

# Nursing Students' Perceptions and Lived Experiences of Hospital Placements: A Case Study at ISTM-Kinshasa

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## ABSTRACT

### Introduction

Hospital clinical placements constitute a fundamental component of nursing education, enabling students to integrate theoretical knowledge, develop clinical competencies, and form a professional identity. In the Democratic Republic of the Congo (DRC), nursing students' lived experiences and perceptions during hospital placements remain underdocumented.

### Purpose

To explore the perceptions, lived experiences, challenges, and learning opportunities of nursing students at the Higher Institute of Medical Techniques of Kinshasa (ISTM-Kinshasa) during hospital-based clinical placements.

### Methods

A descriptive qualitative study was conducted among 24 undergraduate nursing students (L1 to L3) who had completed at least one hospital clinical placement. Participants were selected via purposive sampling. Data were collected through semi-structured individual interviews and analyzed using inductive thematic analysis following Braun and Clarke's framework.

### Results

Six major themes emerged: (1) perceptions of clinical placements as learning opportunities; (2) organizational and material challenges; (3) emotional responses and coping strategies; (4) supervisory dynamics and staff relationships; (5) theory–practice gap; and (6) student expectations and recommendations. While students acknowledged placements as essential for practical skill acquisition and professional identity formation, systemic constraints—such as equipment shortages, inadequate preceptor ratios, high patient loads, and variable supervision quality—hindered their learning.

### Conclusion

Optimizing clinical nursing education at ISTM-Kinshasa requires structured preceptor training, provision of essential clinical supplies, harmonized clinical evaluation tools, and improved academic-clinical partnerships.

## INTRODUCTION

Hospital-based clinical placements are indispensable to nursing education worldwide, providing the empirical foundation for bridging classroom theory and clinical execution (Benner, 2001). Clinical environments offer authentic experiential opportunities where students synthesize complex pathophysiology, master psychomotor skills, cultivate clinical reasoning, and internalize professional ethics (Oermann & Gaberson, 2016; World Health Organization [WHO], 2020). However, nursing students globally encounter persistent challenges during hospital placements, including excessive workloads among clinical educators, resource scarcity, and misalignment between academic curricula and practice realities (Cant & Cooper, 2017; Oermann & Gaberson, 2016).

Although simulation-based training has expanded as a supplementary modality in health professions education (Jeffries, 2022), direct patient interaction within hospital wards remains irreplaceable for developing emotional resilience, interprofessional communication, and adaptive decision-making (Cant & Cooper, 2017). Evolving public health demands and aging patient demographics further necessitate adaptable nursing curricula that equip graduates for high-acuity care (Newton et al., 2012; WHO, 2020).

In Sub-Saharan Africa, nursing education institutions encounter acute structural challenges. Inadequate health infrastructure, severe shortages of medical consumables, underfunded clinical training programs, and unfavorable nurse-to-patient ratios impair the clinical learning environment (Jaganath et al., 2022; Kloppe et al., 2012). Clinical preceptors and ward staff are frequently overwhelmed by heavy patient workloads, leaving limited time for direct instruction, bedside demonstration, or constructive feedback (Kloppe et al., 2012). Consequently, students often report elevated levels of anxiety, vulnerability, and role ambiguity when required to navigate complex clinical tasks with minimal oversight (Emanuel et al., 2011).

In the Democratic Republic of the Congo (DRC), these institutional and systemic constraints are particularly pronounced. Nursing programs face gaps in formal academic-clinical coordination, absence of standardized clinical preceptor frameworks, and critical shortages of basic ward equipment (Bisimwa, 2018; Ramoetsi & Tlou, 2024). High student-to-preceptor ratios severely impede individualized mentorship, predisposing trainees to cognitive overload, clinical apprehension, and early professional disengagement (Kazadi, 2022). Although

institutional initiatives—such as competency-based curriculum reforms and bilateral training agreements—have been initiated across the country (Kalenga, 2020; Nzanu, 2021), substantial gaps persist in how nursing students experience and navigate these clinical learning environments.

When clinical instruction is disjointed, students experience a pronounced theory–practice gap, leading to diminished professional confidence and heightened fear of clinical error (Afaneh et al., 2023; Tanda & Denham, 2009). While previous research in the DRC has predominantly evaluated quantitative indicators, curriculum structures, or institutional policies, qualitative evidence capturing the lived, subjective experiences of nursing students remains sparse. Understanding these lived realities is vital for formulating context-specific educational interventions, refining clinical preceptor models, and ultimately safeguarding patient safety.

