Success in the Clinical Setting: Nursing Students' Perspectives

by

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Abstract

The purpose of this qualitative study was to explore students' perceptions and experiences of feeling confident in some clinical areas and not in others and to explore how clinical teachers may increase students' feelings of self-efficacy during clinical practice.

Using Bandura's (1997) theory of Self-efficacy as a guide three major themes and several subthemes emerged from the data as important influences to student learning. Clinical Education facilitator (CEF) was the term used in this study for clinical teacher (CT) and was considered by students to be the most important influence to clinical learning. The CEF was the most developed theme followed by the theme of the environment and the theme of the student.

The findings of this research were found to be consistent with the literature related to self-efficacy and student learning in the clinical setting. Implications for nursing education and recommendations for further research were discussed.

Dedication

In memory of my father

Peter Uhryn

July 11, 1929 - March 5, 1997

And my mother in law

Yvonne Townsend

February 5, 1936 - October 11, 1995

Who both taught me invaluable lessons for life

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Chapter One

Introduction

Health care educators across the globe consider client safety to be an important priority (World Health Organization, 2009). Nurse educators are now faced with the challenge of educating nurses to practice in an increasingly complex healthcare environment, in which professional attentiveness, responsibility, and excellence are necessary to ensure patient safety. At a time when nurses face new demands on their knowledge and responsibilities, nursing education must meet the needs of a transforming profession. Scholars agree that the role of the nurse has become progressively more challenging over the years (Benner, Sutphen, Leonard & Day, 2010; Reilly & Obermann, 1999; Myrick &Yonge, 2005; McEwan & Wills, 2007).

The nursing profession has evolved at a rapid pace not only in the practice domain, but also in its role within the health care system locally, nationally, and internationally (Reilly & Obermann, 1999). Nurses practice in widely diverse settings ranging from specialized acute hospital care to in-home and long term care facilities, and are continuously challenged to maintain patient safety, while at the same time managing multiple intrusive technologies where the allowable margin of error is extremely narrow (Benner et al., 2010). Because the nurse spends significant time at the bedside or in a clinic setting with his/her patients, s/he knows and understands his/her physical, emotional, and spiritual needs, and therefore is the best advocate for the patient and his or her family in what has become a complex and sometimes confusing healthcare system (Miers & Pollard, 2009).

Nurses are at the forefront of mapping the future of health care and are expected to have the knowledge and expertise to be capable of meeting these challenges (CNA, 2009; ANA, 2011). Nurses need to be confident in the face of uncertainty, and believe they are capable and qualified to advocate for an improved health care system that is in the best interest of their patients. In light of these challenges, Benner et al. (2010) claim that re-designing nursing education is an urgent societal agenda.

Traditionally students in the classroom are introduced to nursing concepts, clinical decision making, reasoning, and even psychomotor skills through a series of lectures (Arundell & Cioffi, 2005; Salyers, 2009). The need for good learning experiences in the clinical setting has been a subject of ongoing discussion in nursing education. Tanner (2006) asserts that nursing students in the clinical area need to be well prepared. They need to be capable of recognizing signs and symptoms and qualitative changes in patient conditions; they need to distinguish between a range of possible manifestations, meanings, and experiences for each patient. They need to feel confident in their decisions for patient care.

McEwen and Wills (2007) suggest that to best meet the learning needs of students at the beginning of the 21st century, nurse educators should move beyond their reliance on traditional techniques and incorporate other teaching strategies that are based on sound theoretical principals. The literature review in Chapter two demonstrates that self-efficacy is a strong predictor of success in many domains. Self-efficacy theory predicts that if faculty members can improve a student's self-efficacy beliefs about performing in the clinical setting then students will be better able to maintain their newly learned behaviour in clinical practice. (Clark, Owen, & Tholcken, 2004). By gaining a better

understanding of what makes nursing students in the clinical environment believe that they can succeed using the theoretical framework of self-efficacy as a guide, clinical teachers (CTs) may learn and adapt pedagogical methods of teaching and learning to improve overall nursing student success in the clinical area. As a result, new graduates will be better prepared to practice in today's complex healthcare system.

Purpose of the Study

The purpose of this study is to explore students' perceptions and experiences of feeling confident in some clinical areas and not in others and to explore how clinical teachers may increase students' feelings of self-efficacy during clinical practice.

Research Questions

1) What aspects of clinical learning help students feel confident in the clinical environment?

2) What aspects of clinical learning do not help students feel confident in the clinical environment?

3) What can clinical teachers do to build self-efficacy in nursing students?

Significance of the Study

There is an abundance of information on various techniques that clinical teachers use to enhance clinical student learning; some quantitative studies explore the role of self-efficacy in student learning in the clinical setting (Cheraghi, Hassani, Yaghmaei, &Alvi- Majed, 2009; Lauder et. al, 2008; Clark et al., 2004). However there is a gap in qualitative research done in this area. The intent of this study is to add to the literature on clinical teaching and learning through the voice of the student using self-efficacy as a theoretical framework. Exploring what helps students to feel confident in the clinical

setting through a qualitative study may provide valuable information for clinical teachers.

Qualitative research is important when a detailed understanding of a question is desired.

This detail can only be established through talking directly to individuals familiar with

the phenomenon of interest and allowing them to tell their stories unencumbered by what

is expected, or by what is in the research (Creswell, 2007). By doing qualitative research

individual voices are heard and power relationships between the researcher and the

participant can be minimized (Creswell, 2007).

This descriptive qualitative study explores which factors students think foster the

development of their confidence in the clinical setting using self-efficacy theory as a

guide. Using theory to drive research provides a guide for developing a study, and allows

the findings to be placed in or linked to a larger body of knowledge. Therefore using a

theoretical perspective increases the value of a study's findings (McEwan & Wills, 2007).

By further exploring pedagogical methods to increase the success of nursing students in

the clinical setting, using self-efficacy theory as a framework, significant findings may be

uncovered to revitalize and improve the future of nursing education.

Models of Clinical Practice/Education

The following section explores clinical practice models commonly used by

nursing schools in Canada focusing specifically on the practice model that is used by the

school of the participants in this study. The purpose for exploring these practice models is

to understand the context of this study. In 2003, the Canadian Association of Schools of

Nursing (CASN) completed an extensive review of the literature regarding current

clinical practice models used in North America and Australia. Five different models were

identified and described based on who is responsible for supervision of students: 1) direct

faculty-supervised model, 2) preceptorship model, 3) clinical teaching associate model, 4) dedicated education unit model, and 5) collaborative learning unit model (CASN, 2003, p.4).

Nursing students in the direct faculty supervision model of clinical education are assigned to a specific nursing unit under the guidance of a CT employed by the educational institution. The preceptorship model requires an experienced nurse to work on a one to one basis with a student in the clinical setting. This model is frequently used by students in their final practicum; however in recent years it has been adopted by some educational institutions to teach beginning courses as well. The clinical teaching associate model employs staff nurses from the educational institution to supervise students, while the faculty person serves as a lead teacher for the relationship and provides staff on the unit with research and educational opportunities. The dedicated education unit model develops a specific unit for teaching that specifically allows for the shared responsibility of teaching between the hospital and the educational institution. The collaborative unit model was developed by the University of Victoria, British Columbia and is an adaptation of the dedicated education unit model. The two most common models of clinical education in Canada are the direct faculty supervision and preceptorship models (CASN, 2003). The direct faculty supervision model is integral to this study and is described below.

Direct faculty supervision

Nursing students in this model of clinical education are assigned to a specific nursing unit under the guidance of a CT employed by the educational institution. The CT is responsible for developing the patient assignment for each student and overseeing the

teaching and learning done on the clinical unit. The CT is also responsible for student evaluations throughout the term. In this model, the CT acts as a facilitator, coach, role model, and evaluator (CASN, 2003, p.5). Students are informed about their patients prior to each experience so they can adequately prepare for the upcoming clinical day. The CT ensures that each student is adequately prepared for their clinical day by reviewing the assignment and asking questions to each student individually. During the shift the CT is responsible to ensure that all patients assigned receive expected care and that students are properly supervised by a qualified nurse when practicing new skills or unfamiliar procedures. Throughout the term the CT evaluates the progress of students and provides feedback to improve student clinical performances.

In the CASN (2003) survey faculty student ratios ranged from 1:6 to 1:10. Since students in Year 3 typically have an assignment of 2-3 patients each, this means that the CT may oversee the care for a potential of 12-30 patients. Although many educational institutions use this clinical practice model it is not without fault. Faculty, given their responsibility to the educational institution, may not be current in practice, and opportunities for student learning are often limited given that the CT cannot safely supervise too many students (CASN, 2003). Also, this model can be work-intensive for faculty and costly for the institution.

Theoretical Foundation: Self-efficacy Theory

Theoretical frameworks provide direction in regards to the selection of research design, methodology, and data analysis (McEwen & Wills, 2007). The conceptual framework for this study is based on Albert Bandura's (1997) self-efficacy theory. Self -efficacy theory is based on the belief that what people think, believe, and feel, affect how

they will behave. The intrinsic effects of their actions in turn can influence their thoughts, reactions and behaviour (Bandura, 1997). Self-efficacy theory is a relevant theoretical framework for building student skills, motivation, and confidence to deal with adverse patient care issues (McConville & Lane, 2006). An attractive aspect of self-efficacy theory for clinical teachers is the notion that a student's self-efficacy is malleable and can be enhanced through training (McConville & Lane, 2006).

Self-efficacy theory is considered to be an explanatory theory with a broad scope of purpose and operative generality (Bandura, 1997), and is well suited to guide this qualitative descriptive exploratory study on clinical student learning. There are several concepts to self-efficacy theory explained by Bandura (1997). Self-efficacy is the central concept on which self-efficacy theory is built upon. The concept of self-efficacy and outcome expectations suggests that outcome expectations are largely based on an individual's self-efficacy expectations. Freedom of choice is also a central concept to the theory. Freedom can be defined positively as the exercise of self-influence that brings about desired results. The concept of human agency or personal agency operates within a broad network of sociostructural influences; people are producers as well as products of their environments and as such have a hand in shaping their environments. How people interpret their own performance attainments informs and alters their environments and self-beliefs. As a result subsequent performances may be affected. Finally the concept of reciprocal causation suggests that individual cognitive ability, the environment, and performance behaviour are all factors that influence each other bi-directionally. These concepts as well as the four sources of self-efficacy information; mastery experiences,

vicarious experiences, social persuasion, and physiological and affective state will be further explained and described in Chapter Two.

Summary of Introduction

Chapter One first discussed the importance of examining and changing current clinical nursing education practice to better meet the needs of graduating nurses. The significance of the problem and proposed research questions were identified and explained. Current models of practice for nursing education were reviewed and discussed. A brief overview of self-efficacy theory and how it may relate to student learning was explained providing a firm foundation for Chapter Two in which a detailed examination of the current literature on the concept of self-efficacy and of current pedagogical methods to increase self-efficacy will be described.

Chapter Two

Literature Review

The primary purpose for reviewing relevant literature is to gain a background of information related to the question that is being investigated. A good literature review has a clearly defined logic that makes a case for the proposed study (Sandelowski & Barroso, 2003). Theorists now understand that conceptual meaning is pivotal in helping make their work valid. It is imperative that scholars define concepts clearly and distinctly so that readers may thoroughly and accurately comprehend what is discussed (McEwen & Wills, 2007). Analysing concepts in a study can be useful in in clarifying vague or ambiguous meanings so that everyone subsequently using the term will be speaking of the same thing (Walker & Avant, 2005).

Portions of the following literature review are based upon a concept analysis on self-efficacy and student learning in the clinical setting previously published by Townsend and Scanlan (2011). The review will first examine the concept of self-efficacy and analyze the meaning in the context of nursing education as well from other disciplines. Gaining a thorough understanding of the concept self-efficacy is the first step in understanding its significance in relation to clinical nursing education. Next, teaching and learning methods currently used by clinical teachers to enhance student learning will be reviewed and analysed to determine how these methods fit the theoretical framework of self-efficacy. Exploring how pedagogical methods presently used for clinical teaching relate to self-efficacy theory will provide a firm foundation for the methodology of this study.

This literature review is based on electronic searches - PUBMED, CINAHL, ERIC, SCOPUS, and PsycINFO – and books in the university library. Reference lists were reviewed to identify relevant articles not found in previous searches. Articles were eliminated that were repeated, did not address the concept, or were not obtainable in a timely manner.

Self-efficacy

Self-efficacy has been linked with career development and improved job performance (Lent, Brown & Larkin,1986; Betz, 2004) and with success in nursing education programs (Cheraghi et al., 2009; Lauder et al., 2008; Clark, et al., 2004). If research demonstrates that high self-efficacy beliefs improve job performance, encourage career development, and increase student success in nursing education, then self-efficacy should be a priority for nurse educators to understand, particularly the relationship of self-efficacy to student learning.

The following section will first discuss the definition of self-efficacy from the perspective of Albert Bandura followed by an overview of the concepts of self-efficacy theory. Definitions will be highlighted from dictionaries and thesauruses, and finally definitions will be presented in context from a broad review of the literature.

Bandura's Definition of Self-efficacy

Bandura (1977) first coined self-efficacy in his Social Learning Theory. At this time, Bandura defined self-efficacy as an individual's judgement of his or her abilities to accomplish specific tasks or objectives, and that self-efficacy is a mediating construct

whereby high levels of self-efficacy produce an approach behaviour and low levels of self-efficacy produce an avoidance behaviour.

By the mid 1980's Bandura transitioned from "Social Learning Theory" to "Social Cognitive Theory". In Social Cognitive Theory (1986), Bandura claims that human functioning is the product of a dynamic interplay of personal, behavioural, and environmental influences.

Bandura (1997) expanded the concept of human agency to include collective agency and once again renamed his theory to "Self-Efficacy Theory", whereby individuals work together on the shared beliefs of their capabilities and common aspirations to improve their lives. This conceptual extension renders the theory more applicable to human adaptation and change in both collectively oriented thinking, as well as in the context of individual thinking. In his book *"Self-Efficacy: The Exercise of Control"* (1997)*,* Bandura describes in detail the basic tenets of the updated version of his theory and demonstrates its applications for the fields of life course development, education, health and psychopathology, athletics, business, and international affairs. Bandura examines the contemporary conditions of life that undermine the development of collective efficacy and the new social arrangements that people strive for to achieve control over their lives. There are several concepts to Self-efficacy Theory described in the following section.

Self-efficacy and outcome expectations.

Self-efficacy can be defined as an individual's judgement of his or her abilities to organize and carry out the courses of action required to attain specific types of performances (Bandura, 1997). Self-efficacy beliefs provide the foundation for human

motivation, well-being and personal accomplishment (Resnick, 2004). Through reflective thought, use of knowledge and skills as well as other tools of self-influence, a person will decide how to behave (Bandura, 1997). There is a distinction drawn between the roles of self-efficacy beliefs versus outcome expectations (Parajes, 1997). Self- efficacy is a comprehensive summary or judgement of an ability to perform a specific task. It is a dynamic construct - as new experiences are acquired, self-efficacy beliefs are developed. The development of self-efficacy involves the construction of adaptive performance to fit changing circumstances (Resnick, 2004). Outcome expectations on the other hand are an individual's belief that certain behaviour will result in a specific outcome even though that individual may not believe that s/he is capable of performing the behaviour required for that outcome to occur. For example, a nursing student may believe that practicing in the skills lab may result in improved clinical performance, yet s/he may not believe that finding time to practice is possible. Therefore the student may not practice. In some circumstances outcomes are disassociated from self-efficacy expectations. For example, if the clinical course is graded using a pass or fail method, and student knows that s/he can "get by" without extra practice s/he may not be interested in practicing in the lab to improve performance.

According to Resnick (2004) some researchers have found that perceived self-efficacy expectations predict behaviour much better than outcome expectations, while others have found that outcome expectations explain behaviour beyond the influence of self-efficacy expectations. Pajares (1997) states that outcome expectations and self-efficacy are both important determinants of behaviour. Which one is more important may depend on the features and circumstances of each particular situation.

Freedom of choice.

