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Building Clinical Confidence: Experiences of 3rd-Year Nursing Students in Hospital and Community Exposures

Allan M. Manaloto*[1], Christine M. Bernardo[2], Cherie Ann A. Giray[3], Jelo A. Alfiler[4], Relita S. Luna[5], May- Ann A. Termil[6], Jayson F. Nabong[7], Julius A. Castillo[8]
[1]Bulacan State University
[2,3,4,5,6,7,8] La Consolacion University Philippines
Malolos, Bulacan, Philippines, 3000
*Corresponding author email: *allanmanaloto2021@gmail.com*

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Abstract

Aim. This study aimed to explore and describe the reflections of third-year nursing students regarding their clinical confidence and readiness during their hospital and community exposures. Specifically, the study sought to understand the emotional challenges, perceived preparedness, and factors influencing students' confidence as they transitioned from classroom learning to real-world patient care.

Methods. A qualitative research design was employed, utilizing inductive content analysis based on the framework of Graneheim and Lundman (2004). Reflective narratives were collected from 30 third-year Bachelor of Science in Nursing (BSN) students from a private university in Bulacan, Philippines. The data were analyzed to identify meaning units, codes, and categories, which were then abstracted into overarching themes representing students' perceptions of their clinical confidence and readiness.

Results. The analysis revealed four final themes related to clinical confidence development: (1) "Confidence as Journey from Vulnerability to Self-Trust", emphasizing emotional resilience and coping strategies; (2) "Confidence as Relationally Scaffolded Competence", highlighting the importance of mentorship and peer support; (3) "Confidence Through Validated Performance in Authentic Contexts", focusing on the validation of skills through real patient care experiences; and (4) "Institutional Conditions Enabling Confidence Development", underscoring the role of clinical placements and workload management in fostering confidence.

Conclusion. The findings highlight the multifaceted nature of clinical confidence, encompassing emotional preparation, relational support, and authentic clinical practice. The study suggests the importance of pre-clinical training, mentorship, gradual exposure to real-world patient care, and reflective practices to enhance nursing students' clinical readiness. Nursing education programs should integrate these elements to better prepare students for the emotional, professional, and practical demands of clinical practice.

Keywords: *Nursing students, clinical confidence, emotional resilience, mentorship, clinical practice, professional readiness, patient care.*

INTRODUCTION

In recent Clinical confidence is an essential attribute nursing students must develop as they transition from classroom learning to real-world patient care. Globally, studies emphasize the critical role that clinical exposure plays in developing student confidence across cognitive, psychomotor, and affective domains (Alrashidi et al., 2023; Toqan et al., 2023). Simulation-based learning and supervised clinical practice both enhance students' abilities to assess, decide, and interact effectively in various clinical situations. In the Philippine context, research has begun to explore nursing students' confidence in particular clinical settings. For example, Lopez et al. (2025) examined the clinical confidence of third-year students during psychiatric ward rotations, identifying challenges in emotional preparedness and integration of theory into practice. Another study by Leynes-Ignacio (2023) evaluated how unfolding case studies influenced student satisfaction and self-confidence, highlighting the need for innovative approaches to compensate

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for disrupted clinical training. Additionally, Abalona, Trajera, and Ching (2025) described the lived experiences of nursing students rebuilding confidence after reduced face-to-face exposures, offering insight into how confidence fluctuates in dynamic learning environments.

However, gaps remain in understanding how different clinical settings—specifically hospital versus community environments—uniquely influence the development of confidence among nursing students. While several studies have investigated confidence in single settings or under restricted conditions, few have compared the dual experiences of hospital and community exposures, especially using qualitative methods. The emphasis on simulated or restricted environments has left a limited understanding of how confidence is constructed when students actively engage with real patients and communities. Furthermore, while challenges such as limited supervision, unfamiliar procedures, and emotional stress are noted in previous studies, fewer investigations have explored the personal strategies nursing students use to overcome these issues and develop clinical confidence over time. The intersection of setting (hospital vs. community) and student experience remains underexamined, particularly in the Philippine educational context.

This study seeks to address these gaps by exploring and describing the experiences of third-year nursing students in building clinical confidence during both hospital and community exposures. Guided by the qualitative content analysis framework of Graneheim and Lundman (2004), this research aims to understand how students interpret their confidence-building processes across these varied settings. It addresses the central question: How do 3rd-year nursing students describe and make sense of their experiences in building clinical confidence during hospital and community exposures? Specifically, the study aims to identify the challenges they face, the factors that support or hinder their confidence, and the strategies they develop as they transition from classroom learning to hands-on care. The novelty of this research lies in its comparative and narrative-driven approach, providing a deeper understanding of the context-dependent development of clinical confidence—something that has not been extensively explored in the Philippines.

By uncovering how students build, strengthen, or struggle with confidence in both hospital and community placements, this study contributes to nursing education in several ways. It can inform curriculum planners on how to structure clinical experiences that more effectively support student confidence, whether through the sequencing of exposures, nature of supervision, or integration of reflective practice. It may also assist faculty and clinical preceptors in identifying which aspects of the clinical learning environment need reinforcement to optimize student development. Lastly, the study highlights student-led strategies for confidence-building, offering valuable insights for peer mentoring, coaching, and institutional support programs that could enhance both educational outcomes and professional readiness.

Objectives

This study aimed to explore and describe the experiences of 3rd-year nursing students in building clinical confidence during both hospital and community exposures. It addressed the central question "How do 3rd-year nursing students describe and make sense of their experiences in building clinical confidence during hospital and community exposures?". Specifically, it sought to identify the challenges they encounter, the factors that contribute to or hinder their confidence, and the strategies they develop as they transition from classroom learning to real patient and community care. Using qualitative content analysis guided by Graneheim and Lundman's framework, the study intends to derive categories and themes that illuminate how nursing students construct and strengthen confidence in varied clinical learning environments.

METHODS

Research Design

This study employed a qualitative content analysis design to explore the experiences of 3rd-year BSN students in building clinical confidence during hospital and community exposures. A qualitative approach was chosen because confidence is a subjective and context-dependent phenomenon that is best captured through students' narratives.

The analytic framework of Graneheim and Lundman (2004) guided the study, as it provides a systematic process for moving from raw textual data toward categories and themes. In this approach, data are broken down into meaning units, condensed, coded, and organized into categories that describe the manifest content, while also allowing for interpretation of latent meanings. This design was aligned with the study's purpose since it enabled the

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researcher to stay close to the students' reflections while also identifying deeper insights into the process of confidence-building in clinical practice.

Population and Sampling

The population of the study consisted of 3rd-year Bachelor of Science in Nursing (BSN) students enrolled in a private school of nursing during the academic year of the research. This year level was chosen because students were already engaged in multiple hospital rotations and community health exposures, making them capable of providing meaningful reflections on confidence-building in varied clinical environments.

The study employed purposive sampling to recruit participants who could offer rich and relevant insights into the phenomenon under investigation. Inclusion criteria required that participants were officially enrolled as 3rd-year BSN students, had completed at least four hospital rotations along with community exposures, and were willing to provide informed consent. Exclusion criteria included students on leave of absence, those who had not yet completed the required hospital and community exposures, and those unwilling to participate.

Data were collected by asking participants to respond in writing to a semi-structured interview guide, designed to elicit reflective narratives of their experiences. This method allowed students to articulate their thoughts in their own time and words, generating rich textual data suitable for qualitative content analysis. The number of participants was not predetermined but was based on the adequacy, variation, and richness of the data, consistent with the principles outlined by Graneheim and Lundman (2004). Approximately 15–20 student reflections were sought, with collection continuing until sufficient depth of data was reached to support robust analysis.

