International Journal of Sustainability and Advanced Integrated Research
Volume 2, Issue 2 (April-June 2026) | ISSN: 3107-7854
DOI: https://doi.org/10.65339/ijsair.V2.I2.248

Comparative Study of Clinical Learning Evaluation, Self-Efficacy, and Practice Readiness Among Nursing Students in a Selected School in Quezon City

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Publication history: Received: February 28, 2026; Revised: April 10, 2026; Accepted: April 17, 2026
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Abstract

This study examined the clinical learning evaluation, self-efficacy, and practice readiness of nursing students in a selected school in Quezon City and determined the relationships among these variables. Anchored on Benner's Novice to Expert Theory, Roy's Adaptation Model, and Bandura's Social Learning Theory, the study viewed nursing readiness as a product of clinical exposure, adaptation to learning demands, and confidence in one's capabilities. A quantitative descriptive-comparative design was used. The respondents were 293 second-, third-, and fourth-year nursing students officially enrolled during the second semester of academic year 2024–2025. Data were gathered through a self-administered questionnaire covering profile characteristics, clinical learning evaluation, competency self-efficacy, and practice readiness, and were analyzed using frequency, percentage, weighted mean, standard deviation, t-test, one-way ANOVA, and Pearson r. The findings showed that the respondents had highly positive evaluations of their clinical learning environment, particularly in learning experiences, availability of learning objectives, and effectiveness of clinical learning. Self-efficacy in the clinical learning environment was rated high, with strongest confidence observed in respect, patient advocacy, safety principles, and teamwork. Practice readiness was rated positively in clinical problem-solving, learning techniques, and professional identity, while trials and tribulations yielded an undecided result, indicating continuing difficulties in areas such as electronic documentation, ethical concerns, prioritization, and recognition of patient changes. The study further revealed strong to very strong statistically significant relationships between practice readiness and clinical learning evaluation, and between practice readiness and self-efficacy. The study concludes that a supportive, structured, and feedback-rich clinical learning environment strengthens nursing students' confidence and readiness for professional practice. It recommends enhancing simulation and skills-based training, reflective practice, digital health competencies, mentorship, and curriculum review to better align academic preparation with clinical realities. The study supports SDG 3, SDG 4, and SDG 8 by promoting safe healthcare practice, quality nursing education, and readiness for professional work. Its sustainability impact lies in strengthening educational quality, institutional responsiveness, and the long-term preparedness of the nursing workforce.

Keywords: Clinical Learning Environment, Clinical Learning Evaluation, Nursing Education, Nursing Students, Practice Readiness, Professional Identity, Self-Efficacy, Simulation-Based Learning

1. Introduction

The transition from nursing education to clinical practice is a critical stage in the preparation of future nurses because it requires the integration of theoretical knowledge, technical competence, critical thinking, communication, ethical judgment, and psychological readiness. In this study, clinical learning evaluation, self-efficacy, and practice readiness are presented as closely connected dimensions of student development, especially in the context of post-pandemic nursing education and the continuing demand for competent and practice-ready graduates. The study therefore situates nursing readiness not only in terms of technical ability, but also in terms of confidence, adaptability, and the quality of the clinical learning environment.

Clinical practicum is a central component of nursing education because it enables students to apply classroom knowledge in real healthcare settings, refine practical skills, improve communication, and demonstrate professional behavior (Alsharari et, al, 2025). Readiness for clinical practice involves not only competence in procedures but also adaptability, interdisciplinary collaboration, ethical decision-making, and adherence to patient safety standards (Stenseth, et al, 2025). As nursing education evolves, student performance in clinical settings is shaped by the learning environment, instructional quality, and personal beliefs about capability. In this context, Clinical Learning Evaluation (CLE) refers to students' appraisal of their clinical experiences, including supervision, instructional support, peer interaction, and the organizational climate of practice settings (Ferri et al, 2023). Positive CLE supports engagement and improved outcomes, while poor clinical environments can weaken morale and learning (Ferri, et al, 2023; Mirzanezam, et al, 2024). Self-efficacy, defined

as one's belief in the ability to perform specific tasks successfully (Bandura, 1997), is likewise essential because students with stronger self-efficacy show greater persistence, confidence, and clinical performance (Lee, et al, 2023), whereas those with lower self-efficacy report hesitation and reduced confidence in essential procedures (Tayag, et al, 2021). Together, CLE and self-efficacy shape practice readiness, which includes not only technical skill but also clinical reasoning, communication, and ethical comportment (Irvine, et al, 2025).

