

Challenges in clinical training for professional nurse students: A qualitative study

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Abstract

Background: Clinical training is a cornerstone of nursing education, equipping students with the practical competencies required for professional practice. However, professional nursing students often face significant obstacles, including limited supervision, communication barriers, emotional strain, and resource constraints that hinder their clinical learning. Despite these concerns, few studies in Indonesia have systematically explored these challenges, creating a gap in understanding the specific contextual factors shaping clinical training experiences.

Purpose: This study aimed to explore the challenges experienced by professional nursing students during clinical training in Indonesia.

Methods: A qualitative descriptive study was conducted using semi-structured interviews with 25 professional nursing students from accredited nursing programs in Indonesia. Data collection occurred between March and June 2025 to provide temporal context. Participants were purposively sampled to ensure diverse experiences. Thematic analysis followed Braun and Clarke's six-step framework, and NVivo software supported data management. Trustworthiness was ensured through credibility, dependability, confirmability, and transferability strategies.

Results: Analysis revealed five central themes: (1) Inadequate clinical supervision, characterized by limited instructor availability and insufficient feedback; (2) Communication barriers, including hierarchical dynamics, medical jargon, and language differences; (3) Emotional and psychological strain, stemming from high workloads and performance anxiety; (4) Resource constraints, such as limited access to modern tools and simulation facilities; and (5) Interpersonal challenges, involving peer competition and difficulties in collaborative learning. These issues were further influenced by Indonesia's cultural and institutional context.

Conclusion: Overcoming these barriers requires a holistic strategy encompassing improved student-to-instructor ratios, enhanced communication training, stress management initiatives, investment in educational resources, and fostering positive peer relationships. Institutional dedication to these interventions is critical to advancing clinical training outcomes and cultivating competent nursing professionals.

Keywords: communication barriers; clinical training; emotional strain; nursing education; qualitative study

Introduction

Clinical education serves as the cornerstone of nursing programs, equipping students with critical hands-on experiences essential for building competencies required in professional practice. However, nursing students worldwide face significant challenges during clinical training, including limited clinical placement opportunities, inadequate supervision, emotional demands of patient care, and communication barriers (Chan et al., 2020; Labrague et al., 2021; Storaker et al., 2022). Overcoming these challenges is crucial to ensuring that clinical education effectively fosters skilled and

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competent nursing professionals.

A primary challenge is the scarcity of clinical placements, which often limits students' exposure to diverse clinical scenarios and hampers the development of practical skills (Aghamohammadi-Kalkhoran et al., 2022). In Indonesia, this issue is compounded by a growing number of nursing students, insufficient collaboration between educational institutions and healthcare facilities, and inadequate infrastructure (Yusuf et al., 2020; Smith et al., 2020). Variations in clinical training quality across institutions, driven by disparities in resources and faculty expertise, further exacerbate the problem (Utami et al., 2021).

Communication barriers also hinder the learning experience, particularly in culturally complex settings. Indonesian nursing students often struggle to bridge the gap between theoretical knowledge and real-world application, which can lead to reduced confidence and increased stress (Nursester, 2023). Factors such as hierarchical relationships and cultural norms emphasizing respect for authority often discourage students from expressing concerns or seeking assistance, limiting open communication and critical thinking opportunities (Wong et al., 2020; Raharjo et al., 2022). A supportive supervisory relationship and a positive pedagogical environment are essential to addressing these issues (Wati et al., 2024).

Emotional demands present another significant challenge. Managing critical patients, dealing with end-of-life care, and navigating ethical dilemmas can cause stress and emotional exhaustion, adversely affecting students' well-being and academic performance (Labrague et al., 2021). During the COVID-19 pandemic, Indonesian nursing students reported heightened anxiety and fear during clinical rotations, highlighting the need for robust psychological support systems (Achmad et al., 2021).

To address these barriers, innovative strategies such as simulated learning environments, interprofessional education, and mentorship programs have shown promise. Simulated environments allow students to practice clinical skills in a controlled setting, fostering critical thinking and decision-making without the pressure of real-life scenarios (Kim et al., 2020). Interprofessional education enhances teamwork and communication skills, while mentorship programs provide guidance, emotional support, and role modeling, improving students' confidence and competence (Henderson et al., 2022; Oates et al., 2021). However, the success of these strategies depends on institutional commitment, resource allocation, and stakeholder engagement.

Despite these advancements, few studies had comprehensively examined the multifaceted challenges of clinical education in Indonesia, particularly the influence of cultural communication patterns, emotional preparedness, and institutional policies on students' learning experiences.

