

**An exploration of the clinical mentoring process in nursing education
placements in Hong Kong**

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List of Abbreviations

CI	Clinical instructor
CM	Clinical mentor
CMP	Chinese medicine practitioner
GDP	Gross domestic product
HCA	Healthcare assistant
HKCAAVQ	Hong Kong Council for Accreditation of Academic and Vocational Qualifications
HKSAR	Hong Kong Special Administrative Region
RN	Registered nurse
MLT	Medical laboratory technician
NCHK	Nursing Council of Hong Kong
OT	Occupational therapist
PT	Physiotherapist
UK	United Kingdom

Abstract

Background: Clinical mentoring in pre-registration nursing students is an important but under researched aspect, particularly in Hong Kong. A review of relevant literature revealed that clinical mentoring is mainly portrayed from a single perspective of either clinicians, educators or students. Research has been carried out mainly in western settings. Clinical mentoring is co-constructed by the interactions between the people, environment and organisations. It was useful to qualitatively explore the social process of mentoring in hospital placements.

Aim: to explore the social process of mentoring within the context of pre-registration nursing clinical placements in hospital settings in Hong Kong

Method: This study adopted the methodology of constructivist grounded theory. Participants, including organisers of clinical placements, clinical instructors, clinical mentors and students were recruited by purposive sampling initially; theoretical sampling was adopted later. 19 individual face-to-face intensive interviews were conducted and analysed using constant comparison. Relevant documents sampled from different organisations were also included in the data analysis. Strategies recommended for use in constructivist grounded theory were adopted to ensure the rigour of the study. The study received ethical approval from the relevant authorities and followed the required ethical guidelines to protect participants and assure research integrity.

Findings: The social process of clinical mentoring was co-constructed by multiple core interactions process within the organisational and cultural context. Clinical instructors/mentors and students underwent an expectation-impression-social judgment-feedback cycle within the core interactive mentoring process. Expectations of students were influenced by various official guidelines, clinical instructors'/mentors' past experiences and the organisational context. Clinical instructors/mentors assess their students by different assessment strategies and formed their impression of students. They made social judgment and provided feedback accordingly. Feedback was designed to shape students' actions in subsequent interactions. Three types of feedback were identified, and this could bring impacts to students' competence and confident.

Discussion: Clinical mentoring was predominantly influenced by the clinical rather than educational organisations involved. Mandatory clinical assessments were formalised and conducted ceremonially in the form of rituals which emphasised symbolic meaning of action instead of evidence-based practice. Clinical instructors/mentors used destructive feedback to manage poor student performance, errors and mistakes often with negative consequences. A theoretical framework of clinical mentoring process was constructed based on the data. This could be best understood by using a dramaturgical approach. The current practice of clinical mentoring thus failed to adequately foster critical thinking, produced inadequate clinical mentoring, failed in adequately performing its role as a gatekeeper, and produced negative impacts on students.

Conclusion: A theoretical framework explaining the social process of clinical mentoring illustrated how different people interacted in the environment of a hospital setting within clinical mentoring. This study confirmed findings from previous literature and provide new insights about the importance of the clinical learning environment to the development of constructive clinical mentoring.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Dedication

This thesis is dedicated to nursing education in Hong Kong, the starting point of my life and my beloved hometown.

Acknowledgement

This PhD study would not have been possible without assistance and support from many people. Firstly, I am deeply indebted to my supervisors, Dr. Moira Attree, Dr. Hannah Cooke and Dr. Shaun Speed, for their patience, guidance and encouragement throughout my journey of PhD. They provided me extensive knowledge and valuable advice that broaden my horizon and facilitate my personal and professional development. I am so grateful for all you have done.

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About the Author

I am a Registered Nurse (RN) from Hong Kong. My career in nursing profession started from receiving pre-registration undergraduate nursing education in the University of Hong Kong. I was graduated in 2003 and completed the Master of Nursing from the Hong Kong Polytechnic University in 2008. I first started working as a RN in a public hospital and worked for a theme park three years later. After graduated from Master degree, I started my career in nursing education and first worked as assistant lecturer in the university. I was responsible for teaching Paediatric Nursing and health concepts for pre-enrolled and pre-registered nursing students as well as conducting clinical assessments. I started this study after working as nurse educator for three years.

I am particularly interested in workplace relationship of nursing profession due to my first placement experience in hospital setting and my early working experiences as a RN. I had my first placement at a medical ward of a public hospital in a group of eight nursing students. We were supervised by a clinical instructor from the university and were assigned to provide basic nursing care, such as vital sign taking and changing napkins. All of us were blamed badly without guidance provided by our clinical instructor and the ward staff each day for working slowly and unable to make appropriate clinical judgment, such as reporting the abnormal finding. I had some enjoyable clinical placement experience afterwards even though I started to get used to be blamed. My early working experience in public hospital was also miserable. Blaming, shaming, undermining, and scapegoating was not uncommon. I tried to request for internal transfer to another department, but my effort was in vain. This explained why I chose to leave the hospital and never work in hospital setting again.

I became an assistant lecturer at a university many years later. My main duty at that time was to conduct mandatory clinical assessments for pre-enrolled and pre-registered nursing students. There were times that I had conflicts with my students. I was angry and used strong words when providing feedback. I realised that I acted like the clinical instructor and the nurses who I did not want to work with. I hoped I could know why the poor working experience occurred repeatedly and what I should do to prevent its occurrence. That was the reason for choosing this research topic.

Organisation of the Thesis

This thesis consists of nine chapters. In chapter one, the background context of this study conducted in Hong Kong and the definitions of key terms will be introduced. Chapter two will present a scoping review of the literature on mentoring nursing students in clinical placements. Chapter three discusses the study methodology, methods and how ethical issues were addressed. This chapter was written in first person approach so as to acknowledge the inseparable involvement of the researcher from a constructivist grounded theory study and illustrate the reflexive account in the theory formation (Charmaz, 2014; Norton, 1999; Webb, 1992). Chapters four to eight, present the context of the findings and study findings with illustrative quotations. Finally, chapter nine will discuss the study findings in relation to relevant theories and evidence and discuss the study's implications for research, theory and practice, as well as presenting the strengths and limitations and recommendations of this study.

1. Background

1.1. Introduction

This chapter consists of four parts, the first provides an overview of background information about the setting, Hong Kong, the second provides an overview of healthcare system in Hong Kong, the third part introduces the nurse registration system and nurse education in Hong Kong, and the fourth part provides definitions of key concepts used in this study. This study focuses on the supervisory relationship between nursing clinical instructors, clinical mentors and undergraduate pre-registration nursing students during their clinical placements in Hong Kong. It is important to understand the background context of the study, so the background information presented about Hong Kong includes an overview of Hong Kong, its healthcare system, nurse registration system and nursing education system.

1.2. Overview of Hong Kong

Hong Kong is located on the southeast coast of China and consists of Hong Kong Island, Kowloon Peninsula, the New Territories, Lantau Island and 262 outlying islands (see Figure 1.1). The area of Hong Kong was established as being around 1106 square kilometers in 2019 (Hong Kong Special Administrative Region Government, 2019a; Census and Statistic Department, 2017a, 2019a). Historically, Hong Kong was a fishing village that was governed by China (Leung, 2019). In 1842 Hong Kong was leased to the British after the First Opium War and became a British colony for more than one hundred years (Leung, 2019). On July 1, 1997, Hong Kong was returned to China, and designated by China as a special administrative region of the Peoples of Republic of China (Leung, 2019). Hong Kong is ruled by China under the principle of “one country, two systems” (Leung, 2019) meaning that the Hong Kong

Special Administrative Region (HKSAR) government has some autonomy to rule Hong Kong. Hong Kong is thus governed under a different administrative system from mainland China. The details of the political system, economic system, education system and the demographic characteristics of the population will be discussed below. (See Figure 1.1)

Hong Kong and Vicinity



(Library of Congress, 1998)

Figure 1.1: Map of Hong Kong

1.2.1. Political System

Hong Kong is ruled in accordance with Basic Law which is in the form of a constitutional document agreed to by both the Chinese and British Governments (Hong Kong Special Administrative Region Government, 2008). According to the Basic Law, the political system

in Hong Kong consists of three parts, namely the executive authorities, legislature and judiciary (Hong Kong Special Administrative Region Government, 2008). The executive authorities term refers to the government of the HKSAR that is led by the Chief Executive. The Chief Executive is responsible for policy making and leading the government in implementing policy (Hong Kong Special Administrative Region Government, 1990, 2019b). The legislature refers to the law-making process in the Legislative Council (Hong Kong Special Administrative Region Government, 1990). The Legislative Council is a law-making organisation which comprises 70 elected members. The members of the Legislative Council debate the bill that is introduced by either the Chief Executive or the Legislative Council member (Legislative Council, 2017). The bill becomes the law after three readings and a majority vote is obtained (Legislative Council, 2017). The judiciary in Hong Kong operates independently from the executive authorities and legislature (Hong Kong Special Administrative Region Government, 2019b). The legal system of Hong Kong was developed from United Kingdom common law (Hong Kong Special Administrative Region Government, 1990). The responsibility of the judiciary is to handle the administration of justice in Hong Kong, which includes all criminal prosecutions and civil disputes, including disputes between individuals and the Government (Hong Kong Special Administrative Region Government, 2018). The political climate in Hong Kong has been changing since 2014. The influence of the Chinese government has become more prominent recently. When this study took place, especially during data collection, Hong Kong's autonomy and governance was reduced. Starting from 2019, some governance and administration arrangements was changed and reduced its autonomy in legislation and jurisdiction.

1.2.2. The economy in Hong Kong

Hong Kong is a high-income developing society (United Nations, 2019a). The gross domestic product (GDP) per capita in 2018 was US\$ 48,958 (Hong Kong Trade Development Council, 2019a); which was higher than the GDP per capita of many developed countries (United Nations, 2019a). The economy in Hong Kong comprises of four major industries including financial services, trading and logistics, tourism, and professional and manufacturing services (Hong Kong Trade Development Council, 2019a). The economy of Hong Kong has benefited from the free trade and low taxation associated with its special semi-autonomous status (Heritage Foundation, 2019; Hong Kong Special Administrative Region Government, 2019a).

Hong Kong has its own taxation system (Hong Kong Special Administrative Region Government, 1990). The tax rate in Hong Kong is low, ranging from 15% to 17% in 2019 (Hong Kong Trade Development Council, 2019b). The taxation system in Hong Kong has relied on two sources, namely direct tax and indirect tax. Direct tax includes profit tax, salaries taxes and property tax while indirect tax includes stamp duty, betting duty, estate duty and so on (Inland Revenue Department, 2019). The tax collected is used by the HKSAR government exclusively. The tax collected in 2018 contributed 62.7% of the HKSAR government revenue (Inland Revenue Department, 2019). The government revenue is then used to support the operation of the HKSAR government including health care.

1.2.3. Characteristics of the population of Hong Kong

In mid-2019, Hong Kong had a population of 7.524 million people (Census and Statistic Department, 2019a). The population growth in Hong Kong is relatively steady (Census and Statistic Department, 2019b). Population growth is determined by the difference between the birth rate and inflow of immigrants mainly from China, and the death rate (Census and Statistic Department, 2019a). The next section will describe the current characteristics of the population of Hong Kong according to three aspects, namely the aging trend, the combination of a Western and Chinese cultural background and epidemiological changes in the prevalence of various health conditions (Census and Statistic Department, 2017a; Department of Health, 2019; Kam, 2010). These three demographic characteristics are closely related and influence the overall health of the population in Hong Kong.

1.2.3.1. The aging trend

The population of Hong Kong showed an aging trend that is related to a low birth rate and high life expectancy (Census and Statistic Department, 2019a). The crude birth rate in 2018 was 7.3 births per 1000 population (Department of Health, 2019), which was much lower than the world crude birth rate (United Nations, 2019b). On the other hand, Hong Kong has the highest life expectancy in the world (United Nations, 2019c). The life expectancy of the Hong Kong population was 84.7 years of age in 2018 (Census and Statistic Department, 2019c). This aging trend was reflected through the median age of the Hong Kong population, which was 44.3 in 2016 and is estimated to increase to 54.6 by 2066 (Census and Statistic Department, 2017a). This demographic profile could lead to an increase in the consumption of healthcare services and increase the demand for nurses.

1.2.3.2. The combination of Western and Chinese cultural backgrounds

The majority of the population in Hong Kong is ethnically Chinese (Hong Kong Special Administrative Region Government, 2019a). The remaining of the Hong Kong population is mainly people of Filipino, Indonesian and other Southeast Asian origins (Census and Statistic Department, 2017b). Only 0.8% of Hong Kong population are Whites. As the majority of the population is Chinese, Chinese culture plays an important role in the culture of Hong Kong. However, Hong Kong was previously a colony of the United Kingdom (UK) for 100 years until 1997, and post-colonial cultural influences on the culture of Hong Kong are still evident. The influence of post-colonial culture is related to the language used and the education received (Chan, 2002). Over 66% of the population in Hong Kong were able to speak and read both Chinese and English (Census and Statistic Department, 2017c). English is considered to be cultural capital that can result in success (Chan, 2002). The bi-literacy of Chinese and English reflects the unique culture of Hong Kong which combines Western and Chinese culture in its own particular way (Kam, 2010).

The education system in Hong Kong was developed from the previous British education system (Costantini, 2019). According to the census conducted in 2016, about 80% of the population in Hong Kong had received secondary education and 74% of the population had received post-secondary education (Census and Statistic Department, 2017c; United Nations, 2019d). Hence, the population in Hong Kong was well educated (The World Bank, 2019). Under the influence of Western and particularly UK culture, Hong Kong has a mixed culture of ethnic Chinese and colonial cultures, which is described in the quote below.

Hong Kong found its firm cultural ground and became a translation space where Chinese-ness was interpreted for “Westerners” and Western-ness was translated for Chinese.
(Kam, 2010, p.2)

The culture of Hong Kong is partly influenced by the Confucianism (Lin and Ho, 2009). The behaviour of people in Hong Kong is influenced by the five principles of Confucianism which included humanity, righteousness, propriety, wisdom and faithfulness (Fan, 2000). The society was considered as a family. people within the society have their own position in the hierarchy of such family and apply the five principles of Confucianism to maintain the harmonious relationship within the society (Fan, 2000). The unique cultural background of the Hong Kong population influences their behaviours, which in turn, influences the health conditions of the population in Hong Kong.

1.2.4. Health conditions of the population in Hong Kong

As mentioned in the previous section, Hong Kong had the highest life expectancy in the world in 2018 (United Nations, 2019c). The life expectancy of females and males in the Hong Kong population in 2018 was 87.6 and 82.2 respectively (Department of Health, 2019). In 2018 the major causes of death were malignant neoplasm, diseases of the respiratory systems and diseases of the circulatory systems (Department of Health, 2019). These are typical for a country with an ageing population.

In the household population health survey conducted in 2014/2015 about 69% of the population in Hong Kong rated their health status as “excellent” (Centre for Health Protection, 2017). Self-rated health decreased with age and the prevalence of chronic

health problems (Centre for Health Protection, 2017). In 2018, 31.2% of the population in Hong Kong was diagnosed with chronic diseases (Census and Statistic Department, 2019d). The prevalence of chronic diseases increased especially in the population over 65 years old (Census and Statistic Department, 2019d). The three commonest chronic diseases in the Hong Kong population were hypertension (46.6%), hyperlipidemia (23.6%) and diabetes mellitus (21.2 %) (Census and Statistic Department, 2019d). Therefore, the health status of the population in Hong Kong is similar to other developed Western countries (Zheng et al., 2019).

1.3. The healthcare system in Hong Kong

The healthcare system in Hong Kong is governed by the Food and Health Bureau of the HKSAR government (Hong Kong Special Administrative Region Government, 2019d). The Food and Health Bureau is a regulatory organisation responsible for healthcare-related policy and the operation of healthcare services in Hong Kong (Schoeb, 2016). There are two main medical systems practised in Hong Kong, namely Western medicine and Chinese medicine. According to the Census and Statistic Department (2019d), the majority of the Hong Kong population consulted Western medicine practitioners when they had health problems (Census and Statistic Department, 2019d). However, 7.3% of the Hong Kong population consulted both Western and Chinese medicine practitioners at the same time, while 4.5% of population in Hong Kong consulted Chinese medicine practitioners only (Census and Statistic Department, 2019d). This health consultation behaviour reflects the combination of Western and Chinese cultural backgrounds among the population of Hong Kong. As the majority of healthcare services in Hong Kong are based on Western medicine

(Leung et al., 2005), the healthcare services providers delivering Western medicine will be discussed below.

1.3.1. Healthcare service providers

The healthcare service in Hong Kong is delivered through a dual track system that involves both the publicly run health service and private sectors (Hong Kong Special Administrative Region Government, 2019d; Kong et al., 2015; Schoeb, 2016). These two sectors vary both in their sources of funding and the healthcare services provided for the population of Hong Kong (Schoeb, 2016).

1.3.1.1. The publicly run health service

The publicly run health service is operated by two government departments, namely the Department of Health and the Hospital Authority. The Department of Health serves two main roles in the healthcare system in Hong Kong (Hong Kong Special Administrative Region Government, 2019d). Firstly, it is a statutory organisation which regulates the registration of different healthcare professionals, including medical practitioners, nurses, dentists (Department of Health, 2018). The details of nursing registration will be discussed in the next section. Secondly, the Department of Health is responsible for managing public health issues through disease prevention and control in the community (Department of Health, 2018). Hence, the Department of Health conducts various public health surveillance activities and implements various health promotion strategies through community health centres. These services include early screening for health issues, health education and

different health promotion services throughout the life span of people (Department of Health, 2018).

The Hospital Authority is another organisation that provides publicly run health services focusing on disease management since 1990s (Leung and Bacon-Shone, 2006; Hospital Authority, 2019b). The services of the Hospital Authority cover three levels of healthcare, namely primary, secondary and tertiary health care. For primary health care, 73 general out-patient clinics are operated by the Hospital Authority (Food and Health Bureau, 2017) and provide primary health care for patients with minor health problems and chronic disease patients with stable conditions. The Hospital Authority is the main service provider for secondary and tertiary health care in Hong Kong. These services are delivered through 43 public hospitals and 49 specialist out-patient clinics (Hospital Authority, 2019c).

The publicly run health service in Hong Kong is mainly funded by taxation (Leung and Bacon-Shone, 2006; Kong et al., 2015). Only 5 % of the expenditure of publicly run health services is paid by patients directly (Kong et al., 2015). Residents in Hong Kong pay a small fee when they access publicly run health services. If patients are unable to afford the consultation fee it will be waived according to the fee waiving mechanism (Hospital Authority, 2019a).

Hence, patients tend to shift from private sectors to public sectors especially when they need secondary and tertiary health care services.

1.3.1.2. The private sector

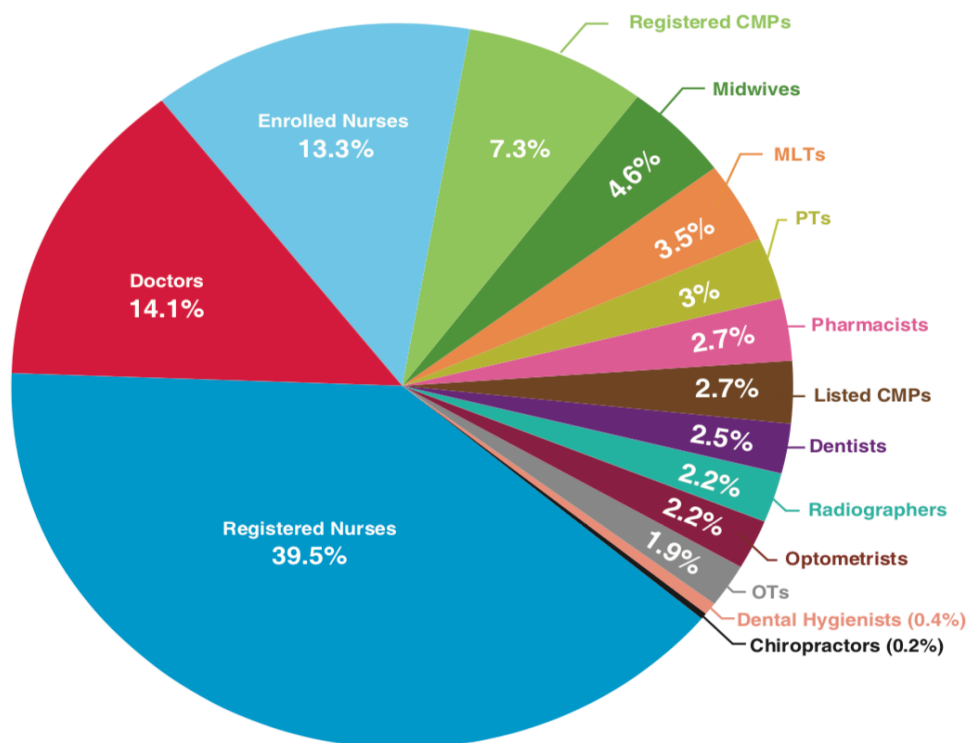
Private healthcare service in Hong Kong is mainly provided by private practice general practitioners, specialists and private hospitals (Hong Kong Special Administrative Region Government, 2019d). These personnel and organisations provide the same three levels of health care as the public sector.

Private general practitioners are the major primary health care providers in Hong Kong. 70% of the Hong Kong population visited private general practitioners for primary health care (Food and Health Bureau, 2017). Primary health care in Hong Kong relies heavily on the private sector. Residents in Hong Kong tend to visit private general practitioners when they encounter any acute health problem, unless they have financial difficulties (Griffiths and Lee, 2012). Most patients pay for private primary health services at their own expense (Food and Health Bureau, 2017). Only 29.3% of these consultations were paid for by private medical insurance (Census and Statistic Department, 2017a).

In contrast, 29% of the Hong Kong population consumed secondary and tertiary health care services from the private sector (Census and Statistic Department, 2019d). This lower uptake of private hospital services is related to the high cost of the private hospital care. However the use of the private healthcare services by the Hong Kong population was higher than that of the United Kingdom population (Office for National Statistics, 2019). Patients with a higher income tend to access private secondary and tertiary health care services as they normally pay these expenses through private medical insurance (Yin and He, 2018; Census and Statistic Department, 2019d). Over half of the Hong Kong population was covered by either private medical insurance or medical insurance paid by their employers.

1.3.2. Healthcare professionals

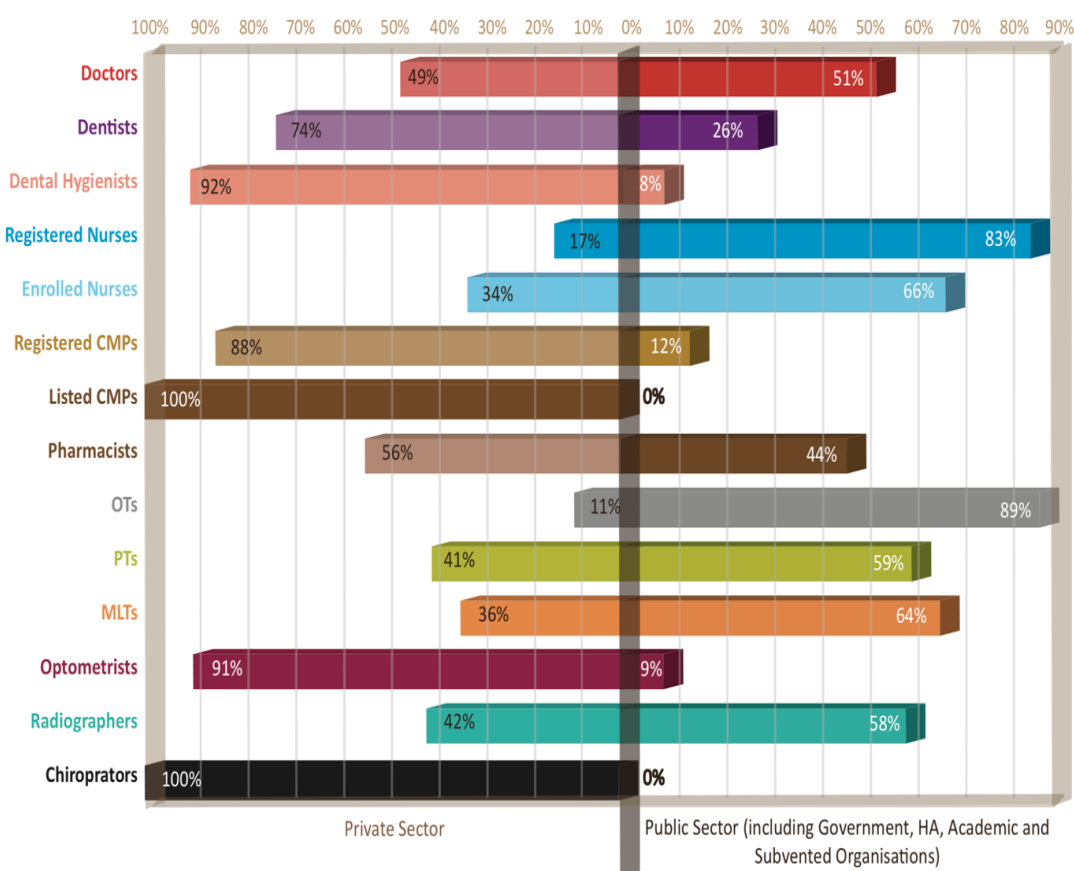
Various healthcare professionals work in the healthcare system in Hong Kong, including doctors, nurses, Chinese medicine practitioners (Registered CMPs and Listed CMPs), physiotherapists (PTs), occupational therapists (OTs), dentists, chiropractors, midwives, medical laboratory technicians (MLTs), radiographers, pharmacists, optometrists and dental hygienists (Department of Health, 2019). Healthcare professionals are required to register and are governed by the Department of Health (Department of Health, 2018). In 2019, nurses were the largest group of healthcare professionals registered in Hong Kong. There were 56,723 nurses registered under Department of Health in 2019 (Department of Health, 2019). (See Figure 1.2)



(Food and Health Bureau, 2017)

Figure 1.2: Distribution of registered healthcare professionals in Hong Kong as at end of 2016

Once these healthcare professionals are registered in Hong Kong they are eligible to work either in the public or in private sectors. The diagram below (Figure 1.3) illustrates the distribution of various healthcare professionals in Hong Kong working in the public and private sectors.



(Food and Health Bureau, 2017)

Figure 1.3: Distribution of healthcare professionals working in public and private Sectors

The majority of the nurses work in the public sector (Food and Health Bureau, 2017). Nurses are required to fulfil the educational requirements and complete nursing registration with

The Nursing Council of Hong Kong (NCHK) before they can practice in healthcare settings in Hong Kong. The registration of nurses in Hong Kong is a two-tier system (Nursing Council of Hong Kong, 2010a). The level of registration depends on the type of nursing education. The registration system for nurses in Hong Kong is introduced in the next section.

1.4. Nurse registration system

The registration system for nurses in Hong Kong has been in operation since 1958 (Chan and Wong, 1999). It was developed from the previous British nursing registration system. The professional body responsible for registering nurses in Hong Kong is the NCHK. Initially when the nursing registration system was first established in Hong Kong, the registered nurse (RN) was the only registration type available. However, due to the shortage of nurses in the 1960s in Hong Kong, the enrolled nurse role was introduced (Chan and Wong, 1999). These two types of nursing qualifications are still available for registration in Hong Kong. Among the 56,723 nurses, there were 42,485 registered and 14, 238 enrolled nurses by the end of 2018 (Nursing Council of Hong Kong, 2019a). Most of the new nurse registrations are graduates from Hong Kong nursing programmes rather than nurses who have trained outside Hong Kong (Food and Health Bureau, 2017). Nurses who receive nursing education overseas, including China, are required to pass both the Nursing Council of Hong Kong Nursing Licencing Examination's written and practical examinations according to their level of nursing registration (Nursing Council of Hong Kong, 2010b). They are able to enrol/register with the NCHK and ultimately practise in Hong Kong (Nursing Council of Hong Kong, 2010b). The details of the two levels of registration will be discussed next.

1.4.1. Enrolled nurses

The qualification for an enrolled nurse is the second level of nurse registration in Hong Kong. Enrolled nurses practise as RN assistants and are professionally trained in basic nursing competence and professional attributes (Nursing Council of Hong Kong, 2015). Enrolled nurses are required to be competent in four areas of core competencies, namely professional, legal and ethical nursing practices, provision of care, personal and professional attributes and teamwork (Nursing Council of Hong Kong, 2015). Enrolled nurses provide nursing care in different health care settings under the supervision of RNs (Nursing Council of Hong Kong, 2015). However, the participants in this study reported that the role of enrolled nurses was similar to that of RNs, except that only RNs could be team leaders and in-charge of a ward. As enrolled nurses work as assistants to RNs, the educational requirements for enrolled nurses are lower than those for RNs. Enrolled nursing students need to undertake at least two years formal nursing education in order to enrol for a nursing license (Nursing Council of Hong Kong, 2010a). The enrolment for different enrolled nursing licences depends on the nursing education received. There are two types of enrolled nursing licences, namely an Enrolled Nurse (General) and the Enrolled Nurse (Psychiatric) (Nursing Council of Hong Kong, 2019a). Enrolled nurses are able to upgrade their registration to RNs after they have completed an accredited nursing conversion programme (Nursing Council of Hong Kong, 2010a).

1.4.2. Registered nurses

RNs belong to the first level of nursing registration in Hong Kong. The NCHK requires RNs to be competent in five areas of core competencies, namely professional, legal and ethical nursing practices, health promotion and health education, management and leadership, and

research in personal effectiveness and professional development (Nursing Council of Hong Kong, 2016). RN have broader roles as health promoters, educators, counsellors, care coordinators, case managers, and researchers as well as that of being client advocates (Nursing Council of Hong Kong, 2012). These broader roles reflect that RNs are not only expected to provide high quality nursing care in primary, secondary and tertiary health care, but are also expected to be capable of taking up leadership and research roles (Nursing Council of Hong Kong, 2016). Due to the extended roles of RNs, they have to fulfil higher entry requirements for training and higher registration requirements.

The minimum entry requirement for admission to a pre-registration nursing education programme for RNs is Level 3 in both the Chinese and English languages in Hong Kong Diploma of Secondary Education examination (Nursing Council of Hong Kong, 2011) which is equivalent to a grade E in the General Certificate Secondary Education-Advanced Level (Hong Kong Examination and Assessment Authority, 2017). Students are also required to obtain a Level 2 (which is below an advanced level standard) in mathematics, liberal studies and an elective subject (Nursing Council of Hong Kong, 2011).

Pre-registration nursing students need to receive at least three years formal nursing education in order to be registered as a RN (Nursing Council of Hong Kong, 2010b). Similar to enrolled nurses, in Hong Kong there are different types of registered nursing licences, namely general, psychiatric, 'mentally sub-normal' and 'sick children' (Nursing Council of Hong Kong, 2019a). The licence for the 'mental sub-normal' and 'sick children' are historically adopted from the former British nursing registration system and are listed in the legislation (Hong Kong Special Administrative Region Government, 1997). However, in Hong

Kong there are currently no accredited nursing education programmes for ‘mental sub-normal’ or ‘sick children’ nursing. In 2019, there were 42, 485 RNs in Hong Kong. 39, 576 of the RNs obtained a licence for a Registered Nurse (General) and 2, 898 RNs obtained a licence for a Registered Nurse (Psychiatric) (Nursing Council of Hong Kong, 2019a). The numbers of registrations for the licenses of a Registered Nurse (Mentally Subnormal) license and a Registered Nurse (Sick Children) license was low (Nursing Council of Hong Kong, 2019b). Only four nurses are registered as Registered Nurse (Mentally Subnormal) and seven nurses are registered as Registered Nurse (Sick Children) (Nursing Council of Hong Kong, 2019a).

1.4.3. Registration of Advanced Nursing Practitioners

RNs can also take up advanced roles after completing post-registration education. Registration of advanced nursing roles has not been developed by the NCHK. Hence, the Hong Kong nursing registration system is unable monitor and regulate the development of advanced roles among RNs. A working group on advanced and specialised nursing practice was established by the members of the NCHK in April 2018 to consider developing a registration system for advanced practice nurses (Tiwari, 2019). As the development of a system to register advanced practice nurses is still at an early stage, no further information was found. As the majority of enrolled nurses and RNs were locally trained in Hong Kong (Food and Health Bureau, 2017), the nursing education system in Hong Kong will be discussed in the next section.

1.5. Nursing education in Hong Kong

Nursing education in Hong Kong developed from the British nursing education system from 1893 onwards which was based on a structured curriculum and training (Hallett and Cooke, 2011). These nursing programmes were run by the teaching hospitals and had to gain approval from the General Nursing Council (Hallett and Cooke, 2011). Similar to the British nursing education system, the previous nursing education programmes in Hong Kong adopted a British three-year apprenticeship programme (Chair et al., 2018). These programmes were accredited by the NCHK and run by hospitals. Students attended the lectures required and worked in hospitals as apprentices to gain clinical experience (Hallett and Cooke, 2011; Chair et al., 2018). By the 1960s, a two-year hospital based nursing programme was introduced to train enrolled nurses (Chair et al., 2018). Nursing students were solely trained in nursing schools until the 1990s. In 1990, the first undergraduate nursing programmes were offered in universities. These programmes replaced the nursing education provided by nursing schools after 2000 (Food and Health Bureau, 2017). However, nursing schools reopened in 2008 and offered two-year and three-year higher diploma programmes to train enrolled nurses and RNs in order to address shortages in the nursing workforce. By 2018 the majority of nursing students were receiving nursing education in a university (Chair et al., 2018).

Thus, nursing education in Hong Kong takes place in the tertiary education sector in order to train secondary school graduates to become professional nurses (Chan and Wong, 1999).

The higher education institutions which provide nursing education must pass accreditation by the NCHK every five years in order to assure the quality of nursing education (Nursing Council of Hong Kong, 2017).

The higher education institutions are required to demonstrate the ability to fulfil various standards in organisational administration, training facilities, the qualifications of teaching staff and programmes offered (Nursing Council of Hong Kong, 2017). For example, the teaching staff recruited by the accredited higher education institutions are required to complete a Masters or a higher degree in a nursing or a health care discipline (Nursing Council of Hong Kong, 2017). The nursing programmes offered by the accredited higher education institutions are based on a syllabus set by the NCHK (Nursing Council of Hong Kong, 2015, 2016). Members of the NCHK examine the accreditation documents and pay an accreditation visit to judge whether the higher education institutions pass the accreditation or not (Nursing Council of Hong Kong, 2017). The accreditation visit also includes site visits to clinical placement areas (Nursing Council of Hong Kong, 2017). However, there is no document that describes the required standards for clinical placements. Students who graduate from these accredited higher education institutions are able to obtain a licence according to the nursing programme completed.

Apart from accreditation by the NCHK, higher education institutions are also required to undergo different quality assurance processes to assure academic standards. Universities have their own quality assurance systems starting from the course level to the institutional level (University Grant Committee, 2020; Open University of Hong Kong, 2020). The courses and programmes provided by universities are audited by external members from academic and related professional communities. The external members include both local and overseas academics from the nursing profession and the management of public and private health organisations. Other higher education institutions, such as nursing schools and community colleges do not have their own quality assurance system, and undergo an

educational accreditation conducted by the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (HKCAAVQ) (Hong Kong Council for Accreditation of Academic and Vocational Qualifications, 2019). The quality assurance mechanisms of these higher education institutions are less stringent than for the universities (Chair et al., 2018). In order to assure the academic standards, the pre-registration nursing programmes provided by nursing schools are also accredited by a workgroup formed by experts from the nursing and education field (Hong Kong Council for Accreditation of Academic and Vocational Qualifications, 2019). Members of the workgroup included undergo a similar process of accreditation as the accreditation conducted by the NCHK. The purpose of accreditation by the HKCAAVQ is to ensure the quality of nursing programmes offered by these nursing schools. The standard of the accreditation by the HKCAAVA not only focuses on the operation of the institution, including financial status and staffing, but also the implementation of the education programmes (Hong Kong Council for Accreditation of Academic and Vocational Qualifications, 2018). The institution being accredited is required to submit related documents. However, there is no further information that describes how the accreditation process is conducted. After being accredited, the academic qualifications granted by these nursing schools are officially recognised (Hong Kong Council for Accreditation of Academic and Vocational Qualifications, 2019), meaning that the accredited nursing schools are eligible to award academic qualifications. Accredited higher education institutions, therefore, play an important role in the nursing education in Hong Kong.

1.5.1. Accredited higher education institutions

Accredited higher education institutions include nursing schools, post-secondary colleges and universities (Nursing Council of Hong Kong, 2019b). Different accredited higher education institutions offer different levels of nursing programmes. Nursing students are able to enrol or register with the NCHK depending on their course of study. The accredited higher education institutions award the academic qualifications after students have completed the nursing programmes.

1.5.1.1. Nursing schools

Nursing schools are higher education institutions that offer different nursing programmes for pre-enrolled and pre-registration nursing students. There are twenty-two accredited nursing schools in Hong Kong (Nursing Council of Hong Kong, 2018a, 2019c). Eighteen of these nursing schools are operated by public hospitals and four are operated by private hospitals. Different types of nursing programmes offered by some of these nursing schools (See table 1.1).

Types of Nursing Programme	Number of Nursing Schools Offered the Nursing Programme
Pre-enrolled general nursing programmes	1 Public nursing school 4 Private nursing schools
Pre-registered general nursing programmes	3 Public nursing schools 0 Private nursing school
Pre-enrolled and pre-registered psychiatric nursing programmes	None of the nursing schools offer these two types of programmes

Table 1.1: Types of nursing education programmes offered by different nursing schools

(Nursing Council of Hong Kong, 2019b)

There are in total, about 125 pre-enrolled and pre-registered nursing students who graduate from these eight nursing schools every year so the numbers per school are low (Food and Health Bureau, 2017).

Nursing schools provide more affordable nursing education in comparison to that provided by post-secondary colleges and universities. Some students receive an allowance during their study in addition to free tuition (Hong Kong Sanatorium Hospital School of Nursing, 2019). Nursing students who receive an allowance are considered to be employees of the respective hospital and may need to work during their training. Their clinical placement experience could therefore be different from that experienced by the nursing students from other accredited higher education institutions.

1.5.1.2. Post-secondary colleges and universities

Post-secondary colleges and universities also offer two-year pre-enrolled higher diploma programmes and five-year undergraduate pre-registration nursing programmes in Hong Kong (Nursing Council of Hong Kong, 2018a, 2019c). They are regulated by respectively by university ordinance and post-secondary college ordinance (Hong Kong Special Administrative Region Government, 2019e). Universities have greater capacities in the development, research and award of postgraduate degrees (Hong Kong Special Administrative Region Government, 2002a, 2002b, 2012a, 2012b, 2018, 2019c). There are twenty-nine post-secondary colleges and universities in Hong Kong (Committee on Self-financing Post-secondary Education, 2019). These institutions are categorised (see Table 1.2) according to the source of funding and the nature of the institution.

Source of Funding	Nature of Institution
Government-funded Institutions	8 Universities 2 Post-secondary Colleges
Self-financing Institutions	3 Universities 16 Post-secondary Colleges

(Education Bureau, 2019a)

Table 1.2: List of post-secondary colleges and universities in Hong Kong

Government-funded institutions are financially supported by government revenue, while self-financed institutions are funded by donations and tuition fees received from students (Education Bureau, 2019b). Among these post-secondary colleges and universities, three government funded universities, one self-financed university and three self-financed higher education institutions provide pre-registration nursing undergraduate programmes (Nursing Council of Hong Kong, 2019b). Only one self-financed university and one self-financed post-secondary college provide pre-enrolled nursing programmes (Nursing Council of Hong Kong, 2019b). All of these institutions offer general nursing programmes; only the self-financed university offers psychiatric pre-enrolled and pre-registration nursing programmes. About 1800 nursing students graduated from nursing programmes in post-secondary colleges and universities in 2016 (Food and Health Bureau, 2017). The majority of the graduates were eligible to register as a Registered Nurse (General) or to enrol as an Enrolled Nurse (General). There are about 125 nursing students who graduate from psychiatric pre-enrolled and pre-registration nursing programmes each year (Joint University Programmes Admissions System, 2019a).

Most of the nursing programmes are subsidised by government revenue. Nursing students from these tertiary institutions are still required to pay tuition fees for their nursing

education. In 2018/19, the tuition fee ranged from HKD\$42,100 (around £4,210) to HKD\$ 47,000 per year (around £4,700) (Joint University Programmes Admissions System, 2019a, 2019b).

The duration of pre-registration nursing programmes in Hong Kong varies between nursing schools and post-secondary colleges and universities. Post-secondary colleges and universities offer longer undergraduate nursing programme of five years in length. Undergraduate nursing students are awarded a Bachelor degree after graduating, while pre-registration nursing students from nursing schools will be awarded a higher diploma qualification. Both types of nursing students are eligible to become RNs. The difference in duration of study is due to differences in the curriculum. Post-secondary colleges and universities provide more theoretical content in the curriculum, with more in depth coverage of professional disciplinary knowledge, critical-thinking, clinical practice skills, leadership, and research skills that go beyond the NCHK core competencies (Chair et al., 2018). In 2017, about 10% of nursing students received their nursing education in nursing schools. The majority of nursing students were studying in nursing programmes provided by universities (Food and Health Bureau, 2017). RNs who graduated from a nursing school are encouraged to top up their qualifications to a degree level through further education (Chair et al., 2018). As this study focused on the undergraduate nursing students, the discussion on requirement of clinical placement for pre-registration nursing training will be in discussed below.

1.5.2. Requirements of pre-registration nursing training

As stated in the previous section, all nursing programmes in Hong Kong must be accredited by the NCHK (Nursing Council of Hong Kong, 2017). Higher education institutions that

provide the pre-registration nursing programmes are required to follow the syllabus set by the NCHK (Nursing Council of Hong Kong, 2017). The syllabus of pre-registration nursing training was developed to meet the below core competencies (See Table 1.3) (Nursing Council of Hong Kong, 2015, 2016).

Core competencies for Registered Nurse
Professional, Legal and Ethical Nursing Practice
Health Promotion and Health Education
Management and Leadership
Research
Personal Effectiveness and Professional Development

Table 1.3: Core competencies for registered nurses

As mentioned earlier, the core competencies outline the required abilities that RNs should have. Graduates from the accredited nursing programmes need to attain these required core competencies. The syllabus consists of two parts the theoretical and the clinical practice requirement.

