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Patterns of clinical mentorship in undergraduate nurse education: A comparative case analysis of eleven EU and non-EU countries☆

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SUMMARY

Background: In spite of the number of studies available in the field and policy documents developed both at the national and the international levels, there is no reliable data available regarding the variation of roles occupied by clinical mentors (CMs) across countries.
Objectives: To describe and compare the CM's role; responsibilities; qualifications; employment requirements and experience in undergraduate nurse education as enacted in 11 European Union (EU) and non- EU countries.
Design: A case study design.
Participants and Setting: A panel of expert nurse educators from 11 countries within and outside of the EU (Croatia, Czech Republic, England, Iceland, Ireland, Italy, Poland, Serbia, Slovenia, Spain, and the USA).
Methods: A questionnaire containing both quantitative and qualitative questions was developed and agreed by the panel using a Nominal Group Technique (NGT); four cycles of data collection and analysis were conducted involving key experts in nursing education in each country.

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Results: In all countries, there are at least two types of clinical mentorship dedicated to undergraduate nursing students: the first is offered by higher education institutions, and the second is offered by health care providers. Variation was noted in terms of profile, responsibilities and professional requirements to act as a CM; however, the CM role is mainly carried out by registered nurses, and in most countries there are no special requirements in terms of education and experience. Those who act as CMs at the bedside continue to manage their usual caseload, thus the role adds to their work burden.
Conclusions: Whilst it is imperative to have respect for the different national traditions in undergraduate nurse education, the globalisation of the nursing workforce and greater opportunities for student mobility during the course of their undergraduate education suggests that in areas such as clinical mentorship, jurisdictions, particularly within the EU, should work towards greater system harmonisation.

Introduction

Among the many factors that impact on the teaching-learning process and the professional socialisation of undergraduate nursing students in clinical learning environments, the role and responsibility of a clinical mentor (CM) are considered crucial (Andrews et al., 2006; Bourbonnais and Kerr, 2007; Price et al., 2011; Houghton et al., 2012; Jokelainen et al., 2013; Morrel and Ridgway, 2014). Within recent times a transformation of nursing education has occurred both in Europe and beyond, in which undergraduate student nurses spend a large amount of time under the supervision of clinical mentors/preceptors within the clinical area (Brunner, 2009; Betlehem et al., 2009; Palese et al., 2014).

The CM's role is to guide and supervise the student nurse, whilst the student is in the clinical area, in the application of theory to practice; developing critical thinking and clinical skills, and act as a role model in order to shape positively a student's clinical practice and their professional attitudes. Additionally, CMs are responsible for facilitating the student's integration into the professional clinical environment and a broader professionalism as expected of nurses by society. The CM also has responsibility for the evaluation of the competences achieved by the student nurse whilst in clinical placement (McSharry et al., 2010; Huybrecht et al., 2011; Price et al., 2011).

In spite of the number of studies available in the field (e.g., Heffernan et al., 2009; Omansky, 2010; Bettancourt et al., 2011; Jokelainen et al., 2013) and policy documents (e.g., Davies, 2008; NMC, 2008; DG Internal Market and Services, 2011), no consistent and reliable data is available regarding the role of the CM between EU and non-EU countries. This lack of data is important when one considers that in some countries there is a debate regarding the value of clinical mentorship, for example in England, where the Willis Commission (2012) on the future of nursing education has offered a strong critique of current mentorship arrangements for student nurses. The Willis Commission has suggested that clinical mentorship does not have sufficient status within the health care/education system and too little time and attention are paid to the role within the UK. When one considers the widespread adoption of the concept within many national nurse education systems, one needs to understand whether or not such issues are a widespread problem or specific to particular national systems. Therefore, the purpose of this study was to examine patterns of clinical mentorship and the role of the CM, looking at differences and commonalities, across a convenience and purposive sample of EU and non-EU countries.

Background to Clinical Mentorship

According to the literature in the field, the concept of clinical mentorship within nursing has different meanings. There is noticeable lack of agreement clarity as this relates to the role and responsibilities of the CM (Andrews et al., 2006; Myall et al., 2008; Heffernan et al., 2009; Murray and Williamson, 2009; Omansky, 2010; Jokelainen et al., 2011a; Saarikoski et al., 2013). One element of ambiguity relates to the distinction (or lack of) between '*mentorship*' and '*preceptorship*'. Some authors argue that mentorship and preceptorship should not be used interchangeably (e.g., Heffernan et al., 2009). In this context, it is argued, preceptorship, means that the student nurse or newly graduated nurse is under the supervision of an experienced registered nurse (RN) on a one-to-one basis, usually for a time limited period. Mentorship, it is argued, is based on the establishment of a longer relationship between student nurse and teacher, focused on clinical teaching, but also with an emphasis on professionalisation and the development of professional maturity (Newton et al., 2012). However, other authors consider preceptorship and mentorship to be interchangeable, the difference in language principally arising from different historical traditions, e.g., 'preceptors' is the preferred role descriptor in Ireland and the USA, whilst in the UK, it is 'mentors' (Heffernan et al., 2009; McSharry et al., 2010; Omansky, 2010). For the purposes of this study the term 'clinical mentor' (CM) will be used for consistency.