### Research Question & Objectives

This study was guided by the following central research question: *How do nursing students at ISTM-Kinshasa perceive and experience their hospital clinical placements, and what challenges and opportunities do these experiences present for their professional training?*

The specific objectives were to:

- Explore nursing students' perceptions regarding the value and role of hospital placements in their professional development.
- Identify the organizational, material, and interpersonal challenges encountered during ward rotations.
- Examine the nature and impact of clinical supervision and staff interactions on student learning.
- Characterize student coping mechanisms and formulate contextual recommendations for clinical education enhancement.

## METHODS

### Study Design

A qualitative descriptive research design was employed to capture an in-depth understanding of nursing students' lived experiences and perceptions (Braun & Clarke, 2006). This design is well-suited for health sciences education research where contextual human experiences, organizational dynamics, and nuances are being systematically explored.

### Study Setting

The study was conducted at the Higher Institute of Medical Techniques of Kinshasa (ISTM-Kinshasa), a major public health-sciences higher education institution situated in the Mont-Ngafula Municipality, Kinshasa, DRC. Clinical placements for ISTM-Kinshasa nursing students are hosted across several affiliated tertiary and secondary public teaching hospitals across the Kinshasa metropolitan area.

### Participants and Sampling

The target population comprised undergraduate nursing students enrolled in the Bachelor of Science in Nursing program (Levels L1, L2, and L3) who had completed at least one hospital-based clinical placement within the preceding 12 months. Purposive sampling was used to select participants, ensuring maximum variation in gender, academic level, and clinical specialty experience (internal medicine, pediatrics, surgery, gynecology/obstetrics, intensive care, emergency).

### Inclusion Criteria:

- a. Active registration in the ISTM-Kinshasa undergraduate nursing program.
- b. Successful completion of  $\geq 1$  clinical placement rotation in an affiliated hospital.
- c. Provision of written informed consent.

### Exclusion Criteria:

- a. Students on academic leave or those whose clinical placements occurred over 12 months prior to data collection.

Data collection continued until theoretical data saturation was achieved—the point at which subsequent interviews yielded no new codes, categories, or thematic insights. Saturation was reached at  $N = 24$  participants.

### Data Collection

Data were collected via face-to-face, semi-structured individual interviews conducted by trained qualitative researchers using a standardized, pre-tested interview guide. The guide explored five key areas: (a) general perceptions of clinical placements; (b) memorable positive and negative clinical experiences; (c) perceived quality of clinical supervision; (d) operational and material challenges; and (e) recommendations for structural improvement.

Interviews were conducted in French, with occasional integration of Lingala expressions when chosen by participants for authentic emotional articulation. Interviews took place in private, quiet seminar rooms at

ISTM-Kinshasa to preserve confidentiality. Each session lasted between 30 and 60 minutes, was audio-recorded with explicit consent, and was transcribed verbatim immediately following completion. Non-verbal observations and contextual field notes were recorded in research journals.

### Theoretical Framework and Data Analysis

Transcript data were analyzed using Braun and Clarke's (2006) six-phase thematic analysis framework:

- a. *Familiarization with data*: Repeated reading of transcripts and audio verification.
- b. *Generating initial codes*: Systematic open coding of text segments using NVivo software (v12).
- c. *Searching for themes*: Collapsing codes into candidate sub-themes and broader themes.
- d. *Reviewing themes*: Checking candidate themes against raw transcript quotes and the entire dataset.
- e. *Defining and naming themes*: Refining thematic definitions and conceptual boundaries.
- f. *Producing the report*: Selecting illustrative verbatim quotes and relating findings back to theoretical frameworks.

The analytical findings were interpreted through the dual lenses of Benner's Novice-to-Expert Model (2001), which outlines skill acquisition across clinical stages, and Kolb's Experiential Learning Theory (1984), which underscores the transformation of concrete clinical experience through reflective observation and conceptualization into functional competency.

### Methodological Rigor and Reflexivity

Methodological trustworthiness was maintained according to Lincoln and Guba's evaluative criteria:

- i. **Credibility**: Established through prolonged engagement, member-checking of transcript summaries with selected participants, and investigator triangulation (cross-checking of initial codes between three independent analysts).
- ii. **Transferability**: Facilitated by comprehensive descriptions of the institutional setting, participant demographics, and clinical placement context.
- iii. **Dependability**: Supported by maintaining an explicit audit trail documenting codebook evolution, raw data, reflexive notes, and analytical decisions.

