students feel like they belong within the team, through the nursing staffs' sense of reception, inclusion, recognition, and support (Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Smedley & Morey, 2010). If the nursing staff on the unit is not supportive of students, then students feel a lack of confidence in themselves and feel a heightened level of anxiety (Gillespie, 2005). Henderson et al. (2010) suggest that there is significant value in implementing processes and structures for staff nurses to enhance their skills in teaching and learning to support student learning. Furthermore, this intervention needs to be entrenched within the culture of nursing practice; that is the values, beliefs and norms around working with students needs to change to enhance students' clinical experience (Henderson et al., 2010).

It is evident that a sense of belonging for students has a stronger relationship to *doing* care than *observing* care, supporting Bandura's (1997) premise that mastery of experience is a powerful source for student self-efficacy. Students want to be included in the multidisciplinary team of care, demonstrate their skills, and be responsible for the entire patient, not just responsible for specific components of patient care. This sort of inclusion can increase student confidence in the provision of care, through a more comfortable learning environment, decreasing a student's stress level; since, a student's physiological and affective states influence their self-efficacy judgment (Bandura, 1997).

Peer-to-peer learning. Peer-to-peer learning allows students to teach and learn from each other (Iwasiw & Goldenberg, 1993). A student's clinical learning experience can create a significant amount of stress and anxiety for the student, and research demonstrates that reducing a student's anxiety can be achieved through peer-to-peer teaching and learning (Sprengel & Job, 2004; Broschius & Saunders, 2001; Giordana & Wedin, 2010); further to this, peer coaching can improve self-confidence in clinical decision-making (Broschius & Saunders, 2001). Nolan (1998) study claims that nursing students feel that a peer-supported environment contributes to their capability to critically think together and collaborate about patient care. Peers can be a source of support and camaraderie in a clinical setting, as they learn from each other, which can influence a student's professional development (Melincavage, 2011). The study by Stables (2012) demonstrates that peer learning has a positive effect on a student's development of his/her clinical skills, confidence, and theoretical understanding.

However, peer influence in the CLE is not always a positive influence upon student learning and self-confidence. According to Lofmark and Wikblad (2001), peer influence on student confidence did not emerge from the data; but this finding can be related to the modeller's skill or perhaps the fit between the modeller and the student. Further to this, Clarke, Kane, Rajacich, and Lafreniere (2012) and Melincavage (2011) claim that peer pressure or bullying exists in nursing education and can be a source of stress for students in the CLE, affecting their self-confidence. Brannagan et al. (2013) declare that peer mentorship does not improve student self-efficacy in performing skills in the lab. Mentees are actually more anxious with the peer mentor than the instructor because mentees feel that the instructor provides more direction, and their critical thinking and problem solving skills improve with the instructor. It is possible that the mentor did not obtain adequate training to guide students through the skills or that the skills

were not complex enough and students had confidence already in performing the skills (Brannagan et al., 2013).

The CLE of a peer-to-peer influence through mentoring or modelling can elicit a calming clinical climate for students, which can affect their physiological response to their learning experience, such as a reduction in anxiety, because student perceptions of their ability to be successful in practice will be influenced by their physiological state (Bandura, 1997). Bandura (1997) recognizes that learning can transpire vicariously through modelling and that this vicarious learning influences student self-efficacy, especially when there is a commonality between the modeller and the trainee. Learning vicariously, through modelling, allows students to utilize that information in their future behaviour of performing the same skill or task. It provides students with an opportunity to self-regulate their own behaviour against the vicarious experience (Bandura, 1997).

Debriefing. Post-conference is a prevalent component of a student's clinical practice day. There is value in providing students with an opportunity to reflect on their experiences that occur throughout the clinical day. This sort of collaboration has great potential to bridge the gap between theory and practice, and assist students to move from novice to expert (Benner et al., 2010). According to Iwasiw and Sleightholm-Cairns (1990), post-conference is salient for students to embrace the true value of experiential learning as the instructor moves students through the cycle of experiential learning, as seen through Kolb's experiential learning cycle, via debriefing, questioning, and discussing. Post-conference creates a great opportunity for students to ask questions and engage in inquiry that can lead to critical reasoning, and reflective practice (Hsu, 2007; Pedrosa-de-jesus, de Sliva Lopes, Moreira, & Watts, 2012). Further to this, debriefing is found to be a salient component after a simulation experience in clinical learning;

knowledge is enhanced only after the debriefing experience, as students have an opportunity to reflect, receive feedback, engage in questioning, and collaborate through problem-solving (Shinnick, Woo, Horwich, & Steadman, 2011).

According to Bandura (1997), this debriefing period allows students to share their experience, interact and receive feedback from their peers, and their CNI, creating an opportunity for vicarious learning in which the students are learning from each other's experiences. Moreover, there is an opportunity for verbal persuasion from the CNI or peers to provide recognition, constructive feedback, support, and encouragement to students. If others have confidence in a student's ability, then it is much easier for the student to feel confident in him/herself (Bandura, 1997).

Clinical journaling. Clinical journaling is a narrative pedagogy seen in nursing education across the country. Often journaling consist of reflection and self-awareness about a particular clinical experience and this process allows the student to integrate theory learned in a classroom setting into the practice realm, identifying gaps in their knowledge, as well as engaging in goal setting for future practice (Kennison, 2012). Further to this, "reflective writing is useful in developing critical thinking skills, documenting professional practice experiences, fostering self-understanding and facilitating coping with critical incidents" (Craft, 2005, p. 53). This writing process allows the student to process the information in a narrative form, a safe environment, so they can utilize the information in their future practice (Benner et al., 2010).

Bandura (1997) claims that this can be an optimal opportunity for the instructor to provide some verbal persuasion as it relates to a student's performance in practice, in order to enhance student self-efficacy. Efficacy beliefs emerge from the student's experience and the student's cognition, such as their reflective thought. Journaling is a platform for the student to

engage in self-reflection and self-regulatory learning, in order to recognize if changes need to be made in his/her performance, allowing the student to take control over his/her learning. This self-regulated learning through journaling consists of the components of reciprocal causation by considering the student's internal process (efficacy beliefs and goals), the CLE (support received from the CNI or staff), and the student's behaviour (the outcome of performing a specific task) (Bandura, 1986).

Constructive feedback. “Experiential learning depends on an environment where feedback on performance is rich and the opportunities for articulating and reflecting on the experience are deliberately planned” (Benner et al., 2010, p. 43). Feedback can be an interactive process and learning experience, which assists the student in gaining a clearer picture about his/her performance by viewing the discrepancy between the student's actual performance and the expected performance; this feedback can be of a constructive or destructive nature, as well as in a formal or informal fashion (Clynes & Raftery, 2008; Fereday, 2006). However, in order for students to grow academically, to expand their self-confidence, to persevere in practice and to be highly motivated, feedback needs to be constructive (Baard & Neville, 1996; Clynes & Raftery, 2008; Glover, 2000; Rowbotham & Owen, 2015; Townsend, 2012).

This constructive feedback becomes the gateway to verbal persuasion to instil confidence within the student, in order for the student to persevere and attempt the task in the near future (Bandura, 1997). According to Glover (2000), appropriate feedback allows the student to self-regulate his/her learning and “study up” (p. 251). The important components of feedback for students should focus on their behaviour, be positive in nature, immediate, and only enough information to make improvements, providing students with an opportunity to reflect on their practice and knowledge, so improvements can be made in their future practice (Glover, 2000).

For the most part, students value the feedback and recognition received from the nursing staff, regarding their efforts in the CLE (Chan, 2002; Hart & Rotem, 1994).

Self-efficacy in Other Contexts

In addition to the effects of one's self-efficacy in the psychological or educational domain, one's self-efficacy has a valuable influence on health behaviour, athletic performance, career development, occupational roles, and job satisfaction. Much of the research, in the health care field, demonstrates a positive relationship between self-efficacy and health behaviour, recognizing the value of the health care provider in improving an individual's self-efficacy and outcome expectations. An epitome of this positive relationship was seen in the research of postpartum women's initiation and perseverance with breastfeeding and level of maternal self-efficacy (Dennis, Heaman, & Mossman, 2011, Loke & Chan, 2013; Blyth et al., 2002; Wilhelm, Rodehorst, Stepan, Hertzog, & Berens, 2008). Further to this, research on health related behaviours, such as self-care practices, demonstrates that efficacious individuals are more likely to demonstrate confidence in their capability of self-care practices, such as post-cardiac events (Padula, Yeaw, & Mystery, 2009), diabetic self-management (Utz et al., 2008), brushing and flossing practice patterns (Buglar, White, & Robinson, 2010), diet choices of adolescents and exercise regimes (Bryne, Barry, & Petry, 2012; Fitzgerald, Heary, Kelly, Nixon, & Shevlin, 2013), as well as condom use among adolescents (Baele, Dusseldorp, & Maes, 2001).

In the competitive realm of sports, an athlete's path to success relates not only to the athlete's physical ability but also to the athlete's mental skills (Bandura, 1997). Research demonstrates a predictive link of an athlete's level of self-efficacy and an athlete's actual performance, effort, and competitive anxiety in a sporting event (Beshart & Pourbohloul, 2011; Gilson, Reyes, & Curnock, 2012). An athlete's progression to success relates to his/her

capability to remain efficacious through the physical pain, challenges, and failures during the event. There is a reciprocal interface between the athlete's skill development and maintenance of his/her efficacy belief (Bandura, 1997).

In a similar vein, according to Bandura (1997), self-efficacy can influence an individual's career development or career progress; individuals begin to make choices about their career path at an early age – the broader efficacy beliefs an individual attains, the more career opportunities an individual will consider for his/her future. For instance, mathematical skills often relate to an individual's mathematical efficacy; if mathematical efficacy is low, the individual avoids scientific or technical careers (Bandura, 1997; Hackett, 1995).

Similarly, not only does an individual's self-efficacy influence the preparation one endures for his/her career but also once the individual is immersed in his/her career, efficacy beliefs influence the roles, responsibilities, and satisfaction of the job. In the business world, managerial skills are closely linked to one's belief about accomplishing or performing tasks (Baron & Morin, 2010; Hannah, Avolio, Walumbwa, & Chan, 2012). Self-efficacy in health related career fields link self-efficacy as a predictor of a health care provider's behaviour in performing challenging tasks; for example, health care providers, such as physicians and nurses, trained in paediatric resuscitation, will struggle in implementing their resuscitation skills on a paediatric patient, if they do not believe that are capable of carrying out the skills necessary to be successful at resuscitation efforts (Carroll, Maibach, & Schieber, 1996; Coolen, Loeffen, & Draaisma, 2010). Further to this, research completed by Herold, Bennett, and Costello (2005) claim that health care providers, such as, rehabilitation professionals lack confidence in advocating for patients, engaging in lifelong learning activities, and performing non-practical skills, which has implications for their career development, the health care system, as well as,

preparation practices for these rehabilitation professionals. In a similar vein, related to preparatory practices, Hechter (2011) claims that a preparatory methods course for preservice elementary science teacher candidates positively influences science teaching self-efficacy, with the premise that science teaching self-efficacy will transfer into the real classroom experience. Additionally, a teacher's level of self-efficacy in various skill sets of his/her job influences job satisfaction; for instance, teachers with high classroom management self-efficacy and high instructional strategies self-efficacy exhibit greater job satisfaction (Klassen & Chiu, 2010).

It is evident that a high level of self-efficacy in a variety of different context represents a valuable form of human capital. The meaning of self-efficacy remains stable throughout the various contexts – maternal self-efficacy, career self-efficacy, performance self-efficacy, teacher self-efficacy, math self-efficacy, or classroom management self-efficacy. All of these contextual representations of self-efficacy relate to an individual's confidence in their capability to fulfill a specific task related to the uniqueness of the context. Additionally, many of these studies recognize the value of Bandura's self-efficacy theory as a predictive and explanatory theory – an individual's cognition and environment can influence his/her behaviour, success and performance (Bandura, 1997).

Summary

This literature review encompassed knowledge about the various clinical practice models, in order to gain an understanding of the uniqueness of the CLE and to recognize how this environment relates to adult learning. Conceptualizing self-efficacy and differentiating between various self-beliefs provided a more robust understanding of the concept. Further to this, exploring self-efficacy through global triadic reciprocal causality assisted in understanding the complexity of the interactions between an individual's thought process, his/her behaviour, and

the environment. Examining how student self-efficacy judgement emerges through social and instructional features of the CLE, assist stakeholders in understanding the positive relationship between learning, self-efficacy, and success. Furthermore, an exploration of self-efficacy in other fields demonstrated a relationship between an individual's self-efficacy and their success, as well as ways to enhance an individual's self-efficacy. This literature review creates a strong body of evidence that considers the relationship between confidence, self-efficacy, learning, and success. Advancing forward with this thesis research, to explore and understand how students perceive their development of confidence in the CLE and what features of the CLE support learning and the development of confidence, will add another layer of knowledge to understanding the development of student confidence in the CLE. Chapter three will focus on the methodological approach of this research.

Chapter Three: Methodology

This chapter details the methodological approach that includes the research design, sampling criteria, recruitment process, setting and site, data collection procedure, data analysis technique, and data management. Additionally, this chapter concludes with a description of how the research will be disseminated, an explanation of the strategies used to achieve trustworthiness, and a depiction of the ethical considerations.

Design

There is limited research in the literature on student perceptions of developing confidence in the CLE and what features of the CLE support learning and development of student confidence. Qualitative research “[addresses] research problems requiring an exploration in which little is known about the problem and a detail understanding of a central phenomenon [is required]” (Creswell, 2008, p. 51). Qualitative research sets out to recognize themes, categories, subcategories, and patterns (Creswell, 2008) through “comprehensive summarizations, in everyday terms, of specific events experienced by individuals or groups of individuals” (Lambert & Lambert, 2012, p. 255). In this research study, a qualitative descriptive approach was used to provide students with an opportunity to share their perceptions of their clinical learning experiences, so stakeholders can gain insight and awareness of how students perceive the development of confidence and to discover what features of the CLE support student learning and their development of confidence. This is an acceptable “design of choice when a straight forward description of a phenomenon is desired” that is important for nursing education to understand, so they can create the best clinical learning experiences for students (Lambert & Lambert, 2012, p. 256). The research questions in this research were of a narrow scope with the goal of focusing on the specific phenomenon of a student’s development of confidence in the

CLE. The outcome of this thesis research was rich descriptive responses from students of their clinical learning experiences and interpretative thematic summaries. These data can be useful knowledge for those working with students in the CLE and for curriculum development in nursing education programs (Sandelowski, 2000; 2010).

Participants

A purposive sampling method, commonly used in qualitative descriptive research, was used for this research based on the premise that this strategy provides rigour for this research study (Sandelowski, 2000). The researcher chose participants that were information rich about the phenomenon of interest, so they could discuss the phenomenon liberally (Creswell, 2008; Hays & Singh, 2012). The participants in this study were third year nursing students in the three year Red River College Baccalaureate Nursing program. These students were either embarking upon or practicing in their Consolidated Senior Practicum consisting of 450 hours of clinical practice time, the last clinical practice course in the nursing program. Participants were all female encompassing a variety of ages. Five participants were under the age of 25 years, three participants were between the ages of 25-35 years, one participant was between the age of 36-39 years, and one participant was over the age of 40 years. Half of the participants were single and the other half were either married or common-law. Three participants had children and for all participants, English was their first language. Hereafter, participants will be referred to as *students* in this thesis research.

Generally, qualitative research consists of a smaller sample size than quantitative research with the focus of gaining deeper insights of a particular phenomenon (Hays & Singh, 2012; Smith et al., 2011). Sample size can range from 1 to 40 participants depending on the type of qualitative research (Creswell, 2013). In this thesis research, a sample size of 10 students

provided rich descriptive data that achieved data saturation. Data saturation occurs when there is repetition of the data collected and no new information surfaces (Polit & Beck, 2012; Streubert & Carpenter, 2011). By the end of the tenth interview, it was evident that saturation was reached since no new themes developed and there was repetition in descriptive data noted throughout the data collection. However, the staff/unit culture theme was less developed and it is possible that with a larger sample size that this theme would have developed more robustly. Nonetheless, it is also possible that this theme is developed fully due to the fact that this theme of staff/unit culture refers to those nurses/staff that would have had limited contact with students, since students interacted more with their buddy nurse and not so much with the other staff. The goal of this thesis research was not to generalize the findings, but rather provide rich description of the phenomenon of interest as described in chapter four.

Students eligible for this research study met the following inclusion sampling criteria:

- a) They completed NRS 3860 Clinical Practice 6 and NURS 3604 Perinatal and Growing Family Health, since the researcher teaches within these courses.
- b) The researcher had no further contact with students as a student-teacher relationship after they completed these courses. This approach minimized the balance of power between the researcher and the students, in order for the students to share their stories freely (Creswell, 2013).
- c) Students were not involved in an appeal process with the researcher, which upheld neutrality and avoided any student bias.

Recruitment Process

Once ethical approval was obtained from Red River College and the University of Manitoba Research Ethics Board, recruitment of eligible students took place through a sequence of events.

- a) First, permission to invite students to participate in the research was obtained from the Chair of the nursing program at Red River College via a letter of request (see Appendix A).
- b) Once permission was obtained from the Chair, the course leaders from the third year clinical practice courses Palliative Care, Mental Health, and the Senior Consolidation Practicum course were contacted to request 10-15 minutes of their class time to explain the research study and begin the recruitment process. A script was utilized to present the information about the thesis research to the students, in order to maintain consistency of information received (see Appendix B). A colleague of the researcher (an individual not affiliated with the nursing department) delivered the script to students to invite them to voluntarily participate in the study. Once the colleague shared the information of the thesis research, students were provided with an information sheet about the study, which included the researcher's contact information should they be interested in participating (see Appendix C).
- c) Students were informed that they will receive an honorarium of a \$25.00 gift certificate to Chapters bookstore, to compensate them for any expenses incurred to participant in the study, such as parking or travelling expenses.
- d) The first ten students to contact the researcher in their interest to participate and meet the sampling criteria were invited by the researcher to participate in the research study. At this time, the researcher arranged with each student a mutually agreed upon place/date/time for a semi-structured interview.

Data Collection

The data collection in this research study encompassed a 45 minute to 1 hour digital audio recorded semi-structured one-on-one interview with each student and the researcher to collectively generate knowledge about the student's clinical learning experiences. Permission

was obtained from the students to digitally audio record the interview. Throughout the interviews, open-ended questions (see Appendix E) were utilized with probing, clarifying, and commentary prompts to allow for some flexibility and opportunity for students to engage with the researcher by sharing and describing their clinical learning experiences in their own words (Hays & Singh, 2012; Polit & Beck, 2012; Streubert & Carpenter, 2011). This approach is commonly used in qualitative descriptive research, since the researcher seeks to discover *the what* of the students experiences (Sandelowski, 2000) to gain a deeper understanding about their experiences and perspectives of the phenomenon (DiCicco-Bloom & Crabtree, 2006; Hays & Singh, 2012). Typically, in qualitative research semi-structured interviews are 30 minutes to several hours in length (DiCicco-Bloom & Crabtree, 2006) and utilizing a digital audio recording device for semi-structured interviews creates a relaxed environment, since the researcher is not compelled to take notes and remains focused on the participant (Whiting, 2008). Digital audio recording in this study served as a purpose for a complete and accurate transcription of student verbatim responses, as well as recognizing any student nuances, such as emotions, during the data analysis process. Note taking during an interview can lack important details, be biased by the researcher's perspective or memory, and make students feel nervous about the interview process (Polit & Beck, 2012). Note taking took place immediately after the interview, regarding student behaviour or emotions during the interview process.

The focus on the quality of the data collected in this thesis research was based upon the strength of engagement between the student and the researcher during the one-on-one interview (Mayan, 2009). The researcher was cognizant in providing students ample time to respond to questions, and although there was an interview protocol, the researcher allowed for flexibility

based on student willingness to share their clinical learning experiences, in order to allow for rich descriptions of their experiences (Hays & Singh, 2012).

Bandura's theory of self-efficacy guided the interview questions, focusing on the sources of self-efficacy, and the principle of reciprocal causation. An interview protocol was utilized to guide the interview process (Creswell, 2008). The researcher had obtained permission from Linda Townsend (see Appendix D), who completed similar research in the area of student confidence within the CLE, to utilize and/or slightly modify her seven open-ended questions for the interview protocol (see Appendix E). Importantly, prior to engaging in data collection with students, the researcher respected the value of establishing rapport with the students to diminish the effect of them providing "socially acceptable answers" (Streubert & Carpenter, 2011, p. 35).

The researcher created a rapport building environment by demonstrating respect towards student thoughts and feelings about their clinical learning experiences, so s/he would feel secure and comfortable sharing their stories freely during the data collection process (DiCicco-Bloom & Crabtree, 2006). Establishing rapport exists through various stages of the interview process. The researcher implemented and valued these stages of rapport throughout the collection of data – apprehension phase, exploratory phase, co-operative phase, and participation phase (DiCicco-Bloom & Crabtree, 2006).

During the apprehension phase, the students may feel insecure or unsure of expectations. In this thesis research, students did not openly express feeling insecure or unsure of expectations. Upon meeting the student in a mutually agreed upon location, the researcher engaged in a brief social dialogue with the student to begin building rapport. Often the dialogue centered on the student's choice of and integration in her Consolidated Senior Practicum. Following this brief social dialogue, the researcher explained to the student the purpose of the research, the format,

the length of the interview, the dissemination of the findings and reaffirmed that she could seek clarification at any time, and ask or decline any of the interview questions (Creswell, 2008; Whiting, 2008).

Following a brief social dialogue and a description of the research study, some demographic information through a questionnaire was gathered from the students to obtain a description of the students in relation to their age, relationship status, gender, number of children, and first language. As well, the researcher shared and emphasized with students how confidentiality and anonymity would be upheld. The researcher explained to the students that the consent form would be retained in a secure location, since it would contain sensitive information of the student's identification, through an encrypted code, as well as her name (Creswell, 2008). Further to this, the student was informed that the information she shares with the researcher that exists in a digital audio recording form, and written transcription would be identifiable only by an encrypted coding system, in order to maintain anonymity (Creswell, 2013). Further to this, students were informed that any information shared with the transcriptionist, research supervisor, or committee members would be of an encrypted code nature with no identifiable names on any documents. Students were asked for permission to digitally audio record the interview and provided some time to read through and sign the written consent form and a copy was given to the student to retain (see Appendix F).

Once the introductory dialogue was completed, and as part of the *apprehension phase*, the researcher began the interview with a broad and open-ended question relating to the research, being non-invasive, and being familiar, in order to create a relaxed setting and encourage the student to engage in a discussion, followed by more guided questions to address various aspects of the research phenomenon (DiCicco-Bloom & Crabtree, 2006). The following question was the

opening question to the students: How would you describe a typical day in clinical practice for you?

Following this phase, the *exploratory phase* created more insightful information from the student's experience and perspective. The researcher was flexible and utilized probing questions, so students were able to elaborate on their experiences to provide rich responses (Hays & Singh, 2012; Whiting, 2008). Some examples of probing questions used in this research were as follows: "Can you give me an example? [;] Tell me a little more about that. [;] What was that like for you?" (Hays & Singh, 2012, p. 242); How do you define...? Caution was taken to ensure that questions were of a probing nature and not of a leading nature (Mayan, 2009).

As all the students moved into the *co-operative phase*, they became comfortable interacting with the researcher by easily sharing details about their clinical learning experiences relating to their development of confidence (DiCicco-Bloom & Crabtree, 2006). The researcher and the student discovered together and collected data about her clinical learning experiences as the researcher clarified comments, and approached sensitive aspects related to the student's clinical learning experience, such as her feelings. This form of knowledge added another layer of richness to the data (DiCicco-Bloom & Crabtree, 2006).

The depth of student responses to the interview questions were diverse. On occasion, some students had difficulty answering a question due to lack of memory or lack of exposure to a clinical experience. Interestingly, students that encountered challenging experiences in their clinical practice had the most comprehensive responses, often discussing the details of the challenge, but also describing how they would have preferred their clinical experience to unfold, in order for them to learn and gain confidence in their nursing practice.

Seven interviews reached the *participation phase* of the interview process – the phase in which the “greatest degree of rapport [was developed and the participant took] on the role of guiding and teaching the [researcher]” (DiCicco-Bloom & Crabtree, 2006, p. 317). These seven students took it upon themselves at the end of the interview to add additional comments about learning in the clinical environment that they felt were important for the researcher to know about their CLE. Their comments ranged from elaborating on negative situations in clinical practice to commendations of the Red River College CNIs. Students also took the opportunity to place emphasis on existing information created during the interview process, such as the importance of student reflection, unit morale, and an approachable CNI.

Upon closing the interview, the researcher expressed her appreciation of the students’ participation in the research study by thanking and reassuring them once again, that the discussions within the interview would remain confidential (Whiting, 2008). Additionally, students were given an opportunity to ask questions and make additional comments, as well as the researcher discussed the utilization of the thesis findings (Creswell, 2008).

Site and Setting

The interviews took place at a mutually agreed upon location between the researcher and the student, outside the nursing department, at Red River College or the health care facility where the student was completing her Consolidated Senior Practicum. The location was private and quiet to eliminate distractions, support confidentiality, and allow for effective digital audio recording. (Creswell, 2008). A ‘do not disturb’ sign was placed on the door to avoid any interruptions. The researcher and the student were seated side by side versus across from each other in order to demonstrate equality and comfort for the student rather than having a table between the researcher and the student (Olson, 2011).

Data Analysis

Data analysis was of an inductive nature, utilizing content analysis as the analytical technique typically used in descriptive or exploratory research (Mayan, 2009; Sandelowski, 2000). Conventional content analysis is often used when little is known about a phenomenon and when the researcher wants to understand phenomenon by obtaining descriptive data from participants without using preconceived categories, permitting categories to emerge from the data (Hsieh & Shannon, 2005). This technique enabled the researcher to describe student perspectives verbatim by using direct quotes to illustrate specific categories (Sandelowski, 2000). Important knowledge was gained about student perceptions of developing confidence through their clinical learning experience and what features of the CLE supported learning and the development of confidence.

The data analysis process progressed as follows (Creswell, 2013):

- (a) The researcher engaged in a reflexive exercise prior to the interview process by documenting her experience related to the phenomenon being studied to separate out her personal experience from the student's experience, so the focus remained on the student's descriptions. Further to this, the researcher documented in a reflexive journal after each interview in regards to any nuances noted during the interview such as students expression of emotions, how this new knowledge supplemented the researcher's current knowledge of the development of student confidence in the CLE, what patterns and themes were emerging, and the researcher's reaction to these data being created (Streubert & Carpenter, 2011).
- (b) Data analysis commenced during the interview process by actively listening to the students verbal descriptions of developing confidence through their clinical learning experiences (Streubert & Carpenter, 2011).

(c) Even though a professional transcriptionist transcribed the data, the researcher reviewed all digital audio recordings to assess for accuracy of the transcription and to recognize any verbal tones that may assist in understanding the data to maintain the authenticity of the data. In addition, the researcher reviewed her reflexive journal particularly, post-interview note taking about student emotions and mannerisms during the interview to add additional meaning to the data collected.

(d) The researcher read each transcript twice, in order to obtain a sense of the raw data in its entirety and highlighted key narratives within each interview transcript to develop a list of significant statements. Note taking in the margins of the transcripts using short phrases or ideas occurred to begin the process of coding.

(e) A list of the significant statements were created and clustered into themes, categories, and sub-categories. Significant statements were re-read several times to cluster data into appropriate categories and sub-categories. An excel program was used to manage, code, and sort data.

(f) The transcripts were reviewed again to re-check for any newly emerging codes. The researcher consulted with the research advisor about the development of themes. The research advisor read a transcript to review the suitability of the themes, categories and sub-categories engendered from the data to enhance the trustworthiness of the analysis.

(g) The researcher summarized the findings of four interviews to provide four students with an opportunity to review the researcher's summary of their comments to enrich the trustworthiness of the analysis (see Appendix H).

(h) The findings were documented in thematic descriptions, including direct quotes of how students' perceive their development of confidence in the CLE and what features of the CLE support students learning and development of confidence.

(i) Finally, the researcher completed a deductive process of comparing thematic descriptions with existing literature to create a discussion of the findings, implications for clinical nursing education and recommendations for future research in nursing education.

Data Management

Data creation via the digital audio recording was transcribed to text data by a professional transcriptionist, employed by the researcher (Creswell, 2008). The researcher ensured that confidentiality and anonymity of the student's information was maintained. The importance of maintaining confidentiality was explained to the professional transcriptionist and she signed a confidentiality form prior to the transcription of the data (Lobiondo-Wood & Haber, 2009) (Appendix G). All raw data was assigned an encrypted code. The informed consent form was the only document that had the encrypted code and the student's name, which was accessible only to the researcher and stored in the researcher's locked filing cabinet, through key entry, separate from all raw data. The consent form will be destroyed through a confidential shredding process at the University of Manitoba Faculty of Education after one year (June 2017) of completing the research.

The raw de-identified data in hard copy version, such as transcriptions of the one-on-one interviews, demographic data, and the researcher's reflexive journal data was stored in the researcher's locked filing cabinet, through key entry. Only the researcher had access to the key/cabinet. These hard copies will be destroyed through a confidential shredding process at the University of Manitoba Faculty of Education after one year (June 2017) of completing the research (Creswell, 2013).

All raw de-identified data in an electronic version, such as transcriptions of the one-on-one interviews, digital audio recordings, and this thesis were stored on a memory stick that was

locked in the researcher's filing cabinet, through key entry, as well as these data were stored on the researcher's personal computer through password protection. Only the researcher had access to the password protected computer. Digital audio recordings and electronic data, excluding the thesis, will be destroyed by deleting files after five years (June 2022) from completing the research. Dr. Marlene Atleo (research advisor) can have access to the hard copy and electronic copy of the de-identified data, upon request (Creswell, 2013).

Data Dissemination

Sharing this valuable information, gained from students in their own words, will be advantageous for CNIs, curriculum development, and members of the health care team who work with students in the CLE. In order to make these findings discernible to others, the researcher will publish the findings in a nursing education peer reviewed journal and present the findings at a nursing education conference in order to heighten awareness of this disciplinary knowledge. Further to this, there will be an opportunity for the researcher to share the findings of this thesis research with the Red River College nursing faculty at a faculty meeting or during the Teaching Excellence Day that occurs at the end of every academic year. Finally, yet importantly, the researcher will provide a summary of the research findings to the nine students, whom requested a copy.

The researcher recognizes the challenges faced in the dissemination of the results from the solo perspective of the student to a group of nursing educators, so the researcher will be committed to communicating student experiences, as specifically described by the student. The dominate voice will be that of the students, possibly describing negative experiences they had encountered with CNIs, so every effort will be made to share students stories in a tactful and respectful manner (Streubert & Carpenter, 2011).

Criteria and Strategies of Trustworthiness

The integrity of this qualitative research was carefully considered throughout the research process (Richards & Morse, 2007). The goal of this research was to provide an “insightful and accurate representation” of student perspectives, ultimately ensuring the trustworthiness of the research study (Polit & Beck, 2012, p. 584). Trustworthiness is a reflection of the researcher’s ability to establish confidence in the truth of the findings; for instance, findings could be applied to a similar context or comparable students; findings would be similar if the research was replicated; and findings would be impartial from the researcher’s biases or interests (Lincoln & Guba, 1985).

Lincoln and Guba’s view of trustworthiness, developed in 1985, is still a prevalent option in 21st century qualitative inquiry and is best suited for this thesis research as a strategy to ensure the trustworthiness. The strategies used in this thesis research to ensure trustworthiness were represented by the criteria of *credibility*, *dependability*, *confirmability*, and *transferability* (Lincoln & Guba, 1985). Further to this, an additional criterion, *authenticity*, developed by Guba and Lincoln in 1994 suits this research study, as well (Polit & Beck, 2012).

Credibility. “Credibility refers to confidence in the truth of the data and interpretations of them” (Polit & Beck, 2012, p. 585). This naturalistic approach was about accurately maintaining the constructs of students’ perspectives (Lincoln & Guba, 1985). There are various approaches to enhance the credibility of qualitative research. This research study represents triangulation, prolong engagement, researcher reflexivity, member checking, and peer debriefing, as strategies to establishing credibility (McMillian, 2012; Polit & Beck, 2012).

Triangulation. Triangulation is a technique that is used to recognize the complexity of the student’s experience by the researcher employing strategies to ensure that the findings are

accurate, complete, and credible (Lobiondo-Wood & Haber, 2009; McMillian, 2012; Streubert & Carpenter, 2011). The researcher reviewed the text transcriptions and digital audio recordings in a comparison manner to ensure the transcriptionist accurately transcribed the digital audio recorded data into a text version, confirming these data was complete and accurate. Also, the researcher's note taking in her reflexive journal post-interviews added another layer of evidence to describe, make meaning of the data, and ensure completeness of the data (Streubert & Carpenter, 2011). Additionally, the research advisor was provide one transcription the read and compare with thematic summaries as a way to enhance the quality of the coding and analysis of the data (Polit & Beck, 2012).

Prolonged engagement. Prolonged engagement is about having a close association with the students (McMillian, 2012). The researcher has worked as a CNI for 11 years with students in baccalaureate and diploma nursing programs. These experiences assisted the researcher in understanding student clinical learning experiences and in asking probing or clarifying questions in order to gain depth of student descriptions of their clinical learning experiences. However, the researcher recognizes that biases formed from these experiences with students can influence the researcher's approach within the research process. Hence, the researcher engaged in reflexive journaling, documenting her assumptions and beliefs about students learning in the CLE before beginning the research process to journaling throughout the research process, in order to compartmentalize her biases. This process can assist the researcher to move forward and allow student perspectives to be clear and prevail (Streubert & Carpenter, 2011).

Additionally, another important component to create accurate, credible and complete data is building rapport with the students during the interview process. The researcher implemented and valued the stages of rapport building throughout the data creation process of the one-on-one

semi-structured interviews described by DiCicco-Bloom and Crabtree (2006). The researcher and seven students reached the participation stage; this stage was achieved with prolonged engagement and viewed as the greatest degree of rapport, since the students began to share information about their clinical learning experience independently. This phase was often evident at the end of the interview when the researcher asked the students if they had anything that they would like to add to the interview. Seven students elaborated on their existing stories of their clinical learning experiences or they shared something that was important to them about their clinical learning that the researcher did not address. For example, one student discussed her thoughts about having a smaller clinical group size because she felt this small size would be beneficial for her learning and she would have more access to her CNI.

Fostering researcher reflexivity. Reflexivity is a way of protecting research from the researcher's bias that evolves from her experiences (Olson, 2011; Polit & Beck, 2012). It is salient for the researcher to be grounded in an activity, such as reflexivity to allow the researcher to consider her perspectives, and biases, from the development of the research questions to the representation of the data; however, it is also a more intentional and a conscious way for the researcher to respond to those thoughts and feelings to consider how his/her experiences, assumptions or biases may be shaping the research process (Doane & Varcoe, 2005; Olson, 2011; Polit & Beck, 2012; Streubert & Carpenter, 2011). This sort of acknowledgement, on behalf of the researcher, added credibility to the research because it allowed the researcher to bracket her beliefs and opinions about a phenomenon, so the data was viewed in its unalloyed form (Polit & Beck, 2012). The researcher maintained an ongoing reflexive journal in order to recognize any further biases, evaluate the researcher's viewpoint, and explore how the research or findings were affecting the researcher (Olson, 2011). Additionally, the researcher debriefed

with the research advisor throughout the various stages of the research process, in order to remain grounded and further engage in a reflexive process (Olson, 2011).

Member checking. This validating strategy allows students to review the interpretations of the research findings, which can occur in writing and/or throughout the interview process to give students the opportunity to modify the researcher's interpretations (McMillian, 2011). The researcher was cognizant to ongoing member checking during the interview process by asking clarifying and probing questions in a neutral tone or perhaps restating or paraphrasing responses, in order to ensure that student perspectives were clearly represented and expressed within the data (Polit & Beck, 2012). For example, the researcher said to a few students during the interview process – Can you describe what *support* looks like for you....? or another example – When you say *morale*, tell me more about that. What does that mean to you?

Further to this, the researcher analyzed and summarized four student interviews for students to review, in which they provided consent (Appendix H). Out of the four summaries, two of the students added some clarifying statements to the researcher's summarized comments, and these comments were considered in the data analysis. This approach gave students a more formal opportunity to review the researcher's interpretation of their comments to ensure accuracy of data interpretation (Polit & Beck, 2012).