The related literature emphasizes three interdependent themes. First, clinical learning evaluation is presented as a multidimensional measure of how effectively the clinical environment supports student learning, including supervision quality, learning opportunities, and alignment of objectives with actual experiences (Alnaami et al., 2020). Structured evaluation tools improve the consistency of competency assessment and feedback (Owolabi, 2023), while supportive environments characterized by effective supervision, constructive feedback, and positive interpersonal relationships enhance student confidence and competence (Nordquist, et al 2019). At the same time, students face barriers such as weak motivation, limited belongingness, workload, lack of resources, inconsistent theory-practice integration, and unsupportive clinical conditions, all of which can diminish competence development (Berhe & Gebretensaye, 2021; Panda, 2021). Second, the literature consistently identifies self-efficacy as a key psychological factor in nursing education. It influences motivation, effort, persistence, and academic and clinical performance (Pajares, 2002). Students who receive constructive and timely feedback tend to report higher self-efficacy and stronger clinical judgment (Lasater, 2007), while effective clinical exposure helps reduce anxiety and improve competence in patient care situations (George et al. (2020); Abdal et al., 2018). Third, practice readiness is described as the extent to which students are prepared to perform safely, competently, and independently in actual practice. It includes clinical problem-solving, communication, professional identity, emotional resilience, and readiness to assume professional responsibility. Readiness is strengthened by comprehensive clinical experiences, feedback, simulation, and experiential learning (NCSBN, 2021; Benner, 2001; Wangensteen et al. (2019)), but may be weakened by the persistent theory-practice gap that limits confidence and preparedness (Al Mekkawi, 2020). Overall, the literature shows that a supportive CLE strengthens self-efficacy, and stronger self-efficacy improves practice readiness.

Globally, nursing education was significantly disrupted by the COVID-19 pandemic, which forced institutions to adopt remote and online delivery strategies. Although these approaches preserved instructional continuity, they were found to be insufficient for developing the hands-on and interpersonal competencies required in clinical practice (Alsharari, et al, 2025). Reduced patient contact and limited clinical placements negatively affected student confidence and readiness (Pepito, et al, 2025). In the Philippine context, nursing schools also shifted many clinical requirements into remote assessments such as video demonstrations, but students often perceived these as inadequate substitutes for authentic immersion, contributing to anxiety, reduced self-confidence, and weaker satisfaction with the clinical environment (Abalona, et al, 2025). These realities pushed institutions to strengthen simulation facilities, clinical skills laboratories, and blended learning infrastructures so that nursing curricula could remain resilient and adaptable without sacrificing educational quality (Constantino, et al, 2025). Nationally, the study also carries relevance for nursing education governance and workforce preparation, since its findings may inform school policies, curriculum improvement, and the broader standards and regulatory concerns of agencies such as CHED and PRC.

The study is anchored in three complementary theories. Benner's Novice to Expert Theory explains how competence develops progressively through experience, from novice to expert, and underscores the importance of clinical exposure and guided practice in nursing education (Handwerker, 2012). Roy's Adaptation Model explains how learners respond to internal and external stimuli and adapt physiologically, psychologically, and socially to the demands of the clinical environment (Gall, 2013). Bandura's Social Learning Theory, particularly the concept of self-efficacy, explains how students' beliefs in their own capabilities influence motivation, effort, persistence, and performance in clinical situations (Wang, et.al., 2023; Shorey & Lopez, 2021). Taken together, these theories support the view that students learn through observation and guided experience, adapt to environmental demands, and build confidence that shapes their readiness for practice. Conceptually, the study positions student profile and clinical learning experiences as influential conditions that relate to self-efficacy and, ultimately, to practice readiness.

Despite the strong body of literature on clinical learning, self-efficacy, and readiness for practice, the reviewed studies show that important gaps remain. The theory-practice gap continues to affect nursing graduates' confidence and preparedness (Al Mekkawi, 2020), and post-pandemic educational disruption has intensified concerns regarding authentic clinical exposure, confidence-building, and readiness for actual patient care (Pepito, et al, 2025; Abalona, et al, 2025). The thesis further argues that there is often a noticeable discrepancy between students' clinical evaluation experiences in school and the demands they encounter in professional nursing practice. This makes it necessary to examine how students in a specific institutional setting evaluate their clinical learning environment, how confident they feel about their competencies, and how ready they perceive themselves to be for actual practice. The rationale of the study, therefore, is to generate evidence that can support curriculum refinement, instructional improvement, and targeted interventions that strengthen both competence and confidence among nursing students in a selected school in Quezon City.

