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Points of tension: a qualitative descriptive study of significant events that influence undergraduate nursing students' sense of belonging

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ABSTRACT

Introduction: Soon-to-be graduate nurses who choose to begin their career in rural hospital settings face not only the challenge of learning to do rural nursing, but also how to navigate the complex personal and professional relationships that characterize the close knit community of rural hospital teams. Since every encounter with registered nurses and other members of the team is contextually mediated, the challenge for students, preceptors, other professional staff members, and nurse educators is to develop a supportive clinical environment that fosters students' sense of belonging. The objective of this study was to describe events that influence undergraduate nursing students' sense of belonging during a rural hospital preceptorship, and to explore their meaning.
Methods: Using the clinical incident technique, a purposive sample of fourth year nursing students completing a rural hospital-based preceptorship in southern Alberta and British Columbia, Canada was used. Individual in-person and telephone interviews as well as written accounts were analyzed. Inductive and comparative analysis was used to uncover the themes 'points of tension' and 'minimizing the differences'.
Results: The clinical environment that includes everyone who interacts with the student has the potential to positively or negatively influence students' sense of belonging. Tension developed when students' expectations of their preceptor, nurses, and other professional team members did not coincide with the reality of the everyday clinical environment. Only when the differences

between themselves and the registered nurses they worked with on daily basis were minimized did the participants in this study feel as if they belonged to the community of professional nurses.

Conclusion: Nurse Educators need to carefully assess not only students' knowledge of rural nursing practice, but also students' expectations of themselves, their preceptor, other professional staff members, and the overall clinical environment. As such, students need to develop social awareness and facility. Preparation also extends to everyone in the clinical setting who is involved in the students' experience so that they learn not only what students know but how to interact with them. In this way the clinical environment is supportive of students' learning and transition to the graduate nurse role.

Key words: nursing students, preceptorship, rural hospital, undergraduate.

Introduction

Most newly graduated registered nurses begin their professional careers working in hospitals where their work is characterized by time constraints, high patient acuity, and cutting edge technology[1]. New graduates who choose to begin their careers working in rural acute care hospitals face two additional challenges. They are required to become multi-skilled generalists capable of providing a wide array of nursing care services to a diverse range of clients frequently in situations without medical or specialist assistance[2]. They are also required to develop technical skills equal to their urban counterparts within the context of a cohesive professional community[3]. Although there appears to be general consensus that new graduates need an environment that is supportive of their transition from university student to graduate nurse, for soon-to-be graduate nurses, becoming a nurse is as much about joining a group of registered nurses as it is about learning the technical skills of nursing[4].

While there is a substantial amount of evidence in the nursing education literature to support the notion that preceptorship helps bridge theory and practice, it fails to examine students' sense of belonging during this type of learning experience. The end result of not belonging is that new graduate nurses might leave the profession, or end up tolerating rejection[5]. Set against a backdrop where rural residents experience a stronger sense of belonging than their urban counterparts[6], and where it might take a long time for a newcomer to become a local[7], it is appropriate to explore events that influence soon-to-be graduate nurses' sense of belonging to the rural hospital nursing team, especially since the rural hospital nursing team has been described as cohesive and close knit, a situation where students are not automatically incorporated into the practice community[3].

Literature review

Preceptorship, typically described as a formal one-to-one relationship of a predetermined length of time between a nursing student and experienced registered nurse, is a popular clinical teaching strategy in Canadian nursing programs[8]. However, the clinical setting has dramatically changed since its original implementation in the 1960s. Patient acuity levels are higher than ever before, shorter patient hospital stays are the norm, staff shortages are coupled with an increased casualization of the workforce, mandatory overtime, and a heavier workload - all of which form the backdrop for today's nursing care environment. Along with having fewer nurses per capita[9] rural hospitals also face threats to the sustainability of the nursing workforce due to aging employees and nurses approaching retirement[10]. It is not surprising then, that healthcare settings focus on workplace goals and outcomes rather than student learning goals[11]. It is also understandable that nurses might perceive the presence of nursing students in the clinical setting as a stressful burden[12], hampering their efforts in supporting student learning[13-15].

