

THE CLINICAL ENVIRONMENT: A SOURCE OF STRESS FOR UNDERGRADUATE NURSES

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ABSTRACT

The clinical area is an important learning environment for undergraduate nursing students. Unfortunately, it can also be a source of significant stress and anxiety for students and there are a number of reasons for this. Much can be done to help alleviate this stress and create a positive learning environment for students. This paper explores the literature to ascertain the common sources of stress for undergraduate students in the clinical area. It also reviews strategies for improving the quality of the learning experience.

INTRODUCTION

In the 1980s New South Wales, Australia, transferred nursing education from the hospital-based apprenticeship system to the tertiary sector. The assumption underlying this transfer was that tertiary education would prepare nurses who were better able than their hospital-based colleagues to meet the challenges of nursing in the future (Perry 1988, p.19). With this transfer universities became solely responsible for the education of student nurses and their preparation for registration. They also assumed responsibility for coordinating the education of nursing students in the clinical area.

One of the many criticisms of undergraduate nursing courses is that they do not contain sufficient clinical experience for students. It is certainly true that nursing students in tertiary programs receive fewer and briefer clinical placements than their hospital-based contemporaries (Perry 1988, p.19). However, Battersby and Hemmings (1991, p.31) suggest that the quantity of time spent in the clinical area may not be as significant as the quality of the experience and guidance the student receives.

Regardless of the amount of time students spend in the clinical area, it can be a very stressful experience. Students are often thrust into foreign surroundings, not knowing the staff, patients or the ward routine. The patients and staff may have high expectations of them, even though they are 'just a student'. The clinical facilitator may also expect them to perform to a certain level even though they are still learning. Students may be expected to be familiar with pathophysiological or pharmacological concepts they have not yet addressed in their studies.

This manuscript reviews the literature related to clinical education and focuses on sources of stress experienced by students in the clinical area. Through understanding the nature and causes of these stressors, nursing academics and clinical facilitators can improve the quality of the clinical learning experience for undergraduates. The areas addressed include clinical supervision, assessment and preceptorship. Recommendations are made for improving the quality of the learning experience.

Disillusionment

Beck and Srivastava (1991) surveyed 94 undergraduate nursing students to investigate their perception of level and source of stress. The data were collected using a questionnaire consisting of three instruments: one to measure general distress and psychiatric disorders; one to describe a recent stressful event as well as stressors from academic, financial, clinical and interpersonal areas; and, a profile sheet to obtain demographic and background information about selected characteristics of the environment and mediating factors (Beck & Srivastava 1991, p.128). Although this study did not focus on the clinical environment, the atmosphere created by the clinical facilitator was ranked as one of the most stressful items. The study found that the students experienced relatively high levels of stress, and quite alarmingly, that the prevalence of psychiatric symptoms was higher in undergraduate nursing students than in the general population (Beck and Srivastava 1991, p.131).

Disillusionment may also occur because of misconceptions about what the nursing role involves. Students may have chosen a nursing career because of their desire to help people but often they are not prepared to deal with the complexities of the world of nursing (Beck and Srivastava 1991, p.128). Experiencing reality shock or realising the realities of the job can make students doubt their career choice (Beck 1993, p.490). The professional education experience can be very stressful and the high incidence of distress in the educational years may lead to impairment in the practising years of the professional (Beck and Srivastava 1991, p.127).

