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6-1-2009

## The Lived Experience of Nurses Working with Student Nurses in the Clinical Environment

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### Recommended APA Citation

Hathorn, D., Machtmes, K., & Tillman, K. (2009). The Lived Experience of Nurses Working with Student Nurses in the Clinical Environment. *The Qualitative Report*, 14(2), 227-244. <https://doi.org/10.46743/2160-3715/2009.1381>

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## The Lived Experience of Nurses Working with Student Nurses in the Clinical Environment

### Abstract

One response to the nursing shortage is to increase promotion and retention in nursing programs: However, negative attitudes of nurses threaten student progression and retention. A phenomenological study explored the lived experience of nurses who worked with student nurses to discover what attitudes nurses had toward student nurses and how negative attitudes were developed. One time semi-structured informal audio taped interviews were conducted with six nurses. Data analysis identified the emerging themes as professional socialization attitudes, beliefs about nursing education, role expectations, and motivational deterrent, and communication factors. Findings suggest collaborative strategies to reduce negative attitudes and promote positive, professional socialization behaviours of nurses toward student nurses in the clinical environment.

### Keywords

Clinical Environment, Professional Socialization, Phenomenology, Nurses, and Student Nurses

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# **The Lived Experience of Nurses Working with Student Nurses in the Clinical Environment**

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*One response to the nursing shortage is to increase promotion and retention in nursing programs: However, negative attitudes of nurses threaten student progression and retention. A phenomenological study explored the lived experience of nurses who worked with student nurses to discover “what” attitudes nurses had toward student nurses and “how” negative attitudes were developed. One time semi-structured informal audio taped interviews were conducted with six nurses. Data analysis identified the emerging themes as professional socialization attitudes, beliefs about nursing education, role expectations, and motivational deterrent, and communication factors. Findings suggest collaborative strategies to reduce negative attitudes and promote positive, professional socialization behaviours of nurses toward student nurses in the clinical environment. Key Words: Clinical Environment, Professional Socialization, Phenomenology, Nurses, and Student Nurses*

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## **Introduction**

Addressing the negative attitudes of nurses is important because the problem of resolving the nursing shortage is compounded by the negative effects these negative attitudes have on nursing education. Wells (2003) stated that inability to retain students in nursing programs negatively impacts the supply of registered nurses to meet the demands of the nursing shortage. Research of nursing students revealed that negative attitudes and behaviors of nurses impede learning (Lofmark & Wikblad, 2001) and threaten student progression and retention within nursing programs (Chan, 2002). Furthermore, if student nurses do not identify with the nursing profession, they will eventually leave (Li, 1997). Nurses need to stop eating their young and help prepare a strong, competent workforce for the future. After all, a component of professionalism is to mentor those seeking to enter the profession. The student nurses' socialization into the profession is dependent upon acceptance and approval by staff nurses, who have the greatest influence on the development of the student nurses' professional role (Hardy & Conway, 1988). The purpose of this study was to gain a personal understanding of “what” kinds of attitudes

nurses have toward student nurses, and “how” nurses develop negative attitudes toward student nurses.

### **Researcher’s Phenomenological Lens**

Moustakas (1994) describes the researcher as an instrument who collects and interprets data about the phenomenon from a particular phenomenological lens. The phenomenological lens informs the reader of the researcher’s perspective because interpretation from different researchers may vary. The phenomenological lens in this study is derived from my personal perspective, and is based on experience in teaching clinical nursing courses.

I, Donna have been a nurse educator for 18 years and have worked in three baccalaureate nursing programs within the Southeastern region of the United States. My basic nursing education is a baccalaureate degree, and I have been a licensed nurse for 30 years with practice experience in acute adult care, labor and delivery, postpartum, nursery, and pediatrics. I earned a Master’s degree in maternal-child nursing education, and a PhD in human resource education and workforce development with a focus on adult education. My experiences in clinical teaching include maternal-child, peri-operative, community, and psychiatric nursing. During my teaching career I have taught clinical courses in various levels of the nursing program from beginning students to graduating seniors. I have also taught clinical nursing courses in various clinical facilities that include private and public, profit and not for profit clinical sites.

After many years of teaching nursing I have dealt with nurses who dislike working with student nurses and display negative attitudes toward student nurses during clinical practice rotations. I have personally experienced the frustration that occurs as a result of nurses who make it difficult for student nurses to participate in direct patient care and meet clinical objectives. Students have complained about certain nursing staff, and stated they did not feel welcomed on the nursing unit. Some of the more common negative behaviors include being overly critical, making rude condescending remarks, refusing to work with students, ignoring students, and not giving patient reports.

My colleagues have also expressed frustration that occurs from dealing with nurses who have negative attitudes toward student nurses. Usually when I encounter a nurse with a negative attitude, I try to manipulate the student patient care assignment in an attempt to avoid the nurse. However, unit staffing and patient census may not permit the avoidance tactic. When avoidance seemed impossible, I confronted the nurse. If that didn’t work, I reported the behavior to the nursing supervisor, despite the risk of worsening the problem.