There appears to be three different patterns of employment in relation to the CM role. The first is a CM who is a RN and works only in the Health Care Provider (HCP) setting; the second is a CM who is a RN and works only in a Higher Education Institution (HEI); and thirdly the CM who is a RN and has a formal established role to work between the HCP and (sometimes on a part-time contract) in the HEI (McSharry et al., 2010; Saarikoski et al., 2013). Omansky (2010) states that students in Australia, Canada, the USA, UK, and Sweden are under the mentorship of staff nurses employed in HCPs. Alternatively, a model of mentorship where a faculty member takes responsibility for mentoring students in clinical placement is reported in Australia, Canada, and North America (McSharry et al., 2010).

Research in this area indicates that CMs who are employed only in HCP environments are inclined to give more attention to practical aspects of clinical education, whereas CMs who are more rooted within an HEI's academic environment may lack clinical skills and may feel insecure in emphasising clinical role performance (McSharry et al., 2010; Bettancourt et al., 2011). The CM primarily employed within a HEI faculty is usually familiar with nursing programme curricula and different teaching strategies and methods aimed at achieving the desired academic outcomes. It is noteworthy that an HEI-employed CM will usually be working as a 'guest' within the clinical setting. This may afford them the opportunity to devote more time to mentoring but at the expense of being a full member of the clinical care team.

A CM employed solely by the HCP is in a position to offer a closer approximation of nursing work in the clinical setting. They are in a position to include students as part of the nursing team, to give a realistic perspective of the hospital or community setting, and to demonstrate confidence and security in skilled nursing interventions and current procedures. In seeking to balance these competing elements some authors suggest that HEI faculty only CMs should have a periodic what is termed a 'clinical refresh', where they work for a period full time in the clinical area in order to achieve and maintain clinical credibility and expertise (Omansky, 2010; McSharry et al., 2010).

To prepare nurses to act as CMs a range of approaches appear to be adopted. One requirement often recommended for candidates assuming the CM role, is a minimum of post registration experience in the clinical field. Other requirements may include the completion of a special course offering knowledge related to clinical teaching/learning and

assessment strategies, communication skills, and practice updates and continuous professional development (Bourbonnais and Kerr, 2007; Myall et al., 2008; Jokelainen et al., 2013). There appears to be some universal agreement that the quality of clinical mentoring is the responsibility of both the HEI and the HCP (Andrews et al., 2006). However, as the Willis Commission (2012) in England has identified, the degree of interest and reward offered to those involved in this partnership is questionable. There is concern that CMs in clinical environments take on the role in addition to managing their existing and often excessive patient care workload (Bourbonnais and Kerr, 2007; Myall et al., 2008; Omansky, 2010). When managers plan strategies for promoting the CM role, with active support for nurses who want to assume this role (underpinned by a reduction in the CM's clinical case load responsibilities), and communicate with the HEI faculty on a regular basis, the effectiveness of the CM's role increases (Bourbonnais and Kerr, 2007).

Design and Methods

Aim

The aim of the study was to describe and compare the CM's role and responsibilities; experience; qualifications and employment requirements in undergraduate nursing education as enacted in eleven EU and non-EU countries.

Study Design

A case study design was undertaken, involving a purposeful convenience sampling strategy (Bromley, 1986; Burns and Grove, 2005; Bruce et al., 2008).

Participants

Nurse educators working in the HEI/University institutions who were members of the UDINE-C international network (Table 1) from 2011 (13 members) to 2014 were selected as the purposeful sample for data collection. They were identified by the research team, as key experts in CM role, responsibilities and requirements.

The Case

The case consisted of the HEI members of the UDINE-C international network made up of members from Europe and the United States each of which offer undergraduate nursing programmes and use some form of clinical mentorship.

Data Collection Process

A Nominal Group Technique (NGT) was firstly established (Bruce et al., 2008) with five members of the UDINE-C international network participating in its annual meeting in Belgrade, in 2011. The NGT was aimed at developing and achieving a consensus on the instrument for data collection (Bruce et al., 2008). Members were canvassed on the elements they considered most relevant for describing the CM role. In addition, the key studies available in the field were retrieved and analysed (Andrews et al., 2006; Myall et al., 2008; Heffernan et al., 2009; Murray and Williamson, 2009; Omansky, 2010).