Sources of stress

Learning in the clinical setting creates challenges that are absent from the classroom: facilitators have little control of environmental conditions; students must combine the use of cognitive, psychomotor and affective skills to respond to individual client needs; client safety must be maintained whilst he or she is cared for by a student; and, facilitators must monitor client needs as well as student needs (Windsor 1987, p.151). Beck (1993) surveyed 18 undergraduate nursing students about their initial experiences in the clinical area. The students' written descriptions were analysed and the significant statements extracted. Some of these were: anxious and nervous; afraid of hurting the patient; no self-confidence; uncomfortable with the equipment; overwhelming; felt incompetent or abandoned; confusing and shocking; felt scared and ignorant; and, felt stupid and worthless (Beck 1993, p.493). These data were clustered into six themes which were: pervading anxiety; feeling abandoned; perceiving self as incompetent; encountering reality shock; doubting nursing as a choice of career; and, uplifting consequences. Although the sample size was small, the findings are still relevant to nursing education today. Beck (1993, p.496) concluded that students need more time to reflect and verbalise their feelings; a climate needs to be created in which less than perfect behaviour at

new skills is acceptable; and, faculty need to concentrate on the positive instead of the negative.

Pagana (1988) explored the initial medical-surgical nursing experience of 262 undergraduate students. The students were approached during the first week of their clinical experience and asked to participate. The survey tool contained open-ended questions which asked the respondent to describe the stresses, challenges and threats they were experiencing. The majority (77%) of students expressed feelings of inadequacy. Other stressful issues were fear of making mistakes (34%), fear of the unknown (28%), the clinical facilitator (26%), feeling scared (19%), and, the threat of failing (14%). The feelings of inadequacy were related to inexperience and lack of knowledge and were reinforced when trying to absorb large amounts of knowledge in a short time. Other sources of these feelings included the high expectations of others, being actively responsible for nursing care or being asked to perform procedures they were not familiar with. Feelings of inadequacy have much to do with the attitude and practices of ward staff (Nolan 1998, p.626). This is a contentious issue because the ward staff may not understand the undergraduate curriculum or may be reluctant to allow students to practise relevant procedures (Napthine 1996, p.22).

Sources of stress in the clinical environment

Exploitation, in which the students are used as *de facto* rostered staff members is not uncommon. This may occur if staff are not familiar with the curriculum or aware of the goals and roles of students. It may also occur because senior staff are more concerned about the budget than patient safety. Exploitation is a potential source of stress for students as they are trying to please the clinical facilitator, the university and the ward staff, whilst trying to 'pass' the clinical placement (Napthine 1996, p.23). This situation creates the threat of failing which causes more anxiety for students.

Harming the patient by making an error or mistake is another source of anxiety for students (Pagana 1988; Wilson 1994). This is a particular concern because of students' limited knowledge bases. Students are concerned not only about harming another human being but also about the implications for their careers. Kleehammer et al (1990) also found that one of the highest levels of anxiety expressed by students concerned fear of making mistakes. They surveyed 92 nursing students over a four-year period. The survey tool addressed 16 different issues including communication and procedural aspects of patient care, interpersonal relationships with health care providers and interactions with members of faculty. Apart from making mistakes, other anxiety producing issues included clinical procedures, hospital equipment, talking with physicians, being late and being observed and assessed by a member of faculty. Other similar potential sources of anxiety identified included unfamiliar clinical

procedures, hospital equipment, talking with physicians, being late and evaluation.

The 'social component' of the clinical setting also brings with it feelings of fear and anxiety, which affects the students' responses to their learning environment (Nolan 1998). This social component may include the complexities of the medical and nursing hierarchies. Unfortunately, these fears are frequently intensified by faculty demand for a near-perfect performance (Wong and Wong 1987, p.508). Being constantly watched by staff and facilitator, as well as being formally assessed is a major constraint on confidence and learning (Nolan 1998, p.625), although feeling abandoned is not an uncommon experience either (Beck 1993).

Improving the quality of the clinical learning experience

The stressful nature of the clinical environment for undergraduate nursing students has been described. Many students complain however that they do not spend enough time in the clinical area, although it is probably the quality of the experience rather than the quantity that makes the most difference. What therefore can be done to improve the quality of the clinical learning experience?