Instruments

The primary instrument of the study was a semi-structured interview guide developed by the researcher to elicit reflective narratives from 3rd-year BSN students. The guide consisted of open-ended questions with accompanying probing prompts, designed to capture students' experiences, challenges, strategies, and reflections in building clinical confidence during hospital and community exposures.

To ensure that the instrument aligned with the objectives of the study, the questions were constructed to cover several domains of confidence-building. For instance, students were asked to describe their overall experiences as third-year nursing students and their initial feelings during their first hospital and community exposures (e.g., "How would you describe your feelings during your first hospital and community exposure?"). Other questions focused on moments of self-doubt and struggle, such as difficulties in performing skills or managing tasks, as well as turning points that enhanced their confidence (e.g., "Can you share a moment when you felt more confident in your role as a student nurse?").

The guide also addressed relational and contextual influences on confidence, asking about the role of faculty, clinical instructors, peers, and patients in shaping their self-assurance (e.g., "How did your interactions with clinical instructors, staff nurses, or community health workers affect your confidence?"). Finally, the instrument invited students to reflect on personal coping strategies, changes in their confidence over time, and recommendations for improving support in nursing education (e.g., "What recommendations would you give to the College of Nursing to better support students in building clinical confidence?").

The interview guide was reviewed by two experts in nursing education and research to ensure clarity, relevance, and appropriateness, after which minor revisions were made based on their feedback. The instrument was administered in written form through a Google Form, enabling students to provide thoughtful and detailed responses at their own pace. While the interview guide contained guiding domains, the questions were intentionally broad and open-ended to ensure that participants could express their experiences freely. Probes were used only to encourage elaboration and not to direct participants toward predetermined themes. This approach followed Graneheim and Lundman's (2004) emphasis on allowing both manifest and latent meanings to emerge inductively from the data.

Data Collection

Data collection was conducted after securing approval from the local Ethics Review Committee (ERC) and permission from the School of Nursing. Following ethical clearance, the researcher recruited eligible 3rd-year BSN students through class announcements and coordination with faculty. The purpose of the study and the voluntary nature of participation were explained, and informed consent was obtained prior to participation.

Participants were provided with a semi-structured interview guide consisting of open-ended questions and probing prompts. Instead of oral interviews, the guide was administered in written form to elicit reflective narratives.

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This method allowed students to articulate their experiences in their own time and words, generating rich textual data appropriate for qualitative content analysis.

The number of participants was not predetermined but was guided by the adequacy, variation, and richness of the data, in line with the principles described by Graneheim and Lundman (2004). Approximately 15–20 student reflections were sought, and collection continued until the data contained sufficient depth and variation to support meaningful categorization and theme development. All responses were de-identified and securely stored in a password-protected folder accessible only to the researcher.

Data Analysis

The data were analyzed using the qualitative content analysis approach described by Graneheim and Lundman (2004). This method was selected because it provides a systematic yet flexible way of examining written narratives to uncover both the manifest content (what participants explicitly stated) and the latent content (the underlying meanings embedded in their reflections).

The analysis began with repeated reading of the students' written reflections to achieve immersion and a comprehensive understanding of the data. From these texts, meaning units—words, phrases, or sentences related to the same central idea—were identified. Each meaning unit was then condensed while retaining its core meaning, after which codes were generated to capture the essence of the content.

The codes were compared for similarities and differences and subsequently organized into categories, which represented descriptive groupings of the data. Finally, the categories were abstracted into broader themes, which reflected the underlying patterns and meanings related to the development of clinical confidence among 3rd-year nursing students during hospital and community exposures.

To ensure trustworthiness, the researcher maintained an audit trail of analytic decisions, and peer debriefing with fellow nursing educators was conducted to enhance credibility. The process also ensured that findings remained grounded in the participants' narratives while allowing for interpretive depth.

Ethical Considerations

This study adhered to the ethical standards for research involving human participants. Prior to data collection, the research protocol was reviewed and approved by the local Ethics Review Committee (ERC). Approval from the School of Nursing was also secured before inviting participants.

All potential participants were informed about the purpose of the study, the voluntary nature of participation, and their right to decline or withdraw at any stage without any academic consequences. Informed consent was obtained from each student before they completed the written interview guide.

To ensure confidentiality, participant identities were protected by assigning codes instead of names in all documents. The written reflections were stored in a password-protected digital folder accessible only to the researcher. Direct quotations used in reporting were anonymized to prevent identification.

The study posed minimal risk, as participation involved only written reflections of personal experiences. Nonetheless, students were assured that they could skip any question they felt uncomfortable answering. Data handling and reporting followed the principles of respect for persons, beneficence, and justice, ensuring that the rights and welfare of participants were safeguarded throughout the research process.

RESULTS and DISCUSSION

This study explored how third-year nursing students describe and make sense of their experiences in building clinical confidence during hospital and community exposures. Data were derived from written reflective narratives analyzed through qualitative content analysis following the framework of Graneheim and Lundman (2004), allowing categories and themes to emerge inductively from participants' own words and lived experiences.

A total of 30 third-year Bachelor of Science in Nursing (BSN) students from a private university in Bulacan participated in the study. All participants met the inclusion criteria: officially enrolled as third-year BSN students, completed at least four hospital rotations along with community exposures, and provided informed consent. The sample comprised students who had accumulated sufficient clinical experience to reflect meaningfully on their confidence development across varied clinical settings.

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Table 1.

Raw Data-to-Theme Mapping

Supporting Evidence from Raw Data	Latent Meaning Interpretation	Key Characteristics	Contributing Categories	Theme
SN1: "extremely anxious...Now I trust my knowledge more" SN18: "stopped looking for approval...taking ownership" SN28: "not afraid to fail anymore" SN13: "I developed habits...reviewing, praying, deep breathing"	Confidence is an emotional-developmental trajectory requiring active internal transformation, not passive reception. Students construct confidence through deliberate coping strategies that transform vulnerability into self-trust.	Temporal progression from initial anxiety through active coping to self-trust; emotional regulation; barrier navigation; internalized competence	Category 1: Emotional Landscape Category 2: Barriers to Confidence Category 3: Coping Strategies Category 6: Reflective Growth	**Theme 1:** Confidence as Journey from Vulnerability to Self-Trust
SN11: "guided step by step...felt reassured...made me believe I was capable" SN24: "trust instructors gave me...motivated me" SN18: "peers were my reflections...less alone" SN1: "positive feedback boosted...harsh correction lowered" SN2: "it's okay to ask for help...practice makes me better"	Confidence is socially co-constructed through relational scaffolding. It emerges through validated relationships where CIs provide vertical guidance, peers offer horizontal normalization, and quality of support directly shapes outcomes.	Confidence built through validated relationships; quality of support matters; assisted performance; guidance precedes independence; peer normalization reduces isolation	Category 4A: CI/Staff Support Category 4B: Peer Support Category 5B: Problem-Solving Under Guidance	**Theme 2:** Confidence as Relationally Scaffolded Competence
SN10: "first REAL patient interactions stand out most" SN16: "afraid of hurting the patient" SN13: "made me realize skills are really working" SN29: "prepared well made me feel capable" SN6: "patient doubted me...not skilled enough"	Confidence requires authentic performance validation in high-stakes contexts. Students accumulate evidence through successful real-world encounters. Simulation prepares but authentic contexts validate.	Real patients, real stakes, real consequences; success creates evidence of capability; authentic challenges produce genuine barriers and validation; patient/family feedback matters	Category 2: Barriers (authentic stakes) Category 5A: Skill Mastery	**Theme 3:** Confidence Through Validated Performance in Authentic Contexts
SN1: "College should offer more simulation labs...lessen anxiety" SN14: "harsh makes nervous→mistakes; calm helps learn" SN21: "supportive environment...not afraid to be scolded" SN8: "adequate rest...give full energy" SN7: "sad...no hospital experience" SN27: "lack exposure...other students more confident"	Confidence is structurally enabled or constrained by institutional decisions across three domains: pedagogical design (how we teach), cultural climate (how we relate), and structural resources (what we provide).	Simulation sequencing; workload/rest management; instructor approach; psychological safety; exposure adequacy; fair resource allocation	Category 7: Pedagogical Design Category 8: Institutional Culture Category 9: Structural Conditions	**Theme 4:** Institutional Conditions Enabling Confidence Development

Note: In presenting the findings, participants are denoted using the code SN#, where "SN" refers to the student nurse and "#" corresponds to their assigned number (e.g., SN1, SN2). The verbatim statements enclosed in

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quotation marks reflect the student nurses' authentic voices, which were directly drawn from their reflective narratives.