I could not understand why nurses who were so caring to their patients, and who were once students themselves, could be so uncaring to student nurses. Rather than continuing to work with the problem and accepting it, my desire was to eliminate the problem by identifying factors that contribute to negative attitudes.

## Literature Review

### Nurses' Influence on Nursing Students

Studies of nursing students' perceptions of the clinical environment concluded that there is a need for nurses to welcome the nursing students into the profession (Atack, Comacu, Kenny, LaBelle, & Miller, 2000; Chan, 2002; Cope, Cuthbertson, & Stoddart, 2000; Drennan, 2002; Li, 1997; Lo, 2002; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998; Suen & Chow, 2001). To promote a positive psychosocial learning environment, nurses should offer support, be nurturing, and treat nursing students with dignity and respect. The interactive experiences nursing students have with nurses give the students the opportunity to internalize the role of the nurse as a caregiver.

In a study conducted by Lofmark and Wikblad (2001), facilitating and obstructing factors for learning in clinical practice were identified by students. Facilitating factors included being allowed to take responsibility, being allowed to work independently, having opportunities to practice tasks and receive feedback, collaborating with staff and supervising others, gaining an overview of the setting, and gaining a sense of control. Obstructing behaviors were identified as a lack of a student-supervisor relationship, organizational shortcoming in supervision, and experience of students' own shortcomings. The negative supervisor behaviors were described as taking over, making condescending comments, being irritated or not interested, and not giving feedback or opportunities to reflect. Other supervisor behaviors, which negatively impacted student learning were not knowing the educational objectives and abilities of the students, staff uneasiness from lack of guidelines for nursing care, stress on the ward and lack of time, and not allowing students to take part in patient care activities.

In a study of students perceptions of the effectiveness of mentors by Suen and Chow (2001), roles identified as essential to that of a mentor were befriending, assisting, guiding, advising, and counseling. Scores of the effectiveness of mentors (as perceived by students) improved after the mentors attended workshops and were provided with materials to assist them with their mentoring roles. Also, the students were given the opportunity to meet with the academic staff to improve communication between the clinical setting and the university. Students felt that many mentors did not achieve the befriending role adequately; most students prepared themselves to be part of the team, but found they were treated as guests. Because of the job stress, the students expected the mentors to have a counseling role, but found this role to be weak. Effective mentoring could not be established without sufficient relationship building between mentors and mentees.

A qualitative study was conducted by Atack et al. (2000) to gain an understanding of the lived experience of staff, and students within a clinical practice model. The most important factor recognized by students in the student-staff relationship was open communication founded on mutual courtesy and respect. Open communication was defined as being direct and not passing the student and going straight to the teacher or other nurses when a conflict or concern developed. It was also important for the students to receive regular feedback in constructive and positive forms. Other components of a beneficial relationship with staff included the sharing of knowledge and decision-making

processes of the nurses with the students, and viewing the students as part of the nursing team.

### **Nursing Students' Influence on Nurses**

Grindel, Patsdaughter, Medici, and Babington (2003) conducted a survey to investigate nurse's perceptions of students' contributions to clinical agencies. They reported that nurses had an increased sense of responsibility and accountability for care provided by students to patients, therefore, producing more job-related stress for the nurses. Findings revealed that the more experienced nurses perceived nursing students as taking up too much time. The less experienced nurses perceived that nursing students did not take up time and freed them for other responsibilities. Both groups of nurses agreed that student participation in clinical, actual practice experiences with patients in clinical agencies, is a source for recruiting nursing staff. Both groups also agreed that nursing students enhance the clinical setting by stimulating staff intellectually, thus establishing collegial relationships. The recommendations of the study were to encourage staff nurses to display positive attitudes to support the learning experience of student nurses and use multi-method approaches using questionnaires, interviews, and observations to confirm the findings.

Matsumura, Callister, Palmer, Cox, and Larsen (2004) conducted a replication and extension of the study by Grindel et al. (2003), and reported that nurses were ambivalent toward nursing students. A qualitative component revealed the following themes: student preparation, student qualities, level of students on the unit, role of the instructor, and opportunities for staff nurse growth. Nurses expressed both positive and negative experiences with students. The nurses expressed frustration when working with problem students; but students could also assist with patient care and allow the nurse to spend more time with high acuity patients. The students were viewed as increasing the workload or slowing the nurses' down by taking too much of their time. The type of experience nurses had with students depended upon how prepared the student was, the student's attitude and willingness to participate in patient care experiences, the patient acuity and staffing of the unit, and the availability and support from the instructor.

Atack et al. (2000) also reported that nurses thought some students decreased their workload, while others thought students added to their burden. Students who required a lot of supervision were more time consuming to work with because the nurse spent more time coaching and stepping in to complete a task. When students left before the end of the shift, the nurses stated they had to catch up on the work missed by students. The nursing staff viewed their roles as educators and coaches, and recognized their patience and understanding was needed when working with students. Nursing staff also related that it was helpful to spend time with each student to determine their competency level in order to establish a trust relationship. Both students and staff suggested that students work a full shift with the staff nurses so that positive relationships could be reinforced. Implications from the study were to emphasize socialization among students and staff, clarify and develop the teaching role of the staff RN, help nurses to adopt teaching strategies with students, and share with the staff their influence on students as a role model.