Peer debriefing. Peer debriefing with experts in the subject matter of methodology or the phenomenon during the research process allowed them to evaluate, challenge, or propose alternatives to the researcher's thought process (McMillian, 2011; Polit & Beck, 2012). In this research study, debriefing with the researcher's advisor and committee members, experts in the field of research, education, nursing, and self-efficacy, was a valuable, enriching, and transparent endeavour to strengthening the credibility of this research. These experts facilitated and critiqued

the research process at various stages (Polit & Beck, 2012). Debriefing with the research advisor and committee members throughout the research process has kept this thesis research grounded in credibility.

Thick descriptions. The researcher engaged in thick descriptions of the findings through in-depth detailed descriptions of student narratives, through verbatim language, incorporating the researcher's note taking from her reflexive journal post-interview of students' verbal nuances during the interview process, and a comprehensive documentation of the research process (Hays & Singh, 2012; Polit & Beck, 2012). Respecting the value of thick descriptions in illustrating the data demonstrates the level of immersion the researcher achieved with the data (Hays & Singh, 2012; McMillian, 2012). Further to this, the researcher documented comprehensive details of entire research process throughout the development of this thesis research.

Transferability. These thick descriptions throughout the research process provides other researchers with an opportunity to judge the transferability of this research to other domains of practice (McMillian, 2012; Streubert & Carpenter, 2011). It is not the responsibility of the researcher to make decisions about transferability, but rather focus on providing rich descriptive information (Lincoln & Guba, 1985).

Dependability. Dependability refers to the reliability of the findings; meaning that, other researchers will arrive at similar findings when the research is replicated, and in order to obtain credibility, there must be dependability (Lincoln & Guba, 1985). Subsequently, the researcher collaborated with her research advisor, internal committee member, and external committee member, to ensure methodological cohesiveness throughout the research process, from developing the research questions to reporting the research findings. The research advisor and committee members examined the research process and the research advisor read one transcript,

to examine and analyze the data comparing her findings to the researcher's findings. This close involvement of research experts enhanced the dependability of the research study with the assertion that these experts will disembark similar interpretations and conclusions as the researcher (Lincoln & Guba, 1985).

Confirmability. This criterion represents the objectiveness of the data presented in the research. More precisely, student descriptions are an accurate representation of the meaning they intended to depict, with limited influence from the researcher's biases (Lincoln & Guba, 1985). To strengthen the confirmability of the findings, the researcher's thought process was represented through a detailed audit trail, which encompassed the researcher's logic from the methodology of the research leading to the conclusions of the research that was shared with the research advisor and committee members (Lincoln & Guba, 1985). This audit trail included, not only the documentation of the research process, but also the researcher's documentation of her assumptions and beliefs and a reflexive journal.

Authenticity. This criterion was developed about 10 years after Lincoln and Guba's original criteria in 1985, in order to contribute further to the rigor within qualitative research, in terms of how the participants' stories are represented in the research findings (Polit & Beck, 2012). The "re-presenting" of the data (Sandelowski, 1998, p. 375) through participant's descriptions should parallel the emotions and context of the participants experience (Polit & Beck, 2012). The researcher re-presented the data by paying attention to any verbal nuances from the student's voice, since this information was a valuable contribution to the creation of data and the meaning of the data, generating authenticity.

Ethics

Prior to this thesis research, ethical approval was obtained from the University of Manitoba and Red River College Ethics Review Board. Ethical issues can arise at any time throughout the research process, so it is salient for the researcher to consider the well-being of human participants by actively preparing prior to the implementation of the research, addressing ethical issues that may arise (Creswell, 2013; Lobiondo-Wood & Haber, 2009; Streubert & Carpenter, 2011). The researcher was diligent in implementing the following ethical principles: beneficence, human dignity, and justice (Lobiondo-Wood & Haber, 2009; Polit & Beck, 2012).

Beneficence. The principle of beneficence focuses on “[minimizing] harm and [maximizing] benefits”, which may affect the participant directly or others within a similar situation (Polit & Beck, 2012, p. 152). There was no immediate positive impact for the students contributing to this research; however, “the opportunity [for students] to give [a] voice to an experience [can be] a validating experience for some [students and] the value of being heard [can be] empowering. . . .” (Streubert & Carpenter, 2011, p. 37). Moreover, this research study has the potential to benefit future student experiences within the CLE, as stakeholders review the research and re-evaluate their pedagogical approach in the CLE.

Researchers are “obligated to avoid, prevent, or minimize harm in studies with humans” (Polit & Beck, 2012, p. 153). Participants should not feel any discomfort or endure any unnecessary risk (Polit & Beck, 2012). This research study posed no more risk to students than expected in their day-to-day activities. However, the researcher was cognizant of sensitive issues, since research of a qualitative nature often requires an in-depth exploration of issues, such as self-efficacy, that can elicit feelings that may capture a participant by surprise (Polit & Beck, 2012). The researcher arranged and obtained permission from counselling services at Red River

College to provide distressed students with counselling contact information. None of the students experienced distress or required the counselling contact information.

The principle of beneficence relates to upholding confidentiality and anonymity of the participants in the research study. With reference to anonymity, the researcher is unable to identify the participant within the data (Polit & Beck, 2012). This approach is a difficult endeavour for qualitative researchers, because of the methods utilized in data collection, such as interviews. According to Polit and Beck (2012), if anonymity cannot be upheld, then the researcher should make every effort to ensure that the participant's information remains confidential, meaning that the participant information will not be accessible or openly shared in a way that identifies them within the data (Polit & Beck, 2012).

Confidentiality was maintained during the decision of the chosen site for the interview, data collection process, documentation of the data, and the distribution of the results. In order to further protect the identity of the students, all raw data (digital audio recordings, transcribed interviews, and demographic data) was encrypted with a numerical code to de-identify the data. The student's name and encrypted code only existed on the written consent form. The consent form was accessible only to the researcher and stored in a locked filing cabinet, through keyed entry, separate from all raw data. The informed consent form will be destroyed through a confidential shedding process at the University of Manitoba Faculty of Education after one year of completing this research study. The raw de-identified data in hard copy version, such as transcriptions of the one-on-one interviews, and demographic data was stored in a locked filing cabinet, through keyed entry. Only the researcher had access to the key/cabinet. These hard copies will be destroyed through a confidential shedding process at the University of Manitoba Faculty of Education after one year of completing the research. All raw de-identified data in an

electronic version, such as transcriptions of the one-on-one interviews, and digital audio recordings were stored on a memory stick that was stored in a locked filing cabinet, through keyed entry, as well as stored on the researcher's personal computer at home that was password protected. Only the researcher had access to the password protected computer. Digital audio recordings and electronic data will be destroyed by deleting files after five years from completing the research. The researcher's advisor had access to the hard copy and electronic copy of the de-identified data, upon request. The transcriptionist only had access to the de-identified digital audio recordings and she signed the oath of confidentiality (see Appendix G).

Respect for Human Dignity. This ethical principle is representative of the right to self-determination and self-disclosure, which is the foundation for informed consent (Craven & Hirnle, 2003; Polit & Beck, 2012). Students were provided with an opportunity to exercise self-determination, that is "have the right to ask questions, to refuse to give information, and to withdrawal from the study" (Polit & Beck, 2012, p. 154), and these options were discussed with students at the beginning of the interview and included on the consent form. During the process of obtaining informed consent, the students were free from coercion and provided with full disclosure regarding the nature of the research, the researcher's responsibility and possible risks and benefits (Polit & Beck, 2012). These explanations also occurred at the recruitment session, before the interview, and within the written consent form.

Justice. Justice, the "principle of fairness, is the basis for the obligation to treat all [participants] equally and fairly" (Craven & Hirnle, 2003, p. 89) and respect their "right to privacy" (Polit & Beck, 2012, p. 155). The researcher made every effort to be sure all students were treated equally and their right to privacy was upheld. For instance, a mini-script/outline was utilized during the recruitment and the interview process in order to maintain consistency. All

interviews took place in a private location at Red River College, outside the nursing department, or at the health care facility where the students were completing their Consolidated Senior Practicum.

Summary

This chapter included an explanation of the qualitative descriptive methodology of this research, in relation to the research questions. A detailed description of the research design, sampling criteria, recruitment process, site and setting were included to demonstrate cohesiveness within the preliminary components of the research process. Further to this, various components of the data, from collecting, analyzing, managing, and disseminating were expressed to provide a clear picture of the respect and value for the data. In addition, the development of rigor within the research was explained using Lincoln and Guba's framework of trustworthiness, and the respect for the well-being of the participant was explained through the ethical considerations of beneficence, dignity, and justice.

Chapter Four: Research Findings

The purpose of this qualitative descriptive research was to explore and describe student perceptions of developing confidence through clinical learning experiences, as well as discover what features of the CLE support learning and the development of confidence. To gain an understanding of student perceptions of developing confidence and aspects of the CLE that support learning and the development of confidence, one-on-one interviews were conducted with 10 students. Throughout the interviews, students were keen about sharing their clinical experiences, whether positive or negative. This chapter describes students' global view of the CLE, an overarching sociostructural theme, along with five themes: the CNI, self, the buddy nurse, the peers, and the staff/unit environment to answer the research questions:

- 1) How do students perceive developing confidence through their clinical learning experiences?
- 2) What features of the CLE support learning and the development of confidence?

Students' Global View of the Clinical Learning Environment

Students viewed the CLE as *"invaluable and could not imagine the program without it... it's like your textbook comes to life"* (Student F). Students definitely regarded the CLE as having the potential to support their learning and their development of confidence. Students thought that their clinical learning experiences assisted them to view the big picture by placing the theory learned in the classroom into a practical context.

Just pulling everything together, I would say. Like, different lab works and disease processes. I felt like you could see like, a big picture in the hospital. (Student I)

It's hard to connect the learned theory to practical application. And if you didn't have a clinical way to do that, I don't know how you could. It's so important because then you draw back to, "Okay, I learned this in class." And if you haven't learnt it yet, when you do learn it, it's like, "Oh, yeah, that, that makes sense because that that happened to my patient." Yeah, you need the clinical experience. Everything from just talking to patients

because in like, Health Assessment, they hire actors and you walk in or there's a dummy in the bed and you talk to it as if it's a person, ... but nothing prepares you for like, when you walk into a room and a patient's crying. So I think that you need those experiences and even practical skills. It's one thing to do it on a dummy that has a perfect incision or... no drainage coming out of anywhere because he's made of plastic. Um, versus when you go in and it's a hectic day and you have all these things to get done, and you have to learn how to think on your feet and how to change your plan. And I don't think you can learn that without the practical setting. (Student H)

When students began describing a typical clinical day, nine out of ten students expressed that the clinical day began the night before the actual clinical practice day, researching their patient/s disease processes, medications, treatments and/or procedures. Some students commented on acquiring very little sleep the night before the clinical practice day because they would stay up late to research their client, in order to feel well prepared to care for their patient/s the next morning. They viewed this preparation for practice as a path to feeling confident, continued learning, and being successful in their clinical practice.

How I prepare is very similar from beginning to end because that's just who I am. You go do research, you come home, you research absolutely every aspect of the client's situation and, and try to understand – where I am emotionally so I can deal with that as well. So that, when I step into that door that next morning, I, I have the best chance of feeling confident. A typical clinical day for me would be having prepared very well, coming in with a pseudo-confidence. I think the way I prepare has everything to do with how that day will unfold. If I don't have the knowledge base that I feel that I need, and if I'm not there emotionally, um, then the day is more of a struggle. I think when you have the knowledge and when you have the confidence, the skill goes that much better. (Student B)

The day for me begins with the patient research. So, before, so you've gone in, mostly it's by yourself... look through the charts, you have your patient list, go home, you research. And, depending on when you've received that list, you can be tired. You know, you're up late and you're, you're trying to get a firm grasp on, you know, what your plan of care is going to be the next day. And then it's, you know, coming prepared in the morning. (Student F)

Further to this, many students made reference to the business of the clinical day, often with a heavy verbal sigh – caring for their own patient/s, completing skills on other patients

when opportunities arose, and getting to know their patients through the utilization of relational skills they learned within the nursing program.

I think we just go a bit above and beyond. So I think our day's a little bit more fuller just because we have so much of that experience that they[nursing instructors] want us to get in before we finish.(Student A)

You sit down and you realize like, "I haven't gone to the bathroom all day." or, "I need to eat something, I need to drink something." Like, it's starts rushing in. (Student F)

Interestingly, student B made reference to the fact that, if you survived a busy clinical day than your confidence was elevated.

All pandemonium broke loose. And then, because I was instructed now to do this, that, and the next thing, and, "Go and do this, and go and do that," and it, it was a crazy day. And that's why I say my confidence was so elevated because I had survived this day. (Student B)

Overarching Theme of Student Perceptions of Developing Confidence.

Data analyzed from the interviews uncovered an *overarching theme* of a sociostructural context that influences student learning and development of confidence in the CLE. Students viewed changes in the physical clinical learning environment, such as a unit/facility utilizing an electronic patient record versus paper charting, as not having an influence on their development of confidence.

The physical unit doesn't so much matter, right. It doesn't really matter. In XXXXX, we opened pill bottles and, and counted them and turned them over as we did our writes. And, you know,... in XXXXX, you have all these, you know, screens in front of you, and it's just so much easier, right. But at the end of the day, it's just learning to adapt to the physical unit, not so important. But what's really important is the nurses. (Student B)

Students conveyed that the sociostructural features of their CLE were most important for their learning and developing confidence in their nursing practice. Students perceived their development of confidence through the reciprocal interplay between the sociostructural features of the CLE, that being the CNI, their peers, the buddy nurse, the staff/ unit environment, as well

as students themselves. Often the individuals within the sociostructural context influenced students' affective state, thought process, and behaviour. For example, if a student's buddy nurse was not willing to teach the student or he/she was upset each time the student asked them questions, then the student may begin to feel nervous and less confident in themselves, avoiding their buddy nurse in future questioning. This avoidance behaviour may influence the student's exposure to new learning opportunities and the potential for them to develop their confidence in the CLE.

Further to this, students viewed themselves as an intrinsic part of the sociostructural features of the clinical environment. They recognized that their behaviour, cognition, and affective state influenced the sociostructural features of the CLE, which had an impact on the type of learning experiences they acquired and their development of confidence. For instance, if a student was very keen to learn and took every opportunity to learn in the CLE, then it was likely that the instructor, the staff, buddy nurse, or peers would reciprocate and provide them with learning opportunities to assist them to build their confidence. Students expressed that if they appeared unprepared or they lacked confidence in clinical practice, their buddy nurse or CNI, would be less likely to challenge or provide them with learning opportunities, influencing their development of confidence and further learning negatively.

It was evident from the data collected that the individuals whom students interacted with in the CLE were very influential upon student learning and development of confidence, and that students also had an influence upon others in their CLE, influencing learning experiences and the development of confidence. Interestingly, students viewed clinical learning and confidence as having a positive relationship, meaning that as learning occurred, confidence was built. Students

expressed that as one's confidence grows, more learning occurs, and perseverance and success were more likely to occur in clinical practice.

I think it's just continued learning. I think that, if I put myself out there and just keep learning things I don't know and keep asking questions I don't know. I think finding out those answers and learning that I am able to do it, will just continue to grow my confidence. (Student A)

What I have learnt is, the broader my knowledge base is, the more I add to that knowledge base year after year, the more intuitive I've been able to become. And I recognize that my level of confidence is as a direct result of, of my desire to learn. So the more I know, the more I've experienced in clinical, the more confident I become, and the quicker learner that I am. (Student B)

Five Sociostructural Themes

Five sociostructural themes emerged with categories and sub-categories from the data analysis, as important features of the CLE that support student learning and the development of confidence: 1) the CNI 2) self 3) the buddy nurse 4) the peers, and 5) the staff/unit culture. Themes one to four were well developed and theme five was less developed.

Theme 1 – Clinical Nursing Instructor (CNI)

The CNI was the most developed theme throughout the 10 one-on-one interviews. It was evident throughout the interviews that students perceived the CNI as the most prominent, powerful, and influential individual in their learning and development of confidence in clinical practice. Seven out of ten students mentioned that the CNI was one of the most influential individuals in their clinical success. As students talked about their CNIs throughout their stories, seven categories emerged with some categories being sub-divided: 1) support me throughout 2) challenge me 3) provide me with feedback 4) be approachable 5) teach me 6) give me time... I am a learner 7) debrief with me.

Support me throughout. Students viewed their CNI as playing a salient role in supporting them through their clinical learning experiences. Students often used the word *support* as a descriptor of a CNI who had a positive influence upon student learning and student outcomes in their clinical practice, such as gains in confidence and success. *Support* from the CNI was seen as doing something for or with the student in a respectful, positive, and willing manner. Further to this, students thought that this sort of behaviour from the CNI aided in them making a connection and enriching their relationship with their CNI. If students felt supported and connected to their CNI, they were more likely to seek out their CNI for assistance or clarification. Students believed that this kind of interaction between the CNI and the student had overall positive effects on the student's clinical learning experience.

Interestingly, Student A was discussing and describing one of her CNI's that she worked with in clinical practice. She made a comment that *support* was a common theme of what she viewed as important for her learning and proceeded to explain how she regarded *support*.

Um, I think a common theme, it sounds like, is support, "Be there to help out." And obviously, "Don't hand-hold throughout the whole time." But, "Be there to provide support and encouragement. And, if they're [nursing students] struggling, come up with a plan, figure out what's going on and just help that person [the nursing student] empower that person, really, to move forward." (Student A)

Student descriptions of *support* from their CNI can be placed into four sub-categories i) advocate for me ii) believe in me and encourage me iii) support me through my mistakes or near misses, and iv) be there for me.

Advocate for me. Students described the importance of the CNI advocating for them in clinical practice. Students expressed that when the CNI advocated for students, this approach created a clinical environment conducive for learning and that students were more likely to feel confident in their clinical capability. There were a variety of ways the CNI could advocate for

students. A common practice of advocating for students originated from providing students with learning opportunities, such as completing skills or tasks. Students conveyed that when they had these sort of learning opportunities, it created gains in their learning and level of confidence. For the most part, students shared that instructors go out of their way to obtain skills for them to do throughout their clinical practice, so they can have numerous opportunities to practice a skill. Student A shared that *“our instructors typically want us to get as much experience as possible for us, right. So they want us to get lots of skills and they want you to do as much as you can for your patient. You know they are coming from a good place.”*

Students also wanted their CNI to advocate for them when conflict arose, especially with their buddy nurse or the unit staff. Student B shared a difficult situation of a power struggle she had with her buddy nurse. Throughout her explanation of the experience she paused and appeared overwhelmed, almost choked-up. Her assessment of her patient was undermined by her buddy nurse and she felt that she had no support from her CNI. The student’s assessment and nursing priorities were correct in relation to her patient’s status, but the CNI favored the buddy nurse’s perspective. The student thought that because the CNI worked on the unit, as a staff nurse, and was friends with many of the nursing staff that she was unable to have clear boundaries and advocate for the student.

Student B describes how the clinical situation shattered her confidence.

I explained you know, the severe emesis that my client was experiencing and my, my assessment of his abdomen clearly told me that there was something amiss, that it needed, uh, further investigation, which they left it for another 24 hours, investigated later, and then found that he had hemorrhaged, and it was just a bit of a mess. But no one ever came back to me and said, “You know what, [student B], your assessment was correct and that young boy should have been looked after, you know 24, 48 hours before then.” There were these assessments that I had made, that weren’t what they should be. And, yet both my instructor and buddy nurse didn’t listen to me. Anyway, what happened was, um, my instructor took the side of the nurse and, it wasn’t a good situation... She [the CNI] was attached to her co-workers, and therefore could not advocate for me,

which was really unfortunate. I felt that that was low of her...[paused and appeared overwhelmed] my instructor was best friends, buddy-buddy with every nurse on the unit. She didn't have my back... I had already dealt with this client on a different day. I knew that my assessments today were much different and, more acute than earlier. And it seemed like, I had no power. She [the CNI] had all the power to dictate what was going to happen, but I had no power, to emphasize what I felt was important because she undermined my assessment ability. That's how I read it. I was asked to stay behind after class, and I didn't receive support from my instructor... my confidence plummeted completely.

Student H shared that sometimes staff on the units share with students that they do tasks/skills differently, but often, the instructor was there to explain to staff that students learn to do tasks in a particular manner, which is in accordance with hospital policy and best practice. This sort of support from their CNI provided students with the confidence they needed to carry forward with the completion of the task. *So they [nurses] can make comments like, "Oh, that's not how we do it," or... and then our instructor's there to kind of back us up, that, "Well, that's how they learn and that's policy now." (Student H)*

Believe in me. Students claimed that when their CNI believed in them, this approach helped students to believe in themselves. Students felt that the CNI believed in them if they took on the behaviour of providing students with opportunities to be independent in completing skills/tasks. Student A explained how the CNI's confidence in her changed her way of thinking that is, second guessing herself.

I was very unsure of myself – I would always go to my instructor and ask her, "Okay, this is what I'm thinking of doing. Is that right?" And, eventually, she pulled me aside and she said, "Whenever you come to me, you're always telling me the right thing. Now I just want you to go do it without having to come, come to me and ask." So it made me feel good because it was like, "Okay, I know what I'm doing. I don't have to keep second-guessing myself and going to the instructor." (Student A)

Additionally, when CNIs provided students with verbal encouragement about their ability or believed in students nursing judgement, this sort of support from the CNI gave students the confidence they needed to tackle a task/skill or preserve in future clinical practice situations.

The more she encouraged me, the less stressed I became, and the more confident I became, and the more I was able to, um, devote my thinking energies. (Student B)

I really appreciate encouragement. I think, like, those are the situations where I would thrive the most... I'm way more confident. (Student C)

I think it was in First Year, my second rotation, I believe. And I had a difficult patient... like, lots of meds and he was very challenging in the way that he didn't really respond to your questions or would kind of ignore you. And sometimes, he couldn't talk so I was like, freaking out, I started crying. And my instructor comes over and she's like, "Let's go into the med room," closes the door and the two of us in there. And she's like, "I wouldn't give you this patient if I didn't think you could handle it." Like, "I would cry too,... it's fine, just take a minute, calm down. I trust you know what you're doing. That's why you've had this patient." she like, let me have time to regain my focus and head back out. When I go into other clinicals and other situations when I have a tough patient, then I don't take it as like, "The teacher's going to try to screw me up,"... "I'm going to better myself. I have to work hard, and I can handle this." Like, you've just got to go in feeling you, feeling like you can do it. (Student E)

I had a catheter, and I hadn't done one, it had been a year and a half and I just was honest, like, "I haven't done one in a long time." [Instructor stated] "You know, you'll be fine. Just take a few minutes, review the policy again." Like, just exuding that confidence in me, like, "You know this, you've done it, go refresh your memory, go gather your supplies. (Student F)

Students also claimed that it was difficult for them to have confidence in themselves, if the CNI did not believe in their capability. For instance, if the CNI judged all students' capabilities as the same, and made assertions that no student can achieve an A or A+ in clinical practice, then this judgment influenced student thought pattern and behaviour. Students questioned the need to put forth the effort in clinical practice to achieve an A or A+ because they felt discouraged by the CNI's comment. So, students would refrain from seeking learning opportunities, which they recognized would influence their clinical learning and development of confidence in a negative manner. Student C's verbal tone expressed the anger she felt about this specific situation below.

Um, some instructors, uh, like, "No problem, you can get an A, an A+," like, "Absolutely, it's attainable." with other instructors, they don't believe that it's ever possible. My instructor said, in her 14 years of working, she had never given any student

an A. That kind of stops me from wanting to do well because I just feel like, “Well, it’s impossible for me to, to get a good mark, and so why am I even going to try?” (Student C)

I don’t know if you’ve heard this, but there’s some instructors that say, “I don’t give A’s.” And then you’re thinking, right from the beginning, “Oh, my God. Like, this is scary. She’s intimidating. You know, I’m not going to do well in this.” And then you just, you know, it’s downhill from there. (Student D)

Support me through my mistakes and/or near misses. When students talked about making mistakes or experiencing near misses in clinical practice, they often described these mishaps occurring when they were really nervous and felt devastated by the experience. Depending on how the CNI managed the mistake or near miss, influenced how shattering the experience was for the student’s confidence and learning, as well as, how the student moved forward in a similar future tasks.

Student F had a near miss in clinical practice, in which she thought she was able to learn and move forward in her practice, due to the fact that her CNI supported her and created a learning experience for the student.

I came too close to making a med error... but those moments where I thought I had...those are very crushing moments... I can’t say it was all that bad because my instructor was incredibly supportive...[CNI stated] “Okay, let’s accept that this happened and move on together. You’re not alone, and I will walk you through the process. And, you know, what steps can we do to make sure this doesn’t happen again?” I was crying. [CNI stated] “Go take a few minutes to yourself in the bathroom, come back when you feel ready to come back.” And, and then, yeah, we worked it out, and you know, and lots of checking on me throughout the day, “How’re you doing?” “How are you managing?” It was still such a valuable learning experience you know, just to have come that close, and that guilt. (Student F)

Be there for me. Students often described the comfort from having their CNI there for them, especially if they were unsure or lacked confidence about tackling a new or challenging situation. Students described the phenomenon of *being there* for the student in a variety of ways; for example, a *quiet physical presence* should the student need their assistance, a *caring and*

compassionate verbal inquiry about how the student was managing or coping through a situation, and/or an attitude of *let's walk through it together*.

During a challenging and/or new situation, students felt some comfort in having a CNI's *quiet physical presence* for them by being nearby should they need their assistance. This approach was most helpful for students because students felt it reduced their anxiety and they felt they were able to persevere at the challenging task, as Student A and Student H described openly.

I did get the opportunity to care for a dying client who was deteriorating very rapidly. It was a very stressful day, but, um, again, my instructor was there with me throughout the whole day, just making sure that I was okay, that I knew what I was doing. Um, I think that just helps you cope, right, because it's a very challenging situation having to experience, um, a dying patient for the very first time. You need that support around you to know that you're not doing this by yourself, you're working together as a team, and... yeah, and I remember I had to call the doctor and get different orders put in place, and my instructor was with me and just making sure that I was comfortable. It was more non-verbal throughout the day, just being there beside me... um, again, just validating what I was thinking, was happening and what was going on, and what we needed to do. (Student A)

We had to change the ventilator settings, so Respiratory Therapy was there. So I was going to be hand-venting the patient, which was very nerve-wracking because you're the lifeline for the patient. So, when they asked me if I would do it, I said, "Yes," But my anxiety was like, through the roof. So I went to my instructor and I said, "We're going to be doing this, but I need you there to spot me, tell me if I'm going too fast, too slow, monitor stats with me." And so she came, my buddy nurse came, and Respiratory Therapy was there and everyone kind of walked through it with me, a lot of positive reinforcement... So that was like, a persevere thing... like, I was so scared to do it, and then I did, and it was like, "Oh, that wasn't so bad,"... And, even, like, at one point, I was going too fast. It's wasn't like, "Stop, you're going too fast." It was like, "Okay, you're doing well. Let's just slow down, breath, breath..." Like, it was... like, calm... Like, I felt I'd done this crazy thing. Like, "This person would not be breathing if it wasn't for my hand pumping it," which it isn't... a difficult thing to do, but it's scary... So it was. It felt really good to have done it in the end. (Student H)

Being there for students was not only about the physical presence but also the emotional support, too. Students valued *compassionate and caring verbal inquiries* from the CNI, because this behaviour created a more comfortable clinical learning environment and assisted students in

making a connection with their CNI. Students expressed that when the CNI cared about how students were managing, students felt that the CNI really wanted them to succeed in clinical practice. This sort of support created a relaxed learning environment, which influenced students' thoughts about their capability in a positive manner, students' feelings of being less nervous, and students' behaviour of perseverance.

Student C and Student D eagerly described how they felt when their CNI supported them in clinical practice.

I felt like there was a lot of support, my instructor was really supportive, and, like, emailed me, I think maybe the next day "And how are you doing?" You know... "I care about you and I know that it was a rough day," and, you know, I think in that way, it did feel very supported. (Student C)

Some instructors like, make you feel like they're more there for you. And others are more just like, "I'm your instructor. This is clinical. See you later." But other ones, I feel like that I can make connections with. So then it's easier to ask them [CNI] questions if I don't know something. Or it'd be like, well, I remember one clinical, I was like, "I honestly have no idea what I'm doing right now." And she's like, "Okay, let's figure it out." Just kind of compassionate, that take an interest in you, Yeah, that they actually, care about us. Like, they actually want to see us do well. (Student E)

Additionally, students expressed that when the CNI had the *let's walk through it together attitude*, especially when students lacked the confidence to complete a task or skill, this support reduced their anxiety and eliminated the daunting feeling of tackling the task or skill. This *attitude of let's walk through it together* was often implemented by the CNI prior to the student entering the patient's room, providing the student with an opportunity to feel confident about performing the task or skill on the patient. The CNI with a *let's walk through it attitude* was often perceived by students as an individual that collaborated with or guided students through a situation, skill, or task in a relaxed and easy-going step-by-step manner. Students described that when they had this support, they felt lucky to have had a CNI with this sort of approach to

teaching/learning and they felt more comfortable communicating with and asking the CNI clarifying questions throughout their clinical rotation.

Student A and Student D explained.

I've been very lucky, I've had lots of fabulous instructors. And what they do, is... they're open to you, for you to come to them, and be like, "I'm scared, I'm nervous." And they acknowledge that, they say, "Thank you for telling me this. Let's walk through it. Let's go through it step by step, one step at a time, and just focus slowly, don't rush it." And that those instructors are always the best because then the next time it happens that you have a skill that you're scared of, you're not scared to go to them and tell them because you know that they're going to help you through it. (Student A)

Her [the CNI] approach was just... really genuine person, and she would be like, "So what do you think you need to do next?" Which is good, I mean, you need to know. But... before you go in, she stops with you, makes sure you have all the right supplies. And she'll like, "Okay, so now, practice on me," let's say. Or, "Let's walk it through before we go into the room." And, you know, and then when you're in the room, it's not like, "Uh, uh, uh, uh, uh, don't do that," or, like, you know, nothing like, scary. It's more just relaxed, like, "Okay, so now let's, let's do this," It was less like, you know, like, you were being judged and like, marked on if you did anything wrong. It was more of her just kind of walking you through it. (Student D)

Student H described the *let's walk through it together attitude*, as the CNI reinforcing what she was already doing during the task, to reaffirm that she was doing the task correctly, giving her the confidence to persevere.

Um, like, after they've seen me do it once, if they kind of let me gather everything and get prepared. And then I check with them and go through what I'm going to do and then they come in, not necessarily prompting you what to do, but, as you're doing it, like, "Okay, so" let's just say for a dressing change, like, "Okay, so you uncovered it. So can you tell me what the drainage looks like? Okay, good, you're going to cleanse." Like, they reinforce what you're already starting to do. (Student H)

In another situation, Student A was struggling in a particular clinical rotation and the instructor approached the student with a *let's walk through it together attitude* and the student thought that this approach helped her to gain the confidence she needed to persevere and be successful in her XXXXX rotation.

I remember in my XXXXX rotation, I was struggling a bit with the rotation. And I remember my instructor pulled me aside and just said, “You know, you’re struggling. What can I do to help you finish this course and get a good mark?” – because she knew I wanted to go into XXXXX [nursing] – “What can I do to facilitate your learning? How can we work together?”... it worked very well. We were able to talk to each other, we were able to figure out a plan. She was just very supportive, and I was able to get a good mark in that clinical just because she helped me out. (Student A)

During a challenging situation, Student D appreciated when her CNI was by her side, walking her through the challenges of caring for a dying patient and helping her to understand the circumstances. The student voiced that she learned a lot from this sort of inclusive support from her CNI being there for her.

I had a patient that was like, rapidly declining. And, um, I guess the husband and family kind of weren’t expecting it, maybe, that quickly. My instructor and I pulled, um, the family friend into the hallway and just kind of explained to her like, “You know, we think that it might be coming soon, and you may want to call in some, some family members.” and then, we talked – me and my instructor – talked to the doctor and said like, you know, “Maybe we should talk to the husband because he looks pretty upset and we want to make sure that he knows what’s happening, and,” and, you know, “if he has any questions,” and stuff. So then I sat down with him and the doctor, we kind of had a meeting together, and we just talked about like, you know, the dying process and what he can expect, and if he had any questions, and does he want us to call anybody for him, and just stuff like that. So, the communication part of it...just learning from how they approach situations and what’s the best things to say in moments like that... Well, it was actually my instructor that like, told me, “Okay, now you need to like, go to the doctor and tell him what’s happening, and then follow the family meeting,”... (Student D)

Some students wanted their instructor to be readily available for them on the unit.

Student H conveyed that some clinical student groups had large student numbers and the CNI just did not have the time for them, hindering their clinical learning experience.

There’s too many students in a clinical group, it can impact your experience because you will spend most of your time looking for your instructor, opposed to being able to do, like, take care of your patient. Um, like, if your patient is in pain, we’re not allowed to get narcotics without our instructor. But if your instructor has eight students, half of them have two patients, it’s almost impossible to hunt them down. (Student H)

Challenge me. Students expressed that they wanted to feel challenged in the clinical learning environment, because engaging in challenging situations meant they were learning and

becoming more confident in their clinical practice. Students described being challenged through two subcategories: i) cue and prompt me to critically think, and ii) let me move beyond a health care aide role into the role of the nurse.

Cue and prompt me to critically think. Students expressed that cueing and prompting were strategies for the CNI to encourage students to critically think, and move past rote learning. Students wanted their CNI to assist them to view the whole picture of their patient's situation by asking them challenging questions to stimulate their critical thinking skills. Several students communicated that this sort of assistance from their CNI would help them to enhance their learning and to be successful in their clinical practice.

I think looking back on like, First Year and the XXXXX rotation, kind of just stepping back and looking, instead of writing down all the diagnosis and all the definitions, just kind of step back and looking at all this patient information and understanding it, ... writing it down from the dictionary or your Potter and Perry book is different than, "What is happening here?... I think I would have really benefitted from that, instead of just providing all the information, instead of just showing to the instructor, "Okay, this is what's happening. This is what I'm going to be looking out for today. This is what I'm going to do if such, such, such happens." I think it would have been hugely beneficial, instead of just saying, "This is the definition, this is the definition, this is the definition,"... A holistic perspective, like, just considering everything. (Student G)

I think having the support of clinical instructor because they're the ones that are able to be the bridge from your theory classes into the clinical setting... when they[CNI] notice... "you do know that theory, like, that's perfect. Like, you're applying it here," or, like [the CNI] positively pushed me to, "Where else can I apply my classroom knowledge into, into clinical," or, "How else can I..." you know, "Now I have a new patient, but I want to continue that critical thinking because that was encouraged, in a previous patient," (Student C)

For me to learn the best, I guess, I mean, it's good, when the instructor kind of quizzes you because then you'll know, if you know it. And if you don't, then you, you look it up and then, you know, you remember it because you've been quizzed on it (Student D).

I think back to my XXXXX rotation and my instructor was huge on the mechanism of action of medications. And so, every med that we had to give, which was like, tons, he'd always be like, "Okay, tell me the mechanism of action." And he'd go over it and then, like, "Why?" the whole bit. And I think that really helped me want to understand the mechanism of action and what's going on in the body when I'm giving a pill?

I feel like that's helping me really understand what I'm giving to a patient and why I'm giving it. (Student J)

Interestingly, one student perceived that overall, students use of critical thinking skills was lacking in the clinical environment. This student expressed that students seemed so focused on getting all the tasks done in a shift that they lose sight of the holistic picture, limiting their clinical learning experience.

I find the clinical very, high anxiety, "You have to do this, you have to do this, you have to do this." And it doesn't give you a chance to kind of think, "Why are you doing this?" Like, you're too worried about, um, like, all these little things that, kind of takes away from the learning experience. Like, you're trying to, you know, meet the expectations... And then you kind of don't really have, "Okay, why am I doing this?" ... Like, that kind of learning experience. (Student G)

Let me move into the role of the nurse. Students expressed the need to become more involved in the nurse's roles and responsibilities, as they progress through the nursing program, which meant, letting go of some of the health care aide duties once entering the third year of the nursing program. Students described feeling unprepared and not confident for the challenges of the nurse's roles and responsibilities, as they entered their Consolidated Senior Practicum. Students perceived the nurse's role as engaging in critical thinking and enduring the challenges related to complex tasks/skills.