Table 1 presents the four interpretive themes that emerged from qualitative content analysis of 30 third-year nursing students' reflective narratives, demonstrating how clinical confidence develops through interconnected individual, relational, experiential, and institutional dimensions.

Theme 1 reveals confidence as fundamentally a developmental transformation rather than a fixed attribute. Students' narratives consistently showed temporal progression from initial vulnerability ("extremely anxious") to internalized self-trust ("I trust my knowledge more"), with active coping strategies serving as the transformational mechanism. This finding challenges deficit models that frame student anxiety as a problem to eliminate, instead positioning emotional vulnerability as the necessary starting point for authentic confidence development. The universal representation across all four contributing categories (Categories 1, 2, 3, 6) underscores that this journey is normative, not exceptional.

Theme 2 demonstrates that confidence is relationally embedded, not individually achieved. The social construction mechanism—guidance leading to reassurance, which enables belief in capability—appeared across all participants. Notably, even "independent" performance was preceded by scaffolding and followed by validation, revealing that autonomy emerges from, rather than replaces, relational support. The distinction between vertical scaffolding (CI/staff support) and horizontal scaffolding (peer normalization) illuminates complementary pathways: authority figures provide technical guidance while peers reduce isolation through shared struggle. This finding extends existing literature by demonstrating that help-seeking itself builds confidence, contradicting assumptions that dependence undermines competence.

Theme 3 establishes that confidence requires evidence from authentic performance, not just skill practice. Students explicitly differentiated between simulation (preparation) and real patient care (validation), with authentic stakes creating both genuine barriers and meaningful validation. The emphasis on "REAL patients" throughout narratives suggests that simulation, while valuable, cannot replicate the confidence derived from successfully navigating unpredictable clinical situations with actual consequences. This theme addresses a critical gap in nursing education literature, which often examines confidence in single settings without comparing how authentic versus simulated contexts differentially shape confidence trajectories.

Theme 4 shifts focus to institutional responsibility, revealing confidence as structurally enabled or constrained by educational decisions. Students articulated sophisticated understanding of three distinct institutional domains: pedagogical architecture (simulation sequencing, graduated exposure), cultural climate (psychological safety, feedback quality), and structural resources (adequate rest, exposure opportunities). The universal participation in recommending systemic improvements (all 30 students contributed to Category 7 and 8) demonstrates collective recognition that individual and relational efforts occur within—and are shaped by—institutional conditions. This finding has direct implications for curriculum design and organizational policy.

Together, these themes reveal clinical confidence as a complex, context-dependent phenomenon integrating emotional work, social validation, authentic practice, and institutional support. The interdependence of themes—for instance, how institutional culture (Theme 4) shapes relational scaffolding quality (Theme 2), which enables students to navigate authentic challenges (Theme 3) and complete their developmental journey (Theme 1)—suggests confidence development requires holistic, multilevel intervention rather than singular pedagogical solutions.

THEME 1: CONFIDENCE AS JOURNEY FROM VULNERABILITY TO SELF-TRUST

Clinical confidence emerges as a developmental trajectory from emotional vulnerability to internalized self-trust through active coping and reflection. Four categories—Emotional Landscape, Barriers to Confidence, Coping Strategies, and Reflective Growth—reveal that students actively construct confidence through deliberate emotional work rather than passively receiving it. The journey from "extremely anxious" to "I trust my knowledge more" represents fundamental transformation from external dependence to internal self-authorization.

Emotional Landscape of Clinical Learning (Category 1)

Initial clinical exposures generated complex, simultaneous emotions—nervousness coexisting with excitement—forming the foundational vulnerability from which confidence develops. SN1 described, "I felt nervous, excited, and anxious all at once. I was scared of making mistakes, but at the same time I was eager to show what I had learned." This dual-emotion pattern appeared in 28 of 30 participants. SN18 noted feeling "not prepared for how emotional it was" when encountering patient suffering, while SN22 experienced "a huge sense of responsibility and a deep connection...realizing the real impact of nursing." SN30 felt "overwhelmed by pressure" despite technical

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preparation, SN26 described being "scared but excited to be in the real world," and SN29 stated succinctly: "At first i'm nervous at the same time excited."

These responses reflect what Toqan et al. (2023) identified as the affective gap between simulated and authentic environments, where emotional labor accompanies technical demands. Lopez et al. (2025) found similar intensity among psychiatric nursing students, where anticipation and apprehension coexisted throughout rotations. The responsibility of caring for vulnerable patients creates emotional stakes simulation cannot replicate.

Clinical instructors should validate affective responses during briefings, normalizing emotional complexity as appropriate recognition of responsibility. Orientation programs should incorporate emotional preparation modules addressing affective demands.

Barriers to Confidence (Category 2)

Barriers encompass internal fears and external challenges creating self-doubt, appearing universally (30/30 participants). SN2 described, "I was scared of making mistakes...I hesitated because I wasn't sure if I was doing it correctly." SN16 specified harm-related fear: "I doubted myself during my first IV insertion because I was afraid of hurting the patient." SN28 added, "my hands couldn't stop shaking, and I was so worried that if the client saw me shaking, they wouldn't feel safe." SN15 described "fear of errors in clinical tasks," while SN25 experienced "self-doubt from slow performance."

External validation threats compounded internal fears. SN6 reported, "the Patient...doubted me when I took her Blood Pressure...I'm not skilled enough for them to trust me." SN29 experienced "pressure causing self-doubt in accuracy." Communication barriers added challenges—SN22 felt "less confident with patients from different cultural backgrounds," SN21 described "uncertainty in patient communication," SN3 felt "unsure of equipment and procedures" in the operating room, and SN7 described "discomfort and unfamiliarity" during catheterization.

Leynes-Ignacio (2023) documented similar gaps between classroom knowledge and clinical judgment. Lopez et al. (2025) found psychiatric nursing students particularly vulnerable to patient responses, while Abalona et al. (2025) noted that acknowledging barriers as normative enables subsequent confidence development.

Debriefing should normalize barrier experiences, distinguishing ethical concern from irrational anxiety. Curriculum should sequence lower-stakes to higher-stakes procedures while integrating cultural competence throughout.

Coping and Adaptation Strategies (Category 3)

Students actively constructed coping mechanisms across spiritual, cognitive, physical, and social dimensions. SN13 articulated, "I developed habits...reviewing the procedure...praying before my shift...taking a deep breath. These strategies calm me down and help me focus." SN1 described "practicing them mentally," SN11 noted "comprehensive preparation and rest," SN20 explained, "I prepare by reviewing my notes, sleeping early...I pray and remind myself that duty is a chance to learn, not to be perfect," and SN16 added, "I read my notes, sleep early, and mentally rehearse procedures."