The study aligns most directly with SDG 3 – Good Health and Well-Being and SDG 4 – Quality Education. It supports SDG 3 because it focuses on preparing nursing students to deliver safe, ethical, and effective patient care in actual healthcare settings. It supports SDG 4 because it examines the quality of the clinical learning environment, the effectiveness of supervision and instruction, and the development of student competence and confidence as educational outcomes. The study also has a practical connection to SDG 8 – Decent Work and Economic Growth in the sense that it addresses readiness for entry into the nursing workforce and the strengthening of professional capability among future health workers. These links are grounded in the thesis emphasis on clinical competence, educational quality, workforce preparation, and safe healthcare delivery.

The study contributes to educational sustainability by supporting improvements in curriculum, clinical supervision, simulation use, feedback systems, and student support mechanisms. It contributes to public health sustainability by helping prepare nursing graduates who are more competent, confident, and ready to provide safe and patient-centered care. It also supports institutional and policy sustainability because its findings may inform school-level decisions on clinical placements, resource allocation, mentoring, and faculty development, as well as broader policy and accreditation concerns related to nursing education. In a wider multidisciplinary sense, the study strengthens the connection among education, healthcare delivery, workforce development, and regulatory quality assurance. By improving the alignment between nursing education and the realities of professional practice, the study supports the long-term sustainability of both nursing education systems and healthcare services.

2. Material and methods

2.1 Research Design

The study used a quantitative, descriptive-comparative research design to examine nursing students' clinical learning environment, self-efficacy, and practice readiness. This design was intended to describe the current status of these variables and compare differences and similarities among selected groups of nursing students based on defined characteristics such as year level or clinical exposure. Because the design examined naturally occurring conditions without manipulating variables, it provided an objective basis for understanding how educational and clinical contexts may support or hinder the development of essential nursing competencies and readiness for professional practice.

2.2 Locale of the Study

The study was conducted in a selected nursing school in Quezon City involving students officially enrolled during the second semester of academic year 2024–2025. The institution was described as a private, non-profit, and church-related school with nursing education rooted in excellence, service, volunteerism, and God-centered values. The locale was chosen because it offers hands-on skills laboratories, simulation models, realistic dummies, and supervised clinical rotations in actual healthcare settings such as hospitals. These features made the school an appropriate environment for assessing students' learning experiences, confidence levels, and readiness for professional nursing practice. To maintain objectivity, the study followed standardized data collection procedures, maintained researcher neutrality, and upheld confidentiality and anonymity so that conclusions would remain empirical, credible, and applicable to similar nursing education settings.

2.3 Respondents of the Study

The respondents were 2nd year, 3rd year, and 4th year nursing students officially enrolled during the second semester of academic year 2024–2025 in the selected nursing school in Quezon City. The population consisted of 1,225 students, including 525 second-year, 350 third-year, and 350 fourth-year students. Qualified respondents were those aged 18 to 59 years, currently enrolled, taking subjects involving exposure in the clinical learning environment, and willing to participate in the study. Students were included if they belonged to the 2nd, 3rd, or 4th year levels and gave consent to participate. Those who were not officially enrolled during the covered semester, freshman students, students from other colleges, and those who did not consent were excluded.

2.4 Sample and Sampling Procedure

The study employed a non-probability convenience sampling technique, wherein nursing students who were readily available and willing to participate during the data collection period were included. Eligible participants were invited through institutional communication channels, including email invitations and online survey distribution, and all who met the inclusion criteria were given the opportunity to participate. The text also states that after determining the strata, the required sample size for each subgroup was computed proportionately using G*Power analysis with a 5% margin of error and a 95% confidence level, resulting in a minimum sample size of 293 respondents. Only students who provided informed consent were included in the final sample. The inclusion of 2nd, 3rd, and 4th year students was intentionally justified to allow a broader developmental analysis of clinical learning, self-efficacy, and practice readiness across different stages of nursing education, consistent with the view that nursing students' self-efficacy and clinical confidence evolve as they gain more clinical exposure and educational experience (George et al 2020). This developmental progression was further

supported by findings that self-efficacy and clinical competencies significantly change across stages of nursing education (Song, et al, 2023).