- iv. **Confirmability:** Enhanced through reflexive self-assessment by the primary researchers (faculty members at ISTM-Kinshasa), acknowledging potential hierarchical or researcher bias and strictly grounding all interpretations in primary participant verbatim quotes.

*Ethical Considerations*

The research protocol was reviewed and granted ethical approval by the Bioethics Committee of the Higher Institute of Medical Techniques of Kinshasa (Ref: No. 268/CBE/ISTM/KIN/DRC/PMBBL/2025, dated October 20, 2025; valid from October 25, 2025 to October 25, 2026). Written administrative authorization was secured from ISTM-Kinshasa institutional leadership and affiliated hospital administrators prior to participant recruitment.

Participation was strictly voluntary. Written informed consent was obtained from all participants after explaining the study aims, benefits, potential psychological discomforts, and the right to withdraw without pedagogical penalty. Confidentiality was maintained by anonymizing all transcripts using alphanumeric identification codes (e.g., P1 to P24). Digital recordings and transcripts were encrypted and stored on password-protected cloud drives accessible only to the principal investigator.

RESULTS

*Socio-Demographic Profile of Participants*

The final study sample consisted of 24 nursing students (N = 24) aged 18 to 28 years (M = 22.1 years). The sample reflected a balanced representation across gender (12 males, 12 females), academic progression levels (L1 = 7, L2 = 9, L3 = 8), and cumulative clinical rotations completed (range: 1 to 7 placements). Participants had rotated through diverse hospital units, including internal medicine, surgery, pediatrics, gynecology, intensive care, and emergency departments. Participant characteristics are detailed in Table 1.

**Table 1:**  
Socio-Demographic Profile and Clinical Placement Background of Participants (N = 24)

| Identifier | Gender | Age (Years) | Academic Level | Completed Placements (n) | Most Recent Clinical Unit |
|------------|--------|-------------|----------------|--------------------------|---------------------------|
| P1         | Male   | 22          | L2             | 2                        | Internal Medicine         |
| P2         | Female | 21          | L2             | 2                        | Pediatrics                |
| P3         | Female | 20          | L1             | 1                        | Internal Medicine         |
| P4         | Male   | 23          | L3             | 4                        | Surgery                   |
| P5         | Female | 24          | L3             | 5                        | Gynecology                |
| P6         | Male   | 22          | L2             | 3                        | Internal Medicine         |
| P7         | Female | 22          | L1             | 2                        | Pediatrics                |
| P8         | Female | 21          | L2             | 1                        | Internal Medicine         |
| P9         | Female | 20          | L1             | 1                        | Internal Medicine         |
| P10        | Female | 18          | L2             | 2                        | Pediatrics                |
| P11        | Male   | 25          | L3             | 7                        | Intensive Care            |
| P12        | Female | 20          | L2             | 3                        | Pediatrics                |

|     |        |    |    |   |                   |
|-----|--------|----|----|---|-------------------|
| P13 | Male   | 24 | L1 | 1 | Internal Medicine |
| P14 | Male   | 28 | L3 | 3 | Pediatrics        |
| P15 | Female | 21 | L2 | 2 | Internal Medicine |
| P16 | Male   | 23 | L3 | 4 | Surgery           |
| P17 | Female | 20 | L1 | 1 | Pediatrics        |
| P18 | Male   | 22 | L2 | 2 | Emergency         |
| P19 | Female | 24 | L3 | 5 | Gynecology        |
| P20 | Male   | 21 | L2 | 2 | Internal Medicine |
| P21 | Female | 22 | L3 | 4 | Pediatrics        |
| P22 | Male   | 23 | L2 | 3 | Surgery           |
| P23 | Female | 20 | L1 | 1 | Internal Medicine |
| P24 | Male   | 25 | L3 | 6 | Intensive Care    |

*Thematic Analysis Findings*

Inductive thematic analysis revealed six primary themes and twelve corresponding sub-themes, summarized in Table 2.