It would be nice to take on more of just the nurse role. We still carry on all of the health care aide duties right into the last clinical day. And, I feel like I'm going to go to my first day of Senior and start pulling out washcloths to wash somebody and the health care aides are going to say, "What are you doing?" It's like, "Well, this is my job," right. That's how I feel... So it'd be nice to have a different relationship... I fully appreciate that nurses wash and feed people on units... [but] let's say I have a learning opportunity; so-and-so's doing a catheter, and I miss it because I have to give someone a shower... I feel, is very frustrating to me. And yet, if I didn't do the shower, that reflects on my ability to organize care. And delegating the shower is sometimes frowned upon. Or, you know, you get guff from the staff. I'm not saying, euh, nurses shouldn't do that. But, I just felt like, "Is this getting in the way of opportunities I could have had?" (Student F)

I needed a step higher. I don't want to be the person washing a patient. Like, I excelled at that part, and I need to provide the care that I'm providing?" Yes, um, activities of daily

living are included in the care, but that should not be my focus. I feel like I didn't learn as much because it's that focused, as opposed to, "Okay, this person has this, this and this. Why do you think he has edema? Why do you think, um, this person's heart...you know, like, the more of a medical perspective, if that makes sense. (Student G)

Student J made reference to the fact that having the combination of the responsibilities of the HCA and some of the nurse's responsibilities in clinical practice was stressful and overwhelming for a learner.

So the morning's really nerve-wracking. And then you also have the responsibility of a health care aide, as well. Like, thinking back to when we were still in school, you did all the health care aide [duties]... [and] everything that a lot of other people would do too, so that made it pretty stressful to try and get it all done in time.

Provide me with feedback. Students voiced strongly the powerful effects of feedback from their CNI. Robustly, nine out of ten students communicated that feedback from the CNI was most influential for their development of confidence in their clinical practice. Several students described feedback, related to both praise and criticism, as valuable for their learning and confidence; however, they were sensitive to how and when feedback was presented. Two subcategories surfaced from the data analysis: i) give me strength-based feedback, and ii) immediate and ongoing feedback is essential. Students felt that the CNI was familiar with the clinical evaluation tool and the expected learning outcomes, so comments from him/her were more valuable than from other individuals they worked with in the clinical learning environment.

The instructors at Red River College...we learn to bow down to them to a certain degree because from my perspective they know best what evidence-based practice is. They know what their outcomes should look like. They know where you should be at, at any particular time. They've had this experience of different students coming through their program, they know, they know good research when they've seen it, they know good practice when they see it. Uh, and I believe that their feedback is most valuable. (Student B)

I think words are very powerful. They hold weight based on the person that says them, right. So, like, I mean, my husband is my rock, right. And if he says, "Oh, yeah, you can do this," I believe him. But, he's not in clinical, right. And when my instructor says, "You did that really well," that holds huge weight. Where they say, "You're going to be so

good at this,” or, you know, “You excel here.” That’s so powerful because they’re in the business, and then vice-versa, if they say something is not well, or you need to improve in this area, that holds more weight... when someone who’s been beside me in patient care says it, it holds weight. (Student F)

I think, whether the comment is positive or negative... affects it, um, proportionately. Like, if it’s positive, it kind of boosts your confidence. And then, if it’s negative, it kind of tears you down, depending on how severe it is, obviously. (Student G)

Student E mentioned that CNI’s were capable of recognizing things about students that others may miss. *They’ve [CNI’s] been working for so much, they can recognize things in us, we trust them... (Student E).*

Give me strength-based feedback. Students expressed that when feedback was provided from a strength-based perspective, it had a positive impact on student learning and was a primary source for developing their confidence in clinical practice. Students described strength-based feedback when the CNI blended the skills of providing constructive criticism, praise, encouragement, and affirmation, assisting students to notice their strengths and weaknesses in clinical practice. With this strength-based feedback, students expressed that they were more engaged in learning and more motivated to be successful in clinical practice.

So I think any time that anyone gives that strength-based feedback, um... for me, if you can tell me what I did really well, but then tell me what I can improve on, I’m more likely to respond to that well. (Student H)

It’s important to get positive feedback and feedback that’s constructive like, that will help you improve. So, I think, yeah, they [the CNI] would have the biggest influence. I think for instructors, it’s important that they give positive [feedback]... I think they don’t do enough. I think that’s important because that’s how you build the confidence. (Student D)

I really appreciate encouragement and maybe I need more encouragement than some other people. And so, I think, like, those are the situations where I would thrive the most. I’m way more confident when I’ve received positive affirmation that, “Yes, you did do that right.” (Student C)

I think just encouraging and saying... “I’ve seen how you did this really good.” And then, like, telling me exactly what I did good... telling me where I did good builds my confidence, for sure. (Student G)

Often, when students received positive feedback from their CNI, they were able to persevere at an existing task and/or confront a similar task in future situations.

If she gives me a lot of positive feedback of where... I did well... then it kind of just reassures... me that, "Okay, I did that well. I feel comfortable with that. If I were to do it again, I think I would do it well." (Student D)

Students wanted the CNI to clearly articulate to them in a constructive and informative manner when their clinical practice did not meet expectations, so they could improve in their clinical practice. Negative feedback was most helpful for student learning, if it was conveyed in a respectful manner and in conjunction with positive feedback. Respectful meant, to the students, that the CNI considered his/her non-verbal and verbal behaviour because when students felt that feedback was a personal attack, students claimed that this type of feedback was ineffective for their learning.

I'm pretty upfront, too. Like, when I go to, to do a skill, I am always like, "Please tell me if I'm doing something wrong." Because if I don't know it's wrong, I can't learn from it. I said, "Stop me if I'm doing something wrong because I just... don't want to jeopardize patient safety, patient care." You know, "And second of all, I need to know the right way to do it." (Student F)

If she [the CNI] would say, "Oh, you did this really well, or..." I would take that to heart and I would be really proud. But then, if she would say, "Oh, you could improve on this," I'd be like, "Okay, I can improve."... Um, but then, if it was kind of a harsher comment, I would really take that home with me; "harsh" is when you can hear the tone of voice is kind of negative, kind of talking rudely or in a demeaning tone... (Student I)

Students did not view negative feedback as completely adverse; in fact, students for the most part felt that when negative feedback was given constructively, it provided them with an opportunity to reflect upon their practice. This self-reflecting activity created a learning opportunity for students and assisted them to move forward in future similar situations.

I had a clinical instructor who was very encouraging. So everything that we did, um, afterwards I would talk about how I thought it went and where I thought I could improve, and then she would either... like, reinforce that feedback, give additional feedback. But it

was always positive with a little bit of, “This is where you could improve,” but it never felt like, you know, like, “This is what you did wrong.” (Student H)

Immediate and ongoing feedback is essential. When positive feedback was ongoing and immediate, students mentioned that it removed that initial anxiety they had entering the clinical practice day. When students’ anxiety decreased, they were able to think and learn in the clinical environment. Students felt that ongoing positive feedback helped them to grow and develop in their clinical practice, building their confidence.

I would just finish drawing up five or six vials of whatever and labeling them all and,... you know, uh, maintaining, um, aseptic technique and she’d look at, at me, eye-to-eye, and just kind of nod her head and slightly smile and say, “Great job.” And, you know what... that was just so incredibly affirming, empowering. It just put such joy in my... step. And do you know what it does? I believe all those neurons in my brain just kind of opened up and said, “Okay, you’ve done such a great job. What else can you learn?” And, “Do you know what, [Student B], these little steps that you’ve just taken, you’re well on your way. You’re doing such a great job.” ... you know... I think importantly... it removes a little bit of that stress that you walk in with, so... if I’m extremely stressed... I mean, we all know that, scientifically, the catecholamines... develop sort of a blockade, and, and you just can’t, uh, get past feeling stressed and nervous. And the more she [CNI] encouraged me, the less stressed I became, and the more confident I became (Student B)

Her [the CNI] feedback was like super-good, because she looked over our stuff, our research, every week and gave it back to us with feedback... “she’s developing you.” Like, “She’s adding stuff to teach you.” And with that, too, she gave us our anecdotes every week. So, rather than wondering in your brain what your anecdotes are going to be for five weeks until your mid-terms... stressing out, she told you every week. So every week, you could develop. Like, every week you could see what she wrote, and it’s like, “Ooh, I need to work on that aspect.” And, and then it’d also be the good stuff that you did, and then that would also build my confidence... Every week was great...I like immediate feedback... Like, I don’t like to wait for it later or, you know, have it in writing. Like, so... after I do a task, I need to know right then what I did good, and then what I need to do better next time. Because then I’ll remember it. I’m a hands-on learner that way. (Student J)

When students did not receive feedback or did not receive feedback in a timely manner, they stated that this lack of feedback made them feel nervous. Often, when students received no

feedback after being observed by the CNI, students would perceive this lack of feedback as a negative evaluation of their performance.

I think when I can't read my instructor... like... when I'm not getting like, any feedback after doing skills or research... I don't know, like, "Where do I stand?" or, "How am I doing?" and... that makes me nervous. (Student C)

If you don't hear any feedback, then, it's more nerve-racking... the things that you think to yourself, like, "Oh, they didn't say anything, so it must have been really bad," or... then you're just left wondering, like, "Where do I stand? How am I doing? What could I do to be better?" So, there's all those feelings that come with that, right. (Student H)

Student G conveyed that the long gap in time from completing a task to receiving the feedback was detrimental to her learning. This student learned that she was inappropriate in clinical practice but did not learn about this behaviour until the clinical evaluation meeting with the CNI. Student G felt frustrated because she was unable to learn from the situation and make a positive change in her clinical practice.

What tears me down... Um, like, when I'm not aware of something that I did wrong, and then it's like, brought up and it affects my grade because of that. But I didn't know I did it wrong. Like, for example... I guess a nurse had mentioned to my instructor that the way I said something... it kind of caught her off guard, and I already have a history of like, being aware of what I say, and just... how it influences people. And I'm, I'm trying to build that and trying to work better at that... And then, when the instructor brought it to my attention during mid-terms, she couldn't even recall what it was that I said, or anything... I couldn't know who I said it to, I couldn't even defend myself as... what my intentions were when I said it... Like,... it threw me off. Like, I did something wrong, but I couldn't fix it, or... you know, I had no chance to fix it...(Student G)

Be approachable. From student perspectives, an approachable CNI was seen as being friendly and this sort of behaviour helped students to feel comfortable in the clinical environment and helped to reduce students' feelings of nervousness, creating an environment conducive for learning, and confidence building. Student described approachability in five subcategories: i) remain calm, ii) your non-verbals matter, iii) consider your tone of voice, iv) be open to questions, and v) don't disrespect others, it influences me.

Remain Calm. Students were less nervous when their CNI had a calm demeanour. A calm CNI assisted students to feel more relaxed, and this relaxed feeling helped students to feel more comfortable asking questions and to feel more confident doing tasks/skills. Students felt they were more likely to be successful and learn in this sort of clinical learning environment.

I would do way better with the instructor that I felt more comfortable with, just like, relaxed. I think the instructor has a huge influence on your confidence because, if you feel intimidated by your instructor or, you know, you don't feel comfortable around them, you're going to be nervous and you're not going to feel confident in what you're doing. Even if you review that skill and you watch the video, you're going to be nervous doing it. And she[the CNI] was just so relaxed. She was awesome. So I loved going to clinical, even though it wasn't my favourite. Her approach was more calm and not intimidating. (Student D)

When an instructor is more relaxed, I feel much more relaxed and I'm much more willing to go and do things that I haven't done before or I've only ever done once, because I feel like, "Oh, she's relaxed... if I need help, she'll calmly walk me through this," or... "She won't think it's such a big deal if I forgot this one thing, or something like that." (Student I)

Your non-verbals matter. Students described non-verbal behaviour as a way for the CNI to express their feelings or thoughts about students. Students termed non-verbal behaviour through the CNI's facial expression, eye movement, body posture, or touch. This non-verbal behaviour reflected disapproval or acceptance of student performance and was just as powerful as verbal commentary that influenced student learning and confidence development.

And she'd look at, at me and, you know, eye-to-eye, and just kind of nod her head and slightly smile and say, "Great job." And, you know what, that was just so incredibly affirming, empowering. (Student B)

She [the CNI] was freaked out about everything and kind of wailed her arms up and down with all students. So, that, to me, hindered the whole experience. Because I was very frightened and I was very scared to ask... any questions or... yeah... for a negative response from her... it made me feel... incompetent, especially when I'm in front of a patient. So that probably really hindered the whole clinical experience... Oh... if you didn't have the vitals as... in a certain order... she would get all frazzled. And if you... went to go pull a dressing change... and accidentally pulled the catheter tray, she would get all frazzled. And... in the patient's room, if you, um, maybe by accident broke the sterile technique, but you have a second dressing tray right there in front of you just in

case... her arms would go up and she would almost shriek... and then the patient gets scared (Student I)

Consider your tone of voice. Students were sensitive to the CNI tone of voice used to deliver feedback to them about their performance. They felt that feedback should be conveyed in a respectful tone of voice, whether negative or positive feedback. When feedback was not provided in a respectful manner, students often took this feedback to heart, feeling insecure and self-doubting their capability.

... just the way she would ask them and the tone that she would ask them,... made me feel, I guess, slightly like, insecure. (Student A)

If it [feedback] was kind of a harsher comment, I would really take that home with me. "Harsh" is when you can hear the tone of voice is kind of negative, kind of talking rudely or in a demeaning tone... Kind of like I'm failing as a student nurse, maybe. (Student I)

Be open to questions. Students expressed the importance of feeling comfortable asking their CNI questions without being penalized. Students perceived being penalized when the CNI made students think like they should know the answer to their question or when asking questions was reflected negatively in their clinical evaluation. Often, students asked questions to seek clarification of their thoughts or to gain important information to carry out their nursing care safely. Being able to ask questions helped students to feel confident in proceeding through a task or skill. Students valued the CNI's knowledge and expertise, and wanted to learn as much as they could from their CNIs. If students felt their CNI was not approachable, then they would go around him/her to seek clarification or answers to their questions. Sometimes students would seek clarification from their peers; however, some students were concerned about the accuracy of the information.

I know a lot of the times, when you feel that you can't go to an instructor... because you're scared, right. It's going to reflect your mark. Or a lot of times, I've gone to an instructor with a question and it just feels like they think I should know that answer. I

shouldn't have to come to them. And I think that's what makes it hard and it kind of kills your confidence a little bit. (Student A)

Being able to feel comfortable to ask questions. Like, not feel like an idiot. Because, when you ask a question... because you're just not sure, and it's like, "Yes, I can go to a computer and research it really quickly."... But you're [the CNI] right here, and you know the answer, then... it help your learning ... for like, an instructor-aspect... I think it's super-important to be really approachable and make it very clear that it's okay to ask questions. (Student J)

One student described that she would not ask the CNI questions because the CNI grades her, so she would go around the CNI, even if that meant asking the patient. The student recognized that this could be a lost opportunity for learning and to feel confident with a particular task.

Yeah, so many times, I, I didn't understand something or I didn't know how to do something, and, and there's no way I would ask my instructor... because I didn't want to jeopardize my grade. And knowing ... like, if we asked any questions..., it comes out in your anecdotes as "requiring prompting". And then... if you require prompting, then that jeopardizes your... A+, maybe an A. One morning, I, I was supposed to change an ostomy on ... one of my patients,... there was no way I was going to ask my instructor... My patient... essentially taught me how to do it... She was willing to explain ... you know, during the situation, if she hadn't been able to explain it to me, or whatever, like, obviously, I would have gone for help... it probably would have been better like, if... a nurse would have actually explained to me, not just the patient... (Student C)

Don't disrespect others, it influences me. When students witnessed a CNI disrespect other students, they began to self-doubt their own abilities. Students wondered how the CNI would interact with them in a clinical situation. Often, this sort of behaviour from the CNI elicited nervousness in the student group and students would make every effort to avoid him/her. However, students recognized that their avoidance behaviour would influence their clinical learning experience negatively because their learning opportunities would be limited.

I remember one of my... [rotations] ... Medicine, I think. And one of my classmates... we had, I don't know if it was midterms or whatever after a post-conference – we carpooled – but she wanted to talk to the teacher about something. She made a med error... And so I stayed and she comes out of there just, like, bawling. And the teacher told her that she

should quit Nursing and shouldn't be a nurse. So, then, like, for me, I was like,... "If I make a mistake, is that how I should take it?" (Student E)

I've had instructors really come down hard on fellow classmates... You know, and I've seen instructors like, yell at students in the hall, or in the med room. And they're [the student] crying... and that... like, decreases my confidence, too... I feel like, "Well,... that could be me." Or... "What are they going to do when I make a mistake?" right. And then it puts you on edge... You think that they're [CNI] in the supportive role. And then, when you see them do that to a student, you're thinking, "Okay, well, what support am I going to receive if it's me?"... So... just witnessing it is enough to, to deflate you. (Student F)

Teach me. Students appreciated when CNIs were passionate about their job and they wanted to share their knowledge and expertise. Students really valued when the CNI inquired about their best learning style. Students thought that this approach helped them to learn and be successful in their clinical practice. Student B described a positive teaching and learning forum she had with her CNI.

... my last instructor did an excellent job of being teaching,... I was doing... a sub cut line... the skill is new to me; um, yes, I've learnt about it in... lecture... I know why we do it; and I've read the Policy and Procedure Manual. So, in my mind, I kind of know the steps, um, but, to be fair, I have not done this before. So, she[the CNI] asked me, "What kind of a learner are you? Would you like me to show you first? Would you like me to guide you as you do it? Would you like to read the Policy and Procedure Manual, and then, uh... and then you want to do it yourself? What would you like?" And, and I said,... "I... personally, I need to read it first and then I, I need... little drawings because ... I'm a visual learner, but I have to read the words as well. Um, so, so let me look at the pictures, let me read the words, let me look at the apparatus. And then, if you could, could, um, just go through, step-by-step with me, first asking me what I would do, and then correct me if I'm wrong, right, before I do it because I, I don't want to do it the wrong way." So she was very, very, good... in understanding... or asking me how... what type of a learner I was, and then... and then doing it the way that I learnt best. And that was wonderful... (Student B)

Give me time...I am a learner. Students wanted CNI to recognize them as learners and to remember that they were once learners, too. Student B commented on the unique characteristic of a learner, that learners are "*not as intuitive*" as experts. Additionally, students expressed that it was important to be given the additional time in a variety of situations without negative consequences. Three subcategories emerged through students descriptions of clinical situations

in which they needed more time: i) time to prepare for a task, ii) time to respond to questions, and iii) time to transition to an increase workload. Having this additional time, provided students with an opportunity to learn and to feel more confident in their knowledge and skill.

... remember that they[CNI] were there once, that would, I think, be the biggest... like, just remember that they had to go through difficult times too and that patient care might be a little slower with us[students], but it's still going to get done... And how else do we learn? I don't know how to word nicely... "we're just slow."
(Student E)

Time to prepare for a task. Students expressed that preparing for a skill/task, by increasing their knowledge, gave them the confidence they required to tackle the skill/task.

I don't know everything, I'm willing to learn anything, um, I need to be respected as an individual learning style that I need time to prepare... "If you expect me to do something that I've only done a couple of times or..., haven't yet done at all, give me some time... read the Policy and Procedure Manual, let me refresh my memory, give me time to remember my confidence, remember myself as the person that, that can do this, so that I can go to the bedside feeling equipped and feeling confident." Because I think, when you have the knowledge and when you're confident, the skill goes that much better. (Student B)

Time to respond to questions. Students often described being unable to think on the spot and feeling nervous when the CNI asked them questions. Being a learner, students expressed that they needed extra time to respond to questions, so they could feel confident in their knowledge, before responding to the CNI.

I've had some really good clinical instructors too who've said, you know, like, "Take a little bit of time to think about this, and then..." you know... And so, like, you know, you have a minute to breathe. You don't just have to like, fire back what you... you know, what you think... (Student C)

Moreover, students commented that the CNI should not only consider responding time as factor in asking questions but also consider the number of questions asked of students at one time. Students described being drilled with a multitude of questions from the CNI made them feel intimidated, and fearful, causing them to shut down and to avoid the CNI.

... with fear... , sometimes you can just shut down,... with an instructor who's just like, peppering you with questions, and like,... "Am I going to get the right answer?" And like, "Is this going to come out in my anecdotes?"... and,... like, struggling to like, think clearly because I'm so tense about... answering the question correctly. (Student C)

If you have an instructor who you go to and say that you're not confident, and then they drill you with questions, and then the next time, they drill you with questions, then you're less likely to go to them and say, "You know, I'm not sure about this." (Student H)

You're always scared to say the wrong thing to your instructor... So they'll ask you questions, and you're so nervous to say the answer. And they'll kind of shut you down and be like, "You missed this, this, and this, and..." whatever, and they make you feel dumb... knock you down for what you didn't know. (Student J)

Time to transition to an increase workload. Students voiced that they needed some time in clinical practice to fulfill a variety of different skills, such as communication, organization, or psychomotor. Having an opportunity to master a variety of skills before progressing to a heavier patient workload was important for students' development of confidence.

... I think that it's important in clinical to have a low patient load because... for example, in our, um, Older Adult in the XXXXX, some people went up to five patients. And I think that we're learning how to interact with people in this setting, and you can't do that if you're jumping from person to person. So I think time and patient load is huge, too... Just until you feel more comfortable. And you're going to meet so many different people and you need to be able to get their story and understand... the impact of this is... to them... And more experienced nurses can probably do that very quickly... (Student H)

Debrief with me. Debriefing gave students an opportunity to learn from clinical situations, to feel confident in their clinical practice, and to persevere into future situations. Students described how valuable it was for their learning to debrief with the CNI in a variety of clinical situations. Three subcategories developed from the data analysis when students talked about various clinical situations, in which they benefitted from debriefing: i) preconference debriefing, ii) debriefing before entering a patient's room, and iii) debriefing after a critical incident.

And afterwards, we talked about how it went... So... and I'm very big on that, about like, debriefing about how something went. And, like, "What could have been done better and what went really well?" So I think that's important after like, every skill. (Student H)

Preconference debriefing. Pre-conference gave students the opportunity to check if they were on the right track with their plan of care for the clinical day. Once they receive affirmation from the CNI, then they were more confident about proceeding with the clinical day.

I found this past XXXXX clinical, um, very helpful... that we were able to have a pre-conference... I think that was very beneficial to just take a breath before starting your day... it kind of gives you a chance to say, "Okay, this is what I'm going to do." And help more with confidence as well... So, you... you go into the day thinking, "Okay, this is what I'm going to go," and you have this idea of what you want to do... But being able to just verbalize what you want to do, or specifically write it down and tell the instructor what you're going to do or what is your goals of care today... then it kind of, "Oh, yeah," like, verifies... like, makes it set in stone that that's what you're going to do and you know how to do that, for sure... It's the independent because like, um, from my experience... um, when I say, "This is my plan of care," I'm telling her [the CNI] that I know what I'm going to be doing. So it gives me a chance to, to build that confidence... to show her that I, I know what I'm doing. (Student G)

Debriefing before entering a patient's room. Students described that when they were able to walk through a skill with the CNI before entering a patient's room, this sort of debriefing allowed them to demonstrate to the CNI that they were knowledgeable and prepared because, often, once students were in the patient's room performing the skill/task events would change or catch students by surprise. During this debriefing session when students recognized that they were ready to enter the patient's room, they felt more confident once in the patient's room.

Giving the student the opportunity to show... the instructor that you know what you're doing... Because it might be a different situation in and out, right?... You know what you're doing here but, when it comes to the bedside, "Oh, this isn't the right way," or, the, the patient says something that threw you off-guard or, you know,... it makes you look like you don't know what you're doing... But you actually really do know what you're doing... I think it helps. I think it influences my confidence... it shows that I'm more prepared, so it decreases anxiety. (Student G)

Debriefing after a critical incident. Sometimes critical incidents occurred in students' clinical practice and students expressed that debriefing was essential to assist them with ongoing

learning and regaining some confidence they may have lost during the difficult situation. If students were feeling deflated from a critical incident, debriefing with their CNI assisted them to reflect, learn, and move forward in their future clinical practice. Student A described how her CNI supported her through debriefing when her patient was dying. This student appreciated how the CNI inquired about her thoughts and feeling about the situation.

And then, at the end of the day, she [CNI] pulled me aside and said, "Do you want to talk about it? What's your feelings about what happened?" and just... kind of debriefed with me... Well, when my instructor... pulled me aside at the end of the day and just said, you know, like, "Talk... what do you think? I think you did a wonderful job today," that kind of thing. That was supportive. (Student A)

Theme 2 – Self (The Nursing Student)

Throughout the data collection, students thought they were an active participant in the outcome of their clinical experience, by the way they behaved or how they felt about themselves. Often, students regarded their influence as taking responsibility for their clinical learning experiences, which in turn had positive effects on building their confidence in clinical practice and on contributing to their clinical learning. In fact six out of ten students thought that *they* were one of the most influential individuals in their clinical success, in addition to their CNI. Seven categories with some subcategories emerged from the data analysis in which students discussed how they influenced their feelings of confidence: 1) being prepared, 2) self-reflecting, 3) feeling nervous, 4) pass it forward, 5) self-talking, 6) previous experiences, and 7) put yourself out there. Student G explained how she was most influential to her clinical success.

I think ... most influential... definitely myself... Most definitely, myself... Because it's me... I'm choosing to do the things that I'm doing. It's my choice, my choice whether or not to stay up a little bit later and get more knowledge. Or, my choice to seek guidance, my choice to, um, like, do my job properly... safely, efficiently... it's me that's driving the bus, type of thing. (Student G)

Being prepared. When students thought they were prepared for clinical practice, they felt confident advancing into the clinical day. The clinical day was more stressful and a struggle

if the student was not prepared. Students described preparation for clinical practice as having the right amount of knowledge to provide safe and competent nursing care. Often this acquisition of knowledge was about learning about their client by completing patient research the night before clinical practice. Students often made reference to their acquisition of knowledge equated to gains in their clinical confidence.

Student B referred to this acquisition of knowledge as “*so I have my back... being prepared is everything.*” Further to this, she described her knowledge and confidence connection.

“The broader my knowledge base,... the more confident I become, and the quicker learner I am.”... I think the way I prepare has everything to do with how that day will unfold. If, I don’t have the knowledge base that I feel that I need, and if I’m not there emotionally, um, then the day is more of a struggle... I recognize that, that client has needs... if I haven’t prepared myself with the proper knowledge-base... then... I don’t feel confident, I feel inadequate...I feel stressed, I feel like,... it’s not going to go well. In my peds rotation, I had already gained considerable knowledge in lecture, so at least I felt confident with what I knew and the assessments I was making... (Student B)

Student A explained the importance of always being prepared for each clinical practice rotation and cautioned other students not to be over confident.

I was feeling pretty confident after my XXXXX rotation, and my XXXXX rotation followed. Perhaps a little too confident, I was thinking... that, in the way that I stopped preparing as much as I did because I was feeling really confident, right... And I think the Pediatrics, that whole experience just make me go, “Okay, you’re still a new nurse. You still need to prep as much as you did yesterday or last term.” And I think it just made me realize that, “It’s... always a learning experience, and you should never stop building that knowledge.”

Student D emphasized that being prepared for clinical practice facilitated her clinical day to unfold uneventfully.

I would say just being, um, prepared... you’re going to have to do a certain skill... on that patient that day, like, maybe like, a wound dressing change or something... watch a video on it and, and be familiar with the Policy and Procedure, know what supplies you’ll need, and..., you know, remind yourself of sterile technique if needed... and kind of practise it at

home, too. That's a good thing about having those kits that we bought is that you can fake-practise it at home so that... it goes smoothly when you have to do it.

Some students claimed that not being prepared for clinical practice heightened one's anxiety about entering clinical practice. *"Students that aren't prepared that, like, it's a random skill that's like, 'Here, you have to go do this,' and they didn't research it. Then they're way more anxious."* (Student D)

Student F claimed that doing the research the night before was important for her learning and that in fact, learning the content in this manner was of a greater depth, rather than researching her client assignment the morning of clinical practice.

I think future students would hate me, but I think it's the research... Coming in [the night before]... and knowing your patient?... you know, you get the patient, I see that they have liver disease, I see that they're scheduled to have like, um, is it paracentesis?... And I'm reading the notes again and again and again. And... just solidify this, "What does this mean? What am I going to see? What am I going to do?" And if I had just walked in, "Oh, your person has this," I'm not sure the learning would have been as deep... I know in, um, Medicine,... there was one day she[the CNI] specifically said, you know, "You're coming in... everyone's coming in blind." Just, it was a learning exercise, and... it was a lot of anxiety for me. Researching the day before,... you just really dig deeper into it, right.

Further to this, students' advice to other students about improving their confidence in clinical practice was that they needed to take responsibility for their learning and be prepared.

"...increase your knowledge, increase your skills, for sure." (Student G) *"You know, 'Poke yourself into the lab whenever you can,' like. But if you like to read, then read up on things really, like, before you come. And so I think just, 'Be prepared,' right."* (Student F)

Interestingly, one student commented that self-care was important in her preparation for clinical practice, in order for her to have the greatest potential to feel confident. If she did not have adequate sleep or nutrition then her *"ability to be all the she can be [was] compromised"* (Student B).

I think you, personally, are your own best advocate... self-care is really important. Um, what I recognize is, if I come to clinical not having had adequate sleep, not having adequate protein, not having all of those things that I know make a difference in my day... then my ability to be the best I can be is compromised. I think our ability to be confident, our ability to, to learn... I think self-care is really important. (Student B)

Self-reflecting. Students viewed self-reflection as a valuable tool for their learning and development of confidence in the clinical learning environment. Self-reflection was acknowledged by the students as their ability to know and understand themselves by exploring their feelings, thoughts, and behaviour within the context of the clinical learning environment. Students considered self-reflection to be an important skill that assisted them to understand the reciprocal interplay between them and their clinical learning environment. This reflective forum provided students with an opportunity to evaluate their current clinical practice, and evaluate their level of confidence, in order to maintain or change their behaviour in future practice. Two subcategories developed as reflection opportunities for students to learn and further their confidence: i) documenting daily anecdotes, and ii) self-talking.

I think we're always continuously learning. And I think, depending on whether or not you are open to change, open to adapting and open to becoming the best nurse that you could possibly be, influences your learning, for sure... Um, like, for example..., if you are willing to take the feedback and recognize your mistakes and your errors and just wanting to grow from there... like, wanting to do better, wanting to take that experience and, and not repeat it, and... "Evaluate how I did wrong, what should I do differently next time?" That... definitely affects you... what can I do to build my confidence... because there's a lot... on my shoulders... not only are we learning about theory and how to properly bathe someone or care for their activities of daily living. But it's, personally, like, you, type of thing. Um, like, "How are you going to grow as a person?" So, not only you're taking the responsibility to learn, you're taking the responsibility to look at yourself and grow as a person and identify your own faults... and change it and want to change it to better yourself. (Student G)

Student H felt that self-reflecting was most important to her developing confidence in her nursing practice.

... being able to reflect on your own practice and saying, "You know, I did this and this went okay, but I think I could have done better if I would have done this," and making kind of a mental note of what you're going to do differently...(Student H)

Documenting daily anecdotes. Students viewed daily anecdotes, a form of journaling, as a path to learning and clinical success. Students described daily anecdotes as a way to grow as a person by identifying their areas of strength and weakness.

So you learn the theory, and then you incorporate that into your practice... And then, um, like, anecdotes kind of help you to learn where, where could you improve, where are you doing well... (Student D)

... It was a terrible experience... but it was a learning experience as well... Like, I could learn from it... how I felt, so then I don't do it to somebody else. Or I could reflect on it... I could just reflect on it and think like, "What would I do in a, in a situation if that occurred again?"... So, even if it was a negative anxiety-provoking experience, there's always a learning opportunity to it... In the moment, it wasn't very nice, but... you, you hate anecdotes and you hate journal entries, but... I feel they are... helpful, and... it gives you an opportunity to sit down and think about stuff. Like, sit, sit down and think, "Why, why, why, why?"... So that's good. (Student G)

And I know everybody hates anecdoting and journaling. "But if you reflect on how you felt about it, you'll get better."... you won't be successful unless you take the steps to be successful. So you identify where you need growth and you seek out ways to improve... And, um, you know, if you have a really good day, you can pat yourself on the back and say, like, "Oh, this went really well."... I think that you could have the best instructor and a patient that was really reassuring and a great buddy nurse. But if you're not going to try to improve, then it won't make any difference. So I think you have to be responsible for your own success.... (Student H)

Student E had some conflict working with a peer on a clinical assignment and found reflection beneficial for her to make some behavioural changes.

Well, I think... we had to do many reflections over the course of this [program]. Um, there was one week where we [the student and the peer] both were kind of frustrated with each other; no one said anything, we just worked it through. But then, when I went home and reflected, I was like, "I need to learn to sit back and, just, 'It'll... it'll happen.' " Like, sometimes I can take myself too seriously. So, going home after that experience, I was able to sort of be like, "Okay, sometimes I'm a little bit too much of a leader." And I took from that... and, like, I can sit back and let other people take charge... So I can take that into many places. (Student E)

Self-talking. Some students discussed the importance of self-talking themselves through a difficult task. This self-talking was about believing in their ability to perform and talking silently to themselves about their belief. Students felt that having the confidence in themselves, this sort of self-assurance, assisted them to persevere, especially at difficult tasks. Student C and Student A shared how this silent self-talking dialogue proceeds.

“Be confident, [student C],” like, “you’ve studied this, you, you know this.” Like, you know, when your instructor’s asking you questions like, you know, “Buy yourself some time, give yourself a minute.” Like, “You... it’ll come to you,” or, or that kind of thing. I would say it’s more internal than external, that... I’m getting that encouragement... I’ve sat in all of the classes,... I’ve been diligent. Like, uh, for the most part, I’m not one to skip a lot of classes or that kind of thing. And... so I think... I just keep reminding myself, like, “You’ve done well on your... exams. You’ve been to class, you know that knowledge.” And so that should translate into being where I should be in the clinicals and so that should translate into confidence in the clinical setting. (Student C)

You go home at the end of the day, you think about what that person/instructor/nurse, whoever, said, and you kind of reflect it on your practice, right, “Okay, so what else could I have done different? Could I have prepared more? Could I have...” (Student A)

Student B shares that she had an unfortunate situation in clinical practice and that there was some value in sitting down and self-talking her way through the experience, as she felt this reflecting activity was confidence building.

...[there] is value in... reflecting on it, and learning from it... I looked at the situation from every possible aspect and came to the conclusion that it wasn’t me that was in the wrong. Uh, and I tried to understand what caused those individuals to, to react and act the way they did, and I think what that did is a couple of things. It made me sit down and look at absolutely every aspect of, of my performance and my emotional level, the knowledge that I brought to the table. And then I looked at what the experience was, and all of the... the players’ reactions to it. I sorted out in a way that, that was really confidence-building for me.

Feeling Nervous. When students discussed feeling nervous in the clinical environment, they described how it influenced them physically, cognitively, and behaviourally. Students expressed being unable to think, focusing only on the task and not so much on the patient. Their hands would shake, which effected their ability to learn, to think, and to feel confident in their

performance. Many students conveyed that when they felt nervous, they were more likely to make a mistake or have a near miss. Students viewed mistakes as detrimental to their development of confidence in clinical practice.

There was an error in the, in the [pump] numbers that had been put in and it was only caught after the fact and, whatever... it was an incident, and... definitely, you know it brought down my confidence... I had, by no means, wanted to make a mistake, and I had thought I was being very careful. (Student C)

I think that when you're nervous and anxious, like, you're more likely to make a mistake. So, you're more shaky and... I don't know, you drop things or knock things over and then, it gets worse, right, because it spirals because you think... (Student H)

Conversely, student I felt that being nervous or anxious motivated her to do her best.

To a point, I think being nervous and anxious is good... I feel like, personally for me, it makes me more thorough. Like, I'm checking the, um, the MAR like, probably five times ... near the end of the day to make sure I didn't miss anything. (Student I)

Further to this, two subcategories surfaced when students elaborated upon situations in clinical practice that exacerbated feelings of nervousness and diminished their feeling of confidence: i) being watched intently, and ii) being in unfamiliar situations.

Being watched intently. Students realized that the CNI needs to observe their performance, but students preferred that they did not watch so intently. Students often described this intense watching as, hovering over them, while they completed a task/skill. This sort of hovering behaviour made students feel extremely nervous, and/or incapacitated, in which they were more likely to make mistakes.