## Methodology

Phenomenology was the method I selected for this study because my intent was to derive meaning from a human experience (Patton, 1990). The lived experience is a self-understanding of a phenomenon through the subjective knowing of the researcher. A purposeful, primary selection sampling strategy was used for this study, and the sample size was determined by saturation of emerging themes and categories from the data (Rossman & Rallis, 2003). Criteria for inclusion in the study was to be a full time staff nurse who worked with nursing students in an acute care clinical facility within the last semester prior to the interview.

Approval to conduct the study was granted by an internal review board from my institution. Permission to record the interviews was obtained from the participants, and an informed consent form was discussed and signed before the interviews began. Additionally, the participants were informed that they could withdraw from the study at any time, and fictitious names were used in the transcripts in an attempt to protect each participant's identity. The interviews were conducted over a period of six months from Fall 2005 to Spring 2006.

Table 1

*Description of Participants by Fictitious Name, Age, Nursing Degree, Nursing Experience, Type of Unit, and Type of Employment*

| Fictitious Name | Age   | Nursing Degree | Nursing Experience | Type of unit     | Type of Employment |
|-----------------|-------|----------------|--------------------|------------------|--------------------|
| <i>Kate</i>     | 41-45 | Diploma        | Over 20            | Cardiac Surgical | Full-time          |
| <i>Jenny</i>    | 46-50 | Associate      | 6-10               | Obstetrical      | Full-time          |
| <i>Sarah</i>    | 25-30 | Bachelor       | 1-5                | Emergency        | Full-time          |
| <i>Tommy</i>    | 36-40 | Bachelor       | Less than one      | Medical-Surgical | Full-time          |
| <i>Natina</i>   | 25-30 | Bachelor       | 1-5                | Medical-Surgical | Full-time          |
| <i>Cindy</i>    | 31-35 | Bachelor       | 1-5                | Surgical         | Full-time          |

I used a semi-structured interview process to gather contextual rich descriptions to uncover truth revealed through reflection of remembered experiences (Morse, 1994). Guiding questions were used to bracket the research topic and acted as a deterrent from collecting data that might have been useless in describing the phenomenon (Miles & Huberman, 1994; Moustakas, 1994). During the interview I was careful to consciously set aside my observations from the past and view the experience fresh and anew. I attempted to practice intersubjectivity, explained by Moustakas as experiencing what others experience. Their experience became my experience, and I lived it with them and interpreted it from my own intersubjectivity. Moustakas stated, "each can experience and know the other, not exactly as one experiences and knows oneself but in the sense of empathy and copresence" (p. 57).

Audio recordings were made of each interview, and transcribed verbatim after each interview and prior to conducting any subsequent interviews. The process of personally transcribing all the audio recordings helped me to become familiar with the

data. Dialogue and reflection helped me to identify the essence of the nurses' experience (Moustakas, 1994).

Triangulation was used to ensure the integrity and accuracy of the findings (Patton, 1990). According to Rossman and Rallis (2003), triangulation is a method for looking at data in different ways or from different points of view. This was accomplished by recruiting two colleagues, whom I referred to as triangulating analysts, to read the transcripts and assist with data analysis. One analyst was not a nurse, but had expertise in qualitative research, and taught phenomenological research methodology in a doctoral program. The second analyst was a nurse educator with experience in phenomenological research. After a time of reflection, the triangulating analysts met with me to compare findings and validate emerging themes, make corrections, and elicit additional information about the phenomenon. I found this process to be very useful in determining data saturation. The participants were given a copy of their transcribed interview, so they could have the opportunity to review it for correctness and validate that the content correctly captured the intent of their responses. The participants did not analyze data.

### **Data Analysis**

I used the modified van Kaam method as described by Moustakas (1994) for data analysis. I found this eight step approach effective in organizing, analyzing, and synthesizing the data.

#### **Step One: Listing and Preliminary Grouping**

I listed and conducted a preliminary grouping of the data by transcribing each audio tape verbatim. I did not omit any statement or word from the transcript, and considered each phrase equally relevant. This is known as horizontalization, viewing each statement as having equal value.

#### **Step Two: Reduction and Elimination**

I accomplished data reduction by repeatedly reading each transcript and eliminating statements that did not answer the guiding question. Overlapping, repetitive, and vague expressions were also eliminated. The remaining statements became the invariant constituents (the meaning units or horizons) of the experience, and described the phenomenon in exact descriptive terms. As participants were added, the invariant constituents increased. I have provided an example of how I reduced the data to the composite invariant constituents that answered the guiding question: "What does being a nurse mean to you?"

*Kate:* I enjoy taking care of people that are ill... I get a sense of satisfaction ... I think being a nurse means being able to help people.