2.5 Research Instrument

The research used a self-administered questionnaire composed of four parts. The first part gathered the respondents' profile in terms of age, sex, and year level. The second part measured clinical learning evaluation using an adapted or modified version of the Clinical Learning Experience of Nursing and Midwifery Students by Amoo and Enyan in 2022. This section covered three domains: learning experience in the clinical environment with 3 items, availability of learning objectives with 4 items, and effectiveness of clinical learning with 5 items, for a total of 12 items. It used a 5-point Likert scale where 5 is Strongly Agree, 4 is Agree, 3 is Neither Agree or Disagree, 2 is Disagree, and 1 is Strongly disagree. According to Amoo et al 2022, content validity was ensured through expert review in nursing education. The third part measured competency self-efficacy using an adopted instrument from The Relationship Between Undergraduate Nursing Students' Satisfaction with the Clinical Learning environment and Their Competency Self-Efficacy by Ibrahim, et. al. (2021). This consisted of a 22-item questionnaire rated on a five-point Likert scale where 5 indicates Very High Competency Self-Efficacy, 4 indicates High Competency Self-Efficacy, 3 indicates Moderate Competency Self-Efficacy, 2 indicates Low Competency Self-Efficacy, and 1 indicates Very Low Competency Self-Efficacy. The instrument was reported to have acceptable internal consistency, with Cronbach's alpha coefficients ranging from 0.78 to 0.82. The last part measured practice readiness using the instrument Adaptation and Validation of the Readiness for Practice Instrument for Senior Undergraduate Nursing Students in China by Dai et al. (2023). This part assessed perceived competence and confidence for transition to professional nursing practice across four domains: Clinical Problem-solving, Learning Techniques, Professional Identity, and Trials and Tribulations. It contained 15 items and used a 5-point rating scale where 5 is Strongly Agree, 4 is Agree, 3 is Undecided, 2 is Disagree, and 1 is Strongly Disagree. The questionnaire could be completed within 10 to 15 minutes and was accompanied by a cover letter and informed consent form. The instrument was subjected to content validation by experts in nursing education and research and was reported as valid and reliable for measuring the study variables.

2.6 Data Gathering Procedure

Prior to data collection, approval was secured from the University Ethics Review Board, followed by formal permission from the appropriate university authorities to access the official list of nursing students and contact potential respondents through institutional email and messaging platforms. Eligible participants were identified based on the inclusion criteria, and invitations were distributed through institutional email accounts and verified messaging platforms. The recruitment process emphasized voluntariness, equal access to the survey link, and the absence of coercion or undue influence. Data were collected through an online survey using Google Forms. Each email invitation contained a cover letter explaining the purpose of the study, procedures, potential risks and benefits, confidentiality safeguards, and the voluntary nature of participation, together with the informed consent form and secure survey link. Only those who electronically indicated consent were allowed to proceed to the questionnaire. Follow-up reminders were sent to nonrespondents in respectful language. To protect anonymity, each accomplished questionnaire was assigned a numerical code and no identifying information was linked to the responses. Completed questionnaires were securely recorded in the online platform, while digital and physical research files were stored in password-protected, encrypted, and locked storage systems accessible only to the principal investigator or researcher, in compliance with institutional and data privacy regulations.

2.7 Data Analysis Techniques

The collected data were organized, coded, and analyzed using appropriate statistical tools. Descriptive statistics, specifically frequency counts, percentage, weighted mean, and standard deviation, were used to summarize the demographic profile of the respondents and describe the measured variables. Mean scores and standard deviations were computed and interpreted according to predefined criteria, while weighted mean was used to classify responses into categorical interpretations. For inferential analysis, the independent samples t-test was used to determine significant differences when respondents were grouped according to dichotomous variables such as sex. One-way Analysis of Variance (ANOVA) was used for variables with more than two categories, such as year level or academic classification, and post hoc tests were conducted when significant differences were found. Pearson r was used to determine the strength and direction of relationships among variables. All statistical tests were conducted at a 0.05 level of significance, with the results serving as basis for accepting or rejecting the null hypotheses.