I know there's been clinical instructors I've had who are very hovering, and you just make 10 more mistakes. I remember doing dressings changes where my instructor's just right there, and you make 20 more mistakes than you would have if they just would have... like, I've had other instructors who just kind of stood back and didn't watch you so intently. And you do way better at that skill, right, because you're not so nervous... (Student A)

It's debilitating when your anxiety is so high that simple things become impossible ... Like, I could not crack the glass of a vial. I went through three, and we kept wasting these

meds because they would shatter. One time, I cut my finger, I needed a Band-Aid... I practised this in lab? Yes. Have I been successful at this? Yes. But when someone's [your CNI's] watching you... I shattered three of them before she finally said, "Enough waste." and, "Let me just open this for you." (Student F)

[Do] not [hover] over me... because it's so hard to like, even do a blood pressure or something when you have someone waiting... it just makes it awkward. You're doing your vital signs, you're checking them over, there's nothing to be nervous about. But, as soon as their [the CNI] eyes are on you, you're like, "My God, why am I sweating?" Like, "This is fine. They're just standing there." But it still just automatically makes you feel that way. I don't know. (Student J)

[The instructor] is standing right over your shoulder... Which I know that we need to be observed because we're learning but if they're standing over your shoulder and not saying anything, probably more [nervous]. It's nerve-wracking when they're staring and not saying anything. (Student H)

Student D's perception of her CNI watching her intently was that her CNI was waiting for her to make a mistake. *You know, she's just breathing down your neck, waiting for you to do something wrong.... (Student D)*

Being in unfamiliar situations. Students described the unfamiliar as the unknown and/or the first time. In fact, six out of ten students made reference to the fact that the unfamiliar made them feel the most nervous in the clinical learning environment. Students described the unfamiliar phenomenon as not knowing the CNI's expectations, not having the theoretical knowledge, or not having a clinical experience in the past and enduring it for the first time. Some students described the unfamiliar as feeling incompetent, intimidating, inadequate, scary, and/or nerve-wracking, which effected their ability to concentrate and feel confident in their performance.

I think the most nervous I ever am in any clinical experience is my first day... where I really don't know my instructor very well,... I still don't have a good perception of what is expected of me by her... this particular rotation... I haven't even had a lecture, right so, you know, I was in XXXXX first; we hadn't really had much of a lecture yet, so... it's intimidating to walk into a unit that you don't know with an instructor that you don't know... Because I don't know the unit, because I don't know the instructor, because I don't have a good knowledge base, because I'm not sure about what I'm doing, I could

fail. I could be seen as inadequate, I could be seen as... incompetent, I could be seen... as not having confidence. And that, to me, would be failure. (Student B)

I remember not sleeping many, many nights just because you're so worried that you're not prepared enough, you don't have enough knowledge about this, you don't have enough, uh, practice doing a skill... I remember having like, lots of IV meds, never doing an IV med, and that would be scary, right, especially because you don't know how your instructor's going to be. Like, you don't know if they're going to be supportive, you don't know if they're going to be like, expect you to know it. So that can be very, very nerve-wracking and, and result in a lot of lack of sleep, which makes it worse, right. (Student A)

If you're doing a skill and there's a whole bunch of family in the room, then... and it's your first time doing it... then you're just shaking and it's very obvious that you're nervous and... yeah, so it, it definitely affects your care. (Student D)

I had... never seen someone die, never... I've never seen a dead person,... so I had a patient for three weeks; he had ALS... he declined very quickly. "What if he dies on my shift?" Like, "What do I do?" like, ... freaking out... like, "I don't know how to deal with it." ... "What do I when they die?" Like, "How do I do this?" And I... like, all I could concentrate on that. (Student E)

When you're first, first new in clinical, and you don't have a relationship with your instructor, so you don't even know yet kind of their standards, you know, or... or it's just such a brand new relationship... it's a very strange relationship... there's anxiety there. (Student F)

Um, I think probably the first time that I was doing I.V. meds and just like, not being super-confident with manipulating like, the syringes and all the needles and switching them, and... probably took 20 times longer than I needed... And I'm pretty sure that I knocked something over and it shattered... (Student H)

Pass it forward. Students used the expression *pass it forward* for describing a situation where they had an opportunity to share their skill/knowledge with another student. When students were able to demonstrate for a peer how to do a skill/task or to walk a peer through a skill/task, students found that this activity empowering and confident boosting.

The beautiful thing that day was I had to do two sub cut lines almost back-to-back. So, you know, the first one, she [the CNI] led me through; the second one, she just watched, and, and I did it. And then someone came in and said, "I have to do one of those." And then I was able to explain it to them, and that was... so confident... And, of course, the instructor's listening to me, and, and... interesting thing was..., this is the beautiful thing, Tracy – I asked them, "What kind of a learner are you?" So, just having felt so understood and so, um, appreciated for who I was, allowed me to pass that forward to my

fellow student. And... then she explained what kind of a learner she was, and... I adapted... the way I showed her. (Student B)

I think like, I've felt... like, maybe it was very confidence-inspiring when... like, I can think of a time when I had already done a dressing change... I kind of had the same woman for maybe three weeks in a row, same patient. And, and then on the fourth week, a different student had that patient. And then the instructor who had seen me do the dressing changes with her, I don't know, a couple times anyways, had sort of like, "[student C], why don't you go in with that student together?" And I felt like it was a big... like, "Wow, you actually trust me to do something," [laughs], you know. And like... and like, affirming that, you know, "You did do those dressing changes correctly. And now, why don't you, you know, show another student?" ...an empowering moment where, "Yes, you do know something." (Student C)

Past experiences. Students viewed past experiences as a way to scaffold one's learning and development of confidence. Past experiences were seen as a way to master a particular skill and learn more about the skill each time, whether they were successful or not at performing the skill. Often, when students had previous experiences with a situation or a skill in clinical practice, they described it as feeling *comfortable* when they needed to complete the task again or when they encountered the situation in the future. Students described past experiences through three subcategories: i) previous clinical experiences, ii) personal experience, and iii) work experience.

Previous clinical experiences. Students made reference to having previous clinical experiences, which assisted them to feel more confident in their clinical practice as they progressed through a variety of clinical courses in the nursing program. Students expressed that with more exposure to the clinical learning environment, they endured new layers of learning and they became more confident in their clinical practice.

I think each clinical, you get stronger... Like, I think... um, you know, communication and like, your knowledge base grows..., skill base grows. Like, your experiences build on each other. Like... I took a picture of myself first day of first clinical in First Year, and then a picture of myself last day of last clinical...three years later. I look at these pictures and think like, "I'm, I'm barely the same person." Like, you've learned so much... each thing just builds and builds and builds... Um, like,... some of the things that were very anxiety-

provoking in Year One and Year Two... are second nature in Year Three... So it's like, over the years and all the things that we've done brought me to that point ... being more secure in your knowledge. Like, I do have a voice and it matters and, you know, just being stronger, I think, as a person, and trusting your instincts a little bit more. (Student F)

We're in Third Year, maybe it's more like home... more comfortable... I know more things. (Student E)

Therein lies the beauty of repetition, right? Repetition is absolutely everything. Um, now, in my RRC experience, what I've learned is that not all clinical experiences are made equal. And, uh, I'll just say, for example, my, my girlfriend was in a clinical experience where she was able to do eight I.V.'s in a day, you know, tromp around with the I.V. team... so, for her,... doing an I.V... she got very confident, right. Every time you do something again, is confidence-building and you learn something new about it... (Student B)

Well, I think that each clinical helps you with the next one even if they're unrelated areas because each one builds your confidence a little bit and... introduces you to different people and then you realize like, that every person is an individual because you'll see people across different settings that seem similar but they're really different. And... each clinical, I get better with communication, and so there are skills that grow through each one. (Student H)

Having done it twice like, a stat order... um, with two consecutive weeks, I felt like that really built my confidence, to know that I did it, correct and well, without any kind of prepping the night before...I feel like you build on everything from Year One to now. Well, maybe like, in First Year, you've kind of just learn how to talk to the patient and then I felt like, maybe in Second Year, it was kind of more skill-focused like, with I.V.s. And then I felt like maybe in Third Year, um, during like, Peds or L&D or something, it's like you're talking to the patient while you're doing a skill... you're kind of combining it all... I would feel more confident. (Student I)

Personal experiences. Personal experience assisted students to feel a certain level of confidence in the clinical learning environment. The level of confidence might be related to interacting with a patient, completing a skill, or being in a practical type environment.

My grandparents had just passed away like, the few years... And I saw the care that they got, and the care I wanted them to have versus what they got, and then the nurses that were like, amazing, kind of thing. And, those are just...the kind of people you want. And I think, too, I think of it... it's like, "How would I want someone to care for my Grandma and Grandpa when they're in the hospital?"(Student J)

One student made an interesting and insightful comment about personal experience.

Student B, a mature student, felt that even though she had personal experiences in her life, a student role was very different and that she still needed to feel confident as a student in the clinical setting.

My first experience out in XXXXX; that was my first clinical rotation; I'll never forget it. You know, I just felt so inexperienced. You know... even at my age. I had already, you know, dealt with elderly people and... helped them in their illnesses and experienced someone dying with me and, and all of those things. So... experiences outside clinical are very important to bring into clinical. But, for clinical itself, in spite of my previous experience, this was still all new because now I'm the student nurse, right. I'm no longer just [Student B]. I'm the student nurse and there is my patient, and there's all the medication. And, and then I have to give a catheter today, and I've not done any of it; I have no clue. (Student B)

Work experiences. Many students described how their work experiences assisted them in feeling comfortable and confident in their clinical practice. Being confident in communicating with patients or staff seemed to be a prominent skill that students were able to transfer from their work experience to their clinical practice.

Working at XXXXX, I grew as an individual as someone that's providing care... I could tell you tons of experiences that allowed me to grow as a person... it makes me feel more confident... I couldn't imagine how other people would feel if they didn't know how to wash a single person. Like, I would feel scared if I were them... But, to me, I feel confident because at least I know how to do that, you know, I have a little bit of background of... and I'm really good with patients. So I know I'm really good with patients and I know how to talk to people and, and build that rapport. So I feel confident in that area... (Student G)

I worked as an activity worker in a personal care home before this for a year or two. So I've worked with older adults and that's where we were going, to XXXXX... kind of going back... previous experience, like, having this... I had worked with older adults so I wasn't nervous, but... I could see... my classmates, they were terrified... they were like, "I'm not talking to that person... like, they're old. I don't know them." (Student E)

In a government setting,... I had to take phone calls from angry taxpayers [laughs]. So, so [laughs], um... I think that that also helped. Like, I can take some criticism and I try not to take it personally because I understand that people have a bad day, and... so that, I feel like, helped a little bit. (Student H)

I used to work for XXXXX... So I did caring for people... like, all sorts of that... disabilities and... or mental stuff, but... so I carried that forward, kind of thing. Like..., I'd be patient in talking with people and like, understanding and kind of being able to look at a person from their eyes and kind of like, not judging someone... I think it just helped me kind of think beyond the patient to the family. Because, when I worked for XXXXX, I had the kids... I found all of the Communication courses... I was like, "I know. I know this." (Student J)

Student C shared that training to be a lifeguard was most helpful for her in the CLE because she was accustomed to being watched while doing a skill.

I have worked as a lifeguard... before this program, and kind of throughout... I'd done a ton of lifeguard exams, um, and continually we're doing re-certifications where you do have someone standing with a clipboard writing down, you know... everything you're doing and where you need to be saying things out loud, or else it didn't happen, um, that kind of thing. And so I think that really prepared me for being in the clinical setting where, you know, if you have an instructor who is, you know, writing... yeah, taking notes while you're doing skills or like that kind of thing, um, uh, maybe it was less intimidating because I've had some experience with that. (Student C)

Student D explained that being a health care aide was very helpful for her confidence in her first clinical experience because she was familiar with dynamics of the unit and was comfortable performing the health care aide tasks that first year students often do in clinical practice.

Being a, a previous health care aide, I was kind of familiar with, with working on the units and stuff. So you kind of gain confidence in that respect because... you're more comfortable and familiar with how things run... just having seen what nurses do. You learn from watching them, too. My very first clinical experience, I remember feeling way more confident than all the other people because I was a health care aide. So our instructor said, "Okay, go in and do A.M. care and, and get these patients washed up and stuff." Well, they were all just like, shaking, nervous... everybody's like, "Oh, I've never even seen a naked person [laughs] before." And I was like, "Okay, well, I'll come and help you." Yeah. (Student D)

Put yourself out there. The advice that students provided for other students to improve their confidence in clinical practice was to *put themselves out there*. Putting themselves out there meant that students had to be determined to embrace every clinical learning opportunity, in order to give them the best chance to be successful. The more willing students were to put themselves

out there, the more likely the individuals they worked with would provide them with clinical learning opportunities. Students explained that the more they practiced a skill, the more confident they became at doing that skill.

Without being determined, first of all, to be that excellent nurse, I don't believe that you get the support that you would otherwise get, because they're still seeing you as back here trying to establish what's important and what's not... I always seek out new learning experiences in my clinical rotations because I recognize the more you do something, the better you get at it, the more confident you are, the easier it is to... (Student B)

I think that they [the nursing student] should just put themselves out there as much as they can. [Even], if they're feeling nervous about a skill, if they don't want to do a skill, "Because I'm scared, just do it, because you'll be able to do it. And, at the end of the day, you'll feel so good because you did it. And that will... alone will improve your confidence." (Student A)

Just take every opportunity... and don't be scared to ask for help. (Student H)

Theme 3 –The Buddy Nurse

Students believed that the relationship with their buddy nurse should be a working relationship to benefit patient care and student learning. There was concern among the students that their buddy nurse perceived them as someone who completed their 'to do' list. Students expressed that they wanted to provide holistic care, considering all aspects of care and not just focus on the completion of a 'to do' list. Students felt that providing holistic care helped them to feel confident in the role of the nurse and provided them with opportunities for high level thinking. Student B described this holistic experience as feeling "nursy."

It feels like I'm able, "I can do this." I feel, I feel almost "nursy"... I no longer feel like the waitress, you know, the one that was given the to-do list... Now I feel like I am part of... the team... and what I have to contribute... is valid, right... My heart is, "If, if you're my buddy nurse, and I'm the student, I'm here for learning. I, I... I'm not here to just kind of, uh, do your want list," right. (Student B)

Throughout the interviews, students were eager to express their expectations of their buddy nurse. Students had strong feelings about how their buddy nurse could help them develop

their confidence and further their learning within the clinical environment, in order for them to be successful. There were three categories with some sub-categories that emerged from students' comments about working with their buddy nurse: 1) work with me 2) respect me, and 3) praise me.

Work with me. Students really appreciated when their buddy nurse was receptive to having a student to work with them, side by side. They felt that this sort of approach helped them to learn and begin to feel confident in the nurse's role. Students described comfort in working closely with their buddy nurse, since it was less intimidating than working closely with their CNI. This feeling of comfort assisted students to feel more relaxed around their buddy nurse and to feel that they could ask him/her questions.

Having a really good buddy nurse who's going to be, like... "Come along. Let's figure this out together." I think that's been huge for me, yeah... having an instructor who's like, "Come along, work with me," is more intimidating because, ultimately, they're the ones still grading you. Whereas I feel like, if I have a buddy nurse who's like, totally willing to take me in in all these learning experiences... they're not grading me so I feel like I can ask any questions I want... you know... they're willing to teach me and they're willing to, you know, show me something cool that's happening. (Student C)

Students described *work with me* in two sub-categories: i) include me in your nursing care, and ii) share your rationale.

Include me in your nursing care. Being included in the nursing care was described by students as a buddy nurse dialoguing with them about patient care or a buddy nurse allowing them to complete a skill/task on the patient. Students expressed that doing the task was better than watching the task being done by the buddy nurse. This inclusiveness in caring for the patient helped students to grow in their level of confidence related to their clinical practice and in their ability to learn within the clinical learning environment.

The following student expressed that she learned from her buddy nurse's approach with the patient because she brought the student into the situation by dialoguing with her. The student shared that this experience was a great learning opportunity for her.

I think of like, one nurse in particular... the patient was throwing up a fair bit and was very close to the end of her life too. And, and just the way that that nurse like, came in there and like... we kind of cleaned her up like, maybe three times in a row while we were in the room, um,... she needed new clothing put on again and again, kind of thing. And, and just how incredibly like, caring and... and gave like... dignified care to this woman,... I was so inspired by her care and even like, just the little things that she said to this woman as she was doing, doing the care, and, and, uh, and had such a like, slow, gentle approach to it... I feel like I learned a lot from her like, directing me to like – you know, some of it, we talked about outside the room too, but – like, “If we move her this way, it will... it will hurt less,” or, like, I don't... like, she had so many little tips and little tricks to, to try to care for the patient better. Um, also, there was quite an odour in the room, and so... she had so many like, you know, “Try this, do this, get...” you know, “get a basin with a kitty litter.” Like, so many different really practical things that like, no one had ever taught me like, that list of things to try [laughs], you know. And, just to make it like, as good of an experience for the family and the patient. Um, and so I think for me like, that was a really inspiring day... to be buddied with that nurse together... and taught me so much, yeah.(Student C)

Student E described her buddy nurse walking her through a task that she had never done before rather than her performing the task by herself. Her patience and guiding approach helped the student to learn how to hook up a PCA pump.

We were hooking up a PCA for my patient. And I had never done it, I had no idea what I was doing. And [she] stood beside me; it was like, “You're doing it... go.” Like, “Here's the monograph, here's the order. Let's do it.”... And I was like, “I don't know what I'm doing.” [She's] like, “Okay, let's figure it out.” And [she] like, stood beside me and we figured it out. And I'm like, “Sorry, I'm slow,” like, “we need to get this done.” [She's] like, “You're a student, right?... Okay, then let's take our time.”(Student E)

Students expressed that buddy nurses sometimes have an attitude that it is faster for her/him to complete the task than the student, so they would just complete the task without providing students with an opportunity. However, students voiced that this approach was a missed learning opportunity for them.

I think we've all been partnered with people who, who would, "Oh, I'll just completely go talk to the doctor about it," and kind of exclude the Nursing student... whereas, like, that could be a huge learning experience. (Student C)

Additionally, Student F described that when her buddy nurse dialogued with her, she felt listen to and included in the nursing care and that helped build her confidence in her practice.

I approach my nurse and I, you know, "I think it's this." And she... kind of like, "Let's, let's dialogue about that," right... My [buddy] nurse looks right at me, and we talk about it... like, peer-to-peer, it feels like... You know, and she listened to me, and she trusted my assessment. You know, I'm able to talk about it; and then, you know, she came to me and said, "You know what? I think you might be on to something," you know. And, you know... your confidence grows. (Student F)

Share your rationale. Students appreciated when their buddy nurse talked out loud to verbalize their thinking and share their knowledge. Students voiced that this was a great learning opportunity and often it helped them to visualize the bigger picture of the patient's situation.

He [CNI] kind of verbalized his critical thinking. He was like, "Okay, so this just happened and she wants this medication. But... she said she got this at home, like, every four hours. But here, they didn't have it every four hours ordered. It's only a p.r.n. So that's going to make me wonder why." And he was like, "so I'm going to go to her liver function tests and I'm going to go here and there." And he like, just stood there and said everything he was thinking... out loud. And it kind of just help... (Student J)

If you say to me, "This, that, and the next thing needs doing and then share with me the rationale as to why, uh, so that I can learn from you what goes in your brain, I'm totally up with that, because I can't be as intuitive as you because you have the knowledge and the experience I don't." (Student B)

Respect me. On numerous occasions during the interviews, students expressed that they wanted to be respected by their buddy nurse. Students stated that a respectful environment created a great learning environment. Two sub-categories emerged when students described how their buddy nurse disrespected them and shattered their confidence: i) don't go behind my back, and ii) don't embarrass me. Interestingly, Student B commented *"You know, we've all heard about, you know, nurses eating their young."* Students articulated that they wanted their buddy nurse to respect them as learners.

I often write this in the thank-you cards, like, you know, "Thank you for remembering that you were once a student, too." You know, like, "Don't forget that, you know, we're learning. And, you know, be nice to us [laughs] because we're, we're learning, you know. We're not going to be as good as you are, and we're not going to be able to, to keep up as well as you do because we're new," you know...(Student D)

Don't go behind my back. Students communicated that it was disrespectful of the buddy nurse to go behind their back to discuss a situation they had with a student. This approach did not make for a good working relationship or a good learning environment; in fact, situations like this hindered students' confidence. Both these students discussed a situation they had with their buddy nurse that hindered their confidence in clinical practice.

I was late for a med, so, instead of approaching me, that [buddy] nurse went into the, med room and started talking badly about me, saying like, "Oh, my student's useless," And like, little did she know, there's other students in the room that overheard...So those students then came up to me and said, like, "Your buddy nurse is talking bad about you in the med room." So then, obviously, it hurt my feelings. "Then approach me specifically and let me know. Don't go know talk, like, about it behind my back," type of thing. (Student D)

She [the buddy nurse] had been having some difficulties with the staff in... um, in doing what she wanted them to do. And I was just basically the straw that broke the camel's back, uh, so she complained to my instructor that I had not followed her instructions – which I had. (Student B)

Don't embarrass me. When the buddy nurse embarrasses students, this behaviour influenced students' confidence negatively and students' ability to learn in the clinical setting. Student D described a situation she had with her buddy nurse that hindered her confidence.

I had changed that tubing bag and you just want to keep like, a replacement one for the next people in the room. So, later on in the day, I had like, a new bag and I was bringing it in just to put it in the room for the next people. And she yelled at me like, from across [laughs] the room in front of a bunch of staff, saying, like, "What are you doing? That's supposed to be done in the morning. You're only changing that bag now? You're so late for that," and whatever. And I'm like, "I'm just bringing in the extra [laughs] for the next person because I like, changed it this morning."... And, yeah, so then that was really embarrassing. (Student D)

Praise me. Students expressed that they appreciate praise from their buddy nurse, since these nurses work on the frontlines. When the buddy nurse praised students' nursing care, students felt that those comments were very empowering and confident boosting. These comments affirmed for students that they were meant to be a nurse because often students self-doubt their capability.

It was so nice to hear someone [your buddy nurse] who's kind of on the same level as you saying that, you know, "You're doing a good job." It almost boosts you up more, right... Like, you feel like, "Okay, I am meant to do this. I can do this."... So, definitely... and I think those are who you interact with the most, right. (Student A)

When I left the unit that day, I felt as though I had all the confidence in the world... I had a young woman with burns on her hands and, and I had dressed her hands... and that buddy nurse, uh, told me that, that, in all the years of her practice, she'd never seen, um, anyone dress, um, hands in that way where,... her manual dexterity was not impaired due to the dressing. (Student B)

Theme 4 – The Peers

Students made reference to the fact that not all students are made equally. Each student will have different clinical experiences and different levels of knowledge. The uniqueness of each student and the willingness of each student to share their knowledge and skill set creates a great opportunity for peer-to-peer learning. Student described their experiences of clinical learning and developing confidence through their interactions with their peers, into four sub-categories: 1) what one doesn't know, what one doesn't think of, the other will, 2) be encouraging 3) share opportunities, and 4) don't throw me under the bus.

What one does not know, what one does not think of, the other will. Students often described *what one does not know, what one does not think of, the other will* as students having each other's back. This collaborative peer-to-peer learning assists students in their clinical learning and confidence building. Students described this phenomenon of *what one does not*

know, what one does not think of, the other will in two subcategories: i) sharing information, and ii) another pair of eyes, ears, hands, and thoughts.

Student B assisted in coining the phrase, *what one does not know, what one does not think of, the other will*, and described it nicely.

“What one didn’t think of, the other one would.” And... I just want to relate that to, to us as students. I mean, just,...testing in, in the classroom makes it obvious that, what some of us... learn, others don’t; and what others learned, we don’t, right.. So, when, when we come together as a group, one would hope that we know everything collaboratively, right. So what I found in, in the clinical experience is we help each other out, um, and, and, in that way, we’re successful. I believe it’s good... it’s really good to work in close contact with other students...

Student H shared the value in seeing a variety of different ways to achieve the same goal.

Peer-to-peer learning was a great learning experience for this student.

You can also bounce ideas off of each other because we’re both learning, so, “I think this might work best. What do you think?” And you might have two totally different ways to work towards the same goal, which is good to see, I think. (Student H)

Sharing information. Students, often, described situations of information sharing among peers occurring in the medication room. Students verbalized that they could rely on each other if they were unsure of something, if they had a question, or if they wanted a second opinion. Also, students expressed that their peers would not make them feel bad for asking questions or asking for clarification. This sort of collaboration helped students to feel more confident in what they were doing or were about to do in clinical practice.

They’re [peers] like another person you can go to and clarify, right, like, “I’m thinking this. What do you think?” because they’re kind of on the same level, and you know that... they’re not going to beat you... they’re not going to make you feel bad about not knowing. (Student A)

So what I found in, in the clinical experience is any time that I spend in the med room with other students, um, they’ll ask me a question, I’ll ask them a question, and, and we, we help each other out, and... in that way, we’re successful... Even if it’s just finding things, “Where’s the filter needle?”... And... the girl behind me says, “What do you use a filter needle for?” It was perfect, you know. So... one student was able to show me where

the filter needle was, and... I was able to, to share with them the importance of a filter needle... "So, yeah, I, I really feel very strongly that we, we learn a great deal from each other... it adds a level of confidence knowing that, again, someone has your back. So... you know how many times have I walked into the med room and said, "I can't think of that word. You know, help me, what is that word when, when, uh, the liver is, is... you know, whatever?" I'll have these three other people looking at me going, "Ah, the word is..." and then someone... it'll just pop, "Yes, thank you." And you know what, that, in itself, is... it's confidence-building, it's team-building... it's knowledge... uh, like... it built on my knowledge and also on... others that didn't think of it. (Student B)

Peers, uh, can, can be very supportive. I feel like we've learned to band together, and, and we...do a lot of talking in the med room with just the students. Like, "Okay, I'm about to do this. I'm going to tell you my steps; make sure I'm doing this right before I go to my instructor and tell her [laughs] what I'm going to do." We do a ton of that, like, "I haven't written this kind of a note before. Can you read it first it before I go show it to my instructor [laughs]?" Or like, that kind of... in that way, I think there's like, a lot of supportive like, comments, or whatever, between, between us as peers. So, like, I think there's been a lot of positive dynamics... in the clinical setting that way, almost like having each others' backs. (Student C)

Interestingly, two students commented that sharing information among peers can have negative consequences because peers may be providing them with inaccurate information.

[Information sharing] it could hinder by picking up bad habits or false information... or inaccurate information. (Student G)

Another student convinces me that I was doing something wrong, but... more specifically, I was doing an I.V. med... and this one student convinced me that, um, I had the tubing wrong... And I kept saying, "No, no, no." And then he, he completely convinced that I was doing it all wrong. So then I changed it... And then when the instructor came in, she said, "Oh, no, you're doing it wrong." (Student I)

Students also made reference to the benefit of having a pre-conference and/or post-conference, since this sort of forum created a great opportunity for students to learn about their peers' client/situation. Student B explained that peer-to-peer sharing of information was a great learning experience because each student had a different clinical situation; one student may have a patient with diabetes and another student may have a patient with liver disease.

My last instructor, she was very intuitive as, as to our ability to learn and how we learned. And what she... her expectation for us was, um, before coming to clinical, we would do all of our research. And then, in pre-conference, we would present our client to the rest of the group. So there's five of us, and, um... and she would have a format, "This

is what you need to present to your group.” ... someone else may not ever have a diabetes patient, someone else may not ever have a liver patient. But, because we can present this patient and tell everybody exactly what we’re going to do, it builds on, uh... it builds on our knowledge base because we’re doing little case studies – um, not actually having to do them ourselves... but we’re just kind of listening to what your case is and everything that you’re doing and... mentally, we’re, we’re able to compare that with, with what... the research that we’ve done. And, and, it... it’s a way of building on it, right. Um, and, there again, I, I see that we’re just, you know, working together as a team for the benefit of, of the client.(Student B)

Another set of eyes, ears, hands, and thoughts. Students often talked about the benefits of providing nursing care together. They would pair up to do skills throughout the clinical day, especially in their first year of clinical practice. They expressed that this sort of pairing approach felt like they were feeding off each other, which reduced their anxiety, and helped the day go smoother. Students discussed that when they were paired together, they were able to talk each other through a task because often one student was more familiar or knowledgeable with the task than the other student, due to past experience. The second student in the room became the helper and the observer, which allowed them to learn the task. Students also expressed that they never felt they were being evaluated by their peer, making for a more relaxed learning environment.

I remember in my XXXXX rotation, we had a great group and we would help each other out, we’d plan morning care together, we’d plan dressing changes together. And it just really makes your day go so much smoother because you’re working together to get stuff done and you have another set of eyes and ears to be in that room with you. (Student A)

You each bring your own experiences... to the table. So it’s like, you know, um, “Have you done this before?” You know, somebody may say, “Yes,” somebody might say, “No.” And it’s like... you either take the lead on a task or you let them take the lead on a task. And the...patient we had, um, was, uh... had a trach... so there was lots of like, med admin and feeding and, and turning every two hours. But being in that partnership, we just... we just worked so well together. And, you know, like... we had the plan of care decided before the day... it lightened the load, it really did... I would say that there was some pressure off. You’ve got two sets of eyes on something, you feel like, “Okay... we’re not going to miss anything.” And, uh, you’re able to converse back and forth without judgment, right, “Oh, do I do this first, or that first? Is it 10 ml or 5?” You know, and we’re just... we just talk things out and converse. And, and, you know, we’re learning together without, um, like, euh, needing to evaluate each other, right. Like, it was my very first time working with a patient who had a trach. And, uh, I think, had that been my

patient alone, then, yeah, my anxiety would have been enormous. And neither of us had experience. So we're both new at it... both learning it. But then, that just helped so tremendously... I think it's... a good learning exercise. I think it builds... it would build teamwork even amongst the students. (Student F)

Nonetheless, student D discussed how beneficial it was for her to be paired with a peer in year one of the nursing program, but that by third year, pairing up with a peer limited her learning experience due to the level of care she was providing in third year.

Year One, um, they paired us up. So we had two students to one patient in one of my clinicals... that was like, a huge anxiety relief, because you're not alone. Like, the worst feeling is like, like you're alone and you're nervous and you're, you know... but then, you know there's another student with you so you can pair up together. And just the comfort of having another student is, is huge... I loved that, that they did that... we just kind of like... you kind of feed off each other... like, some-... somebody will know something and maybe the other doesn't. So I was a health care aide... and the person I was working with wasn't. So she didn't feel comfortable giving a, a bed bath to somebody for the first time because, you know, it's really uncomfortable for the first time... you know, you kind of just... feed off of each other... Yeah. But then, when you come later to like, Third Year, I mean, of course you're not going to be paired because then you're... you wouldn't be learning anything [laughs], ... You're sharing the work...(Student D)

Be encouraging. Encouraging words from peers facilitated students to preserve in their clinical practice. Students described encouragement as providing them with commendation, giving them positive feedback, or inquiring about how they were doing with patient care.

Feedback is a huge, huge tool... And it's, it's not always there. So then, you know, I watch someone do wound care, and, euh, we seem to talk about it on a different level than you would talk about it with your instructor. I think you just... like [stammers] you put more emotion into, it maybe... with your instructor there's ... such a hierarchy, right. You know, the student I watched do the wound care, and then all of a sudden, she'll say to me, like, "You know, oh, that was really hard." And then I can say, "You know, you did really well." ... You know, and I can provide her some of that feedback and then she's, "I wish I had..." you know, and she might fill in some blanks there, you know. Or, "I'm sorry that I did it this way." And, euh... you know, and, "I'm glad I can help you here." And, "Next time..." You know, and so we, we talk... it's... learning. We, we create learning from it. (Student F)

I've known some of the people who graduated last year and, you know, they're like, "It's hard, it's worth it. You'll be fine." [Laughs]... So it's kind of just taking their advice and going for it... we know each other very well. And they can tell when you're having a down day. So they'll just... like, they really... sometimes they just say, "You'll be fine. You can

do it.” you kind of recall what happened and be like, “Yeah, I’ve been through this.”... “I can do it again.”(Student E)

In Year Two, I was inserting this catheter to this woman...who was... extremely obese... And I felt it was very difficult... to see where I was going... And... I contaminated the... first catheter. So my instructor had to go out and get a second one... to be brought in. And another student was with me, and I just turned to her and I looked at her, and... with my... eyes wide open... I didn’t say anything because there’s the patient... She was sleeping. But, um, the other student was just kind of like, “No, you’ve got this.” Like, “You’ll do great.” And, yeah... so the encouragement is what... kind of made me persevere... through it. (Student I)

Share opportunities. Students expressed that opportunities to do tasks or skills in the clinical environment was a great learning experience and a good way to build their confidence in completing a skill/task. Students appreciated when their peers shared these learning opportunities among themselves.

I think that some groups, the students have better communication with each other and we let each other know... “I’ve already done a Sub-Q. Who here wants the opportunity?”... Like, we’ve even had that, like... So, you know, “If you haven’t had a chance, I’m willing to let you have this chance.”... You know, just so that it’s fair across the board. (Student F)

Don’t throw me under the bus. Students described the clinical learning environment as being competitive at times. Some students wanted to be viewed by their CNI as the high achiever in the clinical group; therefore, these students would *throw other students under the bus*.

Throwing other students under the bus was viewed by students as their peers sharing unnecessary negative information about them with the CNI. Students felt that this sort of peer behaviour could influence their clinical experience in an adverse manner because the CNI could judge their ability wrongly and behave negatively toward the student. Ultimately, this peer behaviour could influence their learning experience.

Every now and then, you can run into the personality that doesn’t want to be a team member, that just wants to do it all themselves. So, you can’t get a word in edgewise and the, the instructor’s standing there listening to what the two of you have to say, and there’s only one person talking. So it’s perceived that maybe you’re not contributing. But,

at the end of the day, I, I would hope that the instructor would recognize that I can't get a word in edgewise... as students, um, need to help each other learn as opposed to, um, when I say, "Throw each other under the bus,"... I have had negative experiences working with some individuals that aren't as passionate about Nursing as I am... Um, and so working as a team, you know, hasn't been as successful (Student B)

She [a peer] would, um, kind of say and do things to make the instructor kind of look down on other students. Like, she'd be like, "Oh, I noticed..." like, in front of the instructor deliberately – "I noticed you weren't in class this week," or something... Or she'll... like, point things out that's unnecessary and kind of mean. And everybody is just thinking, like, "Why would you say that, you know, putting other people down just to make yourself look better when, really, it's not making you look better?" (Student D)

Theme 5 – The Staff/Unit Environment

Students expressed that the dynamics of a unit or facility had an influence on their ability to learn and feel confident in their clinical practice. Students explained that often the dynamics of the unit, relating how the staff interacted among themselves, had an influence on how welcoming the staff was to having students on the unit. Being welcomed on the unit was a prominent category that developed when students made reference to staff/unit dynamics. Students strongly voiced that the interaction among the staff influenced how students felt about themselves and how they behaved in clinical practice. For example, if there was tension on the unit, students felt more nervous, their confidence was undermined and they were less likely to seek new learning experiences.

You can have a great instructor, a great group, but if the unit isn't functioning well, it tends to hinder your learning because the staff doesn't get along well. So patient care is usually down because of a low morale. I think it all starts there. (Student A)

I think that being able to have a team that works together well and communicates well. Because I've been on units where everybody talks behind everybody's back... and you're not even a part of the unit and you can feel the tension. (Student H)

When the nurses seem to be wrapped up in a clique, where there's a power struggle between them... the doctor, um, you know, doesn't really want feedback from the nurses, so there's a power issue... there's hierarchal kind of a, a, um, structure that, that works against working... as a cohesive unit, then there's... the student at the bottom, seen as relief work... there seems to be eggshells between the nurses... it makes for not a good

unit for, for students... and it does ...undermine your confidence and it undermines your ability to feel as though you've prepared enough. (Student B)

Be welcoming. Students were not too concerned with the physical clinical environment influencing their learning and development of confidence, but rather they were concerned about the social environment – that being the receptiveness of staff to having students on the unit.

Some units have been more conducive to students... and some have been less. The physical unit doesn't so much matter, right... But what's really important is the nurses. Are they receptive to having students, and... and have they had a little bit of training?... if [they] could just be a little more teaching, a little more encouraging...it's so confidence building. (Student B)

Often the welcoming phenomenon was observed by students upon their first few days to the unit through the staffs' attitude and/or behaviour toward students. The following students described a welcoming unit when the staff were approachable, open to having students on the unit, and not easily annoyed by students. Student I had an angry tone as she verbally explained her frustration with staff on the units.