To aid consensus, the following definition was adopted: the CM is a teacher who is a RN prepared to supervise and teach nursing students within and during their clinical placement at the unit/ward level; the CM works with students directly in the process of developing professional knowledge, skills, and attitudes, and also takes formal responsibility for each phase of the process (Andrews et al., 2006; Myall et al., 2008; Heffernan et al., 2009).

A questionnaire containing both quantitative and qualitative items was developed and agreed by the NGT during 2011–2012 (Table 2).

Table 1
Udine-C Network (Understanding Development Issues in Nurse Educator Careers) strategic aims and members.

The UDINE-C group was established in Udine (Italy) in 2007 with the aim to understand the similarities and unique differences in nursing education, promoting nursing research in this field, exchanging knowledge, and sharing current best practice for the continuous improvement of academic careers in nursing across Europe. The following aims are in the current agenda of the UDINE-C network. a) Career Development of Nurse Academics: UDINE-C members will make a commitment to exchange knowledge and share current best practice for the continuous improvement of academic careers in nursing; b) Nursing Research: UDINE-C network members will share and support opportunities, methodologies and grant applications for nursing research; c)The quality of nurse education and continuous improvement of standards of nurse education: UDINE-C members will develop exchange knowledge and share current best practice for the continuous improvement of standards of nursing education. d) The European nursing workforce: UDINE-C members will seek opportunities to understand the similarities and unique differences in nurse education and career development across Europe. Where appropriate UDINE-C members will work towards harmonisation of opportunity. There are currently 16 members of the group who represent institutions engaged in the process of nursing education and research (universities, high schools, and clinical institutes): Bosnia and Herzegovina, Croatia, Czech Republic, England, Germany, Hungary, Iceland, Ireland, Italy, Poland, Serbia, Slovenia, Spain, Switzerland, Ukraine, and the USA (www.udinenetwork.eu/, 2015).

The questionnaire was piloted in two countries (Poland and England) including nurse educators not involved in the following data collection process. The pilot phase aimed to test the clarity and the comprehensibility of the questions asked.

Therefore, four cycles of collection and analysis were performed involving the key experts identified in each country, as members of the UDINE-C group. After analysing the first cycle (2012), additional items were identified by the Nominal Group for individual countries where incomplete answers had been provided. In the third cycle all data collected in the first two cycles were sent to respondents for verification and updating (2013). A final cycle was performed in 2014, during the manuscript preparation.

Data Analysis

The description of the findings was fixed at country level. Data analysis was performed aimed at describing and comparing the CM's role, responsibilities, and requirements. Therefore, each questionnaire was read several times to understand its global sense; then, each answer was analysed independently by two researchers who provided a synthesis of the core contents (Polit and Tatano-Beck, 2014) developing the tables. To improve trustworthiness (Mays and Pope, 1996), tables were sent out to the key experts, with the aim of triangulating with participants (member-checking). Key experts expressed their agreement with all of the descriptions that emerged for each aspect under study.

Results

Types of Mentorship and Responsibility of the CM

Two main types of clinical mentorship dedicated to undergraduate/pre-registration nursing students were identified in the countries surveyed (Table 3). Firstly, there are CMs who work in HEIs. Despite their diverse profiles, they usually do not undertake a clinical role, apart from some specific activities, such as mentoring students at the beginning of the clinical placement (e.g., Croatia, Czech Republic; Italy, Poland, and Spain) which are aimed at introducing the student into the clinical environment and initial integration of nursing skills learnt in a laboratory setting with the clinical reality.

The second type of CMs concern staff nurses (RNs) usually from HCPs in which clinical placements are offered. In each participating country, all student clinical hours are usually supervised by a RN. In some placements nursing students could be under the supervision of

Table 2
Areas explored with the questionnaire developed for data collection.

1) Levels of mentorship and responsibilities of the CM
▪ levels of mentorship offered in each institution (e.g., at faculty level, at clinical level, both);
▪ the specific responsibilities of CMs, in accordance with the specific responsibilities acknowledged by the frameworks available (Budgen and Gamroth, 2008) as programming student's goals/activities expected in the clinical learning; facilitating the students' learning and their integration within the unit environment/team; assigning patients/activities to the students; supervising the progressive achievements of the competences; evaluating the students' achievements; assuming responsibility for the patients taken care of by students; assuming responsibility for students' achievements
▪ the CM responsibilities level of interdependence with university teachers, tutors, faculty members, or lecturers
2) CM experience, qualifications, and employment requirements
▪ the experience and qualifications required to assume the CM role, the availability of specific, initial programme to become a CM, availability of updating educational courses supporting CMs;
▪ the benefits received by CMs for their contribution to students' education;
▪ the CMs primary employment (HEI; HCP),
▪ the supernumerary role (or not) as if they have nursing care responsibilities during their CM role;
▪ if they are evaluated (or not) in their educational role and by whom (e.g., students, HEI, faculty members, other).