1.5.2.1. The theoretical content of pre-registration nursing syllabus

The theoretical requirement is set by the Education Committee of the NCHK (Nursing Council of Hong Kong, 2019d). The Education Committee is formed by representatives from the Universities, and public and private hospitals. The theoretical requirement is reviewed and revised periodically (Nursing Council of Hong Kong, 2019d). However, no document was found outlining the principles on which the theoretical requirements are based.

The theoretical content is commonly delivered through various teaching methods including lecturing, problem-based learning, simulation-based learning and the flipped-classroom

approach (Ching et al., 2019). Universities tend to have more resources to adopt advanced teaching methods such as simulation-based learning (Chair et al., 2018). The use of advanced teaching methods is restricted to the teaching of theoretical content only. Therefore, advance teaching does not have any impact on the practice hours in clinical placement.

Accredited pre-registration nursing programmes must provide a minimum of 1,250 theoretical contact hours in total (Nursing Council of Hong Kong, 2016). According to the Nursing Council of Hong Kong (2016), the theoretical courses must cover all five core competency areas. The distribution of theoretical contact hours is presented below in Table 1.4.

Core-competence areas	Minimum theoretical hours
1. Professional, Legal and Ethical Nursing Practice	1,112
2. Health Promotion and Health Education	50
3. Management and Leadership	40
4. Research	40
5. Personal Effectiveness and Professional Development	8

(Nursing Council of Hong Kong, 2016)

Table 1.4: Distribution of minimum theoretical Hours for the pre-registration nursing programmes

The main parts of the pre-registration nursing theoretical courses focus on behavioural sciences, life science, nursing practice, legal and ethical issues, communication, the rights and the responsibilities of the individual and information technology in nursing and health care (Nursing Council of Hong Kong, 2016). The requirement of the theoretical courses for pre-registration nursing programmes aims at preparing pre-registration nursing students to

become professional nurses and future leaders of the nursing profession (Chan and Wong, 1999; Nursing Council of Hong Kong, 2016). The pre-registration nursing programmes are also required to fulfil the minimum teacher-to-student ratio of 1:25 (Nursing Council of Hong Kong, 2017). For the undergraduate nursing programme offered by the government funded universities, there were around 250 students per year in each programme (Food and Health Bureau, 2017). Hence, at least 50 academic staff are required to operate the 5-year undergraduate nursing programme. In addition, nursing students are not only required to attend theoretical courses but also to attend clinical placements during their study.

1.5.2.2. Clinical placements

Accredited higher education institutions are also required to fulfil the NCHK clinical practice requirements when they provide nursing education programmes. These institutions collaborate with different clinical partners including the Hospital Authority to organise clinical placements. There is no document which describes the framework for collaboration between higher education and practice. Clinical placements are organised and carried out according to the routines and rules set out locally by the management of both accredited higher education institutions and the Hospital Authority. Hence, management of clinical placements could be based to some extent on custom and practice. More details about the organisation of clinical placements will be discussed in Chapter 4.

Two types of personnel are eligible to act as teaching staff in clinical placements, namely clinical instructors (CIs) and clinical mentors (CMs). CIs are RNs with at least three years of post-registration clinical experience and teaching staff employed by accredited higher education institutions. They are only responsible for the clinical teaching of nursing students

in clinical areas (Nursing Council of Hong Kong, 2017). CMs are also RNs with at least three years post-registration clinical experience but they were employees of the hospital in which the clinical placements takes place. They have dual responsibilities, having to work as ward nurses and act as nursing students’ mentors at the same time (Nursing Council of Hong Kong, 2017). Accredited higher education institutions are required to provide training for CIs and CMs (Nursing Council of Hong Kong, 2017). However, the length and content of mentorship training is not specified by the NCHK. In addition, a monitoring and support system for CIs and CMs is not required by the NCHK. The NCHK Handbook of Accreditation specifies the required teacher-student ratio. This ratio varies between CIs and CMs due to differences in the responsibilities for clinical teaching. Table 1.5 shows the differences in teacher-student ratio between CIs and CMs.

Teaching staff in clinical placements	Teacher-student ratio
Clinical instructors	1 clinical instructor to 8 students
Clinical mentors	1 clinical mentor to 3 students

(Nursing Council of Hong Kong, 2017)

Table 1.5: Teacher-student ratio in clinical placements

The NCHK specify the requirements for clinical placements which include the qualifications and experience of CIs and CMs, the teacher-student ratio of clinical placements and the requirements for the duration of placements and type of placements. Assessment strategies in clinical placements are outlined but not specified in detail. (Nursing Council of Hong Kong, 2015, 2016). Apart from the above-mentioned requirements, there are no regulations for the processes of teaching and support in clinical placements or the activities that students should engage in. Clinical placement activities are therefore implemented according to custom and practice. The details will be discussed in more detail in Chapter 4.

Students are required to practise for at least 1400 hours in total (Nursing Council of Hong Kong, 2016) and complete clinical placements in nine specialties (Nursing Council of Hong Kong, 2016). The requirement for clinical placement hours for pre-registration nursing students is listed in Table 1.6 below.

Clinical area	Minimum clinical placement hours
1. Medical Nursing	440
2. Surgical Nursing	330
3. Paediatric and Adolescent Nursing	60
4. Obstetric Nursing	60
5. Gerontological Nursing	60
6. Mental Health Nursing	60
7. Community Nursing	60
8. Primary Health Care	60
9. Accident and Emergency Department	60
10. Any of clinical area from 1-9	210

(Nursing Council of Hong Kong, 2016)

Table 1.6: The requirement of clinical placement hours for pre-registration nursing students

Over 95% of the required clinical placements are conducted in secondary health care settings. This could be related to the heavy demands on nurses in secondary health care settings (Food and Health Bureau, 2017). Apart from the minimum number of clinical placement hours, the NCHK did not provide any guidelines about how to organise clinical placements and how nursing students and CIs/CMs should participate in clinical placements.

Pre-registration nursing students are not only required to attend the clinical placements according to the above-mentioned requirements, but also to pass the three practical assessments required by the NCHK (Nursing Council of Hong Kong, 2016). The practical

assessments are conducted by clinical assessors, who are appointed by the accredited higher education institutions (Nursing Council of Hong Kong, 2017).

Clinical practice assessments

For pre-registration nursing students there are three clinical practice assessments, namely the aseptic technique, administration of medication and professional nursing competencies (Nursing Council of Hong Kong, 2015; Nursing Council of Hong Kong, 2016). These three practical assessments have been adopted from the four previous General Nursing Council (GNC) practical assessments (Clifford, 1994). Pre-registration nursing students are assessed by either their CIs or CMs for any nursing procedures that require an aseptic technique in the assessment of the aseptic technique (Nursing Council of Hong Kong, 2016) including wound dressing, removal of stitches and urinary catheterisation etc. Pre-registration nursing students are also assessed for their ability to administer medications. They are asked to either administer oral medication to 6- 8 patients or to administer medication to 1-2 patients through injections (Nursing Council of Hong Kong, 2016). For professional nursing competencies, pre-registration nursing students are assessed on their competence in the application of the nursing process by providing total patient care (Nursing Council of Hong Kong, 2016). The NCHK assessment of professional nursing competencies is a combination of the UK General Nursing Council's (GNC) total patient care for one patient and the management of a group of patients practical assessment (Clifford, 1994). However, the precise requirements for the clinical assessments were not described in either the syllabus or Handbook of Accreditation. Thus, accredited higher education institutions have to develop their own clinical placement assessment system and standard of assessment based on the brief outline provided by the NCHK. These institutions have to submit the records of

the clinical assessments and the description of clinical assessments to the NCHK during the accreditation approval process (Nursing Council of Hong Kong, 2017). Students and CIs/CMs engage in clinical placements according to the above-mentioned requirements.

1.6. Key concepts in this study

Clinical placements provide the clinical learning environment in which pre-registration nursing students transform themselves from being a lay person to a nursing professional (Oermann et al., 2017). They learn to become a professional nurse through on-the-job training in the clinical area. In Hong Kong, CIs and CMs are responsible for conducting the on-the-job training of pre-registration nursing students in clinical placements. Various terms were used to describe teaching roles in clinical practice in the nursing literature (Clifford, 1994; Faugier et al., 1994; Butterworth et al., 1998; Dorsey and Baker, 2004; Hays, 2012; Oermann et al., 2017). These terms which include clinical supervision, preceptorship, clinical teaching and mentorship, describe various teaching roles in on-the-job situations. These terms for training are used for both qualified nurses and pre-registration nursing students. Variations in definitions were found in the literature; different terms were at different times and in different countries, with different meanings, thus definition of these key concepts lacks clarity.

1.6.1. Teaching roles in on-the-job training for qualified nurses

Clinical supervision and preceptorship are two common terms that define the teaching roles in on-the-job training for qualified nurses. However, these two terms may sometimes also be used to describe teaching and learning in supervision in clinical placements for pre-registration nursing students in the UK and US (Cutcliffe et al., 2001; Lyth, 2000; McClure

and Black, 2013). They are briefly outlined below as this study's focus is on pre-registration nursing students

1.6.1.1. Clinical supervision

Clinical supervision was first defined by Faugier et al. (1994) to describe the role of the professional learning relationship between experienced nurses and novice nurses. It was seen as an interactive process whereby experienced nurses facilitated the development of the less experienced nurses to learn/develop the competence and confidence of novice nurses in practice. The novice nurses received support through formative and restorative means accordingly (Faugier et al., 1994) meaning that novice nurses were able to receive both emotional support and enhancement of competencies (Creaner, 2014). Clinical supervision therefore served as a supportive role for novice nurses as an adjunct to the supervision of clinical managers.

Butterworth et al. (1998) suggested that the concept of clinical supervision should be adopted in pre-registration nursing education. Clinical supervisors in pre-registration nursing education could enhance students' knowledge and clinical skills and facilitate nursing students in building up their confidence and autonomy as professionals. Clinical supervisors not only need to be clinically competent in, but also able to build up supportive relationships with students (Sloan, 1998; Lyth, 2000). This could ultimately empower students and thus further enhance patient safety by relieving students' stress through counselling (Butterworth et al., 1996). However, Lyth (2000) reported that mentoring was adopted by pre-registration nursing education instead of clinical supervision in the 1990s.

1.6.1.2. Preceptorship

Preceptorship is defined by the Royal College of Nursing (2020) as the support from preceptors that facilitates newly qualified nurses in building up their confidence to practice as independent professionals during a structured post-qualification transition period (Royal College of Nursing, 2020). Preceptors are qualified nurses who support newly qualified nurses during the period of preceptorship as identified by the UK Nursing and Midwifery Council (Nursing and Midwifery Council, 2006). Preceptors and newly qualified graduate nurses engage in a two to twelve week period of supported learning to develop the graduates' clinical skills (Mills et al., 2005). In other countries such as the United States and Ireland, the concept of preceptorship was adopted interchangeably with mentorship (McClure and Black, 2013) and used to describe training in clinical placements for pre-registration nursing students instead of novice nurses. Similar to the UK, preceptorship in Hong Kong is applied to graduate nurses only (Tsang et al., 2012). Clinical teaching and mentorship are more appropriate terms to use to describe the teaching in clinical placements for pre-registration nursing students in nursing education in Hong Kong.

1.6.2. Teaching roles in clinical placements for pre-registration nursing students

Teaching roles in clinical placements for pre-registration nursing students are most frequently described using the terms clinical teaching and mentorship. These two concepts have developed from other healthcare disciplines such as medicine and psychotherapy since the 1960s (Butterworth et al., 1998; Hays, 2012); how these two terms are conceptualised in the literature is outlined below.

1.6.2.1. Clinical teaching

Clinical teaching has been used historically to describe how teaching of clinical skills is conducted in medical and nursing education (Hays, 2012; Oermann et al., 2017). No standard or commonly accepted definition of clinical teaching was found in the literature. Hays (2012) defined clinical teaching as the facilitation for pre-qualified practitioners to learn in clinical areas, where qualified professionals, including doctors and nurses, frequently serve as teachers in the clinical area. Oermann et al. (2017) even considered clinical skill teaching in a classroom as part of clinical teaching. Despite the discrepancy in the definition, both Hays (2012) and Oermann et al. (2017) agreed that clinical teaching emphasises the role of the teacher. Teachers in clinical teaching were responsible for observing, assessing the student's practice and provision of feedback to the students (Hays, 2012; Oermann et al., 2017). The teachers were in a more authoritative position than the students. The focus of clinical teaching is the development of the clinical skills of students (Hays, 2012; Oermann et al., 2017). From the literature in the 1980s, clinical teachers were previously responsible for clinical teaching in nursing education (Robertson, 1986). The role of clinical teachers was similar to the roles of both CIs and CMs as has been currently adopted in Hong Kong. However, developing students' clinical skills was not the only focus of clinical placements. Since 2016, students were expected to develop clinical knowledge, skills, problem solving abilities and professional attitudes through clinical placements (Nursing Council of Hong Kong, 2016). Clinical teaching was no longer sufficient to fulfil the goal of current clinical placements. Mentorship is the approach that the NCHK has currently adopted for clinical placements.

1.6.2.2. Mentorship

The term mentorship was first adopted in psychotherapy and social work training, traditionally with pre-qualified professionals (Butterworth et al., 1998). In the 2000s, the terminology used to describe the educational support of pre-registration nursing students in clinical placements changed from clinical supervision to mentoring in nursing education within European Union countries (Jokelainen et al., 2011b). Mentorship was defined as a form of professional partnership in which an experienced professional (mentor) worked with “a less experienced learner” (mentee) to achieve personal growth and professional development (Dorsey and Baker, 2004). Mentees, which refers to the pre-registration nursing students, may be more dependent on the mentor in the earlier stage of the mentorship (Cooper and Palmer, 2000). The intensity of support will be decreased when the mentee becomes more confident and self-aware (Cooper and Palmer, 2000; Bray and Nettleton, 2007). The roles of mentors in clinical areas were similar in nursing, midwifery and medical training (Bray and Nettleton, 2007). The support provided by mentors was not only related to clinical skills but also to strengthening students’ professionalism and intellectual development, including the development of critical thinking and fostering co-operative relationships with other healthcare professionals (Jokelainen et al., 2011b).

Pre-registration nursing students in Hong Kong are required to develop the core competencies through clinical placements. Although the NCHK did not explicitly specify the concept adopted in clinical placements, the concept of mentorship is applied to pre-qualified nursing education in Hong Kong. This has been indicated in various guidelines and documents from hospitals and accredited higher education institutions, which will be outlined in Chapter 4. Both the healthcare sectors and accredited higher education

institutions expect CIs and CMs to provide assistance, guidance, advice and counselling, in addition to the role of a teacher and assessor. This could ultimately facilitate the pre-qualified students to develop professionally defined values, knowledge and competence (Bailey-McHale and Hart, 2013).

1.7. Conclusion

Nurses are the largest workforce in the healthcare system in Hong Kong (Food and Health Bureau, 2017). In Hong Kong large numbers of nursing students are admitted to different nursing programmes, all of which are comprised of both theoretical teaching and clinical placements. A clinical placement is one of the most important components in nursing education. Both CIs and CMs in Hong Kong conduct the clinical teaching of different types for nursing students during clinical placements. Clinical mentoring is an important but under researched aspect of clinical placements, particularly in Hong Kong. A scoping review of literature about mentoring in nursing clinical practice placements was conducted and is discussed in detail in the next chapter.

2. Literature Review

2.1. Introduction

This chapter provides a scoping review of the literature on clinical mentoring of student nurses in clinical placements. As discussed in the previous chapter, clinical mentoring was introduced as a means of training undergraduate nursing students in clinical skills within clinical placement areas. A scoping review method has been used to explore the current understanding of clinical mentoring in clinical placements in nursing from various perspectives. The chapter will thus review recent evidence on the clinical mentoring of undergraduate students. This scoping review consist of four parts: the first describes the methodology of this review, including the search strategies used for the selection of the literature included in the review. The second and third parts provide an overview of the studies included and describe their findings. The findings of the included studies are discussed and a critique of the literature identifying weakness and gaps in knowledge is presented in part four.

2.2. The literature review method

This literature review was conducted using the Arksey and O'Malley (2005) scoping review framework. A scoping review is able to provide a comprehensive and in-depth overview of the current literature when a systematic review is not feasible or appropriate (Arksey and O'Malley, 2005). A systematic review is used to seek a reliable and minimally biased solution to a precise review question, such as investigating the effectiveness of a particular treatment (Munn et al., 2018). The use of precise review questions limits the breadth of the systematic review (Joanna Briggs Institute, 2020a; Munn et al., 2018). This means that a

systematic review is unable to capture a broad overview of a phenomenon like mentoring experiences (Joanna Briggs Institute, 2020a). In addition, systematic reviews impose limitations on the methodologies of included studies to minimise bias, often limiting reviews to studies that provide evidence from randomised trials and intervention studies (Higgins et al., 2019). This type of study design is not commonly used to explore mentoring experiences. Hence, a scoping review is more appropriate in providing an overview of the literature and to inform research into mentoring experiences.

The scoping review framework devised by Arksey and O'Malley (2005) involves five stages including: “identifying a research question, identifying relevant studies, study selection, charting the data and collecting, and summarising and reporting the results” (Arksey and O'Malley, 2005, p. 22). In the next section the scoping review question, literature search, screening process, and extraction of data from the included articles will be discussed.

2.2.1. The scoping review question

The scoping review question in this literature review was: What are the experiences of CMs/CIs and undergraduate nursing students of clinical mentoring?

2.2.2. The search framework and search strategy

Based on the above question, the literature included was expected to identify the experiences and perceptions of clinical mentoring, factors affecting the experience of clinical mentoring, and the perceived consequences of clinical mentoring experiences. Various keywords were combined to identify the related literature systematically using the

Population, Concept, Context (PCC) framework (Joanna Briggs Institute, 2020a). The keywords used in the literature search are listed in Table 2.1.

Population	Concept	Context
Clinical instructors Clinical mentors Nursing Students Student nurses Undergraduate nursing students	Mentoring Mentorship	Clinical placement Clinical practicum Clinical education Internship Practice placement

Table 2.1: Keywords used in the literature search

No limitations to the study design were applied in the literature search to ensure that broad and in-depth coverage of the literature was undertaken. Ideally, the literature included should reflect recent research findings and current perspectives (Aveyard et al., 2016); thus, the literature search was limited to literature that was published from 2009 to 2020. As the literature search was conducted after data collection in early 2020, literature from 2009 was also included in order to capture the literature published from the previous ten years. The literature was searched according to the inclusion and exclusion criteria presented below in Table 2.2.

Inclusion Criteria	Exclusion Criteria
Written in English or Chinese Published from 2009 to 2020 No geographical limits Full text is available	Written in a language other than English and Chinese Full text was not available
The study participants involved either undergraduate nursing students or clinical mentors/instructors	The study participants involved newly qualified nurses or nurse educators who were not involved in clinical mentoring
The context of the study was related to a clinical placement or clinical practice	The context of study was related to classroom teaching
The study was related to clinical mentoring conducted by qualified professionals	The study was related to peer mentoring

Table 2.2: Inclusion and exclusion criteria of the literature search

2.2.3. The literature search and selection process

The process of the literature search consisted of three stages including an initial database search, hand-searching and bibliography searching (Arksey and O'Malley, 2005; Aveyard et al., 2016). The initial literature search was conducted in four databases, namely Cumulative Index of Nursing and Allied Health Literature plus (CINAHL), PubMed, PsycInfo, and the Education Resource Information Centre (ERIC). These databases provided a wide range of literature related to mentoring in nursing (Aveyard et al., 2016). As listed in Figure 2.1, the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flow chart, 1452 articles were initially identified from these four databases. Hand searching in selected journals, such as Nurse Education Today and Nurse Education in Practice retrieved 53 articles. These articles were found to be duplicated in the literature from the database searches. The reference lists of the selected articles were also screened to identify whether any relevant literature which met the inclusion criteria had been omitted. No further articles were added after the bibliography search.

258 selected articles were found to be duplicated and were removed. The abstracts of 1194 articles were screened, and 1110 articles were excluded after applying the inclusion and exclusion criteria. The full texts of 84 selected articles were reviewed. 16 articles were removed as their topics were either irrelevant to clinical placements or clinical mentoring. 68 articles remained in the review process. The selection process is illustrated in Figure 2.1 below, through the PRISMA flow chart (Moher et al., 2009).

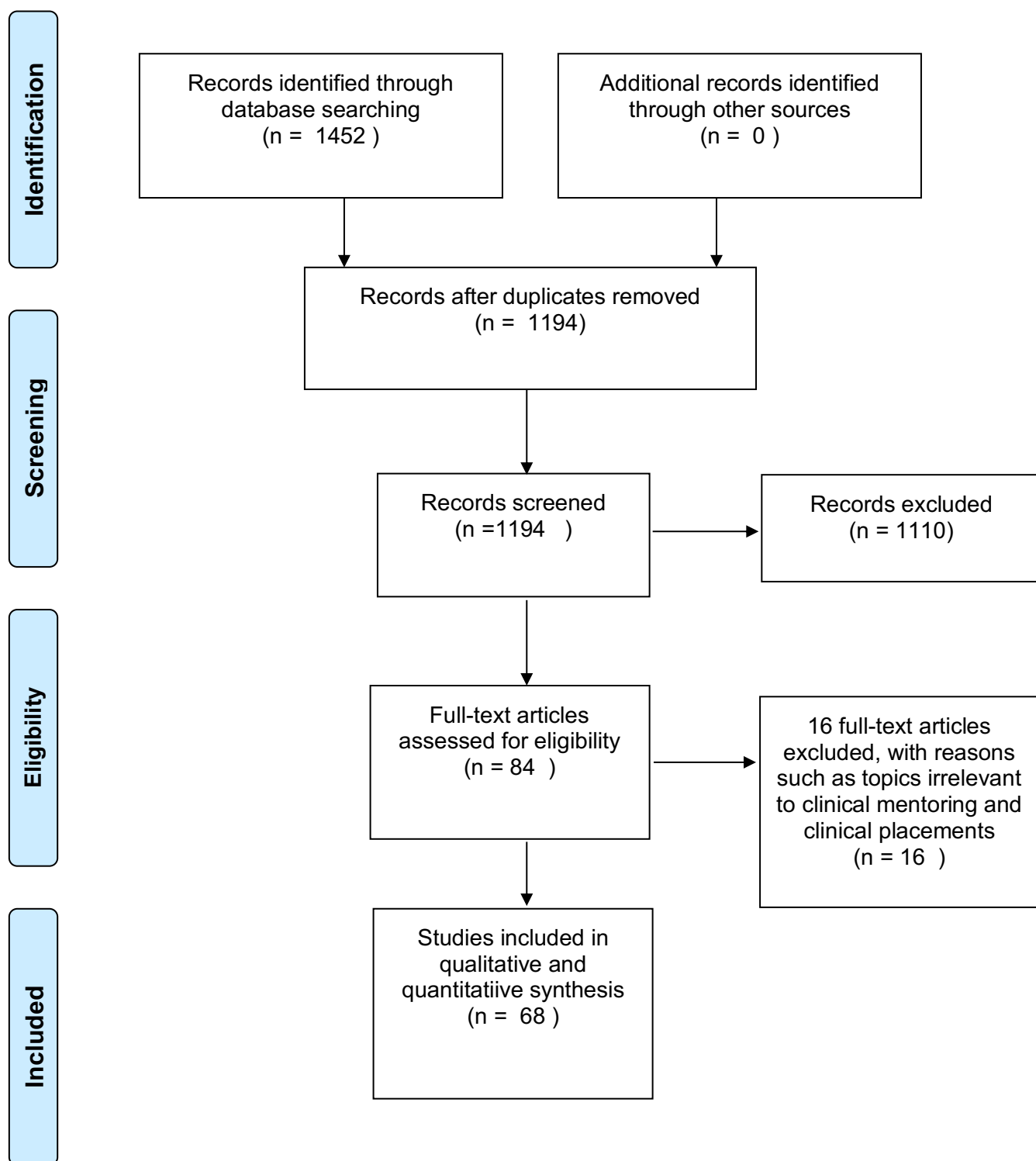


Figure 2.1: PRISMA flow chart

2.2.4. Data extraction

Relevant data was extracted from the included literature for further analysis (Aveyard et al., 2016). A better understanding of clinical mentoring in clinical nursing placements was then gained through the analysis of the extracted data (Arksey and O'Malley, 2005). Key data was charted during the review of the full texts of studies. The charted data included citation, the study location, the study population, methodology and a summary of the main findings. Data extraction charts provided a summary of the included literature (see Appendix 1). All included literature was then critically appraised. Although a critical appraisal of included literature was not required in a scoping review (Arksey and O'Malley, 2005; Munn et al., 2018), the quality of the literature affects the trustworthiness of the findings of a scoping review (Aveyard et al., 2016). The quality of included literature was assessed using various Critical Appraisal Skills Programme (CASP) checklists and the Joanna Briggs Institute Critical Appraisal Tools (Critical Appraisal Skills Programme, 2019a, 2019b, 2019c; Joanna Briggs Institute, 2020b) as relevant to each study's methodology. The strengths and weaknesses of each paper were then also included in the summary (see Appendix 1).

2.3. Overview of included literature

68 journal articles were included for review after the literature search and screening processes. The nature of the included articles is described in Table 2.3 below. As there was no limitation on the research design, the nature of the articles included research papers, literature reviews and discussion papers. The distribution of the types of articles is shown in Table 2.3.

Nature of Articles	Number of Articles
Research papers	48
Literature reviews	9
Discussion papers	11
Total	68

Table 2.3: Nature of the included literature

Of the 48 research articles, there were 14 quantitative studies, 20 qualitative studies and 14 mixed methods studies. The details of the methodologies of the included research articles are listed in Table 2.4.

Methodologies of the Included Research Articles	Included Studies (In Chronological Order)
Quantitative Studies	Warne et al. (2010); Skaalvik et al. (2011); Stayt and Merriman (2013); Helminen et al. (2014); Rooke (2014); Dimitriadou et al. (2015); Skela-Savič and Kiger (2015); Antohe et al. (2016); Gale et al. (2016); Kajander-Unkuri et al. (2016); Papastavrou et al. (2016); Tuomikoski et al. (2018); Mikkonen et al. (2020b); Mikkonen et al. (2020a)
Qualitative Studies	Bradbury-Jones et al. (2010); Allan et al. (2011); Jokelainen et al. (2011b); Coyne and Needham (2012); Halcomb et al. (2012); Hasson et al. (2013); Jokelainen et al. (2013); Peters et al. (2013); Annear et al. (2014); Black et al. (2014); Morrell and Ridgway (2014); Wilson (2014); Sinclair et al. (2015); Dobrowolska et al. (2016); Hunt et al. (2016); Rylance et al. (2017); Thomson et al. (2017); Adamson et al. (2018); Bowen et al. (2019); Liang et al. (2019)
Mixed Method Studies	Levett-Jones et al. (2009); Gidman et al. (2011); Courtney-Pratt et al. (2012); McIntosh et al. (2014); Foster et al. (2015); McInnes et al. (2015); Dahlke et al. (2016); Fuentes-Pumarola et al. (2016); McCallum et al. (2016); Gillespie (2017); Newton et al. (2017); Palese et al. (2017); Jack et al. (2018); Kaphagawani and Useh (2018)

Table 2.4: Methodologies of the included research articles

All 14 quantitative studies used a survey research design. Ten of the 20 qualitative studies adopted a generic rather than a specific qualitative design. The remaining ten qualitative studies adopted a phenomenology (8), grounded theory (1) and a case study (1) design. All

14 of the mixed method studies adopted a survey design with a subsample of qualitative interviews as their combined methods of data collection.

These studies were conducted on populations from different geographical locations. The majority were conducted in the United Kingdom and various European Countries. Only one study (Liang et al., 2019) was conducted on the Chinese population in Taiwan. The geographical locations for the included studies are illustrated in Table 2.5.

Study Location	Number of Included Studies	Included Studies (In Chronological Order)
United Kingdom (* study solely conducted in the UK)	25	Levett-Jones et al. (2009); *Bradbury-Jones et al. (2010); Warne et al. (2010); *Allan et al. (2011); *Gidman et al. (2011); Jokelainen et al. (2011b); Jokelainen et al. (2013); *Stayt and Merriman (2013); *Black et al. (2014); *McIntosh et al. (2014); *Morrell and Ridgway (2014); *Rooke (2014); *Wilson (2014); *Foster et al. (2015); *Sinclair et al. (2015); *Dobrowolska et al. (2016); *Gale et al. (2016); *Hunt et al. (2016); *McCallum et al. (2016); *Gillespie (2017); *Newton et al. (2017); *Rylance et al. (2017); *Thomson et al. (2017); *Adamson et al. (2018); *Jack et al. (2018)
Finland	10	Warne et al. (2010); Jokelainen et al. (2011b); Jokelainen et al. (2013); Black et al. (2014); Helminen et al. (2014); Kajander-Unkuri et al. (2016); Tuomikoski et al. (2018); Mikkonen et al. (2020a); Mikkonen et al. (2020b); Dobrowolska et al. (2016)
Australia	8	Levett-Jones et al. (2009); Courtney-Pratt et al. (2012); Coyne and Needham (2012); Halcomb et al. (2012); Peters et al. (2013); Annear et al. (2014); McInnes et al. (2015); Bowen et al. (2019)
Italy	4	Warne et al. (2010); Dobrowolska et al. (2016); Palese et al. (2017); Mikkonen et al. (2020b)
Spain	4	Warne et al. (2010); Fuentes-Pumarola et al. (2016); Dobrowolska et al. (2016); Mikkonen et al. (2020b)
Ireland	3	Warne et al. (2010); Hasson et al. (2013); Dobrowolska et al. (2016)

Cyprus	3	Dimitriadou et al. (2015); Foster et al. (2015); Papastavrou et al. (2016)
Slovenia	2	Skela-Savič and Kiger (2015); Mikkonen et al. (2020b)
Czech Republic	2	Antohe et al. (2016); Dobrowolska et al. (2016)
Other countries: including Canada, South Africa, Taiwan, United States etc. (a single study in each country)	8	Warne et al. (2010); Skaalvik et al. (2011); Antohe et al. (2016); Dahlke et al. (2016); Dobrowolska et al. (2016); Kaphagawani and Useh (2018); Liang et al. (2019); Mikkonen et al. (2020b)

Table 2.5: Geographical location of the included studies

The literature also included literature reviews and discussion articles. The distribution of the different types of literature review and discussion articles is illustrated in Table 2.6.

Literature other than research articles	Number of Review and Discussion Articles	Included Studies (In Chronological Order)
Narrative Reviews	5	Warren (2010), Wells and McLoughlin (2014), Elliott (2016), Helminen et al. (2016), Bickhoff et al. (2017)
Integrative Reviews	2	Omansky (2010), Rebeiro et al. (2015)
State-of-the art Review	1	Kragelund (2011)
Systematic Review	1	Pramila-Savukoski et al. (2020)
Discussion Papers (*Content related to UK only)	11	Carr et al. (2010); Hewitt (2010); *Barker et al. (2011); *Casey and Clark (2011); *Vinales (2015a); *Vinales (2015b); *Vinales (2015c); Anderson et al. (2016); Shellenbarger and Robb (2016); Timmins et al. (2017); *Foster (2019)

Table 2.6: Distribution of literature reviews and discussion articles

The scope of the literature reviews covered the mentor-student relationship, the learning processes involved in clinical mentoring and the assessment process. Similar themes were

also found in the discussion papers. However, the content of the discussion papers tended to focus on the clinical mentoring process solely in the United Kingdom. All the literature included underwent thematic analysis. The process of conducting thematic analysis and its findings will be discussed in the next section.

2.4. Thematic analysis of included literature

The literature provided an overview of the evidence and debates on clinical mentoring in the last ten years. Thematic analysis was conducted on the literature using Thomas and Harden's (2008) method which consists of three stages, namely the coding of text 'line-by-line', developing descriptive themes and the generation of analytical themes (Thomas and Harden, 2008). Four themes were identified from the thematic analysis of the literature, namely: clinical mentoring activities, the expected role and characteristics of CMs and students, factors influencing clinical mentoring and the rewards of clinical mentoring. The summary of themes and relevant studies is listed in Table 2.7.

Themes identified	Relevant Studies (In chronological order)
Theme 1 Clinical Mentoring Activities	Carr et al. (2010); Omansky (2010); Allan et al. (2011); Casey and Clark (2011); Stayt and Merriman (2013); Black et al. (2014); Dimitriadou et al. (2015); Foster et al. (2015); Vinales (2015a); Vinales (2015b); Vinales (2015c); Fuentes-Pumarola et al. (2016); Helminen et al. (2016); Hunt et al. (2016); McCallum et al. (2016); Kajander-Unkuri et al. (2016); Newton et al. (2017); Adamson et al. (2018); Kaphagawani and Useh (2018); Palese et al. (2017); Rylance et al. (2017); Shellenbarger and Robb (2016); Timmins et al. (2017); Mikkonen et al. (2020b)
Theme 2 Expected Roles and Characteristics of Clinical Mentors and Students	Levett-Jones et al. (2009); Hewitt (2010); Warren (2010); Gidman et al. (2011); Courtney-Pratt et al. (2012); Coyne and Needham (2012); Halcomb et al. (2012); Jokelainen et al. (2013); Peters et al. (2013); McIntosh et al. (2014); Morrell and Ridgway (2014);

	Wilson (2014); Dimitriadou et al. (2015); McInnes et al. (2015); Rebeiro et al. (2015); Skela-Savič and Kiger (2015); Sinclair et al. (2015); Antohe et al. (2016); Dahlke et al. (2016); Papastavrou et al. (2016); Gillespie (2017); Jack et al. (2018); Mikkonen et al. (2020a); Pramila-Savukoski et al. (2020)
Theme 3 Factors influencing Clinical Mentoring	Levett-Jones et al. (2009); Warne et al. (2010); Jokelainen et al. (2011b); Skaalvik et al. (2011); Coyne and Needham (2012); Hasson et al. (2013); Stayt and Merriman (2013); Annear et al. (2014); Rooke (2014); Dimitriadou et al. (2015); McInnes et al. (2015); Antohe et al. (2016); Dahlke et al. (2016); Fuentes-Pumarola et al. (2016); McCallum et al. (2016); Gillespie (2017); Jack et al. (2018); Bowen et al. (2019)
Theme 4 Rewards of Clinical Mentoring	Levett-Jones et al. (2009); Bradbury-Jones et al. (2010); Courtney-Pratt et al. (2012); Halcomb et al. (2012); Morrell and Ridgway (2014); Wells and McLoughlin (2014); Elliott (2016); Shellenbarger and Robb (2016); Rylance et al. (2017); Adamson et al. (2018); Bowen et al. (2019); Liang et al. (2019)

Table 2.7: Summary of themes and relevant studies

These four themes gave an overview of the mentoring experience of students and CMs, and are discussed in more detail in the following sections.

2.4.1. Theme 1: clinical mentoring activities

Both CMs and student participants described three types of clinical mentoring activities. The clinical mentoring activities included the practice of clinical skills, supervision and assessment, and the provision of feedback. These activities could occur concurrently and were closely linked to each other.

2.4.1.1. The practice of clinical skills

In the three mixed method studies, the facilitation of the practice of clinical skills was regarded as the most valuable clinical mentoring activity by nursing students sampled from the final years of the studies (Foster et al., 2015; Fuentes-Pumarola et al., 2016; McCallum et al., 2016). Interestingly, only nursing students mentioned the practice of clinical skills as a part of a clinical mentoring activity. In a study using a self-developed questionnaire (Stayt and Merriman, 2013) more than 30% of 421 nursing students in South England reported that they had opportunities to practice clinical skills all the time. However, information about the reliability and validity of the questionnaire used was not available. The clinical skills which were reported as being practiced by nursing students, ranged from basic nursing care, such as vital sign measurement and feeding patients, to more technical skills required in various specialties including high dependency units and emergency departments (McCallum et al., 2016; Stayt and Merriman, 2013). Nursing students described practising clinical skills through observation first then undertaking hands-on practice (McCallum et al., 2016). Practising clinical skills was described by nursing students as a learning opportunity as it helped them to learn and achieve the required clinical competencies for the practice placements (Fuentes-Pumarola et al., 2016). When nursing students were able to achieve their required competencies, they reported having positive experiences in the clinical placements (McCallum et al., 2016).

Nursing students could practice various clinical skills either with or without supervision (Foster et al., 2015; Stayt and Merriman, 2013). The involvement of CMs in providing practice opportunities remained unclear. Interestingly, no reports of their opinion on their role in providing opportunities for the practice of clinical skills were found in the studies of

CMs/CIs. The low emphasis on the facilitation of the practice of clinical skills by mentors could be related to the limited involvement of CMs in the allocation of work (Allan et al., 2011; Stayt and Merriman, 2013). Thus, the assignment of duties allowing the practice of clinical skills was not completely based on CMs' decisions (Palese et al., 2017). This will be discussed in section 2.4.3. CMs considered themselves as having a more important role in supervision and assessment.

2.4.1.2. Supervision and assessment

Various studies reported that both CMs and nursing students regarded supervision and assessment as important activities in clinical mentoring (Dimitriadou et al., 2015; Foster et al., 2015; Helminen et al., 2014; Kaphagawani and Useh, 2018; Newton et al., 2017; Stayt and Merriman, 2013). Both supervision and assessment shared similar characteristics. They were both conducted by CMs and were the methods used to assess the performance of nursing students in clinical placements (Casey and Clark, 2011). The definition of "supervision" described in the surveys (Dimitriadou et al., 2015; Kaphagawani and Useh, 2018) and a qualitative study (Foster et al., 2015) shared similar characteristics to formative assessment. Supervision and assessment were described as aiming at monitoring the progress of learning and facilitating students in improving their performances. The term "assessment" was then used to refer to the summative assessment that was adopted to judge whether the students met the standards and were eligible for being 'signed off' as having successfully completed a placement (Newton et al., 2017; Helminen et al., 2016; Vinales, 2015c). CMs and students placed different emphases on supervision and assessment. Two small-scale mixed method studies conducted in England, using self-

developed questionnaires (Foster et al., 2015; Stayt and Merriman, 2013), nursing students reported in the open-ended questions that they were more concerned about supervision. In contrast, several narrative reviews and discussion papers suggested that CMs and nurse educators were more concerned about assessment (Casey and Clark, 2011; Foster, 2019; Helminen et al., 2016; Vinales, 2015c).

CMs observed nursing students practising clinical skills during supervision (Vinales, 2015b). Supervision was perceived as a way of monitoring the progress of learning in clinical placements by both students and nurse educators. Stayt and Merriman (2013) reported that about 42% of the 421 nursing student respondents, in their survey of one university in south England reported being supervised frequently by their CMs. This meant that the majority of the students (58%) did not report adequate supervision. The level of supervision was reported as decreasing when the nursing students became competent in particular clinical skills (Vinales, 2015b). Although supervision was expected by the nursing institutions and hospitals (Foster, 2019), the availability of supervision was not guaranteed (Kaphagawani and Useh, 2018; Stayt and Merriman, 2013). Availability could depend on the CMs' interest in clinical mentoring and their workload (Foster et al., 2015; Kaphagawani and Useh, 2018; Omansky, 2010). This will be discussed further in section 2.4.3. An assessment was normally conducted to evaluate whether the nursing students had achieved the required competencies after the students had practiced their skills for a period of time. However, there was no literature that specified when these assessments occurred in different settings.

The discussions of assessment in the literature were mainly concerned with providing an overview of summative assessment and the challenges encountered by CMs when conducting assessments (Helminen et al., 2016; Hunt et al., 2016; Timmins et al., 2017; Vinales, 2015c). An overview of summative assessment was provided in two narrative reviews (Helminen et al., 2016; Vinales, 2015c). The process of assessment covered in these reviews was similar to that described in the guidelines mentioned in Chapter 1 and included preparation for the assessment, standards of assessment, the procedures used in summative assessment and the documentation required after assessment. On the other hand, none of the literature has mentioned the process of formative assessment which took place as a key part of supervision.

Failure to fail students was identified as one of the challenges related to assessment in some studies (Helminen et al., 2014; Black et al., 2014; Kajander-Unkuri et al., 2016). Some narrative reviews reported studies of nurse educators' opinions suggesting that educators believed that CMs failed to fulfill their role of gatekeeper and passed underperforming students in assessments (Casey and Clark, 2011; Timmins et al., 2017; Vinales, 2015a). In a cross-sectional survey conducted in Finland by Helminen et al. (2014), 85 of 108 nurse educators rated CMs as lacking the courage to fail their students, in a self-developed questionnaire which was validated by five expert groups. However, further information about these five expert groups was not available. Black et al. (2014) explored 19 CMs' experiences of failing students in a phenomenological study and found that failure to fail underperforming students was related to conflict between the assessment role and the supportive role of CMs with mentors expressing concerns about the consequences that the students faced after being failed. CMs also reported believing that they were responsible for

the performance of their students (Black et al., 2014). Hence, some CMs reported that they were reluctant to fail their students as they bore the responsibility of an unsatisfactory result from their mentoring (Black et al., 2014).

Another factor that it was suggested may result in a failure to fail students was the misunderstanding of the standard of assessments (Casey and Clark, 2011; Kajander-Unkuri et al., 2016; Vinales, 2015a). A discussion paper by Casey and Clark (2011) suggested that CMs could be more lenient in summative assessment under the influence of the student's personality and the student's performance in supervision. Two discussion papers (Casey and Clark, 2011; Vinales, 2015a), further implied that underachieving students could be passed in the assessment because of the mentors' lowered standards. It was suggested by these authors that the judgment on failing students in assessment, was therefore based on how CMs interpreted the standard of assessments (Casey and Clark, 2011; Kajander-Unkuri et al., 2016).

However, Kajander-Unkuri et al. (2016) asked 42 CMs to rate their students' clinical competencies and students to self-rate their clinical competencies using two validated questionnaires. The ratings from both CMs and their own students were then paired up and the paired ratings were compared (Kajander-Unkuri et al., 2016). The result showed that students tended to rate their clinical competencies better than their CMs (Kajander-Unkuri et al., 2016). The authors inferred that CMs still upheld the standards during assessment. The discrepancy in rating could alternatively suggest that CMs could have excessive expectations of their students and/or that students could be unclear about the standards to be achieved.