*Jenny:* Being able to help people that are hurting and that are sick and that need my help, care for people.

*Sarah:* Caring, taking care of people, taking care of people who need my help.

*Tommy*: The ability to help others either maintain or re-achieve, help.

*Natina*: I think of it as caregiver, it means caring for other people and helping them through an illness or difficult time in their life.

*Cindy*: Basically...just being able to care for people in a clinical environment

### Step Three: Clustering and Thematizing the Invariant Constituents

I clustered the invariant constituents and defined the “core themes of the experience” (Moustakas, 1994, p. 121).

Table 2

*Themes and Definitions of the Lived Experience of Nurses Working with Student Nurses*

| Theme                                | Definition  |
|--------------------------------------|---|
| Beliefs about nursing education      | Experiences as a student<br>Experiences as a nurse  |
| Role Expectations                    | Personal<br>Students<br>Faculty   |
| Communication Structure              | Learning objectives<br>Clinical schedule<br>Student patient assignments<br>Unit organization and management |
| Motivational factors                 | Intrinsic<br>Extrinsic  |
| Deterrent factors                    | Increased workload<br>Liability concerns<br>Not enough time<br>Threat to quality care                       |
| Professional Socialization attitudes | Feelings when students are on the unit<br>Attitudes about students  |

### Step Four: Final Identification of the Invariant Constituents and Themes by Application: Validation

I checked the invariant constituents and the themes against each individual transcript to make sure the theme was expressed either explicitly or was compatible with the constituents. This process helped determine the relevancy of the experience.

### Step Five: Construction of Individual Textural Description

For each participant I described what the nurse experienced using excerpts from the transcript. This was done essentially by explaining the themes in a narrative format. This process helped me to understand “what” the nurse experienced.

**Step Six: Construction of Individual Structural Description**

For each participant I incorporated into the textural description a structure explaining how the experience occurred. As I wrote the textural description I reflected on the conditions that precipitated what the nurse experienced. This process helped me to understand “how” the experience occurred. I used “acts of thinking, judging, imagining, and recollecting, in order to arrive at core structural meanings” (Moustakas, 1994, p. 79). By using imaginative variation, imagining the experience occurring in a variety of structures, I perceived the experience occurring in different circumstances and identified the conditions that accompanied the experience. This helped me understand how the nurses’ attitudes came to be what they were and the conditions that were met to develop negative attitudes.

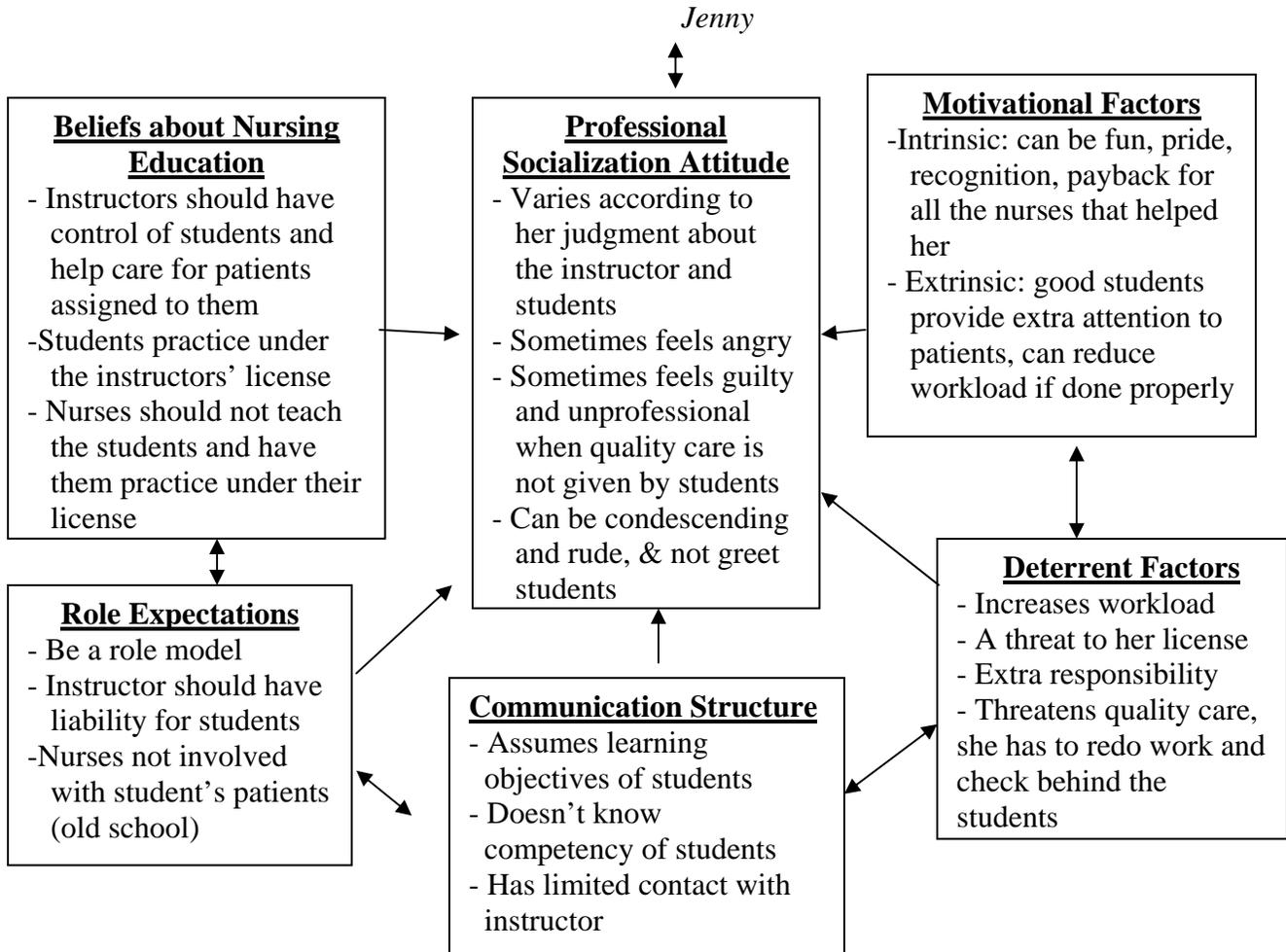
**Step Seven: Construction of a Textural-Structural Description**

