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ORIGINAL PAPER

The difficulties experienced in patient communication by nursing students taking the clinical practice course for the first time – a qualitative study

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ABSTRACT

Introduction and aim. Nursing fields begin to face a wide variety of challenges when they first enter clinical practice. The aim of this study is to determine the difficulties experienced in patient communication by nursing students taking the clinical practice course for the first time

Material and methods. Focus group interview design was used for this study. Focus group design is used to give information about the opinions and experiences of the sample group on any subject. It is reported as a convenient design to identify different perspectives on a subject within the scope of the sample. Focus group interviews are a widely used method as data collection technique.

Results. The findings of the study continue on 4 main themes at level 3, by identifying the similarities and differences in the codes determined by the three experts (researchers consulted and the researcher conducting/reporting the study). The findings of the study were evaluated in comparison with the findings of the studies reached in the literature and conducted in regions such as Israel, Iran, Sri-Lanka, Kenya, and Africa.

Conclusion. There are many problems in student-patient communication in many different dimensions. The difficulties arising due to these problems generally focus on unknown clinical environment, lack of knowledge, differences between theory and practice, and mentor interaction.

Keywords. difficulties first practice, nursing students, patient communication

Introduction

Nursing education consists of an important process covering theoretical, laboratory, and clinical areas and practical training. Clinical teaching covers an important part of nursing education (usually half) and it appears as the most important education process.[1,2] Clinical practice is also known as the most important educational field that can be given to nursing students to improve their professional aspects. At the same time, clinical practice courses teach students "how to communicate" with the patient or healthy individual they will treat.[3,4] Nurses are considered to be leading health professionals who need to develop effective communication with the individual they care for in order to provide effective nursing care and to get the correct nursing diagnosis.[5]

Learning motivations of nursing students mostly vary depending on the environmental conditions in the clinic (the attitude of the professionals in the clinic, the physical environment of the clinic…). When these conditions are not adequately met, the nursing student sees herself as inadequate and unsuccessful. This situation is also reflected in patient communication.[6,7]

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A systematic review revealing how nursing students' communication with patients is improved, proposes that students will benefit from trainings such as role play, or live simulation performed spontaneously using cases.[8] The review reports that realistic, patient-centered, and feedback-included communication approaches described in theoretical courses are important issues that would minimize communication problems in practice areas.[9,10]

Nursing students need to learn communication difficulties during theoretical training in order to adopt innovative communication education approaches and gain the ability to continue learning and developing in the field of practice.[8,11,12]

In a systematic review, it is stated that the best teaching intervention in which nursing students can recognize and solve the difficulties in their communication with the patient is the use of live simulation.[8]

Social skills as well as academic achievements of nursing students contribute to coping with difficulties in communication. For example, when a group project is given and each student takes responsibility for herself, the effective evaluation of the project results also contributes to the development of students' social skills at the basic level. Students learn to intervene in crisis to solve any problem and to develop interpersonal relations and high-level thinking skills with small peer groups. This situation provides a nursing student, who will take the clinical practice course for the first time, with social skills as well as academic knowledge in order to solve patient-centered communication difficulties that she will encounter in the field of practice.[13,14]

The results of a study conducted in Taiwan in 2016 suggest that nursing students should develop their communication skills and communication-related social skills according to their clinical needs (situation-specific). The study reported that students have traumatic-negative communication experiences with individuals with cancer.[15] Moreover, cultural differences related to issues such as illness/health/loss may be a reason for communication problems that nursing students experience in clinical fields.[15,16] A study conducted in Turkey in 2022 reports that nursing students, who encounter a death/terminal period patient for the first time, have inadequacies in communication and cannot receive adequate/comprehensive mentor training in clinic.[17] It is also seen in the results of the study that it is an important issue for nursing students to receive education including realistic and therapeutic techniques (practice-oriented) in theoretical training.[13-17] It is known that nursing students who will enter the field of practice for the first time may encounter many different patient groups.[16,17]

Aim

The aim of this study is to determine the difficulties experienced in patient communication by nursing students taking the clinical practice course for the first time. It is thought that the study will guide future quantitative and experimental studies and contribute to the identification of difficulties.