Practice opportunities, supervision and assessment were not sufficient on their own to facilitate nursing students' learning. Nursing students and nurse educators expected the CMs to provide feedback according to their evaluation of their students' performances (Carr et al., 2010; Foster et al., 2015). In a discussion paper, feedback was perceived as a way of guiding nursing students in improving their performances (Vinales, 2015b).

2.4.1.3. Feedback

Feedback was the third type of clinical mentoring activity found to facilitate learning in clinical placements (Adamson et al., 2018; Foster et al., 2015). Mikkonen et al. (2020b) conducted a cross-sectional survey for 1360 CMs in Italy using a validated questionnaire and found that constructive feedback helped students to achieve the goals of clinical mentoring. A similar claim was also made in a discussion paper by Vinales (2015b). Shellenbarger and Robb (2016) described constructive feedback as a form of verbal feedback and suggested that CMs should discuss, question and share experiences with their students in an atmosphere of open communication. Constructive feedback was believed to have multiple benefits, such as enhancing knowledge and confidence, motivating students, stimulating the students' critical thinking and also, their reflection on their performance (Adamson et al., 2018; Rylance et al., 2017; Shellenbarger and Robb, 2016). Adamson et al. (2018) conducted both individual and focus group interviews with 22 CMs and 27 nursing students to explore the feedback provided in clinical placements. Nursing students who were interviewed claimed that they did not receive frequent feedback from their CMs. In contrast to the students' claims, CMs reported that they provided non-explicit and informal feedback instead (Adamson et al., 2018; McIntosh et al., 2014). This suggested that students were

unable to recognise the non-explicit, informal feedback described by mentors as feedback (Adamson et al., 2018). Apart from the availability of feedback, both CMs and students agreed that students should take the initiative to seek feedback (Adamson et al., 2018). This may imply that CMs expected their students to take responsibility for their learning in clinical placements.

The current literature has outlined a brief overview of verbal feedback and captured the positive aspects of constructive feedback. The full picture of feedback may not be presented in this literature as the current literature does not further explore other forms of feedback given that did not fit the preferred model of constructive feedback. The evidence presented in this section has provided an overview of the three clinical mentoring activities in clinical placements discussed in the literature. However, the evidence from these studies of clinical mentoring activities did not address the involvement of CMs in providing opportunities for practising clinical skills or the process of supervision. There was also limited information on how feedback actually occurred in practice. As mentioned above, the literature indicated that a variety of factors related to CMs and their students, such as students' personality and CMs' workloads and interest in mentoring, could all influence the implementation of clinical mentoring activities, and thus the effectiveness of clinical mentoring. Hence, it is essential to explore how these factors have affected effective clinical mentoring.

2.4.2. Theme 2: roles of students and clinical mentors

Students and CMs have different roles in clinical mentoring. The roles described in all the studies were based on reports by either students or CMs. Some of the descriptions of the

roles mentioned below were different from the ideal role described in the guidelines cited in Chapter 1. This could reflect the discrepancy between the roles expected by nurse educators and the actual roles practiced in clinical mentoring.

2.4.2.1. The roles of students

Several studies have explored the roles of students in clinical mentoring (Coyne and Needham, 2012; Levett-Jones et al., 2009; Morrell and Ridgway, 2014; Sinclair et al., 2015). Two main student roles were identified from these studies across the various years of study, namely, acting as a learner or acting as a helping hand with the placement workload.

Learner

Students are expected to be learners working within the context of clinical mentoring. Students were able to fulfill their learner role when they were engaged in all three clinical mentoring activities with their mentors (Levett-Jones et al., 2009). Sinclair et al. (2015) retrieved posts by students on Twitter related to mentoring, and the findings reported that students treasured their role as a learner. However, no further descriptions were found in the literature about students' experiences of being a learner. On the other hand, CMs expected students to be enthusiastic in learning through being a 'responsible learner' (Coyne and Needham, 2012; McIntosh et al., 2014; Peters et al., 2013). Being a responsible learner meant students should prepare themselves with knowledge before a clinical placement started and should take the initiative to learn (Coyne and Needham, 2012; McIntosh et al., 2014). In a study of 12 Australian CMs using telephone interviews, participants claimed that they could save time teaching fundamental knowledge when

students were well prepared before a clinical placement (Peters et al., 2013). With sufficient preparation, CMs believed that students could then set their learning goals and be involved in learning proactively (McIntosh et al., 2014). These ideas also reflected how CMs perceived their roles in clinical mentoring.

Acting as a Helping Hand with Placement Workloads

Students were identified as having a secondary role as a helping hand with placement workloads (Jack et al., 2018; Morrell and Ridgway, 2014; Sinclair et al., 2015). All of the relevant evidence was based on reports by students through face-to-face interviews and posts on Twitter. For example, eight final year students in a small qualitative study suggested that they were used as healthcare assistants (HCA) to relieve the workload in clinical areas, which they believed hindered learning in clinical placements (Morrell and Ridgway (2014). Discrepancy between the roles of a worker and learner induced feelings of anger and frustration in students (Morrell and Ridgway, 2014; Sinclair et al., 2015). Sinclair et al. (2015) suggested that these feelings could be related to a failure to fulfill expectations about being a learner in clinical placements. These conflicting roles may also result in confusion about what students should achieve through clinical mentoring. Gidman et al. (2011) reported that 174 first year students suggested they were unclear about their roles in relation to clinical mentoring which may result in confusion about the goals of clinical mentoring. This could affect how students fulfilled their role as learners.

2.4.2.2. The role of clinical mentors

The literature extensively investigated and discussed the role of CMs. The role described in the literature is simpler in comparison to that described for students. CMs considered themselves as being a tool for clinical mentoring (Wilson, 2014). The perception of being a tool in mentoring may imply that CMs emphasised their functional role in clinical mentoring. As a tool for clinical mentoring, the role of CMs was described in a number of studies including a cross-sectional survey, a systematic review and a discussion paper, as providing learning support (Hewitt, 2010; McIntosh et al., 2014; Pramila-Savukoski et al., 2020). This learning support served two main functions. Firstly, CMs facilitated students in integrating theory into practice (Courtney-Pratt et al., 2012; Wilson, 2014). 12 CMs interviewed in a phenomenological study described the integration of theory into practice as reflected through the inspiring of the students to use their knowledge in problem solving and daily practice in placements (Wilson, 2014). However, 357 Cypriot second year nursing students who completed a validated questionnaire in a cross-sectional survey by Dimitriadou et al. (2015) reported that in their view, the integration of theory into practice was the role of nurse educators instead of CMs. Dimitriadou et al. (2015) further suggested that students perceived the integration of theory into practice as being facilitated through regular visits by nurse educators rather than by CMs.

The second role of CMs described in the literature was related to the supervision and practice of clinical skills. CMs who participated in the Wilson (2014) study also reported that they “engaged students in activities” and reported “being vigilant”. This meant that CMs arranged opportunities for practice and supervised students in practice (Jack et al., 2018). Gillespie (2017), in a focus group study of seven junior Scottish students, year of study not

specified, suggested that students believed CMs only served as a gatekeeper to control learning opportunities. Thus, contradictory views and evidence regarding the role of CMs was noted in the literature.

Some characteristics of CMs were also reported as influencing their roles in clinical mentoring, namely their professional backgrounds, the attitudes of CMs, the personality of CMs and their relationships with students (Antohe et al., 2016; Courtney-Pratt et al., 2012; Dahlke et al., 2016; Fuentes-Pumarola et al., 2016; McInnes et al., 2015; Warren, 2010).

Professional Background of Clinical Mentors

In a cross-sectional survey conducted in four European countries, 80% of 418 student respondents taking part in a validated questionnaire suggested that the professional background of CMs was important (Antohe et al., 2016). Experience of clinical mentoring and knowledge from both CMs and nurse educators' perspectives were perceived to constitute the professional background of CMs (Courtney-Pratt et al., 2012; Dahlke et al., 2016). Skela-Savič and Kiger (2015) asked 143 CMs in Slovenia to rate their own professional capability in clinical mentoring in a validated questionnaire. The result showed that clinical mentors with better self-reported knowledge reported higher confidence (Skela-Savič and Kiger, 2015). However, the response from these CMs was based on their own perception of their level of knowledge instead of any objective measurement. Their responses may therefore not be valid. The validity of this study may thus be questionable. A similar perception was also reported by five final year students in a small phenomenological study (Morrell and Ridgway, 2014). These five students reported their CMs as being less confident

when these CMs were perceived to have less education in medicine management, physiology and anatomy (Morrell and Ridgway, 2014).

Attitudes of Clinical Mentors

Attitudes of CMs were considered in Dahlke et al. (2016) and Halcomb et al. (2012) as influencing how CMs fulfilled their roles. Sinclair et al. (2015) retrieved posts that related to placements from Twitter. They found that negative clinical mentoring experiences were related to the perceived poor attitudes of CMs (Sinclair et al., 2015). Although the trustworthiness of Sinclair et al. (2015) data was low due to the unclear selection criteria for the sample of Twitter posts and the unknown identity of respondents, a post from a student nurse reported that enthusiastic CMs were “happy to teach” and contributed to a positive clinical mentoring experience. CMs, who were described as having a ‘better’ attitude, were described as being more patient to student and tended to provide reassurance to their students (Halcomb et al., 2012). A study of 12 English CMs using in-depth interviews reported that mentors showed their attitude through an “approachable face” (Wilson, 2014). A study of 22 Australian CMs reported from the open-ended question section of a validated questionnaire that CMs who could be described as having ‘better’ attitudes were more enthusiastic towards clinical mentoring (Dahlke et al., 2016). Enthusiastic CMs had a higher tendency to engage in clinical mentoring activities (McInnes et al., 2015; Mikkonen et al., 2020a). These descriptions of what constituted positive attitudes came from CMs. However, while no evidence was reported concerning students’ views regarding the positive attitudes of CMs, 22 students reported in some unstructured interviews that some CMs showed negative attitudes towards clinical mentoring (Jack et al., 2018). The negative attitudes of CMs were perceived to lead to a negative mentoring experience that may push

students into quitting the nursing programme (Jack et al., 2018). To date, Jack et al. (2018) was the only study that mentioned the negative attitudes of CMs. The characteristics of both positive and negative attitudes of CMs were described vaguely. Thus, the attitudes of CMs needs to be further explored.

Personality of Clinical Mentors

The personality of CMs was also considered as influencing how CMs conducted their roles, in two mixed method studies (Jack et al., 2018; McInnes et al., 2015). A study of 22 students in England using unstructured interviews reported that CMs with a strong personality could support and protect their students in an unwelcoming learning environment (Jack et al., 2018). However, one of the CMs suggested in an interview study of 13 CMs that some CMs were not suitable to be mentors due to their personal attributes (McIntosh et al., 2014). As with the studies of the attitudes of CMs, there was a limited specificity or clarity in the evidence regarding the desirable personality attributes of CMs. Thus, the influence of the personality attributes of CMs on clinical mentoring should be further explored.

Relationships with Students

CMs were expected by both students and nurse educators to build up a relationship with students during clinical mentoring (Fuentes-Pumarola et al., 2016; Warren, 2010; Rebeiro et al., 2015). Rebeiro et al. (2015) conducted a systematic review of seven studies from 1997 to 2013 that covered different forms of nursing education, including the apprenticeship and university-based models. This review described evidence suggesting that CMs required trust and time to build up professional and educational relationships with students. The precise details of these relationships were not stated in this review. However, a small qualitative

interview study with five CMs, cited in Rebeiro et al. (2015), found that the CMs reported building up relationships with students through knowing their students, developing trust, letting students have autonomy and open communication. Warren (2010) discussed similar findings in her discussion article suggesting that open communication between CMs and students could help to build up a good relationship. A focus group study of 22 Finnish CMs and 17 English mentors reported that maintaining a relationship with students helped them to understand their needs (Jokelainen et al., 2013). By learning about the needs of students, CMs were then able to customise clinical mentoring for students and provide more individualised emotional and learning support (Jokelainen et al., 2013). Hence, effective relationships between CMs and students were found to be associated with higher student satisfaction in clinical placements (Papastavrou et al., 2016).

The role of CMs described in the literature is clearer in comparison to the role of students in clinical mentoring. Although CMs and students play an important role in clinical mentoring, the descriptions of the process of clinical mentoring still varied in the literature. Various factors that could affect clinical mentoring were identified in the literature and are discussed below.

2.4.3. Theme 3: factors influencing clinical mentoring

Mentoring is not simply based on engaging students and CMs in mentoring activities. The literature revealed that multiple factors, including clinical settings, organisational culture, clinical placement arrangements and allocation of mentors all exerted an influence on

clinical mentoring. These factors were found to affect mentoring either directly or indirectly. These different factors were found to be interrelated to each other.

2.4.3.1. Clinical settings

Students are assigned to work in various clinical settings, including general wards and various specialised clinical settings in hospitals, nursing homes and primary health settings. Various studies included in the review investigated how the clinical settings influenced clinical mentoring (Dahlke et al., 2016; Fuentes-Pumarola et al., 2016; Gillespie, 2017; Jokelainen et al., 2011b; McCallum et al., 2016; McInnes et al., 2015; Skaalvik et al., 2011). The influence of clinical settings on clinical mentoring was a result of the effects of the nature of the clinical setting and the influence of the physical space in the clinical placement area on communications.

The influence of clinical settings on clinical mentoring was investigated by various qualitative and quantitative studies (Fuentes-Pumarola et al., 2016; Gillespie, 2017; McCallum et al., 2016; McInnes et al., 2015; Skaalvik et al., 2011). Several studies adopted cross-sectional surveys using the validated questionnaire, the Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale (Skaalvik et al., 2011). Self-developed questionnaires without validation were also used to measure students' satisfaction toward clinical placements in various clinical settings (Fuentes-Pumarola et al., 2016; Gillespie, 2017; Jokelainen et al., 2011a; McCallum et al., 2016; McInnes et al., 2015). A study of 216 first year students in Scotland with clinical placement experience in general medical, surgical and specialist hospital settings, reported that they had a higher level of satisfaction with

placements in specialist settings (McCallum et al., 2016). Similar findings were also noted by studies in Spain and Norway. Third- and fourth-year students in Spain also showed a higher level of satisfaction in placements in mental health units, intensive care units and emergency care units compared to general surgical settings (Fuentes-Pumarola et al., 2016). In addition, 511 Norwegian students reported a higher level of satisfaction with clinical experiences in hospital settings than in nursing homes, according to the CLES+T scale (Skaalvik et al., 2011). The difference in satisfaction with different types of clinical placements was found to be related to the perceived learning opportunities available in specific clinical settings. A focus group study of seven students from Scotland described the placement in nursing homes as mundane and lacking learning opportunities (Gillespie, 2017). The findings may suggest that students valued learning technical skills over learning in caring and communication skills. Differences in learning opportunities could affect the effectiveness of clinical mentoring. The effectiveness of clinical mentoring depended on both the quality and quantity of learning opportunities. All of the above studies reflected the students' perspectives. None of the literature reported the CMs' views on learning opportunities in different clinical settings. Dahlke et al. (2016) was the only study to explore CMs' perspectives on the suitability of placements in various clinical settings. In a validated questionnaire seventeen CMs in Canada reported that their clinical area had limited physical space which could not only limit the interaction with students, but may also affect the effectiveness of clinical mentoring (Dahlke et al., 2016).

2.4.3.2. Co-workers of clinical mentors

Apart from the impact of clinical settings, the co-workers of CMs were found to play a role in clinical mentoring. Various co-workers of CMs, including general practitioners (GP) and

Healthcare Assistants (HCA), took on delegated responsibilities for aspects of clinical mentoring (Hasson et al., 2013; McInnes et al., 2015). A variation in satisfaction with clinical mentoring activities involving GPs and HCAs was found in two studies. A survey of 45 Australian students reported higher satisfaction with clinical mentoring experience involving GPs in primary care settings (McInnes et al., 2015). 68.2% of these students reported that their high satisfaction level with clinical mentoring experiences was related to the enthusiasm of the GPs (McInnes et al., 2015). McInnes et al. (2015) suggested that GPs involved in placements may provide more detailed explanations and teaching during clinical placements. On the other hand, the responsibility of clinical mentoring could also be informally delegated to less qualified co-workers such as HCAs, by CMs due to heavy workloads (Hasson et al., 2013). A study by Hasson et al. (2013) suggested that clinical mentoring conducted by HCAs was task orientated and assessment focused. The importance of principles and knowledge was not found to be emphasised when clinical mentoring activities were delegated to HCAs (Hasson et al., 2013). Limited evidence about the delegation of clinical mentoring responsibilities was found. The students' and CMs' perspectives on this issue were not addressed in the literature.

2.4.3.3. Organisational culture

The influence of organisational culture on clinical mentoring was not studied directly in the literature. However, various studies found that the workload of CMs and the working atmosphere of a clinical area influenced the effectiveness of clinical mentoring (Annear et al., 2014; Bowen et al., 2019; Courtney-Pratt et al., 2012; Levett-Jones et al., 2009; Rooke,

2014). These two factors could reflect how the organisation managed clinical mentoring and how other healthcare workers influenced clinical mentoring.

Workload of Clinical Mentors

In the literature, both students and CMs reported that workloads influenced the CMs' engagement in clinical mentoring (Bowen et al., 2019; Rooke, 2014; Stayt and Merriman, 2013). CMs working in Australian rural hospitals and in different clinical settings across the UK reported, in interviews and in open-ended responses to a questionnaire, that their workloads were heavy (Bowen et al., 2019; Rooke, 2014). The reported heavy workloads were related to their dual responsibilities for both clinical mentoring and the delivery of clinical care (Rooke, 2014). No studies reported on organisational responses to the heavy workload of CMs. CMs, therefore, had to manage dual responsibilities on their own and this could influence the effectiveness of clinical mentoring. As discussed in the previous section, CMs could then either shift the responsibility of clinical mentoring to other co-workers (Hasson et al., 2013) or engage in fewer mentoring activities such as supervision and assessment (Stayt and Merriman, 2013; Rooke, 2014). Dahlke et al. (2016) also reported that communication between CMs and their students could be hindered due to a heavy workload. Although heavy workloads adversely influenced the quality of clinical mentoring, students showed understanding toward the impacts of a heavy workload on their CMs (Stayt and Merriman, 2013).

In a small qualitative study, nine CMs from Australia reported in interviews, that heavy workloads were related to a lack of support from administration and management (Bowen et al., 2019). CMs accepted the need to omit mentoring if they had difficulty in fulfilling their

clinical duties (Bowen et al., 2019). This could imply that the culture of the clinical areas tended to put a higher priority on clinical duties than clinical mentoring, due to a lack of resources.

The Working Atmosphere of Clinical Areas

The working atmosphere in a clinical area was reported as a factor affecting clinical mentoring and influenced how the CMs conducted their relationships with their students. Hewitt (2010) suggested in her discussion paper, that CMs should be friendly and welcoming to their students during placements. This reflected the nurse educators' expectations toward a receptive working atmosphere (Jokelainen et al., 2011b). Such an atmosphere was also reported by students from various studies (Levett-Jones et al., 2009; Coyne and Needham, 2012; Annear et al., 2014; McInnes et al., 2015). A receptive atmosphere was indicated by welcoming gestures by CMs and staff. It led to students' sense of belongingness throughout clinical placements.

An interview study of eighteen students in England suggested that a receptive working atmosphere in clinical placements should be created by CMs and other healthcare workers in a clinical area (Levett-Jones et al., 2009). A similar finding was also noted by Annear et al. (2014). A focus group study of ten Australian students reported that students felt a lack of respect from nurses and other healthcare workers when they worked in a less receptive working atmosphere (Annear et al., 2014). Various other qualitative and quantitative studies found that a receptive working atmosphere was related to a better clinical placement experience (Coyne and Needham, 2012; Jack et al., 2018; Levett-Jones et al., 2009). Both Levett-Jones et al. (2009) and Coyne and Needham (2012) reported that students felt they

were being welcomed and included when team members created a receptive working atmosphere. Students in the Coyne and Needham (2012) study further reported that CMs and other healthcare workers were more supportive and provided more opportunities to practice clinical skills in areas with a receptive working atmosphere. Hence, their clinical placement experience was rated as better. A receptive working atmosphere was also related to the development of feelings of students' belongingness in placements (Levett-Jones et al., 2009). This reflected the intensity of student attachment to the relationship with their CMs. Levett-Jones et al. (2009) provided the only qualitative study that explored belongingness in placements from the students' perspectives. Students in the Levett-Jones et al. (2009) study reported that they were trusted and recognised when belongingness was developed.

Students' belongingness was found to facilitate mentoring in clinical placements. Once the students' sense of belongingness in a clinical area was developed, CMs and other healthcare workers then treated students as team members, through actively involving them in patient care and clinical mentoring activities (McIntosh et al., 2014; Levett-Jones et al., 2009). The reported behaviour of CMs was related to the legitimisation of the learner role after belongingness in a placement developed (Levett-Jones et al., 2009). When students developed a sense of belongingness in placements, it meant that mutual supervisory relationships between CMs and students were also established (Jokelainen et al., 2011b). Both Jokelainen et al. (2011b) and Skaalvik et al. (2011) found that a more intense pedagogical atmosphere in placements was created when students and CMs were engaged in mutual supervisory relationships (Jokelainen et al., 2011b; Skaalvik et al., 2011). This offered an explanation as to why students felt ignored and unsupported in clinical

placements when they worked in a less receptive working atmosphere (Jack et al., 2018) and why facilitating students to become part of the team was rated as the second most important aspect of student support by CMs, while facilitating students to acquire clinical skills was the most important characteristic of student support (McIntosh et al., 2014).

2.4.3.4. Clinical placement arrangements

Clinical placement arrangements were mainly controlled by clinical management and nurse educators. Limited studies were conducted to investigate the impact of clinical placement arrangements on clinical mentoring. The literature reviewed was only concerned with the types of clinical mentoring and the duration of clinical mentoring.

CMs and students were assigned to engage in two types of clinical mentoring, either group mentoring or individual mentoring. Two cross-sectional surveys addressed types of mentoring (Antohe et al., 2016; Dimitriadou et al., 2015). The CLES+T scale mentioned earlier, was adopted by Antohe et al. (2016) and Dimitriadou et al. (2015) to measure students' satisfaction towards mentoring. Students' satisfaction was viewed in relation to four dimensions, namely a ward atmosphere, the leadership style of the ward manager, nursing care on the ward, the content of the supervisory relationship, and the role of the nurse teacher (Antohe et al., 2016). This scale focused not only on how CMs mentored their students, but also measured the factors that influenced mentoring. However, both surveys compared students' satisfaction with mentoring according to the type of clinical mentoring. Dimitriadou et al. (2015) showed no statistical difference in satisfaction between group mentoring and individual mentoring for 357 students in Cyprus, while, Antohe et al., (2016) reported a higher satisfaction toward individual mentoring among 418 students from four

European countries (Antohe et al., 2016). No evidence other than the students' perspectives was found. These inconsistent findings indicate that student preferences regarding types of clinical mentoring currently remain unclear.

The duration of clinical placements was another factor that affected clinical mentoring. Warne et al. (2010) is the only study that found that students' satisfaction toward clinical mentoring experiences was related to the duration of clinical placements. A cross-sectional survey of 1903 students from nine European countries (Warne et al., 2010) found that students with longer placements had higher scores on the CLES+T scale. This suggested that students had a higher satisfaction toward clinical mentoring when the duration of the clinical placement was longer. Similar to types of mentoring, it is difficult to know how the duration of clinical placements influences clinical mentoring based on the very limited evidence available.

2.4.4. Theme 4: the rewards of clinical mentoring

In the previous sections various factors related to the implementation of clinical mentoring have been discussed. The rewards of clinical mentoring are implicitly reported in various studies in terms of what is achieved through clinical mentoring. In the literature, individuals, organisations and professions were found to gain different types of rewards from clinical mentoring.

2.4.4.1. The individual level

Several qualitative studies and surveys conducted in Australia and the UK found that CMs and students directly gained different individual rewards from mentoring (Adamson et al., 2018; Courtney-Pratt et al., 2012; Elliott, 2016; Levett-Jones et al., 2009; Shellenbarger and Robb, 2016). The rewards gained by CMs and students varied to a certain extent. Students benefited from developing some of the attributes required of professional nurses, while CMs benefited from further professional development.

Students

Students were assumed to be transformed into professional nurses by nurse educators and CMs after being mentored for a certain period of time. In the literature, clinical mentoring was widely reported as capable of enhancing students' confidence, competency and knowledge (Adamson et al., 2018; Bradbury-Jones et al., 2010; Courtney-Pratt et al., 2012; Levett-Jones et al., 2009; Liang et al., 2019; Morrell and Ridgway, 2014; Rylance et al., 2017). All these findings were based on reports by students.

Student confidence and competence were closely related and it was reported by senior students in interviews and written diaries that both student confidence and competence were enhanced at the same time (Courtney-Pratt et al., 2012; Morrell and Ridgway, 2014; Liang et al., 2019). A study involving in-depth interviews of 178 Australian third and final year students that they became more confident when they felt competent in practice (Courtney-Pratt et al., 2012). A small phenomenological study by Morrell and Ridgway (2014) that analysed the written diaries of eight final year students reported a similar finding in that they felt confident after they were able to successfully complete tasks

(Morrell and Ridgway, 2014). Feedback from CMs could mediate the enhancement of students' confidence and competency levels. Students reported that their confidence was built up when CMs recognised their student's skills and performance (Levett-Jones et al., 2009). Feedback on progress was reported to facilitate students in the practice of skills and this in turn increased students' confidence (Adamson et al., 2018). Management of stress was another factor that was reported to mediate the enhancement of both students' confidence and competencies (Liang et al., 2019). In a study using semi-structured interviews 28 Taiwanese students reported that their confidence and competency was increased after participation in a resilience programme (Liang et al., 2019). These students also reported that they were reluctant to practise skills as they felt stressed about making mistakes. Hence, students were more likely to practise their skills when their stress was reduced. When students were able to practise their skills, their confidence increased.

Knowledge was reported as another reward of clinical mentoring. Bradbury-Jones et al. (2010), in a phenomenological study of 13 first-year students in the UK, was the only study that reported increased student knowledge through placements. Students also reported that their confidence increased when they had more knowledge (Bradbury-Jones et al., 2010). However, what type of knowledge is gained in different placements and in different years of study, and how knowledge enhances students' confidence remains unknown due to limited evidence.

Clinical Mentors

Limited evidence was found reporting that CMs also gained rewards from clinical mentoring. Similar to students, CMs were found to enhance their confidence through clinical mentoring

(Elliott, 2016; Shellenbarger and Robb, 2016). Shellenbarger and Robb (2016), in a discussion paper, suggested that novice CMs gained in confidence through clinical mentoring. Novice CMs could gain confidence through goal setting with their students as this required several mentoring skills such as assessing and communicating with the students (Shellenbarger and Robb, 2016). This may imply that the novice CMs also acquired competency in the process of mentoring. Confidence could also be gained through mentoring underperforming students (Elliott, 2016). This shared a similar logic to the way students built up their confidence through developing their competencies. CMs perceived themselves as competent in clinical mentoring when they found improvements in their underperforming students' performances (Elliott, 2016). Competency in clinical mentoring enhanced the CMs' confidence. Apart from assessment skills and communication skills, CMs could also be rewarded by developing effective feedback (Wells and McLoughlin, 2014). Wells and McLoughlin (2014), in a narrative review of UK literature, described this type of reward as professional development. The discussion about CMs' confidence and competency gained through clinical mentoring was based on narrative reviews and discussion papers only. No research study explored this issue, thus there is no evidence to support these authors' claims regarding the CMs' confidence and competency gained through clinical mentoring.

A qualitative study involving interviews with nine CMs found that the CMs gained job satisfaction through clinical mentoring especially when the students showed improvements in their performances (Bowen et al., 2019). This suggested that the improvement in student performances was seen as reflecting the effectiveness of mentoring. CMs participating in the interview perceived their mentoring as effective when students were able to learn from

them. Expressions of appreciation and feedback from students were also reported as being related to CMs' job satisfaction (Bowen et al., 2019).

A questionnaire study of 169 CMs with two open-ended questions revealed that clinical mentoring offered them opportunities to keep their knowledge up to date and improve their mentoring skills through mentoring different types of students (Rylance et al., 2017).

The updating of knowledge and of mentoring skills served as a reward from their involvement in clinical mentoring. Clinical mentoring provided rewards not only to individuals but also to healthcare organisations and the profession.

2.4.4.2. Organisational and professional rewards

Clinical mentoring was perceived not only to reward the participants but also the organisations and the profession. Two qualitative studies suggested that there were rewards from clinical mentoring for the organisation and the profession (Halcomb et al., 2012; Morrell and Ridgway, 2014). The rewards of clinical mentoring at this level were not explicitly demonstrated as these studies were based on reports from students and CMs.

As mentioned in the previous section, students were asked to relieve the ward workloads during clinical mentoring (Morrell and Ridgway, 2014). Although students perceived that they may not have benefited from being 'helping hands', the hospital could have benefited from the use of student labour to deal with staff shortages. No other evidence confirmed this claim. However, clinical mentoring was reported to be a solution to a shortage of workforce by CMs. This could be achieved through promoting nursing practice first and by

the goal of nurturing future nurses. Eight CMs interviewed by Halcomb et al. (2012) reported that clinical mentoring was a way of promoting nursing practice. They were asked about the “best things about having a student in general practice placement” and claimed that students could know more about nursing practice through clinical mentoring and it attracted them to stay in the profession. Students could then develop the competencies required for professional nurses when they remained in the nursing programme (Halcomb et al., 2012). Mentorship then served the long-term goal of nurturing future nurses to help relieve the shortage of staff.

The findings of the thematic analysis of the included literature were discussed in the previous sections. The summary table of the literature is located in Appendix 1. Some conflicting findings and gaps and methodological limitations were identified during the analysis of the literature: further discussion of this continues in the next section.

2.5. Discussion of the included literature

In a scoping review it is not necessary to critique the literature included in the review (Arksey and O'Malley, 2005). However, the quality of the literature could determine whether the current literature is able to answer the research question (Aveyard, 2019). The evidence included in this scoping review was critically appraised in order to evaluate the quality of the evidence. The strengths and limitations of each included article have been identified and listed in Appendix 1. Several common methodological issues were identified through a critical appraisal of the literature. In this section the discussion will focus on the methodological limitations of the studies, the geographical context of the literature and the fragmented meaning of the clinical mentoring experience as described in these studies.

2.5.1. Limitations of the studies

All the mixed method studies and quantitative studies included in this review adopted the survey approach as a research design (see Table 2.4). After a critical appraisal of these studies, various methodological limitations were identified which could affect the reliability, validity and representativeness of the evidence produced (Creswell, 2016, 2018; De Vaus, 2014). The discussion about the methodological limitations will be related to the nature of the research designs.

Quantitative Research Design

Sampling is a part of the data collection procedure that facilitates addressing the research question (Creswell, 2018). Inappropriate sampling strategies affected the representativeness and lowered the reliability of the results in several studies (Martínez-Mesa et al., 2016). A quantitative study (Mikkonen et al., 2020a) and three mixed method studies (Gillespie, 2017; McInnes et al., 2015; Newton et al., 2017) did not provide sufficient information about sampling to adequately appraise the appropriateness of their sampling strategies. Warne et al. (2010) adopted purposive sampling that was inappropriate in a quantitative survey. According to the information available, two major sampling issues were identified, namely weak sampling methods and low response rates. A summary of the identified quantitative and mixed method studies with the sampling issues identified is provided in Table 2.8. These sampling issues then resulted in the low level of generalisability of these studies.

Name of Study (In Chronological Order)	Methodology	Sampling Method	Sample Size
Warne et al. (2010)	Cross-sectional survey	Purposive sampling	1903 pre-registration nursing students
Gidman et al. (2011)	Mixed method study (Stage 1: Survey)	Convenience sampling	2 groups 174 first year students, 98 final year students
Skaalvik et al. (2011)	Cross-sectional survey	Convenience sampling	511 nursing students
Courtney-Pratt et al. (2012)	Mixed method study (Survey)	Convenience sampling	163 ward nurses, 22 clinical facilitators, 178 second year undergraduate students
Stayt and Merriman (2013)	Cross-sectional survey	Convenience sampling	421 undergraduate students
Helminen et al. (2014)	Survey	Convenience sampling	276 nursing students, 108 nursing teachers and 225 CMs
McIntosh et al. (2014)	Mixed method study (Stage 1: survey)	Convenience sampling	61 CMs
Rooke (2014)	Evaluation survey	Convenience sampling	114 RNs and midwives in phase 1, 37 RNs and midwives in phase 2, 13 nursing lecturers in phase 3
Dimitriadou et al. (2015)	Correlation survey	Convenience Sampling	357 second year undergraduate students
Foster et al. (2015)	Mixed method study (Stage 2: online survey)	Convenience Sampling	Stage 2: 53 nursing students
McInnes et al. (2015)	Mixed method study (Stage 2: survey)	Sampling methods not specified	45 pre-registration nursing students, 22 primary care RN mentors
Skela-Savič and Kiger (2015)	Survey	Convenience Sampling	143 CMs
Antohe et al. (2016)	Online survey	Convenience Sampling	418 nursing students

Dahlke et al. (2016)	Mixed method survey	Convenience Sampling	15 clinical faculty, 17 preceptors
Fuentes-Pumarola et al. (2016)	Mixed method study (Stage 1: survey)	Convenience Sampling	Stage 1: 163 fourth year undergraduate nursing students
Gale et al. (2016)	Online survey	Convenience Sampling	9 nursing students
Kajander-Unkuri et al. (2016)	Comparative survey	Convenience Sampling	42 student-mentor pairs
McCallum et al. (2016)	Mixed method survey	Convenience Sampling	216 students, 39 CMs
Papastavrou et al. (2016)	Descriptive correlational survey	Convenience Sampling	463 undergraduate nursing students
Gillespie (2017)	Mixed method study (Survey)	Sampling method not specified	Survey: 122 student nurses
Newton et al. (2017)	Mixed method study (Stage 3: survey)	Sampling method not specified	Stage 3: 30 sign-off mentors
Palese et al. (2017)	Mixed method study (Stage 1: survey)	Convenience Sampling	352 nursing students
Jack et al. (2018)	Mixed method survey (Stage 1: online survey)	Convenience Sampling	1452 undergraduate nursing students
Mikkonen et al. (2020b)	Cross-sectional survey	Convenience Sampling	1360 mentors
Mikkonen et al. (2020a)	Cross-sectional survey	The sample was selected through a structural equation model. Details of the selecting process was unavailable	187 nursing students

Table 2.8: Summary of the identified quantitative and mixed method studies with sampling issues

Weak sampling methods were commonly found in the quantitative studies and the quantitative phase of the mixed method studies. All of the studies identified as having sampling issues were surveys. The vast majority (21 studies as listed in Table 2.7) adopted a

convenience sampling method to recruit respondents. Convenience sampling is seen as the weakest sampling method used in surveys (De Vaus, 2014). Jager et al. (2017) reported that convenience sampling had lower generalisability in comparison to probability sampling, as it is difficult to estimate the level of error in the sample (De Vaus, 2014). Low generalisability meant that the findings of these studies were more likely to be biased, and therefore may be less capable of application to a wider population (Jager et al., 2017).

In contrast, only two of the 28 quantitative and mixed method studies adopted random sampling (Kaphagawani and Useh, 2018; Tuomikoski et al., 2018). Random sampling is able to recruit respondents that are more likely to represent the true population figure (De Vaus, 2014). This means that the findings of studies that adopt random sampling can be generalisable to the target population. Kaphagawani and Useh (2018) is the only study which described their random sampling process. Tuomikoski et al. (2018) used random sampling, however, generalisability is still in doubt due to the limited information about the randomisation process.

Apart from problems with the sampling methods, the response rate for these studies varied, ranging from 6.7% to 98%. The response rate is closely related to the validity and reliability of study (De Vaus, 2014). Eight of the 28 studies did not specify the response rate of the surveys (Dahlke et al., 2016; Gidman et al., 2011; Gillespie, 2017; Jack et al., 2018; Levett-Jones et al., 2009; McInnes et al., 2015; Rylance et al., 2017; Warne et al., 2010): making it difficult to evaluate the validity and generalisability of these eight studies. In addition, half of the studies had response rates lower than 60%. The low response rates resulted in a smaller sample size that could lead to biased findings (De Vaus, 2014). The risk of biased

findings is related to possible differences in the characteristics of non-responders (Berg, 2005). For example, non-responders could refuse to participate in the studies due to their lack of interest. The findings of studies with low response rates can then reflect partial perspectives, not reflecting the true population (Berg, 2005), which ultimately lowers the validity of the study. Even though four studies reported response rates of over 70%, three of the studies had comparatively small sample sizes that ranged from 13 to 276 (Helminen et al., 2014; Kajander-Unkuri et al., 2016; Rooke, 2014). The representativeness of a sample is affected by the strength of the sampling strategy and adequacy of the response rate, which ultimately affects the characteristics of the sample (Berg, 2005). Hence, it is difficult to judge the representativeness and validity of many of these studies.

The representativeness of a sample is also related to the characteristics of the respondents, such as the field and year of study that the nursing students belonged to. Among the countries in which the studies were conducted, most countries did not have the field specific nursing curriculum used in the UK. 39 out of 48 studies did not specify the field of nursing education studied. 11 of these 39 studies were conducted in the UK. Only nine out of the 48 studies provided information about the field of nursing that the students were engaged in. These studies were conducted in the UK and included four studies specifically for the adult nursing field and five studies which included all fields. No studies were specifically conducted for students in mental health nursing, children's nursing and learning disability nursing. As most countries provided general nursing education in pre-registration training, the findings of the current literature were sufficient to reflect the current situation in clinical mentoring in these countries. Year of study was another characteristic of respondents that could affect the representativeness of the studies. 33 studies recruited

students as respondents. Of these, 16 studies did not provide any information about their respondents' year of studies. Six studies recruited students in different years of study, while nine studies recruited students from a specific year of study. Students in different years of study achieved different goals in different clinical placements. For example, final year students were preparing themselves for practice while more junior students were expected to achieve varying levels of clinical competency (Morrell and Ridgway, 2014). Hence, the students' year of study facilitated the understanding of the clinical mentoring experience throughout the period of study. The findings of the current studies were not sufficient to illustrate the difference in clinical mentoring experience of different years of study. A summary of the year of studies and the field of a curriculum is presented in Table 2.9.

Name of Study (In Chronological Order)	Students' Year of Study	Field of Curriculum
Levett-Jones et al. (2009)	Third Year	Not Specified
Bradbury-Jones et al. (2010)	First Year	Not Specified
Warne et al. (2010)	Not Specified	Not Specified
Allan et al. (2011)	Not Specified	Not Specified
Gidman et al. (2011)	First year & third year	Adult Nursing
Jokelainen et al. (2011b)	Not Specified	Not Specified
Skaalvik et al. (2011)	Across all years of study	Not Specified
Courtney-Pratt et al. (2012)	Second Year	Not Specified
Coyne and Needham (2012)	Not Specified	Not Specified
Halcomb et al. (2012)	Not applicable. Respondents were CMs	Not Specified
Hasson et al. (2013)	Not applicable. Respondents were HCA	Not Specified
Jokelainen et al. (2013)	Not applicable. Respondents were CMs	Not Specified
Peters et al. (2013)	Not applicable. Respondents were CMs	Not Specified
Stayt and Merriman (2013)	Across all years of study	Not Specified
Annear et al. (2014)	Second Year	Not Specified
Black et al. (2014)	Not applicable. Respondents were CMs	Across all fields of curriculum
Helminen et al. (2014)	Not Specified	Not Specified

McIntosh et al. (2014)	Not Specified	Adult Nursing
Morrell and Ridgway (2014)	Not Specified	Adult Nursing
Rooke (2014)	Not applicable. Respondents were CMs	Not Specified
Wilson (2014)	Not applicable. Respondents were CMs	Not Specified
Dimitriadou et al. (2015)	Second Year	Not Specified
Foster et al. (2015)	Third Year	Not Specified
McInnes et al. (2015)	Not Specified. Pre-registration Master Students	Not Specified
Sinclair et al. (2015)	No Respondent Recruited	Not Specified
Skela-Savič and Kiger (2015)	Not applicable. Respondents were CMs	Not Specified
Antohe et al. (2016)	Not Specified	Not Specified
Dahlke et al. (2016)	Not applicable. Respondents were CMs and nurse educators	Not Specified
Dobrowolska et al. (2016)	Not applicable. Respondents were nurse educators	Not Specified
Fuentes-Pumarola et al. (2016)	Fourth Year	Not Specified
Gale et al. (2016)	Not Specified	Not Specified
Hunt et al. (2016)	Not applicable. Respondents were CMs	Across all fields of curriculum
Kajander-Unkuri et al. (2016)	Not Specified	Not Specified
McCallum et al. (2016)	First Year	Not Specified
Papastavrou et al. (2016)	Not Specified	Not Specified
Gillespie (2017)	Not Specified	Not Specified
Newton et al. (2017)	Not Specified	Not Specified
Palese et al. (2017)	Across all years of study	Not Specified
Rylance et al. (2017)	Not applicable. Respondents were CMs	Across all fields of curriculum
Thomson et al. (2017)	Fourth Year	Not Specified
Adamson et al. (2018)	Across all years of study	Not Specified
Jack et al. (2018)	Not Specified	Not Specified
Kaphagawani and Useh (2018)	Across all years of study	Not Specified
Tuomikoski et al. (2018)	Not applicable. Respondents were CMs	Not Specified
Bowen et al. (2019)	Not applicable. Respondents were CMs	Not Specified
Liang et al. (2019)	Not Specified	Not Specified
Mikkonen et al. (2020b)	Not applicable. Respondents were CMs	Not Specified
Mikkonen et al. (2020a)	Not Specified	Not Specified

Table 2.9: Summary of the characteristics of respondents of the included studies

Issues related to the Data Collection Tools

As the majority of the studies adopted a survey as the research design the questionnaire was the main data collection tool used in these studies. The validity and reliability of questionnaires determines the tendency towards error and bias in a study (De Vaus, 2014). A summary of validity and reliability of the questionnaires adopted by the included studies is illustrated in Table 2.10. However, 24 studies did not provide any information about the validity of the questionnaires adopted. Only nine studies adopted questionnaires with a high Cronbach's Alpha score, meaning that these questionnaires had high reliability. None of these studies provided information about the validity of the questionnaires adopted. Only four studies provided information on validation and these had conducted expert reviews of the questionnaires to ensure the content validity. The assessment of content validity was based on a subjective evaluation by an expert panel (Martinez, 2017). The process of expert panel review was not described in the literature and is a weaker form of validity. The rest of the studies did not provide any information about the validity and reliability of their questionnaires. Due to insufficient information, it is difficult to assess the validity and reliability of the questionnaires used.