For each participant I merged the two narratives (textural and structural) that were created from steps five and six. The finished narrative description included my understanding of “what” (texture) occurred, and “how” (structure) the experience occurred for each participant. After an exhaustive imaginative and reflective study, I explained the experience according to how I understood it, from my vantage point, and described the essence of the experience. According to Moustakas (1994), the result of deriving meaning to a phenomenon is to be aware of the essence or the condition which must be present for a phenomenon to occur.

The following text is a selected portion of the textural-structural description of the second participant (identified as Jenny) and is used to illustrate how I used thematic portrayal to describe deterrent factors. I also included a diagram that depicts Jenny’s experience.

The deterrent factors associated with Jenny’s experience of working with nursing students are related to increased workload and liability concerns. These concerns are repeatedly expressed throughout her transcript. For example, Jenny fears that a student may not have sufficient knowledge to report a patient’s dangerously high blood pressure and that the physician may not be notified in time to treat it. As a result, the patient may be harmed, the physician will “fuss” at her, and she may lose her license. Jenny believes that when the clinical instructor is not present with the students to care for her assigned patients, the students are practicing off of her license. Jenny describes this situation as incorrect clinical instruction, and explains how she is aware that she may be liable for the mistakes of the nursing student. “I mean, it’s just that’s a lot more on ya, and going behind them because that’s like, like doing it twice.” Jenny stated it takes more time for her to check the students’ work, and she may have to redo it. Jenny feels that she is responsible for quality patient care, and when the students do not chart properly, she has to make corrections.

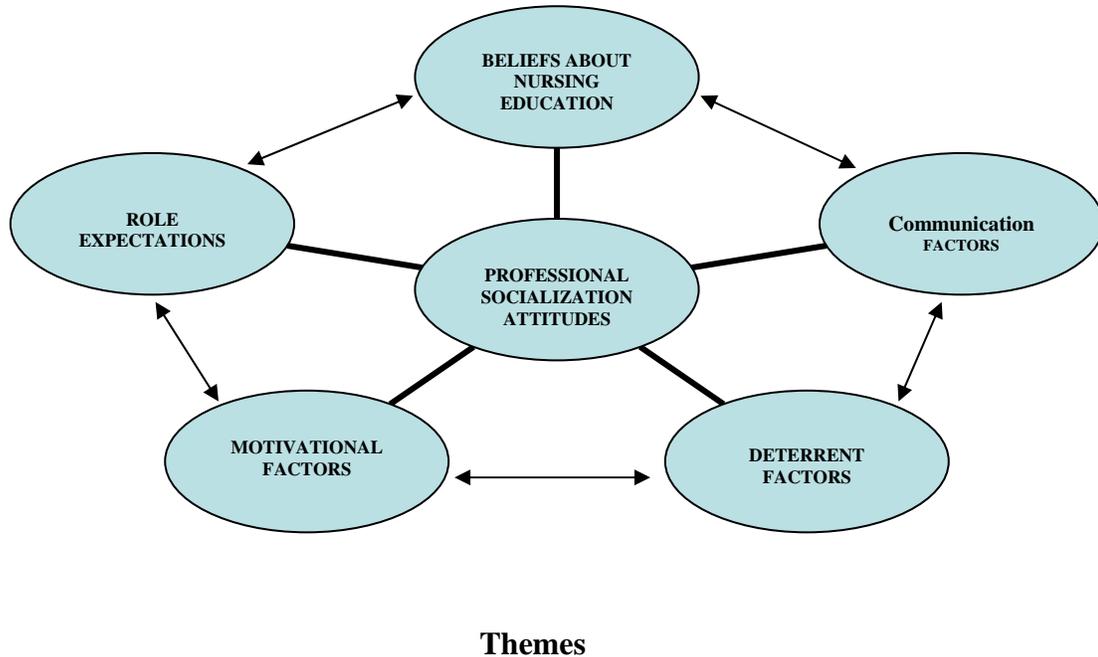
Figure 1. Thematic representation of Jenny's experience of working with student nurses in the acute care clinical environment.