Material and methods

Study design

Focus group interview design was used to determine "The Difficulties Experienced in Patient Communication by Nursing Students Taking the Clinical Practice Course for the First Time." Focus group design is used to give information about the opinions and experiences of the sample group on any subject. It is reported as a convenient design to identify different perspectives on a subject within the scope of the sample. Focus group interviews are a widely used method as a data collection technique. It is expressed as a common and useful way of collecting qualitative data within the sample (in a predetermined group).[18,19] Focus group interviews, which are qualitative data collection techniques for group interviews, are expressed as a method in which the meanings of words are examined (classified) and real emotions are observed.[19,20] They are used to evaluate and determine processes such as attitudes, thoughts, and knowledge about a subject in the sample group and in the group represented by the sample, and to create a background about the subject.[19] It is seen that focus group interviews are used to determine what the sample thinks about an event/situation right after the process or months later, what the sample experiences, what the sample learns, and the emotion that this process creates in the individual.[20-22]

Study universe and sample

For the study, 1st year nursing students at a university in the north-east of Turkey were included in the study. All the students in the 1st year constituted both the universe and the sample of the study. Within the scope of the research, there were 60 (total number of students in the 1st grade and the universe) nursing students. However, 32 students (10 students did not participate in the study, 18 students could not participate in the interviews/dropped out) who accepted to cooperate and could participate in the study process were included in the study (Fig. 1). The participants were asked 7 basic open-ended interview questions in the form in which the study data would be collected. These questions were determined as follows:

1. Which patient problem in the clinic affects you most during practice?
2. In which situations do you feel most at a dead end in communication with patients during practice?
3. How do you feel when there is a problem in your communication with a patient?
4. What do you think about patient-nurse interactions?

5. What do you do when you have problems communicating with a patient?
6. What are the difficulties you experience in communicating with a patient?
7. Do you think you can cope with the difficulties you experience in communicating patients?

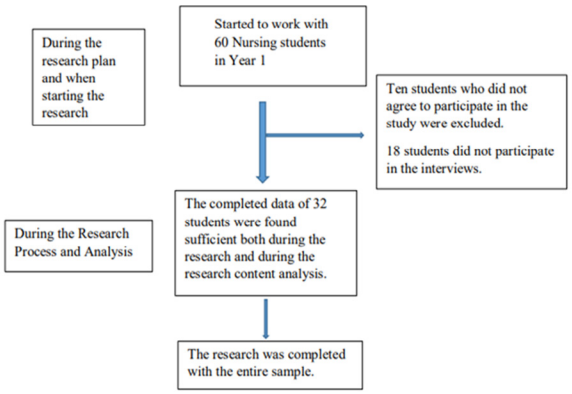

Fig. 1. Flowchart of study

Data collection

While making the study plan, 2 separate forms were created in accordance with the sample and the nature of the study. One of these forms is the socio-demographic data form where we could collect the data of the socio-demographic characteristics (characteristics such as age, sex, marital status, place of residence) of the participants (nursing students), and the second form is the data form that would be collected for the purpose of the qualitative study, which was created by taking expert opinions (3 experts). The second form, which consists of 7 questions, consists of open-ended questions to collect data belonging to the qualitative study. For the 2nd form, group interviews were conducted with all the participants (n: 32 and 6 different groups consisting of 5 students were determined by lottery method). These interviews were recorded in all groups, and verbal and written consent was obtained from the students to record the focus group interviews. In the study, an expert observer was included in the group (like an outside student) without being declared an expert and an observer. This observer observed mimics, behaviors, and gestures in order to evaluate especially nonverbal records. The data of the study were collected and recorded (with a voice recorder) in accordance with the focus group interview design. The interviews were conducted in a calm, quiet, well-ventilated environment where the interviewer could answer the questions well. The interviews were conducted in a suitable classroom of a faculty with a nursing department and lasted approximately 20-40 minutes.

Data analysis

Three steps were followed in the focus group interview analysis:

1. After each interview, an evaluation was made, and the main themes of the interview were dwelled on. Some notes were taken on the importance of the data obtained from the participants and the interview process was reviewed.
2. The obtained records were listened to repeatedly (three expert listeners), themes were defined, and sub-themes were formed.
3. Moreover, while listening to the answers to the questions, the responses given by nonverbal communication were also noted by comparing the records and the notes. Features such as mimics and tone of voice were evaluated in a mutual interaction. Nonverbal responses generating cues appropriate to the content were also evaluated.