Freedom of choice is achieved through reflective thought, generative use of the knowledge and skills at one's command, as well as other tools of self-influence where choice and execution of action are required (Bandura, 1997). People exert some influence over what they do by the alternatives they consider. They do things that give them self-satisfaction and a sense of self-worth. They refrain from behaving in ways that violate their personal standards because it compromises their own sense of integrity (Bandura, 1997). Allowing people to exercise freedom of choice to make a behavioural change is therefore a central consideration to make when using this theory. Encouraging freedom of choice allows students' to be a part of decisions regarding their own clinical learning giving them a sense of satisfaction and self-worth.

Personal agency and collective agency.

The power to originate actions for a purpose is the key feature of personal agency. In Bandura's previous work, conceptions of agent causality were related to individual agency. In self-efficacy theory, a much broader view of agency has been adopted. People do not live their lives in isolation; they often work together to produce the results they desire. Bandura (1997) asserts that the growing interdependence of social and economic life promotes the need to broaden the focus of inquiry beyond the exercise of individual influence to collective action that can shape the course of events. Therefore, in self-efficacy theory the analysis of personal agency has been extended to the exercise of collective agency.

Collective agency is an important concept in clinical education as it implies that clinical learning is not an isolated experience. The CT should consider the needs of the

entire clinical group and foster a teamwork attitude amongst students. Students need to

work together and help each other to promote overall learning of the group. As well, the

clinical teacher needs to build intra-professional relationships, and encourage group

thinking amongst hospital staff so that the entire health care team on the clinical unit is

made to feel that they have a valued role in student learning. A student may learn about

specific chest sounds from the chest physiotherapist, time management of morning care

from the nursing assistant, and how to offer emotional support to a grieving patient from

the spiritual care worker.

Reciprocal causation.

In self-efficacy theory, personal and collective agency operate within an

interdependent causal structure involving what Bandura terms as triadic reciprocal

causation. The term causation in this sense refers to mean functional dependence between

events. In this model of causality it is viewed that (a) personal factors in the form of

cognition, affect and biological events, (b) behaviour, and (c) environmental influences

all operate as interacting determinants that influence each other bi-directionally (Resnick,

2004; Pajares, 1997). Thus with triadic reciprocal causation sociostructural and personal

determinants are treated as interacting co-factors within a unified causal structure. A

study done by Livsey (2009) found a relationship between environmental, cognitive

(personal factors), and practice behaviour among nursing students supporting the notion

that nurse educators need to consider the importance of this relationship on the process

of teaching and learning.

Sources of self-efficacy information.

Self-efficacy beliefs are constructed by the processing of information from four principal sources: mastery experiences, vicarious experiences, social persuasion, and physiological and affective states (Bandura, 1997). These four sub-concepts are formed under the main concept of sources of self-efficacy information.

Mastery experiences.

Bandura (1997) explains that mastery experiences are the most influential source of efficacy information. There has been repeated empirical verification in the literature demonstrating that successful performance of an activity strengthens self-efficacy beliefs in many areas such as: smoke cessation (Heale, & Griffen, 2009); breast feeding (Nichols, Schutte, Brown, Dennis & Price, 2009); and weight loss (Matsuo, et. al, 2009). Mastery experiences strengthens self-efficacy beliefs better than any other informational sources (Bandura, 1997). It is important to recognize that performance alone does not establish self-efficacy beliefs. Other factors such as preconceptions of ability, the perceived difficulty of the task, the amount of effort put out, the situational circumstances, as well as past successes and failures all affect the cognitive evaluation of self-efficacy (Bandura, 1997). Simply put, individuals measure the effects of their actions and their interpretation of these effects to help create their self-efficacy beliefs. Outcomes determined as successful raise self-efficacy and those interpreted as failures lower it (Pajares, 1997).

Vicarious experiences.

The second source of self-efficacy information is the vicarious experience of the effects produced by the actions of others. This source of information is weaker than the

interpretive results of mastery experiences. However, when people are uncertain about their own abilities or have limited prior experiences they become more sensitive to vicarious experience (Bandura, 1997). As demonstrated in a study by Schunk (1987) the effects of models are particularly relevant for self-efficacy. A significant model in one's life can help instil self-beliefs that will influence the course that life will take. This is especially true when the person modelling the desired behaviour is similar to the person who is learning (Bandura, 1997).

Social persuasion.

Social persuasion involves telling an individual that s/he has the capabilities to master behaviour. Persuaders can play an important part in the development of an individual's beliefs; however effective persuasions should not be confused with unwarranted praise or empty inspirational speeches (Pajares, 1997). Persuaders must cultivate people's beliefs in their capabilities while at the same time ensuring that the envisioned success is attainable. Just as positive persuasions may work to encourage and empower, negative persuasions can work to defeat and weaken self-beliefs (Bandura, 1997).

Physiological and affective states.

Individuals rely in part on information from their physiological state in order to judge their abilities. Physiological indicators are especially important in relation to coping with stressors, physical accomplishments, and health functioning. Individuals evaluate their physiological state or arousal and if aversive they may avoid performing the behaviour (Resnick, 2004). Bandura (1997) has observed that people live with psychic environments that are primarily of their own making. In reading themselves they

realize the thoughts and emotional states they themselves have created. Often people can gauge their own confidence by the emotional state they are experiencing when contemplating the performance of an action. When people experience aversive thoughts about their capabilities they are unlikely to succeed (Pajares, 1997).

The aforementioned sources suggest that a student has multiple experiences that form his/her self-efficacy beliefs during a clinical term. For example enactive mastery experience, may take place when a skill is performed for the first time on a real patient verses in the lab. Vicarious experience may occur if a student has the opportunity to watch other students perform a skill they must also learn. Direct feedback from clinical teachers, buddy nurses, nursing peers and patients comes from verbal persuasion, and physiological reactions to the perceived stress of clinical may compose the last source of self-efficacy beliefs.

Dictionary Definitions of Self-efficacy

In the University of Notre Dame Latin Dictionary and Grammar Aid (n.d.) the word efficacy has its Latin origin in the word "efficasitas" meaning power, might, ability, or potency (para.1). In order to find a dictionary definition for the full concept of self-efficacy, it was necessary to explore dictionaries from specific disciplines. In The Academic Press Dictionary of Science and Technology (1992), self-efficacy is defined as "an individual's comprehensive sense of his or her own capabilities; those with adequate self-efficacy can cope with the demands of a wide variety of situations" (para 1). Taber's Medical Dictionary (2009) defines self-efficacy as "an aspect of self-perception postulated by Albert Bandura that pertains to one's belief in his or her ability to perform" (para1). Mosby's Dictionary of Complementary and Alternative Medicine (2005) defines

self-efficacy as "positive subjective assessment of one's ability to cope with a given situation; sense of personal power" (para 1). This latter definition is an interesting modifier, as self-efficacy may be low and interfere with performance.

Use of Self-efficacy in the Literature

A broad search of the literature identifies self-efficacy as a concept incorporated into the work of several professionals, and although most disciplines refer to the concept of self-efficacy using Bandura's original definition, the expectation outcomes do vary, depending on the context in which self-efficacy is used.

A person could refer to self-efficacy with respect to mathematics, investing in stocks, initiating social interactions, or fixing a flat tire. Self-efficacy can be discussed in a variety of ways and depending on the context in which it is referred, the many kinds of self-efficacy expectations are limited only by the possible domains that can be defined (Betz, 2004).

Examining usages of self-efficacy in other professions is helpful to understand how useful the concept is. Self-efficacy has been found as a major determinant in many non-health related fields such as teaching, engineering, and management. In engineering, a student's self-efficacy is the individual's belief in his or her ability to successfully negotiate the academic hurdles of the program (Concannon & Barrow, 2009). Arigbabu and Oludipe (2010) define teacher efficacy as a teacher's judgement of his or her capability to bring about the desired outcome of student engagement in learning, even amongst those students who are difficult or unmotivated. Hechter (2011) discusses the effect science content courses have on preservice elementary science teacher candidates'self-efficacy or confidence to teach science. In relation to management skills

self-efficacy is defined as the belief one is capable to accomplish a given task (Baron & Morin, 2010). In this instance, self-efficacy is associated with group efficacy, creativity, adaptation stress, productivity, performance, management, idea generation, and work performance. Computer self-efficacy is defined as a person's judgement or ability to use a computer, and is believed to influence a person's affect, motivation, persistence, and creativity with computers (Madhaven & Phillips, 2010). In sports, a substantial body of literature identifies a variety of factors that are predictive of self- efficacy regarding an athlete's success (Jackson & Beauchamp, 2010; Hays, Maynard, Thomas, &Bawden, 2007; Law & Hall, 2009; Moritz, Feltz, Fahrbach, & Mack, 2000).

Self-efficacy also is used for discussion and research in many health related fields, such as medicine, nursing, dentistry, and nursing education. Regarding paediatric resuscitation, Coolen, Loeffen, and Draaisma (2010) define self-efficacy as a predictor of behaviour, stating that doctors may fail to apply their resuscitation skills unless they have a strong belief in their own capabilities. In dentistry, the concept of self-efficacy was used to predict the brushing and flossing behaviours of patients (Buglar,White, & Robinson, 2010). Maternal breast feeding self-efficacy is also a popular topic in the literature. A study conducted by Nichols et al. (2009) determined that maternal self-efficacy is associated with significantly higher levels of breastfeeding practice.

Both Ferla, Valcke and Schuyten (2009) and Gore (2006) agree that a strong sense of self-efficacy influences a student's ability to take on more challenging tasks, persist longer in the face of opposition, better self-regulate the learning process, expend greater effort in accomplishing tasks, and apply more cognitive strategies to their learning. Zimmerman (1995) defines academic self-efficacy as a student's personal

judgement about his/her capability to organize and execute the activity required to achieve a designated type of educational performance. Cheraghi et al. (2009) posit that an accurate measure of self-efficacy can be used to predict the performance of nursing students and has an important impact on the education of future nurses. Individuals who perform nursing skills unsuccessfully are likely to do so, not because they lack the ability to do the skills, but because they lack self-efficacy to perform the skills successfully. If an individual perceives s/he is competent to perform the necessary nursing skills, s/he will improve in the performance of these skills (Fereday & Muir-Cochrane, 2006).

Defining Attributes of Self-efficacy

Defining attributes are consistently occurring characteristics of a concept helping distinguish it from others (Walker & Avant, 2005).When considering Bandura's definitions of self-efficacy, dictionary definitions of self-efficacy, and the literature reviewed on self-efficacy in context, the defining attributes of the concept become apparent. Capability, persistence, effectiveness, performance ability, motivation, and confidence are keywords that occurred repeatedly in the definitions that were determined to be most appropriate for student learning in the clinical setting. These key words were extracted from the many reviewed descriptions of self-efficacy, and although they all give meaning to the concept, none of them are capable of standing alone to capture the true meaning of the concept. For example, motivation to change behaviour is a necessary part of self-efficacy; however it does not define a student's ability to achieve the goal. Similarly, performance ability does not reflect a student's confidence or perceived ability to achieve a goal. A student may well have the ability to produce a change, but because of lack of confidence, may not make the attempt (Townsend & Scanlan, 2011).

Mowat and Spence Laschinger (1994) claim that human beings with a high level of self-efficacy have the following four characteristics in common: a firm belief that they are capable of performing a task (confidence), the ability to carry out the task (capability), the ability to be successful at the task over time (persistence), and the ability to perform in stressful situations (strength). These attributes also define self-efficacy in relation to student learning in the clinical setting. For example, students with increased self-efficacy asked to perform a complex skill in the clinical setting, first should believe they can perform the skill; have the physical and mental capability to perform the skill; be willing to persist at trying to succeed at the skill despite having failed the first time; and finally, be able to perform the skill successfully even in a stressful situation. Without these four attributes, a student's self-efficacy is probably low and successful performance of the skill is not likely.

Pedagogical Methods to Increase Self-efficacy

As stated in chapter one baccalaureate education must develop nurses who are capable of practicing as caring professionals using a broad range of competencies and critical thinking skills. Strengthened self-efficacy increases the probability that learners will become more engaged in learning and will persist in moderately challenging tasks, making meaningful gains in their learning (Margolis, 2005). If high self-efficacy beliefs equate to better learning and improved performance, then understanding and further developing pedagogical approaches to enhance learner self-efficacy will ultimately lead to improved clinical competence for nursing students (Pike & O'Donenell, 2010).

The following section will present findings from the literature regarding pedagogical methods currently used by clinical nurse teachers in the clinical setting, and

will identify how each of these methods can be linked to one or more of the four sources of self-efficacy. As previously mentioned the four sources in order of importance are: mastery experiences, vicarious learning, social persuasion, and physiologic response (Bandura, 1997).

Clinical simulation.

Clinical Simulation is a teaching and learning strategy that aims to replicate real life experiences. The use of simulation as a method of teaching and learning is gaining popularity with nursing education. Simulation methods may vary from the use of highly technical computerized mannequins to role play (Pike & O'Donnell, 2010; Bambini Washburn & Perkins, 2009; Sinclair & Ferguson, 2009). Clinical simulation supports Bandura's (1997) theory stating that a student's prior knowledge is an important foundation to further learning. The clinical simulation experience allows the student to use knowledge they learn in the classroom to hands on patient care without jeopardizing patient safety. Students participating in simulations using case studies and role play reported overall increased self-efficacy following the simulation experience (Sinclair & Ferguson, 2009; Bambini, Washburn & Perkins, 2009; Pike & O'Donnell, 2010; Parker & Myrick, 2010; Papp, Markkanen & Mikaela, 2003).

Sinclair and Ferguson (2009) state that the clinical simulation experience benefits student learning for the following reasons. First, clinical simulation increases the self-efficacy of a student to perform in the clinical setting based on prior success (mastery experience). Also, a student working with peers may learn through watching others similar to him/herself (vicarious learning). The immediate feedback that a student receives as part of the simulated experience from the simulator, the teacher, or peers

further develop a student's sense of self-efficacy (social persuasion). Finally, overall anxiety levels significantly decrease as the student becomes more confident to practice in the clinical setting as a result of the clinical experience gained through simulation (physiologic response).

Critical thinking.

Critical thinking is the process students use to solve clinical problems (Reilly & Oermann, 1999). The CT has the opportunity to enhance learning by questioning students and encouraging them to think critically by the use of reflective questions. The CT also can stimulate a student's reflective thinking and encourage problem solving skills through probing questions (Hanson & Stenvig, 2008). Another way to stimulate critical thinking is to give the students a cue when they need to be extra attentive. This probing technique is used to promote critical thinking and reflective skills (Carlson, Wann-Hansson, & Pilhammar, 2009). An example probing question might be "Something here is important. What do you thing that might be"? To further enhance critical thinking skills, students are encouraged to verbalize their thinking and opening up a dialogue between student and teacher (Carlson et al., 2009). Hanson and Stenvig (2008) reported that stimulation of critical thinking in the clinical setting is an attribute to the learning process. One student summed it up as "someone who can get me to think on my own rather than just giving me the answer". Another student in the study stated how it was beneficial to have someone "help click all that information through". Hanson and Stenvig (2008) give a good example of probing clinical questions such as: "Why is it important to follow vital signs after surgery"? or "What might cause a low blood pressure post-operatively "? Clinical educators typically use "what if "? questions to help students

extend their thinking about a situation (Benner et al., 2010). Asking students to think about what would happen to their patients if something in the situation was different encourages the student to think about similar patients in varying circumstances or similar circumstances with varying patients (Benner et al., 2010).

In summary, posing critical thinking questions may help nursing students draw on previous knowledge to enhance their learning in the present (mastery experiences). Opening a dialogue between student and teacher during this encouragement of critical thinking allows the opportunity to praise and encourage students (social persuasion), and build positive interpersonal relationships which Tang, Chou, and Chiang (2005) assert decreases anxiety (physiologic response). Also, during the question period, the clinical teacher can share experiences of his/her own or those of other students in order to promote further learning (vicarious learning).

Reflection / post-conference.