**Table 2:**  
Thematic Coding Framework of Nursing Students' Clinical Experiences

| Major Theme                              | Sub-Theme                             | Primary Analytical Focus                                                                                                        |
|------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| 1. Perception as Learning Opportunity    | Practical Skill Acquisition           | Transitioning classroom knowledge into manual skills; internalizing professional identity and clinical responsibility.          |
|                                          | Professional Socialization            |                                                                                                                                 |
| 2. Organizational & Resource Constraints | Equipment & Material Shortages        | Lack of essential care consumables (gloves, IV lines, BP cuffs); unmanageable nurse-to-patient and student-to-preceptor ratios. |
|                                          | High Workload & Ward Overcrowding     |                                                                                                                                 |
| 3. Emotional Dynamics & Coping           | Clinical Anxiety & Fear of Error      | Stress surrounding invasive procedures and patient harm; developing reliance on observational learning and peer collaboration.  |
|                                          | Adaptive Coping Mechanisms            |                                                                                                                                 |
| 4. Interpersonal Supervision Quality     | Supportive Preceptors                 | Benefits of patient, structured preceptors; negative impact of dismissive or overburdened ward nurses.                          |
|                                          | Relational Friction & Marginalization |                                                                                                                                 |
| 5. Theory-Practice Disconnect            | Curriculum Discrepancies              | Operational contradictions between institutional protocols taught at school and modified techniques used in wards.              |
|                                          | Erosion of Professional Confidence    |                                                                                                                                 |
| 6. Expectations & Recommendations        | Structural Preceptor Framework        | Requests for dedicated, trained preceptors, standardized clinical assessment rubrics, and adequate basic hospital equipment.    |
|                                          | Material & Institutional Reform       |                                                                                                                                 |

*Theme 1:*

*Perception of Clinical Placement as an Essential Learning Opportunity*

Students consistently viewed clinical placements as the primary mechanism for transforming theoretical abstraction into actionable professional practice. Experiential immersion allowed trainees to internalize accountability and understand the practical reality of nursing.

**Practical Skill Acquisition:** Participants highlighted how direct clinical contact permitted them to perform complex procedures that could not be mastered in lecture halls alone.



"Placements helped me become far more responsible. It is at the patient's bedside that you realize the weight of your actions." (P4, Male, L3)

"I learned how to perform technical nursing care – like sterile wound dressings and IV insertions – that I had only read about in textbooks before." (P7, Female, L1)

**Professional Socialization:** Clinical immersion fostered a sense of belonging within the professional health multidisciplinary team, facilitating identity formation.

"The moment I was trusted to independently monitor a post-operative patient, the placement allowed me to feel like a real nurse for the first time." (P11, Male, L3)

#### Theme 2:

##### *Organizational and Material Constraints*

The operational environments across affiliated hospitals presented substantial hurdles that impeded effective learning and compromised procedural standard adherence.

**Material Shortages:** Severe deficiencies in basic healthcare consumables forced students to alter techniques or delay care delivery.

"There is simply not enough equipment to practice properly. We often have to reuse single-use items or improvise, which contradicts what we were taught." (P3, Female, L1)

**High Patient Workload and Staff Overload:** Ward staff faced heavy clinical burdens, leaving negligible time for clinical instruction or supervisory oversight.

"The ward nurses are completely overwhelmed with patients; they candidly tell us they do not have the time to supervise or explain procedures to us." (P8, Female, L2)

"We are often left entirely on our own without qualified supervision, managing complex intravenous drips by trial and error." (P5, Female, L3)

#### Theme 3:

##### *Emotional Dynamics and Adaptive Coping Strategies*

Immersion in under-resourced clinical wards evoked significant psychological stress, particularly among junior students. However, trainees implemented active coping mechanisms to sustain their learning.

**Clinical Anxiety and Fear of Error:** Students frequently experienced acute anxiety stemming from the fear of committing fatal clinical errors in front of patients or staff.

"I was constantly terrified of making a mistake on a real patient – like administering the wrong dosage – and being publicly reprimanded." (P2, Female, L2)

**Development of Adaptive Strategies:** To mitigate these fears, students relied heavily on close peer collaboration, rigorous self-directed observation, and informal consultations.

"When the preceptors are busy, I observe closely from a distance, take detailed notes, and ask my senior student colleagues for advice before attempting a task." (P6, Male, L2)

#### Theme 4:

##### *Quality of Interpersonal Supervision and Ward Relationships*

The interpersonal climate created by ward staff played a decisive role in shaping students' emotional security and learning effectiveness.

**Positive Supervision:** Empathetic, teaching-oriented preceptors dramatically enhanced student confidence and skill mastery.