The evaluation steps making up this part are examined in two ways:

a. Classification and arrangement of words/Classifications according to the theme/Creation of themes and sub-themes
b. Reviewing nonverbal communication sources/ Behaviors revealed at the time of gestures and responses

Table 1. Demonstration of 3 levels of coding/themes/sub-themes

Level 1 codes (general classification)	Level 2 codes (themes)	Level 3 codes (sub-themes)
Fear of communication failure	Lack of self-confidence	Unknown communication process/ Clinical Anxiety
Fear of giving wrong information		Lack of sufficient knowledge about the patient/disease process
Fear of inability to communicate effectively	Feeling inadequate in communication	Differences between ideal theoretical knowledge and area of practice
		Inadequate clinical supervision given to overcome difficulties in communication
Inability to identify difficulties in communication	Difficulty in transforming theoretical knowledge into behavior	
Inability to cope with difficulties in communication	Difficulty in compliance with hospital procedures	
Lack of knowledge	Difficulty in recognizing difficult patients and their behaviors	
Fear of the "unknown" that is likely to be encountered in communication	Anxiety in communicating with an unknown patient/ disease process	

According to the qualitative content analysis approaches developed by Graneheim and Lundman, 6 different themes were determined at level 2.[23] In the interviews developed by Stewart and Shamdasani, in which examined paragraph by paragraph, subject by subject were examined, important situations were coded according to the identified topics.[24] Three experts

(researchers consulted and the researcher conducting/reporting the study) determined the similarities and differences in the codes they determined and finally divided them into 4 main themes at level 3.

In the study, 3 basic level coding was performed.

Level 1 codes consisted of codes that covered the general and reflected the main themes, which were formed after the important and specific answers to the questions asked to the participants.

Level 2 codes were usually prepared comparatively. When the 1st Level codes were created, it was requested to gather them under a more general title in a way covering the determined 1st Level codes.[23,25]

Level 3 codes were the coding level made in the form of main title(s) describing the psycho-social process created by the other coded levels.

The codes were also created/evaluated by 2 different experts (3 experts in total) other than the researcher. Table 1 shows the level-by-level coding results/themes. Since all data cannot be presented due to the nature of qualitative studies, some basic expressions and guidelines for the formation of themes are included in the findings.[21] The researcher who conducted the study and the experts whose opinions were consulted have a significant and long education/experience in the field. The purpose and importance of the study were explained to the students in advance so that they could reveal their real feelings, thoughts, and behaviors. It was tried to provide an environment where the participant students could express themselves freely. Since this is a qualitative study, it was tried to be strengthened in terms of reliability with expert opinion, observation, and basic coding approaches/content analysis.

Results

The socio-demographic characteristics of the sample group included in the study are given in Table 2.

Unknown communication process/Clinical anxiety

When the level 1 and level 2 codes in Table 1 are examined, it is seen that nursing students have problems such as communication failure and fear of giving wrong information, inability to communicate effectively and to identify difficulties in communication. These codes negatively affect students' self-confidence. Some important examples of the development of clinical anxiety of students (including the unknown communication process) are given below.

"*Sometimes I know the answers to the questions patients ask me. These are ordinary theoretical knowledge. However, I still refrain from answering. I also get worried about what if he misunderstands me. And even though I'm sure, I stay very quiet when I think maybe there are things I don't know. Because of this situation, patients sometimes do not make me do simple practices, even if I am accompanied by a mentor. I guess I should be more go-ahead about the things I know.*"

(Male S7)

The anxiety experienced in informing patients about clinical routines and nursing student's inability to answer questions create deficits in "self-confidence".

"*In one case, I informed the patient that his blood pressure was a little high during vital signs monitoring. The patient's blood pressure value, which I measured after 20 minutes, was even higher. I thought it was because I told him his blood pressure was high. I was very worried that day. In my subsequent hospital practices, I avoided informing patients of their vital signs. When patients asked about their vital signs, I usually said that my mentor nurse would give information and left. Sometimes it was really hard for me to go to practice. Saying something wrong without knowing might take me to court.*"

(Female S9)

Nursing students generally refrain from giving information to patients during clinical practice. They get worried that they can cause emotional and spiritual harm to patients. This situation sometimes makes students more anxious when they come to clinical practice. Some students (Male [M] S11, Female [F] S14, M S21, F S9…) think that they can experience legal proceedings because of a statement they say (How much information they can give to patients can be made into a procedure). It is seen that this situation causes nursing students not to be able to adequately answer to patients' questions in the clinic and to experience anxiety while coming to/during clinical practice. Students also say that they "lost their self-confidence" in giving information or wrong practices (M S13, F S17, M S28, M S24, F S22…..).