Clinical learning for students typically occurs in a fast paced health care environment. Traditionally a post-conference session is held at the end of the clinical day providing a forum for students and the clinical teacher to process the day's experiences and learn from them (Hermann, 2006). Meeting for discussion and review after a clinical experience has a positive effect on student learning (Hanson & Stenvig, 2005). The value and significance of reflection on an experience is key to learning from it (Hermann, 2006). Clinical conferences give students the opportunity to share their knowledge through reflection and provide a forum for discussion and critical thinking (Hsu, 2007; Hermann, 2006). Lau and Chuk, (2002) state that a clinical conference session provides a comfortable time in which students can exercise their reflection skills. It is important

for clinical teachers to take the time to reflect and hear students' views on how the day went and how the student felt about it (Burns, Beauchesne, & Ryan-Krause, 2006).

In summary, the literature on reflection/ post-conference infers that during clinical post conference student nurses can learn by reflecting on and learning from their own clinical experiences (mastery experiences) as well as learning from the experiences of other students (vicarious learning), and that post conference is an ideal time for clinical teachers to share experiences with students and offer support and encouragement (social persuasion). The camaraderie that can be achieved by building interpersonal relationships with peers and the clinical teacher in this more relaxed atmosphere can also decrease the overall clinical anxiety of the student (physiologic response).

Positive learning environment.

The clinical environment has a great influence on whether student nurses regard their clinical accomplishments to be successful or not. Livsey (2009) posits there is a direct relationship between student perceptions of motivation, confidence, and self-directed learning. Findings from this study support the notion that baccalaureate nursing programs need to examine and evaluate environmental influences when determining sites for clinical placements.

A learning environment consists of many elements and can be difficult to control. There are a lot of stimuli that make it hard for students to pick up what is essential to know. Clinical teachers need to prepare student nurses and nurse mentors in advance for encountering this enormous amount of stimuli offered by the clinical environment and take charge (Papp, Markkanen & Von Bonsdorff, 2003). When students do not feel accepted, learning cannot proceed (Lofmark & Wikblad, 2001). If students are made to

feel like they belong and are trusted in the clinical environment they will be more

successful (Lofmark & Wikblad, 2001). Bandura (1997) posits that self-efficacy beliefs

and the impact the environment has on shaping these beliefs ultimately influence

behaviour.

To summarize, student nurses need to feel appreciated in their clinical practice

and feel part of the team. By encouraging peer and staff support of student learning

students may have a greater level of self- efficacy as a result of learning from staff and

peers in a positive manner (vicarious learning) and by positive verbal feedback and

support given by ward staff, patients and peers (social persuasion). As well, if a student

feels more comfortable with staff and the overall environment, they will feel less anxious

thereby increasing their self-efficacy to succeed with clinical tasks (physiologic

response).

Clinical teacher behaviour.

The CT in his/her role of both a teacher and an evaluator is a pivotal member of

the student's clinical learning (Allison-Jones, & Hirt, 2004). The CT is responsible to

facilitate an individualized education and provides a learning environment where

theoretical knowledge is linked to practical skills (Carlson et al., 2009). Tang et al.,

(2005) suggest that teachers' attitudes toward students rather than their professional

abilities are the crucial difference between effective and ineffective clinical teachers.

Hanson and Stevig (2008) state that educator knowledge, interpersonal presentation, and

teaching strategies are all positive clinical educator attributes. In a study conducted by

Tang, Chou, and Chiang (2005) it was found that students considered interpersonal

relationships to be the most important attribute of an effective clinical teacher. This study

suggested that it is the teacher's attitude toward students rather than the teacher's ability that is the most crucial factor in effective teaching. The teachers supportive and friendly attitude played a significant role in decreasing the amount of stress a student has in the clinical setting (Tang et al., 2005).

To summarize, according to the above mentioned studies, a CT's attitude and encouragement toward students is considered to be the most important attribute of an effective CT (social persuasion). It was considered less important to a student's learning for a clinical teacher's to facilitate optimal learning experiences. If a student felt that the CT was respectful of the students and had a positive attitude they reported decreased levels of stress in the clinical setting (physiologic response).

Summary of Literature Review

In this chapter a thorough examination and review of the concept self-efficacy was demonstrated. Definitions of self-efficacy were found from a variety of sources and through the examination of these definitions, defining attributes of the concept of self-efficacy were formed. Current pedagogical methods of clinical teaching and learning found in the literature were reviewed and discussed in relation to self-efficacy. By examining current pedagogical methods for clinical nursing education using self-efficacy theory as a guide, a strong relationship between self-efficacy and clinical student learning is evident, building the case for further research to be done in this area. Further exploration of why students feel confident to succeed in some clinical areas and not in others, and what clinical teachers can do to increase a student's feelings of self-efficacy during clinical practice is a first step in understanding what nurse educators can do to

improve the future of clinical nursing education. Chapter three will discuss the

methodology for this research.

Chapter Three

Methodology

In this chapter the research methodology for this study will be examined. First, an explanation of the study's design, sampling plan, method of recruitment and setting will be provided. A description of the method of data collection, treatment, and analysis will be discussed. The chapter will end by discussing ethical considerations and highlight how the study's results will be disseminated.

Research Design

A qualitative research design is beneficial to use when a problem needs to be explored, and the researcher needs a complex detailed understanding of the issue. This detail can best be established by talking directly with individuals familiar with the phenomenon of interest, allowing them to tell their stories unencumbered by what is expected or what is in the literature (Creswell, 2007).

Qualitative research has become immensely popular in the practice disciplines (Sandalowki & Barroso, 2003). Benner et al. (2010) conducted extensive qualitative research yielding a rich array of findings both general and particular about nursing students and educator's experiences with nursing education. Their research serves as valuable groundwork for this researcher's current study which explores self-efficacy and student learning in the clinical setting. This qualitative study aimed to empower nursing students by allowing individual voices to be heard through the results of the research. Through the voice of the participants, important knowledge was gained that can be utilized to improve nursing education.

Qualitative descriptive studies offer a comprehensive analysis of an event in everyday terms. Researchers use a descriptive qualitative method to seek descriptive validity or an accurate account of events that most people (including researchers and participants) who observe the same event would agree is the same (Sandelowski, 2010).

As demonstrated in the previous chapter there are many studies in the literature exploring self-efficacy and learning in many domains. This study adds to the literature by further exploring self-efficacy and student learning in the clinical setting. A qualitative design using a descriptive approach was chosen to explore and gain a deep understanding of how students perceive and experience the development of self-confidence in the clinical practice setting. It should be mentioned that in the literature clinical educators are most often referred to as CTs. The students of this study refer to CTs as Clinical Education Facilitators (CEFs). For the remainder of this thesis CTs will be identified as CEFs.

Sample.

Virtually any purposeful sampling technique can be used for qualitative descriptive studies (Sandelowski, 2010). The ultimate goal of purposeful sampling is to obtain cases that are rich in information for the purpose of the study. The obligation of researchers is to defend their sampling strategies as being reasonable for their purpose (Sandelowski, 2000). Interpretive descriptive data are meant to generate knowledge that require a purposeful selection of participants whose accounts reveal, to some degree, elements that are shared by others (Thorne, Reimer, Kirkham, & MacDonald-Emes, 1997).

The strategy used for the participant selection process in this descriptive study was purposive. Creswell (2007) states that the concept of purposeful sampling is often used in qualitative research, in which the researcher selects individuals and sites for study because those individuals can purposefully inform an understanding of the research problem and the central phenomenon of the study. Approximately 10 baccalaureate nursing students meeting the criteria of a fourth year nursing student in the baccalaureate program were asked to participate in this study. Fourth year clinical nursing students were chosen because these students have more clinical experiences to draw from then students in earlier years of the program.

Recruitment.

To recruit students the researcher adhered to the following procedure. The Dean, Faculty of Nursing University of Manitoba was contacted by letter to request access to fourth year baccalaureate nursing students (Appendix A). This letter included a brief description of the study and information about how students would be contacted. The letter also included information about how the students would be ethically protected during the research process. Once access was granted by the Dean, fourth year theory course leaders were contacted to request 10 minutes of their class time for recruiting. Class time was used to explain the study and invite nursing student participation. The researcher used a script to help explain the study in a thorough and consistent way (Appendix B). Students were then given a letter outlining the study that included the researcher's phone number and email address (Appendix C). Attached to the letter was a response sheet for interested students to complete with their name and preferred method of contact if they wanted to participate in the study (Appendix D). Students were asked to

drop off their letters in a confidential drop off box at the front desk in the Faculty of

Nursing. Students were told that the first 10 names drawn from the box who wished to

participate would be contacted to arrange an interview.

Setting.

Once the researcher obtained 10 students willing to participate in the study

arrangements were made to meet each student at a mutually convenient time in a private

room outside of the Faculty of Nursing to ensure that student confidentiality was

maintained.

Data collection.

In this study students were asked to share their experiences of learning in the

clinical setting and were asked more specifically to give their perspectives on what made

him\her feel more confident or less confident in the clinical setting. Students were asked

questions related the concept of reciprocal causation as well as the four sources of self-

efficacy. Creswell (2007) suggests it is important to determine what type of interview is

practical and will allow the most useful information. For the purpose of this study a one

to one interview using a semi-structured interview guide with seven open ended questions

was thought to be most appropriate. Bandura's 1997 self-efficacy theory was used to

develop the interview guide designed to explore participant perspectives regarding the

effect of self-efficacy regarding student learning (see Appendix E).

Each interview proceeded in the following manner. At the introduction of the

interview the researcher initiated a brief social conversation to establish a comfortable

rapport between the researcher and participant. Following this brief introduction, the

researcher proceeded to explain the purpose of the study and reinforce how

confidentiality and anonymity would be maintained. The researcher then explained that all raw data would be labelled with a code number and that the participant's names and matching code numbers would be together only on the consent form. This consent form would be accessible only to the researcher. The consent forms would be stored in a locked filing cabinet separately from the transcripts. Two copies of the consent form were then given to the participant to review and sign (Appendix F). The participant and researcher each retained one copy.

Participants were informed that if an unsafe practice situation were revealed during the interview, the researcher would be ethically obligated to end the interview and the unsafe practice situation would be reported to the Associate Dean, Undergraduate Programs, for further investigation; and the students name may be revealed to the Associate Dean if further information were required. After consent was obtained each participant was asked to complete a demographic question sheet identified by code only describing specific information about them (Appendix G). The participants were then encouraged to answer all the questions freely or not answer the questions if they chose. Participants were informed that the interview would be audio tape recorded on a digital recorder so they could be transcribed later to facilitate data analysis. During the interview the researcher asked each participant all of the pre-composed questions, while remaining flexible with the order to maximize the flow of the interview. Caution was taken to allow appropriate time for the participant to answer questions, and probes were used to encourage participants to share further information. By using probes such as, "tell me more", the participant was encouraged to share information. The researcher also was cautious to complete the interview within the time frame discussed with the participant

and made every attempt to be unbiased and non-leading during the interview. As stated by Creswell (2007), a good interviewer is a good listener.

By interviewing 10 participants enough data were collected to achieve data saturation. Data saturation refers to the repetition of discovered information and confirmation of previously collected data (Morse, 1994). Streubert and Carpenter (2011) state that data collection should continue until the researcher believes that data saturation has been achieved, that is, when no new themes or messages have emerged from the participants and the data are repeating. If more data were required to achieve data saturation, then more students would have been contacted using the same aforementioned method.

Data treatment.

The tape recorded interviews were reviewed and transcribed in privacy by a hired transcriptionist. The transcriptionist was asked to sign a confidentiality pledge (Appendix H) before transcribing began. The audiotapes and transcriptions were assigned a code number. The participant's names and corresponding code numbers were kept confidential in a locked drawer in the researchers filing cabinet separated from the data. Following the transcription the tapes were reviewed again to check for any information missed during the original transcription and to note any nuances in the speech of the participant such as laughter, silence, or hesitancy.

Data analysis.

Analyzing text and other forms of data may also present a challenge for qualitative researchers (Creswell, 2007). Data analysis in qualitative research consists of preparing and organizing the data for analysis, then reducing the data to find themes

through a process of coding and condensing the codes. Data are then represented in figures tables or a discussion. The study Success in the Clinical Setting: Nursing students' Perspectives used the following method to analyze data.

- The researcher read through the transcribed interviews twice and highlighted significant statements from each interview.

- Significant statements were reread and grouped into larger units of information termed "meaning units" or themes (horizontalization of the data).

- Significant statements under each theme were reread and categories and subcategories under each theme were developed.

- Transcripts were read by the researcher's thesis chair and emerging themes were discussed.

- One participant was chosen by convenience to read the findings and check the appropriateness of the themes, categories, and sub-categories generated from the data.

- The researcher wrote a description of the findings grouped into themes with categories and subcategories. This was written in paragraphs illustrating for the reader the essence of students' experiences with confidence in the clinical setting. Quotes were used to support the analysis, however reference to all students and CEF's in the quotes were changed to a feminine gender to protect anonymity. Care was taken not to use quotes that may identify any person.

Means of Establishing Trustworthiness

The goal of or trustworthiness in research is to accurately represent the experiences of study participants (Streubert & Carpenter, 2011). Research should be as trustworthy as possible and may be evaluated for trustworthiness by examining the procedures used to generate the findings (Graneheim & Lundman, 2004). Although there is a plethora of literature regarding rigor in qualitative research and trustworthiness of findings, Lincoln and Guba's (1985) criteria are commonly referred to by multiple authors (Polit & Hungler, 1999; Granheim & Lundman, 2004; Streubert & Carpenter, 2011) and therefore were used to guide the trustworthiness of this research. Lincoln and Guba (1985) suggest four criteria to establish the trustworthiness of data i) credibility, ii) dependability, iii) transferability and iv) confirmability.

Credibility.

Credibility is defined as confidence in how well the data and process of analysis address the intended focus of the study, and includes activities that increase the probability that credible findings are produced (Lincoln and Guba, 1985). Credibility can be enhanced through the triangulation of data. Triangulation is a method used to enhance trustworthiness by using more than one research strategy with the assumption that the strengths of one approach helps to compensate for the weakness of another (Streubert & Carpenter, 2011). Triangulation was used in this study to increase the credibility. Interviews were tape recorded and reviewed immediately after the interviews to gain an initial understanding of the data. The interviews were transcribed by a transcriptionist and each written transcription was reviewed and checked against the original recording for

accuracy. Evidence was discussed with the thesis chair and incongruent cases were reviewed and discussed to enhance credibility.

One of the best ways to establish credibility is through prolonged engagement with the participants (Streubert & Carpenter, 2011). The researcher has had experience in working as a clinical teacher for 14 years. As a consequence, the researcher was aware of the overall clinical practice experience, and developed her own opinions about how to help students increase their self-efficacy in the clinical setting. Possible effects of prolonged engagement were taken into consideration. Since the researcher had a good understanding of the clinical practice environment and how students interact in that environment it was easier to verify the findings of this study against the researcher's own personal experiences. On the negative side, the researcher's prolonged engagement with the students in the clinical setting could possibly interfere with objectivity. In an effort to decrease researcher bias and be reflexive the researcher reflected upon, and wrote a list of assumptions and beliefs about clinical student learning (Appendix I). By acknowledging her opinions values and beliefs prior to data collection and analysis the researcher attempted to bracket individual ideas and eliminate the impact of the insider perspective on the data analysis by listing them.

Member checks are another way to check the credibility of findings is to see whether the participants of the study recognize the findings to be true to their experiences (Lincoln & Guba, 1985). The researcher asked one student to read and check the findings generated to check for accuracy of theme development. The student agreed that the themes generated made sense and verbalized that she could relate to the findings generated.

Finally, peer debriefing was used to enhance credibility of this study. Peer debriefing is a process of exposing one's ideas to a peer for the purpose of exploring aspects of the research that would only remain within the researcher's mind (Lincoln & Guba, 1985). Debriefing with the thesis chair and internal committee member (nurse educator) helped the researcher to consider credibility of the study through discussion of the process of the study at every step. These discussions allowed the researcher to clarify her thoughts on how to complete this research study in a trustworthy manner.

Dependability.