Name of Study (In Chronological Order)	Questionnaire Adopted	Validity of Questionnaire Adopted	Reliability of Questionnaire Adopted
Levett-Jones et al. (2009)	No information provided	Not Available	Not Available
Warne et al. (2010)	Clinical Learning Environment, Supervision and Nursing Teacher (CLES+T)	Not Available	Cronbach's Alpha score ranged from 0.83 to 0.96
Gidman et al. (2011)	Self-developed Questionnaire	Not Available	Not Available

Skaalvik et al. (2011)	Clinical Learning Environment, Supervision and Nursing Teacher (CLES+T)	Not Available	Not Available
Courtney-Pratt et al. (2012)	Modified Quality Clinical Placement Inventory (QCPI)	Reviewed by expert panel	Not Available
Stayt and Merriman (2013)	Self-developed Questionnaire	Not Available	Not Available
Helminen et al. (2014)	Self-developed Questionnaire	Validated by 5 expert panel groups	Not Available
McIntosh et al. (2014)	Self-developed Questionnaire	Not Available	Not Available
Rooke (2014)	Self-developed Questionnaire	Not Available	Not Available
Dimitriadou et al. (2015)	Clinical Learning Environment, Supervision and Nursing Teacher (CLES+T)	Not Available	Cronbach's Alpha score ranged from 0.82 to 0.96
Foster et al. (2015)	Self-developed Questionnaire	Not Available	Not Available
McInnes et al. (2015)	Clinical Learning Environment Inventory 19 (CLEI-19) Quality Clinical Placement Inventory (QCPI)	Reviewed by expert panel	Cronbach's Alpha score of CLEI-19 ranged from 0.92 to 0.94 Cronbach's Alpha score of QCPI 0.955
Skela-Savič and Kiger (2015)	Self-developed Questionnaire	Not Available	Cronbach's Alpha score ranged from 0.78 to 0.828
Antohe et al. (2016)	Clinical Learning Environment, Supervision and Nursing Teacher (CLES+T)	Not Available	Cronbach's Alpha score ranged from 0.85 to 0.95
Dahlke et al. (2016)	Self-developed Questionnaire	Not Available	Cronbach's Alpha score 0.881
Fuentes-Pumarola et al. (2016)	Self-developed Questionnaire	Not Available	Not Available
Gale et al. (2016)	Self-developed Questionnaire	Not Available	Not Available
Kajander-Unkuri et al. (2016)	Nurse Competence Scale (NSC)	Reviewed by expert panel	Cronbach's Alpha score of NSC ranged from 0.84 to 0.93

	Command of Nursing Function		Cronbach's Alpha score of Command of Nursing Function ranged from 0.87 to 0.94
McCallum et al. (2016)	Self-developed Questionnaire	Not Available	Not Available
Papastavrou et al. (2016)	Clinical Learning Environment, Supervision and Nursing Teacher (CLES+T)	Not Available	Cronbach's Alpha score ranged from 0.82 to 0.96
Gillespie (2017)	Self-developed Questionnaire	Not Available	Not Available
Newton et al. (2017)	Self-developed Questionnaire	Reviewed by three experts	Not Available
Palese et al. (2017)	Self-developed Questionnaire	Not Available	Not Available
Rylance et al. (2017)	Self-developed Questionnaire	Not Available	Not Available
Jack et al. (2018)	Self-developed Questionnaire	Not Available	Not Available
Kaphagawani and Useh (2018)	Self-developed Questionnaire	Not Available	Cronbach's Alpha score 0.8
Tuomikoski et al. (2018)	Mentors' Competence Instrument	Not Available	Cronbach's Alpha score ranged from 0.83 to 0.94
Mikkonen et al. (2020b)	Modified Mentors' Competence Instrument	Not Available	Cronbach's Alpha score ranged from 0.83 to 0.94

Table 2.10: Summary of the strategies used to ensure the validity and reliability of the questionnaires

Qualitative Research Design

The qualitative studies and qualitative arms of the mixed method studies included in this review were assessed for trustworthiness. According to Lincoln et al. (1985), four criteria are adopted to assess trustworthiness, namely credibility, transferability, dependability and confirmability. Limitations in credibility were identified. Similar to the quantitative research design, the studies with a qualitative design also had sampling issues that resulted in

limitations in credibility. Three qualitative studies (Allan et al., 2011; Jokelainen et al., 2013; Rylance et al., 2017) and three mixed method studies (Kaphagawani and Useh, 2018; Gillespie, 2017; Newton et al., 2017) did not provide any information about sampling. Convenience sampling was also adopted in two of the qualitative studies (Coyne and Needham, 2012; Halcomb et al., 2012) and the qualitative phases of the two mixed method studies in recruiting participants for interviews (Foster et al., 2015; Fuentes-Pumarola et al., 2016). The use of convenience sampling in qualitative studies is less likely to identify the participants who have provided rich data related to phenomenon (Creswell and Poth, 2018). This can lead to superficial data which could then lower the credibility of the research (Mason, 2002). For mixed method studies, Creswell (2018) also suggested that purposive sampling was more appropriate to identify participants who “had experience of the central phenomenon” (p. 269). Hence, the credibility of these studies was limited due to the inappropriate sampling methods. Although the above-mentioned studies had a lower credibility due to the sampling issue, nine qualitative studies (Adamson et al., 2018; Annear et al., 2014; Black et al., 2014; Bowen et al., 2019; Bradbury-Jones et al., 2010; Hasson et al., 2013; Jokelainen et al., 2011b; Morrell and Ridgway, 2014; Thomson et al., 2017) and two mixed method studies adopted purposive sampling to ensure credibility.

The credibility of the qualitative data produced in the mixed methods studies could have been affected by the construction of the open-ended questions used in questionnaires. Four mixed method studies used self-administered structured questionnaires that included open-ended questions (Courtney-Pratt et al., 2012; Dahlke et al., 2016; McCallum et al., 2016; Foster et al., 2015). Courtney-Pratt et al. (2012) and Dahlke et al. (2016) used one to two open-ended questions to ask respondents for comments about their overall clinical

placement experiences, and the support and challenges in clinical placements. The other two studies did not provide any information about whether they used any open-ended questions (Foster et al., 2015; McCallum et al., 2016). In consideration of the quantity and the context of open-ended questions, the respondents may not be able to provide in-depth responses and researchers may be unable to clarify their responses if a response is unclear. No description of how the responses to open ended questions were analysed was provided in Foster et al. (2015) or McCallum et al. (2016), making the richness and credibility of the qualitative data presented from these studies questionable. It is difficult to judge how the qualitative data enriched the findings of these quantitative surveys.

Qualitative data was also generated through either individual face-to-face interviews or focus group interviews. Mixed method studies in this review tended to use focus group interviews, while the majority of the qualitative studies adopted individual face-to-face interviews. Most of these studies did not provide any information about the interview topic guide used. Only three qualitative studies (Halcomb et al., 2012; Hasson et al., 2013; Liang et al., 2019) and a mixed method study (Levett-Jones et al., 2009) provided detailed information about their interview guides. The interview guide showed what these researchers had explored in these studies (Mason, 2002). In addition, how these interviews were conducted was not adequately described (Halcomb et al., 2012; Hasson et al., 2013; Levett-Jones et al., 2009; Liang et al., 2019). Hence, it is difficult to assess the credibility of these studies due to insufficient information on the data collection methods. Other than Foster et al. (2015) and McCallum et al. (2016), all the qualitative studies and mixed method studies that used either individual interviews or focused group interviews provided clear descriptions about the data analysis processes. These descriptions provided evidence of an

audit trail of the analysis process and partially ensured the credibility of these studies (Creswell and Poth, 2018; Mason, 2002).

Transferability of these studies was also in doubt. As mentioned earlier in this section, two qualitative studies did not provide any information about their sampling method (Allan et al., 2011; Jokelainen et al., 2011b). Some studies had weak sampling methods such as convenience sampling (Coynne and Needham, 2012; Halcomb et al., 2012; Liang et al., 2019). The use of less appropriate sampling methods resulted in less transferable findings. Apart from the use of appropriate sampling methods, thick description, both of the context and of participants, can facilitate the assessment of transferability (Lincoln et al., 1985). Most studies provided only a brief description of the context of the studies and the demographic characteristics of the participants. Thus, weak sampling methods and a lack of thick description reflected the low transferability of these studies (Polit and Beck, 2010).

The dependability and confirmability of these studies was also difficult to assess. Lincoln et al. (1985) suggested that the dependability of the studies relied on their credibility. It depends on the reader being able to audit the studies. As discussed in the discussion of credibility, most of the qualitative studies and mixed method studies did not provide sufficient information about various stages of their research process, including the sampling, data collection and data analysis. It is thus difficult to establish a “stepwise replication” and to examine the dependability of these studies (Lincoln et al., 1985). A similar issue also affected the assessment of confirmability. Most of these studies claimed that they had adopted a thematic analysis for the data analysis. Some of the exploratory qualitative studies and phenomenological studies were able to outline the clinical experiences in a

specialty area and the mentoring relationships through thematic analysis (Allan et al., 2011; Annear et al., 2014; Black et al., 2014; Bradbury-Jones et al., 2010; Coyne and Needham, 2012; Halcomb et al., 2012; Peters et al., 2013; Wilson, 2014). Other phenomenological studies also adopted a coherent data analysis method to capture the meaning of the clinical experiences (Black et al., 2014; Bradbury-Jones et al., 2010; Jokelainen et al., 2011b; Morrell and Ridgway, 2014). However, the description of the process used for the development of themes was lacking (Lincoln et al., 1985). Hence, it was difficult to evaluate whether the themes derived fully represented the data. All qualitative studies and mixed method studies provided illustrative quotes but all mixed method studies were unable to present the data in detail. The methodological limitations of these qualitative studies and mixed method studies as identified above thus lower the trustworthiness of the evidence from these studies.

Several methodological limitations were found in the included studies. This reflected how the quality of these included studies was less satisfactory and further implied that these studies were inadequate to robustly address the review question on the experiences of clinical mentoring. Methodological limitations were not the only factor that caused the literature to be unable to address the review question. The geographical context of the included literature also provided limited information about clinical mentoring as these studies were predominantly conducted in the context of clinical mentoring in Europe and Australia.

2.5.2. The geographical context of the literature

As reported in section 2.3, 27 of the 68 articles included in the review were purely related to clinical mentoring in the context of the United Kingdom. This included 21 research articles

(see Table 2.5) and six discussion articles (see Table 2.6). Another 17 research studies were conducted in various European countries. This meant that the majority of the literature included illustrations from clinical mentoring experiences in European nursing education settings since both the UK and the other European countries followed the rules laid out in the EU Nursing Directive on nurse education (World Health Organization, 2009). The rest of the literature was related to clinical mentoring in Australia and North America, apart from one research study conducted in Taiwan (Liang et al., 2019). Although this was the only piece of research conducted in the context of there being Chinese nursing students, it was an evaluation study of a resilience programme in a clinical placement for Taiwan nursing students (Liang et al., 2019). This study thus had only limited coverage of clinical mentoring experience generally. Thus, most of the studies reflected the context and culture of clinical mentoring in nursing in more economically developed European and Pacific countries. Mikkonen et al. (2020b) found in a cross-sectional survey in Finland, that the mentoring relationship was influenced by the cultural background of nursing students. Thus, the findings may have limited applicability to clinical mentoring outside European, American and Australian nursing settings and students.

2.5.3. The fragmented meaning of clinical mentoring experience

According to the current literature, mentoring experiences in nursing clinical placements not only involved CMs and students, but was also influenced by other healthcare workers, management and nurse educators. The mentoring experience could be viewed on two levels. CMs and students constructed the core of the mentoring experience through continuous engagement in three mentoring activities. However, there is not sufficient

evidence to show how students learn through these mentoring activities and how these mentoring activities had occurred concurrently in Clinical mentoring. Several studies found that the characteristics of CMs influenced how they performed their roles in mentoring (Dahlke et al., 2016; Halcomb et al., 2012; Jack et al., 2018; McInnes et al., 2015; Rebeiro et al., 2015; Warren, 2010; Wilson, 2014). However, no evidence about the influence of the characteristics of students on mentoring experiences was reported. How students' personal characteristics, such as personality and attitude, influenced their role in mentoring remains unknown.

The mentoring activities in clinical placements served as the context of the mentoring experiences. The context of the mentoring experiences was influenced by various factors, such as the clinical settings (Dahlke et al., 2016; Fuentes-Pumarola et al., 2016; Gillespie, 2017; Jokelainen et al., 2011b; McCallum et al., 2016; McInnes et al., 2015; Skaalvik et al., 2011), the co-workers of the CMs (Hasson et al., 2013; McInnes et al., 2015), the workload of the CMs (Bowen et al., 2019; Rooke, 2014; Stayt and Merriman, 2013) and the working atmosphere of clinical areas (Coyne and Needham, 2012; Jack et al., 2018; Levett-Jones et al., 2009). The above-mentioned factors constructed the mentoring environment for the CMs and students. Factors influencing clinical mentoring were controlled by clinical management and nurse educators. They influenced both the context of the mentoring experiences and the core mentoring experiences. This meant that the environment for clinical mentoring was co-constructed by hospitals and nursing institutions. However, how the environment influenced clinical mentoring was unclear. Several contradictory and unclear findings were identified in relation to delegated mentoring roles performed by other

healthcare workers and types of mentoring (Antohe et al., 2016; Dimitriadou et al., 2015; Hasson et al., 2013; McInnes et al., 2015).

As discussed above, the core mentoring experience and the context of the mentoring experiences, integrated and reflected the current understandings of mentoring experiences. The literature showed that a mentoring experience was based on various interactions between the personnel involved in a clinical placement and the environment. However, the investigations of mentoring experiences were based on personal experiences only. The personal experiences of mentoring were reported by CMs, students, other healthcare workers, management or educators; thus, they represented only single perspectives of mentoring experiences. The single perspectives from the personnel involved in clinical mentoring are difficult to use to illustrate the complete picture of the various interactions within clinical mentoring.

In addition, findings from single perspectives could also be misleading. For example, mentors' reported failures to fail students. This phenomenon was reported in discussion papers by nurse educators only (Casey and Clark, 2011; Timmins et al., 2017; Vinales, 2015a). Other studies revealed the difficulties of failing students encountered by CMs (Black et al., 2014), while Kajander-Unkuri et al. (2016) illustrated the discrepancy in the ratings of performances between CMs and students. These findings have shown a confusing picture about the implementation of assessment. A similar phenomenon was also found in relation to the findings on supervision and feedback. The literature thus illustrated the fragmented meaning of the clinical mentoring experience, which was also related to the focus of the studies included and the diverging views of different groups of participants. The studies included were unable to provide a holistic view of clinical mentoring experience.

In some studies, CMs and students were asked to rate and comment on their previous experiences in clinical placements through surveys and interviews. The quantitative studies included in this review focused on the post-hoc rating of clinical mentoring experiences, whereas the qualitative studies focused on the description of various roles in clinical mentoring, the support provided and the challenges encountered during mentoring. However, clinical mentoring is an ongoing process conducted throughout the period of clinical placements. The findings of the current literature were unable to explore the interactions and the process of clinical mentoring at different time periods in clinical placements and thus were inadequate in fully addressing the review question.

2.6. Summary and conclusion

This scoping review was conducted to explore the evidence on CMs' and undergraduate nursing students' experiences of clinical mentoring. Several themes were identified from the literature included, namely describing clinical mentoring activities, the roles of students and CMs, various factors influencing clinical mentoring and the rewards from clinical mentoring. An evaluation of the methodological quality of the included literature was also conducted in line with the process used in a scoping review (Arksey and O'Malley, 2005). Three knowledge gaps were identified where the evidence was insufficient to address the review question. Firstly, the methodologies used in some of the studies included were limited in their adequacy to address the review question. The quantitative studies and the quantitative arm of the mixed method studies had limitations in sampling, response rates and data collection tools that lowered the reliability and validity of findings. Similar limitations were also found in some qualitative studies and the qualitative arm of the mixed

method studies. The inappropriate use of sampling methods and lack of information about data collection and data analysis lower the trustworthiness of these studies. Secondly, the included literature almost exclusively focused on clinical mentoring in the UK and European Countries. The nursing education system in these countries shared a similar context as they followed the guidelines set by the European Union. Only one study was conducted in Asia and none in Africa or China, so the literature may not be generalisable to these settings. Thirdly, the findings of the current studies considered clinical mentoring primarily as a one way and one-off teaching event. Interactions in the process of clinical mentoring throughout clinical placements were ignored in the literature. To conclude, more research is needed to fully explore CMs' and undergraduate nursing students' experiences of clinical mentoring in its organisational context. In order to address these limitations future studies should include multiple perspectives to explore the ongoing process of clinical mentoring in nursing clinical placements. In the next chapter the research aim and methodology of the proposed study will be discussed.

3. Methodology and Research Methods

3.1. Introduction

The literature review has revealed that the process of clinical mentoring of preregistration nursing students is constructed through the interaction between the different personnel involved in clinical placements, including students, CMs, nurse educators and hospital management. As discussed in Chapter 2, the evidence from the current literature provided a fragmented and incomplete picture of the clinical mentoring of preregistration nursing student experience. Previous studies were based on the single perspectives of different groups of personnel involved in clinical mentoring. The literature has thus been unable to fully illustrate the complex, dynamic and multi-faceted process of clinical mentoring. In order to explore the multiple viewpoints on the process of clinical mentoring of key stakeholders, a qualitative research design is more appropriate for examining the varying perceptions of mentoring held by the key personnel involved in clinical placements (Creswell and Poth, 2018; Denzin and Lincoln, 2017). Hence, a constructivist grounded theory study was conducted to gain a better understanding of the mentoring process from various perspectives of the people involved in the process. This chapter will outline the aim and objectives, methodology and research methods adopted in this study.

3.2. Research aim and objectives

This study aimed to explore the social process of clinical mentoring involving CMs, pre-registration nursing students and the organisations involved during clinical placements. In order to achieve the research aim, the objectives for this study are as follows:

- To describe the process of mentoring in clinical placements in pre-registration nursing courses

- To explore the roles of personnel involved in clinical placements in pre-registration nursing courses
- To explore the organisational involvement in clinical placements in pre-registration nursing courses
- To explore the perceived impact of clinical mentoring from the perspectives of the personnel involved in clinical placements

3.3. Qualitative research design

A qualitative research design was adopted in this study. The justification for adopting a qualitative research design was related to the complexity and social and contextual aspects of the phenomenon. The evidence from the literature review showed that mentoring in clinical placements was a dynamic process that involved interpersonal interactions. However, only parts of the process were described in the literature. The complexity of the mentoring process in a clinical placement is influenced by multiple factors, such as the organisational context and cultural factors. 14 studies identified in literature review were quantitative surveys; the scope of these studies was narrow and the findings most often superficial. Thus, they were unable to illustrate the in-depth meaning of mentorship as a social process or the complex relationships between various organisational and cultural factors which affect the mentoring process. The studies were ultimately unable to provide a clear analysis of the interactional process of mentoring in a clinical placement or the factors affecting mentorship as a social process. Quantitative research design, therefore, was not suitable for addressing the research aim and objectives. A qualitative research design is more appropriate for exploring the meaning and complex dimensions of social reality (Creswell, 2016, Mason, 2002). The choice of a specific qualitative methodology was then

based on the researcher's position on the philosophical assumptions and theoretical perspectives on the studied phenomenon.

3.4. Philosophical assumptions and theoretical perspectives

The philosophical assumptions and theoretical perspectives underpinning a study serve as the framework for the study and provide direction for choosing a suitable methodology to address the research aim and objectives (Creswell, 2016). The philosophical assumptions adopted in this study involved ontological, epistemological and theoretical perspectives (Creswell, 2016; Mason, 2002). These perspectives are closely linked together and guide how the researcher views a studied phenomenon and develops research strategies (Creswell, 2016). In this section, I will illustrate the ontological, epistemological, and theoretical perspective of this study and the methodology chosen through the consideration of these perspectives.

3.4.1. Ontological perspective

The ontological perspective refers to beliefs about the nature and characteristics of social reality (Creswell, 2016; Mason, 2002). Based on my background as a nurse educator and experience in mentoring, I believe that the reality of mentoring is constructed by multiple subjective views of the groups and individuals involved in the mentoring process (Levers, 2013). This belief is aligned with the nature of clinical mentoring described in previous studies. According to the previous literature, mentoring in a clinical placement is comprised of personal experiences, feelings, beliefs, actions and the organisational environment. The components of clinical mentoring are created by the individuals who are involved in mentoring. The meanings of these components are varied as individuals have different

perceptions of these components. This means that the reality of mentoring in clinical placements is reflected through multiple understandings (Levers, 2013; Mills et al., 2006). This then influenced the epistemology of this study.

3.4.2. Epistemological perspective

The epistemological stance refers to the method used to know about the studied phenomenon (Creswell, 2016). Due to the nature of mentoring in a clinical placement, subjectivism was adopted as the epistemological position to explore this. Subjectivism refers to a philosophical belief that the inquirer and inquired co-construct the understanding of the reality (Denzin and Lincoln, 2011). Mentoring in clinical placements served as a social reality where the actors, such as the CMs and students, interact with each other under the influence of various organisational contexts (Denzin and Lincoln, 2011). The interaction between personnel and organisations is influenced by the perceptions of the personnel involved. Thus the knowledge of mentoring in clinical placements could only be illustrated through language and observation (Levers, 2013). I was able to gain understanding of the subjective experience of mentoring in clinical placements through interaction with the participants. In addition, I was able to observe and be partially involved in the action and interaction of clinical mentoring through my identity as a nurse educator. These subjective data facilitated my exploration of the process of mentoring in clinical placements (Levers, 2013).

3.4.3. Theoretical perspectives

Theoretical perspectives serve as “a philosophical stance informing the methodology” (Crotty, 1998, p. 3). Symbolic interactionism was adopted as the theoretical perspective in

this study. Symbolic interactionism is concerned with the nature of human social interaction (Blumer, 1969; Dennis and Smith, 2015). In symbolic interactionism the nature of human social interaction is based on the following three premises: “(1) human beings act toward things on the basis of meanings, (2) these meanings arise in social interaction; and (3) conveying and changing meanings demands that people define and interpret situations” (Dennis and Smith, 2015, p. 352). The meanings of reality and acts of people vary from time to time as people interpret the meaning of reality differently in different social contexts. Hence, human social interaction is dynamic. This theoretical perspective is consistent with the description of mentoring in clinical placements in the previous literature. Mentoring in clinical placements was thus viewed as being constructed by interactions between people within specific organisational environments. To gain an understanding of such interactions, I needed to explore the process of mentoring in clinical placements through the perspectives of the various actors involved in clinical mentorship. Due to the complexity of the mentoring process in a clinical placement, it was essential to explore individual experiences of clinical mentoring and interpret the meanings created by the personnel involved through their experiences. The logic of symbolic interactionism is compatible with the ontological, the epistemological perspectives and the aim of this study. Different qualitative methodologies including phenomenology, case study and were considered. Phenomenology is a type of research design which explore a phenomenon through one’s lived experience and aim at developing a description of the phenomenon (Creswell, 2012; Sokolowski, 2000; Starks and Brown Trinidad, 2007) while case study aim at providing in-depth understanding of cases (Creswell and Poth, 2018). The result of both phenomenological research and case study could be difficult to explore the process of clinical mentoring and unable to develop explanation for such process. These two methodologies were insufficient to achieve the aim

of this study. Under a qualitative research design, symbolic interactionism is associated with grounded theory research design, which will be discussed in the next section.

3.4.4. Grounded theory

Grounded theory originated in sociology (Starks and Brown Trinidad, 2007). It is a method that attempts to explore the social process and interactions in generating knowledge and a theory about reality (Charmaz, 2014; Glaser and Strauss, 1967; Starks and Brown Trinidad, 2007; Suddaby, 2006). In order to develop the explanation, the research design emphasises a continued interpretative process and construction of the meanings and concepts that reflect reality (Suddaby, 2006). Therefore, an explanatory theory of the social process is developed through examining the concepts grounded in the data (Charmaz, 2014; Starks and Brown Trinidad, 2007). Starks and Brown Trinidad (2007) suggested that the result of grounded theory research can benefit clinicians, practitioners and researchers, as developing an explanation of a social process can facilitate the development of interventions to improve the social process. There was a need for a more in-depth understanding of how mentoring in clinical placements occurred and the factors affecting mentoring in clinical placements. Therefore, grounded theory was adopted in this study.

3.4.4.1. Choosing constructivist grounded theory

Grounded theory was first developed by Glaser and Strauss in 1967 (Glaser and Strauss, 1967; Suddaby, 2006). The methodology of grounded theory was further developed into three approaches, the Glaserian approach, the Straussian approach and the Charmazian constructivist grounded theory approach. These three approaches shared similar research strategies, including simultaneous data collection and data analysis, the constant

comparative method and theoretical sampling. The choice of the grounded theory approach in this study was based on the philosophical assumptions of these approaches.

Both the Glaserian and Straussian approaches have a similar ontological stance (Heath and Cowley, 2004) as they both adopted post-positivism (Levers, 2013; Mills et al., 2006). Post-positivists assume social reality exists independently of human beings (Annells, 1996; Denzin and Lincoln, 2011; Levers, 2013). Researchers should remain neutral and serve as passive observers when they discover the phenomenon (Bryant and Charmaz, 2010; Levers, 2013). The methodologies of the Glaserian approach and the Straussian approach were different in terms of epistemology (Heath and Cowley, 2004). Corbin and Strauss (2015) further developed the original grounded theory approach analytic technique from two phases into three phases. These included induction, validation and deduction during the phase of axial coding in the Straussian approach. However, Glaser criticised the new development and suggested that the change in the analytic process may only offer a full conceptual description of the concepts, instead of generating a theory (Glaser, 1992).

The constructivist grounded theory approach had a different ontological stance to the Glaserian and Straussian approaches and takes social constructivism as its theoretical orientation (Charmaz, 2014). Social constructionism refers to a theoretical orientation where social reality is dynamic and constructed by the interaction between individuals (Galbin, 2014). Our understanding of reality is constructed through social interaction in the context of our shared history and culture (Burr, 2003; Galbin, 2014).

Knowledge of reality is dynamic and could be changed by social action (Galbin, 2014). As discussed in Chapter 2, the mentoring experience of CMs and students changed over time.

Mentoring in clinical placements served as a social process that was constructed by the interactions between the people, the environment and organisations. Mentoring in a clinical placement was also historical and culturally specific. The interactions of mentoring in clinical placements varied according to the time and place, as CMs and students engaged in different mentoring activities in different clinical settings throughout the period of clinical placements. Mentoring in clinical placements was also influenced by different cultures, such as the culture of different healthcare occupations and the two types of organisations, including universities and hospitals. As mentoring in a clinical placement served as a social process that involved the subjective meanings of the people involved, it matched the theoretical orientation of a constructivist grounded theory approach in that reality is constructed through social interaction (Charmaz, 2014; Creswell, 2016).

As a nurse educator I have participated in mentoring and clinical assessments during clinical placements. It was impossible for me to explore mentoring in clinical placements without being influenced by the literature and experience. It was less appropriate to adopt the Glaserian approach and the Straussian approach as these two approaches required the researcher to maintain an objective stance which was not feasible and compatible with the ontology of this study. Instead, I needed to make use of my position to participate in interactions to the construct meanings of mentoring in a clinical placement. For these reasons, I adopted the constructivist grounded theory approach in this study.

3.5. Research methods

The research methods adopted in this study were guided by constructivist grounded theory. This involved simultaneous data collection and data analysis, constant comparisons, a

specified coding method, memo writing and theoretical sampling (Charmaz, 2014). This section will outline the sampling method and sample, the data collection method, data analysis, ethical considerations and strategies adopted to demonstrate the rigour of this study.

3.5.1. Sampling method and sample

The sampling method in a qualitative study aims to identify participants who can provide rich information on the phenomenon studied and to enhance the representativeness of the study (Creswell and Poth, 2018; Silverman, 2017). As a constructivist grounded theory approach was adopted in this study, purposive and theoretical sampling was used for the sample selection.

3.5.1.1. Sampling method

The sampling process for this study was first started by recruiting participants through purposive sampling to provide fundamental information on clinical mentoring during a placement (Charmaz, 2014; Creswell and Poth, 2018). Purposive sampling helps to select individuals who can provide rich information related to the study phenomenon (Creswell and Poth, 2018). Potential participants were approached through various means. For example, organisers of clinical placements and CMs/CIs were approached in meetings and mentorship training sessions. Potential student participants were approached in debriefing sessions after they had completed their clinical placements. Three groups of key informants were recruited initially in this study, namely organisers of the clinical placements, CMs/CIs and nursing students. The inclusion criteria for these participant groups are listed in Table 3.1.

Types of Participants	Inclusion Criteria
Organisers of Clinical Placements	Personnel involved in organising clinical placements, including ward managers, hospital management and nursing educators who co-ordinate clinical placements.
CMs/ CIs	<ol style="list-style-type: none"> 1. RNs appointed as clinical mentors by any institution which was accredited by the NCHK 2. RNs employed as CIs by any institution which was accredited by the NCHK 3. The clinical mentors/instructors must have experience of clinical supervision in nursing education.
Nursing Students	<ol style="list-style-type: none"> 1. Nursing students studying in an undergraduate nursing programme in any of the universities in Hong Kong. 2. Nursing students with experience of clinical placements.

Table 3.1: The inclusion criteria for participants in initial recruitment

Initial recruitment started from early June 2016. I first recruited seven participants: three organisers of clinical placements, a CM, two CIs and a student. Data collection and analysis were then conducted concurrently after selecting the initial sample recruitment of participants. I was able to gain a fundamental understanding about the context, such as the involvement of the organisers and the rules of clinical mentoring, and how mentoring was conducted during clinical placements.

After some initial analysis of emerging findings, the initial categories were identified. The next stage of sampling involved theoretical sampling, which is a sampling strategy that facilitates the collection of pertinent data to elaborate and refine the emerging theory (Charmaz, 2014). The criteria for participant recruitment were then adjusted to further explore the understanding of the tentative categories emerging in order to establish a broader theory (Charmaz, 2014; Denzin and Lincoln, 2011). For example, CIs/ CMs and

organisers of clinical placements described their perception of “good students” and “bad students”. Some of the further recruitment of students focused on students with characteristics perceived by mentors as identifying “good students” and “bad students” to explore the views and experiences of these groups of students. Theoretical sampling also focused on the gender of students and CIs/ CMs, the age of the CMs/CIs, ways of managing student performances and the position of the organisers of the clinical placements. These categories further emerged in the subsequent data collection and data analysis. Participants in later interviews frequently mentioned the role of the ward staff in clinical mentoring. Hence, two extra types of participants were included, i. e. healthcare assistants who worked in the clinical settings and RNs who were not eligible to be CMs were theoretically sampled. The characteristics of the participants are presented in the next section.

3.5.1.2. Characteristics of participants

Nineteen participants were recruited for this study. They were classified into four groups, namely organisers of clinical placements, the teaching staff involved in clinical placements, students and ward staff. The breakdown of the participants is presented in Table 3.2. University-based organisers, CIs and nursing students were recruited from a university in Hong Kong, while hospital-based organisers, CMs and ward staff were recruited from various public hospitals in Hong Kong. The details of each group of participants will be introduced separately.

	Number of Participants
Organisers of Clinical Placements	
• Hospital-based Organisers	2
• University-based Organisers	2
Clinical Teaching Staff	
• Clinical Instructors	3
• Clinical Mentors	3
Students	6
Ward Staff	3
Total	19

Table 3.2: Number of participants recruited

Organisers of Clinical Placements

Organisers of clinical placements were responsible for organising and managing clinical placements. Four organisers for clinical placements were interviewed in this study. They were classified into two groups, university-based organisers and hospital-based organisers. Two university-based organisers were recruited from a university in Hong Kong. The hospital-based organisers were recruited from two different public hospitals in Hong Kong. The demographic data of the organisers for clinical placements is presented in Table 3.3.

Code	Age	Gender	Position	Pre-registration nursing education received	Experience in Managing Clinical Placements
O1	31-40	Female	Practicum Coordinator from a university	University	Organised clinical placements for more than 100 times
O2	31-40	Female	Practicum Course Coordinator from a university	University	Organised clinical placements 4 times
O3	31-40	Male	Hospital Coordinator from a public hospital	University	Previous CM Organised clinical placements for more than 100 times
O4	41-50	Female	Ward Manager of rehabilitation setting in a public hospital	Nursing school	Previous practicum coordinator of nursing school Organise clinical placement for more than 100 times

Table 3.3: Demographic data for organisers of clinical placements

Clinical Teaching Staff

Clinical Teaching staff worked within the context of clinical placements. Two types of clinical teaching staff were recruited in this study, namely CIs and CMs. CIs were responsible for group mentoring, while CMs were responsible for individual mentoring. The number of students mentored by the three recruited CIs ranged from 30 to 56. The three CIs working for the university stated that they had not received any training about clinical mentoring beforehand. Three of the CMs recruited in this study were employees of public hospitals and had worked in various clinical settings including an operating theatre, a rehabilitative surgical ward in sub-acute hospitals and a medical ward in acute hospital. The number of students mentored by the three recruited CMs varied from three to more than 100. Similar to the CIs, the three CMs stated that they had received no training for clinical mentoring. The demographic data of the teaching staff for the clinical placements is listed in Table 3.4.

Code	Age	Gender	Position	Pre-registration nursing education received	Working Experience	Experience in Clinical Mentoring
M1	31-40	Female	Advanced practice nurse and CM from an operating theatre	University	13 years	Mentored more than 100 students
M2	31-40	Female	Clinical instructor from a university	University	8 years	Mentored 56 students
M3	41-50	Female	Clinical instructor from a university	Nursing school	20 years	Mentored 50 students
M4	31-40	Female	RN, CM from a surgical ward	University	10 years	Mentored 3 students
M5	31-40	Male	Clinical instructor from a university	University	15 years	Mentored 30 students
M6	21-30	Male	RN for three years, CM from a medical ward	University	3 years	Mentored 4 students

Table 3.4: The demographic data for the teaching staff involved in clinical placements

Nursing Students

Six undergraduate nursing students were recruited in this study. All of them had studied the same curriculum. Three of them were in their fourth year of study. The rest of the students recruited were in their fifth year of study. Only the Year 4 and Year 5 nursing students who were recruited as nursing students from a certain university were required to attend their first clinical placements in their third year of study. As Year 3 students had not completed their clinical placements during the time of the interviews, no Year 3 student was recruited in this study. In addition, Year 4 and Year 5 students had fuller experiences of clinical placements; hence, were more able to provide richer data about clinical mentoring. The demographic data for the nursing students in clinical placements is listed in Table 3.5.

Code	Age	Gender	Year of Study	Number of Clinical Placements Attended	Experience of Clinical Mentoring
S1	21-30	Male	Year 5	2	Individual mentoring only
S2	21-30	Female	Year 4	3	Group mentoring for the first placement and individual for the second placement
S3	21-30	Male	Year 5	3	Individual mentoring only
S4	21-30	Male	Year 4	2 (Poor Performance in first placement)	Group mentoring for the first placement and individual for the second placement
S5	21-30	Female	Year 4	2 (Suspended from second clinical placement)	Group mentoring for the first placement and individual for the second placement
S6	21-30	Female	Year 5	3	Individual mentoring only

Table 3.5: Demographic data for nursing students in the clinical placements

Ward Staff

Three ward staff were recruited in this study, including one junior RN and two healthcare assistants (HCA). Although no official documents from hospitals and the university mentioned the role of ward staff in clinical mentoring, all the ward staff recruited worked on wards with students and served as observers of clinical mentoring and personnel that may have exerted an influence on clinical mentoring. The demographic data for the ward staff from clinical placements is presented in Table 3.6.

Code	Age	Gender	Position	Highest Education Received	Working Experience
W1	21-30	Female	Junior RN in a geriatric rehabilitative setting	Bachelor degree	9 months
W2	41-50	Female	HCA in a cardiology medical ward	Secondary School	18 years
W3	41-50	Female	Junior HCA in a Stroke Unit	Secondary School	1.5 years

Table 3.6: The demographic data for ward staff from clinical placements

After the eligible participants were recruited the data collection process started. The details of the data collection method will be presented in the next section.

3.5.2. Data collection method

Data were collected through two data collection methods. Intensive interviews were adopted as the main data collection method for this study. I engaged in ordinary conversation with eligible participants and listened to the conversations during individual intensive interviews (Lofland and Lofland, 2006). Data is then generated from the natural social interactions through interviews (Lofland and Lofland, 2006). 19 individual intensive interviews were conducted. Apart from the interview data, I also gained access to the official documentation relating to clinical placements through the website of the NCHK, my personal access to the university intranet and from data collecting from the recruited participants working for hospitals. I had access to six documents such as various practicum guidelines and related policy statements. The details of the data collection for these two types of data will be described below.

3.5.2.1. Intensive interview

Intensive interview is a form of interview used in the constructivist grounded theory approach (Charmaz, 2014) and is delivered through individual face-to-face interviews that allow natural social interaction to occur between the researcher and interviewees. The researcher participates in ordinary conversation, listening and observing with sensitivity during the natural social interaction (Charmaz, 2014). The intensive interview loosely guides

the researcher to focus on the research topic, while allowing an interactive space for the researcher to explore participants' substantial experiences (Lofland and Lofland, 2006).

An intensive interview was a suitable method for gathering data in this study in comparison to a focus group interview. Experience of clinical mentoring was considered as being a form of individual biographies. The participants were more comfortable in sharing their experiences of clinical mentoring in individual interviews, especially their negative experiences as they had fewer concerns about confidentiality (Doody et al., 2013). A focus group interview was also less suitable as the data generated from the discussion between participants examine knowledge for a given cultural group and offer a general view on the research topic instead of detailed individual experiences (Atkinson et al., 2000; Doody et al., 2013; Kitzinger, 1995). Due to the above reasons, focused group interviews are unable to explore individual experiences. Hence, an individual intensive interview was adopted. An interview guide was developed before the interview started (see Appendix 2-7).

I developed three sets of initial interview guides for each group of participants (see Appendix 2-7). These guides provided a frame for the intensive interview to guide the exploration of a fundamental understanding of clinical mentoring and to minimise pre-established responses (Charmaz, 2014; Lofland and Lofland, 2006). I outlined several interview questions for each group of participants. The scope of these questions aimed to explore the participants' personal experiences of taking part in clinical mentoring. The interview questions listed in the interview guide were open-ended and reviewed by my supervisors before the initial interviews started. These interview guides were refined intermittently after I had gained the fundamental understanding of mentoring in clinical

placements and had started the theoretical sampling. The refinement of the interview questions was based on the initial results of the data analysis. The refining of interview guides enhanced the emergence of theory which, in turn, facilitated further data collection and enhanced theoretical construction (Charmaz, 2014). For example, destructive feedback was found to be linked to poor impressions. Interview questions related to impressions were then added in the three sets of interview guides and students with perceived characteristics of making poor impressions were invited to be interviewed. The process of refining interview guides was monitored by the supervisors. Feedback and advice were sought from supervisors to refine the interview guides.

The interactional spaces created by an intensive interviews are comprised of ordinary conversations, listening and participant observation (Charmaz, 2014). The ordinary conversations offer intensive interactional spaces to explore the research topic. Listening and observing with sensitivity provides additional information on a participant's language (Lofland and Lofland, 2006). When I listened and observed my participants with sensitivity, I was able to discern cues from their informal communication such as facial expressions, body language and emotions (Creswell and Poth, 2018). These cues obtained from the observations were recorded in field notes and shaped the interaction of the interviews (Charmaz, 2014; Gubrium et al., 2012). These cues helped me to interpret my participants' responses. I was able to immediately follow-up any ideas developed from these interpretations derived from my participants. I was also able to integrate the findings from the interviews and observations and construct the understanding into a theoretical framework. Hence, I not only obtained descriptions of the events, but could also construct a theory that may explain the event through the intensive interviewing (Charmaz, 2014).

Nineteen individual face-to-face interviews were conducted from June 2016 to August 2017. The duration of the interviews lasted from 36 minutes to 132 minutes. All the interviews were conducted in Cantonese and audio recorded. Field notes were also taken for the observations. The procedure used to conduct the intensive interviews will be illustrated in the next section.

Procedure for Intensive Interviewing

The participants recruited were contacted through phone to confirm the appointment of an interview. The time and place of the interview was based on a mutual agreement between the interviewer and the participants. I provided a brief introduction to this study and also myself when confirming the appointment for an interview. These strategies served as a gesture for building up rapport with the participants.

On the day of interview, I wore a different outfit according to the group of participants. I wore a smart casual outfit when I had interviews with organisers of clinical placements and CMs/CIs. I wore a more casual outfit when I had interviews with students and other ward staff. Wearing different outfits for different groups of participants aimed to establish a closeness with the participants and enhance the interactions in the interviews (Gubrium et al., 2012).

At the beginning of each interview, I introduced myself using both of my two identities which included being a senior lecturer working at a university in Hong Kong and a part time PhD student. The information stated on the participation information sheet (see Appendix 8

and 9) was also introduced. The purpose of the study and the topics to be discussed in the interview were also introduced before the interview started. The participants could then raise any questions or clarify any misunderstanding about the study. Written informed consent was also obtained from participants to ensure voluntary participation, and permission to record the interview before the interview started. Demographic data, for example age range and educational background of the participants were collected before the interviews started. The demographic data collection sheet is attached in Appendix 10-12. Asking questions about the demographic data at the beginning of the interviews was a way to get to know about the backgrounds of the participants. Factual questions could serve as a warm-up before asking the interview questions.

Different questions were asked at the start of the interviews with the three different types of participants. I asked student participants to describe their recent experiences in clinical placements. CMs/CIs were asked to describe how they conduct mentoring, while organisers of clinical placements were asked to describe how they organise a clinical placement. The participants and I interacted and explored the related issues of clinical mentoring. When no further issue about their experience of clinical mentoring was identified in the interview, the interview was ended. After each interview was completed, I immediately wrote up researcher diary notes reflecting on the interview. Afterwards, transcription, translation and data analysis were also then started. The next interview was arranged after the previous data analysis was completed. Intensive interviews were not the only data collection method used in this study. Documents related to clinical mentoring were also gathered.