Lack of sufficient knowledge about the patient/disease process

When the codes in Table 1 are examined, it is seen that the nursing students have significant communication difficulties such as fear of inadequacy in effective communication, fear of inadequacy in identifying difficulties in communication, and fear of lack of information. These processes can have multiple causes. However, the nursing students with whom the study was conducted often stated the lack of recognition of comorbid diseases or the primary disease creating the care process, and the fact that individuals did not recognize their unique symptoms/reactions as difficulties in communication.

"*A patient's relative called me to the sick room when the serum was finished. When I entered into the room, the patient was rocking back and forth on the bed. I asked the patient's relative why he did this. I checked his vital signs. I tried to communicate with the patient. I called him. However, he did not look at me. The patient contin-*

ued to rock back and forth in the bed and started shouting. Again, I asked the patient's relative if he could not hear me. At that moment my mentor nurse came. She immediately removed the empty IV set from his arm. "How long has he been in this situation?" he asked. The patient's relative said "it is about 10 minutes". Then the mentor nurse came in and gave a medicine from the patient's order. After observing together, we left the room. I could never enter into that room again. Even if I entered, what would I talk to the patient or his relative? For example, while listening to a topic about communication, I listened to the importance of eye communication with the patient at school. I did not know how to establish eye communication with this patient."

(Female S18)

The fact that students do not know some diseases and symptoms, do not know patients' medical histories, and do not have an idea about their comorbid diseases also affects their communication processes and the speed in the communication network (Students do not recognize the symptoms and communication difficulties to share with their mentors). The nursing students stated that they had more difficulties in the communication process they established with patients with additional diseases that they did not know.

"When I entered into the patient's room, I introduced myself, but then the patient repeatedly asked me who I was. I introduced myself a few more times. When I went to his room for a blood pressure measurement that was in his clinical routine, he did not give me permission to take the measurement. He asked me to call the nurse. When I called the mentor nurse, she always said that she did not know me and that I had not introduced myself to her before. Apparently, the patient had forgotten all the moments when I introduced myself to him. But I don't know why he forgot. At that moment, I did not know what to think about the patient's condition, diagnosis/behaviors. Since this caused me a lot of anxiety, I tried to avoid any possible interaction with the patient."

(Female S23)

The nursing students have difficulty in assessing whether a patient's symptoms develop after a medication, due to an additional disease, or as a result of the primary disease being cared for.

Differences between ideal theoretical knowledge and area of application

Depending on many processes, in the clinical environment, different and incompatible times/environments/events can be experienced from the theoretical teachings. The nursing students stated that they experienced almost all the problems causing theoretical knowledge not to be applied to the clinic.

"Actually, I wanted to catch a quiet time when we could hear each other, in order to communicate with the patient in an effective process and to create an environment of trust. However, unfortunately, we could not find the time to initiate/maintain secure communication with my mentor nurse in the patient rooms. My mentor nurse was constantly taking on intensive care duties, and I participated in these care processes by watching her and helping her from time to time. Although I learned a lot about care, I did not have much time for effective communication. Because I had difficulty in providing time and environment for many communication techniques and processes that I learned at school."

(Female S16)

The nursing students say that they have more problems in initiating and maintaining communication, especially with individuals with neurological, neuropsychiatric, and psychiatric problems (M S11, F S18, M S13, F S19, F S23, F S32, M S31, F S17…).

"When I entered into room 20, the patient had taken off the intravenous catheter we had just put and was dressed. There was blood everywhere. As far as I remembered from a lecture we were taught about communication, I needed to create a safe environment for the patient. When I told him to lie down on the bed and I was going to apply pressure to his arm to stop the bleeding, he suddenly threw the blood contaminated IV set at me. The upper part of my body, including my eyes, was smeared with blood. I remember the patient had been well a few hours ago. After the routine maintenance of the clinic was over, I thought of going to his room to get the data I needed for my course. However, this situation, which developed in just a few hours, took me by surprise. In that situation, it became impossible for me to communicate."*

(Female S32)

It is understood that the students do not know the acute situations that they may experience during the communication process in the internal and surgical units and the symptoms of psychiatric comorbid diagnoses. The student encountered a case of delirium above, and the theoretical (theoretical communication subjects received includes a healthy and routine communication training) approach was insufficient.