Legend: CM, clinical mentor; HEI, Higher Education Institution; HCP, Health Care Providers.

other team members, e.g., an occupational therapist (as in England). In many countries it is often the team leader (chief nurse, ward sister) who acts as a CM (for example, the Czech Republic, Poland, Serbia, Slovenia). In other countries, the chief nurse is responsible for coordinating the learning environment, selecting the CMs, and ensuring that students are mentored appropriately and exposed to the clinical learning environment effectively.

Faculty coordinators are also identified in some countries, with support and supervision responsibilities regarding both mentors' and students' activity in placement (e.g., Italy and Poland). Additionally, the Nurse Teacher (NT) role is visible in the clinical area, who works as a liaison between HEI and HCP (e.g., in England and Ireland).

The integration between these types of mentorship is aimed at ensuring consistency of clinical education. In Poland, for example, students start their clinical learning in placement under the supervision of a faculty teacher and when they are more advanced they learn under the supervision of HCP staff nurses.

The CM is responsible for the whole process of teaching-learning in placement in order to develop the set of competencies defined by national laws and/or according to the curriculum. In all countries, the CM facilitates the students' learning and their integration within the unit environment/team; with the exception of Croatia, CMs have the responsibility to evaluate the learning aims achieved by students in all countries. The different CM responsibilities emerged, are reported in Table 3.

CM Experience, Qualifications and Employment Requirements

Different clinical experience prerequisites for assuming the CM role are required in all countries as reported in Table 4. A minimum level of clinical experience is required in some whilst in others there is some form of registration as a CM. E.g. in Croatia, Serbia, Slovenia, and Spain (at least 5-years); in the Czech Republic and some regions of Italy (2-years); and in Iceland and Poland (at least 1-year). In England, CMs are required to be placed on a list approved by the Nursing & Midwifery Council (NMC). This approval means that they fulfil specific national standards of training, attend an annual update course and review and maintain professional qualifications. They are not required to demonstrate a minimum level of clinical experience but they have to demonstrate experience of being a mentor for at least one student in a period of three years. Similarly, in Ireland and the USA, mentors are obliged to finish an approved course in preceptorship (which in other jurisdictions is called mentorship); but there is no special clinical experience required; however, there is an expectation that the preceptor is clinically competent.

Generally, there are no formal rules with regard the qualification requirements to act as a CM. A few countries have developed national standards. Many requirements are specific to particular nursing programmes, the demands of an HEI, or defined regional standards, for example, qualifications to be a CM range from a minimum of a BSc in Nursing to Master's Degree in Nursing Science (Table 4).

Some countries provide special courses for CMs, e.g., in Slovenia, every year the HEI organises special education for clinical mentors; others, such as Croatia, Poland, and Serbia, do not provide such courses, whilst Italy offers courses in some regions. Only England, Ireland, and the USA emphasise that CMs have to be specifically educated and approved for the role before they can begin to mentor student nurses. However, in the majority of the countries surveyed, the courses for CMs ensuring that they are up-to-date with the requirements of their role are offered by HEIs or HCPs.

In the majority of the countries surveyed, CMs are employed by the HCP where the placement is offered. Nurses who assume the CM role usually receive additional benefits for their work. These are mainly additional salary on the basis of a specific work contract (Croatia, Czech Republic, Poland, Serbia, Slovenia, Spain, and in some Italian regions) or other privileges, e.g., educational credits or the possibility of using faculty facilities such as the library (Iceland, Italy, and USA). In England and Ireland, CMs are not paid additionally but rather the mentorship role is seen as a core function of all nursing duties. However, in those countries where HEIs ask their members to act as CMs in the clinical placement, HEIs pay for their work with students (e.g., in Croatia, Poland, Spain, and some programmes in the USA). In Slovenia, mentors who work beyond normal working time with students in a clinical setting receive a contract from the HEI.

The majority of CMs who work with students also carry a clinical case load. Only those CMs who are employed by HEIs and who mentor students at the beginning of their practical training (e.g., in Croatia, the Czech Republic, Poland, and Spain) dedicate their time only to nursing students without taking the responsibility for the nursing care of patients.