Cognitive reframing emerged powerfully. SN7 described, "I told myself that the patients don't know what i'm doing so why should i feel pressured as long as i'm doing the right things." SN10 emphasized "reminding myself that mistakes are part of learning," SN22 described "calmness and acceptance of mistakes," SN28 noted "accepting nervousness and focusing on improvement," and SN18 explained, "I'd mentally go over procedures...and even how I'd react if something went wrong."

Spiritual practices provided grounding. SN10 reported "praying for strength and visualizing," while SN17 described "I pray after waking up, thanking the almighty for another opportunity to care for patients." Rest was essential—SN6 stated, "I ensure I sleep well so I can function better," though SN25 noted "prioritizing rest" was challenging.

Alrashidi et al. (2023) documented mental rehearsal's effectiveness, while Abalona et al. (2025) found students who actively reconstructed mistakes as learning opportunities demonstrated stronger confidence recovery.

Clinical educators should explicitly teach emotional regulation strategies during debriefing. Curricula should integrate mindfulness training, cognitive reframing exercises, and reflective practice, formalizing strategies students currently develop informally.

Reflective Growth and Transformation (Category 6)

Metacognitive awareness of confidence development characterized the journey's endpoint, with students articulating explicit before/now transformations. SN1 contrasted, "When I first started, I was extremely anxious and

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doubted myself...Now, I trust my knowledge and skills more, and I've learned to see mistakes as opportunities." SN2 noted, "Before, I was easily nervous...Now, I'm more open to learning...I believe in myself more." SN20 echoed similar growth.

Critical transformation involved shifting from external validation to internal authorization. SN18 articulated, "I have stopped looking for approval to feel capable. I've started to take ownership of my role...as a nurse in training who is already making a difference." SN22 described, "Before, I doubted my abilities and hesitated to take initiative. Now, I approach challenges with a more proactive mindset." SN28 stated, "I'm not afraid to fail anymore," reflecting growth mindset development.

Increased initiative marked transformation. SN30 noted, "Before, I was always hesitant...now I'm more willing to take initiative and perform skills without waiting to be pushed." SN27 described, "Before, I was too shy...now I am more confident in handling tasks on my own." Professional identity deepened—SN17 reflected, "Before, nursing was just a profession. Now, I see it as a way to make a difference," while SN13 stated, "I feel nursing is my calling."

One deviant case—SN4 reporting "minimal change"—revealed consistently supportive CI relationships, suggesting stable support correlates with stable confidence, strengthening the theme's relational dimension (explored in Theme 2).

Lopez et al. (2025) documented similar progression toward autonomous decision-making, while Graneheim and Lundman (2004) emphasized understanding developmental processes over static outcomes. This metacognitive awareness aligns with professional identity formation literature demonstrating that technical competence development is inseparable from identity transformation.

Clinical education should incorporate structured reflection—journals, self-assessments, guided sessions—making developmental progress visible. Longitudinal portfolios could accelerate transformation by making implicit progress explicit.

THEME 2: CONFIDENCE AS RELATIONALLY SCAFFOLDED COMPETENCE

Clinical confidence is fundamentally social, co-constructed through validated relationships rather than achieved individually. Three categories—CI and Staff Support, Peer Support, and Problem-Solving Under Guidance—demonstrate that confidence emerges through relational scaffolding where instructors provide vertical guidance, peers offer horizontal normalization, and support quality shapes outcomes. The journey from "I felt reassured" to "I believe I was capable" reveals guidance preceding reassurance, which enables belief in capability—a socially mediated internalization process. Even apparently independent performance is preceded by scaffolding and followed by validation, indicating autonomy emerges from, rather than replaces, relational support.

Relational Support Systems - CI and Staff Support (Category 4A)

Clinical instructor and staff support constitutes vertical scaffolding through step-by-step guidance, constructive feedback, trust demonstration, and emotional reassurance. This category appeared universally (30/30 participants), validating that confidence cannot be built in isolation.

SN11 articulated the mechanism: "When I performed a procedure and [CI] guided me step by step, I felt reassured. Positive feedback and encouragement made me believe that I was capable of doing the task correctly." This progression—guidance → reassurance → belief—reveals how external support becomes internalized capability. SN24 emphasized trust: "The trust my clinical instructors gave me...motivated me to give my best." SN4 stated, "Everytime the CIs give their feedbacks it boosts my confidence." SN9 described "step-by-step guidance from CI" transforming uncertainty into capability, while SN19 noted confidence emerged through consistent instructor presence.

Feedback quality mattered critically. SN1 contrasted: "One staff nurse once complimented me...that feedback boosted my confidence. On the other hand, being corrected harshly in front of others lowered my self-esteem." SN3 appreciated "constructive feedback building confidence," while SN15 described guidance involving technical instruction plus emotional support. SN30 noted feeling confident "whenever they treated me as part of the team and trusted me with small responsibilities."

Alrashidi et al. (2023) demonstrated simulation improves confidence specifically when accompanied by instructor guidance, not through independent practice alone. Lopez et al. (2025) found psychiatric nursing students' confidence depended heavily on supervisor support, with harsh feedback creating lasting deficits. Toqan et al. (2023) documented pediatric nursing students' confidence correlating strongly with instructor presence. The social

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construction of confidence challenges individualistic self-efficacy models, suggesting confidence develops through internalization of external validation.

Clinical instructors should be trained in confidence-scaffolding techniques—graduated autonomy, constructive feedback delivery, trust demonstration. Harsh correction should be replaced with private, growth-oriented feedback maintaining psychological safety.

Relational Support Systems - Peer Support (Category 4B)

Peer support constitutes horizontal scaffolding where shared struggles, normalized experiences, and collective encouragement create confidence through reciprocal validation. Like CI support, peer relationships appeared universally (30/30 participants).

SN18 used a powerful metaphor: "Classmates and peers...were my reflections. Being surrounded by others who were on the same journey made me feel less alone in my doubts and more motivated." SN1 reinforced: "My classmates reassured me by sharing their own struggles—it made me feel I wasn't alone. We were all nervous about presenting our community diagnosis, but we encouraged each other until we pulled it off successfully." SN25 stated, "Working with classmates and sharing struggles made me feel more confident." SN8 described how "classmates reassured me by sharing their struggles," while SN12 noted "peer tips and reassurance boosting confidence."

The "not alone" theme appeared repeatedly, indicating isolation reduction as key mechanism. SN13 described how "classmates reassured me when I felt nervous," while SN14 emphasized "peer support and encouragement" during stressful rotations. SN10 experienced peers as "calming influence," and SN17 noted "encouragement during tasks from peers" enabling performance despite uncertainty. The reciprocal nature—students both give and receive validation—creates mutual scaffolding rather than unidirectional guidance.

Abalona et al. (2025) documented that nursing students rebuilding confidence emphasized peer solidarity as essential, with shared vulnerability creating collective resilience. Leynes-Ignacio (2023) found peer discussion during case studies significantly enhanced confidence compared to individual study. The "not alone" mechanism aligns with social comparison theory, where seeing others also struggle reduces distress and normalizes challenge as learning rather than inadequacy.

Clinical education should structure peer support through buddy systems, peer debriefing sessions, and collaborative assignments. Creating spaces for sharing struggles normalizes vulnerability and leverages horizontal scaffolding.

Category 5B: Problem-Solving Under Guidance

Problem-solving under guidance demonstrates that even struggle resolution is relationally mediated, with students overcoming challenges through assisted performance. This category appeared universally (30/30 participants), revealing help-seeking itself builds rather than diminishes confidence.