It is seen that students coming to clinical practice for the first time may experience deficiencies in various aspects in such cases. As the best way to manage these processes, it is necessary to show what can be done in the face of pathological communication environments and processes under the supervision of a mentor. As a matter of fact, as seen in Table 1, "insufficient clinical supervision given to overcome difficulties in communication", which is one of the level 3 themes, emerges as a final difficulty.

Inadequate clinical supervision to overcome difficulties in communication

The nursing students could not get effective and evidence-based answers for some possible situations they asked their mentor nurses.

Female S26: "How should we respond when a six-year-old child asks us what happened to his mother in the accident?"

Nurse (N) 1: "Of course you will tell the truth!" (Yes, "correct" but "incomplete", this should include a communication/notification process. The general health, emotional, and mental state of the six-year-old child patient should be considered.)

N2: "Explaining this to an individual being treated makes him worse."

(Taken from a few examples FS 26 gave in answering the research questions.)

"We entered into a patient's room for a routine observation. When a patient whose treatment was over said, "I wish I wasn't discharged from the hospital right away, because I still have respiratory distress", the mentor nurse said, "You can't stay here forever, your treatment will continue at home." About an hour later, when I entered into the room, I saw the patient crying. I asked if I could do something for him, and he shook his head no. When I conveyed this to the mentor nurse, she said that some patients may behave like this. In fact, the part that did not sit well with me was this: maybe the patient cried not because of respiratory distress, but because he was afraid of being alone at home or dying. So were we going to just leave the patient alone?"

A student who has not yet received a psychiatry education (a student who came to the clinic for the first time to practice) also noticed the situations in which the mentor's communication deficit is obvious. The student responses reveal different characteristics in the attitudes of mentor nurses regarding communication.

While some students (M S11, F S23, M S28, F S14, M S27…) explained in their answers that the mentor nurses neglected the communication issue due to the intensity of their other work (care/treatment and other non-nurse-related jobs in the service…);

"Last week, when I said to my mentor nurse, 'You said you would go back to the patient's room and listen to her,' she replied, 'I am busy with transfusion right now and unfortunately she is my patient, too and my priorities are different'. I think the nurses are a little busy. However, I could not observe because my mentor nurse could not go to the interview, she was going to have in the patient room." (Female S23)

Student observations that the mentor nurse was busy were frequently expressed. However, many simplified the situation of one of the patients (which can be very important to the patient) when stating priorities, similar to this statement. This is one of the most common communication mistakes.)

Table 2. Descriptive characteristics of the participants

Participants	Age	Marital status	Living place	Working status	Family type	Family income
M S1	18	Single	City	Non-working	Wide	Average
F S2	19	Single	Big city	Non-working	Core	Average
F S3	20	Single	Village	Non-working	Wide	Low
F S4	19	Single	City	Non-working	Core	Average
F S5	19	Single	City	Non-working	Core	Average
M S6	19	Single	Village	Non-working	Wide	Average
M S7	19	Single	City	Non-working	Core	Average
F S8	20	Single	Village	Non-working	Wide	Average
F S9	19	Single	City	Non-working	Core	Average
F S10	19	Single	City	Non-working	Core	Average
M S11	20	Single	City	Non-working	Core	Average
F S12	19	Single	Big City	Non-working	Core	Average
M S13	19	Single	City	Non-working	Core	Average
F S14	19	Single	Big City	Non-working	Core	Average
F S15	19	Single	City	Non-working	Wide	Average
F S16	19	Single	Village	Non-working	Wide	Average
F S17	20	Single	Village	Non-working	Core	Average
F S18	20	Single	City	Non-working	Core	Average
F S19	20	Single	City	Non-working	Core	Average
M S20	22	Single	City	Non-working	Core	Average
F S21	20	Single	City	Non-working	Core	Average
F S22	20	Single	Big City	Non-working	Core	Average
F S23	19	Single	Village	Non-working	Core	Average
M S24	21	Single	Big City	Non-working	Wide	Low
M S25	19	Single	City	Non-working	Core	Average
F S26	19	Single	City	Non-working	Core	Low
M S27	19	Single	City	Non-working	Core	Average
M S28	19	Single	Village	Non-working	Core	Average
F S29	20	Single	City	Non-working	Core	Average
F S30	21	Single	Big City	Non-working	Core	Average
M S31	19	Single	Big City	Non-working	Core	Average
F S32	19	Single	City	Non-working	Core	Average

Other student answers (M S31, F S17, M S13, F S20, M S6…) state that the mentor nurses have a lack of knowledge in patient communication.