"Some nurses are truly dedicated. They take time to explain the rationale behind a treatment, walk us through the steps, and encourage us when we struggle." (P9, Female, L1)

**Relational Friction and Marginalization:** Conversely, dismissive attitudes from staff created hostile learning micro-environments.

"Sometimes we are completely ignored by the ward staff, treated as administrative burdens, or assigned only cleaning duties rather than clinical nursing care." (P1, Male, L2)

#### Theme 5:

##### *The Theory–Practice Disconnect*

A recurring systemic issue was the divergence between theoretical standards taught at the academic institute and real-world practices observed in hospital wards.

**Curriculum Mismatch:** Procedural adaptations in hospitals – often driven by resource constraints – confused students and undermined institutional standards.

"What we are taught at school following ideal academic guidelines is completely different from what nurses actually do in the hospital wards." (P10, Female, L2)

**Impact on Professional Self-Efficacy:** This incongruity induced cognitive dissonance, causing students to question their skill competence and academic evaluation standards.

"It creates confusion during practical exams. Should I perform the procedure the correct way taught at school, or the shortcut way used in the hospital? It makes me doubt my skills." (P12, Female, L2)

### Theme 6:

#### *Student Expectations and Structural Recommendations*

Participants formulated concrete proposals aimed at reforming the administration and pedagogical support of clinical placements.

**Strengthening Supervision Architecture:** Students voiced an urgent need for designated, clinically unencumbered nurse preceptors.

"We need dedicated clinical supervisors in every ward whose primary duty is to guide, teach, and evaluate us, rather than relying on overburdened staff nurses." (P4, Male, L3)

**Improving Ward Conditions:** Participants emphasized the necessity for institutional provision of essential medical consumables and harmonized evaluation rubrics.

"Working and learning conditions in the hospitals must be improved. The institute must ensure host facilities have basic equipment before sending large cohorts of students." (P7, Female, L1)

## DISCUSSION

### *Main Findings and Integration with Prior Literature*

This qualitative inquiry provides nuanced insights into how nursing students at ISTM-Kinshasa experience hospital-based clinical learning within an under-resourced sub-Saharan African health system. The findings demonstrate that while placements are highly valued as essential vehicles for professional socialization and clinical skill construction, their educational efficacy is compromised by resource deficits, severe preceptor shortages, and a stark theory–practice disconnect.

Our results align with Benner's Novice-to-Expert Model (2001). Novice students (L1) demonstrated high levels of clinical anxiety, procedural rigidity, and reliance on explicit rules, reacting strongly to resource deficits. Conversely, advanced students (L2 and L3) exhibited greater contextual adaptability, actively deploying observational coping strategies and peer mentoring to navigate complex clinical ward dynamics. Furthermore, the central role of clinical immersion in transforming abstract knowledge into functional nursing practice strongly reinforces Kolb's Experiential Learning Theory (1984), confirming that concrete clinical encounters—when coupled with reflective debriefing—form the cornerstone of professional nursing competence.

The severe material shortages and high preceptor workloads reported by participants mirror findings from similar low-resource clinical learning environments across Africa (Jaganath et al., 2022; Kloppe et al., 2012; Ramoetsi & Tlou, 2024). When basic medical supplies (e.g., sterile gloves, antiseptic solutions, intravenous catheters) are absent, students are forced to observe or adopt non-standard procedural shortcuts. This operational reality directly drives the pronounced **theory–practice gap** identified in our thematic analysis, echoing findings by Afaneh et al. (2023) and Bisimwa (2018). When academic instruction emphasizes rigid ideal protocols that are systematically unviable in clinical wards, learners experience acute cognitive dissonance and diminished professional self-efficacy.

Supervisory dynamics emerged as the primary determinant of placement quality. Supportive preceptors served as critical buffers against anxiety, whereas dismissive or overburdened staff exacerbated student stress, inducing fear of clinical error. These findings concur with previous studies by Weeraseskara et al. (2023) and Kazadi (2022), which identified the quality of the supervisory relationship and ward pedagogical atmosphere as the single most influential factors governing student satisfaction and competency acquisition. High student-to-preceptor ratios, as flagged by the World Health Organization (2020), severely restrict individualized mentorship, leaving trainees to learn autonomously in high-acuity environments without adequate safety nets.