### Step Eight: Composite Description Textural-Structural

I used synthesis to create a composite textural and structural description. This process helped me to determine the essence of the overall experience. For example, the nurses' feelings and attitudes toward student nurses varied and changed according to the circumstances or structure of the situation within the clinical environment. The nurses' developed negative attitudes toward student nurses when they perceived that quality patient care was threatened. Conditions such as heavy workloads and not enough time to check behind students contributed to negative professional socialization attitudes. Nurses took personal accountability for the care a student gave to their patients, and thought management and patients would see it as a reflection of their nursing care. I constructed a model to graphically depict my understanding of the relationships between themes, and to illustrate the lived experience of nurses working with student nurses.

Figure 2. Model representing the composite thematic and structural description of the lived experience of nurses working with student nurses in the acute care clinical environment.



Data analysis revealed the nurse experiencing varying attitudes toward student nurses and is dependent on the structure or circumstances within the clinical environment. I gained an understanding of what attitudes the nurses experienced and how negative attitudes were developed. Circumstances that influenced negative behaviors were having beliefs about nursing education that differed from the nursing program or faculty, role confusion regarding working with students, and poor communication between faculty, students, and nursing staff. Other influences were deterrent factors such as staffing shortages, high patient census or acuity, and liability concerns. Lack of motivation to work with students also influenced negative attitudes among nurses and included a lack of recognition or appreciation for working with students, and lack of monetary or workload compensation.

### **Beliefs About Nursing Education**

The participants expressed beliefs that a baccalaureate degree in nursing (BSN) should be the basic preparation for entering nursing. For example, Tommy stated, “I firmly believe that if it were up to me, we would not have anything less than a BSN program.” The nurses’ beliefs about nursing education were influenced by their personal experiences as a student. Comparisons were made between past and present day methods of clinical instruction. Jenny stated,

they don’t seem as strict, they don’t seem as disciplined... we didn’t really work with the nurses. We would go on the unit and be with our instructor,

and we would go to our instructor, and our instructor took full responsibility for what we did, and we worked under her license. We didn't work under the nurse on the floor's license. Our instructor would take report from the nurse and she would give us report and then we would work through her... When I would go on clinicals I would report to my instructor for anything that I did, in my charting, in my assessment, and my medications. But we would still talk with the nurses... I think we made more use of our time.

### **Role Expectations**

The nurses included expectations of their role as role model, facilitator to help students practice skills and gain experience, educator, guide, and a patient advocate protecting patients from harm. Other roles included comforting the students when they experience something that could shatter their confidence, support and encourage them to succeed, protect them from emotional harm, and to be a resource for answering student questions. Kate stated that her role was to teach, to take time and not have an attitude with the students or get frustrated. Jenny stated, "We're there to help them answer questions, but we shouldn't have the responsibility of teaching and instructing and doing." Tommy responded that his role is "answering questions, being an example of what to do versus what not to do, picking them (students) up and getting them back on their way, being a role model, and assisting in their education."

The role expectations varied. Some nurses thought it within their role to assist with clinical instruction, while Jenny expressed resentment for the time she spent teaching students and having students work under her license rather than the instructors' as expressed in the following extract,

if we're gonna be expected to train them, we need more time because I can go in and do a catheter in 2 minutes. To show a student or work with a student, you're talking about 20 minutes. I will help you but I'm not taking the responsibility or the pay. I mean you (clinical instructor) are getting paid to put people under your license and you're experienced at having people working under you're license, I'm not.

The data showed that perceptions of roles and responsibilities influenced the nurses' attitudes toward students.

### **Communication Structure**

The nurses shared similar experiences within the theme communication structure. The communication pattern was one way with the instructors disseminating limited information among the nurses regarding the clinical instruction process. The instructors or students usually informed the nurses about student assignments. Nurses' input in the clinical process was absent, but all felt as if they could refuse to work with a student. The most prevalent problem with communication was the nurses' complete unawareness of a formal notification about the students' learning objectives and competencies. The nurses

made assumptions about what the students were to achieve by observing the students or from memories of being a student themselves. The following extract is from Jenny's transcripts and is an example of the communication between the nurse and students and/or instructors. Jenny expressed,

they don't tell us anything. The one (instructor) that comes, she doesn't even talk with us, fool with us, she has her students and she's running the show, so it's her and her students on our unit using some of our patients and she has full responsibility; so, we're not even watching what they're doing. At the end of the day, she turns her chart in, you open it up, it's done, everything's done according to our policy, she (instructor) knows our policy she knows how to tell them how to chart. She's teaching em, we're not, we're not doing anything with em except you know talking to em, answering questions.