("A patient who had to walk in the corridor from time to time, said that he was tired and asked if he was walking enough when my mentor nurse and I were passing by. The mentor nurse told him that she did not see the time he was walking, that she was not sure that he -the patient- could tell the time and distance correctly, so he could not answer. When the patient said that his pain increased as he walked, she said, 'then sit down." – Male S31)

We understand that even when there is not a busy work schedule (even if there is), the nurse treats the patient as a competitor rather than as her caregiver and simplifies the patient's pain and fatigue. This situation reveals that they do not use communication with its methods, they do not make an effort to do this, and they have incomplete information about the patient-nurse communication processes.

Discussion

In this section, 4 themes, which were determined by experts and whose findings were exemplified as a result of the analysis were discussed in the light of the literature. The *"Unknown communication process/Clinical Anxiety"* in the study are revealed in the literature with various dimensions. In a study examining the stress experienced by the nursing students who came to clinical practice for the first time in Israel in 2014 and the ways of coping with this stress, it was reported that the nursing students experienced intense stress due to their lack of clinical communication skills, their relationship with complex patients, and the complexity of the clinical environment.[26] It was reported that the nursing students who came to clinical practice for the first time in Taiwan and Iran could not establish a 'therapeutic relationship' with the patients and the mentors, and therefore experienced intense anxiety during clinical practice.[27,28] In two different studies conducted in Iran in 2015, it was stated that the students defined the unknown clinical environment as "stressful".[29,30] Similarly, the study stated that the nursing students had problems in communicating and identifying their deficiencies in communication, and this often created an environment for making mistakes. When the answers of the nursing students were examined, we saw that they had some difficulties in communicating with the patients and that they had problems of orientation to the clinical environment. Similarly, in a study conducted in Taiwan, it was reported that the students' lack of communication skills caused deeper communication failures in the unknown clinical environment.[31] From a different viewpoint, the results of a study in Ireland reported that the nursing students who came to clinical practice for the first time were very young and were weak against the communicative, emotional, and social problems they would experience in the clinical environment.[32] The fact that the students in the study had no previous clinical experience supports the fact that these students experience communication-related fears in the face of the complexity of the clinical environment. Another study in Iran showed that the fear and communication problems experienced by nursing students in the clinical environment also negatively affected their self-confidence.[33] When the study findings are examined, fear of communication and self-confidence problems created by the unknown clinical environment emerge as frequently detected issues.

When the literature is examined, students' lack of knowledge about care and treatment, low communication skills, insufficient knowledge, and an unfamiliar clinical environment are always shown as sources of stress and anxiety for students.[26-34] In particular, the lack of theoretical knowledge (knowledge of communication, knowledge of clinical environment, knowledge of diseases and illnesses) causes students to be unable to integrate their theoretical knowledge into the clinic.[35] Nursing students who theoretically take inadequate communication training and come to the clinic with insufficient communication skills can also give inadequate answers (or wrong/ineffective) in their interactions with the patient.[36] When they have to cope with a difficult patient or a comorbid diagnosis they do not know, they lose all their motivation. This situation creates an important anxiety environment for them.[37] In a study conducted in Northern Tanzania, 17.6% of nursing students' communication difficulties were due to lack of knowledge.[38] The students' responses and emerging themes in the study show that our findings are in line with the literature. Since nursing students have clinical experience for the first time, they do not know comorbid diagnoses or whether changes in communication with the patient while treatment is ongoing are an acute biochemical/neurological change. This causes fear and withdrawal from communication. It was observed that first-year nursing students, who have very limited theoretical communication knowledge, have problems integrating their existing theoretical knowledge. The reason for this is the "*Differences between ideal theoretical knowledge and area of practice*", which is another theme of the study.