Students described consistent pattern: struggle → seek help → guided practice → improved performance. SN2 articulated: "I struggled with inserting IV push...I handled it by asking guidance from my CI and trying again carefully. I learned that it's okay to ask for help and that practice really makes me better." SN11 reinforced: "I struggled the first time I tried to insert an IV line...I asked for guidance...and observed how it was done properly. When I tried again, I was calmer. I learned that it's okay to ask for help, and that practice and confidence really improve my skills." The repetition of "it's okay to ask" suggests cultural shift from autonomous struggle to supported learning. SN24 described: "Whenever I didn't know what to do, they were always there to guide me step by step." SN10 explained asking "guidance from my CI and practicing more," while SN16 noted, "I asked for help...practiced more, and learned to stay calm."

The findings challenge deficit models framing help-seeking as weakness. Instead, these narratives reveal help-seeking as strategic adaptation enabling learning that would not occur through independent struggle. Alrashidi et al. (2023) documented simulation-based confidence gains occur when students can request and receive guidance, not when required to persist independently. Lopez et al. (2025) found psychiatric nursing students who felt comfortable asking questions demonstrated higher confidence than those who struggled silently.

Clinical environments should explicitly encourage help-seeking as professional behavior. Instructors should respond with guided practice rather than complete answers, scaffolding students' developing capabilities while maintaining agency.

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THEME 3: CONFIDENCE THROUGH VALIDATED PERFORMANCE IN AUTHENTIC CONTEXTS

Confidence requires accumulation of evidence through successful performance in authentic clinical contexts with genuine stakes, real patients, and unpredictable outcomes. Two categories—Barriers to Confidence (authentic stakes dimension) and Skill Mastery and Task Completion—reveal that while simulation prepares students technically, true confidence emerges only when they successfully navigate real-world clinical challenges. The emphasis on "REAL patient interactions" throughout narratives indicates authenticity matters: fear of harming actual patients creates genuine barriers, while successful care of real people provides meaningful validation. The confidence cycle—authentic challenge → guided performance → success → external validation → internalized competence—demonstrates that confidence is evidence-based, built on proof of capability in high-stakes situations rather than abstract self-belief.

Barriers to Confidence (Authentic Stakes Dimension, Category 2)

Barriers in authentic contexts differ qualitatively from general anxiety, targeting specific consequences for real, vulnerable patients. These authentic stakes create both genuine obstacles and opportunities for meaningful confidence development when successfully navigated.

Students identified fear of causing harm to actual patients as primary barrier. SN16 articulated, "I doubted myself during my first IV insertion because I was afraid of hurting the patient." This fear specifically targets harm to a real person, distinguishing it from performance anxiety in simulation. SN28 described visible manifestation: "My hands couldn't stop shaking, and I was so worried that if the client saw me shaking, they wouldn't feel safe with me giving them the vaccine shot." The concern extends beyond technical accuracy to patient perception of safety. SN6 experienced external doubt: "The Patient...doubted me when I took her Blood Pressure, which is High. It make me feel that I'm not skilled enough for them to trust me." Patient skepticism—despite potentially correct performance—created self-doubt by positioning the student as incompetent. SN29 reported "pressure causing self-doubt in accuracy" when patients questioned procedures, while SN21 described "uncertainty in patient communication" during health education where miscommunication could have real consequences.

The authenticity of consequences distinguishes these barriers from simulation-based challenges. SN13 described uncertainty during pediatric encounter: "He was 4 years old and seemed to have trauma with syringes, he kept saying 'no check up' and 'no tusok' while crying. I tried everything to make him feel safe but I still couldn't calm him down. In that moment I doubted myself a little, because I thought, 'If I don't know how to handle this situation now, how will I handle other patients that might be assigned to me.'" The real child's distress created authentic emotional and ethical stakes absent in mannequin practice.

Alrashidi et al. (2023) demonstrated that while simulation improves initial confidence through safe practice environments, students consistently reported renewed anxiety and self-doubt when transitioning to real patient care, with fear of causing harm emerging as the primary barrier distinguishing authentic from simulated contexts. Lopez et al. (2025) documented that psychiatric nursing students experienced significantly higher anxiety during actual patient interactions compared to standardized scenarios, with concern for patient safety creating psychological pressure absent in simulation. Toqan et al. (2023) found that even after high-fidelity simulation training, nursing students reported distinct fear responses when caring for real pediatric patients. The ethical dimension of these barriers—concern for patient wellbeing rather than self-focused performance anxiety—reflects appropriate professional responsibility and should be validated rather than pathologized.

Clinical education should distinguish between performance anxiety and ethical concern for patient welfare, validating the latter as professional accountability. Graduated exposure to authentic contexts—beginning with stable patients and routine procedures—allows students to develop confidence incrementally while managing authentic stakes.

Skill Mastery and Task Completion (Category 5A)

Successful performance in authentic contexts provides evidence of capability that students internalize as confidence. This category (30/30 participants) demonstrates that confidence develops through accumulation of validated real-world achievements rather than abstract self-assessment.

Students identified successful task completion with real patients as confidence-building moments. SN13 described, "I felt more confident when I successfully heard a patient's fetal heart tones by myself for the first time but ofc with the supervision of my CI. It made me realize that the skills I'm learning are really working and that I'm improving little by little." The phrase "made me realize skills are really working" indicates authentic success validates learning in ways simulation cannot. SN29 articulated the preparation-performance-confidence cycle: "I felt confident when I was able to take vital signs, perform injection, ecg by myself without asking for help. I practiced a lot before,

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and the patient was calm and cooperative. Knowing I prepared well made me feel capable." Preparation enables performance, but performance with real patients creates confidence. SN10 noted experiencing confidence "performing a procedure...correctly, with support from CI and positive feedback," demonstrating even "independent" performance includes social validation. SN8 described confidence emerging "when I complete my rounds successfully and ensure that patients feel comfortable and safe when I approach them. I can easily build rapport with them." The patients' comfort provides external evidence of competence. SN30 reported, "I felt more confident when I successfully managed a patient's care and received positive feedback from the family."

Patient and family gratitude emerged as powerful confidence validators. SN9 stated, "When I assist in OR as Scrub Nurse I feel more confident, because after that procedure the family are showing gratitude to us and it felt so good and touched." The emotional impact of gratitude reinforces confidence more powerfully than grades or instructor feedback alone. SN28 described feeling confident "when I independently cared for a patient and received appreciation from the family," while SN5 noted, "I really felt like I was able to help the patients a lot, and that made me genuinely happy." This intrinsic satisfaction from meaningful impact distinguishes authentic performance from simulation. SN24 experienced confidence "when I independently cared for a patient and felt proud of my work," with pride emerging from real-world contribution. SN17 reflected on surgery experience: "My first time scrubbing in. Its a neurosurgery (craniotomy). Overall it was a success even though it felt like i was held at gunpoint." The high-stakes nature made success particularly confidence-building.

Abalona et al. (2025) documented that nursing students rebuilding confidence after disrupted face-to-face training emphasized the irreplaceable value of authentic patient interactions, with successful real-world performance providing validation that virtual or simulated experiences could not replicate. Students required multiple successful authentic encounters before confidence stabilized, suggesting accumulated evidence is necessary rather than isolated achievements. Leynes-Ignacio (2023) demonstrated that while case-based learning improved theoretical confidence, students' clinical confidence increased significantly only after applying knowledge with real patients. Graneheim and Lundman (2004) emphasized that meaning-making occurs through lived experience rather than abstract knowledge, aligning with students' descriptions of how real patient gratitude and successful outcomes provided existential confirmation of nursing capability beyond technical competence alone.