When asked how they knew what the students' learning objectives were the nurses did not reference consistent communication by instructors or students. Extracts from the transcripts reveal that the learning objectives were mostly assumed by the nurses. Sarah stated, "I didn't really discuss it with any of them but I, would think to get experience." Tommy responded,

the visual clues, they are asking me questions about when do you do this and when do you do that, and I can see them trying to figure out what they have to do and when they can do it. But they actually don't tell you that this is what I'm working on today.

All the nurses expressed that they were informed that a student was assigned to their patients at the beginning of the shift. Some instructors asked the nurses' permission to have a student take care of their patient, and some nurses were not approached by the instructor at all.

### **Motivational Factors**

The nurses were motivated to work with nursing students in various ways. The motivational factors identified were to gain knowledge and fresh ideas, provide a change in the work routine, and personal satisfaction and pride in helping, as in Kates' response, "it can be fun, and fulfilling a professional responsibility, just for something different, just so I don't have the same monotonous day at work...I enjoy the students and they are a lot of fun." Sarah shared, "I want them to feel better whenever they go into the job."

Intrinsic motivational factors were intangible and created inner feelings of personal satisfaction. Extrinsic or tangible incentives motivated nurses to work with students because it reduced the workload for nursing assistants, provided help when the unit was short staffed, gave nurses more time to spend with patients, provided special benefits for patients, and served as a source for recruitment. The transcripts contain examples that demonstrate the extrinsic incentives for working with students: Jenny reported,

if done correctly, they take some of the patient load away from you so you can spend more time with your patients ...not only are you spending more time with the people you have left, hopefully they're spending time too....I've learned when they're in clinical they do special stuff that we probably overlooked...they help with the patients too.

Natina added,

they do take a little bit of the work load off. I think it's also a reward for the patient as well; because they get a little bit of extra attention. All the nurses reported that having more experienced nursing students had potential for reducing their workload.

### **Deterrent Factors**

The nurses believed that the students were “working off” of the instructors’ license. Furthermore, the nurses perceived that when the instructor was not present on the unit, their license replaced the instructors’ by default. Additionally, the nurses perceived that they were also responsible for the quality of care they relinquished to the student regardless of the instructors’ presence. The following extracts demonstrate that their concerns related to licensure and quality care caused job strain: Jenny responded that,

being responsible for em on your license. ...someone has to sign behind them. They have to operate under somebody’s license, so what it means to me is when I put my initial that means I’m saying I saw them do this or I know they did this and they did it correctly.

Kate expressed, “it’s a strain.... I’m more worried about them doing something that might hurt the patient.”

Sarah added,

there could be errors in procedures, errors in medication that’s being given, if things aren’t checked properly. A patient could die, that’s the worst consequence. ...you always have to take responsibility yourself. I wouldn’t let anything happen to let my license become threatened.

Natina reinforced the liability concern by expressing,

even though the student had that patient, at the end of the day it’s gonna be on me whether something didn’t get done right, it’s still gonna be back on me because I was that patient’s nurse... As far as license, we’re held accountable for whatever goes on and if something happens with that patient that patient can sue my hospital, they can sue me! I’m still accountable for that, that’s still on my license.

Another deterrent factor was that students caused increased workloads and was time consuming as expressed by Kate.

you get a more heavy load...that doesn't leave you a lot of time to teach or help the students... They've tried to change that but it doesn't always work because the night shift makes all the assignments...So they really don't understand, they think of it as an extra set of hands ...if you have students in the very beginning...it slows you down... because I'm talking and showing and stopping.

Tommy confessed,

the students will come ask me about certain meds about procedures other things and I'm answering more questions instead of giving the meds. ...when they leave I don't know what's been done or what hasn't been done or what's been going on. If I have to go through report with one nurse and then turn around and give report to three different students, it's time consuming and irritating.

Generally speaking, the nurses stated they did not dwell on the negative aspects: However, the nurses coped with the increased stress in different ways and this determined how the nurses socialized with the students.

### **Professional Socialization Attitudes**

The professional socialization attitudes were defined as the nurses' feelings when the students were working with them and the attitudes they had toward the students. The feelings and attitudes of the group varied and changed according to the circumstances. The following extracts demonstrate the nurses' attitudes and their reactions to students: Jenny admitted,

when we're busy they come on ... my attitude is...you look as though here's more stuff for me to do. ...If they're slower than you are and you're busy, that's when you get shafted. ...And then you feel ...the guilt thing, the anger thing, and then you're behind and then you feel like I let my patient down, ....I can't swear that I was never ugly to a nurse...I will be very condescending.

Sarah expressed,

Aggravation. Not necessarily the student personally. But, just aggravated that they can't do it all... I'm more abrupt and sharp with the student. I don't explain things as thoroughly. I try to shorten my time with them as much as I can. The nurses also discussed their perception of the attitudes of other nurses who work with students.

Jenny retorted,

I've heard them talk and I've seen um when we're busy. How we treat them depends on how busy we are, how prepared they are, and how competent their instructor is.