The data of two studies conducted in Malawi and South Africa show us that the clinical practice environment can be very different, the discussion environment in the clinical environment is idealized in theory, and this ideal environment knowledge that students learn in theory and the clinical environment are very different.[39,40] In a study conducted in Israel, it was reported that nursing students were strengthened theoretically, but theoretical knowledge could not be reflected in the clinical field, which has a more complex structure. The study draws attention to gaps in theoretical knowledge and practice.[41] In cases where the clinical environment and theoretical knowledge are incompatible, nursing students generally feel the lack of communication more. This situation may bring to mind the question of "where am I doing wrong" for them. For example, it is clearly seen in our findings that the students learned that they should establish "eye communication" during communication, but the complex clinical environment brought an acute neurological/neuropsychiatric patient to them. At this point, a mentor-student relationship is required, showing how idealized theoretical knowledge can be used in complex situations.

In the mentor-student relationship, the issues related to mentors, such as using their own value judgments, reflecting their own attitudes and efforts to integrate their norms into communication/clinic· ignoring student nurses, and mentors' inadequacy in the clinical environment etc. come to the fore.[42-45] The data of a study in Kenya concluded that 54% of the student nurses stated that

mentor nurses had insufficient communication-interaction.[45] In a study conducted in Africa, it was reported that mentor-registered nurses spent very little time with the nursing students and could not afford enough knowledge/dedication to transform theoretical knowledge into practice.[46,47] In the study, it is clearly seen that the students' answers were that the mentor nurses generally gave insufficient supervision and the reason for this was mostly lack of knowledge (although various reasons were reported) and lack of communication.

According to a study conducted in Sri-Lanka, there are basically two parameters affecting the student-mentor relationship. One of them is reported as workload and the other as socio-cultural differences.[48] Mentor nurses cannot provide supervision that will add value to nursing education in an overcrowded and complex environment.[49] Moreover, the fact that nurses are separated as academic and clinical staff creates a mentor confusion. The fact that they have little or no connection with each other also reveals mentors' knowledge and empathy problems in the clinical environment.[50-51]

Considering that the same problems are present in the study, the fact that mentor nurses are separated from the academic staff and that they do not have enough knowledge/empathy/mentoring training may reveal these problems.

Study limitations

Since the student sample with which the study was conducted was 1st grade, a group that had not received any communication training was selected. When the nursing course contents are examined, it is seen that some schools offer communication-based courses, but some do not. Therefore, the data has a limitation in explaining the communication difficulties of all 1st year nursing students. However, this situation makes the study important in terms of making comparisons with other studies (2nd, 3rd, 4th grade nursing students) in the discussion.

Conclusion

The results of the study show that the clinical environment contains an unknown and students begin by experiencing communication-related fears in this unknown environment. Although orientation programs are useful in this regard, the main issue is how students integrate theoretical knowledge into the clinic. Therefore, 1st year students need to learn this basic theoretical knowledge in the clinic by taking a course such as "health communication". In this case, mentor nurses are responsible for learning that "things are not always as written in the books" in the clinic. However, all literature shows that mentor nurses cannot provide sufficient clinical supervision. In our study, it is thought that there are important problems related to mentor nurses such as ignoring students, heavy workload, and lack of knowledge/ignoring patient communication, as far as it is especially understood from students' answers. The fact that clinical orientations should be a long process that does not include only a few hours, that mentor nurses receive a mentoring training from staff in this context, and that students undergo a basic communication training can be some of the things to be done in this regard.

Declarations

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Author contributions

Conceptualization, P.H. and P.H.; Methodology, P.H.; Software, P.H.; Validation, P.H., P.H. and P.H.; Formal Analysis, P.H.; Investigation, P.H.; Resources, P.H.; Data Curation, P.H.; Writing – Original Draft Preparation, P.H.; Writing – Review & Editing, P.H.; Visualization, P.H.; Supervision, P.H.; Project Administration, P.H.; Funding Acquisition, P.H

Conflicts of interest

There is no conflict of interest in this study.

Data availability

The data set of this study is not shared openly in any medium.

Ethics approval

The ethical permission of the study, numbered 07-22 and dated 30.03.2022, was obtained from Tokat Gaziosmanpaşa University Scientific Research and Publication Ethics. Before this permission, written study permission was obtained from the school of the nursing students where the study would be conducted. The participants were informed verbally and the Helsinki declaration was read to each of them. Informed consent was signed by the participants.

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