Adequate preparation by students for clinical practice has been credited with 'making all the difference in the world' (Windsor 1987, p.152). This preparation may include being familiar with assessment tasks, knowing who the clinical facilitator will be or reading the institution's policy on infection control. All these things can occur before the student arrives in the clinical area. Adequate preparation may also include teaching students priority setting and problem-solving skills early in the undergraduate program (Beck and Srivastava 1991, p.132). Students should also be encouraged to recognise the influence they exert over their own clinical learning environment and to proactively work to create the kind of environment which will best meet their learning needs (Dunn and Hansford 1997, p.1303).

Clinical supervision

The clinical facilitator has been identified as a potential threat to students (Pagana 1988). Terms used by students to describe the facilitator include intimidating, threatening, demeaning, impatient, strict and demanding (Pagana 1988, p.421). Unfortunately facilitators often lack any tertiary teaching background (Naphthine 1996, p.21). As such their ability to guide, supervise, direct and teach students may be inadequate or completely absent. However the reasons such a person could be employed as a facilitator may include budgetary constraints or limited availability and thus choice of other suitable staff (Naphthine 1996, p.23).

Registered Nurses (RNs) working on wards in which students undertake clinical learning experiences should be adequately prepared and supported for their role in student learning (Dunn and Hansford 1997, p.1303). For example, this may involve the RN having a reduced patient

workload so that adequate time can be spent teaching and supervising the student. Students should be made to feel they are an important part of the nursing team. Students appreciate recognition for their contribution to patient care and are disappointed when their work is not acknowledged (Hart and Rotem 1994, p.28).

Wong and Wong (1987) suggest the following for improving the quality of clinical education: pairing of veteran and novice staff members in clinical instruction; utilisation of senior faculty as role models in clinical settings; faculty development programmes on clinical instruction; and, careful selection of candidates for clinical faculty appointment. Wood (1992, p.406) suggests early instructor sensitivity to possible student problems in the clinical situation. She presented the findings of a descriptive and exploratory study aimed at identifying non-traditional student nurse issues. Although the sample size was small, stress was a key factor in five of the situations studied and it actually affected the students' nursing care. She also suggests (p.406) that initial tasks in the clinical area should be relatively simple and straightforward to develop student self-confidence.

ASSESSMENT

Whilst observation and evaluation are necessary aspects of the clinical learning environment, they should be performed in a supportive, non-threatening manner and be used for formative guidance, not just summative evaluation (Kleehammer et al 1990, p.186). This again emphasises the importance of utilising clinical facilitators who are competent and skilled and who know how to teach. Students should not feel that someone is looking over their shoulder waiting for the opportunity to criticise. Instead they should feel that they have immediate help and support available to guide them through difficult tasks at any time they need it. Feelings of incompetence can be decreased by creating a climate for learning where less than perfect 'behaviour' is acceptable (Beck 1993, p.494). Opportunities should be made available for students to reflect and verbalise their feelings about their clinical experiences, be they positive or negative.

Preceptorship

Preceptorships are a useful way of reducing stress in the undergraduate student and fostering their development in the clinical area. Preceptorships are a one-to-one reality-based clinical experience in which the RN supervises the learning experience of the student (Peirce 1991, p.244). The preceptor is an expert nurse who assists students to achieve predetermined clinical learning goals through the use of modelling and subsequent student practise of appropriate nursing behaviour (Perry 1988; Dilbert and Goldenberg 1995). The use of preceptors in nursing is based on the androgogical premise that a one-to-one relationship facilitates effective learning (Clayton, Broome and Ellis 1989, p.73). In the undergraduate degree, the preceptor's roles include reducing transitional

stress and promoting socialisation (Beattie 1998, p.15). Preceptorship is being used frequently in nursing education to facilitate the acquisition of clinical competence by the student (Ferguson and Calder 1993, p.32).