Given that healthcare service organizations and nursing education programs have differing views of how new

graduate nurses are to carry out their role[16], developing a sense of belonging may be difficult for soon-to-be new graduate nurses. Yet the concept of belongingness has yet to be fully explored even though it represents a type of outcome that is critical to the education and professional socialization process[17]. Only two studies were found that explored the concept of 'belonging' among nursing students. In these studies, student participants stated that feeling like they belonged to the community of registered nurses was central to their learning during their clinical placement[3,17].

Even though working with an experienced rural nurse when encountering a potentially life threatening crisis is pivotal for new or novice registered nurses in developing supportive relationships in the workplace[18], lack of knowledge regarding everyday events that influence student belonging is a serious challenge within nursing curricula. This study helps to fill that gap by describing undergraduate nursing students' experiences while in a rural hospital preceptorship, bringing meaning to how these events might influence their sense of belonging.

Purpose of the study and study questions

The purpose of this study was to identify events that influenced students' sense of belonging to the community of rural hospital nurses, and to explore their meaning. The research questions that guided this study were:

- What events influence students' sense of belonging in a rural hospital setting?
- What meanings do these events have for students in a rural hospital-based preceptorship?

Method

The critical incident technique (CIT)[19] was used for this study. Originally developed in World War II to identify flight crew behaviours that led to the success or failure of a mission, CIT played a key role in identifying screening criteria for flight crews and the development of flight training programs[19,20]. In the early days of the technique's development, critical incidents were – and to a large extent continue to be – defined as situations perceived to be overwhelming that subsequently affect an individual's 'normal' coping mechanisms[21]. This definition is synonymous with nursing perceptions of the term 'incident' since in the hospital setting an 'incident' is when something goes wrong or disrupts the 'normal' routine. As such, 'incidents' include medication errors, a patient fall, or a needlestick injury. To access the most meaningful data pertaining to students' sense of belonging, participants in this study were asked to recount important 'non-crisis events'[22], that is *significant* events rather than only clearly demarcated incidents as described above. Changing the term from critical to significant did not change the fundamental process of CIT; rather, it provided the opportunity to emphasize the recollection of events[23].

After receiving ethics approval from the researchers' university and a large western Canadian university, the principle investigator met in-person with the clinical course coordinators. At the meeting arrangements were made to conduct classroom presentations to fourth year undergraduate nursing students. Students undertaking their preceptorship in a rural hospital were invited to participate in the study through receipt of an electronic letter of invitation.

Methodological challenges unique to rural health research include inconsistencies in the definition of the term 'rural'[9,24] partly due to the diversity in rural and remote residents' lifestyles, cultures, and perspectives as well as differences in cultural and social influences. Furthermore, because the typical definitions of rural would eliminate many communities in southern Alberta and British Columbia, Canada, for this study, rural communities designated as towns with a population of less than 9999 people provided the rural setting. The hospitals in these communities tended to offer a limited number of medical and ancillary services. They also had a small number of in-patient hospital beds and were designated a 'Community Health Centre or Complex' or municipal hospital.

In the period 2009–2010, the year this study was conducted, 32 students choose to complete their preceptorship in a rural hospital setting. Twelve interested participants met with the researchers individually to discuss the purpose of the study, procedures, and expected time commitment for participation. A written letter of consent was signed by each participant. To ensure anonymity and confidentiality, participant names were removed from all data sources and were replaced with pseudonyms. All participants were female and were between 24 and 43 years of age. A limitation of the findings of this study is that accounts that influence visible and self-declared minority students were not represented. Therefore, further research exploring this population of students is warranted.

Data generation

Over the course of an 8 month period, audiotaped semi-structured in-person and telephone interviews were conducted. Written accounts were also invited when participants were unable to take part in a verbal interview. Because students were asked to recount everyday events rather than extreme or atypical incidents[19], they were at risk of having difficulty recalling significant events that influenced their sense of belonging from among their thousands of activities throughout their shifts[23]. Therefore, prior to the interview or submission of their written account, the participants were asked to reflect on events that included interactions with their preceptor, professional staff, patients and families that were significant to them. Initial guiding probes for the interviews and written accounts included: 'Think about and describe in as much detail as possible the actions or behaviours you, your preceptor, other professional staff members, or patients engaged in that made you feel that what you were doing was valued and that you were part of the team'. As data analysis proceeded, the probes changed somewhat to include the following: 'Describe for me when you felt you were a professional nurse'.