2.8 Ethical Considerations

Ethical safeguards were given paramount importance throughout the study. Formal approval was obtained from the Dean of the College of nursing, and ethical clearance was granted by the Institutional Ethics Review Committee before data collection began. Informed consent was secured electronically through the university-approved template included in the cover letter, and only participants who consented were allowed to proceed. The consent form explained the study purpose, procedures, duration, possible risks and benefits, confidentiality measures, and the voluntary nature of participation. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki (2013) and complied with the

International Conference on Harmonization-Good Clinical Practice (ICH-GCP) guidelines. The study involved only minimal risk, mainly the time needed to complete the survey, and participants were informed that they could withdraw at any time without penalty or academic consequence. Confidentiality and anonymity were strictly observed, with no names, student numbers, or personal identifiers collected, and all results were reported only in aggregate form. The researcher also adhered to the Data Privacy Act of 2012 (Republic Act No. 10173), stored all study documents securely, retained records for a minimum of three years after study completion, and committed to proper disposal thereafter. The study further emphasized voluntary participation, avoidance of harm, non-disclosure of personal or institutional identifiers, and strict avoidance of research misconduct such as fabrication, falsification, selective reporting, or biased interpretation.

3. Results and Discussion

3.1 Profile Characteristics of the Respondents

3.1.1 Age, Sex, and Year Level

Most respondents were aged 20–21 years old, comprising 63.5% of the sample, followed by those aged 22–23 years old at 18.1%, those aged 18–19 years old at 17.7%, and those above 25 years old at 0.7%. In terms of sex, female students comprised 70% of the respondents, while male students accounted for 30%. In terms of year level, most were second year students at 55.6%, followed by third year students at 29.7% and fourth year students at 14.7%. These results indicate that the respondents largely belonged to the typical college-age nursing population and that females still predominated in the program. The age distribution reflects the stage in which students are actively forming their professional identity, consistent with Erikson's Theory of Psychosocial Development (1950), while the small number of older students may reflect the tendency of mature learners to balance work and family roles or pursue alternative modes of study (Labrague, et. al., 2020). The continuing predominance of female students mirrors broader workforce patterns noted by WHO (2021), Stanley, et.al., 2022, and Saragih, et.al., 2023. The lower proportion of fourth year students also suggests possible attrition as students advance through the program, which may be associated with academic stress, workload, and the need for persistence and adaptability (Fornes-Vives, et.al., 2021; Zamanzadeh et. al., 2020).

3.2 Clinical Learning Evaluation

3.2.1 Learning Experiences in the Clinical Environment

The respondents rated their learning experiences in the clinical environment very positively, with an overall mean of 4.87 interpreted as Strongly Agree. The highest-rated indicators were attendance in scheduled clinical sessions and being given opportunities to learn in the clinical learning environment, both with a mean of 4.94. The lowest-rated item, though still very favorable, was being supervised to achieve the learning objectives, with a mean of 4.73. These findings show that the respondents viewed their clinical exposure as highly supportive and engaging. Regular attendance and strong learning opportunities suggest that students were consistently immersed in clinical activities, while the slightly lower rating for supervision implies that guidance toward learning objectives, although still strong, may still be improved further to maximize clinical learning outcomes.

3.2.2 Availability of Learning Objectives

The respondents also rated the availability of learning objectives positively, with an overall mean of 4.65 interpreted as Strongly Agree. The highest-rated indicator was being guided to practice, with a mean of 4.72. The relatively lower-rated indicators involved the consistency of always having learning objectives and the extent to which those objectives were met or achieved, which fell within the 4.55 to 4.61 range. These results indicate that students generally perceived their clinical duties as guided by clear objectives, although the consistency and full attainment of such objectives may still require reinforcement. This suggests that structured guidance remains central to clinical education and that clearly articulated objectives help students align practical exposure with expected competencies, as supported by Ewertsson, et.al., 2021.

3.2.3 Effectiveness of Clinical Learning

In terms of the effectiveness of clinical learning, the respondents again gave a very favorable rating, with an overall mean of 4.87 interpreted as Strongly Agree. The highest-rated statement was that clinical practice in the clinical learning environment contributes to learning, with a mean of 4.97. The lowest-rated indicator was the extent to which students had used the time given in the clinical learning environment, with a mean of 4.69, though this still fell under Strongly Agree. These results suggest that students clearly recognized the value of clinical exposure in improving learning, practical skills, confidence, and critical thinking. The findings indicate that clinical experience effectively bridges theory and practice, although time utilization in the clinical setting may still be optimized. This interpretation is consistent with Salifu, et. al., 2021; Ewertsson e. al. (2021); Salifu et. al. (2022).