"Just don't get annoyed by us. I know... seven, seven people in grey scrubs... on the floor ... plus an instructor can kind of be a little annoying." ... Um, "Just try not to get annoyed by us. And if we do ask a question, maybe just kindly answer it" (Student I)

... Most for my learning... um, I think approachable environment...like, comfortable environment. Um...Being able to ask questions and...getting a good response, or a comfortable response, or..., uh, like, I don't know how to describe it... like, a... like, "You could come talk to me. It's okay." ... welcoming... for sure... approachable... for sure.(Student G)

I think when the unit is, um, happy... I don't know how to word... like... when there's good teamwork within the unit... Because then..., we feel part of the team, too... I think that'd be a big one. And... when everyone's helpful and... collaborates and whatnot. Because there has definitely been some units where it's like, "Ooh, I don't want to talk to them because they're scary." But then there's other units where it's like, "No problem." Like, and I'll ask, "You're not my buddy nurse, but I need a question answered. Can you help me?" And... like, everyone's approachable and... open to including the students. (Student E)

When students talked about a welcoming environment on the units/facilities, two sub-categories emerged from the data analysis: i) listen to me and trust me, and ii) provide me with opportunities.

Listen to me and trust me. Students often described feeling a part of the team when the staff listened to and acted upon students' thoughts, concerns, and assessments. This approach was a powerful confidence booster for students in their clinical practice.

"My client needs better pain control." And when they listen to your assessment and change the plan of care... my confidence skyrockets. I remember it was First Year, and... this person I was helping, client, had low blood pressure, and the physician assistant was right there. And I said, you know, "This is the blood pressure and yesterday, it was this, and the day before, it was this." And... he implemented some changes and more tests and stuff. And I said to him, "Don't you want to double-check my assessment?" He said, "No, I trust you."... being listened to builds confidence. I really think it does... (Student F)

Provide me with opportunities. Students really appreciated when staff would bring them along to situations that were learning opportunities, such as completing or watching a task or skill. When staff were willing to teach and provide learning opportunities for students, students felt more comfortable asking the staff questions.

Um, I've really appreciated units where the nurses have come to the instructors and said, like, "Hey, I have some extra skills." Like, "Do you have any students, you know, who...[want to do some skills]... I think... like, just those passionate nurses who are like, "Come along, come see this." Like, "There's something different happening here," or... and... not even just nurses, like, other professions too who, who are willing to... explain everything to you... you know, that I really appreciated, those people who would... who would just... take a moment to teach... I don't always know like, "What kind of questions should I ask them?"... You know, because I'm not an expert in their area or, or maybe I know very little about their area... (Student C)

When they're welcoming to a student, and they're like, "Hey, come," like, "let me show you this. Let me tell you that."... And they kind of like bring you into the learning... My Surgery rotation, all the nurses on the floor were so accepting to students... like, all of them. It was a really good experience... They're... all super-positive... (Student J)

There's a Nurse Educator on our floor who is super-amazing. Like, she makes herself really available for questions and stuff. And she did..., practise Code Blues with us when we were starting... And then I also find this floor is..., super-receptive to students... So

that makes like, a big difference... they're always like, "Come to me if you have any questions," like, everybody on the floor. So I feel comfortable approaching them.
(Student J)

Summary

This chapter articulated clearly that the CLE was a valuable and essential component in the nursing program for students to learn and gain confidence in their clinical practice. An overarching theme that students communicated was that the CLE was a system of sociostructural influences. Five sociostructural themes emerged with categories and sub-categories that described important features of the CLE that support learning and the development of confidence: 1) The CNI, 2) Self (The Nursing Student), 3) The Buddy Nurse, 4) The Peers, and 5) The Staff/Unit Environment. Student perceptions of developing confidence through their clinical learning experiences was an interplay between their thoughts and feelings, their behaviour and the other aspects of the CLE. *The CNI theme* was the most developed theme with rich descriptions in all categories/subcategories. It was evident that the CNI was a prominent feature of the CLE, having a significant impact on student learning and confidence. Interestingly, *self (the nursing student) theme* was the next well developed theme with a variety of categories and subcategories. Students viewed themselves as a part of the sociostructural context of the CLE. They thought that they played an agentic role in their learning and development of confidence and that they influenced the other sociostructural aspects of the CLE. *The peers and buddy nurse theme* were comparatively developed with fewer categories/subcategories. The *staff/unit environment theme* was the least developed with only one category and two subcategories. Students perceived their development of confidence occurred through a reciprocal interplay between them and the other sociostructural influences. A discussion of the findings using Bandura's Self-efficacy Theory framework and a comparison to the literature will be presented in Chapter Five, as well as the strengths and limitations.

Chapter Five: Discussion of the Findings

The findings of this thesis research revealed how students perceive developing confidence through clinical learning experiences and what features of the CLE support their learning and development of confidence. Students eagerly shared their clinical learning experiences by describing the interrelatedness between themselves and others in the CLE, influencing their learning and development of confidence. Commonly, students in this thesis research expressed high importance of applying and acquiring knowledge in their clinical practice to become confident and competent nurses. Students conveyed a strong message that their personal efficacy functions in an interdependent manner within the sociostructural features of the CLE, in which students viewed themselves as adapting their behaviour to fit or shape the CLE. Bandura (1997) confirms that students are “producer as well as products of their social environment” (p. vii).

Bandura’s self-efficacy theory (1997) was used as a theoretical framework to guide the development of this thesis research, since confidence, the strength of an individual’s belief, is mapped well within this theory, recognizing the interplay between an individual’s personal factors, behaviour, and environment. This chapter begins with a discussion of the research findings using Bandura’s self-efficacy theory (1997) framework, centering on the concepts of human agency, reciprocal causation, and self-efficacy information. Throughout student descriptions of their clinical learning experiences, these concepts surfaced as having an impact on their learning and development of confidence. Further to this, the findings of this research study are compared and discussed in relation to the literature. Strengths and limitations of this research study are explored and explained later in this chapter.

Personal Agency

It is evident from the stories students shared about their clinical learning experiences that they consider their self-influence seriously in their clinical learning and development of confidence. This self-contribution is a mode for students to be agents in their learning, known as personal agency – meaning that, a student has some control over their self-development, behaviour, and adaptation (Bandura, 1997). Students' belief in their capability to perform in clinical practice functions as an important role in their motivation, perseverance, learning, and academic success (Jeffreys, 2012; Pajares, 1996).

The nature of personal agency is that individuals are not just sensitive to the influences of their environment, but that they take some initiative within their sociostructural environment (Bandura, 1997). It became evident that students in this thesis research understood that their belief in their capability to perform in clinical practice influences their behaviour. Often, when students described their feelings or thoughts they had in clinical practice, they were quick to describe their behaviour that followed. For instance, when students described feeling a lack of self-efficacy, they often described the avoidance of learning opportunities in clinical practice and further compounds the student's lack of confidence. Students also recognized that when their self-efficacy was high, they were more likely to persevere at a difficult task or seek out new clinical opportunities, and receive a positive evaluation. However, there were instances when students unknowingly discussed self-efficacy expectation and outcome expectation as separate entities.

Bandura (1986; 1997) makes reference to the fact that an individual's outcome expectation and self-efficacy expectation can be independent of one another, especially if extrinsic consequences are static. There are circumstances when outcome expectations can

directly impact performance behaviour. For instance, some students explained that if they felt confident in their capability to perform at a high level (self-efficacy expectation), but they understood that they could not achieve an 'A' in clinical practice, because the CNI shared with students that s/he did not allocate 'A's' (outcome expectation), it was possible that this outcome expectancy, independent of students self-efficacy expectation influenced the amount of effort that students placed forward in their clinical practice.

Throughout the interviews, it was impressive how students described the influence they had upon their clinical practice. Students conveyed that being prepared and reflecting throughout clinical practice were important activities for their learning, confidence, and success. Students voiced that these actions were forms of self-responsibility, in order for them to make the most of their clinical learning experiences. A consensus among students in this thesis research demonstrated a common meaning to clinical preparation, which often entailed preparing the night before clinical practice by researching their patient assignment. Students articulated that when they prepared sufficiently for clinical practice, they had the necessary knowledge to feel confident in performing in clinical practice. In fact, students often made reference to the fact that the acquisition of knowledge equated to something learned and that this ongoing learning assisted them to feel more confident upon entering clinical practice. When students felt confident in their knowledge and their ability to perform, they expressed that they were less anxious and more willing to engage in the learning process; views that are consistent with Bandura (1997), Pajares (1996), and Schunk (2003).

Differently, in Townsend's (2012) qualitative descriptive research of similar undergraduate baccalaureate nursing students, the theme of self (the student) was not as developed; however, students made reference to preparing for clinical practice the night before

clinical practice as being overwhelming, and receiving little sleep. Students did not clearly infer a relationship between being prepared for clinical practice and feeling confident. However, other studies indicated that the acquisition of knowledge has a positive influence upon student confidence, but these studies did not specifically discuss preparation prior to clinical practice as being the acquisition of knowledge (Chesser-Symth, 2005; Lofmark & Wikbald, 2001).

Throughout the interviews, students expressed that self-reflection was an important means for them to employ self-influence within their clinical learning experience. This form of self-influence was a prominent category within the theme of self (the student) and students felt it was a positive aspect for their learning and confidence development. Students discussed the effectiveness of daily anecdotes that they completed in each of their clinical rotations, as a way to grow as a person, by exploring their thoughts, feelings, and reactions related to their clinical performance, in order to maintain or change their behavior to provide effective nursing care. Students often found this self-reflection activity confident building, as well as a demonstration of their self-responsibility and accountability.

Perhaps, this cohort of students value self-reflection because the Red River College nursing program places strong value on the concepts of reflection and reflexivity through their Relational Practice curriculum. These students are exposed to reflection and reflexivity activities throughout their clinical and theoretical courses, so they are accustomed to being in tune with having an inquiring mind, considering what influences experience, exploring the entire context of a situation, making meaning of situations, and considering how they shape their environment (Doane & Varcoe, 2005). The Red River College nursing students are educated and encouraged to view their practice as a form of inquiry when they encounter a variety of different relationships, and not to bestow on a stage of conformity or hierarchy. They are to consider their

stance, as locating themselves in the context, while appreciating how they may influence the context (Doane & Varcoe, 2005).

These findings are consistent with Bandura's (1986; 1997) theory of self-efficacy. Bandura (1986; 1997) explains that forethought and self-reflection are agentic characteristics of individuals representing cognitive self-regulation, in which individuals consider their goals, reveal their confidence in their ability to perform, and expose their self-evaluation of their performance behaviour to envisage future endeavors. This self-influence functions deterministically on an individual's behaviour the same way as external influences. As students discussed their clinical learning experiences, they clearly recognized that there is a complexity to their thought process and clinical performance behaviour that functions within an all-encompassing system of sociostructural influences, through a triadic reciprocal causation model (Bandura, 1986; 1997).

Triadic Reciprocal Causation

Bandura (1997) explains the development of self-efficacy through a triadic reciprocal causation model, having a bidirectional functional dependence between three determinants: 1) internal personal factors, 2) behaviour, and 3) the environment. This model of triadic reciprocal causation assists in the understanding of how students perceive the development of confidence through their clinical learning experiences. As students discussed features of the CLE that support their learning and development of confidence, they enthusiastically described the interrelatedness between personal factors, specifically their cognitive and affective aspects, their performance behaviour, and the clinical environment around them; they unknowingly discussed the intertwined determinants of Bandura's (1997) theoretical perspective of triadic reciprocal

causation. There were an array of exemplars from students' stories of their clinical learning experiences that represented the triadic reciprocal causation model.

Aforementioned, each student described the importance of preparation for practice by taking responsibility for their learning, and being motivated. Students described their preparation for practice (performance behaviour) as a forethought, by expressing the value of clinical preparation as creating a favourable outcome of being successful in clinical practice. Students felt that being knowledgeable placed them in an efficacious frame of mind (personal cognition) when they entered clinical practice. If they were confident in their knowledge base, they were more likely to feel confident in providing nursing care. Students explained that when they felt confident in their capability to perform in clinical practice, they were less likely to feel nervous, and they were more likely to cope effectively and persevere, especially in challenging circumstances. This premise supports Bandura's theory (1997) that claims efficacious individuals are more likely to take advantage of opportunities and not become discouraged in challenging situations. Moreover, students felt that when their CNI or buddy nurse realized that they were prepared (performance behaviour) and motivated to engage in challenging circumstances, they often provided them with other learning opportunities in clinical practice (environmental influences). This interplay between the student and the environment demonstrates the bidirectional causal interaction between the student and the environment (Bandura, 1997). The literature supports this finding that when students feel confident in managing challenging situations, they are more likely to set challenging goals, to be motivated, to persevere in hardship, and to be successful (Ferla et al., 2009; Komarraju & Nadler, 2013; Townsend, 2012; Van der Bijl & Shortridge-Baggett, 2002). Bandura (1997) claims that there

are four principal sources of self-efficacy information and these sources are evident throughout students' stories, with some sources being more valuable to students than others.

Four Sources of Self-efficacy Information

Bandura (1997) suggests that self-efficacy beliefs are constructed from a variety of information sources, represented through a hierarchy of importance: i) mastery experience, being the most important, ii) vicarious experience, iii) verbal persuasion, and iv) physiological and emotional states. This hierarchy of importance is noteworthy, since students in this thesis research perceived verbal persuasion as the most influential source of information in their development of confidence, followed by mastery experience and then equally vicarious experience and physiological/emotional states. Similarly, Townsend's (2012) findings confirm that students view verbal persuasion as a prominent source of self-efficacy information in clinical practice; but conversely, followed by physiological and emotional states, and then mastery experience and vicarious experience, jointly. Conversely, Chesser-Smyth and Long (2013) and Porter, Morphet, Missen and Raymond (2013) view skill acquisition (mastery experience) as the most important influence upon student self-efficacy in clinical practice. Research in the area of simulation by Goldenberg et al. (2005), Pike and O'Donnell (2010) and Sinclair and Ferguson (2009) claim that successful performance through simulation is the most important source of self-efficacy information followed by vicarious experiences, verbal persuasion, and physiological, and emotional effects. The following discussion of the research findings scrutinizes the information sources of self-efficacy in order of strength that students in this research study perceived and described throughout their stories. In addition, the discussion of the findings examines the processes students conferred yielding to the integration of the information sources upon their self-efficacy development.

Verbal persuasion. Verbal persuasion is a means for others to strengthen an individual's belief about their capability to perform, by providing encouragement and communication about their confidence in the individual (Bandura, 1997). It is easier for an individual to believe in themselves when others believe in their capability. This sort of verbal persuasion reduces an individual's self-doubt and increases their motivation to put forth the effort to be successful (Bandura, 1997). Students in this thesis research shared that when the CNI, buddy nurse, or staff demonstrated their confidence in them overtly, through verbal encouragement before and during a task, they felt this reassurance helped them to persevere in the existing and future tasks. On the other hand, students communicated examples of covert encouragement from the CNI and staff; meaning that, the CNI created a permissive CLE for students to practice independently and staff respected and listened to students' assessments and thoughts about patient care. It is important for those working with students in clinical practice to recognize that confidence-building behaviours of respectfulness and encouragement support students to feel appreciated, connected, and engaged in clinical learning (Lundberg, 2008).

Students in this research study clearly described that the types of interpersonal relationships they had with their CNI, buddy nurse, and/or staff regulated their learning and development of confidence. When relationships represented an attitude of caring and/or behaviours of supportiveness, and approachability, students felt this approach reduced their anxiety and in fact motivated them to perform, creating an environment where they felt encouraged to ask questions and to share their thoughts and feelings. Student described these relationships as powerful interactions that fostered their ability to learn and development of confidence. These relational issues were paramount in this thesis research, as well as in the

literature (Chan, 2002; Dunn & Hansford, 1997; Hart & Rotem, 1994; Nolan, 1998; Papp et al., 2003; Townsend, 2012) and threaded through Bandura's self-efficacy theory (1997).

Similar findings in the literature demonstrate that students view interpersonal relationships in the CLE as a high priority for learning; in particular, when the CNI interacts with students positively and exhibits concern and understanding for the student's well-being (Chan, 2002; Chan & Ip, 2007; Elcigil & Sari, 2008). Respectful interpersonal interactions between students and CNIs contributes to good working relationships, a positive learning environment, and a promising influence upon students confidence (Chesser-Smyth, 2005; Lofmark & Wilbald, 2001; Myrick & Yonge, 2002; Smedley & Morey, 2009; Spouse, 2001; Tang et al., 2005). Townsend's (2012) study illustrates that students care about compassion, approachability, and support from their CNI and buddy nurse, and students feel that these attributes influence their confidence and learning in clinical practice in a positive manner. Congruently, Redmond (1996) comments that when CNIs create a caring learning environment that entails interest, openness, and encouragement, students express feelings of worth and confidence that allowed them to feel safe to ask questions and critically think.

Students, in this thesis research, really valued and appreciated verbal persuasion from their peers, as well. Many of the students expressed that they found themselves migrating to their peers for support, verbal encouragement, and knowledge. Interactions with their peers were for the most part favourable. Students described a sense of comradery among their peers, as they looked out for each other and helped each other in difficult or unfamiliar situations. Because their peers never made them feel bad about themselves, students felt more comfortable approaching their peers rather than their CNI or buddy nurse. When their peers verbally persuaded them before or during a task, this persuasion helped them to persevere, creating a

supportive and relaxed CLE. Gidman et al. (2011) explain that students can often receive support from their peers in an enthusiastic and motivating manner. In fact, peers seem more approachable and less concerned about the time to complete the task.

Importantly, verbal persuasion is only valuable, if the individual providing the encouragement is knowledgeable and credible about what they believe the individual is capable of performing. It is more believable when there is a minimal degree of appraisal disparity between an individual's belief about their capability and the persuader's judgment (Bandura, 1997). For these students in the thesis research, it was key that the influential individual providing encouragement was someone who was really aware of what the student needed to accomplish. For instance, one student expressed that encouragement or praise from a family member did not hold much merit because they were not aware of the demands of clinical practice.

Notably, Bandura (1997) explained that verbal persuasion can also be conveyed through performance feedback and how that feedback is framed; for instance, punitive feedback can undermine an individual's confidence in their capability and create social distancing; however, positive feedback can boost an individual's confidence in their capability, and can provide an individual with the motivation to be successful (Bandura, 1997). Enthusiastically, students in this thesis research conveyed that they appreciated feedback from their CNI, buddy nurse, and peers; however, feedback from their CNI was most influential for their learning and development of confidence. Students expressed that the CNI was aware of the clinical expectations and had a clear understanding of the clinical learning outcomes within the evaluation tool. Students respected practical feedback from their CNI, so they can grow as a nurse. The connection that

students have with their CNI, influences how students perceive feedback. When students trust, and respect the CNI's opinion, they are likely to utilize and value the feedback (Gillespie, 2005).

Many of the students in this thesis research shared the value in receiving both positive and negative feedback, but they were sensitive to how feedback was provided. They requested that feedback be given in a respectful, and meaningful fashion that represented strength-based feedback. Strength-based feedback was seen by students as being considerate and constructive that explored students' capabilities and assisted them to grow professionally. This finding is consistent with Cederbaum and Klusaritz (2009) that expands this premise to the outcome of strength-based feedback being the creation of a good relationship between the student and the CNI. Students expressed that when feedback was provided in a respectful verbal and non-verbal manner, the feedback felt educational and motivational. Similar to the findings of Elcigil and Sari (2008), students do not want to feel evaluated or criticised based on their personality; feedback should be related to their performance or knowledge, while being encouraging and motivating for them to learn and move forward.

Students voiced that they needed to hear negative feedback in a respectful manner, so they could reflect, modify practice, and grow as nurse. Similarly, Glover (2000), Townsend (2012), and Rowbotham and Owen (2015) contend that constructive feedback allows students to reflect upon their practice, influences their development of confidence in a positive manner, and creates an opportunity for students to learn. When negative feedback was not provided in a constructive manner, students in this thesis research felt that it was a personal attack against them, shattering their confidence. With the intention of building student confidence, students should never be made to feel awful about their performance (Walker et al., 2014) and the CNI should recognize the manner in which feedback is conveyed can be debilitating or enabling for

students development of confidence (Clynes & Raftery, 2008; Maynard, 2012; Townsend, 2012). Interestingly, Lee, Cholowski, and Williams (2002) claim that mature students are not impacted by the manner in which feedback is provided, as younger students. Younger students seem to be more sensitive to negative feedback. However, this phenomenon was not noted in the findings of this thesis research. It was evident from the findings in this thesis research that all the students expressed feedback in a manner that influenced their emotions, thoughts, and behaviour.

Students really enjoyed hearing positive feedback through commendation because it was affirming, motivating, and confidence building. Clynes and Raftery (2008) and Glover (2000) support this finding that positive feedback from the CNI is an important aspect in student performance, learning, and development of confidence in clinical practice. A few students, in this thesis research, made reference to the fact that positive feedback made them feel appreciated, valued, and good about themselves. Similar to the results from Glover (2000), students claim that positive feedback makes them feel a part of the team.

Students expressed that it was nice to hear ‘you will make a great nurse someday’, but they wanted to know more specifically about why they would make a great nurse. Duffy (2013) claims that if the CNI provides constructive feedback, it is crucial for them to be specific about what the student did well, and the effects of their behaviour. It is best to link feedback to learning outcomes because then the student has a clear idea of what behaviour they should continue, assisting in their development of confidence.

Some students expressed that when feedback was not timely and ongoing, they made negative assumptions about their performance, influencing their thoughts about their capability to perform in a future similar task. This finding is contrary to Duffy (2013) that makes reference to the fact that when students receive no feedback, they may assume that “no news is good news”

(p. 54). However, Clynes and Raftery (2008) state that if students receive feedback in an untimely manner, they begin to compare their performance to other more experienced nurses, and are likely to evaluate themselves inaccurately. In order for feedback to be helpful for students, it should have certain qualities, such as being formative, timely, and address student behaviour (Glover, 2000). Further to this, Bandura (1997) claims that providing feedback that an individual is more capable than they believe is not enough to instill confidence in the individual. The persuader must have an idea of the individual's skill set to perform, and clearly and specifically present this knowledge to them, and support them to be successful.

Students in this thesis research did not emphasize the location of feedback; however, one student did make a comment that staff should be cognizant about criticizing a student in front of their CNI. The literature demonstrates that students prefer feedback to be given in a private area on a one-to-one basis, especially if feedback is of a negative nature (Clynes & Raftery, 2008; Elcigil & Sari, 2008; Townsend, 2012). If the CNI provides negative feedback to a student in the presence of the patient or staff nurses, it can humiliate the student and diminish his/her confidence (Elcigil & Sari, 2008). When providing feedback there should be sufficient time for the student and the individual providing the feedback to dialogue, seek clarification, and develop some strategies to make improvements, if need be (Clynes & Raftery, 2008; Kelly, 2007).

In a related vein, students in this thesis research described the forum of debriefing as a way for them to gain some insight into their performance, acquire knowledge and boost their confidence. For instance, when debriefing with their CNI before entering a patient's room to complete a task, students felt they were able to seek clarification and obtain encouragement, which assisted them to feel confident in their capability to complete the task, motivating them to persevere. Additionally, students expressed that debriefing after a task or critical incident

allowed them to learn and make changes to their future practice, if needed. Nonetheless, students voiced that they needed a safe and open environment to debrief about their practice, thoughts, and feelings. They did not want to be criticized, intimidated, or belittled, since this had no value for their learning or development of confidence. Cederbaum and Klusaritz (2009) emphasize the importance of a collaborative partnership between students and CNIs, which invites students to openly discuss and reflect upon their clinical practice. This forum creates an opportunity for the CNI to provide the student with feedback about his/her strengths and areas for improvement, in order to support the student's confidence, competence, and professionalism. According to Bandura (1997), debriefing sessions allow students to reflect upon their thoughts and experiences, creating an opportunity for verbal persuasion from their CNI, through praise, feedback or encouragement. Much of the literature in the area of debriefing focuses on simulation; regardless, debriefing post-performance in a simulation situation is a method for students to learn, critically think, receive feedback, and self-reflect (Shinnick et al., 2011; Wagner et al., 2009).

Students in this research study placed a significant amount of emphasis on the value of self-reflection to improve their clinical performance and develop their confidence. Predominantly, students discussed the value of self-reflection when they encountered difficult situations, so they could identify areas of practice needing improvement for future practice. As students discussed the value of self-reflection in their clinical practice, they demonstrated a maturity by viewing self-reflection as a form of taking responsibility for their learning, actions, and confidence development. Often, students discussed self-reflection in a "reactive control" mode with the thought of engaging in "discrepancy reduction;" this means, students were more focused on their CNI's or buddy nurse's *response* to their performance, in order to make changes

in their future performance, reducing the discrepancy between their actual performance and expected performance (Bandura, 1997, p. 131). Nonetheless, there were instances when students discussed self-motivation through “proactive control” (Bandura, 1997, p. 131). These students illustrated that they would self-assure themselves about their capability and engage in self-verbal persuasion by telling themselves that ‘I can do this.’ Correspondingly, William (2010b) claims that beginning nursing students in her study expressed the importance of believing they can perform because this belief translated into them performing. As aforementioned, it is possible that the cohort of students in the Red River College nursing program are sensitive to the value of utilizing the skill of reflection because they are immersed in a Relational Practice curriculum that emanates a culture of self-reflection, reflexivity, and stance of inquiry. Students might have a heightened awareness of these concepts that are threaded throughout each clinical and theory course in the nursing program. It is not surprising the strong emphasis students place on the value of reflection in their learning and their development of confidence.

This finding supports Bandura’s (1997) view that individuals are self-examiners and self-regulators of their behaviour, and that their environment plays a pivotal role in their thought process and behaviour. Self-efficacy beliefs become organized by an individual’s experience and reflective thought process. In Glover’s (2000) study, one student mentioned that she received “feedback. I listen, reflect and utilize” (p. 251). Based on the feedback the student received, s/he used this information in a reflective manner through journaling to “study up” (p. 251) and improve his/her performance to become competent and confident in clinical practice.

Mastery experience. Mastery experience information influences self-efficacy beliefs more than any other information source, producing a more robust self-efficacy belief than simply other self-efficacy information sources (Bandura, 1997). If an individual is actually able to

perform successfully, this genuine success is more likely to enhance his/her self-efficacy belief; however, if an individual fails in their performance then this failure is likely to weaken his/her self-efficacy belief, especially if self-efficacy belief is not well established, yet (Bandura, 1997).

In this thesis research, students expressed the need to have opportunities to master challenging nursing skills versus basic health care aid skills that they have already mastered by the third year of the nursing program. They expressed that they need to feel more confident in their nursing skills before moving forward into their Consolidate Senior Practicum. A notable comment from students was that they would like to move away from just completing the buddy nurse's *to do list* and instead, to be more involved in the all-encompassing complexity of holistic care in order to feel confident in their nursing skills. This finding is well supported in the literature, which confirms that often students feel their clinical leaning experiences are deemed to "non-nursing duties" or the so called "nursing aide activities" which gives students a feeling of non-inclusiveness on the unit (Hickey, 2010, p. 39). When students are able to gain an understanding of the entirety of the patient's circumstance, and the staff create challenging and appropriate learning opportunities, these approaches facilitate students to become more confident and competent in their nursing practice (Lofmark & Wikblad, 2001; O'Flanagan, 2002; Newton et al., 2009) and these students become better at their decision-making skills (Gillespie & Peterson, 2009; Kitson-Renolds, 2009). New student graduates are having difficulty with decision-making and critical reasoning due to their lack of confidence (Jahanpour, Farkhondeh, Salsali, Kaveh, & Williams, 2010). Students may be competent upon graduation, but not necessarily confident to practice in the complexity of patient care. This attribute of confidence is often not acquired by students in nursing education programs (Crookes et al., 2005). Bradbury-Jones et al. (2011) explains that students want to be valued as learners and not just to be viewed

as helpers. When students feel that they are just an extra pair of hands on the unit, they express feeling “devalued as [a] learner” and this lack of responsibility has an adverse impact on their confidence (p. 370). Students feel motivated and satisfied with their CLE when they are given opportunities to provide holistic care on their patient versus performing only certain tasks (Nabolsi et al., 2012).

Students voiced that when they were provided with learning opportunities in clinical practice, this inclusiveness in patient care made them feel accepted as a part of the team, trusted to perform nursing care, and comfortable in asking questions. They articulated that clinical learning opportunities assisted them to make sense of their theoretical knowledge in a practical fashion, which they interpreted as being engaged in the learning process and as a chance for them to develop their clinical confidence. Similar to the findings of Jonsen et al. (2013) and Nabolsi et al. (2012), students agree that an accommodating CLE allows them to gain clinical opportunities, motivated them and assisted them in their confidence development in their practice. When students perceive trust to perform tasks from their CNI, staff, and/or patients, this perception of trust is confidence boosting for students (Koontz, Mallory, Burns, & Chapman, 2010). Additionally, when students feel a sense of belonging on the unit in which they are socialized into clinical practice, this feeling of belonging minimizes their anxiety, improves the quality of their clinical learning experience, enhances their confidence, and allows them to share their feelings and ask for support or guidance (Bradbury-Jones et al., 2011; Gillespie, 2005; Levett-Jones et al., 2009; Lofmark & Wilbald, 2001; McKenna et al., 2013; Newton et al., 2009; Nolan, 1998; Spouse, 2001). Students in this thesis research conveyed that when they felt excluded, through a non-welcoming attitude or behaviour by the staff on the unit or the CNI, they felt that their clinical learning experience was going to suffer because they found

themselves avoiding the staff, the CNI, and learning opportunities that arose on the unit, in order to evade being criticized or intimidated. Similarly, Nolan (1998) and Spouse (2001) claim that when students feel they do not fit into the unit culture, they often find themselves hiding or missing clinical time. This non-welcoming CLE diminishes a student's chance to feel confident in their clinical skills and learn through their practical experience.

Students in this thesis research communicated that being self-motivated in clinical practice assisted them to master their clinical skills. They recognized that when they demonstrated a keen attitude to partake in learning opportunities, their CNI or buddy nurse were more likely to provide them with a variety of skills. It is possible that these student views are related to students' actual efficacy belief, that being, a resilient sense of self-efficacy. Bandura (1997) conveys that an individual's motivational thinking is often guided by their efficacy belief. Self-doubting individuals frequently avoid situations and these individuals find it difficult to motivate themselves, giving up in the face of challenges. Townsend (2012) found that students expressed that their enthusiasm to learn had a positive influence upon developing a trusting relationship with their CNI or buddy nurse. This trusting relationship assisted students to gain a variety of learning experiences and achieve more autonomy in performing clinical skills.

Students felt that *doing* a skill was more helpful for their learning and development of confidence than *watching* a skill being done by their buddy nurse; in fact, students expressed that they often needed many opportunities to be successful at certain skills, such as intravenous starts. Students described that each time they tackled a similar task or skill, they gained a new layer of knowledge and often this new knowledge was due to the contextual variation of the circumstance. The literature consistently shows the agreement among students that they need and want hands-on opportunities to gain the skills necessary to feel confident in the nurse's role and

that these multiple opportunities create a richer learning experience (Henderson et al., 2007; Hartigan-Rogers et al., 2007; Koontz et al., 2010; Newton et al., 2009; Nolan, 1998).

Bandura (1997) claims that mastery takes time for an individual to develop with an achievement trajectory to feeling competent and confident. This notion is impacted by the contextual aspects of the learning environment that influences an individual's progress and setbacks. These contextual influences can encompass the support they need to complete the task, the challenges endured during the task, or the available resources they can utilize to be successful. When an individual performs a task several times before mastery in a variety of different contexts, they often learn something new about the task each time and perhaps, about themselves. Individuals' experiences are an aggregate of knowledge related to successes, failures, circumstances, and difficulties encountered that influences self-appraisal of their personal efficacy (Bandura, 1997).

In this thesis research, students expressed that they wanted their CNI to view them as *learners* and they wanted their buddy nurse to remember what it was like to be a student. This position of *learner* meant that students wanted to be provided with *time to master a task/skill* by being given time to prepare, time to ask questions, and time to transition to an increase workload. These findings mirror O'Conner's (2006) research study in which students preferred to master their psychosocial skills, especially before moving on to more challenging complex tasks/skills. When students do not feel pressured, they feel that they can learn at their own pace, and this approach assists them in developing their confidence (Walker et al., 2014). Further to this, providing students with opportunities to ask questions is salient to allow students to extend their knowledge base, consider evidence-informed practice, and critically analyze circumstances, which are essential nursing skills (Henderson, 2011).

Nonetheless, students often feared that they were going to make a mistake when they approached clinical skills, and they wanted their CNI to support them through their mistake, rather than deflate their confidence. The literature supports that ‘fear of making a mistake’ is probably one of the most anxiety-provoking experiences for students and it is important for CNIs to support students by allowing them to express their feelings, reflect, and learn (Kim, 2003). When students practice skills in clinical practice, they feel these experiences create opportunities to boost their confidence, to be proficient, and to learn from their mistakes (Lofmark & Wikblad, 2001). Students want their CNI to “build [them] up; don’t shut [them] down” when they error or lack knowledge, so they do not feel inadequate (Townsend, 2012, p. 63).

Students shared that their appraisal of their past experiences influenced their confidence in their capability to perform in similar future experiences in clinical practice. These experiences create information in which students interpret their personal efficacy (Bandura, 1997). All the stories that students shared about their work or personal experience had a positive influence upon their clinical performance. Communication and interpersonal skills were the two prominent transferrable skills identified by students as valuable in clinical practice. There are some thought-provoking parallels from Brown et al. (2003) on professional confidence in baccalaureate nursing students and students’ comments in this thesis research. The students in Brown et al. (2003) study illustrate that work, school, and volunteering experiences prior to entering the nursing program assisted them in feeling confident in some aspects of their clinical practice, depending on what those experiences encompassed. Past experiences “prior to entering the nursing program [seem to provide] a backdrop for experiences within the nursing program” (p. 167).

Vicarious experience. Vicarious experiences, viewed as observational learning, can raise an individual's self-efficacy through modelling (Bandura, 1997). There are processes through a comparative or competency platform that individuals consider in observational learning activities that can affect their personal efficacy. On a comparative platform, if the observer views a similar individual successfully perform a task, then the observer feels more confident in pursuing that task (Bandura, 1997). Students in this thesis research described vicarious experiences through peer-to-peer learning by watching their peers perform a task or by their peers sharing knowledge. Students described this peer-to-peer learning environment as less threatening and more relaxing. They expressed that their peers would not judge them if they made a mistake or if they lacked some knowledge; instead, their peers were quick to step in and help them rather than critique them. This sort of collaboration helped students to feel more confident in tackling a task. In line with Townsend (2012), students appreciated a peer-to-peer learning environment because sharing their feelings, thoughts and knowledge with each other was a way to confirm and feel confident in their knowledge or practice, reducing their anxiety.

Interestingly, students in this thesis research, coined the phrase *pass it forward* as a way to express that they were able to teach or share information with a peer, and this action helped to boost their own confidence in their knowledge and skill. Bandura (1997) agrees that with self-appraisal, individuals recognize that they have the knowledge or the skill to teach others, and this recognition strengthens their own confidence in their capability. This finding is supported in the literature that often, peer-to-peer teaching and learning is a mutually satisfying experience for both students. The student demonstrating the skills feels the experience is rewarding, and builds confidence in their knowledge and teaching ability and the student observing the skill gains in

his/her learning and feeling that s/he can tackle a similar task, if the student demonstrating the skill is successful (Loke & Chow, 2007; McKenna & French, 2011; Stables, 2012).

Students emphasized that being paired up for clinical learning experiences was most helpful in the early years of their nursing program; conversely, being paired up with another student at the end of their nursing program to provide patient care actually limited their learning experience. Students thought that they needed to move out of the observer role into the doer role to make the most of their learning experience. Perhaps, student views are consistent with Bandura's (1997) claim that the observational learning experience has the greatest influence upon an individual's self-efficacy, if the individual has not had the opportunity to participate in the task, which is often the case in the first year of a nursing program.

Interestingly, according to Bandura (1997) on a competency platform, individuals seek to observe models that are competent; that is, an individual that shares his/her expert knowledge with the observer. Even more influential, when the persuader is alongside the individual supporting and encouraging them, an individual is more likely to muster the effort and perseverance to be successful at the task (Bandura, 1997). Students in this thesis research made several references to learning from the expertise of the CNI, buddy nurse or staff. Furthermore, students expressed that they appreciated these experts knowledge and wanted to learn as much as they could from them. When these experts took time to teach them, walked them through a skill, brought them into learning opportunities, and shared their rationale out loud with them, students thought they were receiving the most out their clinical learning experience because the clinical atmosphere was less intimidating, more relaxing and facilitated a deeper level of learning. Students thought that these experiences created layers of their knowledge and skill, engaging them in the learning process, and assisting them to feel confident in their clinical practice. This

finding complements the studies completed by Kelly (2007), Parsh (2010) and Townsend (2012) that express when the CNI teaches, guides, and coaches students in their clinical practice, this approach improves students clinical learning, confidence, and offers an excellent time for the CNI to role model.