Dependability can be described as the stability of the study over time, and the degree to which the measurement stays the same (Streubert & Carpenter, 2011). Issues of dependability have typically received little attention from qualitative researchers who have focused more on achieving greater credibility in their work (Streubert & Carpenter, 2011). Lincoln and Guba (1985) suggest that since there can be no credibility without reliability; an establishment of the former is necessary to demonstrate the latter. Lincoln and Guba (1985) propose that reviewers examine both the process and the product of the research for consistency. Another researcher should be able to examine the data and arrive at similar conclusions. In this research both the chair and internal member of the thesis committee examined the process of the research, including reading one transcript, and the findings generated , which enhanced the dependability of this study.

Confirmbility.

Confirmability is a criterion confirming the process of the research. One way to document the confirmability of findings is by leaving an audit trail. An audit trail is a recording of activities over time that may be followed by other readers of the study

(Lincoln &Guba,1985). The purpose of an audit trail is to illustrate the evidence and thought process that led to the conclusions as clearly as possible (Streubert & Carpenter, 2011). The methodology of this study is described in detail in this chapter, allowing other researchers and readers to follow how data were gathered and analysed. Data are categorized in Chapter Four, and the discussion of findings are linked to these data in Chapter Five.

Transferability.

Transferability refers to the probability that the study findings have meaning to others in similar situations (Streubert & Carpenter, 2011).This probability depends on the situation to which the research is being transferred. The researcher cannot specify the transferability of findings; however can provide sufficient information that can then be used by the reader to determine whether the findings are applicable to a new situation (Lincoln & Guba,1985). A purposive sample of forth year students with multiple clinical experiences was selected to ensure the data were rich, however the participants were all fourth year students from one university using one clinical teaching model. This may limit the transferability of findings and should be considered by those reading he results of this study.

Ethical Considerations

A qualitative researcher faces many ethical issues that surface during data collection, analysis, and dissemination of results (Creswell, 2007). Three major ethical principles guide researchers: autonomy, beneficence, and nonmaleficence (Wood & Ross-Kerr, 2006). After permission to proceed with this study was granted from the University of Manitoba Nursing/ Education Ethical Review Board, and access to students

was granted by the educational institution, the researcher proceeded with the plan to initiate this study considering the aforementioned ethical principles.

Autonomy.

Autonomy refers to an individual's right to self-determination. People are considered to be individuals each having worth, and the freedom to decide whether or not to participate in a research project. The participant must feel that he/she has freedom to make a decision. There must be no known coercion to participate either overtly or covertly. Furthermore, participants need to be informed how privacy will be maintained (Wood & Ross-Kerr, 2006).The researcher obtained informed consent from the research subject by providing adequate information in a form that was clearly understandable to the participant, so that s/he was able to judge whether or not to participate (Wood & Ross-Kerr, 2006).

The researcher of this study verbally explained the purpose of the study and the participants' role in the study in the initial meeting with students. Following the explanation a consent form explaining the study was handed out to all attendees of the class. Those students who consented to participate in the study indicated their willingness on the consent form as well as their contact information and dropped off the form to a confidential drop box at the front desk of the University of Manitoba, Faculty of Nursing. The first10 names of students pulled from the box were contacted. The researcher arranged a mutually convenient time and place outside of the Faculty of Nursing to meet. Before each interview the researcher once again verbally explained the study and how the data collected would remain confidential. This information also was indicated on a

consent form for the participant to sign before the interview began. The participant was given a copy of the consent form.

The researcher disclosed all information regarding the study and did not conceal any information regarding the methodology of the study or the dissemination of the results. The data collected remained anonymous as was previously described. The interviews were conducted privately and the results remained confidential. In no way was the participant's name or any other identifying features used in any materials disseminated. All students, CEF's, and health care workers identified in the interviews were addressed as feminine in order to further protect anonymity. Students were informed that in no way would participation or non- participation in the study affect a student's standing with his/her Faculty of Nursing. The researcher did not anticipate that the students' lives would be affected in anyway by answering the interview questions, however if a student became distressed while discussing a negative clinical experience, I planned to stop the interview and ask the student if s/he wanted to end the interview. In addition, the student counselling and career centre phone number would be offered so that the student could seek further follow-up counselling. There were no students that became distressed during the interview process.

Beneficence.

Beneficence is the principle of "doing good" for another. Doing good for another person requires that someone makes the decision that the act will be good for the individual (Wood & Ross-Kerr, 2006). The researcher explained that the benefits of this study will be of no direct benefit to the participants themselves, but that future students may benefit as a result of this study.

Nonmaleficence.

Nonmaleficence or "do no harm" requires that the researcher do no direct harm, although indirect or unanticipated harm may occur (Wood & Ross-Kerr, 2006). There was no physical or emotional harm as a result of this study.

Communication of Findings

To disseminate the knowledge gained in this study, the researcher plans to publish the findings, in the form of an article, in an appropriate peer reviewed nursing education journal. As well, the researcher will offer to present the findings at nursing education conferences, or to other clinical nurse educators in their place of work. Finally, a summary of the study's findings will be provided to those participants of the study requesting a copy.

Limitations of the Study

The interview process was an effective method to explore the nursing students' perspectives on feeling confident in the clinical setting, however several limitations need to be considered. Data were collected from a purposive sample of ten 4th year students from one mid-western Canadian university nursing program using the direct faculty supervision model. Although the data collected were rich and meaningful, it is possible that students from another educational institution in another place using a different model of teaching may have different perspectives of clinical learning. For example if students were learning under the preceptorship model, the responsibility of teaching lies mostly with the experienced hospital nurse employee rather than with a clinical teacher from the student's educational institution. This may change the dynamics between the student and

hospital staff therefore changing perceptions of student's clinical experiences. Also, all nursing students were in 4th year, and all those who volunteered to be interviewed were female, therefore potentially limiting the perspectives of male nursing student and/or students from other years of the program. This small purposive sample may limit the transferability of the findings.

Another limitation of this study may be the truthfulness and memory of the participants. Although the researcher purposely did not interview her own students it may be possible that the participants were not always truthful with their answers simply because they wanted to give answers that would please the researcher and put them in a good light. Also, it must be considered that students would likely not recall every clinical experience, therefore limiting the accuracy of results.

One final potential limitation to consider is the use of self-efficacy theory to guide the questions. The researcher reflected on the theory when developing the interview questions in an effort to gain clear and meaningful results; however, using self-efficacy to guide the development of questions may have led the students' answers. Using less structured questions and more open questions may have broadened the accuracy of results.

Summary of Methodology

In this chapter the research design and methodology were examined and justified. A descriptive qualitative study was chosen for the purpose of this study. Details of the study design, sample, method of recruitment and setting were provided. Following this, a description of the method of data collection, transcription of data, and analysis of data

were discussed. Finally, the chapter discussed trustworthiness of the findings, ethical

considerations and limitations of the study.

Chapter Four

Findings of the Study

The purpose of this study was to explore students' perceptions and experiences of feeling confident in the clinical setting with the goal of uncovering what clinical teachers might do to increase students' feelings of self-efficacy during clinical practice. To gain a true understanding of what helped or hindered a student to feel confident in his/her previous clinical experiences, one to one interviews were done with ten students. As the researcher progressed through each of the ten interviews it became apparent that the students were eager to share information and wanted their voices heard. Students realized the impact that feeling confident has on their clinical success and wanted to share their experiences to improve the future of nursing education.

> *Once your confidence is shaken you kind of start to hate clinical... If you are confident you kind of like clinical, like you don't dread getting up in the morning and going. (Student 4)*
>
> *If you are afraid to do anything you don't get a good experience... I have learned most of my nursing in clinical and I have been looking at my good clinical rotations where I have learned a lot, but the people who did not have very good clinical rotations, it can either turn them off about that particular ward or even nursing all together. (Student 10)*

In listening to the voices of ten fourth year nursing students three major themes emerged from the data as important influences to student clinical confidence: i) the clinical education facilitator (CEF), ii) the clinical environment, and iii) the student learner. The CEF was considered by students to be the most important influence to

clinical confidence, and therefore was the most developed theme having numerous categories and subcategories.The clinical environment presented itself as the second most important influence to clinical confidence yielding a few categories, some with subcategories. The third theme, the student, was less developed than the other two with a small number of categories and no subcategories.

Although the three themes will be described as separate entities, all three themes interact and impact one another as students learn to practice. For example the actions of the CEF are sometimes influenced by what is going on in the clinical environment. As well, a stressful environment can often lead to an anxious CEF which may affect the rapport between student and CEF. Moreover, the disposition and confidence of the student may also influence the rapport between student and CEF therefore affecting the type of learning opportunities in the clinical environment s/he is assigned.

Description of Study Participants

Ten fourth year students in the Faculty of Nursing, University of Manitoba were recruited. All of the students had multiple clinical placements from previous years. The nursing students that volunteered were all female and under the age of thirty.

Theme 1-The CEF (CT)

The CEF was considered by all students interviewed to be the most important influence to success and confidence in the clinical setting.

> *If you get a bad CEF then it is game over. (Student 10)*
>
> *I kind of want to be a CEF some day... I just think you can make such a difference in a student's experience...a big part of your clinical experience*

is your instructor... they can make you feel confident, or not confident.

(Student 1)

Students wanted CEFs to know and understand what kind of impact the teacher has on the students' clinical experience and on a students' future nursing practice. They suggest CEFs should be reflective and recognize what their strengths and non-strengths are.

I think a CEF should really want to be a teacher and respect what kind of a power that a teacher has. I think they need to recognize maybe some of their own issues, you know strengths and non-strengths... I think you need to be sort of personally invested to a point where you care about every single one of the students and you want to help them... I think it's a really, it's an important relationship, it really sets the tone, like a bad experience for a student it can really affect you right into nursing practice and how you deal with others in sort of a position of authority. (Student 7)

Students made it clear in their interviews that what the CEF does in the clinical setting has a significant impact on their self-confidence and consequently on their ability to learn. There were seven categories some with subcategories that emerged from the responses of the students about the CEF. The categories were: a) inferential behavior, b) clear expectations, c) verbal encouragement, d) letting go, e) being a safety net, f) cueing and prompting, and g) giving feedback.

Inferential behavior.

Students described that how the CEF presented herself to the students and the impression she gave right from the start of the clinical experience had a

significant impact on student self-confidence and learning. Students were sensitive

to the messages sent though a CEF's body language, choice of words, and tone of

voice. There were three subcategories that emerged under the category of

inferential behavior. Students stated that if a CEF could i) set a positive tone, ii)

stay calm, and iii) make the student feel welcome these behaviors made a

significant difference in the student's ability to feel confident and learn in the

clinical setting.

Set a positive tone.

Students wanted a CEF who appeared enthusiastic about her job and about teaching

students. The first impression given by the CEF set the tone for the whole experience.

>*That first meeting with your CEF is huge… just sort of calming your*
>
>*nerves or if they meet you with a smile, or if they would be a more serious*
>
>*personality it really affects how you go into your rotation… Just this*
>
>*rotation I just went through meeting my CEF for the first time… I could*
>
>*tell right away she was very intelligent and sort of more quiet but really*
>
>*excited, it was a quiet excitement and over the past few weeks she just,*
>
>*she's just gotten to be this phenomenal CEF for me, just a great*
>
>*mentor/guider but the first impression is everything. If you meet someone*
>
>*and they're just not, um, there's not this openness to them or even a smile*
>
>*it makes a huge difference… Going in beforehand and hearing from a*
>
>*teacher that it's going to be okay and that you're going to really enjoy this*
>
>*rotation and sort of giving you an idea of what you're going to be going*
>
>*through beforehand, that makes all the difference. (Student 6)*

The same student went on to describe that the body language of the CEF or whether or not she smiled made a long lasting impression. She wanted a CEF who sent the message that she wanted to teach students, and that realized the importance of her job.

> *The whole rotation I look back on it slightly negatively because from the very beginning she wasn't excited to work with students, um she, she was just there and it felt like she was doing her job, if that makes sense... I don't want someone who just wants, whose just there to be there... I want someone who is there because they want to help shape future nurses. There's some CEF's who, who just go into this just to do it and I think that they don't really realize that they're shaping someone's future, they're shaping a person's entire career really in how they hold themselves and work as a nurse... It's um, it's, it's a relationship that we need right from the beginning to be built on support and encouragement and um just empathy, empathy you know its we're not nurses yet, we're students and it's amazing the difference it can make with someone telling you," I understand what you're going through" or "I acknowledge that you're feeling really nervous about this and I want to work through this with you"... Sometimes you don't need words you know a smile can make such a difference and it's little things. I'm aware of how I hold myself and how a smile can make a difference in my patients' lives. I think CEF's should hold themselves in the same manner... We students take it all in and it can either build us up or chip us down. (Student 6)*

Stay calm.

Students stated that it was important for a CEF to stay calm and be reassuring. If the CEF was anxious it made the students feel anxious and confused about where to get help if they needed it.

> *I find too even like the tone can really set you... like I don't know, I've had CEFs who approached you in a very nice you know calm way and one's that you know bark at you... It's pretty important when, um if the instructors don't get frazzled and you know bark at the wrong student or bark at a student because you know they've got four coming at once. It needs to be more a calm approach as opposed to being like you know"you're going to have to wait, I'm busy". A frazzled CEF makes the student feel frazzled. Then you think, well now whose going to help me, who do I go to? (Student 4)*

Make me feel welcome.

Students wanted a CEF who was approachable. When the CEF was open they could ask questions and feel safe to confess making mistakes.

> *My CEF just sort of had that motherly personality, taking you under her wing and was approachable. That's a big thing. You want to be able to say "You know I did make this mistake and how do I fix it? How do I learn from it?" But if you're afraid to tell someone that you made a mistake then you're not going to tell them and you're not going to learn from it. (Student 10)*

When the CEF was warm, relaxed, and welcoming, these behaviors helped the student to feel confident.

> *I found that my CEF's personality really helped me feel confident and I think our whole group felt confident. She was a really relaxed, warm, kind and made me feel very welcome to ask questions, come to her with anything. (Student 7)*

Clear expectations.

Students appreciated when they had a clear understanding of the course expectations and in particular the expectations of their CEF. They appreciated a clear written description of how to earn the grade they wanted and that the grading would be consistent between CEF's.

> *I find the CEF's that were probably the most beneficial are the ones that gave out the binders with everything they expected from you, like you know "this is what I see as an A paper, this is what I see as a B paper" right, so then they give you their standards, so you're not just shooting in the dark when you're handing in stuff. Every CEF should have the same binder with the same things that tell you what you're trying to, what is an A. I find sometimes it's so subjective. (Student 3)*

The following student shared how stressful it was when doing research on a complex patient because she did not know what kind of questions the CEF was going to ask in clinical the next day.

> *If you have a patient that's like super complex and you go home at night and you're wondering, I learnt all this stuff and now what and what's she*

going want me to know tomorrow and or is she going to drill me a million

questions and what do I need to know, how much do I need to know, what

am I going to have to do? I find that you could really be thinking all night.

(Student 4)

Verbal encouragement.

Students felt much more confident when they knew that their CEF had confidence in them. When the CEF took the time to instill confidence through verbal encouragement the student felt supported. The following students describe how they increased confidence when they knew their CEF believed in them.

Sometimes you do need someone… who you would see as knowing,

knowing better than you. You need someone like that to tell you "yes, you

can do it" because you know we all get in those situations where we've,

you know, we're facing something that we've never done before or we've

never experienced and you know maybe a little shaky on how to do it. It's

nice to have someone supporting you like that and just saying "You know

what, yes you can do this, here's how, let's go do it". It helps to have

someone, um have that confidence in you in, like in a position over you,

like in an authority position. (Student 8)

Say you're with your CEF and before you even go into a room just them

stopping and saying, "I know you're going to be nervous doing this in

front of me but I don't want you to be because I have confidence in you".

(Student 6)

I think that for me I, I have felt the most confident when my CEF felt

confident in me, um when there's a definite attitude of you know you can

do this, like you don't have to be afraid (Student 1).

Letting go.

Students learned more when their CEFs encouraged them to continue performing a task with guidance when they were unsure, rather than taking over the task. When the CEF took over the task it sent a message to the student that she was not capable. A student wants to fix her own mistakes and learn from them just as she would have to if she were a real nurse.