3.3 Self-Efficacy in the Clinical Learning Environment

3.3.1 Competency Self-Efficacy

The overall mean for self-efficacy in the clinical learning environment was 4.36, interpreted as High. The highest-rated indicators were Demonstrate respect at 4.86, Advocate for patients at 4.68, Users safety principles at 4.62, Promote positive outcomes at 4.61, Report evaluation at 4.55, and Consult team at 4.53. The lowest-rated indicators were Broad knowledge

at 4.00, Identity research points and applications at 4.02, and Conflict resolution at 4.04, though all remained within the High level. These findings indicate that the respondents had a strong belief in their capacity to perform clinical responsibilities, especially in areas involving respect, advocacy, safety, teamwork, and patient-centered care. At the same time, the relatively lower ratings in broad knowledge, research application, and conflict resolution suggest areas where greater academic integration and clinical exposure may further strengthen confidence. This supports the self-efficacy perspective of Bandura, 1997, which emphasizes that confidence in one's capabilities is strengthened through successful learning and performance experiences.

3.4 Practice Readiness

3.4.1 Clinical Problem-Solving

The respondents rated their practice readiness in clinical problem-solving positively, with an overall mean of 4.17 interpreted as Agree. The highest-rated indicator was the use of current evidence to make clinical decisions, with a mean of 4.56. Other favorable indicators included confidence in identifying safety risks to patients at 4.41, comfort in communicating and coordinating with the interdisciplinary team at 4.36, and comfort in taking action to solve problems at 4.34. The lowest-rated indicator was comfort in knowing what to do for a dying patient, with a mean of 3.57. These results indicate that the respondents generally perceived themselves as ready to solve clinical problems, especially in evidence-based decision-making and patient safety. However, lower confidence in end-of-life care and in some communication and problem-solving tasks suggests that more complex and emotionally demanding situations remain challenging. This aligns with the need to strengthen higher-order clinical reasoning and evidence-based practice, as noted by Ross, et.al., 2021 and Melynk (2021).

3.4.2 Learning Techniques

The respondents rated practice readiness in terms of learning techniques positively, with an overall mean of 4.42 interpreted as Agree. The highest-rated indicator was that simulations helped them feel prepared for clinical practice, with a mean of 4.78. The lowest-rated indicator was that writing reflective journals or logs provided insights into their own clinical decision-making skills, with a mean of 4.05. These findings suggest that simulation-based learning was perceived as the most helpful technique in preparing students for clinical practice, while reflective journaling, although still positively rated, may not have been as strongly appreciated or maximized by the respondents. This indicates that experiential and simulation-based strategies were more immediately meaningful to students, although reflective practice remains important for deeper learning and clinical reasoning, as emphasized by Cant and Cooper, 2020.

3.4.3 Professional Identity

The respondents rated their professional identity favorably, with an overall mean of 4.45 interpreted as Agree. The highest-rated indicator was satisfaction with choosing nursing as a career, with a mean of 4.65, followed by comfort in asking for help at 4.58 and comfort in communicating with patients and families at 4.53. The lowest-rated indicator was feeling ready for the professional nursing role, with a mean of 4.01. These results show that the respondents generally possessed a positive and developing professional identity. They were strongly committed to nursing and comfortable in core relational aspects of practice, but some uncertainty remained regarding full assumption of the professional role, suggesting transitional anxiety before graduation. This pattern supports the view that professional identity develops progressively through exposure and supervision, as noted by Johnson, et. al., 2022, and that stronger clinical feedback and guidance from instructors can further support readiness for the RN role, consistent with Ewertsson et al (2021) and Cant et. al (2020).

3.4.4 Trials and Tribulations

The respondents' ratings in trials and tribulations yielded an overall mean of 2.53, interpreted as Undecided. The highest-rated difficulty was documenting care in the electronic medical record, with a mean of 2.73, followed by feeling overwhelmed by ethical issues in patients at 2.52. Lower-rated difficulties included recognizing a significant change in a patient's condition at 2.48 and prioritizing patient care needs at 2.38. These findings suggest that the respondents experienced mixed feelings regarding difficulties encountered in clinical practice. While they did not strongly affirm having major difficulties in all areas, the results indicate notable uncertainty in documentation, ethical concerns, prioritization, and recognition of patient changes. This implies that students may still need more guided exposure and mentorship in complex or high-pressure aspects of practice, which supports the observations of McCutcheon, et. al., 2020.