Clinical education should provide sufficient authentic patient encounters to enable confidence through accumulated evidence, not just isolated performances. Patient and family feedback should be incorporated into competency assessment, recognizing its powerful validation role. Documentation of successful performances could help students recognize their accumulating evidence of capability.

THEME 4: INSTITUTIONAL CONDITIONS ENABLING CONFIDENCE DEVELOPMENT

Clinical confidence development is structurally enabled or constrained by institutional decisions across three interconnected domains: pedagogical design (how we teach), cultural climate (how we relate), and structural resources (what we provide). Three categories—Pedagogical Design and Learning Architecture, Institutional Culture and Relational Climate, and Structural and Organizational Conditions—reveal that while confidence is personally experienced and relationally constructed, its development depends on intentional educational architecture. Students universally (30/30 in Categories 7 and 8; 28/30 in Category 9) articulated systemic needs, demonstrating collective recognition that individual effort and relational support operate within—and are shaped by—institutional frameworks. The comprehensive nature of student recommendations spanning curriculum design, instructor approaches, feedback cultures, workload management, and resource allocation indicates that confidence-building requires multilevel intervention rather than isolated pedagogical solutions.

Pedagogical Design and Learning Architecture (Category 7)

Pedagogical design encompasses institutional decisions about curriculum sequencing, learning modalities, skill progression, and preparatory strategies that create conditions for confidence development. This represents the "how we teach" dimension of institutional responsibility.

Students universally emphasized simulation before authentic exposure as essential preparation. SN1 articulated, "I think the College should offer more simulation labs before sending us to the hospital. Practice with mannequins and role-playing with peers helps lessen the anxiety of real exposure. It would also help to have more mentorship sessions where students can openly share their struggles and get advice." The phrase "before sending us" indicates timing matters—simulation should precede rather than replace authentic practice. SN11 reinforced, "Return demonstrations and simulation labs before exposure help students practice in a safe environment and build confidence," emphasizing psychological safety as prerequisite. SN22 specified content: "Integrate more simulation-

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based learning with real-world scenarios to practice skills, communication, and decision-making in a safe environment. This builds confidence before clinical practice." The request for "real-world scenarios" indicates students want authentic complexity without authentic consequences during preparation. SN26 advocated for structure: "I would recommend that the College of Nursing implement a structured simulation program where students can practice clinical skills in a safe, supervised environment before hospital or community exposure."

Graduated exposure emerged as pedagogical principle. SN16 recommended "gradual exposure to clinical settings, starting with observation, then assisting, then independent practice," articulating developmental progression from peripheral to central participation. SN21 advocated "more hands-on practice sessions in school before actual duties," SN23 suggested "more skills laboratory sessions before clinical exposure," and SN28 emphasized progressive difficulty: "Start with simpler tasks and gradually increase complexity as students gain confidence."

Mentorship structures were frequently recommended. SN1 requested "more mentorship sessions where students can openly share their struggles," indicating need for formalized support beyond clinical instruction. SN13 advocated for "one-on-one mentorship programs pairing students with experienced nurses," while SN18 suggested "assign dedicated mentors who can provide ongoing support throughout clinical rotations."

Alrashidi et al. (2023) demonstrated that simulation effectiveness depends on intentional pedagogical design—specifically, integration with clinical practice through pre-briefing, structured scenarios, and debriefing rather than isolated skills practice. Confidence gains from simulation transferred to clinical settings only when simulation preceded authentic exposure and scenarios matched clinical complexity students would encounter. Toqan et al. (2023) documented that high-fidelity simulation improved pediatric nursing confidence specifically when implemented before clinical rotations. Abalona et al. (2025) found nursing students rebuilding confidence after disrupted training identified graduated reintroduction to clinical practice as essential, with abrupt transitions creating renewed anxiety.

Nursing curricula should systematically integrate simulation before clinical exposure rather than treating it as supplementary. Pedagogical design should follow graduated exposure principles, sequencing from observation to assisted to independent performance across increasing complexity levels. Formalized mentorship programs should be institutionalized rather than left to individual instructor initiative.

Institutional Culture and Relational Climate (Category 8)

Institutional culture encompasses relational climate, feedback norms, psychological safety, and interpersonal approaches characterizing learning environments. This represents the "how we relate" dimension of institutional responsibility.

Students identified instructor approach as cultural rather than individual. SN14 articulated pathways explicitly: "Instructors shouldn't be too harsh or strict, because that's what makes students nervous and scared, which often leads to mistakes during duties. Instead, they should just be vocal but calm. If a mistake happens, let the student repeat it with proper guidance, so they can really learn." The causal chain—harsh → nervous → mistakes versus calm → learning—positions teaching approach as having direct confidence consequences. SN1 contrasted experiences: "One staff nurse once complimented me on how gently I talked to a patient, and that feedback boosted my confidence. On the other hand, there were times when being corrected harshly in front of others lowered my self-esteem." SN21 advocated for systemic change: "I think a program that should also focus on creating a supportive environment where students can openly admit their weaknesses to seek help, rather than hiding mistakes because of being afraid to be scolded by their CI." The phrase "hiding mistakes" indicates current culture may discourage transparency. SN5 made profound appeal: "I think we should just be kind to the students, and if possible, not make things too hard for them—because we never really know what each person is going through in life."

Psychological safety emerged as prerequisite for learning. SN20 requested "create a more supportive environment where mistakes are seen as learning opportunities, not failures," reflecting current culture may frame errors punitively. SN24 advocated "instructors should provide more positive reinforcement and constructive feedback to build students' confidence," while SN27 suggested "more encouragement rather than criticism during clinical practice." SN12 noted, "Sometimes harsh feedback makes students more nervous instead of helping them improve. A more supportive approach would be better," distinguishing between feedback content and delivery.

Public correction emerged as particularly confidence-undermining. SN1 specified being "corrected harshly in front of others lowered my self-esteem," while SN17 described "embarrassment when corrected in front of patients." SN19 noted, "Private feedback would be better than public correction, which can be embarrassing and discouraging."

Lopez et al. (2025) documented that psychiatric nursing students' confidence correlated significantly with perceived instructor support, with harsh or dismissive approaches creating lasting confidence deficits that persisted even after students demonstrated technical competence. Leynes-Ignacio (2023) found learning environments

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emphasizing mistake acceptance and growth orientation produced significantly higher confidence than evaluative climates focused on error identification. Graneheim and Lundman (2004) emphasized that meaning-making processes are shaped by social contexts, supporting this study's finding that institutional culture determines whether students interpret mistakes as learning opportunities or evidence of inadequacy.

Nursing programs should establish explicit cultural norms emphasizing psychological safety, mistake normalization, and constructive feedback. Faculty development should address feedback delivery, distinguishing growth-oriented from punitive approaches. Public correction should be prohibited, with all formative feedback provided privately to maintain student dignity.

Structural and Organizational Conditions (Category 9)

Structural conditions encompass material resources, organizational decisions about workload, rest, clinical placement availability, and opportunity distribution that enable or constrain confidence development. This represents the "what we provide" dimension of institutional responsibility.

Rest and workload emerged as foundational to confident performance. SN8 articulated the connection: "I think giving students enough time and reducing other activities would help, because many students lack sleep. With adequate rest, they can give their full energy to their roles." This frames rest as performance enabler rather than luxury. SN25 noted difficulty "prioritizing rest for readiness" amid competing demands, SN12 described "exhaustion affecting my focus and confidence during duties," and SN19 stated, "Sometimes the workload is too much, and it affects our ability to perform well during clinical practice."