If you're doing something and your instructor has her hands in

there, I want to say, "Can you not please do that" and let me do it. I

can do it myself. I'd prefer like maybe if they could watch versus

doing it with me. I know they might mean well and they just want to

help but it is more helpful if they let us do it. If the instructor comes

in and takes over then it sends the message that she didn't think I

could finish it myself. If I was the nurse by myself doing it and I was

going to break the sterile field I wouldn't get somebody else to do it.

I would have to fix the problem myself. Once your confidence is

shaken you start to hate clinical. (Student 4)

Students expressed how they would like to be trusted to perform independently.

I find you're a lot more confident when your instructor puts more

confidence in you. So maybe letting you organize your workload yourself,

maybe letting you get your own medications ready, maybe letting you do

your own wound care yourself kind of makes you feel like a real nurse not

having to have someone watch you the whole time. (Student 4)

Another student wanted CEF's to know how she felt when she was allowed independence in her practice.

I really found that my CEF has just allowed me full reins to be

independent. She's there when I need her and she's watching the rest of

the time… Allowing a little bit more independence for the students who

are independent is good. The CEF should, gauge what type of learning is

best for each student. Do they need one to one or can that student have a

little bit more independence. Now in fourth year to have that independence

it's just, it's beautiful to me and I feel like okay, I'm getting it, I can do

this on my own, while still knowing that there's a support there if I need it.

(Student 6)

There are times when a CEF needs to watch students and evaluate their performance. One student appreciated having a CEF present to make sure she was "doing it right". Having the CEF watch her actually increased her confidence as long as the CEF did not hover. Once the student felt confident, letting go and allowing her to perform on her own was important.

It's about having your CEF watching you for the first time you're doing a

skill, as long as they're not really hovering over you or they're sort of just

making sure you're doing it right and giving you that, that distance, that

space, just sort of makes you relaxed…I had done some wound care and

my CEF sort of watched the first time. She didn't really hover over me,

just sort of made sure I was doing it right, giving me that distance, that

space, it made me relaxed. That sort of supervision helped ease my

anxiety. The next day I had wound care on a different client and she said,

"I've seen you do it once, I know you can do it again, go". I guess

professionally it just builds your confidence. (Student 9)

Yesterday at clinical I put in a sub-Q line on my patient and when I was

done my instructor said "you know, that was great, that was perfect, I

couldn't have done it better, you can do them by yourself now". Stuff like

that is like great because I feel trusted and I know I did it properly.

(Student 4)

Being a safety net.

Students identified how important it was to them to feel supported by their CEF when they were feeling unconfident or if they were encountering a new clinical situation. They described themselves as feeling overwhelmed by details at times. They needed their CEF to be there as a safety net for them when they were unsure of themselves. When students described their CEF as a safety net three subcategories emerged: i) she has my back, ii) she is there if I need her, and iii) she shows me how.

She has my back.

A student described feeling overwhelmed by the amount they needed to remember. Not worrying about every detail allowed the student to focus on the patient as a whole.

I tried to bring everything that I would need into the room when I needed it, like the IV medications or the dressings or whatever, but sometimes I would forget things. My CEF she had my back. You know she would have the extra luer lock or something like that just in case, but it wouldn't be held against me. Like oh, you forget the luer lock. When you're a student those little details are the worst and it just causes anxiety when it's really not like a huge deal. I find that collecting all the materials before you go is important but it's so easy to get too caught up in that and then you just get anxious over something that you shouldn't get anxious about when you're caring for a patient. (Student 1)

Being there.

If students were scared or unsure of how to handle a clinical situation they wanted to know that their CEF was close by if they needed support or advice, especially in serious situations when the stakes were high.

I was nervous my patient was going to die. I was scared to go in the room, you know that kind of thing. When I am scared I want my instructor to be there and ask, "are you okay? Can you handle the situation? Do you need me to go with you?" And then to just to stand at the door, she doesn't have to do anything, just stand there in case I need her. (Student 4)

She shows me how.

When students were not feeling confident to perform a task they appreciated when a CEF gave a demonstration showing the student the correct way to carry out the task.

I was nervous and I said, "Like I haven't had much experience holding a

baby". My CEF kind of gave me that encouragement and gave a

demonstration and showed me that it's not that hard, and just getting that

verbal encouragement and support was helpful. (Student 5)

Students also appreciated having their CEF confirm that they were on the right track and telling them if they were not. Having a CEF that didn't seem to care about her learning made this student feel less confident.

One time I was listening for chest sounds and I wasn't sure if I heard

crackles but I thought I heard crackles, so I asked my instructor to come

listen with me and then she helped confirm with me that I heard the right

thing. This improved my confidence... I had a similar, situation where I

thought I heard crackles but I wasn't sure and when I asked my CEF if she

could come listen, she asked me what I thought I heard, and then didn't

come listen. I never really found out if what I heard was real or not real. I

was worried approaching her another time cause she just didn't, like you

know she didn't take, uh care in my learning and she made me feel like I

just didn't know what I was doing as opposed to not knowing what I was

hearing.(Student 3)

Cueing and prompting.

Overall students expressed that they wanted to figure things out themselves as much as they could instead of just being given the answers; however they appreciated a bit of prompting to draw out the information they knew if they were having trouble articulating what was occurring with the patient. Students want to be stimulated to think

critically. They want to know that their CEF would help them to i) fill in the gaps, and ii) encourage their thinking.

Fill in the gaps

Students described feeling reassured when their CEF reviewed their plan of care and filled in the gaps if they forgot something. This reassurance allowed the student to feel more confident to proceed with patient care.

> *I guess my CEF really helped me feel confident um by you know assessing what I did know but then helping me fill in the gaps with what I didn't know, so that when I went to actually care for the patient, I felt like I could do this, like I know what I need to know. (Student 1)*

> *My CEF's usually comes to see me to go over the plan with me and I find that helpful, like they ask "okay what's your plan with your patients today". So I tell them what I'm going to be doing and what my goals are for that day, and, and they help fill in any missing gaps like if I'm forgetting to check something or evaluate something on my patient. And that makes me feel better. (Student 5)*

Encourage thinking.

Students wanted to be given the opportunity to think critically and find the answers instead of being told the correct answer. They wanted to learn for themselves and have a chance to figure things out on their own.

> *A CEF needs to let students figure things out as much as they can so that they are actually trying and learning for themselves and not just being*

given the information right away, but allow them to say, "can I get back to you on that"? I think it's okay for the CEF to ask, "well what do you think"? That's not the question students always wants to hear but I think it's helpful because I think it's important to try to draw out information that's probably in your head but just not at the front right now. (Student 1)

There have been some CEF's that while they are reviewing your plan for the day ask certain questions to get you thinking a little more critically and trying to get the whole picture of the, of the client or the situation. So I think that's good getting us students to think critically on the spot and use the, the knowledge that we have. There might be moments where you might forget something or it isn't coming together and you feel frustrated but, but I think in the long-run it's, good. (Student 5)

Being supported and guided to think helped students succeed in finding the right answers and made them feel confident and capable. The following student described her "aha" moment when it all came together after being guided by her CEF.

It was just working between going and looking for the knowledge in the books and coming and trying to figure out everything with my CEF and all of a sudden everything just came together. We looked at test results I just remember that aha moment. Just putting it all together and knowing then that I could essentially approach the doctor and say, "I think this is what's going on". I walked out feeling like a real nurse because of the support and the encouragement. It was really just the positive reinforcement and

encouragement from my CEF to keep looking and keep trying to look to

the root of problems. (Student 6)

Although most students agreed that cueing and prompting from their CEF increased their confidence in the clinical setting, one student felt that her CEF asking questions made her feel anxious and gave her the impression that she was failing.

CEF's seem to try to be really strict teachers in the clinical setting.

They just test us, they quiz us, they ask many hard questions. Then

students get really anxious and we think we are failing. I feel

stressed and anxious. I cannot do anything if my hands are shaking

and I become sweaty. (Student2)

Giving Feedback.

Students all appreciated having feedback regarding their clinical performance, but they felt strongly about the way feedback was given. The message regarding feedback that students wanted their CEF's to know is described in the following 2 subcategories i) build me up-don't shut me down, and ii) tell me right away.

Build me up- don't shut me down.

Students were sensitive to how they received feedback. They wanted to know when they were doing things right and wanted to be corrected if they were not. However, they did not want to feel inadequate if they did not know the right way or if they did not have the correct answer. The following student described a situation where she was made to feel stupid for not knowing the answers even when she had not yet covered the material in her theory class. She wanted to share how awful she felt because of the way she was given feedback from her CEF.

There's definitely a way to go about correcting someone in a way that doesn't make you feel bad. Corrective feedback can be given in a positive way, it doesn't have to shut you down. It can make you feel more confident for the next time. In the third year of clinical I didn't know what PSA was and my patient was diagnosed with prostate cancer and that's why he has to take that test. I asked my CEF if she could tell me what PSA was and she said, "oh my God you don't know this"? There were five or six other nurses there at the desk and she was teasing me in front of those nurses. I turned totally red. My CEF made me feel stupid for not knowing what this PSA test was but the fact was that we didn't learn about PSA and Prostate Cancer for another 2 months in theory class. That moment was awful for me. (Student 2)

Students felt that it was important for negative feedback to be given privately and in a way that did not interfere with the student's confidence in front of the patient unless patient safety was in jeopardy.

Giving feedback should be given in a way that does not shake your confidence, that is the key. It should be given in private outside the patient's room. Of course if a mistake was going to jeopardize the patient's safety you'd have to say it right there in the room but maybe you could just be brief inside the room and outside the room you could talk about what you could do next time. (Student 4)

Don't make me wait.

Students also expressed the importance of having feedback given to them immediately so that they could develop and improve rather than waiting until midterm or final evaluation time.

Giving verbal feedback right after the student performed allowed them to know that they were on the right path, consequently increasing their confidence.

> *If a CEF thinks you did something really good instead of just keeping it and writing it on the evaluation they should tell you right after, like you're doing really great work, "I really like how you did that". Then that day you think you're doing good. Otherwise you wonder did I even do it right, did I screw up, is that why she didn't say anything? (Student 4)*
>
> *Sometimes I'd like more comments that kind of say "oh you could improve more on this", like sometimes let's say at mid-term CEF's they give you a list of things that you could work on but I wouldn't mind that information during clinical time too. They don't have to say it in front of a patient but at the end of the day one on one or something. Just say these are the things that you can improve on along the way, instead of waiting till mid-term. I like being told like you know that was good or you know change this or work on this because I want to adjust things right away and not, wait till mid-term for example. (Student 5)*

Theme 2 - The Clinical Environment

Throughout the interviews students frequently spoke about the clinical environment as having an effect on their clinical confidence and learning. Although the

students did not consider the environment as significant an influence to clinical confidence as the CEF was, the practice environment was definitely considered to be important.

> *I've gone from a really crappy clinical or like a clinical where I've just had like I felt like my confidence was just completely stripped, um and then gone into a, a much better setting and just being shocked by you know like what a nurturing environment it was. So, um, so the clinical environment is going to affect a student for a long time. I think it's important for instructors to realize that. The environment can make or break a student. (Student 8)*

Under the theme of clinical environment, there were three categories, some with subcategories that were identified a) buddy nurses, b) other students, and c) available learning opportunities.

Buddy nurses.

Students felt strongly that their buddy nurses had tremendous power to affect a student's level of confidence. There were two subcategories that emerged under buddy nurses, i) comments matter, ii) feeling part of the team,

Comments matter.

Students placed a lot of value in comments given by the buddy nurses. What a buddy nurse says to the student really affects a student's confidence and their ability to learn.

> *When buddy nurses give me good comments, I feel really confident because I know I'm doing the right thing in the right way so I think it*

affects my learning a lot. I listen to buddy nurses very actively.

When they comment about me then I just trust that right away. When

they give me good comments I feel really good. But when they say

something negative, then I feel frustrated and I get more stressed.

(Student 2)

One student described how positive comments from her buddy nurse reinforced her learning and made her feel she knew what she was doing.

If you hear a good job from a staff member it makes you feel really good,

like I was told recently "it's really good how you've been charting

throughout the day", and I think, oh that's great, I'm going to keep doing

that. It reinforces that you're doing what you're supposed to be doing.

(Student 1)

Another student wanted to share how a negative experience with one of her buddy nurses made her feel inadequate and small. This encounter affected her self-confidence and ability to perform on the unit for a period of time afterward.

I was paired up with this nurse and I was actually just going to

collect a stool sample for this occult blood test but I'd never done it

before and so I took the, the patient's label and I put it vertically

across it the specimen bottle because it didn't fit otherwise. And so

she looks at it and she looks at me and she said "why did you put the

label on that way? That was a really stupid move, that wasn't very

smart". And she said it front of other nurses, and I was just standing

there like I didn't even know what to say, I was just so shocked

because no one's talked to me like that before on any rotation really.

I was so furious and then I walked into my patient's room and had to

almost bite my lip and just give my head a shake and not give her the

satisfaction, but you know it's just instances like that here you're

just made to feel so small. I was just jittery after that for about an

hour. (Student 6)

Being part of the team.

Some wards were really good at making students feel like part of the team. Students wanted to be treated on the same level as other nurses and feel like part of the team. Feeling the respect of her buddy nurses made this student feel like she wanted to come back and learn more.

You feel like you want to be treated on the same level as the other

nurses are, but I feel like there's still that feeling of you're just a

student. Some wards are super good about respecting you and

stuff... It makes me think I am actually part of the team, not just the

student. You feel way better about yourself and when you go home at

night. You think like wow, I had a great day at clinical, I'm not

dreading going there tomorrow. (Student 4)

One student identified how it made her feel confident and like an important part of the team when the buddy nurses encouraged her to be involved and ask questions.

The nurses make a point of making us feel like part of the team as

soon as you came onto this floor. "We want you to be involved, we

want you to ask us questions, we want you to learn" and they were

super helpful. So by having those team members feel confident in

you, you feel confident. (Student 9)

Allow me to try it myself.

Students felt confident when their buddy nurses gave them independence. Students wanted the chance to try things themselves and to be trusted by their buddy nurses.

When your buddy nurse kind of tries to still do everything for the

patient that you're supposed to be in charge of doing, that kind of

downgrades my confidence and makes me feel like they don't trust

that I'm able to do it myself. I'm never going to learn if I'm not

given an opportunity. I would like to try it out myself and then seek

help if I need it. (Student 4)

Other students.

Other students in the clinical group were also a category that emerged from the data as significant. There were three subcategories under the category of other students that were identified as important to student learning and confidence in the clinical setting. i) learning by watching, ii) discussing and comparing, and iii) we're all in this together.

Learning by watching.

Students appreciated being able to watch another student do a task. This helped them feel more confident about the prospect of having to do it by themselves.

In my medicine rotation whenever someone was doing something

new, we all went and watched. My classmate was giving a blood

transfusion so we all set it up, we all watched how to set it up

together. She did it, but you know again it was our first time so our

CEF went over it with us and made sure it was given right. Then the

next week I had to do it and it was great because I had seen this

done before and even though I still needed my CEF there, I was

more confident. (Student1)

Discussing and comparing.

Discussing and comparing clinical situations with other students can help the student feel more confident. One student described how knowing that another student was getting similar answers to her made her feel like she was on the right path. She also explained that she appreciated discussions with other students on the same level as she was.

I think its maybe when I was able to talk with other students. And

just get feedback or, or finding out that I was thinking the same

thing they were. Just recently we had to do an assignment on drugs

for mental health, and a few of us in our group were confused about

some of the questions. But when we started talking we all were along

the same lines with the answer, so that made me feel better that I

wasn't completely off on, off on the wrong path and that it was the

right answer. Other students are not in that authoritative position.

You're kind of on the same level, even though everyone should be

kind of on the same level…It would probably make me feel better to

work with someone in the same position as me and would make me

feel better to talk with them, get their ideas and work on a situation

together like brainstorm ideas of what to do. (Student 5)

Sometimes students felt less intimidated when they could discuss clinical matters with other students rather than authority figures.