From the data collected, CMs performance is evaluated usually by the HEI, a faculty coordinator, and students. Those CMs who do not meet the required standard of the HEI or the HCP, are not assigned further students (e.g., in Iceland, Serbia or in Poland).

Two Types of Clinical Mentorship

Types of Mentorship and Responsibility of the CM

In most of the countries surveyed, nursing students have contact with two types of clinical mentorship: CMs working at the academic level and CMs working at the unit level, both supervising students at different stages of clinical education. Therefore, two different and separate settings play a crucial role in developing high quality nursing education: the HEI setting and the HCP setting (Saarikoski et al., 2013). The nursing philosophy underpinning the CM's role, as well as their practical integration, is crucial to ensure consistency in the educational experience of the nursing student between HEI and clinical setting.

The two main types of CMs have a different scope of responsibilities and function in different countries: the first, focused mainly on not only introducing students to the clinical environment, but also bridging and integrating theory and practice into a clinical reality; and the second, developing competences in the clinical area. Previously, only in countries such as Australia, Canada, and North America, has it been reported that clinical teaching in placement is supervised by university based mentors (McSharry et al., 2010). There are pros and cons to this approach. Thus university mentors seasonally enter the clinical

Table 3
Types of clinical mentorship and responsibilities enacted by the clinical mentor at the bedside (CM).

Country	Clinical mentorship levels in the nursing programme	Clinical mentor at the bedside responsibilities[a]						
		Programming goals/activities expected in the clinical learning	Facilitating the students' learning and their integration within the unit environment/team	Assigning patients/activities to the students	Supervising the progressive achievements of the competences	Evaluating the students' achievements	Assuming responsibility for the patients taken care of by students	Assuming responsibility for students' achievements
Croatia	1) Teachers from HEI — they usually work with students in placements at the beginning of clinical training in each nursing field 2) RN from HCP — they assume the role of clinical mentors and work with students in placement	X	X	X			X	
Czech Republic	1) Teachers from HEI — they usually work with students in placements at the beginning of clinical training in each nursing field (usually during first year of their placement) 2) RN from the HCP — they assume the role of clinical mentors and closely cooperate with the HEI in order to facilitate the students' practical learning		X			X	X	
England	1) Teachers from HEI — they provide a support role to students/clinical mentors 2) RN from HCP — they assume the role of clinical mentor in clinical placements	X	X	X	X	X	X	X
Iceland	1) Teachers from HEI (supervising teachers) — set the goals to achieve during clinical placement 2) RN from HCP — they assume the role of clinical mentor, developing and evaluating the clinical competences in accordance with those expected by the HEIs		X	X	X	X[a]	X	X
Ireland	1) HEI lecturers – they liaise with clinical learning environments 2) RN from HCP - Clinical Practice Co-ordinators (CPCs) – they coordinate the process of clinical learning at the unit level 3) RN from HCP (preceptors) — they assist the CPCs, educating and evaluating student performance in the clinical area	X[a]	X[a]			X[a]		
Italy	1) University tutor from HEI — they usually work with students in placements at the beginning of clinical training and during the clinical training monitor the advancement of the competence 2) Faculty coordinator of clinical training — facilitates and supervises University tutors' work and the overall process of clinical learning 3) RN from HCP — they assume the role of clinical mentor and closely cooperate with the HEI in order to facilitate the students' practical learning	X[a]	X	X	X	X[a]	X	
Poland	1) Teachers from HEI — they usually work with students in placements at the beginning of clinical training in each nursing field 2) Faculty coordinator of clinical training — facilitates and supervises mentors' work 3) RN from HCP — they assume the role of clinical mentors and work with students in placement when they are more advanced	X[a]	X	X	X	X	X	X
Serbia		X[a]	X	X	X	X[a]	X	X

Table 3 (*continued*)

Country	Clinical mentorship levels in the nursing programme	Clinical mentor at the bedside responsibilities[a]						
		Programming goals/activities expected in the clinical learning	Facilitating the students' learning and their integration within the unit environment/team	Assigning patients/activities to the students	Supervising the progressive achievements of the competences	Evaluating the students' achievements	Assuming responsibility for the patients taken care of by students	Assuming responsibility for students' achievements
	1) Teachers from HEI — they usually work with students in placements at the beginning of clinical training in each nursing field 2) RN from HCP — they assume the role of clinical mentors and work with students in placement							
Slovenia	1) Faculty coordinator — is responsible for bridging the gap between theory and practice, provides a support role to students and clinical mentor as well as preparing teaching nursing documentation 2) RN mentors from HCP — they assume the role of the clinical mentor who teaches and supervises the students' practical training in close cooperation with coordinator from HEI in order to facilitate the students' practical learning	X[a]	X	X	X	X[a]	X	X
Spain	1) Teachers from HEI — they usually work with students in placements at the beginning of clinical training in each nursing field 2) RN from HCP — they assume the role of clinical mentors and work with students in placement	X	X	X	X	X		X
USA	1) Programme faculty who are programming goals/activities expected in the clinical learning and deciding if the student has achieved the expected learning outcomes 2) The preceptor/mentor plays a role in the teaching, supervision and evaluation of the student in partnership with the faculty coordinator		X[a]	X[a]	X	X[a]		