Kate related,

It was a while back we had a nurse, for some reason they kept putting nursing students with her, and she just didn't have the personality for it... she would get frustrated with them and I think they dreaded coming to clinical...a lot of times she would embarrass them... When we are really busy what embarrasses me is when they come up and say "Here's such and such she's going to be working with you" and they are like (sigh) Oh, I can't have a student today.

Sarah shared,

Some hold a grudge and they'll like I'm not gonna work with anymore students and just, that's just too much aggravation for me I don't want to do it, I don't have the time to sit here and talk to em. So I'm just not gonna do it anymore...(In reference to behaviors of nurses when aggravated) Talking in a rude tone, making them feel stupid, like why aren't your getting this? is that hard to understand?" Ignore em, out of site out of mind thing. If I don't see that student then I don't have to deal with em, and I'll just veer away from em.

Cindy responded,

The ones I know who would rather not deal with them ...they are set in their ways of doing things and it kind of bothers them to be out of that. And I've noticed it makes the students feel nervous and afraid to ask the nurse anything. ...There are some nurses who try to be their instructor...And I feel sorry for them, cause the nurse is over there drilling them.

### **Findings and Discussion**

Although conclusions from this study cannot be generalized beyond the sample, the consumer of qualitative research findings should determine the degree to which they can relate to the findings from practical experiences. This study captured the lived experience of six nurses working with student nurses. The experience described "what" attitudes nurses had toward student nurses and "how" negative attitudes were developed. Nurses' concerns about legal liability, role confusion, lack of communication regarding students' learning objectives, differences in beliefs about nursing education, and lack monetary or workload compensation fostered negative attitudes. Nurses admitted to

acting out these negative attitudes by being condescending, ignoring, or being judgmental to the student nurses. In the study by Lofmark and Wikblad (2001) student nurses described identical attitudes of nurses toward student nurses and identified them as barriers to learning. In this study, some nurses voiced feelings of guilt about how nurses were treating nursing students, and how that treatment reduced the quality care of patients.

The nurses' belief that nursing students are a source of recruitment, and that nursing students increase or decrease the nurses' workload depending upon the student's preparation, attitude, and willingness to participate in patient care experiences is consistent with the studies by Grindel et al. (2003) and Matsumara et al. (2004). Another consistency is that nurses' attitudes of nursing students are influenced by patient acuity, unit staffing, and the availability of and support from the instructor (Grindel et al.). Other findings that agree with previous studies are the need for: improving communication between academia and service, teaching staff nurses how to work with nursing students, adjusting nursing staff assignments when working with student nurses, assigning student nurses to spend prolonged times with nurses, and recognizing or rewarding nurses who work with student nurses (Matsumara et al.; Atack et al., 2000; Chan, 2002; Cope et al., 2000; Drennan, 2002; Li, 1997; Lo, 2002; Lofmark & Wikblad, 2001; Seigel & Lucey, 1998; Suen & Chow, 2001).

Nursing educators can improve communication by clearly informing nurses who work with student nurses of the students' competencies and learning objectives. Nursing education can assist in the provision of continuing education programs for nurses that focus on topics such as how to work best with students and faculty, role expectations, and philosophies of baccalaureate nursing programs. Clinical nursing educators should teach nursing students to socialize with nurses by being prepared for the clinical experience, relating their learning objectives to nurses, being competent, and displaying a willingness to learn.

Empowering nurses by allowing them to voice their opinions and concerns regarding student assignments, role expectations, and workload issues while working with students may strengthen relationships and foster positive, professional socialization attitudes among nurses who work with student nurses. Nursing faculty can play a role in building collaborative relationships with nurses by inviting nurses to participate in clinical assignments for students, scheduling students to listen to change of shift reports with the nurses to avoid double reporting by the nurses, and planning a time for socialization with nurses at the beginning of a clinical placement. Nursing faculty should also encourage communication between the nurses and student nurses regarding patient care, so that students become a part of the nursing team rather than guests in the facility.

An additional finding from this study is that a need exists for the assessment of nurses' knowledge pertaining to legal liability issues while working with student nurses. The existence and prevalence of the perception that students "work off" of the license of a nurse should be corrected. Legal implications for all involved in nursing education should be reviewed, and the interpretation of these implications should be clarified by the governing body for nursing in the state or region.

Incorporation of collaborative strategies that promote professional socialization attitudes of nurses whom work with student nurses has the potential to improve the quality of the clinical experiences for both students and staff nurses. Positive clinical

learning experiences may reduce the attrition rates of nurses and nursing students, increasing the number of qualified professional registered nurses in the workforce. Continued research of nurses who work with student nurses, as well as exploration of the nurse educator's perspective, is needed. Finally, the establishment of evidenced based practice for optimal clinical instruction should be the ultimate direction of future research in nursing education.

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### Article Citation

Hathorn, D., Machtmes, K., & Tillman, K. (2009). The lived experience of nurses working with student nurses in the clinical environment. *The Qualitative Report*, 14(2), 227-244. Retrieved from <http://www.nova.edu/ssss/QR/QR14-2/hathorn.pdf>

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