If you feel like you can't approach your CEF it's good to have other

resources like other students and buddy nurses. (Student 3)

Before you do something you don't necessarily want to ask your

CEF cause you should know it. But if you can just get a classmate's

feedback it helps because I think it's still nice to have someone

agree with us before we go and do it. I like having classmates

around for sure. (Student 1)

One student did not agree with the majority. She felt intimidated by other students especially those who knew more than she did.

Some members in my group they are really smart or they're very

prepared, then on the first, first day of clinical I feel that oh my God

I'm not that much prepared I better study more, oh she's so smart

she knows everything, then I go to study more and more. But

sometimes it can be stressful too because I feel oh I don't know

much of stuff, I'm not good enough. (Student 2)

We're all in this together.

Students enjoyed the feeling of sharing their experiences and stated how they liked knowing that other students were experiencing similar things that they were and

they could help each other. One student summed up this perspective when she stated, " I like the we're all in this together feeling".

> *I like the we're all in this together feeling. We're all exhausted, you know it's not just me, we're all excited, we're all you know, and it's nice to have. One person might know something a little better than the other person and that's okay and then we can help each other figure things out. (Student 1)*

Having a classmate to lean can make a student feel more confident in a stressful situation. This student described how having a friend to lean on helped ease her anxiety.

> *I was really concerned my patient was going to die on Wednesday at clinical, like I was super worried she was going to die and I was scared to go in the room alone, in case I found her you know already dead. So I got my friend to come with me and you know turn her with me in case she was gone already. I think it that helped ease my anxieties. (Student4)*

> *We're all sharing our experiences, we're all going through the same things together, and it does help to talk things out and to know that what you're feeling and going through is normal. And it sort of unites us and makes us stronger going through the rotation to know we can lean on each other. It's a different type of bond with the student, just because you're both learning and neither is grading the other, that actually was really great support to have during the rotation. (Student 6)*

Available learning opportunities.

Students realized that all clinical environments were not the same regarding learning opportunities. They wanted the best opportunities possible to learn and grow from. Students felt anxious when they did not have the opportunity to look after complex patients or perform skills they wanted practice with.

> *Getting an opportunity to like perform skills is important. Like I know lots of people have never started an IV. This makes students anxious when going into certain clinical settings. (Student 3)*

Students appreciated a CEF who asked what her students have and have not experienced, and tried to assign experiences fairly from opportunities available in the clinical environment. Students want complex patients to be shared equitably. This student illustrates the ability to care for a complex patient as "getting really lucky".

> I *think that when instructors assign they should maybe find out from the students, what things they have never had an opportunity to do, and maybe try and find those for the students to do. Now my CEF right now, went around and asked you know "Who hasn't started a catheter before" because the opportunity became available. The same thing with like assigning patients. Some students get really lucky and have a patient who is pretty complex and you know needs a lot of IV's, needs a lot of this and a lot of that and they really build on those skills. But then there's the students who like you know have a patient who just has oral meds and they never really get that*

chance. I think every student should get equal opportunities.

(Student 4)

Clinical experiences that reinforced what this student learnt in the textbook helped her understand and reinforce the learning of that theory, consequently increasing her confidence.

Once you've had a patient with diabetes or with um a pigtail or whatever it happens to be, then it sticks, it's there. I, you know I can read in textbooks till I'm blue in the face about um about palliative care or communication or whatever type of um you know disease. It's just never the same until you're actually there seeing it, learning the meds, giving the meds, you know having a patient ask you about their meds. So then it, for me, that's just what makes it stick is the hands on.(Student 9)

Repeating experiences.

Students identified the benefit of being able to perform a task or look after the same patient more than once. Repeating their experiences helped to reinforce their learning.

I think the first time it's always scary and the second time it's always a little less scary. You know and that's why I mean it's kind of funny cause you just feel like you got the hang of it and then you move onto the next rotation. But it, I mean I guess there's only a limited amount of time. We only have 4 years or 3 years in the Faculty. But it's just like you, it takes time, so the first few times are always going to be scary and I mean that's just the way it is, cause you have to get confident um. But I think yeah

once you do something once the next time you know it's not so unfamiliar.

(Student 1)

Other students supported the claim that repeating experiences helped increase confidence and learning.

If you have an experience and then you can repeat that experience without having a huge amount of time elapse it helps your learning, and it helps your confidence. (Student 3)

The first time that I ever did like an IV start or that I ever was doing anything you know with an IV, I was super shaky, super nervous. My CEFs was watching me and I got all jittery and then after that it was okay. You get better and better and better and now I mean you're efficient and fast and you know what you're doing. (Student 4)

Theme 3 - The Student

The third theme that emerged from the data as an important influence to student learning and confidence was "the student". Although students did not disclose that they themselves made a difference to their own clinical confidence it was evident in the stories they shared. Three categories emerged in the theme related to student confidence in the clinical setting a) anxiety, b) prepping for clinical, and c) personal experiences.

Anxiety.

It was clear that anxiety permeated all ten students' clinical learning experiences at one time or another. One student suggested that some anxiety is good because it can

encourage a student to work harder and be more attentive however if nervousness is excessive it "can just make you shut down".

>*I think at the beginning of any clinical rotation you're always nervous because it's new. I think it's okay to be nervous a little because it means that it's important to you to do well. Nervousness at a certain level can be helpful because it can make you really particular about what you're doing but not to the point where you're like nauseous, that's not good. A little bit of nervousness is good because it makes you, yeah more thorough and you, you know if you're nervous you really want to do well. Um but excessive nervousness can just make you shutdown. (Student 1)*

Students commonly experienced physical symptoms as a result of their anxiety, such as shaky hands, inability to focus, and memory loss. These physical symptoms occurred when they were excessively nervous making it difficult for the student to perform.

>*I just feel like sometimes the night before I get a little worked up about things like… do I have all the proper information I need for the following day? Is anything going to happen that I'm not prepared for? There have been times where I was so nervous that maybe the following day I was feeling a little sick to my stomach, not to the point where I would get sick but to the point where it was affecting my thinking in the morning perhaps. It just keeps running through, through information, or if I already know the patient then just thinking about that patient what I'll be doing during*

the day. And there are times where I dream about clinical the night before

and what's going to happen that day. (Student 5)

I think lots of it is just that it is easier to forget things when you're

nervous, it's easier to feel less confident when you're nervous. (Student 1)

I feel stressed and anxious I cannot do it if my hands are shaking and I

become sweaty. (Student 2)

Anxiety makes you more likely to screw up which makes you look even

worse when you're done which makes you feel even more unconfident.

(Student 3)

This student described having anxiety to be exhausting and to chip away at her confidence.

It chips away at your confidence, you second guess yourself and you

exhaust yourself, being nervous, you just exhaust yourself. (Student 6)

Prepping for clinical.

Students want to be well prepared for clinical so they can deliver the best care possible to patients but they describe preparing for clinical as overwhelming. The following student disclosed that no matter how much research she did she was still scared that she would not remember everything she needed to know.

I think the most influential experience that I've had is with a patient that

was dying of cancer and it was a very hard situation. He was rather young

and I was scared to be like have this patient because I didn't want to

screw up. Like this is a big deal, this is bad. This is a really sad situation

and he was in a lot of pain and I'm thinking this is my second week of like

medicine and I don't know anything. I did my research and I tried to know

as much as I could know before going to clinical, but I mean you still

never know what everything you're going to have to know. (Student 1)

Another student agreed there so much to know resulting in too much pressure for students to know too many details.

I hope they don't expect us to know everything on the first day or second

day, they just say okay you did your patient research yesterday, you're

supposed to know this and this, this, but we are learning here, we are not

teaching somebody or we are not experts right, so I hope they don't just,

they don't give us too much pressure about it. (Student 2)

It was surprising to hear how little sleep some students got before a clinical day as a result of the preparation work they did. These students claimed that too much time was wasted on research making for extremely late nights. The stress induced by worrying that they were not prepared enough interfered with their ability to sleep the night before clinical practice.

We get more nervous, anxious before we go to clinical, oh did I

forget something, oh, should I study more, should I prepare more? I

usually sleep for like three or four hours before I go to clinical

because I have too much stress and am too anxious. I spend like a

lot of time on patient research and making drug cards and I go to

bed around 2 a.m. and I have to wake up at 5 a.m. to go to clinical.

If we would get more time for patient research that will be helpful,

but we get only like one day right. (Student 2)

During clinicals I probably get like 4 hours of sleep a night because

of the homework load. I also think it's the anxiety. I just think about

clinical. If I don't have something done I've gotten up at 3 a.m. to

prepare before I go in for clinical. I think wasting time writing out

20 drugs is not the best use of our time. I think getting 8 hours of

sleep would probably be more beneficial. It would be almost like

most beneficial of having like students buy a package, like, like drug

cards, like a package of disease cards right because it's easier to go

through and read through them than it is to sit there writing

everything out right. When you're spending like I mean obscene

amounts of time researching illnesses and writing stuff so fast you're

not really learning either. (Student 3)

Personal experiences.

Personal experiences with friends and family helped students to better understand their patients who were in similar situations. Personal experiences helped these students to feel more confident in providing care.

In palliative care right now um I had a similar experience as my patient's

son was dealing with and I totally felt like I could see where this guy's

coming from. I think if you can kind of understand more about how a

person might be feeling you can provide better care. I know you don't

really ever understand how someone else feels, but if you can put yourself

in someone else's shoes maybe you could do better in clinical. Maybe this

person doesn't want to take pain medications for whatever reason, and if

you can understand that maybe you can be better when you approach the

situation. (Student 4)

A lot of times when I would um come into certain clinical situations, I

would relate it to a past feeling or experience like with a family member.

Last week, our second week in palliative was really hard because I'm

coming into it thinking of my grandpa who died last year. You know you

start seeing your grandparent in your patients and maybe it's empathy

where you're just relating so much to your patients that you're picturing

yourself in their shoes. It got to the point last week where I was feeling

super low in the clinical experience because I was bringing that in and it

took me sitting down and writing it all out and journaling it and sending it

to my CEF and she supported me. She said "this is normal to feel like this

and to bring your personal experience and your personal fears into your

clinical experience and it's okay" and she sort of helped me work through

it which I needed someone to do. (Student 6)

Summary of Findings

This chapter described three themes related to student confidence in the

clinical setting: i) the CEF, ii) the clinical environment, and iii) the student. The

first theme (the CEF) was well developed with several categories and subcategories. Students were clear that the CEF was pivotal to the development of confidence in the clinical setting. The second theme (the clinical environment), although not as rich and full as the first theme, was relatively well developed with categories and subcategories. Students asserted that the clinical environment in which they learned had a significant influence on their confidence. The third theme (the student) was less developed with only three categories and no subcategories. Students did not directly state how their own actions and behavior influenced their clinical confidence. However, this theme emerged indirectly through the stories the students told. Although the three themes were described as separate entities, the CEF, the clinical environment, and the student all interacted and impacted one another in the development of student's confidence in clinical practice. The interpretation of the student's clinical experience is informed by self-efficacy theory and will be discussed in Chapter five.

Chapter 5

Discussion of the Findings

The findings of this study contribute to the understanding of how clinical educators may increase students' beliefs of self-efficacy during clinical practice. The results revealed the perceptions and experiences of what helped or hindered student nurses to feel confident in the clinical setting. Bandura's self-efficacy theory (1997) is based on the belief that what people think, believe, and feel affect how they behave. The intrinsic effects of their actions can, in turn, influence their thoughts, reactions, and behaviour. Self-efficacy theory is an explanatory theory well suited to guide and describe the findings of this qualitative descriptive study on clinical student learning. If high self-efficacy beliefs influence better learning and improved performance, then understanding and further developing pedagogical approaches to enhance self-efficacy in the nursing student will ultimately lead to improved clinical competence (Pike & O' Donnell, 2010).

This final chapter begins with a discussion of the interpretation of findings through the lens of Bandura's (1997) self-efficacy theory focusing specifically on the concepts of reciprocal causation, as well as the four sources of self-efficacy. The implications of this study for nursing education are then described. Finally, recommendations for further research are suggested.

Reciprocal Causation

Bandura's (1997) theory posits that self-efficacy is dependent on reciprocal causality. Reciprocal in this sense means functional dependence between events. In this model of causality (a) personal factors in the form of cognition, affect, and biological

events, (b) behaviour, and (c) environmental influences all operate as interacting

determinants that influence each other bi-directionally. Livsey (2009) supports Bandura's

claim that there is a relationship between environmental factors, cognitive (personal

factors), and the practice behavior of nursing students. The concept of reciprocal

causation helped guide the understanding of how themes in this study related, interacted,

and impacted one another. As students described their clinical experiences it became

evident that the three aforementioned concepts were interwoven throughout.

Personal factors (cognition) of the student was a theme that emerged from the

data of this study. Results revealed that previous experiences in a student's personal life

helped develop his/her view of the world and affected how the student reacted to what

happened in the clinical setting. These results support Bandura's (1997) theory stating

that a student's prior knowledge is an important foundation to further learning. Students

disclosed they felt more confident when they could relate their clinical experiences to

situations experienced in their own world. Clinical situations similar to personal

situations students experienced before with friends and/or family were confidence

builders because they could relate and empathize with their patients and their families.

Students also discussed that excessive anxiety had a negative effect on their

learning; however, the results of the interviews revealed that anxiety affected some

students' ability to perform more than others. Some students considered anxiety to be

debilitating and voiced this frequently throughout their interviews, while other students

did not dwell on anxiety as much. These data suggest that past experiences and the

personal factors of a student, such as the ability to cope in stressful situations, all play a

part in the student's perception of an event and his/her ability to perform confidently and competently.

If a student interprets a situation negatively based on personal factors, his/her behavior and performance may not be at its best. Students described how they were unable to perform up to their usual standards after negative experiences occurred in clinical practice. They also described how circumstantial environmental influences such as the inferential behavior of the CEF, other students, and buddy nurses could all impact their confidence further affecting their behavior performance.

Just as factors in the environment can have an effect on student behavior, student behavior can have an effect on the environment. A student who is not performing well can influence the environment in which they are learning. Patients, buddy nurses, and CEFs may interpret the student as incompetent if his/her behavior and performance are negative. The student's demonstration of incompetence may influence the size and scope of clinical opportunities that are offered to him/her in the future. Students in this study disclosed how important it was to have a relationship of trust with their CEF and buddy nurse; and that they wanted to earn this trust so they would be allowed independence when providing nursing care to their patients. Student nurses want to be trusted by nurses, instructors, and patients (Koontz, Mallery, Burns, & Chapman, 2010). If a student's opportunities are limited because the CEF or buddy does not trust that s/he is competent the message sent by the CEF to the student is that s/he is not capable. This message may further influence the student's confidence in his/her ability to succeed, and therefore, may further affect his/her performance behavior. Feeling that s/he is not trusted by his/her CEF may also have an effect on the student's overall perception of self, consequently

influencing personal factors. Reciprocal causality for students in the clinical setting is bi-directional and endless.

The Four Sources of Self-efficacy

Other concepts of self-efficacy theory that were helpful in guiding the researcher's thinking and explaining student confidence in clinical learning are the four sources of self-efficacy. Bandura (1997) determined the four sources of self-efficacy in order of importance are mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states. What was revealed in this study as different from Bandura's (1997) claims was that the order of importance for the sources of source of self-efficacy was different. It became evident through the voices of the students that, when practicing in the clinical setting, the most important source to build source self-efficacy was the words and actions of the CEF and buddy nurses fitting with the category of verbal persuasion. This discovery is supported by the literature, in which the clinical teacher and buddy nurses were found in many studies to be pivotal in the development of student confidence in the clinical setting (Levette-Jones, Lathlean, Higgins & McMillan, 2009; Newton, Billet & Ockerby, 2009; Koontz, Mallory, Burns & Chapman, 2010; Bradbury- Jones, Sambrook & Irvine, 2011; Gillespie, 2002; Allison- Jones & Hirt, 2004).

The second most important influence on self-efficacy in this study was the physiological and affective state of the student. Students vividly described the symptoms of anxiety as significant determinants of their ability to perform in the clinical setting. Mastery experiences and vicarious experiences also were considered to be important influences to clinical learning; however, it should be noted that it is the CEF and the

buddy nurses who control what opportunities are given. Therefore these sources cannot be viewed without also considering these authority figures to the student and the relationship between them.