While written accounts of significant events might have taken up more of the students' time, they did have several advantages. Written responses to the probes permitted the participants to consider their responses and include greater detail if they felt it was needed. Written accounts also allowed students who were dispersed over a wide geographical area to participate in the study because all participants had access to email. Finally, some students indicated that describing an event for this study helped them with their reflective journal assignments.

Another consideration that influenced the generation of data was the events themselves. Although no less than 50 events be collected to ensure that the differences in the participants' self-expression and a sufficient amount of quality and usable data is generated, at the beginning of the study the exact number of events that were to be collected could not be known because of the complexity of the practice setting and the research questions[23]. Therefore, the sample size of events depended on their meaning, rather than on the number of participants[25]. Ultimately, interviews and written accounts were solicited until redundancy in the events and their meanings appeared and saturation occurred[26]. Twenty-four different accounts made up the final account sample size.

Data analysis

Data generation and analysis occurred concurrently beginning after the first interview. To begin data analysis, after each interview or when a written account was received, a contact summary sheet summarizing the salient points of the interview or account was developed[27]. These sheets helped both researchers identify questions arising from the interview that needed to be included in the next interview.

Initially, data were inductively analyzed[28]. Individual participant transcripts and written accounts were read and re-read by both researchers in order to identify categories and subcategories. The event, context, and circumstances were also analyzed to facilitate understanding of the meaning of the events. As analysis proceeded, categories were developed and were subject to revision and refinement in light of the emerging information. Once all transcripts and written accounts were analyzed individually, comparative analysis where the transcripts and written accounts were read 'horizontally' was undertaken[28]. At this point, segments of

text shared between transcripts and written accounts were grouped together. This strategy allowed the researcher to identify differences and similarities within the transcripts and written accounts and helped in the development of overarching themes. Inconsistencies or contradictions were also more readily identified and gave insights into the participants' experiences. Once data analysis was completed a taxonomy of meanings was developed.

Credibility, dependability, confirmability, and transferability were used to establish the trustworthiness of the study[26]. To establish credibility, interviewing participants continued until there was redundancy in significant events. Sources of data included in-person and telephone interviews, written accounts, and field notes. A student not part of the participant sample but who had undertaken a rural hospital preceptorship was asked to review the findings and interpretations. Dependability was achieved by having an external reviewer examine the data. An audit and decision making trail helped establish confirmability. Transferability is achieved through thick descriptions of significant events that influenced students' sense of belonging.

Results

The participants in this study described a wide array of clinical situations that fostered or inhibited their sense of belonging to the nursing team. Further, it was evident from their stories that belongingness was influenced by such factors as: individual characteristics (staff and student); interpersonal relationships between the student, other professional team members (nursing, medical, and ancillary staff) and patients and their family[17]; and the clinical environment. It was especially evident that interactions where they felt they were '*being treated like a nurse*' (Rebecca), '*not as a student but as a peer, an equal*' (Bev) significantly influenced their sense of belonging. However, students who did not feel that they belonged to the team experienced anger, frustration, decreased self-confidence, confusion and even despair[3]. They '*didn't want to be there [and would] rather had not been sent there*' (Heather). As a result, interactions with all members of the team as well as the patients and their family had a great potential to positively or negatively influence their sense of belonging.

Given that the effect of preceptorship on nursing students' role socialization is yet to be established[29], the findings of this study are significant. Indeed, describing and understanding the meaning of events for students' sense of belonging to the nursing team during a rural hospital preceptorship helps strengthen the effectiveness of this type of clinical teaching model.

In the following section, two major categories that emerged from the data analysis are presented. These represent both explicit and tacit aspects of the everyday behaviours[30] of students, preceptors, other professional staff, patients and families that influenced students' sense of belonging. By integrating excerpts from interviews and written accounts with published literature, soon-to-be graduate nurses' experience of belonging during a rural hospital preceptorship is described.

Points of tension

Although there are many determinants that influence the teaching-learning process, the clinical environment which includes each person in the agency and the physical structure is instrumental in influencing soon-to-be graduate nurses' sense of belonging. Consequently, preceptors and staff are key factors in the establishment of a constructive and supportive environment[8]. It is also reasonable to say that students themselves influence the learning environment since they enter into the preceptorship with the belief that they are at least to some degree already part of the team[31]. For the students in this study, the differences between their expectations of themselves, their preceptor and staff, and the clinical environment resulted in points of tension.