3.5 Relationship Between Variables

3.5.1 Practice Readiness and Clinical Learning Evaluation

There was a strong positive and statistically significant relationship between practice readiness and clinical learning evaluation. The computed correlation values were 0.796 and 0.957, with a significance value of .000 and N = 293, indicating that as ratings in clinical learning evaluation increased, practice readiness also tended to increase. This result indicates that a supportive, structured, and effective clinical learning environment contributes substantially to students' preparation for actual nursing practice. It suggests that positive clinical experiences strengthen competence, confidence,

and self-directed learning. This is consistent with the idea that readiness before entering actual practice is crucial and affects self-confidence, communication, nursing interventions, and problem-solving skills, as noted by Avsar (2024), and with the view that clinical readiness includes self-assurance, professional skills, communication, and self-management, as emphasized by Konlan, 2024.

3.5.2 Practice Readiness and Self-Efficacy in the Learning Environment

There was also a very strong and statistically significant relationship between practice readiness and self-efficacy in the learning environment. The computed correlation values were 0.885 and 0.988, with a significance value of .000 and N = 293, indicating that higher self-efficacy was associated with higher practice readiness. This means that students who believe more strongly in their ability to perform clinical tasks are more confident and prepared to engage in professional nursing practice. The finding supports the role of self-efficacy as a critical determinant of performance, persistence, and clinical decision-making, consistent with Wang et al, 2023. It also agrees with the finding that readiness for interprofessional learning and academic self-efficacy are positively correlated among nursing students, as stated by An et al. (2024).

4. Conclusion & Recommendations

This study concludes that a positive clinical learning environment plays a central role in strengthening nursing students' self-efficacy and readiness for professional practice, since supportive, well-structured, and feedback-rich clinical settings enable students to translate theoretical knowledge into competent and confident patient care. The findings further indicate that current curricular design and clinical exposure strategies contribute meaningfully to students' confidence, decision-making ability, and performance of clinical tasks, although moderate gaps remain in prioritization, ethical decision-making, and digital health documentation. Overall, the study affirms that experiential learning, reflective practice, and constructive instructor feedback remain fundamental in developing competent, confident, and practice-ready future nurses (Lakhani, 2024; Anbari, et al, 2025; Pascua, 2025; Chang, et al, 2025; Tantuico, 2025).

Based on the findings, nursing education institutions are encouraged to enhance simulation and skills-based training, particularly for complex situations such as end-of-life care, ethical dilemmas, prioritization, and high-risk clinical scenarios; strengthen reflective practice through journaling, guided debriefing, and regular feedback sessions; incorporate digital health competencies such as electronic health records, telehealth, and clinical informatics into the curriculum; establish structured mentorship programs for junior students; continuously review and enhance the curriculum to better align theory with clinical demands through evidence-based practice, clinical reasoning, patient safety, ethical decision-making, and interprofessional collaboration; and support future research using longitudinal and mixed-method designs to deepen understanding of clinical competence, self-efficacy, and practice readiness over time.

The study was limited to clinical learning evaluation, self-efficacy, and practice readiness among nursing students in a selected nursing school in Quezon City, specifically those officially enrolled during the second semester of school year 2024–2025, enrolled in nursing subjects with clinical learning exposure or related learning experience, and willing to participate in the study. It excluded those who were not enrolled, previous students of the selected nursing school, and those inhibited from participation due to personal reasons. The clinical learning environment covered hospital, laboratory, and other similar settings where students acquired their learning objectives in fulfilling their nursing degree.

Compliance with ethical standards

This study adhered to institutional ethical standards and received formal approval from the Dean of the College of Nursing and ethical clearance from the Institutional Ethics Review Committee prior to data gathering. The research was conducted in accordance with the ethical principles of the Declaration of Helsinki (2013), the International Conference on Harmonization-Good Clinical Practice guidelines, and the Data Privacy Act of 2012 (Republic Act No. 10173). Participation was entirely voluntary, and informed consent was obtained electronically from all respondents before they were allowed to answer the questionnaire; participants were likewise informed of the purpose of the study, procedures, possible risks and benefits, their right to withdraw at any time without penalty, and the confidentiality measures observed throughout the research.

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