Legend: NHS, National Health Service; HEI, Higher Education Institution; HCP, Health Care Providers.
[a] Enacted mainly by CMs in cooperation with university teachers, tutors, faculty members, or lecturers.

environment and they may have some problems in remaining up-to-date in their clinical practice. This seasonal entry into the clinical environment occurs, for example, in countries where the academic year for health care education follows the standard academic year for all other courses. Some countries (e.g., England) do not follow such a trajectory and so academic mentor engagement is available all year round. On the other hand, CMs who are staff nurses, employed by HCPs, are often accused of lacking teaching experience and pedagogical education, something which of course academic based CMs often possess. Alternatively, whilst university CMs are more familiar with curricula, teaching aims and methods, criteria and strategies of assessment, they have considerable difficulty in undertaking clinical roles due to the demands placed upon them in relation to their academic role.

In the UK, the Nursing and Midwifery Council (NMC, 2008; McSharry et al., 2010) requires nursing teachers to spend approximately 20% of their time in the clinical practice environment with the aim of supporting students and mentors. In the US, many programmes require that their preceptors/mentors or clinical faculty have both active clinical practises and pedagogical expertise which follows the model of physician education. How to better integrate the academic and the clinical settings and how to involve university mentors in clinical practice as occurs in other professions remains a challenge. One functioning solution is the role of what are termed nurse teachers (NTs) or link tutors (LTs) who work as a link between these two important environments for nursing clinical education. However, their role is more indirect and frequency of contact with students and mentors in placement vary among countries (Andrews et al., 2006; Saarikoski et al., 2013; Foster et al., 2015). This model is visible e.g., in Ireland and England.

In accordance with these findings, the CMs are considered responsible for the entire clinical learning process in the placement (e.g., in Poland, Serbia, England and Slovenia) or for specific moments, demonstrating the great variability in their roles/responsibilities across countries. Such organisational variation in CMs' work may affect students' mobility and also be a challenge in the process of evaluation of the effectiveness of nursing education cross national boundaries. The clinical evaluation process is multifactorial and many elements have to be taken into account what makes it difficult and challenging for CMs, especially when they work only in HCPs and experience lack of methodical preparation (Jokelainen et al., 2011a; Heaslip and Scammell, 2012; DeBrew and Lewallen, 2014). In UK 'sign-off mentor' role is established, responsible for final evaluation of students' achievements at final placement (Murray and Williamson, 2009). However, from methodical point of view, it can be discussed whether separation of these important elements of teaching-learning process is effective from the student's perspective.

Ward managers/ward nurses play a significant role in the process of shaping an optimal learning environment both as managers of the learning environment and clinical mentors, which, in all participating

Table 4
Clinical mentors (CMs): experience, qualifications, and employment requirements.