3.5.2.2. Documents related to clinical placements

Documentation related to clinical placements served as a supplementary data source. When there were questions about the rules and regulations for clinical mentoring raised in the interview, I would seek the answers from various types of documents from different organisations. These documents were accessed through the internet, university intranet and by making personal requests to the participants. Ten official documents were included (See the details of documents in Table 3.7).

Code	Organisation	Nature of Document	Year of Publication	Source of Document
D1	Nursing Council of Hong Kong	Handbook for Accreditation of Training Institutions for Pre-enrolment/Pre-registration Nursing Education	March 2017	Website
D2	Nursing Council of Hong Kong	Syllabus and Requirements for the Preparation of a Registered Nurse (General) in the Hong Kong Special Administrative Region	June 2016	Website
D3	A hospital in Hong Kong	Guideline for High-Risk Procedures	2015	Personal Request
D4	A university in Hong Kong	Manual for Clinical Mentoring	2013	University Intranet
D5	A university in Hong Kong	Guidelines and Instructions to Students for Clinical Placements	2018	University Intranet
D6	A university in Hong Kong	Student Practicum Handbook	2017	University Intranet
D7	A university in Hong Kong	Guideline for clinical placement: A Reference for Clinical Institutions	2018	University Intranet
D8	A university in Hong Kong	Operational Guideline on clinical mentor training	2017	University Intranet

D9	A university in Hong Kong	Suggested Clinical Learning Activities for Clinical instructors	2017	University Intranet
D10	A university in Hong Kong	Definitive document of undergraduate nursing programme	2018	University Intranet

Table 3.7: Details of documents included in the data collection

The documents from the NCHK briefly outlined the minimum requirement for clinical placements and the assessments in clinical placements. The document from a hospital included a list of procedures that are regarded as high risk and described how CMs should complete these procedures with their students. This information outlined the context of the clinical mentoring process. The documents from a university enhanced the understanding on how different clinical placements were integrated into a nursing programme, how the clinical placement was organised and what types of rules and regulations that CMs/CIs and students were required to comply with. These documents enriched the data collected in the interviews and explained the context and interactions at the various stages of a clinical mentoring process. All the data collected in the interviews and the documents underwent data analysis. The details of the data analysis will be discussed in the next section.

3.5.3. Data analysis

Data analysis in this study consisted of data management, and coding and memo writing (Charmaz, 2014). I started the data analysis process from the data management. A constructivist grounded theory specific coding process was then adopted (Charmaz, 2014). Codes were first assigned to the data collected according to meaning. These codes were compared and merged into categories. The categories were concepts constructed by various meanings from the codes. The various categories served to provide the construction of a

theory. The process of data analysis was completed when a theory had been constructed (Charmaz, 2014). I first gained the understanding of mentoring in clinical placements through various levels of coding and a constant comparative method. The questions raised in the early stages of data analysis were then added in the subsequent interviews and the analysis of related documents. The process of data analysis was incorporated with the data collection to develop in-depth and abstract concepts that explained the social process of mentoring in clinical placements. The development of explanations of mentoring in clinical placements was based on the reflexivity of the researcher and documented in memos (see Appendix 13). In this section, the process of data analysis will be presented separately below.

3.5.3.1. Data management

Data should be managed before conducting any further data analysis (Creswell and Poth, 2018). After each interview was conducted, I transcribed the audio recording of the interview verbatim. All the transcripts were then checked against the relevant audio recordings to identify and rectify any errors in transcription. As the interviews were conducted in Cantonese, all 19 transcripts were written in Chinese. I translated all verbatim transcriptions into English before coding them, after the Chinese version of the verbatim transcripts were verified. I read through each sentence and rewrote the meaning of the sentence in English. I used an Oxford Advanced Learner's English-Chinese Dictionary published by Oxford University Press (1996) to ensure the accuracy of the wording used in a translation. When the participants used Chinese slang in the interview, I also looked up references from a book called "Cantonese Colloquial Expressions" that was published by The Chinese University Press (2007) and adopted the translation of the slang in the translated

transcripts. The first three translated transcripts were sent to a translator for back translation to ensure the accuracy of the translation (van Nes et al., 2010). I compared the backward translated transcript with original transcripts to check that the meaning of both versions of the transcript were consistent. The process of data analysis then proceeded to coding and memo writing.

3.5.3.2. Coding

Coding is a process that allows the researcher to identify the concepts arising from the studied phenomenon which ultimately guide the researcher to generate a theory to explain the studied phenomenon (Charmaz, 2014). A code refers to the short phrase that represent an “essence-capturing attribute” from language-based data (Charmaz, 2014; Saldaña, 2016). Coding in the constructivist grounded theory approach consists of four stages, namely initial coding, focused coding, axial coding and theoretical coding (Charmaz, 2014). During the process of coding, I assigned a code to a segment of the transcript. After the transcripts were verified, computer assisted qualitative analysis software (CAQAS), NVivo version 12, was used for coding in July 2016 (Hutchison et al., 2010). In the next section I will illustrate the use of the four stages of coding used in this study to generate one of the theoretical codes, “feedback”.

Initial coding

Initial coding was started once the translated transcript for each interview was available. Initial coding reflects the closest view of data and tends to be descriptive of the content (Charmaz, 2014). Initial coding allowed the researcher to remain open and explore the theoretical possibilities from the data to achieve theoretical plausibility (Charmaz, 2014). I

conducted line-by-line coding and coding an incident with another incident during initial coding (Charmaz, 2014). Line-by-line coding refers to the procedure of naming each line of the transcript (Charmaz, 2014; Saldaña, 2016).

The following excerpt from a transcript of an interview with a student illustrates how the line-by-line coding was conducted.

Transcript	Initial Codes
<p>I feel fine if the mentor blames me. However, the mentor should not make it personal. I think that it is normal for the students to have a less satisfactory performance. We may have learned about it (some procedures) before. We may not be able to link up with what we have learnt. As I have no experience, it is not possible to know how to perform a procedure by observation and the teaching of the school. It is difficult to make my own judgment. Some nurses may blame you.</p>	<p>Feeling acceptable to be blamed Not to insult student through blame Feeling the difficulty to link knowledge to practice</p> <p>Feeling it being difficult to learn the skill from observation</p> <p>Feeling difficulty to make clinical judgment Blaming student by some clinical mentors</p>

Table 3.8: Example of initial coding

I separated the data into segments according to their meanings through line-by-line coding. During the conversation, I asked the student to describe their perspective of the characters of a good mentor. The above codes captured how students felt about blaming by CMs. This included what type of blame was unacceptable, reasons for being blamed and how commonly that blame occurred.

I also coded an incident linking it to another incident to examine the context of each incident to analyse the relationship between time, identity and awareness, through comparison (Charmaz, 2014). As various incidents of blame were commonly reported by different participants, the acceptance of blame varied between different reports. Hence, the

acceptance of blame was explored through coding an incident in relation to another incident. The following excerpts of transcripts of interviews with student that report blame incidents illustrate how a coding incident linking it with another incident was conducted.

Excerpt 1: S1 was blamed in strong language with a relaxing tone		Excerpt 2: S5 was blamed in humiliating words	
I feel less frightened. As the ward staff (from the male ward)...he uses a tone as if playing with you. I feel that becomes acceptable. The ward staff may pat your shoulder and say "Fuck you! Perform better next time. Do not make this mistake again." I feel that is okay. If the ward staff swears in a harsh tone, it is not right and unacceptable. The ward staff should not blame the student with foul language. If the ward staff talk about it in a relaxing tone, I feel that is acceptable.	Feeling acceptable to be blamed in strong language with a relaxing tone	Um...I think that's different. It could be the difference in attitude. I felt that it was not a big mistake. It was not a big deal to let her blame me. However, I did not think that my performance was good in the second practicum. I had to be blamed. They blamed you with some humiliating words. "Do you take the brain with you? Are you as stupid as this?" I felt that was so...	Feeling it was acceptable to be blamed Feeling humiliated during blaming

Table 3.9: Example of a coding incident compared with another incident

Both S1 and S5 were blamed in a critical way by CMs/CIs in various incidents and accepted that they should only be blamed for less satisfactory performances, but they felt differently toward being blamed. By comparing both incidents of blame, I found that the tone used by CMs for blaming influenced student's feelings towards being blamed. Each coded transcript

was then sent to the supervisors for review. To enhance the credibility of the data analysis, all initial codes were discussed with my supervisors as to the accuracy of the interpretation of the participant's meaning.

Focused coding

Focused coding is a process that develops "the most salient category" through comparison between codes from different cases (Charmaz, 2014; Saldaña, 2016). Codes from initial coding tended to be descriptive. I compared the initial codes and identified the similarities and differences between them (Charmaz, 2014). Similar codes were grouped and formed into a set of tentative categories. For example, the codes "being blamed privately" and "being blamed publicly" were grouped under the tentative category "Occasions of blaming students". Comparison between different initial codes was able to be condensed and the meaning of the initial codes were sharpened during focused coding. Several tentative categories were formed after a comparison including types of blame, consequences after being blamed etc. A further comparison between tentative categories was made. The relationship between the tentative categories was revealed through comparison. I also raised questions to conceptualise the meaning of the tentative categories throughout the comparison. This served as a guide for the next step in the data collection and data analysis (Charmaz, 2014). The interview guide and the criteria for the participants was then refined to explore the identified gaps in the subsequent interviews.

Axial coding

Previously formed categories in focused coding further emerged when theoretical sampling and interviews were conducted simultaneously (Saldaña, 2016). I then compared the newly

generated data from subsequent interviews with the categories formed in the focused coding. I also wrote memos to outline and elaborate the meaning of the categories and sub-categories. With enhanced understanding of categories and sub-categories I was able to organise and outline the hierarchy for these categories. These actions helped me to develop the dimensions of the categories, including the categories and sub-categories (Charmaz, 2014). The tentative categories were compared and grouped into the category “Blaming students”, for example, during the process of axial coding. The structure of this category is shown in Figure 3.1.

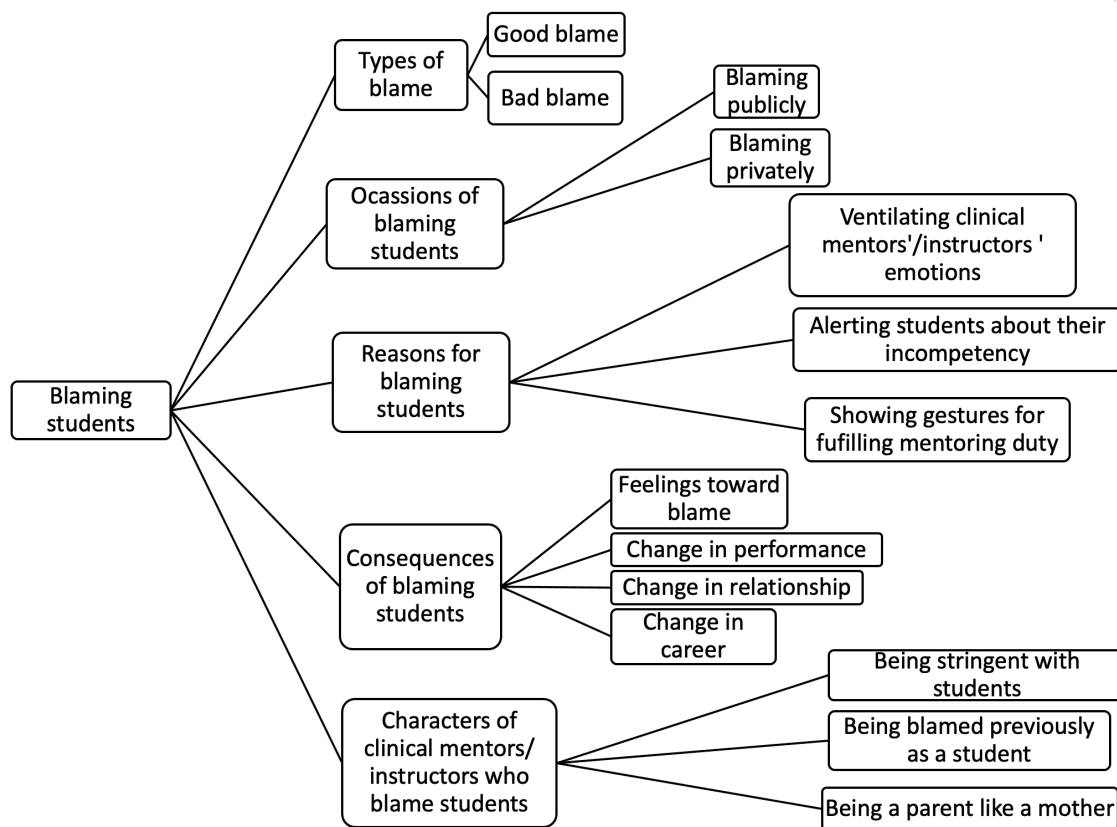


Figure 3.1: Structure of the category “blaming students”

The five sub-categories were related to CMs’/CIs’ behaviour in blaming students. These five sub-categories were then grouped under the category of “blaming students”. The linkage between the category “blaming students” and its five sub-categories offered answers to

questions i.e. the 'when, where, why, who, how, and with what consequences' aspects of the categories (Charmaz, 2014, p 147; Glaser, 1978). These linkages served as the dimensions of a category and defined the category. Hence, the category "blaming students" was conceptualised.

Theoretical coding

Theoretical coding which is the last stage of the coding process theorised the data from the subsequent interviews and integrated the data into a theory (Charmaz, 2014). Previously formed categories were compared and emerged into a theoretical category. The category "blaming students" and other categories that shared the characteristics of feedback provided by the CMs/CIs were grouped under the theoretical category "feedback". The theoretical category "feedback" was formed by three types of feedback, namely "constructive feedback", "minimal feedback" and "destructive feedback". Each type of feedback was a concept that shared a similar structure to the tentative category "blaming students". Students received different types of feedback from their CMs/CIs. During the process of theoretical coding, I raised questions about why various types of destructive feedback were provided during the social process of mentoring despite the less favourable consequences. This question was explored in later interviews. Hence, the six C's coding family was adopted to illustrate the relationship between categories and to explain why a phenomenon happened (Glaser, 1978). I compared the incidents of destructive feedback according to the causes, contexts, contingencies, consequences, covariances and conditions of the incidents (Glaser, 1978). I found that CMs/CIs provided destructive feedback based on their perceptions of students' performances. Further comparison was made between other theoretical categories such as assessment and expectations. I discovered that CMs/CIs

assessed their students based on their expectations through various means including observation and adopting others' opinions. Theoretical codes were then established from the integration and synthesis of the categories and served as the backbone for the grounded theory and established theoretical centrality (Charmaz, 2014; Saldaña, 2016). The pattern of 'expectation-assessment- feedback' was also found in other interactions between students and CMs. This explained how the social process of mentoring occurred in clinical placements. The details of the theoretical codes will be presented in Chapters 5, 6, 7 and 8.

3.5.3.3. Memo writing

Memo writing is an essential grounded theory task that facilitates the researcher in capturing the linkage between codes and categories and crystallises questions and the theoretical direction (Charmaz, 2014). I used memo writing in different stages of the data analysis. Memo writing was first started after each interview was completed. In interview memos, I wrote about my personal impression of each participant, a reflection on the interview and further questions about the topics discussed. Memo writing continued during the coding process. In coding memos, I wrote about the preliminary concept learnt from the coding process, the inquiry developed from the codes and questions raised by the codes. Hence, memo writing helped to develop theoretical ideas and to engage in reflexivity during the data analysis (Charmaz, 2014). The details of the reflexivity process will be discussed in Section 3.7.5. Memo writing could also help me to avoid subjective analysis and minimise the risk of bias during the data analysis (Silverman, 2017). I wrote about the development of concepts and categories and my reflection separately in the memo to help me to be consciously aware of how concepts were developed from the data and how my personal perspectives were integrated into the data analysis. The memos also served as a track

record of the research process. All memos were sent to the supervisors for review so that rigour could be ensured. A sample of a memo is attached in Appendix 13.

3.5.3.4. Theoretical Sensitivity

Data analysis was not simply a mechanical coding procedure. The emergence of theory also required the researcher to have theoretical sensitivity. Theoretical sensitivity refers to the ability to have an abstract understanding of the studied phenomenon (Bryant and Charmaz, 2010; Glaser, 1978). I adopted several strategies including “whimsy and wonder”, close-in comparison, analysis of negative cases, and the use of metaphor (Charmaz, 2014; Corbin and Strauss, 2015). I incorporated these strategies into the data collection and coding process to develop theories from the data.

Firstly, I maintained “whimsy and wonder” throughout the research process (Charmaz, 2014), meaning that I had to keep open to all unexpected findings and avoid the influence of preconception, and explore any theoretical possibilities. Hence, I also avoided reading mentoring related literature during the early stage of data collection and data analysis. (Bryant and Charmaz, 2010). This helped to minimise the influence of preconceptions on initial and focused coding and ensure that the foundation of the theory was generated from the preliminary data (Charmaz, 2014).

Secondly, I also conducted close-in comparisons in the analysis of the characteristics of students with poor performances. Close-in comparison refers to the comparison between similar cases in terms of types (Corbin and Strauss, 2015). Different cases of students perceived to have poor performances were compared. I found that shy students and

students who had a more 'fashionable' appearance were labelled by mentors as "students with a poor performance". The comparison between these two cases enhanced the understanding of the character of students who were perceived to have poor performances and the meaning of poor performance from the CMs' perspectives.

Thirdly, a flip-flop technique was also adopted to obtain different perspectives in the subsequent interviews. The flip-flop technique explores the concepts from inside-out or upside-down perspectives (Corbin and Strauss, 2015). For example, I asked students to describe their perception of the characteristics of a "good student" and a "bad student". This served as an inside-out perspective. In contrast, CMs and CIs were also asked to describe and explain their standards of a "good student" and a "poor student". This action provided an upside-down perspective about the standard of students in clinical placements. Contrasting these two perspectives helped me to understand that there was no universal standard of students and the standard of students varied between personal perceptions.

An analysis of negative cases was adopted to ensure theoretical sensitivity. By comparing a negative case with an ordinary case, new insights could be gained (Charmaz, 2014). An example of a negative case in this study was related to the mentoring experience of a CI. The students asked this CI not to supervise their practice in clinical placements. It was completely different from the common reports from the students that students wanted to be supervised by a CI all the time. After comparing the individual, situation and categories developed from previous data analysis, I found that the students being mentored by this CI were experienced enrolled nurses who had undertaken a registered nurse conversion course. These students considered a clinical placement as being a ritual that they should

complete to upgrade their nurse licences, while the pre-registration nursing students considered a clinical placement as being a way to learn to be professional nurses. The analysis of negative cases offered an explanation about the differences in behaviour in clinical placements.

At the stage of theoretical coding the researcher adopted a metaphor in the analysis of theoretical codes to create an image of the various interactions in clinical mentoring (Corbin and Strauss, 2015). The metaphor of dramaturgy was adopted in this study as the participants of clinical mentoring act within a combination of the guidelines and the participants' interpretations to please audiences such as the public and organisers of clinical placements. CMs, students and other healthcare workers served as actors on the stage of a clinical placement while the hospital management and nurse educators served as the directors of the drama in placements. The guidelines and regulations for clinical placements served as the script. The interactions between CMs and students which were reflected in their actions, were bounded by the script of a clinical placement. These actions in operation between CMs and students varied as the people involved in the drama of a clinical placement had their own interpretation of the script. The metaphor of drama helped to raise the meaning of the theoretical codes from descriptive to abstract.

3.5.3.5. Theoretical saturation

The data collection and data analysis processes were completed when theoretical saturation was reached. Theoretical saturation refers to the situation when no new categories are emerging from the concurrent data collection and data analysis process (Charmaz, 2014;

Bryant and Charmaz, 2010) and the existing categories have been saturated. This means that no further theoretical insight can be gained from further data collection. I discovered that theoretical saturation had been reached after analysing the emerging data from 16 interviews. The same concepts were generated repeatedly in the subsequent data collection and data analysis. Three theoretical codes, namely expectations, assessments and feedback were being generated at that time. Comparison was made within and between each theoretical code. For example, a discrepancy between the expectations of CMs and students was found during the comparison within the theoretical code, 'expectations'. Awareness of this discrepancy was considered during the comparison with the results of the assessments. When students were unaware of this discrepancy, they were likely to be judged as students with poor performances. Further comparison was made with the feedback. The character of CMs, the past experiences of CMs, and their impressions of students were all considered in the comparisons. These three theoretical codes illustrated the interactions during mentoring in clinical placements. Similar to the findings of the literature review, other ward staff were also reported to be involved in clinical mentoring. Two healthcare assistants and one junior RN were recruited to explore their involvement in clinical mentoring and to compare with the theoretical codes that emerged from the people directly involved in mentoring in clinical placements. Comparison was made between the data from these three interviews and previous data. Theoretical saturation was then confirmed. The decision that theoretical saturation had been reached was also discussed with the supervisors to avoid ending the data collection and data analysis too early. Ethical considerations for this study will be discussed in the next section.

3.6. Ethical considerations

Ethical approval was granted by the University of Manchester (Ref: ethics/16135) on May 18, 2016 (see appendix 14) and the Open University of Hong Kong in November 2015. All the procedures in this study were reviewed by these two ethical committees to ensure there was no violation of ethical principles (Creswell and Poth, 2018; Silverman, 2017). Peer review of the research protocol serves as a strategy that promotes the quality of the research and the safety of the participants (Creswell and Poth, 2018). I adopted the research ethics guideline from the Royal College of Nursing to minimise the risk for participants and to preserve the rights of the participants (Royal College of Nursing, 2004). Several ethical issues including informed consent, confidentiality and anonymity, and beneficence were considered. The preservation strategies were implemented in this study and are presented below.

3.6.1. Informed consent

Informed consent was one of the major ethical principles considered during participant recruitment and before the data collection (Creswell and Poth, 2018; Royal College of Nursing, 2004; Silverman, 2017). The purpose of gaining informed consent was to ensure participants were able to make an informed decision to participate in the study voluntarily, instead of feeling an obligation from the university (Silverman, 2017; Gubrium et al., 2012). Hence, the participants were fully informed and had explained to them the purpose, methodology, their rights and implications of their involvement in this study and the potential risks that they may encounter in participation of this study, verbally (Silverman, 2017) and by a written participation information sheet (see Appendix 8 and 9). I introduced all the related information for the study to the participants during recruitment. An

electronic copy of the participant information sheets was sent to all potential participants. All the participants had at least 48 hours to read the information and clarify any misunderstanding of the study and to consider whether they wished to join the study or not. The participants rights were reiterated before the interview. The rights of the participants included the right to refuse to participate or withdraw from the study at any time and for whatever reason. The participants were free of coercion if they refused to participate or withdraw from the study. They were also invited to ask questions before the interview. When the participants had no further questions and agreed to participate in the study, written informed consent was obtained. The written informed consent form is attached in Appendix 15 and 16.

3.6.2. Anonymity and confidentiality

Anonymity and confidentiality were the two ethical issues that could have arisen from the data collection and data analysis (Gubrium et al., 2012). Anonymity concerns the identity of the participants. The identities of the participants were kept anonymous by assigning a pseudonym to each participant (Gubrium et al., 2012). The pseudonyms were used to address the participants instead of using their names throughout the research process. In addition, access to the identity of the participants was limited to the researcher only. Confidentiality refers to the protection of the data collected from participants (Gubrium et al., 2012). The strategies that ensured confidentiality were related to the storage of data and limitation of access (Silverman, 2017). The recordings and transcripts of the interviews were kept in encrypted devices and stored in a locked cabinet. The access to the data was also limited to me and my supervisors only. The principle of confidentiality would only be breached if a participant disclosed information related to the serious harm of the people

involved, a serious crime and public interest (Silverman, 2017). A disclosure protocol was set up for managing these three situations: see in Appendix 17.

3.6.3. Beneficence

Beneficence refers to the balance of the potential risks and benefits to the participants. Potential risks included both physical risks and emotional distress (Silverman, 2017). As participants in this study may recall negative experiences in clinical mentoring, emotional distress was considered as a risk that could be encountered by the participants. Hence, a distress protocol (see Appendix 18) was created to avoid/minimise inducing emotional distress in the interviews and to minimise harm if the participants experienced emotional distress. In the distress protocol, several strategies were proposed if the participants felt upset in the interviews. In the depth of an interview, caution was also needed to avoid any harmful effects to the participants (Corbin and Morse, 2003, Gubrium et al., 2012). The participants had the right to refuse to answer any question if they felt uncomfortable. The interview would be suspended if the participant felt emotionally upset and unable to talk about the clinical mentoring experience (Corbin and Morse, 2003). Information about a counsellor was provided for the participants to ensure they had access to professional support for the emotional distress. Any distressed participants were also to be contacted by phone the day after the interview, and a week after the interview to check if further support was needed. Among the 19 interviews, I found that only one student participant experienced emotional distress during the interview. That interview was suspended. I stayed with the participant for about 30 minutes. This student had a conversation with me about her feelings after the interview was suspended. She reported feeling fine afterwards and returned home. I contacted her by phone according to the distress protocol and she

reported no sign of emotional distress the next day. No further action was needed for this student.

The above-mentioned strategies were adopted in this study to ensure ethical research principles were upheld. No adverse event occurred throughout the implementation of the study. The rigour of the study will be further discussed in the next section.

3.7. Rigour of the study

The rigour of qualitative research is equivalent to validity and reliability in quantitative studies (Davies and Dodd, 2002). Rigour serves as an evaluation of the quality of the qualitative study (Davies and Dodd, 2002; Sandelowski, 1986). A good qualitative research study should be able to fulfil the criteria for rigour. Charmaz and Thornberg (2020) suggested a framework to test the rigour of constructivist grounded theory studies, which includes credibility, originality, resonance and usefulness. In addition, reflexivity is another criterion that influences the rigour of a grounded theory study. The strategies that fulfil these criteria will be discussed below.

3.7.1. Credibility

Credibility refers to the ability of the study to accurately reflect the truth value of the studied phenomenon (Charmaz and Thornberg, 2020; Chiovitti and Piran, 2003). This means that the study has reported the participants reality of the studied phenomenon (Charmaz and Thornberg, 2020). As the researcher learnt about the reality of the phenomenon through an interpretation of participants' responses, an instant interpretation of participant responses could be falsified during the research process (Lincoln et al., 1985). Hence, I had

to undertake a prolonged engagement in the data collection and data analysis processes. The data collection period lasted for longer than one year, which allowed me to develop an intimate familiarity with the research topic (Charmaz, 2014). Prolonged engagement with the interviews also enriched the appropriateness of the data. Most interviews in this study lasted longer than 1.5 hours. I was able to have sufficient time to observe the various non-verbal cues of the participants. These cues were marked in the field notes and served as extra evidence to support the claims developed in the data analysis. Similarly, various documents related to the clinical placements were also included in the data analysis. These documents served as an additional source of data that supported the claims developed. In addition, each stage of the research process was documented in the reflections, memos and field notes. This documentation also served as an audit trail that allows the reader to understand how the raw data was interpreted and developed into categories. It provided the evidence for validating the accuracy of the findings (Wolf, 2003).

3.7.2. Originality

Originality refers to the ability of a study to provide new insights into the research inquiry and any significance for future research (Charmaz, 2014; Charmaz and Thornberg, 2020). The categories developed in this study were based on participants with diverse characteristics in various settings. The heterogenous sample illustrated various interactions at various stages of clinical mentoring. The findings of this study showed that clinical mentoring was a dynamic process that was constructed by multiple interactions between people involved in clinical placements. It served as a new insight into clinical mentoring as it was described as a single event that was controlled by CMs/CIs. Each occasion for clinical

mentoring was unique and was influenced by multiple factors. For example, CIs and students had to present a favourable impression to the ward staff to gain learning opportunities. In contrast, a CM, who had a dual identity in working as a CM and ward staff in a ward, used their dual identity to manage the learning opportunities. The findings explained how CMs/CIs and students behaved in the context of clinical mentoring.

3.7.3. Resonance

Resonance refers to the extent that the data represents the phenomenon and offers in-depth insight into the studied phenomenon (Charmaz, 2014; Charmaz and Thornberg, 2020). Participants with diverse characteristics were recruited for this study. Three groups of participants including placement organisers, CMs and students, were recruited initially. In order to capture a full picture of clinical mentoring, a junior RN and HCAs were also theoretically sampled and recruited for interview to provide ward observers' perspectives of clinical mentoring. One of the examples was related to the conflict between CMs and students in placements. CMs and students perceived that admitting mistakes was considered by the mentors to be a desirable student behaviour. By comparing findings from the interviews of the initial participants and the observers, admitting a mistake regardless of the situation was a strategy used by students to present a humble impression in relation to their CMs. This could enhance the supervisory relationship between the CMs and students and further confirmed the students' perspectives that they could have more learning opportunities and better clinical placement experience through presenting the impression that CMs expected. This served as an example that illustrated how resonance was ensured in this study.

3.7.4. Usefulness

Usefulness refers to the ability of the study to offer an interpretation of a studied phenomenon that is applicable to everyday life (Charmaz, 2014; Charmaz and Thornberg, 2020). The participants recruited in this study were actively involved in clinical mentoring and clinical placements during data collection. They provided their first-hand experience of clinical mentoring that reflected the experience commonly shared by CMs and students during clinical mentoring. The categories that emerged in the data analysis included expectations, assessment and feedback and these suggested a generic process of interaction between the CMs and students in clinical mentoring. The conceptual analysis of the clinical mentoring process was presented to healthcare professionals and educators, including nurse educators, several times at the University of Manchester, the Open University of Hong Kong and overseas conferences through various oral presentations and a poster presentation. Feedback was received from the audiences that the findings were consistent with their clinical mentoring experiences. Presentation audiences reported that they had been alerted about the impacts of minimal and destructive feedback and wanted to adjust their way of clinical mentoring based on the findings of this study. This further confirmed the usefulness of this study.

3.7.5. Reflexivity

As a constructivist grounded theory was adopted as the study methodology the researcher needed to be reflexive throughout the research process to ensure the credibility of the study (Berger, 2015; Bryant and Charmaz, 2010). Reflexivity refers to the process through which the researcher becomes explicitly aware of the influence of their positionality on the research, including age, gender, personal experiences and the profession (Berger, 2015;

Bryant and Charmaz, 2010; Charmaz, 2014). The explicit awareness of these influences facilitated the researcher in exploring the studied phenomenon and in minimising any bias (Berger, 2015).

Reflexivity occurred throughout this study. Reflexivity at the start of this study involved the generation of the study focus. The idea for this study originated from my personal experience of having a conflict with a student during an assessment in a clinical placement and also a conflict with my CI when I undertook my undergraduate pre-registration training. The recurrent conflicting relationship during mentoring in clinical placement aroused my interest to further explore this phenomenon. I was working as a senior lecturer in a university when this study started. My background facilitated the access to the participants and documents in this study. It also influenced the interaction with all the participants during the interviews.

Some participants including the CMs, CIs and students frankly shared their past mentoring experiences and their perspectives about mentoring, especially about the negative feedback received by students and the management of students with poor performances. My personal feelings toward the poor clinical mentoring experienced by students with poor performances and the management of students with poor performances were documented in the memos right after the interviews. The reflection on these two issues guided the further exploration on the impacts of poor clinical experiences and how CMs/CIs managed students' performances.

On the other hand, a student participant also provided her story of clinical mentoring which she perceived as being compatible with my expectation of a good student. I discovered this perception in the conversation with this participant during a debriefing. I wrote this in the memo and it served as an alert for the idea of 'impression management' and how my lecturer background had hindered the participant in sharing their full story. The idea of impression management was then explored in the subsequent interviews and integrated into the data analysis.

Reflexivity also facilitates the process of data analysis. My own experience of conflict with another student offered insight to me when the data analysis proceeded to focused coding. I was upset about the performance of a student during a clinical assessment and had provided critical feedback to this student. After the conflict, that student refused to interact with me. When I reflected on this conflict, I noticed my unintended negative emotion towards poor performances. The unintended negative emotion was linked to the response towards the student with a poor performance and the withdrawal response from student resulting from the negative emotions. Similar incidents were also reported by students and CMs. This also reflected a lack of knowledge about the management of students with poor performances and the consequences of ineffective management of students with poor performances. The above-mentioned experiences and interpretations were documented in memos. As a novice researcher, all these memos were reviewed and discussed with the supervisors to avoid generating biased findings (Bryant and Charmaz, 2010).

3.8. Conclusion

A constructivist grounded theory research design was adopted. Mentoring in clinical placements is a product of the interaction between the people, environment and organisations according to the findings from the literature review. Due to the dynamic and co-constructed nature of mentoring in clinical placements, it was useful to adopt a constructivist perspective to explore the process of mentoring in clinical placements. Participants were first recruited by purposive sampling. 19 intensive interviews were conducted and ten documents were also collected. The procedures for the data collection and data analysis were conducted concurrently. The sampling methods moved on from a purposive sampling method to theoretical sampling to facilitate the formation of theory when the fundamental understanding of mentoring in the clinical placements had been gained. Several strategies were adopted to ensure the rigour of the study. Ethical principles were also considered and strategies to protect these were implemented. The study findings will be discussed in the next five chapters.

4. Context of study

4.1. Introduction

This chapter will outline the context of this study and provide information about the study settings and the organisational aspects of the organisation of clinical placements and the requirements of clinical mentoring. In this study, clinical placements were implemented within the context of one university and five public hospitals in Hong Kong. The people responsible for organising the clinical placements (namely hospital coordinator, ward manager and nurse educators) had to comply with the regulations and syllabus of the NCHK (Nursing Council of Hong Kong, 2016, 2017). Hospital coordinators and nurse educators were responsible for organising clinical placements through the setting up of guidelines, the appointment of CIs/ CMs and the arrangement of the actual clinical placement that students attended. CIs were responsible for group mentoring that engaged in clinical mentoring with eight students whereas CMs were responsible for individual mentoring. Official guidelines and policies related to clinical placement and clinical mentoring from NCHK, hospital and university were reviewed as listed in Chapter 3. These policies and guidelines offered brief guidance to ward managers, CMs / CIs and students. The brief guidance from the official policies and guidelines offered flexibility for ward manager, CIs/ CMs to handle situation encounter in clinical placement and clinical mentoring. It implied that they could manage clinical placement and clinical mentoring based on customs and personal preference.

4.2. Study settings

The study settings included one university and the five public hospitals which were utilised for clinical placements units in Hong Kong. The university involved in this study was a self-

financed (not funded from Government funding) university that provided undergraduate and higher diploma pre-qualified nursing programmes in general and mental health nursing for both pre-registration nursing students and pre-enrolled nursing students. The students participated in this study were students of that undergraduate pre-registration nursing programme in general nursing. Five clinical placements were arranged for these students by the university. The details of clinical placement in the undergraduate pre-registration nursing programme is outlined in table 4.1 as specified in the excerpt from the practicum course handbook below.

	Undergraduate Pre-registration Nursing Programme
Length of programme	5 years
Number of clinical placements	5. Students were required in one clinical placement each year.
Duration of clinical placements	38 weeks in total. Students had to complete 5 clinical placements throughout their programme. The duration of each clinical placement varies ranging from 2 weeks to 14 weeks. Students worked 8 hours each day and five days a week during the clinical placement.
Venue of clinical placements	Various specialties in community setting, acute and sub-acute hospitals including medical nursing, surgical nursing, paediatric and adolescent nursing, obstetric nursing, gerontological nursing, mental health nursing, community nursing, primary health care and accident and emergency department (emergency nursing)
License obtained upon completion	Registered Nurse

(D6, student practicum handbook, 2017)

Table 4.1: Summary of practicum courses of the undergraduate pre-qualified nursing programme

The students interviewed in this study between June 2016 and August 2017 were required to attend one practicum course in each year. The nature and duration of all required practicum course is listed in table 4.2.

Year	Course	Nature of Clinical Placement	Duration (Week)
1	Clinical Practicum I (General Health Care)	Community-based health care related agencies/institutions (Visit)	-- *Occasional visits within the period of practicum course. The visiting hours were not count as clinical practice hour
2	Clinical Practicum II (General Health Care)	Primary health care	2
3	Clinical Practicum III (General Health Care)	Medical nursing Surgical nursing Operating theatre nursing Paediatric and adolescent nursing Specialty nursing: Obstetric nursing	8
4	Clinical Practicum IV (General Health Care)	Medical nursing Surgical nursing Operating theatre nursing Paediatric and adolescent nursing Specialty nursing: Geriatrics, Community nursing service, Psychiatric nursing (Any 2 specialties)	14
5	Clinical Practicum V (General Health Care)	Medical nursing Surgical nursing Operating theatre nursing Paediatric and adolescent nursing Accident and emergency nursing Specialty nursing: GERI, CNS, PSY (Any 1 specialty)	14

(D6, student practicum handbook, 2017)

Table 4.2: The nature and duration of all required practicum courses

The nature of clinical placement varied between each different year of study. Year 1 and year 2 nursing students visit various community and primary health care setting for a short period of 2 weeks under group mentoring. Students attend longer clinical placement in hospital settings starting from their third year of study. The first clinical placement in

hospital setting is conducted in a form of group mentoring and the next two clinical placements are conducted through individual mentoring. Students mainly attended their clinical placement in public hospitals. Hospital managements, ward managers, CMs and ward staff were recruited from five public hospitals. These five hospitals consist of three acute regional hospitals and two community-based hospitals that provided comprehensive acute care and sub-acute rehabilitative care respectively (Hospital Authority, 2019a). Students were required to carry out clinical duties in these two types of hospitals throughout their study of their programme. Clinical placements were organised in partnership between the Hospital Authority and the university. In the next two sections the official guidelines and policies related to clinical mentoring and clinical placement are outlined to explain the organisation of clinical placement and implementation of clinical mentoring.

4.3. Organisation of clinical placement

Hospital-based organisers, including hospital coordinator and ward manager, and nurse educators organised clinical placements based on their own organisations separate guidelines and policies. As mentioned earlier, these guidelines and policies were brief and lacked detail. Some information was supplemented with the reports from hospital-based organisers and nurse educators to enhance the understanding of organising and managing clinical placement. The organisation of clinical placement by hospital-based organisers and nurse educators will be outlined in the next two sections.

4.3.1. Organisation of clinical placement by hospital-based organisers

Clinical placement was organised by hospital-based organisers at two level, namely organisation and ward level. Hospital co-ordinators were responsible for organising clinical placements at the organisation level, whereas ward managers organised clinical placements at ward level. As there was no standard document concerning the roles of hospital-based organisers, the organisation of clinical placement by hospital-based organisers were based on the reports of hospital-based organisers and nurse educators. Hospital coordinators were responsible for identifying clinical placement area and organising the clinical placement at the hospital level. They first coordinated with ward managers in assigning students to different wards and arranging training for CMs even though the university should be responsible for mentorship training (Nursing Council of Hong Kong, 2017).

After they (the head office of Hospital Authority) let us know about the quota (the number of students that will attend the practicum in the later time... We will contact the ward manager of that specialty or the responsible person to make further arrangement... I may also need to arrange the training for the mentors and resource. These are things that I needed to do. (O3, hospital coordinator responsible for organising placements)

Hospital coordinators were also responsible for making arrangements for students to facilitate their attendance of clinical placement. These arrangements included sharing of essential information with students and access to the facilities in hospital.

We may arrange the infection control talk. We also provide some information related to the meal and the transportation as the students come to an unfamiliar environment...

We may also need to arrange these things for the students. The locker, uniform and the meal... We also provide PA room¹. (O3, hospital coordinator)

After the hospital coordinators managed these logistic of clinical placement, ward managers took over from the hospital-based organisers and organised the clinical placement at ward level just before the clinical placement started. The arrangement of clinical placement varied as clinical mentoring could be conducted by either CMs or CIs. When clinical mentoring was required to be conducted by CMs, ward manager assigned students to eligible CMs and shared related information to CMs and ward staff. The information provided could be related to the assessments and duty roster for students.

The ward manager needed the time to settle the duty roster. Some other ward had to settle the duty 4 to 8 weeks before the practicum. I can understand that the ward manager kept asking me about the information... The ward managers also need to disseminate the information. They need to find an appropriate person to mentor the students. Or the students need to have assessment during the practicum. There should be something to do. (O4, ward manager)

Ward managers were also responsible for arranging students' duty rosters. Such arrangement aimed to enhance the supervision of students' practice as students were expected to work with their CMs if possible.

If they (clinical mentors and the students) don't have special request, it will be better. If they have request, it will be difficult for me to arrange the duty. If they have no request, I will try to match their duty for the first two weeks. For the days that the student could not work with the clinical mentors, we would mark the duty roster and assign another colleague to supervise the student. (O4, ward manager)

¹ PA room refers to a temporary accommodation for the students to rest between the afternoon shift and morning shift. The schedule of shift is as follows. Morning shift (A shift) starts from 0700 to 1548. Afternoon Shift (P shift) starts from 1200 to 2048. Day shift starts from 0900 to 1748. (D5, Guideline on Clinical Mentoring)

Hospital coordinators and ward managers participating in this study reported that there was no specific policy or rules to follow in arranging student's duty rosters. However, some hospitals had a specific policy for arrangement of duty that could influence the contact hours between clinical mentors and students

Some of the cluster² may set a rule to state that the students need to have one night shift per week. The students will work for one night shift in a week. Some of the clusters do not set the rule explicitly. (O2, practicum course coordinator)

In contrast, the university also provided guidelines to hospital-based organisers about the arrangement of duty; however, the university guideline provided was quite general.

Flexibility in arrangement of students' duty was offered to the hospital-based organisers by university.

A student will be assigned shift duties in the placement according to the arrangements of the clinical institution.

A student is entitled to have one day off per week and gazetted public holidays which may not exactly fall on Sunday and the day of public holiday (D7, Guideline for clinical placement: A Reference for Clinical Institutions from university, 2018)

We will also provide the flexibility in coordination to the colleagues (clinical partner) of that cluster. Therefore, we may not set a rule (of the duty) but we state the basic requirement clearly. (O2, practicum course coordinator)

Arrangement of students' duty was entirely ward managers' responsibility. Ward managers had to coordinate the requirements and requests of the students and CMs, the requirements of the hospital placement policy and the statutory leave days. Thus,

² All public hospitals are grouped into seven clusters according to their location. Each cluster managed various acute and sub-acute hospitals independently. All seven clusters are managed by the head office of Hospital Authority

organising the clinical placement was a complicated and difficult task when clinical mentoring was conducted by CMs.