Indeed, initially, some students seemed to be unprepared and somewhat surprised that they felt uncertain of what to do and how to behave.

> *My very first shift I just sat in the chairs outside the nursing desk. At first I wasn't sure where my boundaries were.* (Jane)

Not only did they feel uncertain about what to do and how to behave, lack of self-confidence led some students to believe that staff members perceived them as existing on the fringes of the nursing team[31].

> *As students it's our habit to maybe see ourselves as a lesser member of the team and so we perceive that the rest of the team doesn't feel that we're part of the team.* (Laura)

While their initial few shifts created uncertainty that affected most students' self-confidence, some of the participants expected their learning needs would be a preceptor priority.

> *I expected to be her priority, but I wasn't. I had questions about the routine: what I should be doing. I wanted to make sure I was doing things correctly but I'd have to wait and double-check things.* (Heather)

Although most students recognized that their learning needs could not always be the preceptor's priority, some students perceived this as a '*lack of interest*' (Heather) in their learning and, that they '*were not welcomed*' (Susan). In particular, emergency situations seemed to confirm for most students that they had unique needs that were not always immediately recognized by their preceptor or other nurses. As a result students perceived themselves as being 'different' from the registered nurses they worked with on a daily basis.

> *As the adrenalin subsided, I had the opportunity to think about what just happened and realized that I needed to debrief about the event. However, the staff went about the day because there were other patients who needed to be tended to. The fact that I was unable to debrief about the event made me feel that I should be able to simply shelf the experience and move on – which is what I did for the rest of the shift.*

> *I feel that this event kind of separated me from the rest of the team because they all simply moved on and I felt like I shouldn't ask about the event or request a debriefing because they dealt with it so matter of fact.* (Susan)

The clinical learning environment also presented students with points of tension. Encounters with the registered nurses were contextually mediated[32] and affected their level of enthusiasm.

> *I would go to work with a different attitude if I knew I was working with certain nurses. Knowing I was going to work with some nurses I went in with a really good attitude and I had a really good day. Sometimes though, I knew I was going to be working with these other nurses. I knew I would have one of those days and I would be bummed out before I even got there. I knew I would hear cattiness or be made to feel inferior or people would be really skeptical of me and my work.* (Charlene)

For some students unit dynamics characterized by complex and difficult relationships among staff members were difficult to navigate and ultimately negatively impacted their learning and becoming part of the team.

> *There was lots of politics on the unit. There were certain nurses that my preceptor didn't get along with so I would be told 'Don't you dare go and help those other nurses!' So I felt very much like I was my preceptor's possession and she didn't want me to kind of spread out and be that team member that I wanted to be. In the end, if there was something interesting that I hadn't done before on the other side, I wasn't allowed to go. I felt that I was missing out on learning.* (Jane)

Unit dynamics also extended to the manner in which physicians and nurses interacted with students. For example, although all of the participants expected to be asked many questions early on in their preceptorship, they also expected

that the number of questions and the frequency of the questioning would subside as the preceptorship progressed. For the participants in this study, being asked fewer questions meant that the physicians and nurses had come to trust their knowledge and skill level. When this did not happen, students felt inferior and lacking in some way.

> *There was one senior doctor who throughout my entire time there, refused to discuss patients and their care with me, and always went to find my preceptor to assist him. This doctor would not share the orders with me and requested assistance from my preceptor while I just stood there doing nothing* (Edna)

> *My preceptor was always right on top of everything. Everything I did she would kind of double-check. If the doctor was there she was there and I just felt like I didn't really get to ask any questions or be a part of the decision-making.* (Rebecca)

Some students expected to be able to develop and implement their own approach to providing nursing care. However, they quickly learned that doing things differently than was the custom resulted in the preceptor expressing displeasure.

> *My preceptor was really big on how she likes to do things. It was like, X, Y, and Z: it needs to be done in this order all the time regardless. I know what needs to be done but I still don't do it exactly the way she would like it done because I'm a different person. She's big on you go in there with your blood pressure machine, your towels in case they want to shower, your basin and all your dressing supplies, whereas I need to break it down a little bit more. I still don't put everything together the way that she does.* (Heather)

At times the clinical environment was so toxic and demeaning that students felt they did not have any credibility[33] and so were unable to be themselves.