Cultural attributes such as collectivism and high-context communication significantly influence student-supervisor interactions, often hindering assertiveness and open communication (Mulyanah & Krisnawati, 2023). Institutional policies, including accreditation and quality assurance measures, also play a pivotal role in shaping the quality of clinical education (World Bank, 2012; BAN-PT, 2019). However, these aspects remain underexplored in the Indonesian context.

This study aimed to investigate the challenges faced by professional nursing students in clinical education in Indonesia and to develop integrated strategies for improvement. By examining factors such as emotional preparedness, communication dynamics, and cultural influences, this research sought to provide a comprehensive understanding of these challenges and offered practical recommendations to enhance clinical training outcomes.

Materials and Methods

Study design

This research utilized a qualitative descriptive approach to investigate the challenges encountered by professional nursing students during their clinical training in Indonesia. Data collection was conducted between March and June 2025, allowing researchers to capture recent and contextually relevant experiences of students within the current clinical education environment. This method facilitated an in-depth exploration of the participants' experiences and perceptions, offering critical insights into the multifaceted nature of clinical education in nursing (Creswell, 2018). By emphasizing participants' first-hand accounts, this design ensured a comprehensive understanding of the obstacles faced and their potential impact on learning outcomes and professional development.

Sample

Participants were recruited from four accredited universities across three major regions of Indonesia (Java, Sumatra, and Sulawesi) to ensure broad geographic and institutional representation. A purposive sampling approach was employed to recruit participants, ensuring the inclusion of students with significant clinical training experience. Operationally, students were considered to have significant clinical training experience if they had completed a minimum of one full clinical rotation (equivalent to 6–8 weeks) in a hospital or community health setting and had direct involvement in patient care under supervision. This criterion ensured that participants had substantial exposure to real clinical environments and could articulate meaningful insights regarding the challenges encountered.

To enhance contextual richness and representativeness, participants were recruited from both public and private institutions located across different geographic regions, including Java,

Table 1. Interview guideline**Opening questions:**

“Can you tell me about your overall experience as a professional nurse student?”
“What motivated you to pursue nursing as a profession?”

Main questions:

“What challenges have you encountered during your clinical training?”
“Can you describe a specific instance where you felt unsupported or unprepared during clinical training?”
“What factors do you think contribute to these challenges?”

Probing questions:

“Can you elaborate on how that experience impacted your learning?”
“What kind of support do you think could have helped in that situation?”

Closing questions:

“What advice would you give to other nursing students facing similar challenges?”
“Is there anything else you would like to share about your clinical training experience?”

Sumatra, and Sulawesi. This diversity allowed the study to capture variations in clinical training structure, institutional resources, and cultural dynamics across Indonesian nursing programs.

Participants eligible for inclusion were professional nursing students who had completed at least one clinical training rotation, demonstrated proficiency in the Indonesian language for effective communication during interviews, and expressed a willingness to participate by providing informed consent. Conversely, students who were on academic leave, had discontinued their clinical training, or possessed incomplete clinical training records were excluded from the study. The sample size was guided by the principle of data saturation, a widely recognized standard in qualitative research (Patton, 2002). Data collection continued until no new themes or insights were identified during the interviews, ensuring the depth and reliability of the findings. The final sample consisted of 25 participants, reflecting the point at which thematic saturation was achieved.

Interview Guideline

The interview guideline was developed through a literature review and consultations with experts in nursing education. The initial draft was reviewed by three nursing educators and two qualitative research methodologists to ensure clarity, relevance, and comprehensiveness. A pilot interview was conducted with two professional nurse students to refine the questions and probes. Table 1 shows an example of interview guideline.

Procedure

Participants were recruited through nursing faculty coordinators and student networks to ensure access to students with relevant clinical training experiences. To minimize potential gatekeeper influence or selection bias, faculty coordinators were instructed to distribute a standardized recruitment invitation to all eligible students rather than selectively approaching individuals. Similarly, announcements shared through student networks used identical

wording and were disseminated through multiple channels (e.g., official class groups, student forums) to maximize reach and reduce selection skew. Interested students contacted the research team directly, ensuring voluntary participation without faculty involvement in the final selection.

Prior to participation, all individuals received an information sheet explaining the study's objectives, procedures, and ethical considerations. Written informed consent was obtained from each participant before commencing the interviews, adhering to ethical research standards. Data collection involved semi-structured interviews conducted either in person or virtually, depending on participants' preferences and logistical accessibility. Both formats followed the same interview guide, and interviewers received standardized training to ensure consistency in questioning style, probing techniques, and rapport-building strategies.