Organising clinical placement was less complicated when clinical mentoring was conducted by CIs. Ward managers were only required to share related information with ward staff. The arrangement of duty was not required.

The role of the ward does not have much involvement as the students are supervised by their clinical instructors...When they come to my ward...I actually provided some information to the ward in-charge and colleagues before the students visited the ward.
(O4, ward manager)

Hospital-based organisers assigned their staff and students to participate in clinical placements and arrange the logistics of clinical placement. As there is lack of documentation on the policy of organising clinical placement it is difficult to understand the role of hospital-based organisers systematically. Organisation of clinical placement was seen as difficult as hospital-based organisers put a lot of effort into coordinating various organisational policies and meeting the needs of CMs and students. Clinical placements could not be organised by hospital-based organisers alone. They had to work with university-based organisers when they organised clinical placement.

4.3.2. Organisation of clinical placement by nurse educators

Nurse educators were responsible for organising clinical placement according to university guidelines. Similar to the hospital-based organisers, nurse educators also organised clinical placement at two levels including organisation and course level. There were two roles of nurse educators, namely practicum coordinator and practicum course coordinator.

Practicum coordinator was responsible for organising clinical placement at organisational level. The practicum coordinator was responsible for liaison and communication with external parties, such as hospital coordinators. As there is no other document available that described the role of the practicum coordinator, information from O1, practicum coordinator, is presented. She was responsible for setting up various clinical placement guidelines for CIs and students, managing the manpower for clinical placement and administration work in clinical placement.

I am responsible for over (overall) coordination such as arranging placement with the hospital. Get the place for clinical placement. I will arrange the overall placement in (different) programmes. (O1, practicum coordinator)

The practicum coordinator also collaborated with hospital coordinators to appointment of CMs and clinical assessors and managing the administration work of training for CMs. These two tasks were essential components in the organisation of the clinical placement, as the following excerpt from the university guidance on CM training outlines (See Box 4.1).

<p><i>Practicum Coordinator</i></p> <ul style="list-style-type: none">• <i>Liaise with hospital coordinators to encourage clinical staff to apply for Clinical Mentor & Clinical Assessors³</i>• <i>Liaise with and disseminate the training workshop enrolment and the Clinical Mentor & Clinical Assessors application information to coordinators of clinical partners</i> <p>(D8, Operational Guideline on clinical mentor training from university, 2018)</p>
--

Box 4.1: Role of practicum coordinators in collaboration with external parties

³ Clinical mentors and clinical assessors are two roles that required nomination by ward managers. As required by NCHK, clinical mentors are eligible to conduct clinical mentoring and clinical assessors are eligible to conduct the three mandatory clinical assessments. Eligible registered nurses usually appointed as both clinical mentors and clinical assessors.

Apart from collaboration with external parties, practicum coordinators also collaborated with practicum course coordinator to allocate students into different clinical settings to accommodate the requirement of the practicum course.

For the internal (coordination), there are different practicum courses. I need to coordinate with different (practicum) course coordinator and arrange the clinical placement with different years of students. The students are required to visit different specialties in different years of study. It may influence “getting a place for clinical placement”. There are also some internal operation issues. (O1, practicum coordinator)

After the appointment of CMs and the allocation of clinical placement area was settled, the organisation of clinical placement was then cascaded to course level. The practicum course coordinators mainly focused on student-related clinical placement issues and delivery of mentorship training for CMs. They were involved in preparatory work of clinical placement for students that included assignment of different clinical placement venues and arrangement of various pre-practicum training. The requirement of pre-practicum training varied between different hospitals. Some hospitals could require providing part of the pre-practicum training, such as infection control training, by their own staff. When the hospitals did not provide any part of the required pre-practicum training, practicum course coordinator were required to fulfill the students’ pre-practicum training need before the clinical placement started.

For the hospitals of HA (Hospital Authority), the students have been allocated into all clusters⁴. As a coordinator, we need to consider whether the students are able to attend the A shift (morning shift) in the later practicum and how to facilitate them to have practicum (in the future). As the students should have the practicum in the same cluster (throughout the study), I need to collect information about where the students live.

They (the students) could choose two clusters for us to consider. We also need to compare the choice with the plan of HA (hospital authority) to check the availability (places of placement) of different clusters and allocate the students into different clusters. There will be more work in organising the first practicum. In addition, we also need to handle the infection control issue. We need to make sure the students have attended the infection control training. There are also “fire talk training” (training related to contingency of fire) and “ICAC training” (training related to corruption in hospital setting). These are the pre-practicum training that we need to coordinate. (O2, practicum course coordinator)

After the clinical placement started, practicum course coordinator also needed to handle issues that arose during clinical placement especially complaint of students.

I have a bit feeling like customer service. When others (clinical mentors/ clinical instructors) make a complaint, you of course need to perform some investigation. There would be some action to take in an appropriate condition such as suspend a student’s practicum. (O2, practicum course coordinator)

Practicum course coordinators delivered half-day mentorship training for CMs through workshops through seminars every six months. Similar to pre-practicum training, some hospital provided mentorship training for their own staff. Eligible CMs could enroll in mentorship training from either their hospital or university.

Practicum Course Coordinators

- *Conduct the teaching activities in the training workshop as speakers*

(D8, Operational Guideline on clinical mentor training from university, 2018)

Hospital-based organisers and nurse educators organised clinical placement with minimal collaboration. Both of them asserted different level of control over clinical mentoring

throughout the clinical placement. After the environment for clinical placement was set up, teaching staff and students then engaged in the mentoring.

4.4. Implementation of clinical mentoring

As mentioned in Chapter 1, clinical mentoring involved mentor and mentee engaging in different activities during placement. Both CMs and CIs are eligible to serve as teaching staff and conduct clinical mentoring for students in Hong Kong (Nursing Council of Hong Kong, 2017). In this section, the official standard roles of these participants and activities in clinical mentoring described in the official guidelines and policies will be outlined.

4.4.1. The standard roles of teaching staff and students in clinical mentoring

Official guidelines and policies from NCHK and university described the roles of teaching staff and students in clinical mentoring. This information served as the standard that the organisations expected the teaching staff and students to achieve in clinical mentoring.

4.4.1.1. Teaching staff of clinical mentoring

CMs and CIs were the teaching staff for clinical mentoring. They were also required to have registered nurse qualification with higher degree of nursing education and at least three years post-registration clinical experience by the NCHK (Nursing Council of Hong Kong, 2017). CIs and CMs also needed to fulfill the requirement of the teacher-student ratio as required by NCHK. Requirements about teaching staff by NCHK were outlined in Chapter 1.

Both of them were expected to be trained by either the university or hospital and appointed by the university.

Clinical teachers (s) and clinical mentors are important resources for the students. They should be trained and appointed to provide clinical skill training and on-the-job coaching for students. (Nursing Council of Hong Kong, 2017)

Apart from clinical skill training, on-the-job coaching was expected to be delivered through clinical mentoring. This reflected the NCHK's perspective on clinical mentoring that clinical mentoring was a form of informal learning which should be learner-led and non-routinised (Bjørk et al., 2013; Marsick and Volpe, 1999). The perspective of clinical mentoring that NCHK held was different from the university's perspective. As shown in the university roles and responsibilities of CIs (Listed in Box 4.2), clinical mentoring was expected to be teacher-led and highly structured.

The major duties and responsibilities of the clinical instructors are:

- A. prepare learning needs and outcomes with students daily;*
- B. provide students learning opportunities;*
- C. assist students to get familiar with the ward setting;*
- D. facilitate students to active participate in ward activities;*
- E. teach, supervise and evaluate students' performance in ward;*
- F. supervise students to organise and provide patient care;*
- G. assign different patient care and learning activities to students according to students' learning progress;*
- H. ensure both patients' and students' safety in ward;*
- I. encourage students to apply critical thinking and integrate theoretical knowledge into clinical practice;*
- J. provide support for students in the event of unforeseen problem/ incidents during the clinical practicum;*

K. evaluate, assess and provide feedback to students on their learning needs and outcomes L. manage unsatisfactory or unsafe practice together with course coordinator and ward staff;

M. maintain effective communication with clinical staff;

N. liaise with Course Coordinator and ward staff with regard to students performance and incidents;

(D4, Manual for Clinical Mentoring from the university, 2013)

Box 4.2: The roles and responsibilities of clinical instructors

CMs had a similar role and responsibilities as CIs and were required to arrange appropriate learning opportunities, supervise and assess their students during clinical placement. The description of roles and responsibilities of CMs was less detailed. Accommodation of students' learning need, liaison and communication with related parties within clinical mentoring were less emphasised in the manual.

Students placed in these clinical areas should be closely supervised and coached by Clinical Mentors (CM). The CMs should, in accordance with the university's clinical learning outcomes that are set up in every ward of the clinical training grounds, select clinical learning opportunities for students and coach and supervise students throughout their placement... Assessment and examination of the clinical placement are based on the concept of clinical competency. The formative clinical competency of each student is continuously assessed by the CMs who supervise students' satisfactory completion of the Clinical Learning Outcomes Records. (D4, Manual for Clinical Mentoring, 2013)

In summary, CMs and CIs were required to fulfil the learning needs of students and conduct assessments during clinical placement. The data showed that they fulfill more roles than the described in the official documents. The details of roles of CIs/ CMs will be discussed in Chapter 5. CIs/ CMs play important roles in identification and management of students with

poor/ substandard performance. Hence, they also served as a gatekeeper of nursing profession. The details of assessments and management of students’ performance will be discussed in Chapter 7 and 8.

4.4.1.2. Students

The information about the standard and requirement of students in clinical mentoring was limited. None of the documents from NCHK mentioned the required standard of students in clinical mentoring. The standard of professional conduct for students in clinical mentoring was only found in a university document, D5 Guidelines and Instructions to Students for Clinical Placements. Students were required to behave professionally during clinical placement by the university.

A student is expected to maintain the highest standard of professional conduct during the practicum.

(D5, Guidelines and Instructions to Students for Clinical Placements)

The standard of professional conduct for students concerned the requirement of professional appearance, interactions within clinical mentoring, and confidentiality and privacy. The details are listed in table 4.3.

	Details of the Requirement
Professional appearance	<ul style="list-style-type: none"> • wearing full uniform. • wearing appropriate undergarments, which must be concealed by the uniform. • putting on an student card, an nursing students badge and/or a clinical institution ID card. • maintaining black, clean and neat hair. • avoiding heavy make-up. • keeping fingernails short and clean with no nail polish. • avoiding wearing ornaments.

	<ul style="list-style-type: none"> • maintaining personal hygiene and tidiness.
Interactions within clinical mentoring	<p>Requirement related to interaction with clinical mentors</p> <ul style="list-style-type: none"> • introducing himself/herself as nursing student. • strictly complying with the rules and regulations of the clinical institution, e.g. infection control measures, overnight dormitory rules. • complying with the clinical institution’s protocol of patient care. • seeking permission from the CM before performing patient care. • taking responsibility for all relevant aspects of client care within the limitations of the student role determined by the CM. • behaving in a manner which is not disruptive to clinical institution or staff. • showing courtesy and understanding of the roles and responsibilities of all members of the health care team.
	<p>Requirements related to interaction with clients</p> <ul style="list-style-type: none"> • introducing himself/herself as nursing student. • acknowledging and responding to individual client’s needs. • seeking permission from a client before performing nursing care. • behaving in a manner which is not disruptive to client. • showing courtesy towards clients and their family members.
Confidentiality and privacy	<ul style="list-style-type: none"> • maintain confidentiality of information pertaining to a client’s condition and treatment. • never accessing clients’ information which is not directly related to the nursing care performed by the student

(D5, Guidelines and Instructions to Students for Clinical Placements)

Table 4.3: The requirement of professional appearance, interactions within clinical mentoring, and confidentiality and privacy

The above-mentioned requirement of professional conduct that students should achieve are not related to the competencies required by NCHK, except for the requirement of confidence and privacy. Students were expected to obey and follow the rules of professional appearance, the interaction etiquette in communication with CMs and clients and the other rules of the clinical settings. Expectations of students was also reflected in the reports from all participants; details of the expected roles will be discussed in Chapter 6. These requirements influenced how students behaved and how CMs judged the performance of the students: related findings will be discussed in Chapter 7. Other standard of professional conduct including the role of students in clinical mentoring and consequences of failure in fulfilling these requirements were not covered in any official document.

4.4.2. Activities in clinical mentoring

CIs/ CMs and students engaged in different clinical and educational activities within clinical mentoring. The NCHK did not provide any guidelines about appropriate activities in clinical mentoring. In contrast, the university provided guidelines to suggest appropriate activities that CIs and students should engage within clinical mentoring. Three types of clinical and educational activities including arrangement of learning activities, conducting clinical practice assessment and providing feedback were identified from the university guidelines during clinical mentoring.

4.4.2.1. Arrangement of learning activities

CIs and CMs were expected to arrange for their students to practice various nursing skills and participate in activities during the clinical placement by the university. A university document, D9, described the suggested learning activities for CIs (table 4.4). Such guidelines did not specify whether the suggested learning activities were applicable for group mentoring or individual mentoring. CIs could then follow the below guideline below and arrange students to practise according to the weeks of clinical placement.

Week	Details of the suggested students' practice
Week 1	<ul style="list-style-type: none"> • <i>Familiarise with the hospital and ward setting including the environment, structure and roles of different staff in ward, ward routines, nursing kardex, different guidelines, forms and equipments in ward.</i> • <i>Provide basic nursing care activities with the assistance and supervision of clinical instructors, for example, bed making, turning, changing napkins, vital signs taking, health assessment, simple dressing, assist clients' daily activities and personal care etc.</i> • <i>Observe and assist invasive nursing care procedures, for example, nasogastric tube insertion, suction, urinary catheter and etc.</i>
Week 2	<ul style="list-style-type: none"> • <i>Provide basic nursing care activities with occasional assistance by Clinical instructors, for example, bed making, turning, changing napkins, vital signs taking, simple dressing, assist clients' daily activities and etc.</i> • <i>Identify the commonly used medicines, dressing lotions, disinfectant, IV fluids in ward.</i> • <i>Learn to prioritise client care routines and handover cases to clinical instructors or ward staff.</i> • <i>Assist in clients' health assessment, client admission and client discharge activities under the supervision of Clinical instructors.</i>

	<ul style="list-style-type: none"> • <i>Assist or provide invasive nursing care procedures under the supervision of clinical instructors, for example, nasogastric tube insertion, suction, urinary catheter and etc.</i>
Week 3	<ul style="list-style-type: none"> • <i>Provide basic nursing care activities independently, for example, bed making, turning, changing napkins, vital signs taking, wound dressing, assist clients' daily activities and etc.</i> • <i>Prioritise client care routines and handover cases to clinical instructors or ward staff.</i> • <i>Assist and participate in clients' health assessment, client admission and client discharge activities under the supervision of Clinical instructors.</i> • <i>Provide invasive nursing care procedures independently with minimal assistance by clinical instructors, for example, nasogastric tube insertion, suction, urinary catheter and etc.</i>
Week 4 until the end of clinical placement	<ul style="list-style-type: none"> • <i>In addition with the learning activities which suggested in week 3, learning activities listed as below could be assigned to students:</i> • <i>Communicate with clients</i> • <i>Present and discuss different kinds of clinical cases</i> • <i>Prepare the commonly used medicines in ward included the indication, side effect and precaution of the medicines</i> • <i>Discuss the results of different kinds of laboratory reports</i> • <i>Discuss the information of nursing notes in nursing kardex</i> • <i>Explore the use of equipment in treatment room, linen room and sluice room</i> • <i>Explore the equipment and medicines used in the emergency trolley</i>

(D9, Suggested Clinical Learning Activities for Clinical instructors, 2019)

Table 4.4: Suggested learning activities in clinical placement

No suggestions for CMs for the arrangement of learning activities was found in any document. Thus, CMs could assign students to clinical task that could be seen as of low educational value. Students may not be able to learn through practising clinical skills at various level of complexity. The suggested learning activities heavily focused on hands-on practice of clinical skill for the first three weeks. As stated in section 4.2, students had to attend clinical placement in two to three specialty settings within the 8 to 14 weeks period of clinical placement. Students could keep practising the basic clinical skills and have no chance to practise communication skill and higher level clinical skill such as case management. This could mean that students may not be able to apply their knowledge to practice and develop the required competencies.

4.4.2.2. Clinical practice assessments

Clinical practice assessments were the second type of activities undertaken by CIs and CMs in clinical placement. As stated in different guidelines of the NCHK and university, two types of assessments that included field evaluation and mandatory clinical assessments (as stated as clinical assessment in table 4.5) were required to be conducted by CIs and CMs (Nursing Council of Hong Kong, 2016). Students were required to pass both assessments in a practicum course (table 4.5).

Assessment	Continuous assessment	60%
	<ul style="list-style-type: none"> ● Assignment (30%) ● Field evaluation (30%) 	
	Examination	40%
	<ul style="list-style-type: none"> ● Clinical assessment 	
Criteria for a Pass Grade: Pass in both continuous assessment and examination		

(D10, Definitive document of undergraduate nursing programme, 2018)

Table 4.5: Assessment requirement of a practicum course

A field evaluation is a formative assessment that was required by the NCHK, conducted by CIs/ CMs to monitor students' performance continuously throughout clinical placement.

During the clinical practicum, there must be a system in place to assess students' clinical knowledge, skills, problem solving ability and professional attitudes. (Nursing Council of Hong Kong, 2017)

The formative clinical competency of each student is continuously assessed by the clinical mentors who supervise students' satisfactory completion of the Clinical Learning Outcomes Records. (D4, Manual for Clinical Mentoring, 2013)

The scope of a field evaluation was broad as it covered the core competencies required by NCHK (Nursing Council of Hong Kong, 2016). A detailed list of competencies that students should achieve in clinical placement was included in a university document D6. An excerpt (Box 4.3) from list of competencies illustrated the competencies required in caring patients with cardiovascular disorders.

Upon completion of this clinical placement, the students should be able to:

(I) Adopt a nursing process approach to deliver holistic nursing care to clients with the following system disorders:

Cardiovascular disorders

A Perform health assessment of clients with cardiovascular disorders:

- Health history*
- Focus assessment.*

B Identify common health problems related to cardiovascular disorders:

- Decreased cardiac output*
- Excess fluid volume*
- Altered tissue perfusion: peripheral*
- Others.*

C Provide nursing care to clients with cardiovascular disorders on receiving the following diagnostic investigations and/or medical management:

- *Electrocardiography (ECG)*
- *Cardiac monitoring*
- *Echocardiography*
- *Holter*
- *Others.*

(D6, Student Practicum Handbook, 2017)

Box 4.3: Competencies required in caring patients with cardiovascular disorders

The competencies required to be achieved in clinical placement was listed according to body system disorders. The competencies listed were task-oriented. It could mean that students could be competent in completing these tasks separately, rather than being competent in providing holistic care for patients. In field evaluation, both CMs / CIs and students were asked to rate the students' performance.

During the clinical practicum, students' clinical performance is assessed by both students and clinical mentors. (D6, Student Practicum Handbook, 2017)

Apart from the list of competencies, there is no description about how to assess students' performance and how the ratings from CIs/ CMs and students were adopted as a result of field evaluation. Field evaluations could be conducted in a subtle covert way meaning students may be unaware of the assessment. Showing those competencies was not the only requirement to pass the field evaluation. Students could also be failed in the field evaluation when they were unable to follow the guidelines and instructions for clinical placement. Similar to the assessment of competencies, there is no criteria for CIs/ CMs to judge whether students complied with the guidelines and instruction or not.

Failure to comply with the guidelines and instructions for clinical placement or failure to demonstrate clinical competency will result in failure in the continuous assessment (field evaluation) and/or suspension of clinical placement (D5, Guideline to Students for Clinical Placement, 2018)

The consequence of failing a field evaluation was serious. Students faced the same consequence as failing in mandatory clinical assessment, despite field evaluation being a formative assessment. Students had to retake the practicum course later. The nature and pass criteria of field evaluation was, however, unclear. It was designated as a formative assessment in the manual of clinical mentoring, but in practice it was used as a summative assessment. As a result, students with unsatisfactory performance were suspended from practice instead of receiving extra support. Students were hindered from learning and improving their knowledge and skill through formative assessment.

Mandatory Clinical Assessments

Mandatory Clinical assessments refer to the three clinical practice assessments required by NCHK. The information about mandatory clinical assessment were more complete. The requirement of the mandatory clinical assessment by NCHK was discussed in section 1.6.2.2. The requirement from NCHK served as a framework for nurse educators to set up guidelines and standards for mandatory clinical assessment. Students recruited in this study completed one mandatory clinical assessment in each practicum that was conducted in hospital setting. As stated in table 4.5, mandatory clinical assessments were used as summative assessment of the practicum course. Each mandatory clinical assessments had its own assessment criteria. The assessment criteria were developed according to the nursing process (Nursing

Council of Hong Kong, 2016). CIs/ CMs conducted the mandatory clinical assessment based on these assessment criteria. The Nursing Council of Hong Kong (2018a) assessment criteria for these mandatory clinical assessments was unclear. Thus, CIs/ CMs could have their own interpretation on these assessment criteria, which could further influence the fairness of the mandatory clinical assessment. Unlike field evaluation, the mandatory clinical assessments were conducted openly. Students are permitted to have three attempts to complete these clinical assessments by NCHK and university that were conducted by CIs/ CMs.

Assessment of these clinical assessments should normally be completed within the period of clinical placement. Students are permitted to have two more attempts for each type of the clinical assessment should the student fail the initial attempt. Students are required to retake the Practicum should they fail to achieve a Pass after two further attempts. (D4, Manual of Clinical Mentoring, 2013)

When students passed the designated assessments in clinical placement they were considered as having passed the examination of that practicum course. Apart from the above quote in the Manual of Clinical Mentoring, no other official guideline about the implementation of mandatory clinical assessment was found. It is difficult to understand how mandatory clinical assessment should be conducted by CIs/ CMs. The details of how mandatory clinical assessments were conducted in actual practice will be discussed in Chapter 7.

4.4.2.3. Feedback

CIs/ CMs were expected by the university to provide constructive feedback to enhance students' performance throughout the clinical placement. The requirement for constructive

feedback was stated in a university document, D4, Manual of Clinical Mentoring. The principles of constructive feedback expected were listed in box 4.4.

1. *Give precise and specific information to students.*
2. *Include both verbal and visual cues, especially for procedures and skills.*
3. *Give feedback to students about their performance at the time of learning or immediately following.*
4. *Adapt the feedback to the learner's needs.*
5. *Remember that feedback is intended to be diagnostic.*
6. *Give feedback on your student's behaviour rather than her or his personality.*
7. *Base feedback on your observations rather than assumptions.*
8. *Focus on information sharing rather than instruction giving.*

(D4, Manual of Clinical Mentoring, 2013)

Box 4.4: The principles of constructive feedback expected by the university

These principles of constructive feedback focused on improvement of less satisfactory performance. Other constructive feedback such as praise and encouragement, were not included in this manual. It reflected the nurse educators' perception of error and mistakes as they were more concerned about correction of less satisfactory practice than reinforcing satisfactory practice. More data and details about feedback will be discussed in Chapter 8.

4.5. Conclusion

This chapter outlined the context of this study including information about the study setting, organisation of clinical placement and activities in clinical mentoring. Official guidelines and policies from NCHK and university were also reviewed to explore how clinical placements were officially expected to organise and how clinical mentoring should be conducted from

the organisations' perspectives. Official documents provided a very brief guidance for organising clinical placement and clinical mentoring which resulted in a discrepancy between intended goals to be achieved and actual results noted in clinical placement and clinical mentoring. Hence, students may not develop the competencies required for becoming professional nurses through clinical mentoring. The contextual information of this study illustrated what the organisers of clinical placement expected to achieve in clinical placement and how they managed CIs/ CMs and students, which will facilitate understanding of the study findings. The findings of this study will be discussed in the next four chapters.

5. Expectations in clinical placement: clinical instructors and clinical mentors

5.1 Introduction

In this chapter, various expectations related to CIs and CMs will be discussed. These expectations included CIs' and CMs' expectations of clinical placements, organisers of clinical placement 's expectations towards CIs and CMs and CIs' and CMs' expectations of students. CIs and CMs shared similar perspectives on expectations in clinical placements and CIs and CMs to the organisers of clinical placements. However, CIs had different expectations of students from CMs and some organisers of clinical placement. These expectations shaped how the CIs and CMs conducted clinical mentoring.

5.2 Expectations of clinical placement

Most of the CIs and CMs saw 'nurturing' future nurses as the goal to be achieved in clinical placement while using the students to relieve ward workloads at the same time. Interestingly, both the organisers of the clinical placement and the ward staff also agreed with these two expectations.

5.2.1 Nurturance of future nurses

Participants from various positions that ranged from coordinators of clinical placement to health care assistants (HCAs) working in placement areas reported that the clinical placement was a mean to nurture future nurses. A ward manager (O4), suggested that the purpose of clinical placement was to produce the workforce of the future.

We need to nurture the students. If I do not nurture the students, there will be no successor in the future. (O4, ward manager)

Similar findings were also reported by a junior RN (W1), who had practiced for less than one year and recalled her previous clinical placement experience as students.

When that student becomes your colleagues after graduating, you would be in trouble. I think that...a good industry relies on nurturing. If that student has a good (placement) experience, that student will become a good nurse. "Your step" (action) is really helpful. If your step makes the students to become "hea"⁵ and laid back, the students will become a bad nurse. The students would not improve this industry. (W1, junior registered nurse)

These two participants perceived that clinical placement was an essential process in the socialisation of future nurses. It was interesting that the junior nurse perceived nursing as an 'industry'. According to this view, students were transformed from lay people to workers after receiving training from their CIs and CMs. W1 further suggested that the production of a good nurse was dependent on "your steps". This referred to the steps taken by CIs and CMs to conduct satisfactory mentoring. It reflected the organisers of clinical placement, CIs and CMs' perception on "nurturing". They believed that satisfactory mentoring was a way to nurture future nurses. Satisfactory mentoring could be achieved through demonstrations, supervision and offering repeated practice opportunities. The following ward manager describes one way in which she took "steps" to nurture future nurses.

We may let that student observe the procedure for a few more times or supervise that student to practice for a few more times. It is the problem of whether the student performed the procedure or not. (O4, ward manager)

Placement organisers believed that these were considered as acts to "nurture future nurses". On the other hand, they also shifted the responsibility for successful nurturance onto students seeing it as dependent on their willingness to practice. Students were expected to become skilful workers through engaging in repeated practices and by

⁵ "Hea" is an idiom meaning careless in the report of W1.

becoming part of the workforce in the ward. Hence, they were responsible for engaging in repeated practice when they had the opportunities. This was consistent with the report from W1 that using students as helping hands to alleviate heavy ward workloads could be rationalised as giving students opportunities for repeated practice. CIs and CMs, therefore, required students to practice tasks repeatedly regardless the difficulty of tasks. This showed that CIs and CMs focused their effort on training students fit into the current ward workforce instead of nurturing students to develop skills they would need in the future.

5.2.2 Using students to relieve heavy ward workloads

The use of students to relieve heavy workloads was reported by the hospital coordinator (O3) who was part of the management of the hospital. This participant suggested that reliance on student labour was part of the strategy to manage heavy workloads in clinical areas regardless of the type of mentoring conducted. Here we can see how the students were pulled into the realities of practice in the ward area.

When there is winter surge, the ward staffs become busy. The students are attending placement in the ward. They become the helping hands. (O3, hospital coordinator)

The hospital coordinator further elaborated how students and CIs were used to relieve heavy workload by providing basic care.

There is an extra group of 6-8 people. The ward may be short of manpower. It may offer some helping hands. They (the students and the clinical instructors) are the helpers to provide the basic care, promote hygiene or even feeding the patients. When there is more manpower, it will help to relieve the workload of the ward.

The hospital co-ordinator referred to the “Winter surge” as one of the examples that explained why the workload was increased temporarily. The increased workload could also

be permanent. It was related to both increased requirement for care and higher expectations regarding quality of care. An experienced HCA (W2) described the related examples.

There are a lot of tasks nowadays that were not required in the past...Take BP chart as an example. We could stick any type of patient label on the BP chart previously. For the practice nowadays...it is required to put the label without patient's IC card number⁶.

The patients in the past made less requests. We need to offer each patient with a cup of warm water in each medication round. We have more tasks. (W2, experienced healthcare assistant)

Although a higher standard of care was expected by patients and hospital management, students helped the ward staff to perform the basic tasks with minimal supervision or even no supervision. It could be difficult to know whether students' practice was appropriate or not. Thus the quality of care delivered by students was sometimes in doubt. This situation could potentially undermine other expectations regarding high standards of care. Some CMs and ward staff justified the use of students to relieve workload by claiming that it facilitated the students' learning. They believed that the students could learn through repetitive practice from their previous placement experience.

My goal is...I am not very smart actually. It was because the others offered me learning opportunities. More practices and adjustments. I become who I am. (M6, clinical mentor)

⁶ Patient label with Hong Kong Identity card number were widely used in hospital previously. This practice changed due to personal privacy issue. Health care workers use patient's hospital number to confirm patient's identity instead of using patient's Hong Kong Identity card number. Hence, patient label without Hong Kong Identity care number are used in most of the documentations.

Er...Some nurses may tell the students to do this and that. In a certain extent, I think that the nurses “put money in your pocket”⁷...If you work harder during the practicum...if you practise diligently and get more familiar with the skill, you will be better (more competent) when you become a nurse. The route⁸ could be at least more comfortable. It let others to have a feeling that the new nurse is good and competent. Familiar with the work. It is different from those who do not know anything. People would have such comparison. I think that it is better to prepare yourself to learn here. It is so real. When you are familiar with the procedure, you will know the tricks. (W3, health care assistant)

The comments from this HCA further enriched the meaning of a good nurse. The requirements of good nurses were not only helping hands for other ward staff but also being “familiar with the work”. It showed that the ward staff expected that the students could work as nursing procedure technicians and become familiar with procedures in order to function in any working environment. This expectation could be unrealistic for students. Students could not achieve this expectation. In contrast, CIs and a minority of CMs felt that clinical mentoring had the higher priority than using students as a strategy to relieve workloads.

The ward staffs may not...the ward staffs will treat you as a runner⁹... I, as an instructor, do not dare to accept so many tasks...Some of the ward do not think so. They think that they give us all those procedures as there are a lot of students. You should be able to handle these. I think that is the difference in expectation. The ward staffs expect us to

⁷ “Put money in your pocket” is a Cantonese slang term that suggest a person offers help or benefits someone. In the report of W3, she perceived that asking students to complete the tasks for nurses was a form of help or benefit. Although nurses saved time and effort in their job, W3 believed that students were benefited from the practice opportunities offered by the nurses. Therefore, this statement implied the meaning of “I give you a free lesson” in this interview.

⁸ The route means career pathway from W3’s perspective.

⁹ Runner is a role that involves handling all the routine work and helping the team nurse to complete some procedure.

handle a certain amount of workload. That is different from my expectation to supervise the students. (M2, clinical instructor)

This CI believed that the role of student should not be the same as ward staff. She tried to assert her control in order to balance nurturance with relieving the workload in the ward. She achieved this through reducing the students' involvement in the practice of basic nursing care and enhancing the supervision of students. In addition, CIs and CMs also had more concerns about the lack of exposure of students to more complex levels of nursing care when they were used to relieve ward workloads. In particular the advanced levels of nursing care could involve more complex practical skills and the development of clinical judgment. These were considered as essential skills for a qualified nurse.

For the advanced task, the students may need to understand the case (management). That means they need to know what to observe and continuous monitoring. They also need to know what to report based on the monitoring (observation)... The students did not work as a team nurse. The students were not even responsible for a case. To be the case nurse or the team nurse. The students may not be able to observe. It is different from insertion of foley and ryles tube. When you perform it every day, you will become more familiar with it. The performance will become better. As a case nurse or team nurse, you need to do some thinking. (M4, experienced clinical mentor)

An experienced CM (M4) pointed out that being a case nurse was a form of advanced nursing skill. It involved "observation" and "do some thinking" which guided the students to make clinical judgment instead of simply performing technical tasks to order. Different CIs and CMs had different views about mentoring. Some perceived allocating repetitive practice of basic nursing skills as an acceptable way to mentor students. The use of repetitive task-oriented practice as a learning method allowed the student to be used to relieve the workload at the same time as undertaking some placement learning. On the other hand,

some of CMs believed that placement learning could be enhanced through direct supervision and opportunities to practice a variety levels of nursing skills. When comparing student learning and the relief of ward workloads, learning still had a lower priority than relieving workloads.

This showed the different ways in which the CIs and CMs believed the nurturance of future nurses should be accomplished. CMs like M4 put more emphasis on nurturing the students to develop advanced skills such as ability of clinical judgment. Hospital management viewed clinical placement in a more pragmatic way. They had a task-oriented view of nursing care. Hence, having “free helping hands” to complete ward tasks had a higher priority than training qualified nurses in the full range of skills required. It implied that hospital management accepted to compromise quality of care and mentoring when there was conflict between maintaining ward operation and conducting clinical mentoring. Due to the conflict between these different expectations, the CIs and CMs tried to balance these contradictory expectations within the clinical placement. These contradictory expectations then shaped the CIs/ CMs’ expectations of the students.

5.3 Clinical instructors’ and mentors’ expectations of students

CIs and CMs had contradictory expectations of their students which were linked to the conflicting and contradictory expectations of clinical placements held by placement organisers. These contradictory expectations of students were reflected in their images of a ‘good student’ who could fulfil all of the expectations of clinical placement. The expectations outlined below were not included in the official guidelines from either the hospital or the nursing institution. They therefore served as informal requirements used by

CIs and CMs to make judgments about the students that they supervised in clinical placement. These informal requirements included learning attitudes, etiquette and being professional.

5.3.1 Learning attitudes

Learning attitudes were frequently mentioned in the interviews by the CIs/CMs, who expected their students to have 'positive' learning attitudes. However, positive learning attitudes were described in contradictory terms such as "being an active learner" but "being obedient" and "being humble".

5.3.1.1 Being an active learner

Being an active learner was characterised through different behaviours which showed willingness to learn. There was no consensus about the behaviours of an active learner amongst CIs and CMs. Asking questions and looking for practice opportunities were examples that were described by participants as indicating how to be an active learner. Asking questions was also considered to be behaviour that showed that the students took the initiative to learn.

It is because the student wants to know. The student is curious about it. The students do not understand and they ask the question. (O4, ward manager)

However, asking questions was not always perceived as indicating willingness to learn. It depended upon the presentation of questions and the content of questions. If students presented questions in ways which were considered unacceptable, asking a question could be seen as a sign of not being obedient. This will be discussed in the next section. The

content of the question could also influence the impressions others formed of the students.

A year 4 student (S2) recalled her friend's experience of asking a perceived 'stupid' question.

As my friend asked about strict I&O¹⁰, she was blamed immediately. The first sentence must be "your school did not teach you about that." The nurse said "Have you ever attended the practicum?" for the second sentence. "Why do you act like this?" "How come you did not know it?" However, the nurse did not tell my friend what was strict I&O. (S2, year 4 student)

The incident in the illustrative quotation above shows that students asking a question did not create a positive impression all the time. It also reflected that students may not learn anything by asking questions. On the other hand, students were unclear what the appropriate content of questions should be and how they should present their questions. It was difficult for students to know whether their questions were either acceptable or presenting an impression of disobedience or stupidity.

Apart from asking questions, looking for practice opportunities was also a strategy to show an active learning attitude. Similar to asking a question, both the hospital coordinator (O3) and CM, reported that it could be seen as reflecting eagerness to practice.

If the students are active and willing to learn, they will ask questions or try to practice their skill proactively. The students could try to practice some procedures under the supervision. (O3, Hospital coordinator)

As mentioned above, students were considered to play an important role as helping hands by doing the basic nursing care. The ward staff complained that they had to complete the basic tasks when the students wanted to try the more highly valued tasks. Students

¹⁰ Strict I&O refers to strict measurement of input and output.

perceived that these tasks were seen as more attractive in terms of learning. Students, therefore, tended to fight for the opportunity to practice certain highly valued tasks.

They told me that the students did not complete their routine tasks and fight for the opportunities for practice. The routine tasks could not be completed. It means that somebody else will have to complete the routine tasks or the students may miss the routine tasks. (S3, year 5 student)

Students showed an active learning attitude by asking questions and looking for practice opportunities. These behaviours could create an impression of being an active learner but it was interesting that CIs and CMs could perceive these actions differently. The contradictory perceptions of behaviour that indicated active learning could be related to different factors. Being an active learner may be seen as a threat towards CIs' and CMs' control. It could be perceived as failure to obey and respect CIs and CMs. On the other hand, being active learners could also affect the ward routine and further affect the workload of the CMs and ward staff. When students spent time practising highly valued tasks and discussing their questions with CMs, more of the basic care workload shifted onto ward staff. This could further influence the ward operation. Hence, these activities were considered as exceptions which depended on whether the ward routine could still be completed efficiently. The ward routine was frequently given a higher priority than clinical mentoring. During periods of workload pressure, students were then more likely to keep practising basic tasks instead of learning more advanced tasks.

5.3.1.2 Being obedient

Being obedient was perceived as showing a positive learning attitude. It was not only the perception of the CIs, but some CIs suggested it was also the perception of general public.

The families of the patient praise the students. They told me that the students were good. The students were good to patients and obedient. (M5, clinical instructor)

CIs and CMs suggested that the attitude of obedience was reflected through accepting advice and critical comments. Acceptance of advice and comments was reported as an expectation from the CIs and CMs. M6, a junior CM, claimed that the students could learn more if they accepted advice from their CMs and ward staff. Accepting advice was perceived as useful when students were considered as unable to manage the clinical situation with their current knowledge.

If the students insist their thought... if the senior (staff) teach them and the students keep rejecting other's thought...they may not be willing to accept it as they think that it is an "old-fashioned "method. The students could not learn from others and could not judge which method of practice is better through critical thinking. (M6, junior clinical mentor)

M6 pointed out that failing to accept the other's advice and comments may relate to differences in thought between students and CMs. It commonly happened when students noted the difference between the teaching of the nursing institution and the practice in the clinical area.

Take dressing as an example. The mentor taught you not to transfer forceps. They told me that it was not necessary to do so. I told the mentor about what I learned from the school. (S2, year 4 student)

Some students may want to clarify the difference in thought by asking questions. This may lead to the conflict between the expectation of being obedient and the expectation of being an active learner. Students could be perceived as disobedient when they asked questions to clarify the difference in thought. O4, claimed that this could be related to the presentation

of question.

To be honest, the students tell the senior staff that “the school did not teach us to perform like this”. The senior staff have their own identity. They, of course, feel uncomfortable. Therefore, it depends on how the students ask the question. (O4, ward manager)

The way that the students asked question could upset the senior staff. The senior staff could perceive the students as not being obedient. On the other hand, some participants expressed the opposite opinion suggesting that obedience may not be an essential criterion of a good student. Differences in practice were found in different clinical areas. Being obedient was believed by some to limit the students’ ability to adapt to the reality of clinical work.

The students become less flexible. I found that it is common. The students could not adapt the change as they keep memorising the teaching from the school ...The students would mix it up as they did not think about it. It is not because of Step 1 to10. It is not the requirement of the institution or the ward. It is because of the patient. The patient could either need the step 1, 2, 3, 4, 5 or step 6, 7, 8, 9, 10 to be performed. (O4, ward manager)

These differing opinions illustrated that the expectation of being obedient varied. Many CIs and CMs wanted students who would accept their opinion during supervision. This may reflect how much the CIs and CMs valued the students’ deference to their opinions. The importance placed on students’ deference could reflect the importance CIs and CMs placed upon students showing respect to their authority through being obedient. On the other hand, CIs and CMs would also like their students to adapt their clinical practice to handle changes in patients’ conditions and changes in clinical environments by making appropriate

clinical judgments. Students could however fail to demonstrate obedience when they exercised their own clinical judgment.

Making appropriate clinical judgments required critical thinking. When the students were asked to perform tasks without critical thinking, they did not have the chance to learn how to make appropriate clinical judgments. However, they were discouraged from learning to think critically sometimes through asking questions. Students may try to struggle to balance autonomy and being obedient throughout the clinical placement.

5.3.1.3 Being humble

Being humble was the learning attitude that CIs and CMs perceived as enhancing the interpersonal relationship with students during interactions with them in clinical placement.

Firstly, the most important thing for the students is their attitude...I would teach them some interpersonal skill. The students may not perform the tasks perfectly once they learned about the skill. Therefore, the students should be humble at work. Otherwise, the students will have a hard time if they work in the future. (M5, clinical instructor)

Admitting mistakes was also seen as a gesture showing humility from the CIs/ CMs and ward staff's perspectives. It could not only enhance the working relationship but also enhance survival during the clinical placement when the students admitted their mistakes in clinical placement.

When you make a mistake, you would admit it. You would not insist and talk back when you know that you are wrong. If you make a mistake, you really need to communicate as if interaction with the mentor. "I am sorry. I will do it better next time." I think that nurses are human. If you tell the nurse about it (apology), the nurses will not treat you

badly. If you talk back due to the mistake, the relationship will be worsened. It is more difficult to work in the practicum. (W1, junior registered nurse)

W1 pointed out that the consequence of not admitting the mistake could lead to poor clinical placement experience as this act was considered as unacceptable. A HCA (W2) also reported that there were consequences of failing to admit mistakes.

If the students apologise and acknowledge it, there will be nothing happened. If the students are not willing to apologise and meet the trouble one, the nurse will inform their mentor. To handover for further management. I know that the nurses would do so. Each student is assigned with a RN as mentor. The nurse may inform their mentor. If the student could say sorry and admit the mistake, it will not be a problem. (W2, experienced healthcare assistant)

The consequence was not only reflected by the labelling of the students but also potentially by an official complaint to the nursing institution. The practicum course coordinator (O2) reported a complaint about a student's failure to apologise from a ward manager.

You can imagine the (ward) manager or the clinical partners may give feedback about this situation. When this kind of feedback is received, that student may not feel good in that ward...The clinical partners also feel that the students even don't know how to greet others when they enter the ward. The student may not apologise when they are late. It is out of the expectation. It is not acceptable that they don't have the basic manners. (O2, practicum course coordinator)

The concerned practicum coordinator was asked to teach that student to learn about other's expectations and behave accordingly. On the other hand, this could lead to students admitting mistakes which they had not committed in order to show an impression of being humble. This could help them to avoid negative consequences that could follow for students not appearing humble.