Countries	Requirements to be appointed as a CM			Institution employing the CM	Benefits received by CM, by whom	Working as a supernumerary RN (yes/no)	Formal evaluation of the CM (yes/no) and by whom
	Experience	Qualification (1)	Additional course, by whom				
Croatia	Yes — 5 years	Yes — courses on methodology/didactics issues or MNSc	No	HEI	Yes — contract with HEI	No – CMs from HEI when have students under supervision work only with students – on a basis of extra work contract with HEI. No — CMs from HCP have the responsibility for patients and students at the same time	Yes — by HEI, students and by Accreditation Body which evaluates nursing education
Czech Republic	Yes — 2 years in the field where RN acts as mentor	No, in some HEI nurse specialist, in some experienced nurse	Yes — special course for CMs in some institutions, by some HEIs	HCP	Yes — the nurse acting as a CM is in higher salary category within their contract at the HCP. The HEI pays a salary to their employees only (to the teachers of the clinical placement)	No	No — there is no formal, official evaluation of CMs work
England	Yes — must also be registered as a mentor of a database help by the placement provider. Minimum 1 student in period of 3 years to remain active.	Yes — Mentorship course plus additional 'sign-off' mentor training for those working with students on their final management placement	Yes — by HEI	HCP	Not directly — the HCP received a small amount of funding per student	No	Yes — by students at the end of each placement
Iceland	Yes — 1 year	Yes — MNSc or diploma degree	Yes — Special course for CMs offered by HEI	HCP	Yes — they may receive extra salary or continuing education credits by HEI	No — CMs supervise students during their work as RNs	Yes — by HEI and students
Ireland	No	Yes — preceptorship course	Yes — by HEI	HCP	No	No	No
Italy	No — but in some regions at least 2 years of experience is required	Yes — course for clinical supervisors	Yes — Local Hospitals and Universities	HCP	Yes — they may receive extra salary (in some regions) or continuing education credits by HCP	No — CMs supervise students during their work as RNs	Yes — by HEI and students but lack of uniformity within the country
Poland	Yes — at least 1 year of work experience in the field of nursing in which RN acts as mentor	No — MNSc in some HEIs, in others, nurse specialist	No — during Master's Degree programme it is required to complete medical didactic course	HEI employs university mentors and faculty coordinator; HCP employs mentors from HCP	Yes – special contract with HEI for university/school mentors. Mentors from HCP may receive extra income – it varies among institutions and is decided by HCP.	No, CMs from HEI when have students under supervision work only with students — on a basis of extra work contract with HEI. No — CMs from HCP have the responsibility for patients and students at the same time.	Yes — by HEI, students and by Accreditation Body which evaluates nursing education
Serbia	Yes — 5 years	Yes — nurse specialist (in some nursing fields)	Yes — every 5 years, at the time of accreditation programme, HEI organises a pedagogical course	HCP + contract with HEI.	Yes — by HEI	No — CMs supervise students during their work as RNs	Yes — by HEI and students
Slovenia	Yes — mostly 5 years (in some institutions 3 years of work experience in the field of nursing in which RN acts as mentor)	No – RN Diploma degree (1st cycle Bologna Study programme – 3 years)	Yes — every year HEI organises special education for clinical mentors	HCP	No — mentors who work beyond normal working time with students in a clinical setting receive contract from HEI (e.g., part-time students or full-time students in the afternoon)	No — CMs supervise students during their work as RNs	Yes — by students at the end of each placement
Spain	No formal rules, generally, 5 years	No — in some regions MNSc	No — some universities offer specific training courses	HEI	Yes — by HEI	Yes — on a basis of extra work contract	Yes — by HEI and students
USA	Yes — RN, identified by employer as having the practice knowledge and experience necessary to act in this role	Minimum of BNSs. An "orientation to the role" programme is offered	Yes — by HEI. National accreditors expect programmes to orient their preceptors but do not mandate how this occurs.	HCP	Yes — the HEI may offer continuing education credits, discounts on tuition, or privileges for use HEI library	No — the clinical preceptor works regularly as an RN or as an Advanced Practice Nurse	Yes — by students, preceptors, and the faculty coordinator
	In some programmes a clinical faculty member supervises between 6 and 8 students during a shift on a clinical unit.	These faculty are minimally MNSc prepared		HEI	These faculty are the HEI tuition that students reimbursed by the HEI. The funds usually are charged for their education.		

Legend: (1), in addition to BNSc or nursing diploma course; HCP, Health Care Provider; HEI, Higher Education Institution.

countries in this study, is undertaken by a RN. This role has been highlighted in previous studies that have focused on the positive effects of staff attitudes and ward atmosphere on students' clinical experience (Henderson et al., 2007). In fact, the role of the CM is highly dependent on a supportive context provided by other ward staff and nurse managers (Bourbonnais and Kerr, 2007; Heffernan et al., 2009); the CMs play a key role linking staff nurses and students with each other to prevent the development of a parallel student community outside the clinical team (Houghton et al., 2012).

CM Experience, Qualifications and Employment Requirements

Clinical mentorship is a dynamic and complex process involving different internal and external organisational demands and complex personal interactions (Andrews et al., 2006; Omansky, 2010). The CMs help students to grow, offer support in difficult times, teach effective decision-making, shape team working skills, provide guidance, assist in setting priorities, and also act as professional role models (Bourbonnais and Kerr, 2007; Jokelainen et al., 2011b).

Given the complexity of their role, it could be argued that CMs need both a certain minimum level of post registration clinical experience and specific expertise to be successful. In the eleven countries taking part in this study, there was no clear requirement regarding clinical experience for CMs. The requirements related solely to post registered time qualified and varied from one to five years with usually no formal national standard as this related to the specifics of clinical experience. Current literature suggests that the length of time one is post registration qualified is not necessarily associated with competence in the clinical mentoring of nursing students (Peters et al., 2013). Therefore, instead of length of clinical experience, the importance of completion of special programmes of study for CMs is recommended (Heffernan et al., 2009; Jokelainen et al., 2011b, 2013).