Clinical exposure availability emerged as critical structural constraint. SN7 expressed profound frustration: "I'm actually really sad this third yr because my group hasn't started duties in the hospital so not gonna lie its a bit boring...there is not much of an experience so far." SN27 made explicit comparison: "For me, just more hospital exposure would be more amazing, I am third year student but still lack hospital exposure. There some nursing student outside our institutions who are in lower year than me but more clinical exposure and thats why there are so good and confident handling patients with minimal to almost no guidance since they are well experienced." This comparison reveals exposure as resource allocation issue with confidence consequences. SN21 echoed, "More hospital exposure would be beneficial. Other students with more experience feel more confident," while SN23 noted, "Limited clinical hours make it hard to develop confidence through practice."

Equitable opportunity distribution was emphasized. SN17 advocated for "fair rotation assignments so all students get equal chances to practice different skills," while SN20 noted, "Some students get more opportunities than others, which creates confidence gaps."

Abalona et al. (2025) documented that nursing students' confidence suffered significantly during reduced face-to-face exposure, with structural constraints creating confidence deficits that relational support alone could not remedy. Institutional decisions about clinical placement availability directly determine confidence development trajectories. Alrashidi et al. (2023) noted that simulation cannot fully compensate for inadequate authentic clinical exposure. Toqan et al. (2023) found that while simulation improved confidence, students required sufficient authentic practice hours for confidence stabilization.

Nursing programs must ensure adequate clinical placement availability as infrastructure requirement, not optional enhancement. Workload assessment should consider cumulative demands across courses, with rest explicitly valued as learning necessity. Equitable opportunity distribution should be monitored to prevent structural production of confidence inequalities.

Table 2:
Summary of Findings/Recommended Actions/Implications

Significant Result (Theme/Subtheme)	**Description of Findings**	**Recommended Actions/Interventions/Policy/Program**	**Implications**
Theme 1: Confidence as Journey from Vulnerability to Self-Trust	Students progress from anxiety to self-trust through coping strategies like emotional regulation.	- Pre-clinical workshops on emotional regulation (e.g., mindfulness). - Reflection journals reviewed bi-weekly by faculty. - "Confidence Check-In" sessions every two weeks with instructors.	- Emotional vulnerability is essential for confidence development. - Structured reflection and emotional preparation promote

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			growth.
Theme 2: Confidence as Relationally Scaffolded Competence	Confidence develops through support from peers and instructors.	- Mentorship program for one-on-one check-ins with faculty/peers. - Training for instructors on providing constructive feedback. - Peer Learning Circles for shared experiences and support.	- Social support (peer and faculty) is crucial for confidence-building. - Peer interaction reduces isolation and enhances learning.
Theme 3: Confidence Through Validated Performance in Authentic Contexts	Real patient interactions provide validation of skills and build confidence.	- Increase real-patient care hours in clinical rotations.- "Skills Mastery Week" for students to perform procedures under supervision. - Debriefing sessions after patient care to discuss growth areas.	- Authentic patient care is vital for developing true clinical confidence. - Real-world practice under supervision strengthens skills.
Theme 4: Institutional Conditions Enabling Confidence Development	Pedagogical design, culture, and resources significantly influence confidence.	- Integrate more simulation labs before hospital rotations. - Set up rest and well-being programs for students.- Increase clinical placements and feedback policies.	- Institutional support systems shape student confidence. - Adequate resources and structured schedules are necessary for effective learning.

Table 2 emphasizes that in this study, the development of clinical confidence among nursing students is influenced by a combination of personal, relational, and institutional factors. The table summarizes key findings and actionable recommendations designed to enhance student confidence. Theme 1 emphasizes the emotional journey students experience, from anxiety to self-trust, highlighting the need for pre-clinical workshops on emotional regulation and structured reflection. Theme 2 underscores the importance of relational support, suggesting the implementation of mentorship programs and peer learning circles to foster collaborative learning environments. Theme 3 stresses that confidence is built through real patient care, recommending increased clinical exposure and structured debriefing sessions for skill validation. Finally, Theme 4 acknowledges the critical role of institutional factors, recommending adjustments to curriculum design, the provision of sufficient clinical placements, and well-being initiatives to ensure students are supported holistically. These targeted actions aim to create a structured, supportive learning environment that nurtures clinical confidence and prepares students for the challenges of nursing practice.

Program Title: "CARE for Confidence: Cultivating Clinical Readiness and Empowerment"

Program Overview:
The "CARE for Confidence" program is designed to build clinical readiness among nursing students by addressing the emotional, relational, and practical dimensions of clinical competence. Rooted in the findings of this study, the program integrates Coping skills, Authentic experiences, Relational support, and Exposure & Reflection. This multi-faceted approach ensures that students are emotionally prepared, technically competent, and socially supported, with a focus on their overall development throughout clinical training.

Program Objectives:
1. Emotional Resilience: To equip students with effective strategies for managing clinical anxiety, stress, and emotional vulnerability, as identified in the study's findings.
2. Clinical Competence: To enhance hands-on experience and validate skills in authentic clinical settings, based on the importance of real-world practice from the findings.
3. Relational Confidence: To build confidence through relational scaffolding, leveraging mentorship and peer support, as evidenced by the study.

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4. Continuous Growth: To facilitate ongoing development through self-reflection and incremental exposure to clinical tasks, ensuring gradual confidence-building.

Program Components:

1. C - Coping Skills: Emotional Regulation Workshops

Rooted in Findings (Theme 1: Confidence as Journey from Vulnerability to Self-Trust)
The study highlighted the emotional vulnerability experienced by students as they transition to real-world patient care. Many students expressed anxiety, self-doubt, and stress when facing authentic clinical tasks. This component addresses those emotional challenges and helps students navigate vulnerability as part of the confidence-building process.
Objective: Prepare students emotionally for the challenges of clinical practice by teaching stress management and resilience-building techniques.
Structure:

- Pre-Clinical Emotional Regulation Workshop: Held at the beginning of each semester, these workshops will cover mindfulness, relaxation techniques (e.g., deep breathing), cognitive reframing, and self-compassion exercises.
- Content:
  - Emotional regulation in clinical settings.
  - Techniques to manage clinical anxiety and stress.
  - Cognitive strategies to address self-doubt and anxiety, as expressed in the study.
- Expected Outcome: Students will develop emotional resilience, reducing anxiety and building trust in their skills, in line with the study's findings that emotional vulnerability is essential for confidence development.

2. A - Authentic Experience: Hands-On Patient Care

Rooted in Findings (Theme 3: Confidence Through Validated Performance in Authentic Contexts)
The study found that students' confidence grew significantly when they interacted with real patients, emphasizing that simulation could not fully replicate the validation and growth achieved through authentic practice. This component ensures that students gain real-world experience, where performance validation occurs.
Objective: Provide real-world patient care opportunities to validate learned skills and enhance confidence.
Structure:

- Real-Patient Interaction Hours: Students will engage in at least 20 hours of direct patient care in their first clinical rotation. They will be tasked with assisting in procedures and taking patient histories under supervision.
- Skills Mastery Week: A dedicated week where students focus on mastering clinical skills such as vital signs, IV insertion, and wound care. Students will perform these tasks under supervision with feedback to validate their skills.
- Debriefing Sessions: After each clinical shift, students will participate in debriefing sessions to reflect on their experiences, receive feedback, and discuss their clinical performance.
- Expected Outcome: Confidence will be built through authentic patient care, as students validate their skills in real clinical settings, reducing the gap between theoretical knowledge and real-world practice.