I think that I did not do anything wrong. I will feel unhappy if the mentor blames me. However... I will not argue or fight for anything as I think that I just work here for a short period of time. Therefore, I will take it. The mentor is responsible for rating my performance in the assessment. I may think like that. I prefer not to make any trouble. I will tolerate it. (S1, year 5 student)

Thus, learning attitude was not simply seen as a description of how the students learnt but also how they maintained acceptable relationships with those in authority during clinical placement. As per the report from the practicum coordinator (O2), apologising was not only considered as a gesture of humbleness but also a form of basic manners. This was also related to the etiquette expected in the clinical placement.

5.3.2 Etiquette

CIs and CMs expected students to behave according to their expectations of ward etiquette. The expected etiquette or set of ideas about socially acceptable behaviour in clinical placement included being polite and greeting others appropriately.

5.3.2.1 Being polite

Being polite was expected as a basic requirement in the clinical placement as reported by ward manager.

These are the basic requirement. I think that there is another thing is to be polite. (O4, ward manager)

All participants reported that being polite should be reflected in the student's interaction with the CIs/ CMs and ward staff. However, expectation about being polite in the interactions between students and patients were not mentioned by CIs/ CMs. A

demonstration of being polite could be as simple as saying thank you for information sharing.

The students may thank us politely. Some students are less polite. These are the bad students. (W2, experienced healthcare assistant)

CIs/ CMs perceived the performance of any students perceived as less polite as 'bad'. When a student was perceived as impolite a negative image of that student was projected in the CIs and CMs' minds. In spite of the fact that, politeness did not necessarily have any relationship to the student's clinical performance. The practicum course coordinator (O2) claimed that she tried to remind the students to be polite in the clinical placement.

We will tell the students that they should beware of the manner issue in the briefing session and emphasise that they need to be polite throughout practicum. However, there are still a big group of students in a class who may not be aware that they miss out the manners. They may have their own personality, or they become laid back¹¹ after period of practicum is completed. (O2, practicum course coordinator)

Similar to the report from the experienced HCA, failure to act politely could have negative influence on the perceived performance of a student. The practicum coordinator further pointed out that this may be related to the personality of the students. Various participants including the students reported that each student had their own personality in regard to politeness. In comparison between reports from different participants, they described the negative personality traits of the students into two ways namely, self-centred and arrogant.

¹¹ 'Laid back' consists of the meaning of lazy. In the report of O2, students felt that it was not necessary to maintain the polite image especially after the assessment was completed

One student also reported his view about the personality of the junior students who worked with him.

I met the junior students from other university. They tend to be self-centred. (S3, year 5 student)

This student further described his understanding of what was meant by 'self-centred' as practice according to one's own interests instead of the patient's interests.

There are quite a lot of junior students who are self-centred...They may think that they are the centre of the ward...It should be perform like that... in order to accommodate their thought...We need to check the "fever temp" (temperature for the febrile patients) at 12 noon. They may complete much earlier than the scheduled time. They were blamed by the nurse. "Why did you take the temperature so early?" They told the nurse "Ar! I have just completed my tasks. I want to finish all the tasks soon." They always think of themselves first. (S3, year 5 student)

A HCA (W2) also suggested that students in the younger generation tended to be self-centred. Students were perceived as acting in their own interests. Though their actions did not affect the patient's safety, it could violate the requirement of practice and increase the workload of ward staff.

The students nowadays and some RNs are nonsense. I think that ...I don't know if it is related to the shortened period of the practicum or the students were raised up by maids or related to "princess sickness"¹². Many RNs act like that nowadays. They just leave it there and do not work on it. Really a lot. It is too much to tell. It is so dirty to leave it (the used glove and catheter) on the table. (W2, experienced healthcare assistant)

¹² In Hong Kong people with "Princess/prince sickness" refers to people who are perceived as spoilt, self-centred and self-indulgent, often at the expense of friends and family. They are believed to usually surround themselves with people who accommodate their behaviour.

The above-mentioned conversation and behaviour were perceived as impolite by a student (S3) and experienced HCA (W2). The perceived impoliteness had no relationship with the performance of basic nursing care but it upset the junior students' and young nurses' co-workers instead. Students were implicitly expected to be considerate in clinical placement. However, these students may believe that clearing up after procedure should be performed by a lower rank of ward staff such as a HCA. It reflected the fact that these students perceived themselves as superior than HCAs and believed that HCAs should help them to clear up after they completed the procedures.

I also feel that the undergraduate students are arrogant. They act high and mighty. They do not know how to respect others as they receive more education. They may have such thought... I think that this type of attitude is not acceptable as everything starts from the basics. When you are not able to perform the basic tasks well, it would not be possible to perform the difficult tasks. However, they...are arrogant. When they are asked to perform some simple tasks, they will become arrogant. "Hah! Assign such simple task to me again." (W1, junior registered nurse)

This RN suggested that the way undergraduate nursing students perceived themselves resulted from attitudes of entitlement instilled through their educational background despite this RN had recently graduated from the undergraduate nursing programme. The undergraduate students were considered as "arrogant" and "impolite" when they were reluctant to practise basic skills. A student expressing their own opinion could also be perceived as violating the expectation of being humble. Students may expose themselves at risk of presenting a negative impression when they expressed their own desire to receive more advanced training.

In comparison, the junior RN (W1) echoed the reports from the other participants that students should be trained from basics. It was interesting that the data from this participant reflected the discrepancies in perceptions between the CIs/ CMs and their students regarding students' capability to receive training in more advanced skills. Students believed that they were capable of receiving training in advanced skills at an earlier stage than CIs/ CMs believed it was appropriate. CIs and CMs believed that students should first develop their nursing capability through repeated practices of basic nursing care before learning more advanced skills. In this situation, students needed to show willingness to perform the basic nursing care in order to exchange this for opportunities to practice more advanced skills. Similarly, CIs had to ensure the ward operation by contributing to relieve the ward workload so that they could exchange this help for access to more desired learning activities for their students. Both CIs and students encountered a similar situation in their efforts to obtain desired learning opportunities.

5.3.2.2 Greeting others appropriately

Greeting others appropriately was another form of etiquette expected of students in the clinical placements by CIs and CMs. The practicum course coordinator (O2) reported on the feedback received from the clinical partners.

The clinical partners also feel that the students even don't know how to greet others when they enter the ward... It is out of the expectation. It is not acceptable that they don't have the basic manner. (O2, practicum course coordinator)

A CI (M2) reported that the undergraduate students did not think that greeting was an important issue in clinical placement.

I think they do not care about the manners. For example, they won't say good morning to Miss (instructor). It's always the Miss (instructor) who says good morning to them first. (M2, clinical instructor)

She further explained in the conversation that greeting proactively was perceived as a gesture that showed that her students showed willingness to build up a relationship.

Building up a relationship was expected to be initiated by the students due to the difference in hierarchical level between CIs and CMs and students.

I talked about "You greet people when you go into their house, and so you are supposed to worship gods when you enter a temple" (Greet people when you come to a place). We will tell the students that they should beware of the manner issue in the briefing session and emphasise that they need to be polite throughout practicum. (O2, practicum course coordinator)

She also stated clearly that CIs and CMs deserve to have a higher hierarchical status than the students. Greeting initiated by people lower in the hierarchy was perceived as the correct socially acceptable behaviour in the clinical area. It reflected an attitude of being humble and obedient toward people in a higher position in the hierarchy.

5.3.3 Being professional

The CIs and CMs expected the students to work like a 'professional'. The criteria for being professional had great diversity. Professionalism could be described through desired standards of clinical practice and other professional behaviours that were related to giving the impression of being professional.

5.3.3.1 A desired standard of clinical practice

Based on data from CIs and CMs, the desired standard of clinical practice consisted of four stages: being knowledgeable, linking knowledge with practical skills, making appropriate clinical judgments and practising independently. These components could be linked with each other in sequence.

The first stage of desired standard of clinical practice was to be knowledgeable. In addition to the learning attitude mentioned previously, some CIs and CMs expected their students to prepare their knowledge before clinical placement.

The second thing is that the students really need to prepare themselves beforehand. It is not just the preparation of knowledge. Knowledge is considered as the very basic criteria. (W1, junior registered nurse)

An experienced CM (M4) pointed out that the scope of knowledge should be related to the practical skill to be performed.

The students need to self-study before they can practice the skill for real. They should not think about the next step when the play (the procedure) is started. I always tell them that working for clinical placement is similar as performing in a show. You should not revise the script and remember the script when the play is started. You need to prepare yourself beforehand. (M4, experienced clinical mentor)

However, CIs and CMs did not have a clear or consistent view about what knowledge the student should prepare before clinical placement. One CI (M3) showed contradictory views about what the students should prepare before clinical placement and learn during clinical placement.

I expect the students to obtain the very basic skill and also to have the knowledge. The students should be able to obtain the knowledge related to the task that they practice during practicum. (M3, experienced clinical instructor)

Once the students were perceived as well prepared in knowledge, CIs and CMs then expected students to enter the second stage to achieve the desired standard of clinical practice. Their requirement for the desired standard of clinical practice was not simply completion of assigned tasks. As the students would be nurses in future, they were expected to achieve higher standards than HCAs. Hence, the students needed to link knowledge with practical skill. This expectation was seen as differentiating the competency levels of professional nurses and supporting staff.

I also hope the students can...I hope the students can be different from the HCA (health care assistant) or supporting staff. The students should not perform the procedures or take obs (vital signs) according to other's instruction only. (M5, clinical instructor)

Both CIs and CMs suggested that professional nurses should be more knowledgeable than the supporting staff. With sufficient knowledge, students were not only able to act as a health care technician but also become a health care professional able to make clinical judgments accurately. After the students could link knowledge with practical skill, they could move to the third stage of the desired standard of clinical practice: making appropriate clinical judgments.

Making appropriate clinical judgments could be illustrated through identification of abnormal conditions in the patients and the reporting the abnormal conditions identified to an accountable person such as CI/CM and case nurse.

When there is anything abnormal, they do not know how to handle. I hope...the students could perform some simple tasks when they identify some abnormalities...They could be alerted for the abnormality. (M5, clinical instructor)

After the students were able to identify the abnormality, CIs and CMs would expect their students to react appropriately towards the abnormality. For example, report the case to the ward staff.

If the students can think of the intervention, they will manage the case. If they are unable to think of the intervention, they will approach the others to seek help. "Oh. The patient is not the same as what I have seen. The condition of the patient is different from usual." That is a feeling. The students should know to report. (M5, clinical instructor)

In the fourth stage, the students were considered capable to practise independently. When the student identified the abnormal condition of the patient, the competent student could implement the appropriate nursing intervention. A junior RN, recalled her previous experience as a student who was able to practise independently.

A good student should make others to have an impression that one should help the team nurse during sudden incident... For an instance, a patient complained of shortness of breath. The student may have already...When I first discover the patient to have shortness of breath, I may be able to complete the vital signs before reporting. You could provide the intervention as well such as place the Oxygen mask at the bed side. If you think that I am not qualified to provide oxygen, I will place the oxygen mask at the bed side. The nurses at least could get the mask immediately when you report the case...as it represents that you have the ability. (W1, junior registered nurse)

To practise independently required the students to achieve a higher level of clinical judgment. They not only needed to identify and report abnormal conditions but also needed to decide the appropriate intervention that could alleviate the abnormal condition. Hence,

students, who were able to practise independently, were also able to manage the basic tasks and advanced tasks as well. That means that they were believed to have the competencies of a qualified nurse by their CIs/ CMs.

5.3.3.2 Other professional behaviours

Other professional behaviours including punctuality and a conservative appearance were described as enhancing the professional image of the student by both CIs and CMs. These behaviours were considered important despite not having a direct relationship with practising competently as a nurse. None of the professional behaviour was stated in the requirements from the NCHK though it may be part of general employment conditions for paid staff.

CIs and CMs considered punctuality as basic requirement for the students to act as a professional.

The behaviour of good students. The basic requirement is not to be late or leave early. Not to disappear. (O4, ward manager)

Conservative appearance was another form of professional behaviour that was expected from students. A practicum coordinator from a nursing institution, claimed that professional behaviour could be reflected through appearance.

The most basic thing is the appearance. This is how the students' appearance look like during clinical placement. How should the hair style look like? How should the student look like when they are in uniforms? For example, we ask the students to put on a badge that indicate the year of study. Apart from the requirement of proper outlook (uniform), we do not allow our students to wear accessories like ring and earrings. The students are also not allowed to put on nail polish. (O1, practicum coordinator)

A CI managed a complaint about student who was described as having a 'fashionable appearance'. The complaint was made by a nursing officer who was the ward in-charge in some shifts when this instructor conducted clinical mentoring. That nursing officer had developed a poor impression of a 'fashionable' student. The perceived poor impression was related to failing to meet the nursing officer own's expectation of a professional nurse's appearance.

People felt that she was not sincere sometimes...I would...um...um the old fashioned (traditional) people or the sister (nursing officer) noted her at that moment. (M5, clinical instructor)

Interestingly, the perceived poor impression was reversed after the student changed her appearance following advice from her instructor.

It was one of the female students in the previous practicum. She was ...Her outlook was quite fashionable. For example, she wore thick-rimmed glasses and a few earrings. That are two to three earrings at the same ear... After that student knew about it, she became aware (alert)... (I asked her to) wear less earrings and wear an ordinary (less stylish) glasses during the practicum. It became ok afterward. That sister¹³ supervised that student once when I was not available. The sister supervised a group of female students to insert the foley in a female ward. That sister said "oh. The students are quite good. Their technique is not bad." (M5, clinical instructor)

A similar case was also reported by CI that students' physical posture was described as having a negative effect on the impression a student gave.

I have also witnessed something such as the posture. The problem of posture. Or some weird comment on others. I would let the students to know about it. "You stand in such

¹³ Sister is a nickname of advanced practice nurse and nursing officer.

a posture. The others would think that you are “swinging¹⁴”. As a ward staff told me that those two “ar sir”¹⁵, one was very good. The other one did not know what to do and keep “hea”¹⁶ in the ward.” As I have done my own observation, I told “ar sir”¹⁷ that “Yes. He really stands like this. He doesn’t work in a lay back attitude. It is just his habit. He is a good student and willing to work. He may be thinking at that moment. He used to think when he stood in such posture.” I may explain it to the ward staff. I would also let that student to know about the comment from the ward staff. “There was a staff who comment your act like this. You may have to think about how to improve it. Otherwise, the others may have misunderstanding about you.” The reason is that somebody may have misunderstanding about you. (M3, experienced clinical instructor)

Expectations of students from the CIs, CMs and the practicum organisers were used to build up a perceived impression of a ‘good student’, which was often unrelated to the quality of their clinical performance. CIs’ and CMs’ expectations of the students could be varied due to differences in emphasis regarding the expectations of the clinical placement. CIs put more emphasis on skills acquisition as they were employed by the nursing institution for clinical mentoring only. Students were expected to learn as many skills as they could during clinical placement. In contrast, CMs, who were RNs employed by the clinical area, had to take care of their patients and conduct clinical mentoring at the same time. Students were expected to play their part in relieving the ward workload. Their expectations of students, therefore, were firstly that they would be good workers in clinical area. The difference in expectations of students shaped the clinical mentoring conducted by CIs and CMs. When CIs tried to

¹⁴ “Swinging” means hanging around with nothing to do in Cantonese. A person who hangs around with nothing to do present an impression of being unorganised. It means that this person could be less competent and is not reliable.

¹⁵ “Ar sir” means male nurses in Cantonese regardless the nursing student and the registered nurse. “Ar sir” here referred to the two male students.

¹⁶ “Hea” means laid back in Cantonese.

¹⁷ This “ar sir” referred to the male nurse who commented on the student as laid back.

nurture students to achieve the clinical standards that would be expected of qualified nurses, students were more likely to be a learner instead of working as free labour. This could affect the operation of clinical area as it took students away from basic care. CIs would thus need to mediate the students' practice through interaction with staff in the clinical area. Staff in clinical area had various expectations towards the CIs. Similar to the situation of students, CIs may need to fulfill clinical staff's expectation to facilitate clinical mentoring. Like students, they too could face the conflict between working as free labour and assuming the responsibilities of clinical mentoring. It implied the difference in identity within the clinical area. Both CIs and students were outsiders of the ward. They were required to fulfill the ward staff's (insider) expectations in order to obtain the permission for practice opportunities.

5.4 Expectations towards clinical instructors from clinical partners' perspectives

CIs were supposed to be responsible for conducting clinical mentoring. However, staff in clinical area had the control over mentoring activities. CIs, therefore, had to fulfill clinical partner's expectations in order to facilitate clinical mentoring. The control of mentoring activities could be due to special status of CIs during the clinical placement. CIs were employees of the university and worked in the clinical ward. They were neither ward nor hospital staff and were not familiar with the setting of the clinical areas.

The students are not the only one to adapt the environment. The instructor also needs to adapt it. I have never been to that hospital. I have never worked in that specialty or ward. (M2, Clinical instructor)

The CIs were considered as eligible to supervise students and practise in the wards as the ward staff believed that CIs was a qualified nursing professional.

It is relaxing for them (the ward staff) if the “duckling tour”¹⁸ come for clinical placement. When the clinical instructors from the schools take up the responsibility of teaching, the ward staffs become “hand off”. The ward staffs may just communicate with the instructor about the arrangement of the procedure. As we are all qualified nurses, it easier in communication. The ward staffs do not need to work for the teaching role. Therefore, it is more relaxing. (O3, hospital coordinator)

The CIs were treated partly as members of staff in clinical area. However, ward staff could have some contradictory perceptions about the CIs. They also treated the CIs partly as outsiders. This affected the ward staff and the hospital management’s expectations of the CIs due to their ambiguous identity in the clinical area.

One hospital coordinator reported that ward staff had the responsibility of monitoring the tasks completed by CIs and students.

The responsibility is still there. For example, who is responsible for administer the medication or some other procedures. The ward staffs need to become a leader that is a case manager. They need to monitor the case about the treatment and the quality of the procedure...The ward staffs also hope that the group of students or the clinical instructors could complete the task through teaching (under guidance or supervision) and report to the ward staffs...If the task is performed by others, the ward staffs will need to check whether they (the students and the clinical instructors) have completed the task or the outcome is achieved. (O3, hospital coordinator)

As CIs were outsider on the ward, ward staff were also required to bear the responsibility for rectification of work when CIs and students were unable to fulfil the requirements of the nursing care.

¹⁸ “Duckling tour” refers to group mentoring for the junior year students that is offered by the clinical instructors from the nursing institution.

The most serious thing is making mistake or mix up something. They (the students and the clinical instructors) may mix up between patients. Or they may leave the record incomplete. Take an example. They may need to take the observation such as taking blood pressure and temperature. The students may not be familiar (with the documentation). The students may miss out some tasks. It will affect the work of the ward staffs as they are required to finish all the tasks within the shift. (O3, hospital coordinator)

Hence, ward staff could try to ensure ward operation by allowing and monitoring CIs' and students' practice cautiously. These acts could reflect the lack of trust between ward staff and CIs. When ward staff did not trust CIs throughout clinical placement, they could limit CIs' and students' practice. It could then be difficult for CIs to conduct clinical mentoring. CIs would then try to fulfill these expectations to build up and maintain trusting relationships so that they could ensure the effectiveness of the clinical placement.

5.4.1 Comply with rules of the ward

As a partial outsider on the ward, CIs were expected to comply with the ward rules. The ward staff could feel threatened by a group of outsiders that included the CI and students. One CI suggested that the ward staff could have feeling of being invaded.

The ward staff feel confident about you. They would let to perform the task freely. If the ward staff do not feel confident to let us to practice, we will not gain anything from the practicum. We are not able to perform some hands-on task. I think that is the meaning of "manage the ward". The purpose is to let the ward staff feeling that we are the helping hands. We are not "step their field"¹⁹. They will feel confident to let us to practice. (M5, clinical instructor)

¹⁹ "Step their field" means invading and messing up one's colony. The field could be either physical environment or context of responsibility. For example, the ward operation

Complying with the rules of the ward was, therefore, a way for the CIs to build up the relationships and trust with ward staff. The CIs could then gain more opportunities of practice for their students. The effectiveness of clinical mentoring would be enhanced. An experienced CI even claimed that she was able to work on the tasks that were forbidden by the ward manager as the ward staff helped her to cover up due to their trusting relationship.

Willing to let us to perform the tasks though the nurses allowed us to practice secretly. We had to complete the procedure before the ward manager came back to the ward. That ward manager did not know about it. The nurse reminded us that the ward manager should know about it. Ok. No problem. We cooperated with each other. Of course. That nurse felt confident to me as they (some nurses) recognised me. There were one or two nurses who recognised me. They said "Miss, we give you "face". We let the students to practice because of you (M3). So you can complete the task" (From M3) "I know. Ok. No problem. I would not get into trouble. If I have anything that I am not clear, I will ask you." I would cooperate with the nurses." (M3, experienced clinical instructor)

When the CIs built up relationships and trust with the ward staff, they tended to be treated as member of the clinical area and less likely to be treated as outsider. Hence, the CIs had to learn and comply with the rules of an unfamiliar workplace from the start of clinical placement. These actions could benefit the students by encouraging ward staff to allow less restrictive practice by students and this could in turn ultimately enhance the effectiveness of the clinical placement.

5.4.2 Being responsible

The ward manager and ward staff expected the CIs to be responsible for the ward operation and quality of care. Being responsible was an abstract concept. It could be reflected in three

types of activities, namely communication with ward staff, completing the allocated tasks appropriately and adequate supervision.

5.4.2.1 Constant communication with ward staff

Constant sharing of information was considered a very important form of face-to-face communication in clinical placement. Adequate communication could facilitate the CIs to build up trust with the ward staff.

If the students do not know about something, we will ask the nurses. Or if we are unable to perform some tasks, I will tell the nurses in advance. It helps to gain the trust from the nurses. (M3, experienced clinical instructor)

The ward staffs also hope that the group of students or the CIs could complete the task through teaching (under guidance or supervision) and report to the ward staffs. It could be the "biggest" responsibility. The ward staff handover the task to a team...If the task is performed by others, the ward staffs will need to check whether they (the students and the clinical instructors) have completed the task or the outcome is achieved. (O3, hospital coordinator)

The purposes of constant communication included clarification of misunderstanding, report of abnormality and completion of task. Constant communication could be perceived as act that demonstrated being responsible. It not only helped to minimise mistakes in nursing care but also facilitated the work of ward staff. When CIs were considered as being responsible, then a trusting relationship could be built up.

On the other hand, CIs served as a connection between the ward staff and the students during group mentoring. They were the chief persons to communicate with the ward staff.

When the ward staffs know that “Miss” (the instructor) is a responsible person. For example, greet the ward staffs when we come to work and leave the ward. We will inform the wards staffs when we have our tea time. We will not disappear suddenly. Or we perform the procedures carefully and make sure everything is clear. I think the ward staffs will know that “Miss” perform everything carefully. The ward staffs feel reassured. They afraid that the “Miss” is a careless person and supervise student. (M2, experienced clinical instructor)

This CI pointed out that CIs were responsible for all the actions of their own group of students as they were considered as the leader of the group of students. Communication was a strategy to show how the CIs would be responsible for the clinical area. CIs had to initiate communication to manage relationships, clarify misunderstandings and report to the ward staff. There could be similarities to the expectation of being humble. Being humble could facilitate building up a relationship. CIs could then become members of the ward after they communicated with ward staff humbly. Ward staff had the control over the practice opportunities that facilitated CIs’ ability to conduct clinical mentoring. When CIs were able to build up trusting relationship with ward staff, ward staff were more likely to offer practice opportunities. Apart from constant communication with ward staff, the CIs were also expected to monitor the students to complete the tasks in a timely way.

5.4.2.2 Complete the allocated task appropriately

As clinical mentoring was the first priority of the CIs, they could reserve the appropriate tasks for their students. Ward staff tended to accommodate the CIs’ requests if possible.

We would try to accommodate their requests if possible. We would reserve some tasks for the clinical instructors to let their students to practice under supervision. (O4, ward manager)

When the CIs were able to reserve their desired tasks, they were expected to complete those tasks appropriately in return.

The trust comes from working performance of my students and me. For example, you did not miss out some tasks and did not bring trouble to the ward staff. The trust will be built up between the ward staffs and you gradually. (M2, clinical instructor)

This CI claimed that trust could be built up through completion of reserved tasks appropriately. She further described what was meant by completion reserved tasks appropriately as “did not bring trouble to the ward staff”. This could be achieved through completing the reserved task on time and ensuring the patient’s safety. CIs were not only expected to be responsible for clinical mentoring but also ensure the ward operation was not negatively affected by the presence of students. However, it could be unavoidable to have some delays in clinical work.

Take routine task as example. The clinical instructors and the students follow our routine to complete those tasks. However, it would be slower if the clinical instructor to lead “the kids” (students) to complete the routine tasks. (O4 ward manager)

Time therefore was one of the considerations when the CIs reserved the tasks in clinical placement.

As an instructor, I need to decide whether I should reserve the procedure according to the time we have. Whether I should accept the offer or it is impossible for me to supervise all the procedures. (M2, clinical instructor)

The CIs not only worried about being unable to complete the tasks on time but also how to balance the allocated workload of clinical tasks and opportunities for clinical mentoring. This could have an impact on patient safety.

5.4.2.3 Ensure patient safety

All participants agreed that patient safety was the first priority of clinical placement. The students were not qualified to practice as professional nurses. When the students practiced in the ward, the CIs were responsible for supervising their practice.

As the clinical instructors are teachers, they are responsible for supervising their students. (O4, ward manager)

Adequate supervision was a strategy to ensure patient safety. A practicum course coordinator described what the CIs would do in adequate supervision.

As the clinical instructor is beside you, you would be likely to rely on the clinical instructors. If there is any problem encountered, I will just stop and ask the clinical instructors. (O2, practicum course coordinator)

The CIs had to closely monitor the students to practice. They also had to intervene when there was occasion that may cause hazard to patient safety.

I kept pushing the students and monitor the condition of that patient at the same time. Apart from supervising the student, I mainly monitor the condition of that patient. However, that patient "desat" (desaturation) before we completed the whole procedure. I performed the suction. That student was able to complete the procedure in the end. It was fine. (M5, clinical instructor)

When CIs and students were occupied by performing nursing care, CIs may not be able to closely supervise their other students on the ward.

One clinical instructor supervises eight students. It depends on whether the clinical instructor can manage the students. When the students first come to the ward, the clinical instructor, of course, supervises how the student performs the task. The students may work in a particular cubicle. It should be within sight of the clinical instructor. The students may work in two or three cubicles at a later time of the practicum. I don't

know how my colleagues feel about it but I am a bit worry about it. I doubt if the clinical instructor could supervise the students or not. (O4, ward manager)

Once CIs were able to complete the reserved tasks appropriately, ward staff could be more willing to offer either more tasks or different types of tasks for clinical mentoring.

The ward staffs will be willing to let you to perform the procedure or let you to try different procedures. Or the ward staffs may tell you proactively. "We have a conference today. Are you interested to attend?" All sort of these. (M2, experienced clinical instructor)

These actions reflected that the trust was built up between CIs and ward staff. When CIs completed the reserved task appropriately, it meant that patient safety was ensured. Ward staff could then believe that CIs were able to be a guardian of patient safety. A trusting relationship was developed as patient safety was ensured. This ultimately facilitated clinical mentoring.

5.5 Expectations towards clinical mentors from organisers' perspectives

CMs were nurses working in the clinical area. They had already formed trusting relationship with their colleagues. CMs did not have the issue of identity that CIs had to deal with.

Organisers of clinical placement had simpler expectations towards CMs. Practicum coordinators from university expected CMs to assume the role of mentors. On the other hand, the hospital management expected the CMs to fulfil the role of both of nurses and CMs.

The staff needs to be mentor and work on clinical duties as the same time. (O3, hospital coordinator)

As mentioned previously, the clinical workload was high. CMs had to manage both roles in clinical placement. Their workload became higher than the other nurses.

As a ward staff, you are not just required to handle the cases. In my ward, the ward staff may have their own duty apart from managing the cases. You know there are quite a lot of things to handle. Yes. It is very busy. (O4, ward manager)

CMs had to manage these two roles at the same time. They were required to complete their clinical work first. Clinical work was put at a higher priority due to time limits. CMs could then mentor their students after their shift was completed.

Is there any change in the workload? I have to be a team nurse. There is no chance for not being a team nurse. I usually use extra time. I use my own time to mentor the students. (M6, clinical mentor)

Clinical mentoring was considered as additional workload for CMs. The organisers of clinical placement agreed that CMs should put clinical work at a higher priority than clinical mentoring.

The only concern is not to overload the ward. (O3, hospital coordinator)

Some wards or hospitals may also send the students to attend class. It is the additional resources. It really depends on the management of the ward. The ward (staff) may ask the students to stay and help the operation of the ward and let the staff to attend the class. (O2, practicum course coordinator)

Under this circumstance, the CMs may either use their own time to conduct mentoring or even omit clinical mentoring during the clinical placement. Apart difficulties caused by heavy workloads, some CMs believed that clinical mentoring was not part of their job.

The most challenge is that there is no black & white to state that the clinical staffs need to supervise the students. That means we did not put down in “black & white” in the contract. It is out of their job description... On the other hand, there are also colleagues who may refuse or reluctant to be mentor as they think that it is out of their job description and workload. This is the challenge. (O3, hospital coordinator)

When CMs failed to conduct clinical mentoring, students completed their clinical placement by working as free labour instead of learning in clinical area. In contrast, students could spend less time working as free labour and more time in learning when they were mentored by CIs. CIs could mediate the activities for their students during clinical placement. Clinical placement without clinical mentoring failed to nurture the future nurses. It could also lead to risks to patient safety. When students practised in a ward without any supervision, they could have no idea about ways to improve their performance and ways of improvement. Students could then simply continuously provide basic care. This could potentially expose patients to harm.

5.6 Conclusion

Expectations of clinical placement from the CIs and CMs’ perspective showed their perceptions of the goals of the clinical placement. They believed that CIs/ CMs should be able to nurture the future nurses and relieve the workload in clinical placement. These expectations shaped CIs’ and CMs’ perception of good students. It further influenced how CIs and CMs chose to conduct clinical mentoring. Clinical mentoring could be conducted by either CIs or CMs. Different expectations applied to CIs and CMs to achieve the goal of clinical placement. It could be related to difference in identity in the clinical area. For CIs, they had to build up trusting relationship with ward staff to facilitate clinical mentoring. In contrast, CMs had to ensure clinical works was completed first before they conduct clinical

mentoring. Clinical mentoring could be either put as a lower priority or omitted by CMs. Clearly, CIs, CMs and students all agreed that completing clinical works was at higher priority than clinical mentoring. In comparison between CIs and students, CIs could still ensure some clinical mentoring in clinical placement. Students had less control over their opportunities to assume in the role of learner as this was controlled by their CIs and CMs. Students had their own perspectives about clinical placement and how they worked with their CIs and CMs which will be discussed in the next chapter.

6. Expectations in clinical placement: students

6.1 Introduction

This chapter will present data that outlines students' expectations of clinical placements and how they achieved their expectations of clinical placement by responding toward their CMs'/ CIs' and clinical expectations. Students expected their CIs and CMs to reward them for conforming with their expectations through providing the clinical mentoring that they expected. This reciprocal exchange could ultimately achieve students' expectations of clinical placement. Students had relatively submissive role in clinical placement in comparison to CIs and CMs. Their behaviours in clinical placement could be shaped by their CIs' and CMs' expectations. When this occurred students would undergo professional socialisation by learning to conform to the expectations of CIs and CMs in the placement context.

6.2 Expectations of clinical placement

Students' expectations of clinical placement were simple in comparison to those of CIs and CMs. Most student participants agreed that completing clinical placements was a means for them to achieve graduation and thus qualified nurse status.

I study in this programme. It is required to attend the practicum. Even though I did not receive any salary, I would attend the practicum. Yes. As I want to graduate. (S6, year 5 student)

Students had to pass all types of assessments in clinical placements in order to be considered as having completed their clinical placements. Hence, their expectations of clinical placement tended to be assessment oriented. As outlined in Chapter 4, two types of assessments including field evaluation and mandatory clinical assessment were adopted to

assess the competency of students. These two assessments served different purposes in fulfilling expectations of clinical placement. Success could be achieved by passing the mandatory clinical assessments in clinical placement and this in turn depended on having sufficient learning opportunities to practise the relevant skills.

6.2.1 Passing all types of assessments in clinical placement

Passing all types of assessments in clinical placement was considered by students to be the most important requirement to be achieved in clinical placement.

I think that the ultimate goal of the placement is to pass the placement (practicum course). If I am not able to get the pass, it will be meaningless. No matter how many things you have learnt in the placement. You are not able to get the license. I think in this way. I must pass the assessment. (S1, year 5 student)

Students put more emphasis on mandatory clinical assessment. Passing mandatory clinical assessments was given a higher priority than wider learning in clinical placement. A year 5 student (S4) perceived that learning to act according to the requirement of the assessment was more important than acquiring broader competencies in practical skills.

I just wanted to pass... pass... pass the test in the end of the practicum. I may not perform some of the routine work. I tried not to perform it. Take an example. When there was a chance for me to insert the foley, I may not focus on it as I just wanted to pass the test (S4, year 5 student).

Organisers of clinical placement had a different view on assessment from students. They perceived field evaluation as a strategy to assess the clinical competency of students.

As we need to practice on a real patient in the ward environment, we must ensure the competency of the students. It is because they do not have license, or they are not

authorised to perform any task. As a result, the mentors really need to perform some extra work to perform the pre-assessment to check the competency of students. (O3, hospital coordinator)

Similarly, CMs and ward staff also suggested that they could conduct field evaluation before they assigned the task to students.

Also...er...Haven't ...before assessing the ability of the students, I would not let the students to perform some tasks easily. (W1, junior registered nurse)

When students were considered as competent after being assessed in field evaluation of their skills, this resulted in these students not only being able to obtain more practice opportunities but also being allowed to perform that skill independently afterwards.

I can perform the procedure on my own after the nurses audit my performance once. (S2, year 4 student)

Apart from influence of field evaluation, the practice opportunities could be varied in nature after students passed the mandatory clinical assessment. A year 5 student (S6) recalled her experience after she passed the assessment of aseptic technique.

As I attended my first practicum in surgical ward, the nurses let me to perform dressing for surgical wound. They tended not to let me to perform dressing for surgical wound before the assessment of AT... I performed dressing for the bed sore all the time. (S6, year 5 student)

Passing an assessment could not only enhance the quantity of practice opportunities but also the variety of practice opportunities. In contrast, students who were considered to have 'failed' field evaluation of competence could be restricted from practising many skills. Another year 5 student (S4) recalled his experience after failing to report an abnormality of

a patient in his first clinical placement. He reported that failure to report an abnormality was considered by his CI as signifying that he had 'failed' in the field evaluation of his communication skill.

I was not allowed to...even taking the BP for that patient. Yup. I was assigned to manage two patients in the beginning of the practicum. I was responsible for that patient (patient whose stool with blood stain). I was no longer allow to do so. I was restricted from performing any procedure for that patient. I managed one patient only. (S4, year 5 student)

This student was restricted from performing practical skills even though he had been assessed as 'failing' in communication skills only. He reported that he was perceived as incompetent. Field evaluation influenced CIs' and CMs' impression of student competency. It also depended on whether students pass their mandatory clinical assessments or not. Students could be perceived as competent when they passed the mandatory clinical assessments, which could influence CIs and CMs' decisions about task assignment. Hence, the more competent the students were perceived to be by CIs & CMs, the more likely they were to have more learning and practice opportunities.

6.2.2 Having sufficient learning opportunities

Having sufficient learning opportunities was seen as an important means to become a competent nurse. Students had similar thoughts to their CIs and CMs about practising skills. They agreed that their competency could be improved through repeated practice.

My mentor provided me a few times for practice by the end of the practicum. I think that I know how to perform the injection. (S3, year 5 student)

This year 5 student perceived that he was able to manage skill of injection by practising “a few times”. On the other hand, CIs and CMs did not specify the numbers of times students needed to develop their competency. As discussed in Chapter 5, the hospital coordinator and CMs stated that students had many opportunities to practice basic nursing care. Having sufficient learning opportunities was not only concerned with the quantity of practice but also the nature of the learning opportunities.

We did not know how to handle a team of patients. The experienced nurses expected a newly graduated nurse to know how to handle a team of patient. I think that it is ridiculous as we have not learnt about it. Even for the very minor thing such as how to use the CMS²⁰. If you ask me to book NEATS²¹, I would not know about it. To be honest. There are a lot of small things that the clinical mentor would not teach you. You have to explore by yourself. (S2, year 4 student)

This expectation was similar to the point of view of some CMs that the students should be allowed more opportunities to practise the nursing skills that will be required after graduation. However, passing assessments and having learning opportunities were mostly controlled by CIs and CMs. Hence, students were only able to pass assessments and receive learning opportunities if they fulfilled their CIs/CMs’ expectations. They could pass assessment by performing the practical skill appropriately. On the other hand, they could also achieve these expectations through showing CIs’ and CMs’ a desired impression. In the next section, students’ responses towards CIs’ and CMs’ expectations will be discussed.

²⁰ CMS is an electronic system that manages care of the patients. Healthcare professionals could order laboratory tests, diet management and view the records of their patients.

²¹ NEATS referred to non-emergency ambulance booking system that is a booking system for non-emergency use of ambulance. It usually used to reserve the ambulance for transferring patients to nursing home during discharge and transportation for follow up.

6.3 Students' responses toward clinical instructors' and clinical mentors' expectations

Students had their own expectations of clinical placement. These expectations could be achieved by responding to CIs' and CMs' expectations. Some of the students' responses were similar to the expectations of CIs and CMs. They could also receive information about CIs' and CMs' expectations through orientation. CIs and CMs could let students to know about their expectations of students explicitly either before or in the beginning of the clinical placement.

I usually meet the student before the practicum. At least meet the students once. I need to know about their name and tell them about my requirement of practicum. (M2, clinical instructor)

I would provide orientation about the operation of work. To make it simpler. It is related to the routine and my requirement for the students. (M6, clinical mentor)

In contrast, some CMs may not explicitly tell their students about their expectations. A junior RN (W1) recalled the sharing from her colleagues who were CMs. They queried whether their students would know their expectations.

Through the sharing of the colleagues... I will know about the student. "Oh! There is a group of students visiting my ward this time. For example, their knowledge level, ability and the attitude after completed the tasks. Or can the students feel the requirement of the task completed by them? (W1, junior registered nurse)

When students were not explicitly informed about the expectations of them, they could make a guess at their CIs' and CMs' expectations and create their own interpretation of these expectations. Hence, students attempt to meet expectations could diverge from the actual expectations of their CIs and CMs. Students' attempts to respond to their CIs' and CMs' expectations could be reflected in how they tried to demonstrate three attributes,

namely learning attitudes, being responsible and not making mistakes. Students perceived that they need to acquire these three attributes to become nurses.

6.3.1 Learning attitudes

Learning attitudes was one of the CIs' and CMs' expectations. Students were expected to be active learners, as well as being obedient and being humble in clinical placement. Their responses reflected their perceptions about how to meet these expectations. Students perceived that they should be an active learner and not to be arrogant in clinical placement. They believed this could help them to become nurses by and maintaining satisfactory interactions with others in clinical area and thus acquiring opportunities to acquire necessary skill.

6.3.1.1 Being an active learner

Similar to the data in Chapter 4 from the CIs/CMs, students believed that good students should be active learners.

Good student needs to ask question proactively, "R" (search for) opportunity to practice proactively. (S2, year 4 student)

Asking questions and looking for practice opportunities were the gestures suggested by students for showing an active learning attitude. CIs and CMs believed that these behaviours showed willingness to learn. A year 5 student (S1) suggested that demonstrating active learning behaviours meant showing others that you were proactive and willing to learn.

I think that learning proactively is to discover...things that you do not know. You may encounter many things that you do not know. You need to think whether you have learnt about it in the first place. I think I think that...you have to review what you have learnt as you cannot keep asking others for everything that you do not know. The other may feel bothered when you ask everything. For the students who learn proactively, they would discover the answer for the question identified...I may be able to know some of the answers. When I still have something unclear, I would ask the mentor why it may happen. The mentor or the staff will teach you. If the mentor or the staff recognised that you are well prepared, they feel that you are willing to learn... (S1, year 5 student)

In order for students to show that they were active learners, they needed to show initiative in their learning. This act of exploration was a gesture that showed initiative in learning. Students also believed that their active learning behaviour could impact their CIs and CMs at the same time and increase the workload of CIs and CMs. When students asked questions, their CIs and CMs needed to spend time to answer their students' questions. Students, therefore, tried to demonstrate that they had made an effort to discover answers first. They only approached their CIs and CMs when they could not solve their questions. The year 5 student (S1) suggested finding out answers could present an impression of being "well prepared". Students thus needed to revise their previous knowledge learnt and revisit their questions to give the impression of being an active learner. Students could also start to develop the skill of critical thinking. Their questions could become more sophisticated. CIs and CMs could perceive this process as a form of preparation. Students engaged in learning activities through thinking critically about their questions. This could further imply an impression of being "willing to learn". This may also explain why CIs and CMs believed that good students were those who were well prepared for clinical placement as they showed they were willing to learn by being active in the learning process in clinical placement.

Students suggested they could be more likely to acquire knowledge and skill by being active learner. They not only expected themselves to be active learner but also not to be 'arrogant' in clinical placement.

6.3.1.2 Not to be arrogant

Students took on the message from their CIs and CMs that they should not be arrogant during clinical placement.

You should not be arrogant all the time. (S3, year 5 student)

Students perceived that being 'arrogant' could be reflected through several behaviours. They, therefore believed that they should avoid certain behaviours, such as trying to select tasks to be completed or 'talking back', in order to prevent themselves from being perceived as arrogant. As mentioned in Chapter 5, students were asked to perform basic nursing care in clinical placements. However, they preferred practising what they considered as 'high value' tasks that may require complex and advanced nursing skills. Nevertheless, students believed that they should perform all assigned tasks without selection in order to be accepted by the staff in clinical placements.