The research team also reflected on potential differences between in-person and virtual interviews. While in-person interviews allowed for richer observation of nonverbal cues, virtual interviews were not perceived to substantially reduce the depth or quality of responses, as participants appeared equally comfortable sharing experiences in both settings. Many students reported that virtual interviews provided a sense of convenience and privacy, which facilitated open discussion.

Each interview lasted 45–60 minutes and was audio-recorded with explicit consent to ensure accurate documentation of responses. The recordings were transcribed verbatim to maintain data integrity. To enhance the credibility of the findings, participants were invited to review their transcripts through a member-checking process, enabling them to verify or clarify their statements as necessary.

Data analysis

The data analysis was conducted using thematic analysis, adhering to the six-step framework developed by Braun and Clarke. This analytical approach encompassed a systematic process

Table 2. Demographic Characteristics of Participants

Characteristics	n	Percentage (%)
Gender		
Male	7	28.0
Female	18	72.0
Age (years)		
20–22	14	56.0
23–25	11	44.0
Clinical Training Completion		
One rotation	10	40.0
Two or more rotations	15	60.0
University Accreditation		
A-grade	18	72.0
B-grade	7	28.0

Note: A-grade and B-grade refer to the national university accreditation ratings issued by the National Accreditation Board for Higher Education (BAN-PT) in Indonesia. An A-grade indicates that the university meets excellent standards in academic quality, resources, governance, and educational outcomes, while a B-grade reflects good but not yet excellent overall performance according to BAN-PT evaluation criteria.

that began with an in-depth familiarization with the data to gain a comprehensive understanding. Following this, initial codes were generated to identify significant features of the data. The analysis progressed with the identification and exploration of overarching themes, which were then rigorously reviewed to ensure coherence and relevance. Subsequently, these themes were refined, defined, and clearly named to encapsulate their essence accurately. The final stage involved synthesizing the findings into a comprehensive and cohesive report, as outlined by Braun and Clarke (2006). To enhance the efficiency and organization of the coding process, NVivo software (version 15) was utilized as a supportive tool, enabling systematic data management and analysis.

Trustworthiness

Ensuring trustworthiness in qualitative research is essential for establishing the credibility, dependability, confirmability, and transferability of findings (Lincoln & Guba, 1985; Korstjens & Moser, 2018). In this study, multiple rigorous strategies were applied throughout the research process to maintain the integrity and validity of the data and analysis. Credibility was supported through prolonged engagement and careful, systematic interaction with participants. Prolonged engagement in this study involved multiple points of contact with each participant, including initial rapport-building conversations and one full semi-structured interview, resulting in approximately 60–90 minutes of total contact time per participant. This extended interaction created a comfortable interview environment and allowed participants to discuss their experiences more openly. While the study did not employ direct observational methods,

“persistent observation” was adapted conceptually to refer to the interviewer’s sustained focus on emerging patterns, emotional nuances, and contextual cues throughout the interviews, ensuring that key issues related to clinical training challenges were explored in depth. This usage aligns with its application in interview-based qualitative studies rather than ethnographic field observations.

Dependability was enhanced through a detailed and transparent audit trail documenting each phase of the study, including sampling decisions, interview procedures, coding steps, and theme development. This clear documentation enables independent scrutiny and supports the replicability of the research under comparable conditions. Reflexive journaling was also used throughout data collection and analysis, allowing the researchers to critically examine how their assumptions and professional backgrounds might shape data interpretation. Confirmability was strengthened through systematic documentation of analytic decisions and the inclusion of external peer debriefing. The debriefing process involved a qualitative research expert with no direct involvement in the study, holding a graduate specialization in qualitative health research and experience supervising multiple qualitative nursing studies. The debriefer reviewed preliminary codes, emerging themes, and representative quotations to assess whether interpretations were grounded in the data. Feedback from the debriefer was integrated into theme refinement, particularly in clarifying theme boundaries and ensuring that thematic labels accurately reflected participant narratives. Transferability was supported by providing a thick description of the study context, including participant demographics, institutional characteristics, and the sociocultural environment of clinical nursing