Despite the fact that students valued working with their CNI, students stated that they seemed to prefer working with their buddy nurse, because the CNI evaluates or grades their performance and students felt more nervous in the presence of the CNI than their buddy nurse when completing skills. Similarly, Koontz et al. (2010) demonstrate that students respected the opportunity to observe and perform skills with staff nurses because often they gained a different perspective of the task and these students just felt more comfortable and less intimidated partnering with the staff nurses on the unit rather than their CNI. In the study by Glover (2000) students describe “handy hints” by the staff nurses, as encouraging and helpful for their learning, which reduced their feelings of nervousness (p. 250). When the nurses on the unit shared their knowledge and expertise, students attained feelings of inclusiveness, practical knowledge, and gains in their confidence (Henderson, 2011).

Many students, throughout the interviews, concurred that the best clinical learning experiences were when the CNI and buddy nurse were supportive and collaborative. If the CNI or buddy nurse had a collaborative attitude of *let's walk through it together* and a behaviour of assisting students through cueing or prompting, this approach encouraged and motivated students to learn. Correspondingly, Spouse's (2001) study illustrates that the collaborative approach of student-staff interactions help students to understand how to talk to patients, how to recognize issues, and how to manage patient care. When the staff are open to sharing their rationale with students, this approach provides students with a comfort to ask clarifying questions, in order to

enhance their knowledge and learning (Spouse, 2001). Students do not always feel motivated, so it is most helpful to have a CNI or buddy nurse motivate students by guiding and encouraging them through a skill (Nabolsi et al., 2012).

Physiological and emotional states. Physiological and emotional states are information that individuals consider in judging their confidence in their capability to perform (Bandura, 1997). Physiological reactions can represent themselves through somatic information, such as sweating, nausea, shaking, or stomach upset. Emotional states can exemplify anxiety, fear, anger, apprehension, or excitement. This information alone does not define personal efficacy, rather it is the cognitive processing through which this information is managed; for instance, the context related to the source, circumstances, and pre-existing personal efficacy influences perceived self-efficacy. These influences apply meaning to the individual's physiological or emotional state (Bandura, 1997). These cognitive processes were evident when students in this thesis research discussed their physical or emotional states influencing their ability to learn and their development of confidence.

In considering the *source* of the activation related to an emotional or physiological state, students often made reference to the fact that the CNI observes and evaluates them, providing them with a grade based on their performance. This evaluative process involved the CNI observing students perform a skill, task or assessment. Students expressed that being watched intently by the CNI as they were performing a task caused them to be shaky, nervous, and make more errors. Students did not ascribe the shaking to being cold in the room or having a low blood sugar, rather their perception of the emotional and physical arousal was related to the intense watching by the CNI. Students just wanted the CNI to be there in the room as a support person but not intently watch them complete a task. When the buddy nurse observed students

completing a skill, students commented that they felt more relaxed. Kim (2003) supports this finding, since most of the students in her study expressed that being observed by the CNI is an anxiety-provoking experience.

Further to this, students expressed that when the CNI declared, “I don’t give A’s”, they felt this deflated their motivation, intimidated them, and heightened their anxiety. Students explained that this comment influenced how they felt about themselves and how they performed in practice. Plausibly, this discouraging phrase may actually be a self-fulfilled prophecy. This finding is reflected in Nabolsi et al. (2012) study in which students express the expectation differences among CNIs as frustrating and these differences influenced their motivation to learn. CNIs should explore students’ goals, encourage students to meet those goals and provide students with a fair evaluation of their performance.

In considering *the circumstance* of an emotional or physiological state, students often made reference to the unfamiliar making them feel the most nervous in clinical practice. The unknown expectations of the CNI, not knowing the theoretical knowledge or not being familiar with the clinical situations felt intimidating and scary for students. This finding concurs with Bradbury-Jones (2012) that CLEs are often unfamiliar to students, creating some student anxiety; however, when staff on the unit make students feel like part of the team, students often begin to feel more relaxed and able to learn. In this thesis research, some students described the inability to concentrate in these circumstances and when they felt nervous or inadequate, it influenced their confidence and learning negatively. Students appreciated when the CNI cared about them by inquiring about their well-being because it gave the impression that they wanted students to succeed. This caring atmosphere helped students to feel respected, more relaxed in clinical practice, able to learn, and develop their confidence. This finding is consistent with Zamanzadeh,

Shohani, and Palmeh (2015) in which students perceived two prominent caring behaviours from their CNI as being respectful and instilling confidence.

Another *circumstance* that was shared by students throughout the interviews revolved around the various interpersonal relationships students encountered in their clinical practice. When interpersonal relations with their buddy nurse or CNI exemplified approachability and supportiveness, students described this CLE as being more relaxed, reducing their sense of nervousness. Students were definitely reading their somatic information through their physical or emotional states, which influenced their personal efficacy. For instance, students described that if they were nervous on the first clinical day, they often felt less confident in their capability; however, when they realized that the CNI was approachable and supportive, they began to feel more relaxed. Paying attention to these feelings, students reappraised their personal efficacy and felt more confident. In fact, students described that they were able to learn and feel more comfortable in this sort of CLE. This finding is well supported in the literature that interpersonal relationships students encountered in the CLE can influence their level of stress and anxiety; supportive, approachable, and respectful interpersonal relationships are key for students learning and development of confidence (Chernomas & Shapiro, 2012; Townsend, 2012; Melincavage, 2011). Prominent stressors for students in clinical practice are the difficult relations they may experience with unit staff (Evan & Kelly, 2004; Suresh, Matthews, & Coyne, 2013) and if students feel their clinical experience is undesirable or unsatisfying, they will most likely not be as engaged in the learning experience (Bandura, 1997; Schunk & Pajares, 2002; Zimmerman, 2000).

Students referred to their *pre-existing self-efficacy* influencing their feeling of comfort and ability to learn in clinical practice. Students felt that coming prepared for practice provided

them with confidence in their knowledge upon entering the clinical experience, which helped them to embrace further learning opportunities. Furthermore, students explained that previous clinical, work or personal experiences allowed them to transfer particular skills into clinical practice, providing them with a feeling of confidence in managing certain circumstances. For instance, a few students had work experience as a health care aid before entering the nursing program and they felt that they were not as nervous as their peers in clinical practice, especially in the first year of the nursing program. They watched their peers exhibit concerns about communicating to patients; however, they were comfortable and confident about communicating with patients due to their past experience. Students described that communication skills, interpersonal relations and exposure to working under pressure were common past experiences that could be transferred into their clinical practice. In the same way, Townsend (2012) illustrates that students appreciated how past experiences through personal and clinical experiences can influence their confidence in a positive manner.

The features of the CLE that students described contributing to their learning and development of confidence are consistent with Bandura's four sources of self-efficacy. Students perceive the development of confidence through their clinical learning experiences by way of the triadic reciprocal causation process. These findings draw our attention to how powerful the CLE is in contributing to the growth of student confidence and ability to learn. Student confidence is an important quality to consider in clinical pedagogical strategies and future research in clinical nursing education.

Strengths and Limitations of this Research Study

The research questions of this thesis research were best answered through a qualitative descriptive design in order to engender meaningful insights of the phenomenon related to student

perceptions of the development of confidence through their clinical learning experiences (Lambert & Lambert, 2012). This qualitative descriptive design was appropriate to explore and describe this under researched phenomenon and this design was considered a strength of this research study (Creswell, 2008). With the idea of providing students with a voice to explain and describe their clinical experiences, qualitative descriptive research allows for “straight descriptions of phenomenon” (Sandelowski, 2010, p. 339).

Another strength of this thesis research was related to the sample size. Sample size in qualitative research is usually small with the goal of obtaining comprehensive insights about a phenomenon of an individual’s experience and this claim can be viewed as a strength in this research study (Polit & Beck, 2012). There are no firm guidelines to sampling in qualitative research; however, the focus of sampling should be upon information-rich data that irradiates patterns, and themes, creating various dimensions of the phenomenon being explored (Polit & Beck, 2012). Although the sample size was ten students, the researcher implemented strategies to promote the trustworthiness of the research study by considering credibility, dependability, confirmability, transferability, and authenticity. Additionally, due to the fact that the researcher was a novice in performing semi-structured interviews, 10 students seemed reasonable versus a smaller sample, due to the fact that the novice researcher may need a larger sample size to achieve data saturation, as a result of their inexperience in data collection (Polit & Beck, 2012).

Further to this, a strength existed in the method of sampling. Purposive sampling permitted for a rapid emergence of data saturation from the 10 interviews, since the students were information-rich, due to their numerous clinical experiences within the nursing program. Additionally, the students were a relatively articulate verbal population. The goal related to a sampling strategy in qualitative research is often to understand and gain insights of an

individual's experience related to a phenomenon rather than being concerned about generalizing findings to a large group of individuals (Polit & Beck, 2012). Although students were purposively sampled according to the amount experience they acquired in the CLE, students were required to remember experiences that related to developing confidence through their clinical learning experiences. It was possible that students remembered some of their experiences or remembered only certain types of experiences. Students in this thesis research commented on a variety of their clinical experiences from year one to three, as well positive and negative experiences related to their learning and development of confidence. The researcher was cognizant about using good interviewing techniques to create the richest data and reviewed digital audio recording after each interview to reflect upon and improve her interviewing skills for subsequent interviews. Post-interview reflections were documented in her reflexive journal and shared with her research advisor. These reflections brought the researcher's thoughts, feelings and concerns to the forefront, reminding the researcher of the purpose of this thesis research.

Utilizing one-on-one semi-structured interviews with open-ended questions was a strength because this approach allowed for students to share their stories freely, creating a richer view of the phenomenon being explored (Hays & Singh, 2012). The researcher considered probing and clarifying questions in advance and was very flexible about the format of the interview so the student's voice was expressed openly. Being a novice researcher, a good quality interview was important, since this approach was the mode of collecting the data. The researcher considered and valued the various phases of the interview process, with the ultimate goal of establishing rapport with the students, so they would feel at ease in sharing their stories related to their clinical experiences (DiCicco-Bloom & Crabtree, 2006). However, this interview process

had some limitations related to the researcher's inexperience with qualitative research. After the researcher listened to the first few digital audio recordings of the interviews, she quickly recognized that she asked a few double-barrel questions or missed an opportunity to follow-up with a student's comment or description of an experience. Reviewing each interview and documenting in her reflexive journal, immediately after each interview, was most help to make improvements in future interviews by fine tuning her interviewing skills and being cognizant about not making assumptions. Additionally, debriefing with the research advisor was helpful in confirming modifications needed for future interviews and the researcher felt encouraged to move forward.

The researcher chose to refrain from note taking during the interview process. This approach can be viewed as a strength, but perhaps as a limitation, as well. The rationale behind abstaining from note taking was to eliminate as many distractions, so the students did not feel interrupted in their discussion of their experiences (Olson, 2011). The researcher engaged in note taking in her reflexive journal immediately after the interview to document any nuances that may be valuable to the data; therefore, she had to rely on her mental note taking and the digital audio recording.

Some limitations are difficult to overcome; however, it is important to recognize the limitations when considering the research findings, generalizability, or transferability (McMillan, 2012). The most prominent limitation of this thesis research was the sample of students recruited from a Canadian Baccalaureate nursing program in which the emphasis is on a direct faculty supervision model for clinical practice. These students may have an altered perspective about the CLE and self-confidence from students who completed clinical practice using another clinical practice models, such as a dedicated education unit model. Furthermore, students volunteered to

participant in the research, creating a selection bias (Polit & Beck, 2012). It is possible that students who volunteered to participate in this thesis research had some strong opinions about their clinical experience that they wanted heard, and perhaps a narrow perspective was expressed. The researcher was mindful about asking the students questions that related to features of their CLE which hindered or boosted their confidence to obtain well-rounded responses. The transferability of the findings to other settings should be done cautiously. Additionally, this purposive sample was third year nursing students at the end of their nursing program, so generalizing from these findings to all nursing students should be done thoughtfully (McMillan, 2012).

Another limitation was that the sample was restricted to student perceptions. Perceptions from a variety of individuals working in the CLE, such as CNI and unit staff could create a broader pool of knowledge to gain a comprehensive picture in understanding learning and the development of student confidence in the CLE. Perhaps, future research in this area can include perceptions from those working with students in the CLE. Expanding upon the characteristics of the student sample, another limitation relates to the demographics of the students. Students were diverse for age, relationship status, and number of children; however, all the students were female, at the completion of their nursing program, and English was their first language; therefore, limiting perceptions to females rather than males, 3rd year students rather than 1st year nursing student and to student with English as their first language rather than English as their second language.

The utilization of Bandura's self-efficacy theory was a lens to inform the researcher of an understanding of the development of student confidence. This theory was the guiding framework for the interview questions, but perhaps lead students to respond in a particular manner. The

researcher was cognizant of the fact that interview questions were not of a leading nature. For instance, asking students to tell the researcher about what factors from your CNI hindered your self-confidence within the CLE, assumes that the student had a negative experience with a CNI. A more appropriate approach used in this study was to remain open-ended with a broader question, such as; can you share with me a clinical experience that affected your confidence? Perhaps utilizing “less structured questions and more open questions may have broadened the accuracy of the results” (Townsend, 2012, p. 52).

Potentially, students may feel the need to impress the researcher and provide her with the answers that she desires. To overcome this phenomenon, the researcher engaged in the process of building genuine rapport in order to assist students to feel comfortable in sharing their true feelings. Additionally, the sampling criteria included students that would not have a student-teacher relationship with the researcher in the future to reduce the students need to impress the researcher or for the students to feel that they are unable to be truthful with the researcher.

Summary

This chapter demonstrated how the findings of this research study strengthens the limited research of understanding students’ perceptions of learning and developing confidence through their clinical learning experiences. The discussion of the findings occurred through Bandura’s self-efficacy theory, particularly the four sources of self-efficacy and the model of reciprocal causation, and compared to existing research literature on this topic. Strengths and limitation of this research study were considered and explored. Implications for clinical nursing education, considerations for future nursing education research and a conclusion are documented in Chapter Six.

Chapter Six: Implications and Considerations

The findings of this thesis research provided some insightful knowledge and awareness of students learning and development of confidence through their clinical learning experiences that can guide pedagogical practices and future research in clinical nursing education. In this chapter, the implications for clinical nursing education are discussed through the use of Bandura's theory of self-efficacy. Considerations for future nursing research are explored with a conclusion finalizing this thesis work.

Implications for Clinical Nursing Education

As the demand for nurses rises in this country, nursing education faces the challenge of reducing attrition rates. It is critical that nursing programs consider their attrition rates and govern how to enhance student success within their programs (Harris, Rosenberg & O'Rourke, 2014). Clinical practice is one of the most challenging, valuable, and essential components in nursing education for students to facilitate the melding of theory with practice (McBrien, 2006). This practical forum needs to include purposeful learning opportunities to prepare students to be competent and confident, as beginning practitioners (Chesser-Smyth & Long, 2012; Nolan, 1998). It is evident from these data that clinical learning experiences in nursing education are an interaction between students' cognition, behaviour and environmental influences (Bandura, 1997). These findings demonstrate that clinical learning experiences can shape students attitudes about learning, and can mould student confidence, which appeals to the implications for clinical nursing education. Often the clinical learning experiences that students described throughout the interviews were a variety of experiences infused by the attitudes and behaviours of those working with them in the CLE that mattered most to their learning and development of confidence in clinical practice.

Clearly, students' descriptions about learning and their development of confidence are a reflection of the art and science of their nursing practice and it is evident that students spend a lot of cognitive energy to construct meaning of their clinical learning experiences. Often, students think about their clinical learning experiences before, during, and beyond their clinical practice day. Students implore that individuals working with them in the CLE uphold a positive clinical learning culture because this culture is pivotal for their learning and development of confidence. In order for students to engage in the learning process, and become more confident in their capability, they must be satisfied with their CLE (Smedley & Morey, 2010). When students discussed their development of confidence, they often exuded an excitement and aspiration of wanting to learn, doing tasks/skills, being respected as a learner, being more involved in the complexity of nursing care, and acquiring good interpersonal relationships with the individuals involved in their clinical practice, especially the CNI.

All stakeholders, such as CNIs, clinical course leaders, nursing educators involve in curriculum design, managers and nursing staff in health care facilities need to recognize that there are pedagogical strategies to enhance student confidence, by considering Bandura's (1997) four information sources of self-efficacy and the triadic reciprocal causation model within his theoretical framework. In nursing education programs, curricular design should consider the concept of student confidence throughout all clinical courses. Even when curriculum has layers of meaning or conceptualization, student learning and success should be at the heart of this framework. Crooks et al. (2005) supports this recommendation that curriculum should consider how CNIs can instill confidence in students, in order to be considered a "caring nursing curriculum" (p. 360). One of the most unique characteristic of an effective CNI is the ability to promote student confidence in clinical practice (Valiee, Moridi, Khaledi, & Gardibi, 2016).

In this thesis research, Bandura's self-efficacy theory (1997) was used as a framework to present the literature review, formulate the interview questions, and analyze and discuss the findings. So, it only seems fitting that the implications for clinical nursing education are structured using the four sources of self-efficacy information. Instilling confidence in students through the four sources of self-efficacy information is essential for students to learn, to develop their skills successfully, and to engage in decision-making or critical thinking in nursing practice (AL-Sagarat, ALSarirh, Masadeh, & Moxham, 2015; Hagbaghery, Salsali, & Ahmadi, 2004).

Verbal persuasion. The findings of the research study confirm that CNIs are the most powerful feature of the CLE that contribute to student learning and development of confidence. It is evident that students view their CNI as having overt and covert influences upon their clinical learning experiences and their development of confidence. CNIs should be aware that students perceive verbal persuasion as the most influential source of self-efficacy. They view verbal persuasion in a form of encouragement, through respectful relationships, debriefing opportunities, strength-based feedback, and self-reflection opportunities.

Students, in this thesis research, expressed the value of good interpersonal relationships with CNIs, buddy nurses and staff, because these types of relationships help students to become motivated to learn and develop their confidence. Individuals who work with students in clinical practice, especially the CNI, need to recognize that a good interpersonal relationship with students is viewed by students as being supportive, encouraging, respectful, approachable and inclusive, so they feel valued, a part of the team, and supported as a learner. When these individuals make an effort to communicate in a positive and supportive attitude, as well as a respectful and considerate behaviour toward students, it reduces students stress and feelings of nervousness when entering clinical practice (Melincavage, 2011). These attitudes and behaviours

of the CNI and staff can influence students feelings about their ability to be successful or not, to be satisfied rather than frustrated, and/or to be relaxed versus nervous (Tang et al., 2005). It is important for the CNI and staff to be cognizant about how they welcome students to the clinical practice area, how they assist students through a task or skill, as well as how they provide students with feedback, by paying attention to their body language and verbal cues (Townsend, 2012). Educational institutions need to consider the impact of verbal persuasion, through CNIs attitudes and behaviours, upon student learning and development of confidence. Incorporating this knowledge through an open discussion with CNIs in an orientation forum, workshops, and/or clinical team meetings can help to shape effective CNIs and form CLEs conducive for student learning and confidence building.

Further to this, CNIs need to pay attention to negative interactions between staff and students, such as unwelcoming attitudes and intimidating behaviours toward students, in order for them to intervene or advocate for students well-being (Townsend, 2012). This sort of behaviour conveys a message to students that the CNI is there to support them, and this supportive environment becomes less scary for students. Often, CNIs are employed on the unit that they facilitate students. Perhaps, this sort of dichotomy creates blurred boundaries between the staff and the CNI. CNIs need some support from their educational institution, through workshops or clinical course leader support, to assist them in managing how to discuss issues they may encounter with the staff they work with on a regular basis. In order to create the best CLE, facilities and educational institutions need to collaborate to consider a CLE that supports student learning and the development of confidence (Papp et al., 2003). When there is a good relationship between the CNI and staff, the CLE feels more like a supportive environment for student learning (Nabolsi et al., 2012).

In a similar mind set of creating a supportive CLE, CNIs should invite students into a debriefing forum to discuss patient care, encourage critical thinking, and facilitate active learning (Wickers, 2010). Beneficially, this debriefing forum is a critical time for the CNI to make reference to positive aspects of students' thought process and to remind students of their previous successes, because often students feeling of success can be short lived (Morgolis & McCabe, 2004). There are a variety of different means to debrief with students. The CNI and buddy nurse should take some time to verbally walk through a task with students before entering a patient's room. This rehearsal strategy between the student and the CNI or buddy nurse can be motivating for the student and s/he is more likely to place the effort forward and perform successfully (Bandura, 1995; Komarraju & Nadler, 2013). In addition, a debriefing forum is an opportunity for the CNI or buddy nurse to prompt or cue students, and to challenge students by posing *what if questions*, creating a teaching and learning opportunity. Often, students are competent in completing tasks or skills but have a difficult time with decision-making and critical thinking, so questioning provides students with a chance to apply their knowledge to the clinical situation, critically think, and problem solve (Gillespie & Paterson, 2009; Kitson-Reynolds, 2009). Nonetheless, questioning should be done in a manner that is timely and appropriate to the situation to enhance students' depth and breadth of answers, to allow them to retrieve prior knowledge, and to develop clinical judgment skills (Myrick & Yonge, 2002). According to Lundberg (2008), guiding students through questioning, instead of exploring what they may not know is a preferred confidence-building strategy. Students often self-doubt themselves and do not need the CNI contributing to this self-doubt; instead, CNIs can respond to students in a more favorable manner, such as "yes, and..." instead of "no, but...." This approach encourages the

student that there is more information needed to answer the question and acknowledges their good effort (Lundberg, 2008, p. 87).

The evaluation process and providing feedback seems to be a prominent topic among CNIs, so workshops and clinical team meetings among CNIs and clinical course leaders should be a routine practice to prepare, guide, and support them in evaluating and providing feedback effectively. Often, CNIs do not feel confident in their own evaluation skills to provide students with constructive feedback (Duffy, 2013). Feedback, whether negative or positive, is viewed by students in this thesis research as a learning opportunity and as a chance for them to reflect upon their practice. CNIs should be cognizant of their verbal and non-verbal cues when providing students with feedback, especially negative feedback. Students in this thesis research claim that when they interpret feedback as being disrespectful, it raises their anxiety, deflates their confidence, and reduces their willingness to learn or perform. CNIs should structure feedback in a manner that is caring, supportive, encouraging, and respectful, so students utilize the feedback in their future clinical practice, reflect upon their practice, and as a way to boost their confidence, rather than perceiving feedback as a personal attack (Glover, 2000; Wickers, 2010). Workshops should include a discussion on the five principles in providing constructive feedback: i) share your expectations clearly so you have a reference point to providing feedback; ii) explore students expectations of feedback; iii) be sure you have accurate information; iv) be timely, so students can learn and become competent; v) be specific about the feedback (Duffy, 2013).

Encouraging students to self-reflect through journaling or self-evaluation creates an opportunity for the CNI to engage in written feedback. CNIs should provide written feedback upon student self-reflections that focuses on student success and they should guide students with a lack of confidence to focus their self-reflections on something they did well in clinical practice

(Lundberg, 2008). Self-reflection upon clinical practice is an important skill for students in the development of their confidence, providing students with an opportunity to *know* themselves as they reflect on their performance in order to modify or sustain their practice (Crooks et al., 2005). CNIs can verbally encourage and coach students through self-reflection exercises, so the student acquires the benefits of this important cognitive process.

Mastery experience. Students expressed that being directly involved in patient care and having the opportunity to do skills were more helpful for their learning and development of confidence than just observing a task or skill being completed by someone else. When the CNI creates student-patient assignments, s/he should consider students previous experiences in order to extend their prior knowledge, build their confidence, and prime them for success. Clinical learning experiences should be appropriate for each student, with student goals and current practice in mind (Papp et al., 2003). When CNIs are familiar with students' current and past clinical practice, then they can plan confidence-building tasks. Often student confidence fluctuates with regards to circumstances and/or tasks (Lundberg, 2008). CNIs should have a dialogue with students or have students complete a *get to know me questionnaire* prior to clinical practice to become acquainted with students, understand their clinical goals, and be aware of their strengths and weaknesses from a student perspective, in order to provide them with appropriate learning opportunities. When the CNI encourages students to set goals, this approach can motivate them to achieve skill acquisition, develop their confidence, build on their strengths, and combat their weaknesses (Bandura, 1997; Komarraju & Nadler, 2013); additionally, this approach can help students to feel supported and cared about in their clinical practice (Gillespie, 2005). Further to this, in order for students to gain the opportunities to master skills in the CLE, the CNI needs to clearly share and educate staff about students theoretical knowledge and

clinical experience, so staff have an idea of what kind of experiences they can offer students. It is about narrowing the gap between learning opportunities available to students and students engaging in learning opportunities provided by staff.

Repetition of skills or tasks can assist students to feel confident in their ability to perform in clinical practice (Bandura, 1997). CNIs can plan tasks or skills that students have done successfully before to solidify their confidence with that particular task or skill. Moreover, often, prior to a clinical rotation, CNIs can plan for round robin activities that allows students to practice skills that they may encounter in that particular clinical rotation (Mayne et al., 2004). These round robin activities can be of a simulation nature, which can be a great opportunity for students to engage in repetition, to be challenged, and to gain confidence in their performance (Pike & O' Donnell, 2010; Sinclair & Ferguson, 2009). Learning should not be solely viewed as quantity of skills or tasks but rather the clinical learning experience should be about "constructing meaning and understanding, and is therefore a matter of quality" (McAllister, 2011, p. 309).

Vicarious experience. Students in this thesis research appreciated learning from others who were willing to teach or demonstrate for them how to perform a skill or task or how to think through a clinical situation. CNIs should consider pathways for vicarious learning, when possible and appropriate, to engage students in the learning process and foster their confidence. A vicarious experience is very powerful, motivating, and confidence building endeavor for the student performing the task, as well as the observing student (Bandura, 1997; Lofmark & Wikblad, 2001). Perhaps, when CNIs plan student-patient assignments, mostly for first year students, a buddy system or sharing a patient would be beneficial for both students learning and development of confidence. If the CNI is aware of a skill or task that a student has mastered and

another student needs some supervision completing the same skill or task, then this would be a great opportunity for the CNI to request the student of mastery to guide the student completing an unfamiliar skill or task.

Students appreciated when their buddy nurse would talk out loud to share their thinking process and bring them into learning opportunities because this approach helped them to feel a sense of inclusion and helped them to understand the role of the nurse. Nursing programs are not only about preparing students to have the knowledge or facts, or about completing the skill or task, rather it is about students being able to hone critical thinking skills that they will need in challenging and changing CLEs (McAllister, 2001). It is important for the CNI and staff to consider students a part of the team and invite students to learn from their experience. When students are included in the culture of the unit, this inclusiveness often provides students with a satisfaction with the CLE, allowing the student to expend their energies learning and building upon their confidence (Smedley & Morey, 2009).

Students in this thesis research did not make a strong reference to the CNI's teaching ability as being an important aspect for the learning or the development of confidence; however, some of the aspects of vicarious experience discussed by students may be viewed as the CNI's ability to actually teach students. Interestingly, similar to the literature, students are often not concerned about the skill of the CNI, but rather it is the CNI's attitude and behaviour that are most important for their learning (Tang et al., 2005). Nonetheless, students expressed that they had a great clinical learning experience when their buddy nurse or CNI shared their expertise.

Physiological and emotional states. Throughout student stories of their clinical learning experiences, students often made reference to feeling nervous and stressed in clinical practice, influencing their ability to perform. Stress can definitely have a negative influence upon

students' ability to learn and perform, so CNIs should be aware of possible triggers that contribute to students stress or feelings of nervousness, in order to plan clinical learning experiences (Chernomas & Shapiro, 2013). Students in this thesis research explained that their triggers to feeling nervous in clinical practice were being watched intently by the CNI, being in unfamiliar situations, as well as the harsh attitudes from CNI or staff, and feeling unwelcomed on the unit. A few students mentioned that these feelings of nervousness would linger for days after the clinical experience. CNIs should pay attention to students coping methods during times of stress to support and provide students with the skills needed to manage through clinical practice effectively (Komarraju & Nadler, 2013; O'Mara et al., 2014). Additionally, when a student that is obviously stressed in clinical practice, the CNI should allow some time to dialogue with the student about how s/he can reduce their stress before tackling any sort of teaching and/or learning with the student (Chernomas & Shapiro, 2013).

CNIs and staff should create a warm, nurturing, and inclusive learning environment for students, so that students could feel safe to learn, be open to opportunities, and build upon their confidence. These individuals are one's who provide clinical learning opportunities for students; students need to feel supported, guided and included, if they are to tackle the demands of the clinical practice (Dunn & Hansford, 1997, p. 1305). This approach can reduce student anxiety upon entering and throughout their clinical practice. Educational nursing programs should consider that student anxiety not only effects student performance but also student attrition rates, as students with high levels of anxiety often leave nursing programs (Melincavage, 2011). Carl Rogers, who conceptualized student-centered learning, stated that when students feel threatened by their learning environment, it is difficult for them to engage any sort of substantial learning. It is no wonder that unwelcoming learning environments are unfavourable for student learning

(Knowles, 2005). Nolan (1998) extended this premise by stating that students will spend a significant amount of time trying to 'fit in' to the social environment, rather than time spent on learning.

Perhaps equally important, CNIs should consider how they can empower students in managing stressors associated with their clinical practice. Workshops are an excellent opportunity for faculty to educate students about stress reduction strategies. Gorostidi et al. (2007) expressed the importance of sharing with students that most of the stressors they will experience in the clinical practice will subside or resolve over time as they become competent in their skills, and make gains in their acquisition of knowledge. However, there is still value in educating students about a healthy approach to managing stressors. Students in this thesis research expressed that they gauge their level of confidence based on their level of nervousness, as they make decisions about performing in clinical practice (Bandura, 1997), so there would be great importance in assisting students to manage their stress.

Finally, CNIs and unit staff working with students in the CLE should consider what their beliefs are about student learning in the CLE, if their beliefs are evidence-informed, and if their beliefs represent the undertones of a creating a confidence-rich CLE to facilitate student learning and success in clinical practice. It is possible that their beliefs will influence their practice with students, particularly their attitudes and behaviour they elicit when they interact with students. Conceivably, some CNIs and staff may not conceptualize that portraying a respectful and caring attitude along with a behaviour that demonstrates approachability, inclusiveness and support are important for student learning and the development of confidence. Formal training for CNIs to be effective instructors should occur and encompass the four information sources of student self-efficacy. CNIs need to understand the importance of teachable and reachable moments with

students when they are interacting with and providing students with opportunities and feedback. Tapping into pedagogical practices based on theoretical determinants of self-efficacy sources through Bandura's self-efficacy theory can inspire students to take risks, eagerly learn, feel confident, and become competent. Finally, it may be beneficial for CNIs to engage in an early assessment of a student's clinical confidence, either formally or informally to better plan student's clinical learning experiences (Lundberg, 2008).

In addition, collaboration between nursing education programs and facilities is paramount if CLEs are to match the learning needs of students. For instance, the CNI and program team managers in the health care facilities can dialogue about how to strengthen the acceptance of students on the unit by staff and how to provide staff with teaching strategies that can benefit the unit and the student (Dunn & Hansford, 1997). CNIs should consider role modelling for staff on how to facilitate student learning; additionally, they should share with the staff on an informal or formal platform students capabilities, goals, and the gains the unit receives from an inclusive behaviour. All stakeholders, nursing faculty involved in curriculum development, CNIs, clinical course leaders, unit managers, and unit staff need to recognize that CLEs can be a challenging, stressful, and unfamiliar, as well as a rewarding, opportunistic, and a confidence-building venue for students. By examining students perceptions of developing confidence through their clinical learning experiences, nursing education is in a better position to understand and develop features of the CLE that support learning and the development of confidence in clinical practice. Students who feel they are confident in their clinical practice are more likely to succeed, and utilize their clinical skills in future practice (Lundberg, 2008).

Considerations for Future Nursing Education Research

This topic is a growing area for educational research to explore because the paucity of research in the area of a student's development of confidence through his/her clinical learning experiences and the contradictory findings of this thesis research to Bandura's self-efficacy theory. There are several thoughts about how to move forward in future research on this topic that can better understand student learning experiences and development of confidence in the CLE.

Further qualitative research, by replicating this thesis research, can extend the research on this topic to understand if these findings are consistent in other similar or different contexts. It may be valuable to consider, explore and compare different student demographics, such gender, student maturity or placement year in nursing programs. Because qualitative research is well-suited to understand an individual's perception, interpretation, or experience (Hays & Singh, 2012), it may be beneficial for nursing education to gain an understanding of the CNIs and unit staff perceptions about student learning and development of confidence in the CLE, in order to identify any gaps between students and CNIs or unit staff perceptions. Understanding CNIs and unit staff perceptions about student learning and development of confidence may be critical to developing evidence to guide teaching/learning practices for these individuals. It is possible that CNIs or unit staff approaches to working with students has developed over time and that their approaches may be representative of what has been done in the past, through their own experiences as a student, or perhaps their approaches are based on their own needs. There may be barriers that need to be tackled with these stakeholders, if nursing education expects them to adopt evidence-informed practices in the teaching and learning of students.

Interestingly, and eventually, research studies to understand causal relationships between student self-reflection, self-efficacy, and performance in the clinical practice realm. Self-reflection, in this thesis research, was such a prominent aspect of students learning experience, development of confidence, feelings of persistence, motivation, and *knowing* themselves. Students often explored strategies to be successful based on this self-regulated behaviour. Although students frequently reflected upon experiences through a reactive manner versus proactive fashion, it would be interesting to consider the strength of the relationship between student self-efficacy in the CLE and self-reflection.

Finally, the findings of this thesis research make an important contribution to nursing education by establishing the importance of evidence-informed pedagogical practices in teaching and learning undergraduate nursing students in the CLE, utilizing Bandura's information sources of self-efficacy, as well as understanding student perceptions of learning and developing confidence in the CLE.

Conclusion

The ten students that participated in this thesis research provided valuable insights from their perceptions of developing confidence through their clinical learning experiences and their descriptions of the CLE features that support their learning and development of confidence. It is evident that learning and the development of student confidence in clinical practice is intricate, multifacet, and fluctuates throughout a variety of clinical experiences due to the sociostructural aspects of the CLE. As students discussed their clinical learning experiences, they perceived their development of confidence through the interactions of their thoughts and feelings about themselves, their environment, and their behaviour, supporting the triadic reciprocal causation aspect of Bandura's self-efficacy theory. Additionally, it is evident that the CNI is the most

influential feature of the CLE, through his/her covert and overt influences, to support students learning and development of confidence. This thesis research has captured the importance of verbal persuasion, especially from the CNI, as the most effective source of self-efficacy development, elaborating upon Bandura's self-efficacy theory. The prominence of verbal persuasion as being a primary information source of student self-efficacy was threaded throughout the themes of self, CNI, peers, buddy nurse, but not well developed in the staff/unit culture. Important to note, students described all four information sources of self-efficacy existing in the CLE that contributed to their learning and development of confidence.

Students, in this thesis research, feel that they have a responsibility for their learning and development of confidence. This finding is unique, since much of the research that discusses the CLE often alludes to those individuals around the student, rather than centered specifically on the student them self. These findings offer an important contribution to nursing education research in understanding what features of the CLE support or hinder student learning and development of student confidence, from a student's perspective.

Individuals working with students, especially the CNI need to concentrate on pedagogical strategies that impact student learning and confidence in a positive manner. The CLE needs to be one of opportunity and not survival, as well as the creation of knowledge and skill, competence, caring, and confidence. Clearly, students perceive the CLE as particularly important in shaping their beliefs about their capability, emotions, and performance behaviour. They deserve the support and facilitation of those working with them to assist them through their academic journey to become the best nurses possible. CLE should be an important focus in nursing education in order to improve student competence, confidence, and outcomes. Confident nurses are more likely to persevere in difficult situations, set challenging goals, and be more successful

(Bandura, 1997). I have learned through this thesis research that the best gift nursing education can give students is showing them that they are willing to walk through their academic journey *with* them rather than *among* them.