The following discussion is described through the lens of Bandura's four sources of self- efficacy. However, the order of importance is changed to reflect the findings of this study: verbal persuasion, physiological state, mastery experiences and finally vicarious experiences.

Verbal persuasion.

Students in this study interpreted verbal encouragement to be the most significant source of self-efficacy in clinical learning. Verbal persuasion involves verbally telling an individual that s/he has the capabilities to master a given behaviour (Bandura, 1997). Persuasion can play an important role in an individual's self-efficacy beliefs. Persuaders cultivate an individual's belief in his/her capabilities, while at the same time ensuring the envisioned success is an attainable goal. It is important to note that, just as positive persuasions may encourage and empower, negative persuasions may weaken self-beliefs. In fact, it is usually easier to weaken self-efficacy beliefs through negative appraisals than strengthen self-beliefs through positive encouragement (Bandura, 1997). The literature states that a CEF's attitude and encouragement toward students is considered to be the most important attribute of an effective CEF, and that the teacher's attitude toward students rather than his/her ability is the most crucial factor in effective teaching (Tang, et al., 2005; Girija, 2012; Gillespie, 2002). The relationship between student and CEF is the strongest influence to clinical learning, and the development of the student's professional identity of a nurse. Students preferred clinical instructors who were

clinically competent, knowledgeable, confident, respectful, and supportive of the student (Gillespie, 2002; Girija, 2012).

This study adds to the literature, not only by indicating the importance of the CEF to clinical learning, but by revealing what characteristics of the CEF students considered to be important. Students revealed that they appreciated a CEF who set a positive tone right from the beginning of the term. Students wanted a CEF who was enthusiastic and appeared to enjoy teaching. Students found it helpful when their CEF remained calm even when the environment became difficult or busy, and appreciated clear expectations to be given verbally and in writing throughout the term so that they were able to understand what the expectations were to succeed.

Students in this study also illustrated that they wanted to feel like part of the team. Feeling respect from buddy nurses and the CEF made students feel like they wanted to come back to the clinical setting and learn more. The need to belong is universal and pervasive exerting a powerful influence on thought processes, behavior, emotions, health and happiness. Nursing student's motivation and capacity to learn are influenced by the extent to which they experience belongingness (Levette-Jones, Lathlean, Higgins & McMillan, 2009). Bradbury-Jones, Sambrook, and Irvine (2011) posit that feeling valued as a person, a team member, and a learner is significant to student learning in the clinical setting and that effective mentorship and a supportive environment fosters a sense of control and self-efficacy in the nursing student.

Students in this study placed considerable value on comments made by both CEF's and buddy nurses. Through their statements, students illustrated how they actively listen to buddy nurses and CEFs, and believe what these nurses say. Students identified

that, even when they knew that negative comments were unfair and unwarranted, they still felt that these comments impacted their learning and confidence negatively. Feeling incompetent as a result of buddy nurses and/or their CEF caused stress and anxiety to students. Because of the nature of the student/teacher relationship in which a teacher has power over student, students felt powerless to retaliate.

Feedback was also an important factor influencing student self-efficacy in the clinical setting. Students wanted feedback to be given privately, constructively, and as soon as possible so they could learn and improve. Positive verbal persuasion through feedback from the CEF was considered by students to be significant in the development of self-confidence (Gillespie, 2002). Being cued or prompted to find the right answer also was appreciated by students. Even if students did not know the answer immediately they wanted to be given a chance to find it with some cueing and prompting. The literature supports this finding indicating that stimulation of critical thinking enhances the learning process (Hansen & Stenvig, 2008; Carlson et al., 2009, Benner et al., 2010).

Physiological and affective state.

The second most important source of self-efficacy as determined by the students of this study was their physiologic and affective state. Bandura (1997) states that a person relies on somatic information conveyed by his/her physical and/ or emotional state to judge his/her own capabilities and that physiological states such as anxiety, stress, arousal, and fatigue have the power to alter a person's self-efficacy beliefs. Pajares (1997) states that people live within positive or negative psychic environments that are primarily of their own making. When people experience aversive and emotional thoughts about their own capabilities, those negative affective reactions can further lower

perceptions of capability, and trigger the stress and agitation that help ensure the inadequate performance they fear.

A study by Melincavage (2011) revealed that stress and anxiety are common to nursing students who are learning in the clinical environment, and that students are particularly affected by the disposition and attitudes of authority figures they must work with on the clinical unit. There were multiple experiences described by students in this study that supported these beliefs. Students described that they experienced physical symptoms as a result of stress and anxiety that were debilitating to their performance in the clinical environment. Symptoms such as nausea, dizziness, shaky hands, memory loss, inability to focus, and exhaustion were all symptoms of anxiety that students described as interfering with their confidence and ability to perform.

Students disclosed how much they appreciated a CEF who acted as their "safety net" for situations in which they were feeling unsure of themselves. They wanted to feel supported in their learning by their CEF and buddy nurses, and to know that these authority figures were there to help them when they did not know the answer or were about to make a mistake. They wanted to feel safe to ask questions and not feel judged in situations in which they felt unsure and required assistance to be safe with patient care. Knowing that the CEF and/or buddy nurse was there to help a student succeed without making him/her feel incompetent reduced anxiety allowing the student to perform at her/his best without experiencing the physiological symptoms of stress s\he described as debilitating. Tang et al. (2005) support these findings, asserting that positive relationships established between teacher and student decrease anxiety allowing for improved student performance in the clinical setting.

Mastery experiences.

Success builds a strong belief in self-efficacy while failures undermine it. Development of a resilient sense of self-efficacy requires experience in overcoming obstacles by perseverance. Repeated failures tend to lower feelings of self-efficacy, especially if the failure is not a result of lack of effort. In addition, once a moderate level of self-efficacy is achieved, the development of a strong resilient sense of personal efficacy requires success in increasingly complex tasks (Bandura, 1997). The literature supports Bandura's belief that repeated experiences increase a learner's sense of self-efficacy (Lauder et al., 2008; Cheraghi et al., 2009; Jackson & Beauchamp, 2010; Nichols et al., 2009).

This study contributes to the belief that mastery experiences are significant to self-efficacy in the clinical environment. Students identified the benefit of being able to perform a task or look after the same patient more than once. Repeating experiences helped reinforce learning and consequently increased students' confidence to do the task again. When students did not do well at a task, they wanted to have feedback given in a constructive way so they could improve next time. Students appreciated CEFs who put thought into making clinical assignments. In particular, they appreciated having the same assignment two days in a row. Repeated assignments gave students the chance to reinforce what was learned on the first day. Repeated assignments also gave students a chance to demonstrate to themselves and others that they were capable of learning from feedback given. Students wanted to demonstrate their ability to learn from feedback and understood that expressing a willingness to learn helps develop trust between the student and the CEF or buddy nurse. Developing trust was important to achieving clinical

confidence. Students who developed a trusting relationship with their CEF felt they were more engaged in learning and as a consequence were given more independence to reinforce their learning though mastery experiences. Students described feeling confident when a CEF told them they did a good job with performing a task, and that they were safe to repeat the task without being watched the next time. Strengthened self-efficacy increases the probability that learners will become more engaged in learning, and will persist in moderately challenging tasks making meaningful gains in their learning (Margolis, 2005).

Vicarious experiences.

Vicarious experiences are the learned behaviours developed by observing the actions of others (Bandura, 1997). This source of information is weaker than the interpretive results of mastery experiences, but when people are uncertain about their own abilities or have limited prior experiences, they become more sensitive to their vicarious experiences (Pajaras, 1997). Bandura (1997) suggests that the greater the perceived similarity between the individual and the model, the more persuasive the model will be in convincing the individual that s/he too can be successful. In other words, a student would feel a higher sense of self efficacy to perform a task if s/he watched a fellow student be successful at completing the task, rather than watching a CEF be successful at the task.

Students identified how they learned through vicarious experience from their CEF, their buddy nurses, and other students. In the case of the CEF and the buddy nurse, students illustrated that they wanted to be shown how to do things properly and then be given a chance to do the task independently. There were times when learning through

watching a CEF was desirable to students because they want to confirm that they were correct in their thinking therefore they wanted an experienced opinion. For example, a student's confidence was increased when her CEF listened to a patient's chest sounds with her, and confirmed that what she was hearing was correct. Knowing that she had received correct information from a reliable source made her feel more confident that she could do it again. Gillespie (2002) supports this, stating that students appreciated a CEF who would walk him/her through psychomotor skills gradually providing less structured learning experiences and allowing for more independence.

Students also identified that they appreciated learning from other students who were similar to themselves. Students stated that they appreciated having another student with whom they could discuss patient care and compare notes. Not only did students describe how they learned from discussing and comparing their ideas, they also found it helpful to watch each other perform tasks. Knowing that other students were at a similar level of knowledge and ability built a sense of camaraderie between students. As described by one student learning with other students gaves her a "we're all in this together" feeling. The literature supports the benefit of vicarious learning suggesting that students working with peers, similar to themselves benefit through watching each other (Bandura, 1997; Sinclair & Ferguson, 2009; Bambini, Washburn & Perkins, 2009).

Implications for Nursing Education

The interpretation of data from this study suggests that self-efficacy is an important concept for nurse educators to consider in planning for clinical. CEFs were described by the students of this study to have a considerable impact on a student's self-efficacy in the clinical setting. The importance of the CEF was the most prominent theme that

emerged from this study and was a common thread that weaved through all themes. Even where the CEF was not the direct determinant of self-efficacy, she had the ability to influence or alter the situation. For example if the actions of a buddy nurse were the cause of low self-efficacy in a student, the CEF could act as a resource to help the buddy nurse improve her methods of teaching and communicating. The CEF could also provide support for the student and offer another perspective on the student's performance in a constructive way that could further their learning. The literature supports this revealing that the CEF is pivotal to a student's self-efficacy in the clinical setting (Melincavage, 2011; Benner et al., 2010, Girija, 2012).

CEFs should be aware of the impact their behavior and actions have on student self-efficacy and clinical learning. Based on the knowledge gained from this study and from the literature, it is recommended that all CEFs attend a learning session on how to increase self-efficacy in student learning prior to starting employment. CEFs should also attend a workshop annually where pedagogical methods are reviewed and discussed. The content of the workshop for new CEFs should focus on teaching and learning using the theory of self-efficacy as a guide. Scholars agree that the use of theory to guide practice helps promote rational and systematic practice (McEwan & Wills, 2007). Using self-efficacy theory to guide CEFs can therefore provide structure and consistency to their practices of teaching. The following suggestions articulate how CEFs can help increase self-efficacy in nursing students, and therefore their success in learning.

CEFs must consider the importance of reciprocal causation (Bandura, 1997) to student learning in the clinical environment, and be aware that personal factors, behaviour, and the environment (the three tenets of reciprocal causation) are all

interwoven and influence one another. Every effort must be made by CEFs to create a positive learning environment. CEFs should consider the effect that other experiences outside nursing have on a student's overall perception of their ability to perform in the present. Spending time with each student to find out more about his/her previous learning experiences would help the CEF alter the learning environment for each student based on individual needs, and provide clinical assignments that are challenging yet not overwhelming. CEFs should also be observing the interaction between staff and students on the clinical unit and be ready to intervene if a student is having a negative experience with a buddy nurse or any other member of the health care team. It is crucial that clinical teachers foster a supportive environment conducive to student learning (Moscaritolo, 2009).

CEFs should also develop an understanding of Bandura (1997)'s four sources of self- efficacy and the impact that these sources can have on student confidence in the clinical setting. The results of this study suggested that verbal encouragement is the most powerful source of student self-efficacy in the clinical setting. CEFs need to be aware of their own inferential behaviors on student confidence and try to make students feel welcome with the words they use and their body language. Encouraging critical thinking has been identified as helpful to student learning both in the literature (Reilly & Oermann, 1999; Hanson & Stenvig, 2008; Carlson et al., 2009) and in this study. CEFs should encourage students to think critically with prompting when necessary. CEFs should also be cognizant of how and when they give feedback and instructed in a way that is developmental and not destructive to the students. Feedback should be given

privately whenever possible and as often as possible (Gillespie, 2002; Koontz et al., 2010).

The physiologic state of a student (anxiety) can significantly affect a student's ability to perform. Students in this study identified that they become anxious if they are put in unfamiliar situations, if they are given negative verbal appraisals, or if they are made to feel unwelcome. It is important to note that some students presented with more anxiety than others when discussing their clinical experiences. CEF's need to consider that each student may present with a different level of stress, and that some students may cope with stress better than others. High levels of anxiety can affect clinical performance, presenting a clear threat to success in clinical practice (Gillespie, 2002; Melincavage, 2011). When creating patient assignments CEFs need to consider the level of experience of each student and be aware of each student's abilities and limitations so that they are feeling challenged yet not overwhelmed with their clinical assignment. CEFs also need to build positive relationships with their students and facilitate a positive and respectful relationship between students and clinical unit staff so that student anxiety in clinical is minimized. If nurse educators can better understand the anxiety of student nurses during clinical, learning may be increased (Melincavage, 2011).

When considering mastery experiences, CEFs should create assignments that will build a student's confidence through repeated experiences. The findings of this study, as well as many others in the literature (Heale & Griffen, 2009; Nichols et al., 2009; Matsuo, et. al, 2009), support the importance of repeating experiences in building self-efficacy. Students should be encouraged to practice the clinical skills with which they are having difficulty, and be given the chance to repeat the skill in the clinical setting another

time. If possible, students should be given experiences, and clinical assignments, that build on to what they have already learned. The source of mastery experience should also be considered by nurse educators who are planning clinical placements. Students stated in their interviews how just when they feeling comfortable in a clinical setting, it is time to switch to a new clinical unit in another hospital. Longer clinical rotations in one clinical setting would allow students to concentrate more on learning, rather than spending their efforts on adjusting to a new hospital and or clinical unit just when they began to feel comfortable in their previous one.

Regarding vicarious learning, CEFs should be aware that, although students appreciate learning from knowledgeable experienced nurses, such as the CEF or buddy nurse, students also value what they learn from each other. While peer pressure may be stressful, peers can help each other through difficult learning experiences and learn from each other (Melincavage, 2011). It is important that CEFs remember that students feel more confident in their own ability to perform if they can observe another person similar to themselves succeed at a task. CEFs should allow opportunities for students to learn from each other. Students could work together in pairs on the ward and can share their learning experiences at the end of the clinical day in a post conference.

Lastly, the literature states that clinical simulation (Lau & Chuk, 2002; Hsu, 2007) and post clinical discussions (Bambini et al. , 2009; Parker & Myrick, 2010) are beneficial to student learning. These two practices are important for nurse educators to consider as they promote all four sources of self-efficacy. In clinical simulation, students value hands on learning (mastery experiences), watching their peers (vicarious learning), positive and immediate feedback of the CEF and/or peers (verbal persuasion), and a safe

environment where anxiety is minimized (physiological/ affective state). In post clinical discussions students value discussing clinical situations (mastery experiences), learning through the stories of their peers (vicarious learning) , positive encouragement and feedback from CEF and peers, (verbal persuasion) while in a controlled safe environment (physiological and affective state).

Recommendations for Further Nursing Education Research

Nurses in the clinical environment need to be well prepared and feel confident in their decisions for patient care. Teaching a nurse to be confident should start at the student level. Bandura's (1997) theory of self-efficacy proved to be an excellent theory to guide this research on the perceptions and experiences of student self-efficacy in the clinical setting. Students were enthusiastic to share their thoughts and perceptions of their clinical experiences so that the future of nursing education may be improved. Through the voices of the students important discoveries regarding self-efficacy and student learning were revealed and the literature regarding self-efficacy and student learning was reinforced. The study Success in the Clinical Setting: Nursing Students' Perspectives revealed that verbal persuasion is a more important source of self-efficacy than any other source in the clinical setting. This is a significant as it is contrary to Bandura's (1997) claims that mastery experiences is the most important source of self-efficacy. Further research should be done to reinforce this discovery using open ended questions to guide the interviews. Further research using a different sample of students from a different educational institution using a different model of teaching may produce different results from this study therefore providing an even deeper understanding of what makes students in the clinical environment believe they can succeed. Through the findings of this study

and further research to reinforce it, a strong case would be built for clinical teachers to learn and adapt pedagogical methods of teaching and learning using the theory of self-efficacy as a guide. As a result nursing graduates will be better prepared to practice.