Table 3. Theme, category, and code

Theme	Category	Code
Inadequate Clinical Supervision	Limited Presence of Instructors	Infrequent Instructor Availability, Overburdened Instructors, Lack of Real-Time Support
	Irregular Supervision	Unscheduled Supervision Visits, Insufficient Supervision Frequency, Missed Learning Opportunities
	Insufficient Feedback	Lack of Constructive Feedback, One-Way Communication, Infrequent Feedback
Communication Barriers	Language Barriers	Use of Local Dialects, Translation Dependence, Limited Exposure to Diverse Languages
	Misunderstanding Medical Jargon	Unfamiliar Medical Terms, Insufficient Training on Technical Language, Misinterpretation of Instructions
	Hierarchical Communication Patterns	Fear of Supervisors, Fear of Reprimands, Lack of Mentorship Culture
	Nonverbal Communication Challenges	Misinterpretation of Body Language, Inconsistent Tone of Voice, Lack of Training in Nonverbal Cues
	Time Constraints	Rushed Clinical Rounds, Overworked Supervisors, Competing Demands
Emotional and Psychological Strain During Clinical Training	Overwhelming Workload	Physical Exhaustion, Mental Fatigue, Imbalance Between Practice and Learning
	High-Pressure Environment	Fear of Errors, Pressure to Perform Perfectly, Performance Anxiety in High-Stakes Scenarios
	Internal Psychological Challenges	Self-Doubt, Comparison with Peers, Imposter Syndrome
Resource Constraints	Insufficient Supplies	Shortage of Materials for Practice, Overcrowded Practice Sessions, Limited Access to Essential Resources
	Outdated Tools	Use of Outdated Equipment, Inability to Learn Modern Techniques, Lack of Alignment with Industry Standards
	Limited Simulation Opportunities	Rare Access to Simulation Labs, Lack of Practical Exposure, Insufficient Practice of Clinical Scenarios
	Faculty and Staff Constraints	Inadequate Faculty-to-Student Ratio, Lack of Specialized Expertise, Limited Interaction Time with Instructors
Interpersonal Dynamics in Collaborative Learning	Challenges in Collaborative Dynamics	Unequal Workload Distribution, Interpersonal Conflicts, Lack of Communication Skills
	Impact of Competition Among Peers	Unhealthy Rivalry, Fear of Judgment, Stress and Anxiety
	Benefits of Positive Peer Interactions	Emotional Support, Knowledge Sharing, Building Trust and Cooperation

education in Indonesia. This detail enables readers to determine the applicability of the findings to similar settings or populations.

Ethical consideration

The study obtained ethical approval from the Institutional Review Board (IRB) of Universitas Muhammadiyah Jakarta (Approval No. E078). All procedures adhered to the ethical principles outlined in the Declaration of Helsinki and its subsequent amendments. Prior to data collection, participants were informed about the study's purpose, procedures, potential risks, and their rights as research participants. Written informed consent

was obtained from all students who agreed to participate. Confidentiality was strictly maintained by anonymizing all identifying information and securely storing interview data. Participation was entirely voluntary, and students were free to decline or withdraw from the study at any point without penalty or academic consequences.

Results

Participant Demographics

Table 2 shows that the majority of participants were female (72%), which aligns with the predominantly female demographic typically observed in nursing

student populations. Most participants were between 20 and 22 years old (56%), suggesting that many were in the early stages of their clinical education. In terms of clinical exposure, 60% had completed two or more clinical rotations, indicating that most participants possessed a relatively higher level of hands-on clinical experience. Additionally, a substantial proportion of participants (72%) were enrolled in universities with A-grade accreditation, reflecting that the sample largely came from institutions with higher academic standing.

Note: A-grade and B-grade refer to the national university accreditation ratings issued by the National Accreditation Board for Higher Education (BAN-PT) in Indonesia. An A-grade indicates that the university meets excellent standards in academic quality, resources, governance, and educational outcomes, while a B-grade reflects good but not yet excellent overall performance according to BAN-PT evaluation criteria.

The themes identified during clinical training highlight various challenges. Inadequate clinical supervision arises from the limited presence of instructors, irregular oversight, and insufficient feedback. Communication barriers are evident due to language differences, misunderstandings of medical jargon, hierarchical communication patterns, nonverbal challenges, and time constraints. Emotional and psychological strain is fueled by overwhelming workloads, high-pressure environments, and internal psychological challenges. Resource constraints include insufficient supplies, outdated tools, limited simulation opportunities, and faculty shortages. Interpersonal dynamics in collaborative learning reflect challenges in teamwork, the impact of peer competition, and the advantages of positive peer interactions. The details are presented in [Table 3](#).

Theme 1: Inadequate Clinical Supervision

Clinical supervision is a critical component of healthcare education. However, students highlighted deficiencies in supervision, which negatively impacted their learning, confidence, and preparedness for clinical decision-making. The issues ranged from a lack of presence by instructors to insufficient feedback and irregular schedules. This theme encapsulates the barriers students face in achieving optimal clinical training.