Walking *with students* through their academic journey to become confident and competent nurses rather than *among students* means having *purposeful interactions* with students that elicit positive learning experiences and represent confidence building practices. As a clinical course leader, I plan to approach discussions and explore with CNIs their *purposeful interactions* they have with students that:

- 1) incorporates well thought out learning opportunities, so students have the chance to master a variety of *nursing* skills,
- 2) provides strength-based feedback, so students feel respect, included, and that they can use this feedback to grow professionally,
- 3) guides and facilitates student learning in performing nursing tasks/skills, and
- 4) assists students to manage and cope with stress and anxiety.

“In order to succeed, people need a sense of self-efficacy, to struggle together with resilience to meet the inevitable obstacles and inequities of life.” – Dr. Albert Bandura

<http://stanford.edu/dept/psychology/bandura/autobiography.html>

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**Appendix A: Letter of Permission for Research at Red River College Baccalaureate
Nursing Program (on U of M letterhead)**

Tracy Luedtke
Masters of Education student
University of Manitoba
XXXXXX
Winnipeg, Manitoba, XXXXX
Telephone (H): (204) XXXXX
Email: luedtket@cc.umanitoba.ca

March 31, 2015

Cathy Baxter
Chair, Baccalaureate Nursing Program
Red River College
2055 Notre Dame Avenue
Winnipeg, Manitoba, R3H0J9
Telephone: (204) 632-2506
Email: CBaxter@rrc.mb.ca

Dear Cathy Baxter,

I am a student at the University of Manitoba in the Master of Education program – Adult and Post-secondary Education stream. My research advisor is Dr. Marlene Atleo; internal committee member is Dr. Richard Hechter; and external committee member is Dr. Wanda Chernomas of the College of Nursing, University of Manitoba. My thesis research is titled: *Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences*. This research study is partial fulfillment for the requirements of a degree in the Masters of Education program.

The purpose of this research study will be to explore and describe nursing student perceptions of developing confidence through clinical learning experiences, as well as discover how the clinical learning environment supports learning and the development of confidence. Understanding and respecting nursing student perceptions will offer some renewed insights about the clinical learning environment – an essential step towards improving this environment and student success in nursing education.

I am requesting permission to access third year nursing students in person as a large collective group who have completed NRSG 3860 Clinical Practice 6, and NRSG 3604 Perinatal and Growing Family Health, and students who have not been involved in an appeal process with the researcher. I intend to collect data from eight to ten third year students, who will have a wealth of clinical experience in the nursing program. Therefore, I plan to contact the third year course leaders to request about 10-15 minutes of his/her class time to begin the recruitment process. I

will ask a colleague, outside the nursing department, to read a script that I prepared, inviting students to participate in this research study. The colleague will provide potential participants with an information sheet regarding a description of the research study and my contact information (email address) should they be interested in participating. The first eight to ten interested participants, who meet the sampling criteria, to email me their interest to participate in the research study, will be contacted by me, the principal investigator, to set up a date/time/location to complete the interview. Thereafter, if any additional nursing students want to participate, I will send a return response to the nursing students via email that the number of participants needed for the research has been achieved. Additionally, a thank you to the nursing student for his/her interest at this time will be provided and he/she will be asked if I can contact them in the near future, should any participants not follow through with participating in the research study.

Data collection period will be scheduled over April/May/June 2015. One-on-one semi-structure interviews will be used to engage nursing students in sharing their clinical experiences. The interviews will be digital audio recorded and then transcribed by a transcriptionist who will sign a pledge of confidentiality. Confidentiality and anonymity will be maintained throughout the research process, from recruiting, collecting, analyzing, and disseminating the data. Attached to this letter is the recruitment script.

The research ethics board at the University of Manitoba and Red River College has approved this research study, and copies of the approvals are attached. If you wish to obtain a copy of the findings, I would be pleased to provide you with a summary. A copy of the completed thesis will be placed in the Red River College and University of Manitoba library. If you have any questions or concerns please feel free to contact me.

Thank you for your consideration and I look forward to hearing from you soon.

Sincerely,

Tracy Luedtke

Appendix B: Recruitment Script

Hello nursing students

I am XXXXX. I am here on behalf of my colleague Tracy Luedtke. Tracy is a graduate student in the Master of Education program at the University of Manitoba – adult and post-secondary stream. The purpose of her master research is to better understand clinical learning environments through the perceptions and experiences of undergraduate nursing students like your selves. Of particular interest is the development of confidence in the context of clinical learning environments. The goal is to gain a better understanding about what aspects of your clinical learning experiences affect your confidence in nursing practice and to use that information to improve the clinical learning experience for future nursing students.

You have been selected to participate in this research study because you have a wealth of clinical learning experiences to think about. Your participation in this research study would be a valuable contribution to nursing education. The criteria for participating in this research study are that you have completed NRS 3860 Clinical Practice 6, NRS 3604 Perinatal and Growing Family Health, and have not been involved in an appeal process with the Tracy Luedtke in the past. Your participation in this research study means that you would participate in a 60-90 minute digital audio recorded interview with Tracy Luedtke. The interview will be made up of questions that relate to aspects of your clinical learning experiences that affect your development of confidence in your nursing practice. At the time of the interview, Tracy will explain the interview process and you will be required to share some demographic information about yourself, such as your age, gender, relationship status, number of children, and first language. Additionally, Tracy will ask you to read and sign a consent form and then you and Tracy will begin the interview process. The interview will be a semi-structured 60-90 minute digital audio recorded interview with Tracy Luedtke, at a location that will be convenient and private for you both. The information you share during the interview will be transcribed and used in the research study as data for analysis. All the information collected during this research study will remain confidential and anonymous. Only Tracy will know your identity. If you decide not to participate, you are free to do so and your decision will not be disclosed to anyone. The University of Manitoba and Red River College research ethics board has approved this research study.

Your participation in the research is voluntary and does not affect your academic standing. You are able to withdraw from the research study at anytime and you have the right to answer only the questions you feel comfortable with answering during the interview process. As an appreciation for your time and any expenses incurred, an honorarium of a \$ 25.00 gift certificate to Chapters will be provided for you.

If you are interested in participating in this research study, please contact Tracy Luedtke by email or phone, as stated on your letter of invitation.
Thank you so much for your class time.

Appendix C: Letter of Invitation to Participate (on U of M letterhead)

My name is Tracy Luedtke, a masters student at the University of Manitoba, Faculty of Education. I would like to invite you to participate in a research study that I am implementing as partial fulfillment of the requirement to completion of a master degree. My thesis research is titled: *Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences*. My research advisor is Dr. Marlene Atleo. The research ethics board at the University of Manitoba and Red River College has approved this research study. The purpose of this research study will be to explore and describe nursing student perceptions of developing confidence through their clinical learning experiences, as well as to understand how the clinical learning environment can support learning and the development of confidence.

You have been selected to be a potential participant in this research study, because you have a wealth of clinical experience to reflect upon. The criteria for participating in this research study are that you would have completed NRS 3860 Clinical Practice 6, NRS 3604 Perinatal and Growing Family Health, and would have not been involved in an appeal process with the principal investigator in the past.

Your participation in this research study means that you would participate in a 60-90 minute digital audio recorded interview with Tracy Luedtke. The interview will encompass questions that relate to aspects of your clinical learning experiences that affect your development of confidence within your nursing practice. We would mutually agree on a location and time for the interview that is convenient and private for both of us at Red River College outside the nursing department. Additionally, prior to beginning the interview you will be asked some demographic information and asked to read and sign a consent form. You will receive a copy of the consent form for your future reference. All the information collected during this research study will remain confidential and anonymous. Only, Tracy Luedtke, the principal investigator will know your identity. All documents will be encrypted with a code, and the code and your name will only be located on the consent form that will be locked in a secure filing cabinet at the principal investigator's home, in which only she has access. All data shared with the transcriptionist, research supervisor or committee members will be of a coded nature, with no identifiable names located on any documents. This research study poses minimal risk to you and your participation is voluntary. If you decide not to participate, your decision will not be disclosed to anyone.

This research study will allow you to share information about your clinical learning experiences, in order for nursing education to gain an understanding of these experiences in relation to you developing confidence within your nursing practice. There may be no direct benefit to you; however, this research study has the potential to improve future nursing student success within this learning environment, allowing nursing education to review current teaching practices within this unique environment, in order to modify or maintain these practices.

If you wish to participate in this research study, please contact Tracy Luedtke through the email address luedtket@cc.umanitoba.ca or by phone at (204) XXXXXX. The first eight to ten participants interested in participating in this research study that meet the criteria will be contacted by Tracy Luedtke. A mutually agreed upon location and time between yourself and

Tracy Luedtke will be arrange at the time of the return email or phone confirmation of your willingness to participate in the research study.

You have the right to withdrawal from the research study at anytime and the right to refuse to answer any of the interview questions, without any ramification. If you wish to withdrawal, at any time, you would contact Tracy Luedtke or Dr. Marlene Atleo. Contact information is located below.

The findings of this research study will be disseminated through a variety of presentations, and a publication in a peer reviewed journal. No identifiable names will be located on these documents.

If you have any questions, you can contact the principal investigator, Tracy Luedtke, via email or telephone, noted below. Please keep this letter for future information.

Tracy Luedtke
Master's student, University of Manitoba
Faculty of Education
Adult and Post-secondary stream
Winnipeg Manitoba,
Telephone: (204) XXXXX
Email: luedtket@cc.umanitoba.ca

Marlene Atleo
Research advisor, University of Manitoba
Faculty of Education
Adult and Post-secondary stream
Winnipeg Manitoba,
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Email: Marlene.Atleo@umanitoba.ca

Appendix D: Permission from Linda Townsend

UNIVERSITY
OF MANITOBA

Faculty of Education

Department of Educational Administration,
Foundations and Psychology

230 Education Building
University of Manitoba
Winnipeg, Manitoba
Canada R3T 2N2
Telephone (204) 474-9018
Fax (204) 474-7550

Letter of Permission

I, Linda Townsend, agree for Tracy Luedtke, a graduate student in the Faculty of Education at the University of Manitoba, to utilize or modified some of the interview protocol that was used in my thesis research: *Success in the Clinical Setting: Nursing Students' Perspectives*, for Tracy's thesis research: *Undergraduate Nursing Students' Perceptions of Developing Confidence Through their Clinical Learning Experiences*

I understand that Tracy will provide written recognition in her thesis regarding the source of the questions.

Signature: [Redacted]

Researcher Signature: [Redacted]

Date: January 12, 2015

Appendix E: Semi-structured Interview Protocol (Questions to Guide the Principal Investigator)

Brief Description of the Research Study: I want to explore, understand, and describe undergraduate nursing student perceptions of developing confidence through their clinical learning experiences and gain knowledge about what aspects of the clinical learning environment support learning and the development of confidence.

The importance of building rapport with participants through the various stages of rapport – apprehension phase, exploration phase, co-operation phase, and participation phase will be implemented to create a comfortable and relaxed environment for participants to feel free to share their clinical learning experiences (DiCicco-Bloom & Crabtree, 2006).

Participant Demographic Information:

Encrypted Code: _____

Age: Under 25 years _____, 25-35 years _____, 36-39 years _____, over 40 _____

Gender: Male _____, Female _____

Relationship status: Single _____, Common Law _____, Married _____, Divorced _____,
Separated _____

Number of Children: 0 _____, 1 _____, 2 _____, 3 _____, 4 _____, more than 4 _____

Is English your 1st language? Yes _____

No _____, if no, state your first language _____

Apprehension Phase:

Goal: This phase will engage the participant in a discussion, utilizing questions of a non-threatening nature.

Rationale: This approach will assist the participant to relax because he/she will be asked about something familiar to them, but yet relevant to the research (DiCicco-Bloom & Crabtree, 2006).

1. How would you describe a typical day in clinical practice for you?

Probe: You mentioned . . . can you tell me a more about that experience?

Exploration Phase:

Goal: This phase will allow the participant to engage in an in-depth description of his/her perceptions of developing confidence through his/her clinical learning experiences.

Rationale: This approach will provide an opportunity for the researcher to gain deeper insights into participants' experiences of developing confidence within their nursing practice (DiCicco-Bloom & Crabtree, 2006).

2. Describe a clinical learning experience or situation that helped you to develop confidence within your nursing practice.

Probe: What stood out for you that helped you to feel confident? (Who? How?)

3. Describe a clinical learning experience or situation that hindered your development of confidence within your nursing practice.

Probe: What stood out for you that made you feel less confident? (Who? How?)

4. How do comments from others affect your clinical learning experience?

Probe: Whose comment affects you the most?

Co-operation Phase:

Goal: This phase of the interview will add another layer of richness by asking questions related to participants' feelings.

Rationale: This approach will provide an opportunity for the researcher to gain a deeper understanding of the participants' feelings and provide the participant with an opportunity to reflect on their feelings in regards to their clinical learning experiences (DiCicco-Bloom & Crabtree, 2006).

5. How do you think being nervous or anxious affects your clinical learning experience?

Probe: Can you think of a situation where you felt nervous or anxious?

Probe: Is there anything related to your clinical learning experiences that makes you feel more nervous?

Probe: Is there anything related to your clinical learning experiences that make you feel less nervous?

6. How does working in a group or pairing up with other students in the clinical learning environment effect your clinical learning experience?

Probe: What of sort group dynamics affect your clinical learning experiences in a positive manner?

Probe: What sorts of group dynamics affect your clinical learning experiences in a negative manner?

7. What aspects of your clinical learning experience assist you in persevering at a difficult or challenging task?

Probe: How did you feel after this situation?

Probe: How did this affect you in a similar future situation?

8. Can you provide an example of a situation where you felt that an instructor, peer, or staff member assisted you in being successful in your practice (ie. think of a skill: psychomotor, communication, critical thinking, organization, or relational skills)?

Probe: How do you feel this experience influenced your clinical learning experience?

Participation Phase:

Goal: This phase of the interview will represent the greatest development of rapport between the researcher and the participant. The participant takes a more prominent role in giving direction to the interview.

Rationale: This approach will provide an opportunity for participants' to voice their own opinion about various aspects of their clinical learning experiences (DiCicco-Bloom & Crabtree, 2006).

9. What advice would you provide for other nursing students about how to improve their confidence within their nursing practice?

10. What advice would you provide for others working with you in the clinical learning environment to assist you in being successful within your nursing practice?

Probe: Who has been the most influential in your clinical success? Can you elaborate on why they were so influential in your success?

11. How does the clinical learning environment support your learning?

Probe: What aspect of the clinical learning environment is most important to your learning?

12. What is most important to you in developing confidence within your nursing practice?

13. Do you have anything else to add to the interview about learning within the clinical environment?

Some of these research questions have been adapted and modified from the research of Townsend (2012). Permission has been granted from Linda Townsend to utilize some of the aforementioned questions.

DiCicco-Bloom, B., & Crabtree, B. (2006). Making sense of qualitative research: the qualitative research interview. *Medical Education*, 40(4), 314-321. doi: 10.1111/j.1365-2929.2006.02418.x

Appendix F: Participant Informed Consent (on U of M Letterhead)

Research Project Title: *Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences*

Principal Investigator: Tracy Luedtke, Graduate Student, Faculty of Education, Department of Educational Administration, Foundations & Psychology; (204) XXXXX or luedtket@cc.umanitoba.ca

Research Supervisor/Committee Chair: Dr. Marlene Atleo, Associate Professor, Faculty of Education, Department of Educational Administration, Foundations & Psychology; (204) 474-6039 or Marlene.Atleo@umanitoba.ca

Sponsors: None

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

1. The purpose of this research study will be to explore and describe nursing student perceptions of developing confidence through clinical learning experiences, as well as discover what aspects of the clinical learning environment support learning and the development of confidence. You were chosen to participate in this research study, since you have a wealth of clinical experience to reflect upon. Participant criteria for this research study consists of the following:

- Students who are enrolled in the third year of the nursing program and have completed NRS 3860 Clinical Practice 6 and NRS 3604 Perinatal and Growing Family Health.
- Students who have not been involved in an appeal process with the principal investigator.

2. If you agree to participate in this research, you will be asked questions about your clinical learning experiences and developing confidence within your nursing practice. Additionally, you will be asked about some demographic information, such as age, gender, relationship status, number of children, and your first language. This process will take place through a 60-90 minute digital audio recorded one-on-one semi-structured interview with the principal investigator in a quiet location outside the nursing department at Red River College.

3. The digital audio recording will serve as foundation for accurate complete data intended for the purpose of transcription and analysis.

4. While you may benefit by participating in this research through reflecting on your practice, future students may benefit, since this research study may lead to alternate approaches to teaching/learning in the clinical environment that may contribute to improved student success in clinical practice.

5. This research study poses no more risk than is to be expected in day-to-day activities and your participation is voluntary. If you decide not to participate, your decision will not be disclosed to anyone. You have the right to refuse to answer any question, stop the interview, or withdrawal from the research study at any time with no negative consequences. In order to withdraw from the research study, you can contact the principal investigator, Tracy Luedtke through email at luedtke@cc.umanitoba.ca or by phone at (204) XXXXX or the research supervisor, Dr. Marlene Atleo through email at Marlene.Atleo@umanitoba.ca or by phone at (204) 474-6039.

6. If you become distressed during the interview from sharing a clinical experience, the principal investigator will respectfully provide you with an opportunity to terminate the interview and seek counseling services at Red River College, if needed, by contacting Jennifer Gaulin in Counseling Services D102 Notre Dame Campus at jgaulin@rrc.ca or by phone at (204) 632-3966.

7. In order to protect the identity of the participants, all raw data (digital audio recordings, transcribed interviews, and demographic data) will be encrypted with a numerical code to de-identify the data. The participant's name and numerical code will only exist on the informed consent form. This consent form will be accessible only to the principal investigator and stored in a locked filing cabinet, through keyed entry, at the principal research's home (XXXXX, Winnipeg, Manitoba) separate from all raw data. The consent form will be destroyed through a confidential shredding process at the University of Manitoba Faculty of Education after one year of completing the research in June 2017.

The raw de-identified data in hard copy version, such as transcriptions of the one-on-one interviews, and demographic data will be stored in a locked filing cabinet, through keyed entry, at the principal investigator's home (XXXXX, Winnipeg, Manitoba). Only the principal investigator will have access to the key/cabinet. These hard copies will be destroyed through a confidential shredding process at the University of Manitoba Faculty of Education after one year of completing the research in June 2017.

All raw de-identified data in an electronic version, such as transcriptions of the one-on-one interviews, and digital audio recordings will be stored on a memory stick that will be stored in a locked filing cabinet, through keyed entry, at the principal investigator's home (XXXXX, Winnipeg, Manitoba), as well as stored on the principal investigator's personal computer at home that will be password protected. Only the principal investigator will have access to the password protected computer. Digital audio recordings and electronic data will be destroyed by deleting files after five years from completing the research in June 2022. Dr. Marlene Atleo (Research Supervisor) can have access to the hard copy and electronic copy of the de-identified data, upon request. The transcriptionist will only have access to the de-identified digital audio recordings. The transcriptionist will sign the oath of confidentiality (See Appendix G).

8. An honorarium of a \$25.00 gift certificate to Chapters will be provided to you, in order to compensate you for your parking, travel expenses, and any other expenses.

9. The principal investigator requires three to four participants to review a summary of their interview. You will be given an opportunity to review the principal investigator's summary of your comments to ensure accuracy.

10. The results from this research study could be useful in curriculum development, especially in reviewing the teaching/learning approach within the clinical learning environment, in order to assist students to be successful in clinical practice. The findings may be presented at a nursing education conference, and/or at a Red River College nursing faculty forum, and/or published in an academic journal. Further to this, the findings will be made available in the University of Manitoba and Red River College library. However, at no time will your name be used in any of these circumstances.

11. The principal investigator will provide you with an opportunity to request a summary of the research findings and the method in which you would like to receive the findings ie) email or mail.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdrawal from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the University of Manitoba Research Ethics Board and the Red River College Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at the University of Manitoba (204) 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature	Date
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Researcher and/or Delegate's Signature	Date
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Once the research is completed, if you wish to receive a summary of the research findings final outcomes, please provide your email or mailing address as a means of contact below. This contact information will be stored separately from the research data.

Email Address: _____

or

Mailing Address: Name: _____

Address: _____

Postal Code: _____

City: _____

If you are willing to review and provide feedback on the principal investigator's summary of your comments from your one-on-one interview, please provide your email address or mailing address as a means of contact below.

Same as above: ☐

or

Email Address: _____

or

Mailing Address: Name: _____

Address: _____

Postal Code: _____

City: _____

Thank you, in advance, for your participation in this research study.

Appendix G: Confidentiality Pledge (on U of M letterhead)

Research Project: *Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences.*

Principal Investigator: Tracy Luedtke – a graduate student in the Faculty of Education at the University of Manitoba

I, _____, agree to maintain confidentiality of all the information that I have privy to for this research study. Under no circumstance will I share any of the information (verbally, electronically, or in any other manner) with other individuals outside this research team.

Signature: _____

Date: _____

Appendix H: Four Student Interview Summaries

Interview Summary- Student A

Thank you so much for volunteering to participate in the research study- Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences- during a busy academic time, as you embarked on your Consolidated Senior Practice. I really appreciate and value your comments and stories that you shared with me. Additionally, thank you for agreeing to review a summary of our interview. This document summarizes your comments from the interview process. Additionally, the **green font** represents your own voice. The purpose of the summary is to provide you with an opportunity to review my interpretation of your comments in order to maintain the accuracy of the data created during our interview. If you agree with the summary below please return the summary with a statement in **red** at the end of the summary that you agree with the comments. If there are any portions of the summary that you disagree with, then please make changes in **red**.

Summary: Your perception of developing confidence through clinical learning experiences is multifaceted. There are a variety of features of the clinical learning environment that support your learning and your development of confidence. Instructors, nursing staff, peers and the nursing student (self) seem to be prominent aspects of the clinical learning environment that support your learning and development of confidence. The themes that emerged from each category above are as follows: Nursing instructor (advocacy, verbal encouragement, working with the nursing student, exploring the nursing student's feelings and thoughts, expectations, and verbal tone); nursing staff (comments, a good working unit); peers (being supportive of each other); self (being prepared, building your knowledge, practicing skills, and reflecting).

Clinical learning experiences are very busy with many opportunities for nursing students to gain a variety of clinical skills. Nursing students often have more time with their patients because they have a lighter workload than the staff nurses on the unit. These clinical experiences create learning opportunities for students to allow nursing students to enhance their confidence in their nursing practice: *I think nursing students just go a bit above and beyond...Our days are a bit fuller because we have so much experience that they [nurses/nursing instructors] want us to get in before we finish.*

Clinical nursing instructors often *advocate* for student learning by seeking out clinical skills on the unit for nursing students to experience and for the most part have the nursing student's best interest in mind. *You know they [nursing instructors] are coming from a good place.*

Clinical nursing instructors can assist nursing students in developing their confidence in nursing practice by *being supportive. Verbal encouragement from the clinical nursing instructor* that the nursing student is capable of completing a task or that the student's thought process about patient care is progressing in the right direction can enhance the nursing student's confidence. *"You're doing a good job. You are going to be a great nurse".... These good comments boost your confidence.*

Additionally, being supportive is about *working with nursing students*. Working with the nursing student is about *being there* beside the student to assist them, but not hovering. There's been clinical instructors I've had who are very hovering, and you just make 10 more mistakes. I remember doing dressings changes where my instructor's just right there, and you make 20 more mistakes than you would have if they just would have... stood back and didn't watch you so intently. And you do better at that skill because you're not so nervous...

Being there is about *validating* what the student is thinking or doing, or assisting the nursing student to feel comfortable *by exploring the nursing student's feelings and thoughts*. These are nursing instructors open to you...for you to come to them and share, I'm scared, I'm nervous. And they acknowledge, "thank you for telling me this. Let's walk through it. Let's go through it step by step, one step at a time, and just focus slowly, don't rush." I was struggling a bit with the rotation and my instructor pulled me aside to and said "what can I do to facilitate your learning? How can we work together?" We were able to talk to each other and figure out a plan. This approach facilitates the nursing student's learning and assists the student to being successful in clinical practice.

You also shared in the interview that clinical nursing instructors not only assist a nursing student in developing their confidence but also they can be a part of hindering a nursing student's confidence. A *nursing instructors approach* has the potential to influence how the nursing student feels about them self. A nursing instructor that has very *high expectations* of nursing students makes it difficult for nursing students to seek out the nursing instructor for assistance because they are scared that this sort of behaviour will affect their grade. A nursing instructor that has high expectations can make the nursing student feel like they should know the answer and this approach can make the nursing student feel insecure and hinder their confidence. I've gone to an instructor with a question and it just feels like they think I should know that answer. I shouldn't have to come to them. And I think that's what makes it hard and it kind of kills your confidence...

Additionally, a clinical nursing instructor's *verbal tone* can influence how a nursing student feels. A negative verbal tone can make a nursing student feel scared and less confident in their ability, influencing the nursing student's behaviour. *Just the way the nursing instructor would ask the question...the non-verbal made me feel insecure and scared...so you would go around them and ask other nurses*. Overall, nursing instructors are the most influential in a nursing student's success and their feedback/comments mean the most because they are the individuals that evaluate the nursing student in clinical practice. *Your buddy nurse and nursing instructor should...be there to provide support and verbal encouragement*.

Nursing staff comments also influence how nursing students feel about themselves. *It is nice to hear someone who is kind of on the same level as you that, "You're doing a good job. You are going to be a great nurseand you feel like you are meant to do this. I can do this."* These comments mean a lot to you because you interact the most with the staff nurses. Further to this, an environment that support your learning is a good functioning unit; *I think it really all starts*

there. You can have a great instructor, a great group, but if the unit isn't functioning well, it tends to hinder your learning because the staff doesn't get along well. So patient care is usually down because of a low morale. Patient care is often a priority on these sort of units and being included as a team member allows nursing students to get the most out the clinical experience, in order to feel confident in their practice.

Peers (other nursing students) also can influence a nursing student's clinical learning experience. *Being supportive of each other* helps the nursing student's clinical experience go easier. It makes it way better when you have each other. I remember in my XXXXX rotation, we had a great group and we would help each other out, we'd plan morning care together, we'd plan dressing changes together. And it just really makes your day go so much smoother because you're working together to get stuff done and you have another set of eyes and ears to be in that room with you...they're like another person you can go to and clarify, "I'm thinking this. What do you think?" because you are... on the same level as them, and you know they're not going to make you feel bad about not knowing. Some clinical experience can be very challenging, a dying patient for the very first time, and having the support of your peers just helps you cope.

Self (*the nursing student*) is definitely influenced by the clinical learning environment, depending on the features of the clinical learning environment, that being positive or negative. A negative clinical learning environment can make a nursing student feel scared or nervous. Additionally, a nursing student feels more scared and nervous when then are not confident in their level of knowledge, practice or preparation. Lots of times, when you get your patient assignment the night before... or a few nights before, and you have all these new skills; I remember not sleeping many nights just because you're so worried that you're not prepared enough, you don't have enough knowledge about this, you don't have enough practice doing a skill, ...especially because you don't know how your instructor's going to be. ...You don't know if they're going to be supportive, you don't know if they're going to expect you to know it. So that can be very, very nerve-wracking and, and result in a lot of lack of sleep, which makes it worse.

Preparing for practice, building your knowledge and practicing skills are key to feeling confident in a nursing student's practice. I think it's just learning... if I put myself out there and just keep learning things I don't know and keep asking questions about thing I do not know...I will just continue to grow my confidence. I think nursing students should just put themselves... out there as much as they can. If they're feeling nervous about a skill, if they don't want to do a skill, because they are scared, just do it, because you'll be able to do it. And, at the end of the day, you'll feel so good because you did it. And that will... alone improve your confidence.

Furthermore, nursing students can influence the clinical learning environment by *engaging in reflection*. Reflecting on their practice allows the student to make changes in their future behaviour to improve their confidence. I feel it is also good to hear the negative comments...because you go home at the end of the day, you think about what that

person/instructor/nurse, whoever, said, and you kind of reflect it on your practice “Okay, so what else could I have done different? Could I have prepared more?”

Overall, clinical learning and a nursing student confidence have a positive relationship, meaning that as learning is occurring, confidence is building, as confidence grows more learning occurs. A nursing student’s clinical learning environment can influence how the nursing student feels about them self and in turn effect how a nursing student behaves. Likewise, a nursing student’s behavior can influence his/her clinical learning environment and therefore how he/she feels or thinks.

Once again, thank you so much for your time and thoughts

Sincerely,

Tracy Luedtke

I agree with the interpretation of the document/interview and do not have any request for changes.

Interview Summary- Student B

Thank you so much for volunteering to participate in the research study- Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences- during a busy academic time, as you embarked on your Consolidated Senior Practice. I really appreciate and value your comments and stories that you shared with me. Additionally, thank you for agreeing to review a summary of our interview. This document summarizes your comments from the interview process. Additionally, the **green font** represents your own voice. The purpose of the summary is to provide you with an opportunity to review my interpretation of your comments in order to maintain the accuracy of the data created during our interview. If you agree with the summary below please return the summary with a statement in **red** at the end of the summary that you agree with the comments. If there are any portions of the summary that you disagree with, then please make changes in **red**.

Summary: Your perception of developing confidence through clinical learning experiences is multifaceted. There are a variety of features of the clinical learning environment that support your learning and your development of confidence. Instructors, nursing staff/unit, buddy nurse, peers and the nursing student (self) seem to be prominent aspects of the clinical learning environment that support your learning and development of confidence. The themes that emerged from each of the categories above are as follows: Nursing instructor (*verbally praise, non-verbal cues, attached to the co-worker relationship, care about my learning style, encouragement*); the dynamics of the unit(*cliques, talking negatively about nursing students,*

being receptive to having nursing students); buddy nurse (complete my to do list, don't undermine my skills, share your rationale/talk out loud, praise me); self (being prepared and having knowledge, make a connection with staff, making errors, feeling empowered, feeling a part of a team, being nervous, reflecting, repetition, life experience, pay it forward to your fellow peers, no one has my back, self-care); peers (what one doesn't think of, what one doesn't know, the other will; learning from each other, don't through me under the bus)

Clinical learning experiences are very busy with many opportunities for nursing students to gain a variety of clinical skills. The clinical experience begins from the preparation the night before, by going to the unit to gather information about the patient, to having the clinical experience, to coming home and reflecting on the clinical experience. This preparation of researching your client the night before, of understanding the client's situation, and of exploring the emotional self is *the best chance of feeling confident*.

The experience of **clinical nursing instructors** that *verbally praise* you, by stating "great job" is *incredibly affirming, empowering. I believe that those neurons in my brain just open up and said, "Okay you have done a great job. What else can I you learn? My level of confidence is a direct result of my desire to learn. So the more you learn, the more knowledge you have and the more confident you become. However, it is not only the verbal praise from the clinical instructor but also the non-verbal cues that are just as important for your learning and development of confidence. She looked at me...eye-to-eye and just...nodded her head and slightly smiled.*

Often clinical instructors are employed on the unit where they bring nursing students for their clinical learning experience. It is important for instructors to advocate for their students when needed and not be too *attached to the co-worker relationship* when working with students on the unit. I recognized that my instructor had worked on that ward and was very, very close on an emotional level with these other nurses. She was attached to her co-workers and therefore could not advocate for me, which was really unfortunate. I felt that was low of her. There is huge value in working with a buddy nurse because you work with each other ...for the benefit of the client.

Care about my learning style as you are a unique individual and you learn best in a particular manner, so teach me accordingly. My last instructor did an excellent job of... teaching... She asked me, "What kind of a learner are you? Would you like me to show you first? Would you like me to guide you as you do it? Would you like to read the Policy and Procedure Manual, and then, uh... and then you want to do it yourself? What would you like?" And, and I said, "Well,...I... personally, I need to read it first..., I appreciate...drawings because...I'm a visual learner, but I have to read the words as well...Let me look at the pictures, let me read the words, let me look at the apparatus. And then, if you could... go through, step-by-step with me, first asking me what I would do, and then correct me if I'm wrong, right, before I do it because I, I don't want to do it the wrong way." So she was very, very, good... in understanding... or asking me... what type of a learner I was, and then... and then doing it the way that I learnt best. And that was wonderful.

Comments for your instructor can create or reduce your stress in clinical practice.

Encouragement from the nursing instructor creates a more positive learning environment, reducing stress levels and rising confidence levels. This positive comment creates an attitude that 'you can do it.' The more she encouraged me, ... the less stressed I became, and the more confident I became, and... the more I was able to, um, devote my energies, my, my thinking energies, the way I... the way I perceived the world was positive...it removes a little bit of that stress...for myself. If I'm extremely stressed... I mean, we all know that, scientifically, the catecholamines develops sort of a blockade, and, and you just can't, uh, get past feeling stressed and nervous.

The **dynamics of the unit**, such as *cliques*, can make for a difficult learning environment. There is a power struggle between them [the nursing staff] and the student is on the bottom and sort of seen as relief work. It does undermined your confidence and it undermines your ability to feel as though you've prepared enough. There seems to be eggshells between the nurses...not a good dynamic for learning...undermines your confidence.

Nursing staff *talking negatively about nursing students* can impact a student's learning in the clinical environment. I was in the med room and the med room seems like an L-shape. And, the two nurses that were in the L-shape did not see who it was that walked in the door...happened to be me; they happened to be talking about me. And they were talking about my instructor. It was perfect because it confirmed for me the political context of the unit. But did their negative comments positively impact the way I learnt that day? Absolutely not...my learning that day was undermined and really all I did was try to stay out of trouble. Like, I didn't want... anyone seeing anything that I did that day as anything that they could talk about. So, did I learn anything that day? No, I learnt how to stay under the radar.

Some units are very *receptive to having nursing students* on the unit and this sort of approach with students is important for students to feel or gain confidence. The physical unit does not matter much...what's really important is the nurses. Are they receptive to students and have they had a little bit of training? If they can be a little more teaching, a little more encouraging...it's so confidence building.

The **buddy nurse** you work closely with can definitely influence your clinical learning experience. If the buddy nurse has the attitude that the nursing student is an individual who will *complete my to do list*, then it is possible that there will be little learning that occurs as he/she has no interest in teaching the student. There is huge value in having a buddy nurse because you work with each other for the benefit of the patient... I'm a student, I am here for learning. I'm not here to just kind of, do your want list. Further to this, *don't undermine my skills*. As much as I brought... my assessments to her... I had already dealt with this client on a different day. I knew that my assessments today were much different and more acute than I had assessed earlier. And it seemed like... like, I had no power. She had all the power to dictate what was going to happen, but I had no power... to emphasize what I felt was important because she undermined my

assessment ability...I confirmed with my instructor, and when I went back to speak to this nurse, um, she had a power struggle with what I had to share with her, and she didn't listen to what I had to say. Um, her concern was the fact that I had... I had not changed the PICC line instructor that I had not followed her instructions – which I had – and I had confirmed them with my instructor. And I went back to her and explained... and I also explained that,..., the severe emesis that my client was experiencing and my, my assessment of his abdomen clearly told me that there was something amiss, that...it needed further investigation, which... they left it for another 24 hours...investigated later, and then found that he had hemorrhaged, and it was just a bit of a mess. But no one ever came back to me and said, “You know what, [student B], your assessment was correct...”

There is great potential to learn from a buddy nurse's thought process by having him/her *talk out loud*. For instance, when the buddy nurse talks out loud to explain his/her rationale it becomes a teaching and learning session for the student/buddy nurse. Share with me the rationale as to why, so that I can learn from you what goes in your brain, I'm totally up with that, because I can't be as intuitive as you because you have the knowledge and the experience I don't.

Verbal persuasion is most help for a nursing student's development of confidence, so *praise me*. We have been prepared here, and if could just be a little more teaching and a little more encouraging. If your student does something that's positive, then say so. I had a young woman with burns on her hands and, and I had dressed her hands in, in a way, and...that buddy nurse, uh, told me that, that, in all the years of her practice, she'd never seen, anyone dress, hands in that way where, the hands were entirely... able... her manual dexterity was not impaired due to the dressing... I left feeling as though I was very confident.

Self plays a large role in one's development of confidence. *Being prepared* for clinical practice and *having the knowledge* necessary to care for patients safely and competently can boost one's confidence. How I prepare is very similar from beginning to end because that's just who I am... you go do research, you come home, you research absolutely every aspect of the client's situation and, and try to understand – where I am emotionally so I can deal with that as well. So that, when I ...step into that door that next morning, I, I have the best chance of feeling confident...a typical clinical day for me would be having prepared very well...coming in with a pseudo-confidence...I think the way I prepare has everything to do with how that day will unfold... if I don't have the knowledge base that I feel that I need, and if I'm not there emotionally, um, then the day is more of a struggle... I think when you have the knowledge and when you have the confidence, the skill goes that much better.