> *We had a group of third year students on the unit one day and they asked me questions about two of their patients. I'm like, 'You know what? Sorry, I don't know'. At one point my preceptor looked at me and said, 'Oh, I must be mistaken. I thought this was your side today'.* (Rebecca)

> *There were times where I didn't really act like myself because if I did that's also when I would get shushed or things like that. So it was almost hard to even be myself around some of the nurses.* (Charlene)

To cope with the above examples of horizontal violence of silencing[34] and being made to feel inferior, students engaged in self-talk and in modifying their behaviour in a way that they perceived would be more acceptable to the nurses and the team.

> *Knowing I had to work with certain individuals those were the days that I was like, 'Okay, I can do this. You've done this before, you can do this. You've been complimented on doing this'. It was more with having to boost my own self-esteem before I went in since I felt kind of shattered by other people.* (Rebecca).

> *You have to learn how to work with the different people. You have to learn their personalities. So, I really had to curb my tongue at times. There were certain things that I didn't say whether it was because of the age difference or because of their background: their cultural or religious background. You learn how to act with certain people.* (Jane)

Minimizing the differences

By minimizing the differences between the student and professional nurse roles, participants in this study felt they were able to achieve a greater degree of belonging to the nursing team. Catching on to the routine that included being able to anticipate physician practices and preferences seemed to help minimize the differences between being a student and professional nurse.

> *I had really caught onto the routine and was able to actively participate independently without a lot of*

> *instruction. So I was able to work with the doctor. I caught onto her routine so I was able to get her the things she needed when she needed them.* (Heather)

Being able to demonstrate their ability to critically think and make sound nursing judgements seemed to help preceptors, nurses, and other professional staff members to recognize them as professional nurses.

> *I was making nursing judgments with my patients instead of always asking them what they would do. I would do some research, go through the policies and procedures and tell them, 'This is what my plan is. What do you think?' So the nurses and physicians could see that I was thinking things through.* (Lisa)

> *Because I've been so open with the knowledge that I do have they're now very open to treating me like an equal and they respect my opinion professionally.* (Joan)

As a result, these participants felt they were being treated like a nurse which generally meant that they were included in the patient care decision-making process.

> *The nurses and doctors talk to you; they explain what's going on. It's not just an observational role; you're actually a part of it. They include you in decision-making; they include you in group processes rather than just being an outside observer* (Joan)

> *I did not have a lot of experience with wound care. Despite this, I used my limited knowledge and participated in an in-depth discussion, which led to us agreeing on a solution. For the nurse to value my opinion really made me feel part of the team.* (Julie)

The result of being able to minimize the differences in the student role and the professional nurse role was that patients asked for them by name. This seemed to be a clear indication that they had become a professional nurse and part of the team.

> *My preceptor mentioned I had some sort of impact on the patient since she asked for me specifically. He told me to see it as being part of the team in the hospital and not an observer putting in hours.* (Sharon)

From these accounts, it is clear that the clinical environment that includes everyone within the setting has the potential to significantly influence soon-to-be graduate nurses' learning and sense of belonging. Students experience points of tension and work to minimize the differences between the student and professional nurse role. Being able to be a '*contributing*' (Heather) member of the nursing team enhances their self-esteem and self-worth, sense of connectedness[35], and produces a coherent sense of identity[36] within the community of registered nurses.

Discussion

With the demands of health care environments requiring nursing graduates be prepared to 'hit the ground running', the process of transitioning from the student to registered nurse role must be maximized in order to reduce the transitional stress experienced by new graduate nurses[31]. Sources of stress in the clinical environment include exploitation of students, fear of making an error or mistake, hospital equipment, and being observed[37]. Another source of stress for students in the clinical setting is the social component of the clinical environment[38]. Data from this study suggest that within the close knit community of the rural hospital healthcare team, students must learn to reconcile their expectations of themselves, preceptors and staff, and the clinical environment with the reality of the everyday work environment. This has implications for how students, preceptors, healthcare team members, and nurse educators understand the rural clinical environment. Moreover, understanding the significance of how students experience and interpret belonging is invaluable for hospital managers who are seeking to recruit and retain a future nursing workforce.