Category 1: Limited Presence of Instructors

Students consistently expressed frustration over the absence of instructors during clinical practice. Their physical unavailability often left students feeling unsupported and underprepared. Limited instructor presence creates a gap in real-time learning and mentorship. Students rely on timely guidance to navigate clinical challenges, and its absence leads to reduced confidence and an increased risk of errors.

Infrequent Instructor Availability

"We rarely see our instructors during clinical practice because they are often assigned to other responsibilities." (PW11)

"Sometimes, we are left to figure out things on our own due to the lack of instructors." (PG2)

Overburdened Instructors

"Our instructors are responsible for so many things that they can't focus on guiding us." (PW4)

"They have administrative duties that take them away from clinical teaching." (PG5)

Lack of Real-Time Support

"During emergencies, we don't always have someone to guide us, which is really stressful." (PW6)

"Without immediate help, we often make decisions based on guesswork, which feels unsafe." (PW15)

Category 2: Irregular Supervision

Unpredictable supervision schedules added to the stress and uncertainty students experienced during clinical training. Irregular supervision disrupts the learning continuum. A predictable schedule fosters a structured environment where students feel secure and confident in seeking help.

Unscheduled Supervision Visits

"The schedule for supervision is irregular, making it hard for us to know when to expect help." (PW3)

"Sometimes, instructors visit without prior notice, which makes us feel unprepared." (PG6)

Insufficient Supervision Frequency

"Some instructors show up once a week, which is not enough for us to learn effectively." (PW17)

"We need regular interaction, but the current supervision pattern doesn't allow that." (PW8)

Missed Learning Opportunities

"When instructors are irregular, we miss the chance to learn important skills in real time." (PW17)

"Supervision gaps mean we might overlook critical steps in patient care." (PW8)

Category 3: Insufficient Feedback

Students highlighted that the quality and frequency of feedback from instructors were inadequate, leaving them uncertain about their progress and areas for improvement. Constructive feedback is essential for skill refinement and confidence-building. The absence of detailed, actionable feedback leaves students feeling disconnected and inadequately prepared for real-world clinical situations.

Lack of Constructive Feedback

"We rarely receive constructive feedback, which leaves us unsure about our progress." (PW5)

"When feedback is given, it's usually very brief and not detailed enough to help us improve." (PW14)

One-Way Communication

"Feedback sessions feel like lectures rather than discussions." (PW16)

"We are told what we did wrong but not how to fix it or do better next time." (PG3)

Infrequent Feedback

"Sometimes, we go through weeks without any feedback at all." (PW11)

"I feel disconnected from my learning outcomes because feedback is so rare." (PG3)

Theme 2: Communication Barriers

Communication barriers hinder effective interaction and the learning process in clinical settings. These barriers range from language differences and technical jargon to hierarchical relationships and other situational challenges that affect students' confidence and understanding.

Category 1: Language Barriers

Language difficulties create obstacles in establishing rapport with patients and understanding their needs, particularly in diverse linguistic environments.

Use of local dialects

"Some patients speak in dialects that we don't understand, making communication very difficult." (PW12)

"We have to guess the meaning when patients use unfamiliar local terms, which is risky." (PG7)

Translation dependence

"I often rely on my peers to translate, which takes extra time and effort." (PW1)

"Asking staff for help with translation slows down the workflow." (PW18)

Limited exposure to diverse languages

"Our training didn't prepare us for handling patients who speak multiple dialects." (PW9)

"I wish we had language training specific to the regions where we're placed." (PW7)

Category 2: Misunderstanding Medical Jargon

The use of complex or unfamiliar medical terminology impedes students' ability to follow clinical instructions accurately. The lack of familiarity with medical jargon creates confusion and anxiety for students, leading to potential errors and a sense of inadequacy in clinical tasks. Focused training on medical language is essential to bridge this gap.

Unfamiliar medical terms

"Sometimes, medical terms used by doctors are unfamiliar to us, causing confusion." (PG2)

"We are expected to understand terms we've never encountered before." (PW3)

Insufficient training on technical language

"We need more training on how to interpret technical language during rounds." (PW13)

"I struggle to remember terms that are only briefly explained." (PW6)

Misinterpretation of instructions

"Once, I misunderstood an instruction because I didn't know what a specific term meant." (PW8)

"Misinterpreting a single term can lead to errors in patient care." (PW15)

Category 3: Hierarchical Communication Patterns

Power dynamics in clinical settings often make students hesitant to seek clarification, impacting their confidence and learning. Hierarchical communication patterns create an environment where students fear judgment and reprimands, limiting their ability to clarify doubts or learn effectively. Promoting a culture of mentorship and open dialogue can alleviate these barriers.