It is important *to make a connection* with the nursing staff so the nursing student has someone to rely on through the clinical shift. You know, the unexpected happens... and I think that's where collaboration comes in. I... feel as though I try to make..., contact or connections with the other staff so that, when I need help or someone to collaborate with, then I have that. So, yeah, you... walk into the day feeling somewhat confident.

When nursing students *make errors* it can be very deflating for his/her confidence. I left [feeling] as though I was very confident. But then... I was asked to stay behind after class, and... I was told that I had made a med error; and... my confidence plummeted completely...

Feeling empowered, perhaps comes from instructor or staff nurse comments, and positive comments can really minimize anxiety, boost one's confidence, and *make a nursing student feel a part of the team*. The more she encouraged me,...the less stressed I became, and the more confident I became, and the more ...I was able to devote my energies, my thinking energies... I know I'll walk out of here and say, "I should have explained it that way"... it makes learning easier...it makes me feel empowered, "I can do this." I feel, I feel almost "nursy"...I no longer feel like a waitress..., I am part of the team.

Being nervous in the clinical learning environment can come from the unknown...the I don't know phenomenon as the nursing student approaches that clinical day. I think the most nervous I ever am in any clinical experience is my first day...where I really don't know my instructor very well,...I still don't have a good perception of...what is expected of me... sometimes I haven't even had a lecture, right. I was in XXXXX first; we hadn't really had much of a lecture yet, and my instructor says... "[Student B], there's a person in Room whatever, she's 7 centimeters dilated, I think her husband's sitting in the corner. Go in and help them." I'm going, "Ah." So it's intimidating... it's intimidating to walk into a unit that you don't know, with an instructor that you don't know;...and I don't have a good knowledge base. Um, and the bottom line is, because...I don't know the unit, because I don't know the instructor, because I don't have a good knowledge base, because I'm not sure about what I'm doing, I could fail. I could be seen as inadequate, I could be seen as... incompetent, I could be seen as not having confidence. And that, to me, would be failure.

Reflecting is a skill that allows the nursing student an opportunity to learn from the clinical experience. Especially, when the experience is a negative one. The only negative experience that I had in clinical... I believe the value in it... is reflecting on it and, and learning from it....what I did was I...looked at the situation from every possible aspect and came to the conclusion that it wasn't me that was in the wrong. Uh, and I tried to understand...what caused those individuals to, to react and act the way they did. And then I advocated for myself to... the Clinical Supervisor... not my instructor... well, my instructor first, but when I wasn't listened to, then to the...Clinical Supervisor. Um, and I think what that did, is,... it... made me sit down and look at absolutely every aspect of, of my performance and... my emotional level, the knowledge that I brought to the table. And then I looked at what the experience was, and all of the individual players' reactions to it... I sorted out in a way that, that was really confidence-building for me.

Repetition is a great method to master a skill and gain confidence in that particular skill.

Repetition is absolutely everything. I've learned that clinical experience are not all made equal; ...for example, my, my girlfriend was in a clinical experience where she was able to do eight I.V.'s in a day, you know, tromp around with the I.V. team;...she got very confident...I always

seek out new learning experiences in my clinical rotations because I recognize the more you do something, the better you get at it, the more confident you are, the easier it is to do...

Bringing *life experience* into the clinical learning environment can be helpful; however, it is important to remember that the nursing student's role in a particular clinical setting is different than caring for a sick family member. The roles are just different. *Experience outside clinical* are very important to bring into clinical. But, for clinical itself, in spite of my previous experience, this was still all new because now I'm the student nurse, right. I'm no longer just me... I am expected...to perform in a certain way.

Pay it forward to your fellow peers is rewarding experience and a confidence builder. So when a nursing student has a clinical instructor that cares about his/her learning style and takes the time to walk the nursing student through the skill, they become a great role model for that nursing student, who may pass this same approach forward to another fellow student. That is, the nursing student will take the time to assess their fellow peer and walk them step-by-step through the skill. This sort of behaviour has great potential to be a confidence builder. *The [instructor] led me [through the skill]... uh, the beautiful thing that day was I had to do two of them almost back-to-back. So, you know, the first one, she led me through; the second one, she just watched, and, and I did it. And then someone came in and said, "I have to do one of those." And then I was able to explain it to them, and that was... Oh, so confident. And, of course, the instructor's listening to me, and... interesting thing was,...the beautiful thing, Tracy – I asked them, "What kind of a learner are you?... Just having felt so understood and so, um, appreciated for who I was, allowed me to pass that forward to my fellow student. And... and then she explained what kind of a learner she was, and....I adapted. She was looked at as an individual, and respected as the learner that she is, right. "Tell someone and they'll forget...Let them do it and they'll remember."*

No one has my back because the instructor does not even know me and for some of my clinical experience the buddy nurse does not have my back because they do not know me; they do not know my skills. It is very intimidating when I feel that no one has my back. *On the first day of clinical, I have not developed a rapport with my instructor. So she doesn't know my needs. I don't know the buddy nurse, and my experience is that not all buddy nurses have my back; as a matter of fact, they've given me a laundry list, and by virtue of how I complete this laundry list, is what they give feedback to my instructor. So, do they have my back? Do they have my learning, um, at heart? No. Um, and, in my XXXXX rotation, where my instructor was best friends, buddy-buddy, with every, every nurse on the unit, and... uh, she didn't have my back. So I was on my own. And the good thing about XXXXX was, by the time I got there, I had already had several... um, uh, I had already gained considerable knowledge in lecture, so at least I felt confident with what I knew and the assessments I was making. So I had my back, at least.*

Self-care reflects how one feels about them self, especially in one's ability to learn and one's ability to believe that they are capable can influence a nursing student's clinical experience ...what I recognize is, if I come to clinical not having had adequate sleep, not having adequate

protein, not having all of those things that I know make a difference in my day...then I am already... compromised. So, so, nutrition, uh, sleep, hydration,... some clinical days are so busy, that it's really hard to take a break. Um, and at... and at the end of the day, I don't really have to take a break, as long as I get to go to the washroom every now and then, have a sip of water. Um, but I think, in the long run, I think we, we student nurses we should be taught that self-care is very important,...I think our ability to be confident, our ability to, to learn... I think self-care is really important.

Peers

What one doesn't think of, what one doesn't know, the other will. For the most part, clinical groups work together and support each other in their learning. This sort of learning adds a level of confidence knowing that, again, someone has your back. How many times have I the med room and said, "I can't think of that word. You know, help me, what is that word when, when, uh, the liver is, is... you know, whatever? And someone will... I'll have these three other people looking at me going, "Ah, the word is..."...it'll just pop, "Yes, thank you." And you know what, that, in itself, is...confidence-building, it's team-building...

Learning from each other is a great way to build one's knowledge. Pre-conference is a great opportunity to learn from others in the clinical group, as they share their client's status/situation. In pre-conference, we would present our client to the rest of the group. So there's five of us, and, um... and she [the nursing instructor] would have a format, "This is what you need to present to your group." ...Someone else may not ever have a diabetes patient, someone else may not ever have a liver patient. But, because we can present this patient and tell everybody exactly what we're going to do,... it builds on our knowledge base because we're doing little case studies... So the... the more I know, the more I've experienced in clinical, the more confident I become, and the quicker learner that I am.

Don't throw me under the bus because this is not team building and this approach has no benefit for the patient. Working with other students isn't always the best, but I would say, for the most part, it is. You run into the personality that doesn't want to be a team member, they just want to do it themselves. You can't get a word in edgewise and the, the instructor's standing there listening to what the two of you have to say, and there's only one person talking. So it's...perceived that... you're not contributing. I feel that, that, we, as students, um, need to help each other learn as opposed to, um, when I say, "Throw each other under the bus," I have had negative experiences working with some individuals that... aren't as passionate about nursing as I am...

Overall, clinical learning and a nursing student confidence have a positive relationship, meaning that as learning is occurring, confidence is building, as confidence grows more learning occurs. A nursing student's clinical learning environment can influence how the nursing student feels about them self and in turn effect how a nursing student behaves. Likewise, a nursing

student's behavior can influence his/her clinical learning environment and therefore how he/she feels or thinks. Comments from your clinical instructor and being respected as a learner by your instructor are most influential in your success; further to this, 'you' are very influential in your success by taking responsibility for your learning, preparing for clinical practice, building your knowledge, maintaining self-reflection, and considering self-care.

Once again, thank you for your time and thoughts

Sincerely,

Tracy Luedtke

Thank you for the opportunity to review the transcript. I have not made any changes and agree with your interpretations.

Interview Summary- Student C

Thank you so much for volunteering to participate in the research study- Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences- during a busy academic time, as you embarked on your Consolidated Senior Practice. I really appreciate and value your comments and stories that you shared with me. Additionally, thank you for agreeing to review a summary of our interview. This document summarizes your comments from the interview process. Additionally, the **green font** represents your own voice. The purpose of the summary is to provide you with an opportunity to review my interpretation of your comments in order to maintain the accuracy of the data created during our interview. If you agree with the summary below please return the summary with a statement in **red** at the end of the summary that you agree with the comments. If there are any portions of the summary that you disagree with, then please make changes in **red**.

Summary: Your perception of developing confidence through clinical learning experiences is multifaceted. There are a variety of features of the clinical learning environment that support your learning and your development of confidence. Instructors, nursing staff, buddy nurse, peers, and the nursing student (self) seem to be prominent aspects of the clinical learning environment that support your learning and development of confidence. The themes that emerged from each of the categories above are as follows: Nursing instructor (*immediate positive feedback, believe in me, give me time to answer, praise me; allow me to ask questions without penalty*); staff on the unit (*teach me; talk me through*); buddy nurse (*make me feel included, show me a different way*); self (*self-talking, need the knowledge, making mistakes, past experience, pass it forward*); peers (*what one doesn't think of, what one doesn't know, the other will*).

Clinical learning experiences are very busy with many opportunities for nursing students to gain a variety of clinical skills. The clinical experience begins from the preparation the night before,

by going to the unit to gather information about the patient, to having the clinical experience the next day. The clinical days are very busy and filled with a variety of skills.

Clinical nursing instructors have the potential to build up a nursing student's confidence and facilitate his/her learning, but they also have the potential to hinder a nursing student's confidence based on their attitude and behaviour towards the student in clinical practice.

Immediate feedback, especially positive feedback after completing a task, from the clinical nursing instructor is confidence boosting. When nursing students do not receive that immediate feedback, they may begin to self-doubt their ability and feel nervous. If I think back to like, some of the skills we did in first year,..., I had some instructors that were very silent that way and just kind of stood there... with the clipboard, you know, wrote a couple notes, and then, "Okay," and we walked out of the room, and that was it, kind of thing. And now that I look back, "No, I did do all the steps correctly, you know, I know that it was right." But, in that moment, as you know, doing a skill for the very first time,... I had no idea if I was doing it right...at the end, when I got my grades and got my anecdotes... then I realized, "Okay, there was no negative comments from that situation so... I... must have, done the procedure correctly." But, but there was no feedback, um, after that task. When I'm not getting like, any feedback after doing skills or research... I don't know,... "Where do I stand?" Or, "How am I doing?" and, and maybe that makes me nervous. Maybe I need more encouragement than some other people;... those are the situations where I would thrive the most. And I don't know that my marks would necessarily look different... from one instructor who's very encouraging and one who isn't. Um, but I think that I, I... I'm way more confident when I've received positive affirmation that, "Yes, you did do that right."

Clinical nursing instructors evaluate and grade nursing students, but it seems that there are some variation among instructors in grading students. The variation comes from the instructor's belief in a student's capability, and that belief can shatter or boost a nursing student's confidence. It makes it difficult for a nursing student to believe they are capable, if the instructor doesn't believe in them. *Believe in me* and I can believe in myself. I know that there is... the rubric or...the outcomes that they're supposed to be looking at. And they do, but everyone interprets everything their own way;... there's going to be variation in...what they're looking for. And so I think that's...been a frustrating point in clinical for me. Um, some instructors, uh, like, "No problem, you can get an A, an A+," like, "Absolutely, it's attainable."...with other instructors, they, they don't believe that it's ever possible...I have consistently gotten A's and A+'s in all my clinicals... I just had, um... uh, my last clinical that I just finished; my instructor said, in her 14 years of working, she had never given any student an A. And so I didn't get an A, um,... but I felt like my work was consistent with where I had been throughout the rest of the year. I felt like I had gone above and beyond in this clinical as well. That kind of stops me from wanting to do well because I just feel like, "Well, it's impossible for me to, to get a good mark, and so why am I even going to try?" I think what I was trying to say here is that trying to win in the system was hard. My grade wasn't dependant on how well I did but rather on the instructor's personal scale.

For example when giving an IV medication I may require one prompt from the instructor. One instructor grades this at an A (criteria: minimal prompting needed), another gives this a B (prompting required). While the instructor is consistent in their own grading within their clinical group the grading is not constant between different instructors. This lack of constancy made me want to give up because my grade did not accurately represent how I was doing nor did it fairly compare me to my peers.

Some instructors ask numerous questions and this can make a nursing student feel nervous and effect the student's ability to learn. *Give me time to answer* the question before moving on to the next question, so I do not shut down. An instructor who's just like, peppering you with questions, and like, "Okay,...am I going to get the right answer?"... "Is this going to come out in my anecdotes?" struggling to... think clearly because I'm so tense about...answering the question correctly That being said, I've had some really good clinical instructors too who've said, you know, like, "Take a little bit of time to think about this..." you have a minute to breathe. You don't just have to like, fire back what you... you know, what you think.

The most important aspect for developing confidence is the support from the clinical nursing instructor. *Praise me* would be the kind of support that would help me to develop confidence and to persevere in a future situations. *Feeling like they're supporting me, and that they...notice, like, "you do know, that theory,.. that's perfect...you're applying it here,"...then I begin to think..."Where else can I apply my...classroom knowledge into,... clinical. Now I have a new patient, but I want to continue that critical thinking because that was encouraged, you know, in a previous patient."*

Allow me to ask questions without penalty, because this is how I can learn and begin to develop confidence. (Yes! This was huge for me! And this was a tough habit for me to get out of while I was completing senior.) I do feel like my learning was often hindered by my goal of getting a good grade. ...there were many times when I was uncertain about something, but there's no way I was going to ask my instructor because I didn't want to jeopardize my, my grade. And knowing ...if you ask any questions, it comes out in your anecdotes as "requiring prompting"...if you require prompting, then that jeopardizes your... A+, maybe an A... I often wouldn't ask any questions, and, you know, hope for the best or, or go in the room and ask the patient how they... how it's normally done.

Nursing staff or other medical staff on the unit can be very helpful for me to learn practical skills and achieve success in practice, especially when they *teach me*. Those passionate nurses who are like, "Come along, come see this." Like, "There's something different happening here," or ...not even just nurses... like, other professions too who, who are willing to...explain everything to you..., to teach me..., even though I didn't ask that specific question.

Talk me through a skill or a situation because it is important to assist me in my learning. Having people who are willing to talk me through it...and willing to, to come with me and do it... or

show me, yeah, not just this expectation that like, “Three years ago, you saw a little demo on a plastic person in the lab...and now go in there and... and I’m going to grade you. I’m going to stand on the other side, I’m going to grade you while, you know, while you try to remember it.” But, I think that staff that are like, right in there with you or, or pulling you in with them... has been the most helpful.

A buddy nurse who makes me feel included, makes me feel less nervous in clinical practice. Feeling included means the nursing student is involved in discussions, in caring for the patients, and in knowledge sharing. This approach is about working with the nursing student, and not separate from the student, so the student can be successful in practice. A really good buddy nurse who is going to be, “come along. Let’s figure this out together”...even having an instructor who’s like, “Come along, work with me,” is more intimidating because, ultimately, they’re the ones still grading you. Whereas I feel like, if I have a buddy nurse who’s like, totally willing to take me in in all these learning experiences...they’re not grading me so I feel like I can ask any questions I want.

Show me a different way because this is a great way for me to learn and understand that there are a variety of approaches to nursing care that constitute best practice. I was so inspired by her care...just the little things that she said to this woman as she was doing, doing the care,... had such a..., slow, gentle approach to it.... every single time it was so, so gentle ...I feel like I learned a lot from her.... we talked...outside the room.... “If we move her this way, it will... it will hurt less,” she had so many little tips and little tricks to, to try to care for the patient better. Um, also, there was quite an odour in the room, and so she... had so many like, you know, “Try this, do this, get...” you know, “get a basin with a kitty litter.” Like, so many different really practical things that like, no one had ever taught me like, that list of things to try... to make it like, as good of an experience for the family and the patient. Um, and so I think for me like, that was a really inspiring day...

Self (the nursing student) can influence how confidence develops. How a nursing student responds to a situation or challenge can influence his/her development of confidence. For example, *self-talking* can assist a nursing student to believe that he/she are capable of performing and coping in the clinical learning environment. I think maybe it [confidence] comesfrom myself, saying like, “Be confident, student C,” like, “you’ve studied this, you, you know this.” Like, you know, when your instructor’s asking you questions like, you know, “Buy yourself some time, give yourself a minute...it’ll come to you,” or, or that kind of thing. I would say it’s more internal than external.

Additionally, nursing students need to acquire a certain level of *knowledge*, in order to feel confident. I just keep reminding myself... “You’ve done well on your, on your exams. You’ve been to class, you know that knowledge.” And so that should translate into being where I should be in clinical.

Making mistakes can hinder a nursing student's confidence. So we went in, and then, afterwards... after I set everything up in there, I said, "Can you check this pump for me?" And she went through the settings and, and I guess we both missed it... there was an error in the, in the numbers that had been put in...it was only caught after the fact....it was an incident, and.... it brought down my confidence.

Past experiences can assist a nursing student in feeling comfortable and confident in their clinical learning environment. I have worked as a lifeguard... before this program, and kind of throughout...And so from that, I was used to a ton of lifeguard exams, and continually we're doing re-certifications where you do have someone standing with a clipboard writing down ...everything you're doing...and where you need to be saying things out loud, or else it didn't happen, um, that kind of thing. And so I think that really prepared me for being in the clinical setting where, you know, if you have an instructor who is, you know, writing..., taking notes while you're doing skills or like that kind of thing..., maybe it was less intimidating because I've had some experience with that.

Pass it forward means that nursing students pass on their knowledge to other nursing students and this sort of behaviour can be confidence boosting for the student passing forward his/her knowledge. I think... it was very confidence-inspiring when... like, I can think of a time when I had already done a dressing change on....the same woman for maybe three weeks in a row, same patient. And, and then on the fourth week, a different student had that patient. And then the instructor who had seen me do the dressing changes with her, ...a couple times [said] "Student C, why don't you go in with that student together?" And I felt like.... "Wow, you actually trust me to do something," affirming that, you know, "You did do those dressing changes correctly. And now, why don't you, you..., show another student?"

Peers in the clinical learning environment are important for each other's learning and development of confidence. However, there are situations when peers can create stress for other nursing students, influencing the clinical learning experience and the development of confidence in a negative manner. The belief that *what one doesn't think of, what one doesn't know, the other will* is often seen in the clinical learning environment among nursing students. ...Peers... can be very supportive.... I feel like we've learned to band together, and, and we do.... a lot of talking in the med room. Like, "Okay, I'm about to do this. I'm going to tell you my steps; make sure I'm doing this right before I go to my instructor and tell her what I'm going to do." We do a ton of that and a ton of like..., "I haven't written this kind of a note before. Can you read it first it before I go show it to my instructor?" Or like, that kind of... I think there is a lot of support,... between us as peers... almost like having each others' backs...

Overall, clinical learning and a nursing student confidence have a positive relationship, meaning that as learning is occurring, confidence is building, as confidence grows more learning occurs. A nursing student's clinical learning environment can influence how the nursing student feels about them self and in turn effect how a nursing student behaves. Likewise, a nursing

student's behavior can influence his/her clinical learning environment and therefore how he/she feels or thinks. Most important for your learning in the clinical environment is to have nursing staff who are willing to teach you, come with you, work with you and do a skill with you. This sort of behaviour can assist you in being successful in practice and in building your confidence. Interestingly, you express that when clinical practice is graded, nursing students may avoid the instructor by not asking him/her questions or clarification, so as not to jeopardize their grade. This sort of thought process and behaviour may hinder a learning opportunity for the nursing student; and, therefore the student's chance to further their confidence.

Once again, thank you for your time and thoughts

Sincerely,

Tracy Luedtke

Interview Summary- Student F

Thank you so much for volunteering to participate in the research study- Undergraduate Nursing Student Perceptions of Developing Confidence through Clinical Learning Experiences- during a busy academic time, as you embarked on your Consolidated Senior Practice. I really appreciate and value your comments and stories that you shared with me. Additionally, thank you for agreeing to review a summary of our interview. This document summarizes your comments from the interview process. Additionally, the **green font** represents your own voice. The purpose of the summary is to provide you with an opportunity to review my interpretation of your comments in order to maintain the accuracy of the data created during our interview. If you agree with the summary below please return the summary with a statement in **red** at the end of the summary that you agree with the comments. If there are any portions of the summary that you disagree with, then please make changes in **red**.

Summary: Your perception of developing confidence through clinical learning experiences is multifaceted. There are a variety of features of the clinical learning environment that support your learning and your development of confidence. Instructors, nursing staff, the buddy nurse, peers, and the nursing student (self) seem to be prominent aspects of the clinical learning environment that support your learning and development of confidence. The themes that emerged from each of the categories above are as follows: Nursing instructor (*feedback, believe in me, support me through mistakes, praise me, talk it through and cue, challenge me, if you disrespect others; this influences my feelings, evaluating me*); staff on the unit (*listen and trust my judgement, need to have the total experience of being a nurse*); buddy nurse (*listen to me and dialogue with me, be calm*); self (*being prepared, being nervous, past experience*); peers (*what one doesn't think of; what one doesn't know; the other will, advocate for me, encouraging words help me persevere*).

Clinical learning experiences are very busy with many opportunities for nursing students to gain a variety of clinical skills. The clinical experience begins from the preparation the night before, by going to the unit to gather information about the patient, in order to research medications, disease processes or skills. Often the clinical practice day begins with a preconference in the morning, allowing the nursing student to present his/her patient and share the plan of care. This sort of forum allows student groups to learn about a variety of patient cases. The clinical days are usually very busy with organizing activities, skills, medication delivery or collaborating with other staff, in order to provide the best possible patient care.

Clinical nursing instructors have the potential to build up a nursing student's confidence and facilitate his/her learning. The clinical nursing instructor's *feedback*, especially positive, is most important for a nursing student to develop his/her confidence and paramount in order for learning to occur in the clinical environment. "Please tell me if I'm doing something wrong." Because if I don't know it's wrong, I can't learn from it. "Stop me if I'm doing something wrong because... I don't want to jeopardize patient safety, patient care...and second of all, I need to know the right way to do it." And then... and then just like, encouraging words along the way. Feedback from the clinical nursing instructor can be very powerful. I think words are very powerful...they hold weight based on the person that says them, right So, like, I mean, my husband is my rock, right. And if he says, "Oh, yeah, you can do this," I believe him. But he's never... in clinical, right. And when my instructor says, "You did that really well," that holds huge weight. or the nursing instructor states "You're going to be so good at this," or, you know, "You excel here." That's so powerful because they're in the business, right. If they say something is not well, or you need to improve in this area, that holds more weight... it has value...when someone who's been beside me in patient care says it.

When a nursing instructor *believes in me* it assists me to believe in myself. I had a catheter... come up, I'm thinking it had been a year and a half...I had planned to come to the lab and practise, but this showed up before my scheduled lab visit... I just was honest, like, "I haven't done one in a long time." The nursing instructor stated, "You'll be fine. Just take a few minutes, review the policy again." Like, just exuding that confidence in me, like, "You know this, you've done it....go refresh your memory, go gather your supplies. We'll talk through it." And so then there was that pre-kind-of conversation, "Let's talk through it," and very calming and matter-of-fact...who exudes confidence in me.

When a nursing instructor is *supportive through mistakes*, this sort of behaviour assists nursing students in moving forward and have the confidence to persevere in the future endeavors. I came to close to making a med error. Like, it didn't... actually... happen...moments where I thought I had...those are very crushing moments...my instructor was incredibly supportive. The nursing instructor stated, "Okay, let's accept that this happened...and move on together...you know, you're not alone, and I will walk you through the process. And, you know, what steps can we do to make sure this doesn't happen again?" I was crying. So I got hugs and I got, you know, like, "Go take a few minutes to yourself in the bathroom....Come back when you feel ready to come

back.” And, and then, yeah, we worked it out, and... you know, and lots of checking on me throughout the day, “How’re you doing?” You know, “How are you managing?” And when it turned out that it was a non-issue, it was still such a valuable learning experience...when I’ve had instructors really come down hard on fellow classmates. You know, and I’ve seen instructors like, yell at students in the hall, or in the med room. And... they’re crying, you know. And that... like, decreases my confidence, too.

Talk it through and cue is a very helpful nursing instructor trait that nursing students can benefit from for their learning and in the reduction of anxiety. The nursing instructor stated, “go refresh your memory, go gather your supplies. We’ll talk through it.” And so then there was that pre-kind-of conversation, “Let’s talk through it,” and very calming and matter-of-fact.

Challenge me, especially to transition into the role of the nurse. It is important for nursing students to practice safe and competent care, so they need to experience the complete role of the nurse. As we’re moving into the final clinical...it would be nice to take on more of just the nurse role. Like, I don’t know if that’s clear, but, um... we still carry on all of the health care aide duties right into the last clinical day. And,...I feel like I’m going to go to my first day of Senior and start pulling out washcloths to wash somebody and the health care aides are going to say, “What are you doing?” It’s like, “Well, this is my job,” right. That’s how I feel,...So it’d be nice to have a different relationship... I can... I fully appreciate having those skills, and I fully appreciate that nurses wash and feed people on units....

So, you know, when I have... let’s say I have a learning opportunity; so-and-so’s doing a catheter. And I miss it because I have to give someone a shower, that... that, I feel, is very frustrating to me. And yet, if I didn’t do the shower, that reflects on my ability to organize care. And delegating the shower is sometimes frowned upon.

Or you want...to sit in on doctors’ rounds, but you’re feeding breakfast to somebody. You know, and it’s like, at some, some stage in... near the end...could,... the health care aides not cross their name off the list...and I feel like I don’t have a working relationship with them. You know..., I haven’t worked with them. They’ve never reported to me.

If you disrespect others; this influences my feelings. When nursing students observe clinical nursing instructors disrespect their peers, it can make that nursing student feel nervous and perhaps worried about how the clinical instructor will respond to them when they need some support or when they make a mistake. This sort of behaviour from the clinical nursing instructor can influence how the nursing student may perceive his/her ability to perform in the clinical learning environment. I’ve had instructors really come down hard on fellow classmates. I’ve seen instructors like, yell at students in the hall, or in the med room. And they’re, they’re crying, you know. And that... like, decreases my confidence, too... I feel like, “Well, ... that could be me.” Or... “What are they going to do when I make a mistake?” right. And then it puts you on edge... You think that they’re in the supportive role. And then, when you see them do that to a

student, you're thinking, "Okay, well, what support am I going to receive if it's me?"...just witnessing it is enough to, to deflate you.

Evaluating me can influence learning and the development of confidence. This person is there to guide you and support you, and they, they can be extremely friendly. But yet... there's a huge evaluative component...that, um, causes like, a barrier, right. The evaluative component can be a barrier in the sense that the nursing student may not seek clarification from the clinical nursing instructor, in fear that the nursing student seems unprepared or lacks the knowledge. Because of this thinking, the nursing student may refrain from asking questions, missing an opportunity for learning to occur.

In order for a nursing student to develop confidence, it is important for the *staff on the unit listen and trust my judgement*. When others believe in the nursing student's skill, then it makes it easier for the nursing student to believe in them self. I think for the other staff,... "Listen or ask maybe what our opinions are." ... because...I think we have a lot to add, a lot of value to add. And, you know, like, being listened to builds confidence. I really think it does.

I've had many opportunities to approach a doctor, you know, like, um, "My client needs better pain control." And when they listen to your assessment and change the plan of care,... my confidence skyrockets....I remember it was First Year, and... this person I was helping, client, had low blood pressure, and the physician assistant was right there. And I said, you know, "This is the blood pressure and yesterday, it was this, and the day before, it was this." And... he implemented some changes and more tests and stuff. And I said to him, "Don't you want to double-check my assessment?" He said, "No, I trust you..." I just was like, "Really?" Like,... I was in awe.

In order for a nursing student to become competent and confident in his/her nursing role, they *need to have the total experience of being a nurse* in their final clinical course. Staff on the unit need to recognize that nursing students are training to be nurses and not nurse's aides. As we're moving into the final clinicals... it would be nice to take on more of just the nurse role... we still carry on all of the health care aide duties right into the last clinical day. And, and it's... I feel like I'm going to go to my first day of Senior and start pulling out washcloths to wash somebody and the health care aides are going to say, "What are you doing?" It's like, "Well, this is my job," right. That's how I feel, like. So it'd be nice to have a different relationship... I can... I fully appreciate having those skills, and I fully appreciate that nurses wash and feed people on units. And, if I get to a unit where that's my role, I will step into it...And to keep us in that role..., it's distracting. So, you know, when I have... a learning opportunity; so-and-so's doing a catheter...And I miss it because I have to give someone a shower, that... that, I feel, is very frustrating to me. And yet, if I didn't do the shower, that reflects on my ability to organize care....And delegating the shower is sometimes frowned upon. Or, you know, you get guff from the staff... So they, they look, and they're, "Oh, students are here." And, and, literally, like, they'll...cross out..., their name and say, "I... hands off with this person." And I even asked

the...health care aide to help me... basically, she said, "Find another student." And, you know, I just felt like, "Is this getting in the way of opportunities I could have had?" right. ...to sit in on doctors' rounds, but you're feeding breakfast to somebody... You know, and it's like, at some, some stage... near the end...could the health care aides not cross their name off the list...

There is great potential for nursing students to learn and to build their confidence through positive interactions with their *buddy nurse*. When the buddy nurse dialogues with the nursing student it helps him/her feel a part of the health care team; further to this, when the buddy nurse listens to and values what the nursing student has to share about the patient, this creates and opportunity for the student to feel confident in their assessments or skills. *Listen to me and dialogue with me.* I approach my nurse and I, you know, "I think it's this." And she... you know,... "Let's, let's dialogue about that," right... I can give an... specific example... Um, but my client stood up and had... felt like her foot was burning, like, fire, right. So, you know, we... I assisted her... to the commode and, and then I ran and found my buddy nurse because I'm thinking, spinal cord compression. She'd had one a few months ago. So I... "This is the... what happened today. She says it's new, it's in this foot," you know, and I said, "This is what I'm thinking." My nurse looks right at me, and we talk about it... like, peer-to-peer, it feels like... You know, and she listened to me, and she trusted my, my, um, assessment. And, you know, she..., "What else could it be? Let's explore this," you know. And, you know, "Why do you think it is this?" You know, and I'm able to talk about it;...a few hours later, she came to me and said, "You know what? I think you might be on to something," you know... your confidence grows. And, you know, her and I together talked to the doctor. We get there, and she says to me..., "Tell him what you have to say." And she lets me do the talking... we're able to dialogue again about it, and he has even further insights, you know... um, you know, really taking it to a XXXXX level...they both believed me, right. They both dialogued with me and listened to me...

Be calm. This sort of behaviour that the buddy nurse exhibits can transfer on to the nursing student's behavior by decreasing his/her anxiety. Additionally, they may feel that they have someone to rely on when they need assistance...there was a third person in the room...who was calming, very calming, very encouraging. And, you know, I think it just kept bringing the anxiety down...My buddy... it was my buddy nurse.

Aspects of **self** can play a role in the nursing student's thinking and behaviour, influencing his/her learning and level of confidence. *Past experience* can influence the nursing student's level of confidence, as those experiences consist of layers of learning over time. I think each clinical, you get stronger...you know, communication and like, your knowledge base grows, your,...skill base grows. Like, your experiences build on each other...when I think of... like, I took a picture of myself first day of first clinical in First Year, and then a picture of myself last day of last clinical... I look at these pictures and think like, "I'm, I'm barely the same person." Like, you've learned so much... You know, so each thing just builds and builds and builds... some of the things that were very anxiety-provoking in Year One and Year Two...are second nature in Year Three... on the first day, if you had said that you're going to walk into a doctor's

office and demand they change the route of med because this person can no longer swallow...I wouldn't have...had the confidence to do that, right...So it's like, over the years and all the things that we've done brought me to that point where it's like, "Yeah, okay, sure, I'll go in there"...Being more secure in your knowledge. Like, I do have a voice and it matters...and, you know, just being stronger, I think, as a person, and trusting your instincts a little bit more.

Being prepared for practice can assist nursing students in feeling more confident in their knowledge and skills. "Be prepared," there's always things that come up that you, you can't prepare for, always...I think my advice to other students is, "Know what you need to do...if it's watch videos or read articles or read Policy and Procedures," like, "What do you need to do?" because everyone's different.

The feeling of *being nervous* really effects the way a nursing student thinks and behaves. ...it's debilitating...when your anxiety is so high that simple things become impossible. Like, I could not crack the glass of a vial. I went through three, and I think it... we kept wasting these meds because they would shatter...one time, I cut my finger, I needed a Band-Aid. Like, it was... you know, have I practised this in lab? Yes. Have I been successful at this? Yes. But when someone's watching you...I shattered three of them before she finally said, "Enough waste." And, "Let me just open this for you."

...you know, where you go to, like, draw the med out, your hand's shaking. And...sometimes I wouldn't even feel the nervousness but it was like I would get the physical symptoms and I'm thinking, "Why is my hand shaking? I've done this before."

Peers can play a large role in the outcome of a clinical learning experience. *What one doesn't think of, what one doesn't know, the other will.* For the most part, clinical groups work together to support each other in their learning. You know...each bring your own experiences to... the table...you either take the lead on a task or you let them take the lead on a task. And the...patient we had, um, was, uh... had a trach. So there trach care. And you know what, it was great because you're not trying to find somebody else to help you because you need two people to do some of these tasks. But being in that partnership, we just... we just worked so well together. And, you know,... we had the plan of care decided before the day... I just thought we attacked really well... it lightened the load, it really did...There was some pressure off. You've got two sets of eyes on something, you feel like, "Okay, I'm not... we're not going to miss anything." And, uh, you're able to converse back and forth without judgment, right, "Oh, do I do this first, or that first? Is it 10 ml or 5?" You know, and we're just... we just talk things out and converse. And, and, you know, we're learning together without... needing to evaluate each other, right... I think, had that been my patient alone..., my anxiety would have been enormous. And neither of us had experience. So we're both new at it...both learning it. But then, that just helped so tremendously...

Advocate for me and this encouragement will build confidence. ... I think that some groups, the students have better communication with each other and we let each other know. Like, it'll be like, "Oh, you know, I'm doing this in about five minutes." You know, or, "I'm doing that in about ten minutes." Or we even had it, like, um, "I've already done a Sub-Q. Who here wants the opportunity?" So, you know, "If you haven't had a chance, I'm willing to let you have this chance." ... You know, just so that it's fair across the board... instead of one person getting three I.V. starts, they... like, sometimes the instructor initiates the sharing of skills. But sometimes it's the students.

Encouraging words help me persevere. This approach gives me the inner drive to be successful. I had a challenging day in my XXXXX rotation. And I had two or three students separately say, "What can I do to help you right now..." ...we just were like that. If you saw someone who had a heavy load, "What can I do right now?" and just, encouraging words, like, "How are you doing in...how's it going? What do you have left to complete?" You know, just helping you stay focused.

Overall, clinical learning and a nursing student confidence have a positive relationship, meaning that as learning is occurring, confidence is building, as confidence grows more learning occurs. A nursing student's clinical learning environment can influence how the nursing student feels about them self and in turn effect how a nursing student behaves. Likewise, a nursing student's behavior can influence his/her clinical learning environment and therefore how he/she feels or thinks. Comments from the clinical nursing instructor are most influential for learning and the development of confidence in the clinical environment. Additionally, preparation for clinical practice, such as obtaining thorough patient research, having a good knowledge base, and practicing skills is paramount for nursing students to improve their confidence in the clinical learning environment. This sort of behaviour can assist nursing students to being successful in practice.

Once again, thank you for your time and thoughts

Sincerely,

Tracy Luedtke

Tracy, I agree with the transcription. It reflects our interview and I hope it is helpful for your study.