### *Limitations and Strengths*

#### *Limitations*

1. *Single-Center Setting:* Conducted exclusively among undergraduate nursing students at ISTM-Kinshasa, which may limit direct transferability to private institutions or rural nursing schools in the DRC.
2. *Self-Report and Recall Bias:* Data relied on subjective participant accounts, introducing potential recall bias regarding past clinical placement events.
3. *Absence of Multi-Stakeholder Perspectives:* The study evaluated student perspectives exclusively; incorporating preceptor, hospital nurse manager, and clinical faculty perspectives would provide a more holistic evaluation.

#### *Strengths*

- a. *Methodological Rigor:* Adherence to qualitative reporting standards, investigator triangulation,

verbatim transcription, and detailed audit trails ensured high trustworthiness.

- b. *First-Hand Evidence*: Provides rare, rich qualitative evidence detailing the lived experiences of nursing students within the specific socio-cultural and economic context of Kinshasa, DRC.
- c. *Actionable Policy Alignment*: Generates concrete, context-specific recommendations directly applicable to health science curriculum designers and academic-clinical policymakers in Central Africa.

### *Practical Implications and Actionable Recommendations*

To address the identified gaps and elevate the quality of clinical nursing education at ISTM-Kinshasa and similar regional institutions, a multi-level strategy is required:

#### *For Institutional Leadership (ISTM-Kinshasa)*

- a) **Establish Dedicated Preceptor Frameworks**: Formulate formal clinical preceptor certification programs to train staff nurses in adult learning principles, supportive feedback, and formative clinical evaluation.
- b) **Harmonize Procedural Guidelines**: Develop standardized clinical procedure manuals jointly agreed upon by academic faculty and hospital clinical leadership to bridge the theory-practice gap.
- c) **Integrate Pre-Placement Simulation**: Expand low- and medium-fidelity clinical skill laboratory simulation prior to hospital entry to reduce student anxiety, build procedural baseline confidence, and promote safety.

#### *For Affiliated Teaching Hospitals*

- I. **Designate Ward-Based Clinical Tutors**: Release selected experienced clinical nurses from full direct-patient assignments to serve as dedicated ward-level student mentors.
- II. **Implement Structured Orientation & Debriefing**: Mandatory formal ward orientation sessions on Day 1 of rotations and weekly reflective debriefing sessions between students and preceptors.
- III. **Ensure Minimum Supply Provision**: Secure essential clinical consumable kits allocated specifically for educational procedure demonstrations.

### *For Ministry of Higher Education & Ministry of Public Health (DRC)*

- i. **National Policy Standardization**: Establish national quality standards, supervisory ratio caps (e.g., maximum 1 preceptor per 5 students), and institutional accreditation criteria for healthcare facilities hosting university nursing students.
- ii. **Academic-Clinical Partnership Funding**: Allocate targeted budgetary resources to support health science education infrastructure, preceptor stipends, and ward teaching materials.

### CONCLUSION

Hospital clinical placements are vital to the professional development and identity formation of nursing students at ISTM-Kinshasa. However, systemic constraints—including acute resource deficits, overburdened clinical staff, inconsistent supervisory support, and a pronounced theory-practice disconnect—severely compromise the clinical learning experience. Mitigating these challenges requires coordinated policy interventions, structured preceptor development, enhanced academic-clinical alignment, and continuous institutional investment in clinical education infrastructure. Optimizing clinical training environments is essential not only for supporting nursing students but also for raising the overall quality and safety of patient care across the Democratic Republic of the Congo.

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#### **Authors' Contributions:**

- i. **Kabambi Tshimbila Franck (KTF)**: Conceptualization, Methodology, Writing – original draft.
- ii. **Diwoto Dowo Jean-Paul (DDJ)**: Conceptualization, Methodology, Writing – original draft.
- iii. **Tshiama Claudine Ruth (TCR)**: Investigation, Formal analysis.
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- vi. **Lufandjolo Masumbuku Jacques (LMJ)**: Supervision, Formal analysis, Writing – review & editing.
- vii. **Amuli Jiwe Jean-Pierre (AJJ)**: Conceptualization, Methodology, Supervision, Formal analysis, Writing – original draft, Writing – review & editing.
- viii. All authors have read and agreed to the published version of the manuscript.

**Data Availability Statement**: The qualitative interview transcripts generated and analyzed during the current study are available from the corresponding author upon reasonable academic request.



**Ethical Approval:** This study was approved by the Bioethics Committee of the Higher Institute of Medical Techniques of Kinshasa (ISTM-Kinshasa), Reference No. 268/CBE/ISTM/KIN/DRC/PMBBL/2025 (Date: October 20, 2025).

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