Fear of supervisors

"I feel intimidated when speaking with supervisors, so I avoid asking questions." (PW2)

"Some supervisors are unapproachable, which discourages communication." (PW5)

Fear of reprimands

"The fear of being scolded makes me hesitant to clarify doubts." (PG10)

"One negative interaction can deter me from asking questions again." (PG17)

Lack of mentorship culture

"We need more supportive mentors who encourage open communication." (WG17)

"A culture of constructive feedback is missing in some teams." (PW4)

Category 4: Nonverbal Communication Challenges

Nonverbal communication plays a crucial role in healthcare, yet it is often overlooked in training. Misinterpretations of tone or body language can create unnecessary tension or misunderstandings, emphasizing the need for training in this area. Nonverbal cues, such as body language and tone, often lead to misunderstandings or discomfort in interactions.

Misinterpretation of body language

"Sometimes, I feel that a supervisor's expression is disapproving, even if it's not intentional." (PW11)

"Patients' nonverbal cues are hard to interpret, especially when they're anxious." (PG3)

Inconsistent tone of voice

"A supervisor's tone can feel harsh even when they're just giving instructions." (PW9)

"It's hard to gauge intent when someone speaks

quickly or sharply.” (PW7)

Lack of training in nonverbal cues

“We haven’t been taught how to interpret nonverbal communication effectively.” (PW1)

“Reading patients’ body language feels like guesswork most of the time.” (PG6)

Category 5: Time Constraints

Time constraints in clinical settings exacerbate existing communication challenges. The pressure to complete tasks efficiently often overrides the importance of clear and meaningful communication between students, supervisors, and patients.

Limited time in clinical settings exacerbates communication barriers, leaving students with little opportunity to clarify doubts or interact meaningfully.

Rushed clinical rounds

“Rounds are so fast-paced that there’s no time to ask questions.” (PW12)

“I struggle to keep up during rounds, so I miss important details.” (PW3)

Overworked supervisors

“Supervisors are often too busy to provide detailed explanations.” (PG5)

“Their workload makes it hard for them to address our queries patiently.” (PG6)

Competing demands

“Balancing documentation and patient care leaves little time for communication.” (PW6)

“We’re expected to multitask, which reduces the focus on effective communication.” (PW14)

Theme 3: Emotional and Psychological Strain During Clinical Training

This theme highlights the multifaceted emotional and psychological challenges faced by nursing students during clinical training. The strain stems from excessive workloads, high expectations, and internal struggles with self-perception. These stressors not only affect students’ mental well-being but also hinder their ability to learn and perform effectively in clinical settings.

Category 1: Overwhelming Workload

The clinical training workload is reported to be excessively demanding, leading to both physical and mental exhaustion. This affects students’ energy levels and their capacity to focus on academic learning and patient care.

Physical Exhaustion

“The workload is too much to handle, leaving us physically and mentally exhausted.” (PW16)

“Sometimes, I can’t even get out of bed the next day because of how drained I feel.” (PW8)

Mental Fatigue

“After long shifts, I find it hard to focus on

academic tasks.” (PW10)

“Even during my time off, I feel mentally stuck and unable to process what I’ve learned.” (PW2)

Imbalance Between Practice and Learning

“We spend so much time working that there’s no time left to study or reflect.” (PW4)

“It feels like the focus is more on surviving the shift rather than learning something new.” (PG7)

Category 2: High-Pressure Environment Fear of Errors

“I am constantly afraid of making errors that could harm patients.” (PW15)

“The fear of doing something wrong paralyzes me during critical tasks.” (PW9)

Pressure to Perform Perfectly

“The pressure to be perfect is overwhelming and affects my confidence.” (PW11)

“We’re expected to act like seasoned professionals, but we’re still learning.” (PW18)

Performance Anxiety

“Every decision feels like it could have life-or-death consequences.” (PW5)

“Knowing that someone’s health depends on me creates immense anxiety.” (PG4)

Category 3: Internal Psychological Challenges Self-Doubt

“I often feel like I’m not good enough to be a professional nurse.” (PW7)

“Sometimes I wonder if I made the right career choice because of how incompetent I feel.” (PW14)

Comparison with Peers

“The comparison with others makes me question my abilities.” (PW3)

“Seeing my peers excel while I struggle makes me feel like a failure.” (PW6)

Imposter Syndrome

“I feel like I don’t deserve to be here and that I’m just pretending to be competent.” (PW1)

“It’s hard to celebrate my successes because I always think I just got lucky.” (PG2)

Theme 4: Resource Constraints

Category 1: Insufficient Supplies

Shortage of Materials

“Sometimes, there aren’t enough supplies for everyone to practice on.” (PW5)