The findings from this study reveal that across the eleven countries, only three (England, Ireland, and the USA) underline that it is mandatory for CMs to be specifically trained for the role before they can be allocated students. The remaining countries accept didactical and methodical competences acquired at Master's level and/or during programmes for nurse specialists. In the available literature (Andrews et al., 2006; Omansky, 2010; Peters et al., 2013) there are clear statements that CMs in nursing are often insufficiently prepared and feel uncomfortable undertaking the role. Moreover, this role is often treated as additional to their normal workload and most CMs learn their responsibilities on-the-job. This would suggest, therefore, that there is a strong need for the development of special educational programmes for CMs (something which our results show currently appears not to be a feature within most European nurse education). This should be organised on a basis of well-prepared cooperation and communication between HEIs and HCPs regarding the process of clinical mentorship and its function within the clinical environment (Middleton and Duffy, 2009; Omansky, 2010; Peters et al., 2013).

Mixed frameworks of CM employment are also evident through this study. In the majority of countries, CMs are employed by HCPs. Some countries (Croatia, Poland, Serbia, Slovenia, Spain, and in some programmes in the USA) it was reported that CMs develop a special contract with HEIs whilst working in the health care setting. According to the literature, it is sometimes difficult to find well-prepared and motivated CMs within the nursing field (Huybrecht et al., 2011; Foster et al., 2015). That is why it is important to establish incentive schemes to reward RNs undertaking the CM role (Jokelainen et al., 2011b). One particular incentive that could encourage RNs to undertake the role of CM is the limitation of professional responsibilities, for example, not being responsible for patient care at the time of acting as a CM (Myall et al., 2008; Murray and Williamson, 2009; Omansky, 2010; Jokelainen et al., 2011b; Foster et al., 2015). However, the price of limiting clinical responsibility may be the concurrent loss of potential learning opportunities when working with patients in the clinical/practice setting and a lessening of clinical practice skills on the part of the CM. In this study, it was found that the majority of CMs mentored students and undertook standard care responsibilities at the same time. Only in the case where a CM comes from the HEI are they not responsible for the day to day management of a clinical caseload.

Limitations of This Study

There are several limitations to this study. Thus experts participating in this study whilst drawn from EU and non-EU countries may not represent the range of CM models working in other countries. The participant countries were a convenience and purposive sample drawn from a specific network of HEIs, which does not at present incorporate representation from the rest of EU member states and others.

A broader definition of 'clinical mentor' might have yielded different results. Further studies should adopt a more consistent definition/framework of clinical mentorship considering that different meanings and attributions are still given to the concept of CM (e.g., Heffernan et al., 2009; Omansky, 2010).

Limited data was collected with regard to the level of integration between the university and clinical mentor roles, their models of cooperation and functioning with regard to reciprocal support. In addition, given that no data was collected with regard to the rationale/philosophies underpinning the clinical mentorship in each participating jurisdiction, more critical analysis of the approaches as they reflected such philosophies might have yielded greater explanatory power.

Conclusions and Implications for Nursing Education Policies

The study findings offer a multidimensional picture of existing models of the organisation of clinical mentorship across EU and non-EU countries. Different standards regarding institution of origin of CMs, their background, experience, qualifications, scope of responsibility and system of reward has emerged; in some countries, there is a lack of established pre-requisites for the role.

Whilst it is imperative to have respect for different traditions that underlie the organisation of clinical mentorship in nursing, countries will need to harmonise such systems as clinical mentorship (particularly in an EU context) within the context of student and post qualification mobility. Such a process of harmonisation should focus on development of unified requirements regarding the clinical mentor's background, experience, and qualifications, especially given the importance of nursing competence that is developed during the clinical placements under the guidance of the clinical mentor. However, before such a process of harmonisation can take place there is a need for the development of national standards for clinical mentorship in the countries surveyed upon which such harmonisation can then be based.

Even though, the key role of CMs in nursing education is recognised and valued, this study's findings show that there are no clear models or established incentives to motivate, prepare or reward clinicians who accept this role that are common across the sampled countries. In addition, in several countries, the CM's primary role remains the care of patients regardless of the extra responsibility for clinical teaching which taking on the mentoring role entails. In this context, further research is needed firstly to assess the effects of the dual-combined responsibility (towards patients and students) in resource constrained environments and how this affects the quality of patient care, the quality of student learning, and the CM in relation to work related stress. In this regard, research is also called for in relation to how services and HEIs can invest in the CM role to ensure a suitable balanced workload that takes account of the responsibility and time that effective clinical mentoring involves. Such research would then need to be translated at an international level to support undergraduate nursing mobility to support the maintenance of post qualifying standards that are at a pan-European level.

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