Summary of Discussion

This chapter discussed how the findings of this study adds to the literature to strengthen the understanding of how clinical educators may increase students' feelings of self-efficacy during clinical practice. Findings were interpreted through the lens of Bandura's (1997) self-efficacy theory focusing specifically on the concepts of reciprocal causation as well as on the four sources of self-efficacy. These findings were then compared to the literature. Following this discussion of findings the implications of this study to nursing education were discussed. Finally, recommendations for further research were suggested.

Conclusion

The purpose of this study was to explore students' perceptions and experiences of feeling confident in some clinical areas and not in others, and to explore how CEFs may increase students' feeling of self-efficacy during clinical practice. Three main themes emerged from the data as being important influences to the self-efficacy of students in the clinical setting: a) The CEF, b) The clinical environment, and c) the students themselves. The data revealed that the CEF had the strongest influence on self-efficacy followed by the clinical environment and lastly the students themselves. However, the clinical teacher was a common thread that wove through all three themes as the CEF may have the power to change both the environment and the student.

As a clinical teacher myself, I was able to compare the data of this study to my own experiences in working with students. By doing this study, I have gained a better understanding of what clinical teachers can do to increase self-efficacy of nursing students' in the clinical setting. The theory of self-efficacy has proven to be a great resource to guide this study and to guide my thinking on how clinical education might be improved.

What became clear to me through doing this study is that students want their voices to be heard. Participants were grateful to have the opportunity to disclose their stories so that nursing students in the future would have better clinical experiences as a result of this study. It is my hope that by disseminating the results of this study, student's perceptions of clinical learning will be acknowledged and the future of clinical nursing education will improve as a result.

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Appendix A

Letter Requesting Access to Nursing Students Letter Requesting Access to Nursing

Students

Dr. Dauna Crooks   Linda Townsend
Dean, Faculty of Nursing   Masters of Nursing Student
Helen Glass Centre for Nursing   8 Bluestem Cove
89 Curry Place, University of Manitoba   Winnipeg, Manitoba, R3R-1H6
Winnipeg, Manitoba, R3T-2N2
Telephone: (204) 474-9201   Telephone: (204) 255-8886
Email: Dauna_Crooks@umanitoba.ca   Email: Linda_Townsend@umanitoba.ca

November 17, 2011

Dear Dr. Crooks,

I am a student in the Master of Nursing program at the University of Manitoba. I am writing to request access for research purposes to students enrolled in fourth year baccalaureate program courses at your educational institution. The title of my study is "Students Perceptions and Experiences of Feeling Confident in the Clinical Setting" The purpose of the study is to explore students' perceptions and experiences of feeling confident in some clinical areas and not in others, and to explore how clinical teachers may increase students' feelings of self-efficacy during clinical practice. The data collected though my research will be used for the purpose of completing the thesis requirement as part of the Masters of Nursing program. On completion of my research I plan to disseminate the results of the study through presentations and publications so that they may be used to improve the future of clinical nursing education.

Data collected from the students will include demographic information and audiotaped responses to interview questions that will be transcribed for the purpose of data analysis. All audiotapes and data sheets will be coded to ensure confidentiality and anonymity. Data will be stored in a locked cabinet in my home for no longer than two years following collection and then be destroyed.

I would like permission to contact your fourth year community, palliative, and mental health theory course leaders so that I may request approximately 10 minutes of classroom time to explain the study to students and initiate recruitment. During recruitment and the informed consent process it will be made clear that student participation is strictly voluntary and will in no way affect their standing with the Faculty of nursing.

The study is being supervised by a thesis committee consisting of Dr. Judith Scanlan, Faculty of Nursing, University of Manitoba (chair); Dr. Wanda Chernomas, Faculty of Nursing, University of Manitoba (internal member); and Dr. Richard Hechter, Faculty of Education, University of Manitoba (external member). This study has been approved by the Education/Nursing Research Ethics Board at the University of Manitoba. A copy of this approval is attached.

A package of information required by MCNHR was prepared and submitted to James Plohman on November 17, 2011. Data collection is planned to begin in Term1/ Term 2, 2011. A summary of the study will be given to you if requested.

Please contact me if you wish further information regarding this study. I look forward to hearing from you. Thank-you.

Sincerely,

Linda Townsend

Appendix B
Script to Recruit Students

Hello students,

My name is Linda Townsend and I am a student in the Masters of Nursing program at the University of Manitoba. I am grateful to your course leader for allowing me this time to invite you to participate in a study that I am doing for my thesis as part of the requirements of my Masters of Nursing education. The purpose of this research is to explore students' perceptions and experiences with feeling confident and not confident in clinical courses. By doing this research I hope to find out more about what clinical teachers might do to help students feel confident in their clinical courses.

If you choose to participate in this study your part would be to participate in an audiotaped interview that will take approximately 60-90 minutes in length, at a time and place that is private and convenient for both of us. Every attempt will be made to maintain your confidentiality before and after this study. Your name and other identifying information will not be attached to the information you give and your name will never be used in the publication of the results. The results of this study will be used as part of my thesis and might be published in a scientific journal. Your name will not be used in any of these documents or in any presentations that may occur as a result of this study.

You personally may not benefit from this study at this time, however, results of this study may lead to further research that may enhance student success in clinical courses.

 There are no monetary costs to you for participating in this study. You will not receive any payment for this study.

Your signature on the response form I have given you indicates that you agree to be contacted by me so that we can arrange a time and place for us to meet and conduct the interview. Remember that you are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence.

I will now leave the room and an envelope will be circulated. Whether or not you choose to participate and fill out the response sheet please return your response sheet to the envelope when it is passed around. If you would like to be contacted please indicate on the response sheet how you would like to be contacted. I will wait outside the room for one student to bring me the envelope. Later in a private room I will open the envelope and contact the first ten names that I draw from the envelope who are interested in participating, and arrange an interview time.

Thank-you for your time.

Appendix C

Letter of Invitation to Nursing Students (using UM letterhead)

Research Project Title: "Student Perceptions and Experiences with Feeling Confident in the Clinical Setting".

Researcher: Linda Townsend
Research Supervisor: Dr. Judith Scanlan
Sponsor (if applicable): None

I would like to invite you to participate in this study. The purpose of this research is to explore students' perceptions and experiences of feeling confident in clinical practice, and to explore how clinical teachers may increase students' feelings of self-confidence during clinical practice. If you choose to participate in this study your part would be to participate in an audiotaped interview that will take no longer than 60-90 minutes in length, at a time and place that is private and convenient for both of us. As part of the interviews I will ask participants about times when they felt confident and about times when they did not. I will also ask you to complete a form that asks a couple of questions that describe you. Every attempt will be made to maintain your confidentiality before and after this study. Your name and other identifying information will not be attached to the information you give and your name will never be used in the publication of the results. The results of this study will be used for my thesis as part of the requirements to complete my Masters of Nursing degree and might be published in a scientific journal. Your name will not be used in any of these documents or in any presentations that may occur as a result of this study.

You personally may not benefit from this study at this time, however, results of this study may lead to further research that may enhance student success in clinical courses.

There are no monetary costs to you for participating in this study and you will not receive any payment for participating in this study.

If you are interested in participating in this study please complete the attached form with your name and contact information. I am interested in interviewing about 10 students. If more than 10 students indicate interest, I will select the first10 with whom I can confirm an interview date and time.

Your signature on the attached response form I have given you indicates that you agree to be contacted by me so that we can arrange a time and place for us to meet and conduct the interview. Remember that you are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence.

Principal Researcher   **Supervisor**

Linda Townsend RN, BN   Judith Scanlan, RN, PhD, Associate
                                             Professor &
Student, Master of Nursing Program   Associate Dean, Graduate Programs
Faculty of Nursing   Faculty of Nursing
Helen Glass Centre for Nursing   Helen Glass Centre for Nursing
University of Manitoba   University of Manitoba
Winnipeg, MB   Winnipeg Manitoba
Telephone: (204) 255-8886   Telephone: (204) 474-9317
E-mail: linda_townsend@umanitoba.ca   E-mail: judith_scanlan@umanitoba.ca

This research has been approved by the University of Manitoba Nursing Education Research Ethics Board.

Appendix D

Interested in Participating?

Please check the box indicating if you would like to participate in this study. There is only 10 participants required therefore names will be drawn from an envelope from those wishing to participate until 10 interviews have been achieved. You will be contacted in the manner that you have indicated below. Thank-you.

 I wish to participate in Linda Townsend's study titled:

"Students Perceptions and Experiences with feeling Confident in the Clinical Setting"

YES_____

If yes please indicate your name and phone number and/ or email address.

Name :_____

Phone #:_____

Email:_____

Suggested time and preferred method of contact_____

Thank-you for your time and consideration,

Linda Townsend

Appendix E

Semi-structured Interview Guide

Interview Protocol Project: Students Perceptions and Experiences of Feeling Confident in the Clinical Setting

Brief Description of Project: I want to find out more about student learning in the clinical setting. From the results of this interview I hope discover what clinical teachers can do to help a student nurse feel more confident in the clinical environment.

1. Describe one experience when you were confident in the clinical setting. What helped you feel confident? (Who? How?)

2. Describe an experience when you did not feel confident in the clinical setting. What made you feel not confident? (Who, How?)

3. How do your previous experiences affect your learning in the clinical setting?

4. Tell me how being a part of a group affects your learning?

5. Tell me how comments by others affect your learning?

6. Tell me how being nervous affects your learning?

7. How can clinical teachers help you succeed in the clinical setting?

Appendix F

Consent to Participate Form (on UM letterhead)

Research Project Title: Student Perceptions and Experiences with Feeling Confident in the Clinical Setting

Code #_____

Principal Researcher	**Research Supervisor**
Linda Townsend RN, BN	Judith Scanlan, RN, PhD, Associate Professor &
Student, Master of Nursing Program	Associate Dean, Graduate Programs
Faculty of Nursing	Faculty of Nursing
Helen Glass Centre for Nursing	Helen Glass Centre for Nursing
University of Manitoba	University of Manitoba
Winnipeg, MB	Winnipeg Manitoba
Telephone: (204) 255-8886	Telephone: (204) 474-9317
E-mail: linda_townsend@umanitoba.ca	E-mail: judith_scanlan@umanitoba.ca

Sponsor : 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 the 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.

Purpose of Research: The purpose of this study is to explore students' perceptions and experiences of feeling confident in some clinical areas and not in others, and to explore how clinical teachers may increase students' feelings of self-confidence during clinical practice.

This document certifies that
I_____, having met the criteria for suitable participant, consent to participate in the study entitled: "*Student Perceptions and Experiences with Feeling Confident in the Clinical Setting*". The Ethical

Review Committee of the University of Manitoba has approved this study proposal. In consenting to participate in this study I understand and agree to the following:

1) I understand the study will be conducted by the researcher, Linda Townsend, as part of the requirements of the Master of Nursing Program at the University of Manitoba. The members of Linda Townsend's thesis committee are: Dr. J. Scanlan, Chair; Dr. W. Chernomas, internal committee member; Dr. Richard Hechter, external committee member.

2) I understand that my part of the study would be to participate in an audiotaped interview that will take approximately 60-90 minutes in length, at a time and place that is private and convenient for both of us.

3) I understand that if I indicate my willingness by checking yes in the box below the researcher may contact me to arrange a time to meet so that I may check the appropriateness of the categories generated from the data.

4) I understand that the researcher may make occasional hand written notes in a reflexive journal during the interview.

5) I understand that I personally may not benefit from this study at this time, however, results of this study may contribute to enhanced understanding of student learning in clinical practice and lead to further research that may enhance student success in clinical courses.

6) I understand that by participating in this study there is no anticipated harm to me. However, should I become distressed while discussing a negative clinical experience, the interview will be stopped and I will be asked if I would like to end the interview.

7) I understand that the only people who have access to raw data will be the researcher, members of the researcher's thesis committee and the transcriptionist and that every effort will be made to keep all information confidential. I understand the researcher when she is not physically with the data will store all materials related to the study in a locked filing cabinet in her home. This information will be identified by code only. This consent form is the only form that will have both my name and code together and will be stored in a separate locked filing cabinet in the researchers home. All raw data will kept no longer than 2 years and then destroyed. The Faculty of Nursing has access to a confidential shredding process. I will work with my advisor to destroy all raw data with this process.

8) I understand that the findings of the study may be published in the form of a manuscript in an appropriate nursing education journal. As well, the researcher will offer to present the findings at nursing education conferences or to other clinical nurse educators in their place of work.

9) I understand that my anonymity will be protected. In the event that an unsafe practice situation is revealed during the interview, the researcher will end the interview and the unsafe practice situation will be reported to the Associate Dean, Undergraduate Programs for further investigation. My name may be revealed to the Associate Dean if further information is required.

10) I understand that I may refuse to answer any study question and that I will be free to withdraw from the study at any point with no penalty to me. Refusing to answer a question or deciding to withdraw will in no way affect my standing as a student at the University of Manitoba.

11) I understand that I am entitled to a copy of a summary of the study results, should I wish one. The researcher will send a summary of the results to me by email or by mail.

12) I understand that I can contact the researcher, Linda Townsend, at any time during the course of this study should I have any questions related to the study or my participation in it.

I would like to be given a summarized copy of the study's findings. Yes___ No___

Name: _____

Address: _____

I would be willing to meet the researcher, Linda Townsend for no longer than one hour to check the appropriateness of the categories generated from the data. Yes___ No___

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 subject. 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 withdraw 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 Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Education/Nursing 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 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

My willingness to participate is indicated by my signature.

Participant:
_____

Researcher:
_____

Date:
_____

Appendix G

Demographic Questions:

Code Name_____

Age Range: Under 30_____**30-40**_____**Over 40**_____

Gender_____

Appendix H

Confidentiality Agreement for Transcriptionist (on UM letterhead)

Research Project Title: Student Perceptions and Experiences with Feeling Confident in the Clinical Setting

I, _____ affirm that I will not disclose or make known any matter or information related to the participants that comes to my knowledge during this research project.

_____   _____

Transcriber   Date

_____   _____   _____

Signature of Witness   Date

Appendix I

Beliefs and Assumptions at Learning about Clinical Student Learning

1) Learning is facilitated best by incorporating students' past experiences, observations of others, and personal ideas and feelings into their present learning situation. The atmosphere should foster trust and acceptance of different ideas and values.

2) Exposure to varied opinions regarding clinical situations helps learners to clarify actions and beliefs to aid meeting their own learning goals. Learning is more effective when the clinical setting supports open exchange, sharing of opinions, and problem-solving strategies.

3) Students experiencing a new learning situation, are likely to feel stress and confusion that impedes learning. Student behaviour will vary according to how they perceive the situation.

4) Some anxiety often increases motivation to learn, but too much anxiety may cause negative physiologic responses such as fatigue and inability to concentrate that interfere with leaning. Positive and meaningful encouragement by clinical teachers and role models empowers students to be confident and successful in their performance.

5) Learning improves when the learner is an active participant in the educational process. Students should have input regarding their clinical assignments.

6) Students learn more and enjoy being cued to critically think through situations themselves because it gives them an opportunity to display what they are capable of thinking.

7) Clinical teachers should encourage students to link theory learned in the classroom to the clinical setting. Learning increases when theoretical concepts and previously learned skills are useful in meeting patient needs. This allows for immediate application of the theory to a practical situation.

8) Constructive feedback given truthfully and immediately is pivotal for students to improve future performance. Learning should be immediately reinforced by feedback.

9) Reflection enhances the student' ability to learn and grow. Clinical teachers should facilitate students to reflect on their experiences after each clinical day.

10) Students at all ages have the potential to learn, with some learning faster than others. Age may or may not affect a person's speed of learning, and individuals vary in the way they like to learn.