“We often run out of basic items like gloves and masks during training.” (PW17)

Overcrowded Practice Sessions

“We had to wait for hours to get a turn with the equipment.” (PW12)

“Too many students in one session make it

impossible to get meaningful practice.” (PW9)

Limited Access

“We only get access to the main equipment during exams, not for regular practice.” (PW4)

“There’s just one machine for the whole class, and we barely get time to use it.” (PG3)

Category 2: Outdated Tools

Use of Outdated Equipment

“The equipment we use is outdated and not what we’ll encounter in real settings.” (PW10)

“We’re using tools from years ago, which don’t reflect the current standards.” (PG6)

Inability to Learn Modern Techniques

“It’s challenging to learn modern techniques with old machines.” (PW13)

“We’re missing out on critical skills because the tools we have are obsolete.” (PW2)

Lack of Alignment with Industry Standards

“Our training isn’t aligned with what hospitals require nowadays.” (PW15)

“Employers expect us to know advanced tools, but we’ve never seen them here.” (PW18)

Category 3: Limited Simulation Opportunities

Rare Access to Labs

“Simulation labs are rarely available, limiting our ability to practice.” (PW6)

“We don’t get enough time in the labs to feel confident in our skills.” (PG5)

Lack of Practical Exposure

“Without simulations, it’s hard to apply theoretical knowledge to practice.” (PW3)

“I feel underprepared because I’ve never had the chance to practice real-life scenarios.” (PW7)

Insufficient Practice of Clinical Scenarios

“We’re not exposed to enough clinical situations to develop confidence.” (PW16)

“Practicing on mannequins once or twice isn’t enough to prepare for real patients.” (PW11)

Theme 5: Interpersonal Dynamics in Collaborative Learning

Category 1: Challenges in Collaborative Dynamics

Unequal Workload Distribution

“Group tasks often end up with unequal workload distribution.” (PW10)

“Some members just don’t contribute, leaving others to do all the work.” (PW1)

Interpersonal Conflicts

“Disagreements in groups sometimes make it hard to focus on learning.” (PW14)

“Arguments over small things derail the entire

discussion.” (PW8)

Lack of Communication Skills

“Some group members struggle to explain their ideas, so discussions are unproductive.” (PW13)

“Miscommunication happens a lot, and it slows us down.” (PW17)

Category 2: Impact of Competition Among Peers

Unhealthy Rivalry

“There’s a lot of competition, which sometimes feels unhealthy.” (PW6)

“I feel like I have to compete even in group projects.” (PG2)

Fear of Judgment

“I’m always afraid my ideas will be criticized harshly.” (PW12)

“People hold back because they don’t want to be wrong in front of others.” (PW9)

Stress and Anxiety

“The pressure to perform better than others is overwhelming.” (PW18)

“It feels like I’m competing against my own friends.” (PW3)

Category 3: Benefits of Positive Peer Interactions

Emotional Support

“Having supportive friends helps me get through tough times.” (PW5)

“When I’m stressed, my friends are always there to encourage me.” (PW7)

Knowledge Sharing

“We often share tips and encourage each other, which makes a difference.” (PW4)

“Learning is easier when we exchange ideas and help each other out.” (PG1)

Building Trust and Cooperation

“Working with people I trust makes group projects more enjoyable.” (PW11)

“When we cooperate well, everything feels smoother and more productive.” (PW16)

Discussion

Inadequate clinical supervision emerged as a critical theme. Although international studies, such as [Labrague et al. \(2020\)](#), similarly report insufficient supervision as a barrier to skill development and confidence-building, the Indonesian context introduces distinct systemic mechanisms. Chronic shortages of clinical educators, uneven distribution of qualified preceptors, and the absence of standardized supervision models create inconsistent learning experiences across institutions. From a Social Learning Theory perspective, limited role modeling reduces opportunities for observational

learning and feedback, hindering the internalization of clinical competencies. This divergence suggests that improving supervision in Indonesia requires not only increasing instructor numbers but also strengthening institutional policies that regulate workload distribution and supervisory expectations.

Communication barriers, including hierarchical interactions and medical terminology challenges, are widely acknowledged globally (Ali et al., 2019). However, these issues manifest differently in Indonesia due to cultural tendencies toward power distance, indirect communication, and linguistic diversity across regions. These cultural norms shape how students interpret authority and engage in professional dialogue. A Cultural Competence framework helps explain how misalignment between communication expectations (e.g., students hesitant to question senior staff) and clinical demands (e.g., assertive communication) can impede clarity and clinical decision-making. These findings extend the global literature by elucidating how cultural hierarchies not only individual skill deficits structure communication challenges.