A clear distinction, however, must be made between preceptor and mentor because although these terms are often used interchangeably, they are not the same. Mentoring is concerned with making the most of human potential (Morton-Cooper and Palmer 1993). It focuses on the development of a deeper relationship between mentor and protégé, capable of influencing major career changes and promoting self-actualisation in both participants (Madison 1994, p.17). Preceptorship relates more closely to an educational relationship (Coates and Gormely 1997). It has a narrower emphasis on individualised teaching, learning and support in the clinical environment (Nearby 2000). Burnard (1990, p.351) states the preceptor is more clinically active, more of a role model, and more concerned with the teaching and learning aspects of the relationship than a mentor. Interestingly, the English National Board (2001) defines a mentor as a nurse who facilitates learning and supervises and assesses students in the practice setting. This is similar to the definition of a preceptor.

Preceptorship is said to enhance the performance of nurses, whilst preceptors remain stimulated educationally and professionally by the experience (Bain 1996, p.105). Perry (1988, p.22) believes that preceptorships have the potential to enhance student learning in tertiary nursing courses by utilising the teaching skills of expert nurses already employed in service settings. However, the assumption being made by Perry (1988) is that if a nurse is an 'expert', he or she will possess teaching skills. Napthine (1996, p.21) says it is a myth that because one is a good clinical nurse, he or she will have knowledge of teaching and learning principles, and will be a good teacher.

The specific role or function of a preceptor, therefore, needs to be clearly defined so that the preceptee can gain the most from the experience. In one study (Coates and Gormley 1997), RNs who acted as preceptors listed their most important duties as role model, teacher and supervisor. The least important were assessor, critic and protector.

A preceptor also needs to be chosen carefully. Too rigid selection criteria will restrict selection to availability rather than ability of preceptors (Bain 1996, p.106). Preceptorships should be constructed in response to specific learning needs of the student and developed independently of learner characteristics such as age, gender and social class (Perry 1988, p.23). A situation in which RNs are chosen as preceptors because it is their turn or because there is no else more suitable, will contribute to problems with the establishment of a positive student-teacher relationship, which precedes the facilitation of meaningful learning (Beattie 1998, p.16).

The potential advantages of incorporating preceptorship programs into nursing education include their value in: transferring theory into practice; aiding in the transmission of desired nursing behaviours throughout the profession; engendering creative synthesis in nursing practice; and, initiating the basis for mentoring and future collegial networks (Perry 1988, p.20). Preceptorship also provides close supervision and allows immediate feedback on performance (Reilly and Oermann 1992). Jairath et al (1991) found that a preceptor program promotes assumption of behaviours consistent with the professional nursing role and thus facilitates the transition from student to professional nurse. Packer (1994, p.412) believes that preceptorships eliminate the reality shock experienced by students. Another advantage is the cost. One-to-one instruction by faculty is prohibitive due to the expense whilst using qualified ward staff acting as preceptors is not (Clayton et al 1989, p.74).

Preceptorship does, however, have its weaknesses or limitations. These may include the demands of work taking over learning; the difficulty in monitoring the progress of one student in isolation from the others; preceptors lacking educational qualifications or ability; and, preceptor burnout (Grealish and Carroll 1998, p.7).

COLLABORATION

Collaboration between the higher education and health care sectors is essential if the clinical learning environment is to best meet the needs of undergraduate nursing students (Dunn and Hansford 1997, p.1301). This collaboration should aim to establish creative models for clinical education which take into account current health and education socioeconomic reforms (Dunn and Hansford 1997, p.1301). For example, the nursing unit manager and clinical facilitator could cooperate in the development and implementation of strategies to enhance the acceptance of students as fully participating members of the ward team (Dunn and Hansford 1997, p.1302).

CONCLUSION

Exposure to the clinical environment is an important part of any undergraduate nursing curriculum. The clinical environment can, however, be a source of stress and anxiety to students. There are numerous strategies that can be used to reduce the impact of these stresses and to improve the quality of the clinical learning experience for students. The use of competent, skilled and empathic facilitators is one. Preceptorship is another.

Although nursing education has been in the university setting for many years, the use of the clinical environment as a learning or teaching experience is yet to be maximised. Academics, educators and clinicians have many options available to them to improve this situation.

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