Because practice environments have largely been silent in their critique of the practice setting as well as factors that hinder effectiveness in practice[39,40], there is a need to identify, develop, and implement specific strategies that enhance students' sense of belonging while in a rural hospital preceptorship.

The following strategies are recommended as a way to help hospital administrators, preceptors, healthcare team members, students, and nurse educators address the points of tension experienced by students. It is also hoped that these strategies will support students' efforts in minimizing the difference between them and the registered nurses with whom they work so that they are able to feel like they belong.

Recommendations

Assessing and preparing students for a rural hospital preceptorship is central to the success of the experience[41]. Nurse educators are encouraged to assess students' knowledge, independent and dependent behaviours, goal oriented behaviours, organizational ability and commitment to learning[42]. Students' understanding of the differences between clinical experiences that are guided and lead by a tutor or faculty member and those that are facilitated by a preceptor also need to be brought to light. In particular, students' understanding of the preceptor role of teacher and facilitator and their associated responsibilities[8] and how these might be expressed in the clinical setting needs to assessed. This type of assessment will help nurse educators and students identify unrealistic student expectations and will help them gain greater insight into what they might more reasonably expect to gain from the experience. Ideally, learning goals developed prior to the start of the preceptorship and expectations of the clinical environment should be shared with preceptors before the first scheduled shift so that they are aware of the students' expectations.

Since not all students are psychologically prepared[42] to navigate the complex relationships that exist within a close knit community of professionals typical of a rural hospital setting, nurse educators need to teach students how to develop smooth, effective interactions. As such, students need to be taught how to: sense non-verbal signals expressed in facial expressions; listen attentively; discern the other person's thoughts, feelings, and intentions; and recognize what's expected of them. Along with helping students develop social awareness, they need to be able to act on nonverbal cues appropriately, present themselves effectively, and express themselves in a way that produces the desired social outcome. Perhaps most importantly, students need to learn how to demonstrate concern by focusing not only on their own needs but by demonstrating awareness and understanding the healthcare team's patient and organizational objectives[43]. In this way, soon-to-be new graduate nurses are alerted to professional adjustment issues and are better prepared for adverse professional interactions[44].

While becoming a nurse requires students to learn the technical skills of nursing practice, joining a community of registered nurses is influenced by contextual encounters with patients, patients' families, nurses, and other professional healthcare members. Each encounter contributes to reinforcing and confirming for students their belonging to the nursing team and subsequently the nursing profession. Preceptors, nurses and other members of the healthcare team need to understand that for soon-to-be new graduate nurses, the nature of confidence and confirmation of being accepted into the team is not experienced separately: each influences the other[32].

Consequently, students need to perceive the clinical environment as a supportive environment[37,45]. Cultivating and growing rural nurses[18] means that experienced members of the team need to recognize when soon-to-be graduate nurses are experiencing a significant event that presents difficulty for them and to act on it. By deliberately bringing together nurses, other team members, and students to debrief following significant events, group members inform each other about the situation that occurred and demonstrate acceptance of responses to the situation[46]. This type of

support fosters group cohesion and a sense of belonging for students and staff alike.

Finally, preceptors, nurses, and other healthcare team members involved with students need to be cognizant of their behaviours toward students[33,45] and how these behaviours impact students' self-confidence, feelings of self-worth, and ultimately their sense of belonging. While all members of the team directly involved with students need to learn what students know and how to interact with them[47], it is also everybody's responsibility to incorporate strategies that express valuing, knowing, acting together, and promoting quality into everyday practice so that students and staff experience belonging[45]. Students, therefore, need to be encouraged to recognize and report instances of horizontal violence to their supervising faculty member. Both students and all members of the hospital team need to learn how to effectively resolve conflicts.

Conclusion

While soon-to-be graduate nurses who choose to begin their career in the rural hospital setting are faced with learning the 'doing' of nursing, they also face additional challenges. They must learn how to navigate through personal and professional relationships within a close knit community in order to become a member of the team. The findings of this study suggest that because every encounter with registered nurses and other members of the healthcare team is contextually mediated, the clinical environment has the potential to positively or negatively influence their sense of belonging. As such, not only is preparing students vital to the success of the preceptored clinical experience but, equally important is preparing everyone who is involved with the students' experience so that soon-to-be graduate nurses might feel like they belong.

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