Emotional and psychological strain, consistent with prior findings by Brown et al. (2021), was strongly reported by participants. However, the sources of stress in this study were closely tied to Indonesia's educational structure, in which many nursing students simultaneously undertake academic responsibilities and part-time clinical work. This dual burden increases role conflict and depletes coping capacity. Drawing on Stress–Coping theory, these pressures may overwhelm students' adaptive resources, leading to heightened vulnerability to anxiety and burnout. This mechanism highlights how structural factors not solely clinical experiences intensify psychological strain in the Indonesian context.

Resource constraints, including limited equipment and outdated simulation tools, have been described globally (Mansour et al., 2020), yet in Indonesia they are amplified by disparities across institutions and regions. Students in resource-limited settings may experience constrained opportunities for skills practice, affecting competence and readiness for independent work. This theme contributes to international literature by emphasizing how geographic and economic factors intersect with pedagogical quality. Interpersonal challenges, particularly peer competition and teamwork difficulties, reflect findings by Lee and Kim (2021), but they also reveal a nuanced interplay within Indonesia's collectivist culture. Although collectivism typically supports cooperation, it can also heighten sensitivity to social comparison, fear of negative evaluation, and avoidance of conflict. These dynamics suggest that peer relationships are shaped by cultural expectations of harmony and respect, which can both support and hinder collaborative learning. Understanding these dynamics through a cultural lens provides a richer interpretation of interpersonal challenges in Indonesian nursing

education.

Implications for Practice and Policy

Addressing these challenges requires strategies tailored to Indonesia's institutional and cultural landscape. Enhancing supervision is essential, but feasibility must be considered: instructor shortages and heavy clinical workloads may limit immediate implementation. Policy-level initiatives, such as incentivizing clinical educators, creating joint academic–hospital appointments, and establishing national supervision standards may offer more sustainable solutions. Improving communication training should incorporate culturally informed approaches, such as role-play scenarios addressing hierarchical interactions or structured communication tools (e.g., SBAR) adapted to local linguistic norms. Stress management initiatives must be accompanied by workload adjustments, accessible counseling services, and organizational support systems. Bridging resource gaps will require targeted investment, but implementation may vary across institutions. Partnerships with hospitals, academic consortia, or government agencies could support access to shared simulation facilities. Interpersonal challenges may be addressed through structured team-based learning, peer mentoring models, and faculty development in conflict management.

Strengths and Study Limitations

Strengths

Despite its limitations, this study offers several notable strengths. The use of qualitative inquiry allowed for a rich and nuanced understanding of students' experiences, capturing contextual factors and personal perspectives that would be difficult to obtain through quantitative methods alone. The inclusion of participants from multiple accredited nursing programs contributes to data diversity and enhances the credibility of the findings. Additionally, employing established techniques for ensuring trustworthiness, such as maintaining an audit trail, investigator triangulation, and member checking strengthened the rigor, credibility, and dependability of the study.

Study Limitations

This study has several limitations. First, although qualitative methods provide depth, the findings are not statistically generalizable beyond the study population. Second, interviews conducted virtually may have influenced the openness or depth of participant disclosure due to privacy constraints or technological challenges. Third, the reliance on self-reported data may introduce recall bias or social desirability bias. Lastly, participants were drawn from accredited programs, which may not reflect the experiences of students in less-resourced or non-accredited institutions, potentially limiting transferability.

Recommendations for Future Research

Future research could adopt mixed-methods designs to deepen and validate insights. An explanatory sequential design could quantify the prevalence of specific challenges, followed by qualitative exploration to explain underlying mechanisms. An embedded mixed-methods design may allow integration of observation data within qualitative interviews to elucidate behavioral patterns. Longitudinal studies could examine how students' coping strategies, communication skills, and supervisory relationships evolve across semesters. Including perspectives from clinical instructors, hospital administrators, and policymakers would provide a multi-level understanding of clinical training challenges.

Conclusion

This study suggests that nursing students in Indonesia face key challenges during clinical training, including inadequate supervision, communication barriers, emotional strain, resource limitations, and interpersonal difficulties. These findings highlight how cultural and institutional contexts shape students' learning experiences. To address these issues, institutions might prioritize two feasible actions: implementing structured mentorship programs to strengthen supervision and expanding access to simulation-based learning to compensate for limited clinical resources. Future research should evaluate the effectiveness of such interventions, particularly mentorship, communication training, and stress-management initiatives using longitudinal or mixed-methods designs to assess their impact on students' competence and well-being.

Declaration of Interest

All author declare no conflict of interest.

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Data Availability

The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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