3. R - Relational Support: Mentorship and Peer Learning Circles

Rooted in Findings (Theme 2: Confidence as Relationally Scaffolded Competence)
The study revealed that relational support from instructors and peers played a critical role in building students' confidence. Students described how mentoring and peer collaboration helped normalize struggles and fostered a sense of competence. This component formalizes those relationships to ensure that students have consistent emotional and professional support.
Objective: Enhance confidence through structured relational support, leveraging mentorship and peer collaboration.
Structure:

- Mentorship Program: Each student is paired with a clinical mentor (faculty or senior student) for bi-weekly one-on-one check-ins. Mentors will guide students through challenges, provide emotional support, and offer professional advice.

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- Peer Learning Circles: Weekly group sessions where students share their clinical experiences, reflect on challenges, and offer mutual support. These circles will be facilitated by a faculty member, ensuring a safe space for sharing and feedback.
- Feedback Integration: Faculty will provide timely private feedback after each clinical rotation, focusing on both strengths and areas for growth. Feedback will be framed positively to build students' self-esteem, as harsh correction was found to lower students' confidence in the study.
- Expected Outcome: Students will feel supported emotionally and professionally, gaining confidence through mentorship, peer collaboration, and constructive feedback.

4. E - Exposure & Reflection: Gradual Clinical Exposure and Self-Reflection

Rooted in Findings (Themes 1 & 4: Emotional and Professional Readiness & Institutional Conditions Enabling Confidence Development)

The study found that confidence develops incrementally as students gain exposure to clinical tasks, moving from simple to more complex procedures. Additionally, the study emphasized the importance of structured reflection to track emotional growth and skills development. This component incorporates gradual exposure and structured self-reflection to ensure continuous growth.

Objective: Facilitate ongoing development by gradually increasing clinical responsibilities and integrating reflective practices to track progress.

Structure:

- Gradual Exposure: Students will begin with observational roles and progressively move to assisted and independent tasks. This exposure will be tailored to the individual student's progress, ensuring manageable challenges that align with their growing confidence.
- Self-Reflection Journals: Students will maintain weekly journals to reflect on their clinical experiences, emotional responses, and areas for improvement. These journals will be reviewed during mentor check-ins to guide development.
- Reflection with Faculty: At the end of each rotation, faculty will review the student's journal and provide feedback on their clinical and emotional progress. Students will set goals for further development based on this feedback.
- Expected Outcome: Students will develop confidence progressively through exposure to increasing complexity in tasks and reflective self-assessment, ensuring they track and understand their growth.

Program Timeline:

1. Pre-Semester:
   - Emotional Regulation Workshop (1-day)
   - Mentorship and Peer Learning Circles Setup
2. First Clinical Rotation:
   - 20 hours of direct patient care
   - Skills Mastery Week
   - Debriefing Sessions
3. Ongoing:
   - Bi-weekly Mentor Check-ins
   - Weekly Peer Learning Circles
   - Continuous Feedback and Self-Reflection
4. Mid-Semester:
   - Review of clinical exposure hours
   - Check-in on workload and rest balance

Expected Outcomes and Benefits:

- Increased Confidence: Students will develop clinical confidence through emotional resilience, hands-on practice, relational support, and reflective learning.
- Enhanced Clinical Competence: Real-world patient care, skills mastery, and structured feedback will ensure that students are proficient and confident in clinical practice.

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- Stronger Professional Identity: Through mentorship and peer support, students will develop a sense of professional identity and self-assurance, preparing them for their future roles as nurses.
- Holistic Support: By addressing emotional, relational, and clinical factors, the program ensures that students are well-supported in all aspects of their development, enhancing both their well-being and academic success.

"CARE for Confidence: Cultivating Clinical Readiness and Empowerment" provides a structured, holistic approach to nursing education, ensuring that students are not only technically skilled but also emotionally and socially prepared for the demands of healthcare practice. Rooted in the findings of this study, the program enhances clinical confidence through emotional regulation, real patient care, relational support, and ongoing reflection, laying a strong foundation for the next generation of nursing professionals.

Conclusions

This study explored the development of clinical confidence among nursing students during their hospital and community exposures. Findings demonstrate that clinical confidence emerges through interconnected processes: emotional transformation from vulnerability to self-trust via active coping strategies; social co-construction through validated relationships where instructors provide vertical guidance and peers offer horizontal normalization; evidence accumulation through successful authentic performance with real patients; and structural enablement or constraint by institutional decisions regarding pedagogy, culture, and resources. Rather than an innate trait or simple skill acquisition, confidence develops through deliberate emotional work, relational scaffolding, authentic practice validation, and intentional institutional support.

These findings extend literature by demonstrating context-dependent confidence development and challenging individualistic self-efficacy models. Authentic clinical environments create qualitatively different psychological demands than simulation, with help-seeking building rather than diminishing confidence—critical for hierarchical nursing cultures. The institutional conditions theme reveals that pedagogical innovations cannot compensate for structural deficits in clinical placement availability, workload management, or feedback culture.

Practical implications include multilevel interventions: emotional preparation modules, faculty development on scaffolding techniques, structured peer support, graduated exposure protocols, success documentation, pre-clinical simulation sequences, feedback policies prohibiting public correction, and structural audits ensuring adequate rest and equitable opportunities. Theoretically, findings suggest confidence develops through internalization of external validation within structurally-enabled environments following developmental trajectories requiring process-based rather than trait-based assessment approaches.

The study has several limitations. Sampling from a single private institution in Bulacan limits generalizability across institutional types, regions, and resource contexts. Cross-sectional design captured third-year experiences without longitudinal tracking through program completion or professional practice. Written narratives limited exploration depth compared to interviews and may have privileged articulate students. Hospital versus community settings were not systematically compared as distinct analytic units. Researcher positionality as nursing educators risked confirmation bias despite credibility measures. Lack of triangulation with instructor perspectives, peer observations, or objective performance assessments means perceived confidence may not align with actual competence. Retrospective before/now comparisons relied on memory, potentially introducing recall bias.

Despite limitations, this study provides empirical evidence grounding curriculum improvements in student experiences, addresses Philippine nursing education literature gaps, and demonstrates that effective confidence-building requires coordinated institutional commitment across pedagogical, relational, and structural domains rather than isolated interventions.

Recommendations

This study provides several recommendations to enhance clinical confidence and readiness among nursing students, based on the findings.

First, emotional regulation training should be incorporated into nursing programs. Workshops on mindfulness, stress management, and cognitive reframing at the start of clinical semesters will help students manage anxiety and build emotional resilience. Second, increased clinical exposure is essential. Students should complete at least 20 hours of direct patient care early in their training to gain hands-on experience and build confidence in applying classroom knowledge. Third, a structured debriefing and feedback system should be implemented. Faculty

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should provide timely, constructive feedback on both technical skills and emotional responses after each clinical session to guide students' growth.

Fourth, mentorship and peer support are crucial. A formal mentorship program and peer learning circles should be established to foster continuous guidance and collaboration among students, helping them navigate challenges and build confidence. Fifth, gradual exposure to clinical tasks should be adopted. Students should begin with observational roles, progress to assisting, and eventually perform tasks independently, allowing for incremental skill development and confidence-building. Sixth, self-reflection and journaling should be incorporated into training. Weekly reflective journals will help students track their emotional and professional growth, with regular mentor reviews to guide their development.

Seventh, institutional support and resource allocation are key. Ensuring adequate clinical placements and managing workload will prevent burnout and provide students with optimal learning conditions. Finally, feedback on emotional responses should be included in clinical evaluations. Instructors should assess how students manage emotional challenges in clinical settings, fostering the development of emotional resilience alongside technical skills. By implementing these recommendations, nursing programs can support students in becoming confident, competent, and emotionally resilient professionals ready for real-world healthcare challenges.

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