The students should not only practice the tasks that they want all the time. For example, the students do not like to take vital signs and change napkins. From my practice, I am willing to perform any tasks. So the nurses like me a lot. You should not think that you do not need to practice the simple tasks. The students should not practice injection only. You must perform the basic skills well. (S2, year 4 student)

Students believed that students who did not select their tasks gave a positive impression to ward staff. These students not only relieved the ward staff's workloads but also showed that they were not 'arrogant'.

They always think like that...they just want to learn about special tasks. I think that this type of attitude is not acceptable as everything start from the basics. When you are not able to perform the basic tasks well, it would not be possible to perform the difficult tasks. However, they...are arrogant. When they are asked to perform some simple tasks, they will become arrogant. "Hah! Assign such simple task to me again." They would feel...they would not feel that they should treasure this learning opportunity or consider this opportunity as a linkage of practice of "big task" for the next time. (W1, junior registered nurse)

This RN echoed the report from the year 4 student (S2). She suggested that students' attitude was unacceptable as they did not value the practice in basic nursing care. This could also be related to CIs' and CMs' expectation toward their students. They expected their students to be obedient. When their students tried to convince their CIs and CMs to allow them to perform advanced nursing care instead of assigned basic nursing care, CIs and CMs could have a feeling of being challenged and then perceived that these challenging students had a character of 'arrogance' as shown in the quote above. Ward staff believed that students should not be allowed to select their tasks in clinical placement.

Similar to selecting tasks, 'talk back' was also perceived as behaviour that reflected an attitude of arrogance.

The students could be...um...too arrogant. They felt that they were good at knowledge or they were invincible in clinical practice. They thought that they need to...challenge the registered nurses all the time. "Why do you perform like that? I don't think that it should be done in this way..." I have heard of that. The registered nurses perceived that

they should be in higher level than the students. However, they are really aggrieved as the students challenged them. (S3, year 5 students)

Students were considered as believing themselves “invincible” when they expressed opinions which challenged ward staff. This year 5 student (S3) further suggested that CIs and CMs could perceive this as a challenge as they believed that their students should recognise their higher hierarchical status. Thus, they could feel offended when students ‘talked back’. Students could also be perceived as ‘arrogant’ when they tried to clarify any misunderstanding in clinical placement. A year 4 student (S2) was told by her CMs that she had missed out a step of a procedure.

I think that “talk back” refer to the poor attitude and being arrogant. Also, when the students do not respect the mentor, the students would talk back. I just want to clarify the misunderstanding in a mild tone. I did not want to challenge the nurse. It is not reasonable for me to skip the first step and perform the second step to challenge the nurse. When the nurse made this claim, I felt unhappy. I think that is not “talk back” behaviour. I just want to clarify. To clarify the instruction from the nurse. To ask me to start the procedure from step 2. My classmate who was next to me also heard of it. That’s fine. The nurse insisted that her claim was right. I just can apologise. I had to say apology. (S2, year 4 student)

When this student clarified the misunderstanding with her CM, her CMs may perceive that she confronted her judgment. The CM could thus feel challenged regardless of her presentation of clarification. When this student tried to clarify the misunderstanding, this could also be perceived as failure to admit a mistake. As a result, she was perceived to have failed to fulfil the mentors’ expectation of being humble. The student, therefore, apologised to her CM for clarifying the misunderstanding to reverse the negative impression perceived by her CM.

The incident reported by this student could reflect how CIs/CMs manage the difference in opinion instead of the actual character of students. CIs and CMs may perceive their students as failure to obey when students expressed a different opinion. Students who expressed a different opinion could be perceived as failing to be humble by their CIs and CMs. Students may not be able to distinguish between their CIs' and CMs' expectation of being humble and obedient. They could perceive both expectations as an expectation "not to be arrogant". Being perceived as arrogant was linked to an impression of having a poor learning attitude. Students, therefore, may either avoid expressing their views or apologise for a mistake that they did not make to maintain a relatively positive impression in the minds of their CIs and CMs. This positive impression could help students to be accepted by their CIs and CMs as acceptable future members of nursing profession.

6.3.2 Being professional

Being professional could also be a way that students developed a professional identity. Similar to CIs and CMs, students also expected to demonstrate that they worked professionally. The perception of being a professional from the students' perspectives was more pragmatic than that expressed by CIs and CMs. Students believed that they should be able to present the impression of professionalism through their perceived standard of practice, by working efficiently and by being punctual. This also reflected that students' perceptions of professionalism. They believed that they could develop a professional identity by being functional in clinical placement.

6.3.2.1 Perceived standard of practice

CIs' and CMs' expectations about the desired standard of practice were more complex than students' perceived standard of practice. They also expected their students to apply knowledge into practice and make appropriate clinical judgments. Students could ultimately practice independently when they achieved this. In contrast, students perceived the desired standard of practice in a much simpler way. Students perceived that not making mistakes was sufficient to achieve their desired standard of practice.

The main goal in the beginning is not to make anybody in trouble. I should be able to complete all of the routine tasks. Not to make mistakes. That means not to harm the patient. (S3, year 5 student)

This student (S3) suggested that the desired standard of practice should be to not make any mistakes. He further gave examples of "not to make mistake" as "complete all of the routine task" and "not to harm patient". Some participants believed that mistakes were unavoidable.

I believe that in this profession...it is very difficult to avoid making any mistake. (S4, year 5 student)

I think that the mentor also needs to be confidence in the students. The students will graduate someday. They always have chance to make mistake. No matter they are student or not, they may still make mistake. (M4, clinical mentor)

Both students and CMs agreed that students may encounter situations in which they could not avoid "making a mistake". This could be related to external factors such as failure in communication between co-workers.

We have breakfast time in my ward. You may have some tasks that have not been completed. You may hand over to others. It happened once. The junior student left for breakfast. He really left the ward and had breakfast without handing over the tasks to

me. I did not know anything. The IC (ward in-charge) suddenly asked me during his breakfast time. "Hey, have you rechecked the patient with H'stix 2.5?" I said "Hah! I don't know anything. 2.5? recheck?" (S3, year 5 student)

This student failed to recheck H'stix because his co-workers had failed to inform him about the patient's condition. This communication failure could result in potential harm to patient. On the other hand, a year 5 student (S4) was also considered as making a "serious mistake" when he reported a patient with blood stain on the napkin only to a health care assistant.

As there was a patient, I changed the napkin with a "Jei Jei" (HCA). I found that there was blood stain in his stool. I told the "jei jei" about this problem at that time. That "jei jei" then told me that it should be fine. So we continued to change napkin for the rest of the patient I am not sure whether the patient could overhear our conversation When that patient saw my "miss" (CI), the patient told her about the conversation between the health care assistant and me. After the clinical instructor knew about it, she told me that I had made a very serious mistake. I did not report to the nurses or the case nurse. (S4, year 5 student)

Students could be considered as making a mistake even if they communicated with a co-worker about the abnormality. S4 failed to inform the expected person instead of failing completely to communicate. This implied that S4 was also failed to observe the ward hierarchy. The junior student who worked with S3 and S4 could be unclear about the actual mistake that they made. They believed that they failed in communication rather than failed in making appropriate clinical judgment. Students had to face consequence after they made mistakes. A year 5 student pointed out his concern about the consequence of making mistake.

I think that the students should be active and do not make mistakes. When you make mistakes, no matter you harm the patient or not, the ward staff would not like you. (S3, year 5 student)

Students perceived that CIs, CMs and ward staff were generally unable to accept students making any mistake regardless the seriousness. Mistakes involving patients were considered as most serious by hospital management.

When the incident involved the patient, it is really serious. (O4, ward manager)

Students believed that it was not acceptable to make any mistake even if it did not cause harm to patients. CIs and CMs further suggested that simple mistakes and repeated mistakes were unacceptable.

It could be related to a very basic... basic tasks that could be completed by ordinary people. The students still made such mistakes. I cannot tolerate it. (M4, clinical mentor)

When they make the same mistake again, I think that...I will say I cannot accept you make this mistake for the third time. "So if you make this mistake again, I will report to the CC (course coordinator)." It is a means to threaten them. Yes. I will mark it in their record. I will tell the student that your performance is poor. (M2, clinical instructor)

Thus students were perceived as failing to meet the desired standard of practice when they made mistakes. Ward staff believed students who made mistake were incompetent. These students were considered as failing in the field evaluation and to be able to fulfil the role of workers. They, therefore, could face a range of negative consequences.

Consequence of making a mistake...For minor things, it may be shared during the handover. For the serious things, it may affect the graduation or fail in the practicum. There would be a high chance that the ward staff do not like you. It may affect your

assessment or life afterwards...The life working in the ward would be really gloomy. (S3, year 5 student)

Consequences that students could encounter was at minimum the mistake “being shared during handover”. CIs and CMs could share the incident of mistakes with ward staff or other students. This could result in the “gloomy” clinical placement experience as described by a year 5 student.

I know that there are students who have a bad experience in the practicum. The nurses blamed that student all the time. That student felt unhappy. He felt unhappy when he worked in the ward each time. He looked really depressed. He felt like being tortured when he went back to ward. (S3, year 5 student)

Students had a poor clinical placement experience after they made mistakes. Students were trying to achieve a standard of practice that they and their CIs/ CMs considered as impossible. They tried to maintain an impression of competence by not making any mistake. Giving an impression of being incompetent could not only bring a poor placement experience to students but also restrict students from learning and practising.

6.3.2.2 Complete work on schedule

Apart from not making mistakes, students internalised the expectation that they complete their work according to the expected time schedule in clinical placement.

Need to complete all routine tasks on time. (S6, year 5 student)

This student’s work in clinical placement was basic nursing care. This was consistent with the data from hospital management and CMs. Students believed that they should complete

their work on time in order to relieve the ward staff's workload of basic nursing care in clinical placement. Duly completed work was used to trade for learning opportunities.

I feel happy if I can help the nurses. Yes. It could also save time for the tasks. I could help the nurse and the nurse could help me as well. (S3, year 5 student)

Similar to CIs, students expected "help" from their CM in return. The "help" that this student referred to could be opportunities to practise more advanced tasks and supervision from his CM.

My mentor may...just like the practicum recently...my IC (mentor) was an APN and the ward-in charge. She said to me suddenly during a shift "S3, come here." I said "Hah? What's happened?" I thought that I have done something wrong. My mentor then said to me "Hey, let me supervise you to give injection." My mentor gave me a lot of opportunities to give injection. (S3, year 5 student)

However, the "help" was not guaranteed all the time. Some students could keep working on the basic nursing care throughout the clinical placement without obtaining any opportunities to practise more advanced tasks or receive supervision from CMs.

The nurses think that we (students) should help them to perform the routine tasks. For the advanced tasks, they would finish them by themselves... The nurses expect you to become a nurse who is capable to be a team nurse after graduation. However, they did not teach you about what you need to do and they expect that you can do it after you graduated. It is quite weird that you are not taught about how to do it (to be team nurse) within these five years. The nurses just treat you as manpower. The students need to help the nurses to perform the work of HCA (health care assistant) or the simple work of the nurses. (S1, year 5 student)

All students perceived themselves as free labour in clinical placement. They expected to have to use their labour as a token which they could exchange to fulfill their learning needs. However, the fulfillment of learning needs depended on the inclinations of CMs.

For example, you know that a patient needs to have a procedure done today. It really depends on the mentor. Whether the mentor wants to let you to try it or not. If the mentor does not want you to try that procedure, no matter how you convince the mentor, the mentor will not allow you to do so. (S1, year 5 student)

The variation in fulfilment of student's learning needs could be related to the priorities of clinical mentoring. CIs tended to put clinical mentoring in a higher priority in clinical placement in comparison to CMs. Students were able to receive the clinical mentoring conducted without the exchange of fulfillment when they were mentored by CIs. Some CMs could even omit the responsibility of clinical mentoring as they believed that clinical mentoring was not part of their job. Students could then trade for learning opportunities by completing their work on time. They could also obtain the opportunities to practice through being punctual. It was one of the ways to maintain professional impression.

6.3.2.3 Be punctual

Students were expected to be punctual and this key message was well understood by the students.

The third thing is to be punctual. I have seen the nurses who come to work later than 7 am (the start of the morning shift). You may found it could be unacceptable. I must be punctual. I think that the punctuality is important. (S2, year 4 student)

This student (S2) further suggested that being punctual demonstrated commitment. It showed how much student were committed to clinical placement.

It is a form of commitment. A commitment to arrive before 7am. (S2, year 4 student)

Students who failed to be punctual could present a negative impression. This echoed the report from the ward manager (O4) that punctuality was a criterion of a good student. The year 4 student (S2) suggested an explanation for why she maintained punctuality during clinical placement.

I cannot give a poor impression to the ward staff. (S2, year 4 student)

Failing to be punctual could be perceived as poor performance and affect the clinical placement experience in a similar way to making mistakes. Students could experience negative impacts as a result of not being punctual. Apart from maintaining a positive impression through being punctual, students attended their clinical placement on time for a pragmatic reason.

We need to count the hours of practice. (S2, year 4 student)

Students believed that they could maintain a positive impression by showing expected learning attitude and acting like a professional. These behaviours not only served as trade-offs between working as free labour and being a learner in clinical placement, but also served as strategies for students to survive in clinical placement. When students responded appropriately toward their CIs' and CMs' expectations, their CIs and CMs could then facilitate students to fulfil their expectations of clinical placement. When CIs and CMs facilitated students to fulfil their expectations of clinical placement, it served as a reward for what was considered to be appropriate students' responses.

6.4 Students' expected rewards from their clinical instructors and clinical mentors

Students expected their CIs and CMs to reward them after they responded appropriately toward their perceived CIs' and CMs' expectations. The expected rewards from CIs and CMs included preferred characteristics of CIs and CMs and mentoring behaviours that were desired by students. Hence, these rewards reflected the desired clinical mentoring expected by students.

6.4.1 Preferred characteristics of clinical instructors and clinical mentors

Students perceived that the characteristics of CIs and CMs could influence how they conducted clinical mentoring. The preferred characters of CIs and CMs included friendly approach and teaching students proactively.

6.4.1.1 Friendly approach

Students preferred to work with CIs and CMs who presented them with a friendly approach during clinical placement.

I, personally, prefer the mentors who are friendly. (S1, year 5 student)

This student (S1) further described how a friendly CI/ CM should behave. It also showed the influences of friendly approach toward learning in clinical placement.

The mentor...if the mentors are friendly to you and they would like to help you, you will feel more comfortable. You will also ask them question when you do not understand. You can feel that the mentor is helping you. Therefore, you can ask them when there is anything I do not know. It is comfortable to interact with them. (S1, year 5 student)

A friendly approach facilitated students in learning. Students felt “comfortable” to approach a friendly CMs for help as they perceived that they were welcomed when seeking help. This could be reflected in the CI’s/ CM’s response towards student seeking help.

The mentors would not feel that you bring them trouble or show you the expression of being bothered. (S3, year 5 student)

CI/ CM could be perceived as friendly when they showed acceptance towards students’ help seeking behaviour such as asking questions. Students then became more likely to engage in the role of an active learner. On the other hand, another year 5 student (S1) described friendly CI/ CM as a helpful person in clinical placement. This also meant that friendly CI/ CM was someone who actively participated in clinical mentoring.

6.4.1.2 Active participation in clinical mentoring

Students were aware of their need to engage in learning activities. However, they could not do this alone. It required active participation by their CMs.

Er...a good mentor should teach the students proactively when they are free. For example, it was less busy in the surgical ward. the mentors may discuss the cases with me during the night shift in the surgical ward. (S6, year 5 student)

This expectation applied to CMs only as they may not fulfil the teaching role due to their priority of work. Students had no control over whether their CMs chose to conduct clinical mentoring or not. Hence, they expected that good CMs took initiative and opportunity to conduct clinical mentoring.

When I have some problems about the clinical practice, I may ask them. They would reply me. The mentors should teach you proactively. They may come to you and teach you proactively or ask you to come over...I was asked to come over by the registered

nurse suddenly all the time. The nurse may “Hey, there will be an insertion of chest drain later. Will you observe the procedure?” or the good registered nurses may wait for you. The procedure will be started when I am there. It is a very good thing. (S3, year 5 student)

Active participation in clinical mentoring was reported by students as a way that could facilitate students to learn directly. CMs could show their participation in clinical mentoring by arranging learning opportunities. Active participation in clinical mentoring could also be reflected through various mentoring behaviours.

6.4.2 Mentoring behaviours

CIs and CMs used different mentoring behaviours when they conducted clinical mentoring. Students perceived that some mentoring behaviours were beneficial to their learning during clinical placement. These expected mentoring behaviours were perceived to occur in a sequence throughout clinical placement. CIs and CMs could start with a demonstration of skills and sharing knowledge and experience. Students also expected their CIs and CMs to supervise their practice and provide suggestions for improvement after they practised their skills. In addition, they also expected psychological support. Students believed that these expected mentoring activities could enhance their practical skills and develop their competency of being qualified nurses.

6.4.2.1 Demonstration of skills

Students perceived that demonstration of skill by CIs and CMs was beneficial in learning.

A good mentor. I think that it would be the best to have one-on-one mentoring like a dog follow the owner. When the mentor performs a procedure, I would observe how she performs the procedure. (S5, year 4 student)

CIs and CMs used demonstration for various purposes. They could demonstrate the practical skill to let the students know about the standard of practice.

For the new procedure, I will not ask the students to perform it on their own. I will guide the student to perform it. At least they will be supervised by me. You know. If the eight students do not feel confidence to perform the skill, I will demonstrate the skill once. The students have to perform the procedure on their own next time. (M2, clinical instructor)

Demonstration could also be used to substitute for opportunities to practise. Some procedures were considered as not suitable for students to practice on their own.

These procedures are relatively ...we think that it shouldn't be handled by the students independently. It doesn't mean that we don't teach. (O4, ward manager)

Some of these procedures could be classified as high-risk by hospital management.

We would identify some procedures as high risk. We would follow the guideline from (Hospital Authority) head office and the guideline of my own department.

Um...some investigations such as NPS, NPA (nasal pharyngeal aspiration). Some of the nursing cares such as ventilator care, care of chest drain. Something like that. There are more than ten procedures. (O4, ward manager)

CIs and CMs demonstrated the skill in order to teach their students when students were unable to perform the high-risk procedure themselves.

You may be able to have more chance to observe the peritoneal dialysis, haemodialysis and central line. More cases with a ventilator. The students could observe more in the acute settings. (O4, ward manager)

Demonstration of high-risk procedures not only served as a teaching strategy but was also seen as a way of ensuring patient safety ensuring during clinical placement.

We all have responsibility to ensure the patient safety in the clinical setting. We also need to protect ourselves, no matter if the students or the mentors. When the student has not performed the task before, I usually ask the student to observe my demonstration for the procedure that he/she wants to perform. (M4, clinical mentor)

On the other hand, hospital management could also believe that time consuming procedures were not useful or suitable for students to practice as well.

The ward staff may spend half an hour to complete the assessment while the students spend two hours to complete the assessment. It may not be useful. Why should we let the student to perform it? I may demonstrate the assessment to the students. If I have time, I will demonstrate the assessment for the students. (O4, ward manager)

Demonstration, therefore, served as a strategy to ensure ward operation while fulfilling the learning needs of students. However, demonstration of a skill depended on the time constraints on CIs and CMs. Students, therefore, expected their CIs and CMs to perform more demonstrations in return for students relieving the basic workload. Learning could be achieved not only through observation but also through the sharing of knowledge and experience from CIs and CMs.

6.4.2.2 Sharing from clinical instructors and clinical mentors

Students expected the CIs and CMs to share knowledge and experience with them. Sharing of knowledge and experience could be achieved through different types of activity. CIs and CMs could share knowledge and experience by answering students' questions.

The student may ask "Miss, what is the purpose to do that?" or "why I have to do it?" We would explain to the student...The students do not understand and they ask the question. We tell the student about the rationale. It is a way to help the students. (O4, ward manager)

Answering students' question were considered to facilitate students to learn. Sharing of knowledge could also be achieved in debriefing after assessment was conducted.

I was assessed on the skill of changing a dressing for that time. She taught me about the use of different (dressing) material...She asked me about it first. If I answered her questions incorrectly, she will teach me. She taught me how to use it. (S1, year 5 student)

Knowledge could also be shared by giving a short lecture.

I would try to give the students the "lectures "throughout the six weeks practicum. It serves as doing the revision with the students. I would do the revision with the students about the basic once such as the major organs... I would try to cover (talk about) the major diseases to the students. (M3, clinical instructor)

Students perceived that they could learn when their CIs and CMs shared knowledge and experience with them. As reported by this CI (M3), sharing of knowledge could be helpful to consolidate students' knowledge. On the other hand, CIs and CMs could also share their previous experience to improve students' practices.

When the students do not perform well, the way of providing feedback depends on the situation, it could be related to lack of experience. I may share my experience with the students. (O3, hospital coordinator)

Sharing experience provided additional information to the students. It could help students to rectify mistakes but also help students to prevent further potential mistakes.

I always ask the students not to trust others for everything. Do not do what others ask you to do. You need to check with the kardex. It is better not to trust yourself. Double, double, double check. I think this is from my previous experience. For example, you thought it should be right and chart the reading for a patient. However, you make a mistake in documentation. The chart clipped together may not belong to the same patient. These kinds of experience would help me to remind the students. The students may make the same mistake as the mistake that I made previously. I think it would be better to remind the students as a prevention. (M2, clinical instructor)

Students perceived that sharing of knowledge and experience could be beneficial to their learning. However, some of the sharing could be related to outdated knowledge and experience. These types of knowledge and experience could be no longer applicable to the current practice.

They will share a lot of their experience if your question is related to clinical (practice). Take an example. It happened long time ago. It was about ryles tube. A mentor who was a nursing officer and an experienced nurse... "When I was in nursing school, I learned another method." said the mentor. This method is no longer updated. We need to remove the plug of the ryles tube and get a cup of water. Then put the ryles tube into the cup of water. If there is bubble in the water, the ryles tube may not be in the right position. It could be inserted into the lung. It was a very strange method to me. From what I have heard, I felt that it was very special. That mentor told me that it was the practice of the nurses in the older generation. It was not stated in the textbook. I think that is the clinical thing. (S3, year 5 student)

The sharing from this student's CM was not of an appropriate practice. Students could apply inappropriate practice learnt from mentors sharing outdated practice which could impact on the quality of care. Students perceived sharing of knowledge and clinical experience by CIs and CMs as an important aspect of clinical mentoring. After students learned from demonstration and sharing, they expected their CIs and CMs to evaluate their practice.

6.4.2.3 Evaluation of students' practice

Evaluation of practice was perceived to enhance learning in clinical placement by students. It consisted of two components, namely supervision of practice and providing suggestions for improving practice. CIs and CMs could evaluate the performance of students when they supervised students' practice. It served as a way to conduct field evaluation. Based on the supervision, CIs and CMs could then provide suggestions to their students. Students perceived that these two components could help them to learn how to reach the required standard of practice and further facilitate them to improve their practice. Students, therefore, expected their CIs and CMs to supervise their practice periodically to monitor their learning progress.

I hope the mentor could audit my performance for more times. It is very important to have more audits. I am not sure whether I perform properly or not when I perform dressing on my own. Although I have performed (wound) packing once, it doesn't mean that all wound packings are the same. (S2, year 4 student)

When students were not supervised in practice, they could not judge whether their practice was correct or not. Hence, they expected their CIs and CM to make such judgments through supervision of practice. Supervision of practice depended on CMs' will.

I then asked the nurses if they can supervise my practice once or I can observe their practice. The nurses who are willing to teach would say OK. (S5, year 4 student)

Supervision of students' practice was part of the tasks involved in clinical mentoring. As mentioned previously, CMs tended to put clinical mentoring at a lower priority than their clinical work. CMs who were willing to conduct clinical mentoring tended to supervise students more often. On the other hand, CMs could be less likely to supervise their students if they were reluctant to conduct clinical mentoring. CIs and CMs were able to judge whether students' practice were up to the required standard after supervision of students' practice. They, therefore, could then give suggestions to students to improve practice.

She may remind me to improve my performance. (S5, year 4 student)

CIs and CMs could let their students to know about the standard of their performance. They may also provide any suggestions to students as to how they should improve their performance. Students, therefore, expected their CIs and CMs to show them how to improve their practice.

The mentor could give me more comment so that I could perform better. Just like the practice in the male ward. It is not only "ok" or "not ok". I really want to improve and perform better. (S2, year 4 student)

Students could not be able to improve their practice without this advice. A year 5 student (S4) was restricted from practice when he failed to report abnormal findings. He expected that his CI would give him suggestions to guide him to improve his performance.

I think that a good mentor should provide some recommendations rather than...happened in the first practicum. To point out your mistake directly and tell you

that “You should not have further practice. I need to restrict you to provide care” (S4, year 5 student)

Students expected CIs and CMs to give concrete suggestions instead of just grading their performance. With meaningful suggestions, students believed they could learn from their weakness and improve their performance.

The nurses...our nurses usually tell the student. “Hey, it should not be performed like this. You should do this and this.” If we find it, we will say “nurse (student), it is not right. We would tell the students. (W3, health care assistant)

Demonstration of skills, sharing from CIs and CMs and suggestions for improvement focused on hands-on skills and knowledge. Apart from skills and knowledge, students also expected their CIs and CMs to provide psychological support during clinical placement.

6.4.2.4 Psychological support

Knowledge and skills were commonly reported by CIs and CMs as the focus of clinical placement. Interestingly, students also expected their CIs and CMs to provide psychological support to them throughout clinical placement. The expected psychological support could be presented into two ways, namely, encouragement and recognition. These psychological supports could be expected in different situations. Students expected their CIs and CMs to provide encouragement when their performance was not up to standard. S4 was a student who had failed an assessment for two times and would fail his practicum course if he failed in his third assessment. He expected the encouragement from CIs and CMs.

I think that ...may be...the mentor could give some encouragement. (S4, year 5 student)

This year 5 student suggested that encouragement served as a kind of psychological support. Students expected encouragement from their CIs and CMs. This student felt that he was under pressure after he failed his second assessment. He perceived that the CI focused on assessment instead of this student's psychological status.

To the clinical instructor...She....failed a student. It was not a matter for her. From her perspective. I think that it really doesn't matter. As a student, I have to bear a huge pressure. On the other hand, from the clinical instructor's perspective, she has no pressure to bear. Therefore, she was calm. She did not give me any encouragement as well. She just told me how I could improve my practice and what I should perform better. (S4, year 5 student)

This student and his CI had different perceptions of his failure in assessment. This student felt stressed after he failed twice for his assessment. He expected encouragement from his CI to support him psychologically. On the other hand, his CI had a more pragmatic perception. She perceived support simply as involving helping him to improve his performance and pass the assessment and did not show awareness of the need of psychological support. Apart from students with poor performance, other students could also describe expecting to receive psychological support in the form of recognition from their CIs and CMs when their performance was satisfactory. The junior RN, who recently graduated from undergraduate nursing programme, recalled her previous clinical placement experience.

I feel that the students usually perform the tasks...I just want a recognition from others. (W1, junior registered nurse)

This junior RN believed that recognition was a form of reward after she completed her tasks. Students could perceive recognition as praise for satisfactory performance. Similarly, the

year 5 student (S4) had experience of being recognised when he attended his second clinical placement. He felt that being recognised brought him positive clinical placement experience.

After I gave injection, that "ar sir" told me the comment. His comment criticised you first then praised you. He told me which part of my performance was less satisfactory. For example, there was something bad when you counterchecked the medication with Nurse B just now. You had missed out something. On the other hand, your skill was OK when you prepared the medication. You can keep it up. I believe that you should practise more if you keep the performance at this level. If there is another chance, for example you work with me in a night shift; I will let you to practice more. My feeling is much better. (S4, year 5 student)

Being recognised did not always mean that the students completed their assigned tasks perfectly. This student (S4) reported that he was praised for the part of the practice that could meet his CM's standard. It served as recognition of his practice. This student felt positively when his CM recognised his performance.

Students felt positively towards recognition and encouragement. These were types of psychological support that motivated students to improve their practice and proceed to learn new skills in their clinical placement. Students could better understand performance requirements through recognition and encouragement. They could be clearer about what they should focus on learning. Students perceived these mentoring behaviours could bring positive impacts on their clinical placement experience. On the other hand, there were other mentoring behaviours which CIs and CMs adopted when they felt they needed to manage unsatisfactory student performance. These mentoring behaviours could influence the students' clinical placement experience more negatively. The details of these mentoring

behaviours and their impacts on managing students' performance will be discussed in Chapter 8.

6.5 Conclusion

Students expected clinical placement to be the means whereby they transformed themselves into qualified nurses. They had a relatively submissive role in the clinical placement as they had minimal control over the process which could allow their transformation from lay person to professional. Students believed that they could influence this process by acting as good students as expected by their CIs and CMs. They hoped to receive what they expected from clinical mentoring after acting as good students. Students' behaviours were thus shaped by CIs' and CMs' expectations and mentoring behaviours. Students thus underwent a process of professional socialisation during clinical placement. Impression was frequently mentioned in the illustrative quotes. Students tried to present an impression that was compatible to their perceived CIs' and CMs' expectations. This influenced how CIs/ CMs responded to their students. Impression plays an important part within the interaction between CIs/ CMs and students. Hence, it was essential to know how the impression of students were developed. This will be discussed in detail in the next chapter.

7. Impression formation in clinical placement

7.1. Introduction

In previous two chapters, various expectations from all participants were discussed. These expectations influenced the formation of impression of students that shaped how CIs and CMs conducted clinical mentoring. This chapter presents data from all participants on how impressions of students are formed by CIs and CMs in clinical placement. Impression formation was a crucial part of the social process of clinical mentoring as it influenced CIs/CMs interactions, mentoring activities, feedback and ultimately the result of clinical assessments. Based on the impression formed, CIs and CMs made a social judgment about their students. This social judgment was critical as it influences the CIs' and CMs' interactions and arrangement of mentoring activities for their students during clinical placement and judge whether their students, and feedback, as well as their judgment/assessment of whether their students competent and eligible to be signed-off by the end of clinical placement.

CIs and CMs formed an impression of their students through two types of assessments: field evaluation and mandatory clinical assessments. These two assessments varied in their assessment strategies and context of assessment. Field evaluation was a type of less structured formative assessment that focused on the daily interactions and practice. In contrast, mandatory clinical assessments were well structured summative assessments and focused on the three clinical skills required by the NCHK. The impression of students was formed based on the interactions between CIs/CMs and students. These interactions constructed the process of impression formation of student that could be conceived as a

form of drama. The drama of assessment, consisting of four phases: setting up the scene, audition, rehearsal of assessment and performing the drama. Organisers of the clinical placement set up the script and the scene of the desired impression which involved setting up guideline and environment, and preparation of CIs/ CMs and students to participate in the process of impression formation. Students served as actors, while CIs and CMs served as the audience and director of the drama of assessment. Students practised and then performed the designated clinical skill in the various phases of the drama of assessment. CIs and CMs then judged whether their students acted according to the script.

7.2. Impression formation through assessments

As outlined in Chapter 4, field evaluations and mandatory clinical assessments were required to be conducted by NCHK and university during clinical placements. Although NCHK and university provided official guidelines and policies for these two assessments, the data from CIs, CMs and students revealed that the actual implementation of these two assessments in clinical placement varied from the requirement stated in those official guidelines. CMs and CIs conducted these two assessments and formed impressions of students from the result of assessments. The practice of field evaluation and mandatory clinical assessment reported by participants will be presented as below.

7.2.1. The practice of field evaluation

According to the official document from NCHK and university outlined in Chapter 4, CIs and CMs should conduct field evaluation continuously to assess and monitor students' performance. However, data from CIs, CMs and students showed that CIs and CMs had their

own interpretation of the official guidance and conducted assessments of student's clinical performance in their own way. CI (M3) reported that CIs and CMs often conducted field evaluation as a one off, instead of continuously.

The students would complete the test in the last three days of the practicum. After the student completed the test, I check the answer. If I feel the answer is correct, I will help the student to fill in the record. Fill in the record on the spot. (M3, clinical instructor)

The field evaluation was conducted summatively at the end of the clinical placement. When CIs and CMs failed to assess their students' clinical performance continuously, they could not provide feedback to their students in time to enhance learning in clinical placement. On the other hand, some students reported that some CMs omitted the field evaluation intentionally.

They will tick assessment and tell you about the details of each disease. You can jot down the notes if needed. "Talk about the disease" is an assessment for you. They will also help you to tick achieve for that item. (S1, year 5 student)

Students reported that CMs gave mini lectures for their students to replace field evaluation. A year 5 student suggested an explanation of omitting the field evaluation. CMs may assume students to have achieved certain level of competencies in clinical performance from their previous clinical placement experience.

The staff may think that you are senior student. They expect that you should know about it. So they will not assess anymore. (S1, year 5 student)

Omission of field evaluation not only failed to monitor students' clinical performance during clinical placement but also failed to facilitate students to learn and enhance their confidence. It could further affect the students' performance in summative assessment.

Organisers of clinical placement seemed unaware that CMs omitted the field evaluations. In the official practice, CMs were required to document the result of the assessment after they conducted field evaluation.

The clinical mentors need to supervise. They have to fill in the documents after supervision. (O4, ward Manager)

However, participant reported in the second quotation of this section that their CMs still documented their performance as “achieved” the competency without any specific assessments having been conducted. When CMs completed the documentation without assessment, this made it difficult for the organisers of clinical placement to monitor the CMs in clinical placement. It further meant that organisers of clinical placement could fail to assure the quality and standard of clinical placement.

Variation in field evaluation could indicate that field evaluation was less valued by CIs and CMs, which could be related to a lack of understanding of formative assessment, such as field evaluation. CIs and CMs did not appear to understand the purpose of conducting formative assessment and the role of formative assessment in clinical mentoring. The information on formative assessment was supposed to be provided through training of clinical mentoring by either university or hospital. As reported in Chapter 5, all CIs and CMs claimed that they received no training about clinical mentoring, which could explain why they appeared treated field evaluation as an unnecessary practice ritual.

7.2.1.1. Assessment strategies for field evaluation

Data from CIs, CMs and students described various assessment strategies as being adopted by CIs and CMs in field evaluation, including supervision, quizzing students and seeking others' opinion. These assessment strategies facilitated CIs and CMs to know and form an impression of their students.

Supervision

Supervision was the preferred assessment strategy described by nurse educators and hospital management. As discussed in Chapter 5, CIs and CMs were expected to supervise their students continuously when they conducted clinical mentoring. A year 4 student reported that CIs/ CMs assessed their students' competencies directly through supervision throughout the period of clinical placement.

How did the mentor assess the items stated in the iPod²²? The mentor would supervise me for one more time and tell me about the result. (S2, year 4 student)

CIs and CMs adopted other clinical placement assessment strategies including quizzing students, seeking opinion from others.

Quizzing students

CIs/ CMs and students reported that students' clinical performance was assessed through asking students questions.

²² An app in iPod was used to document the result of field evaluation for the university that S2 studied. "Items stated in ipod" referred to the list of competencies that students should be assessed in field evaluation.

I would test about the knowledge that the students learned before. For example, I would ask the students to write down three points of bathing nursing care or the conditions that required informing when the student performed vital signs taking. When the patient suffered from high temperature...hyperthermia, the students had to give me 5 points of the related nursing care. It was a very intensive test. It covered everything that we encountered in the practicum. (M3, clinical instructor)

This CI described the questions they used to assess their students' clinical performance focused on the abnormal conditions found in taking vital signs and nursing intervention for various health problems. CIs/ CMs reported perceiving that students were competent when they were able to provide the correct answer. A year 5 student reported that their CM asked them questions about the assigned procedure instead of supervising their practice.

For example, she asked me what I needed to prepare for insertion of foley. Or how to confirm the position after inserted the ryles tube. She would ask me first but she would not supervise my practice. (S6, year 5 student)

CIs and CMs also reported adopting indirect assessment strategies when they assessed students' clinical performance, including seeking the opinion of others.

Seeking others' opinion

Seeking others' opinion about their students was reported as another type of assessment strategy for field evaluation by CIs and CMs in the interviews. CIs and CMs sought opinion from different people, including teaching staff of theoretical course, student and ward staff. A CI reported seeking opinions from the teaching staff that were responsible for teaching their students nursing skill.

I will also talk to the CC (course coordinator) of 150 (the theoretical courses that teach the nursing skill) to see how they perform in previous practical exam and written exam. (M2, clinical instructor)

This CI suggested that the comments from these teaching staff provided information about their students' level of knowledge and competence of nursing skill when students studied the theoretical course. CI perceived that this information could reflect the students' performance. In addition, another CI reported that she also asked their students to comment on other students' performance in placement.

I asked a student how she felt after working with the one with poor performance. The student told me that "Miss, I am exhausted." Or "Miss, this student is really ok." I may even get some information (about the student) from the other students in the same group. To see if the student improve or not. "Do you feel the improvement of that student?" (M3, clinical instructor)

A CI further suggested that comments from other students could ensure the fairness of the assessment conducted.

For example, he (student) did not apply any force when I transferred a patient with him. I told him that he did not apply any force. He may think that "Miss"(clinical instructor) was pinpointing him. When he performed the same task with other students, the other students may give him the same feedback. He may think that "Miss" (clinical instructor) was not the only one who gave me this comment. The other students also had the same thought. (M2, clinical instructor)

CIs were qualified personnel responsible for conducting assessments in clinical placement. However, they reported relying on other students' comments to verify the result of the assessments they conducted. Similarly, CMs also adopted other's comments in assessing students' clinical performance, including other nurses' and health care assistants' observation of students' actual clinical performance.

I don't have much chance to have contact with the students as I usually work in different shift from the students. I can ask the students if they encounter any difficulty when I work in the same shift with them. Or if the students forget about

some skills. I may remind the students again. Otherwise, I just can discuss with the students about their performance in evaluation session... I would ask my colleagues, especially for the runner, RN (registered nurse) and EN (enrolled nurse). They will know about the performance of the students. How do the students perform? They may require the students to perform the procedure perfectly or efficiently. (M6, clinical mentor)

This CM suggested that the comments from other ward staff provided supplementary information about students' clinical performance when supervision was not available. They also stated the reason for being unable to supervise students was that they worked in different duties from their students. Thus, supervision was impossible to be conducted during clinical placement. Seeking comments from others was an indirect assessment strategy that was commonly adopted by CIs and CMs. The people asked to provide comment were not qualified to assess students' clinical performance, including teaching staff, other students and ward staff. They could adopt different standard and be influenced by personal preference when they commented other students' clinical performance. Thus, the accuracy of assessment became questionable as these comments reflected others' perception of students' clinical performance rather than the actual clinical performance of students. As the assessment strategies of field evaluation were diverse and not overt, students may not be aware of the assessment taking place. CIs and CMs also developed their first impression of students from the result of field evaluation.

7.2.2. Actual practice of mandatory clinical assessment

Mandatory clinical assessments are usually conducted after CIs/ CMs and students engaged in clinical mentoring for a short period of time. Thus, CIs and CMs had already formed their

first impression of students which could then influence the actions of CMs and CIs. The details of such influence will be discussed in Chapter 8.

Mandatory clinical assessments were considered important assessments by organisers of clinical placement, CIs/ CMs and students. The requirement and standard of mandatory clinical assessment required by NCHK and university was outlined in Chapter 1 section 1.6.2.2 and Chapter 4 section 4.4.2.2. In comparison to the field evaluation, mandatory clinical assessments were more standardised. Although there was no official guideline about the implementation of clinical assessments, CIs and CMs conducted these three mandatory clinical assessments in a standard pattern. CIs and CMs were required to conduct a coaching session before they assess their students each time by nurse educators.

The clinical instructor...she offered one time of coaching for each attempt of assessment. We can have three attempts of assessment. You will have a coaching session before the first attempt of the assessment. Touch wood! If you fail your first attempt of assessment, you will have the coaching before the second attempt of assessment. (S1, year 5 student)

Students reported practising the designated skill of the mandatory clinical assessment under the supervision of CI/ CMs in the coaching session.

Um...I barely remember that my mentor supervised my practised once before the assessment. That means she supervised my practice once before assessment. (S3, year 5 student)

Coaching served as rehearsal for the clinical assessment, as supervision was similar to that of clinical assessment. CIs/ CMs reported they provided guidance to students in coaching to ensure students perform according to the standard of the clinical assessment

Take coaching as an example. When the student performs the tasks, I would remind the student all along. "Hey, you are going to touch it (contamination). If I were you, I will perform this procedure first. (M5, clinical instructor)

After the coaching session, CIs and CMs assessed their students through supervision.

A male mentor who was my assessor for AOM (administration of medication) taught me a lot of things. On the day of assessment, he supervised me to administer medication for a cubicle of patients. (S3, year 5 student)

The implementation of mandatory clinical assessments was more ritualised than field evaluation as official standards were provided. CIs/ CMs and students participated in mandatory clinical assessments as if a ceremony. Some of their actions during mandatory assessment carried symbolic meaning without any evidence support. The process of assessment and field evaluation can be conceived of as performing a drama. Similar phenomenon could also apply to field evaluation, which will be discussed in next section.

7.3. Drama of assessment

Data from all participants on the process of impression formation was analysed and constructed as performing a drama of assessment. Data revealed that the drama of assessment was started before the clinical placement. Organisers of clinical placement, CIs/ CMs and students involved in all types of assessments in clinical placement are conceived as actors in a drama. The drama of assessment was comprised of four phases: setting up the scene, audition, occurred in a specific sequence. Organisers of clinical placement set up the scene for each clinical placement. The phase of audition and rehearsal of assessment occurred either throughout the period of clinical placement or preparing students for

mandatory clinical assessment. When the time for these assessments was due, students performed the drama of assessment. The details of each phase will be discussed below.

7.3.1. Setting up the scene

The first phase 'setting up the scene' started before clinical placement. Organisers of clinical placement including hospital management and practicum coordinator from the university had a dominant role in this phase and were responsible for setting the scene for assessments. Setting the scene for assessments included assignment of assessors, setting up the guidelines for different assessments and preparation for assessments. The organisers of clinical placement reported setting up various guidelines for assessments before any clinical placement started. These guidelines served as a script for the drama of assessment.

We have a lot of work groups for internal operation. Some of the work groups are responsible related documents... we also have some guidelines related to the requirement of professional behaviour, working hours of practicum, arrangement of adverse weather, introduction of assessment system and assessment strategies...This guideline is served as a reference for our students and clinical partners. (O1, practicum coordinator from university)

The script of the drama of assessments provided information about the role of assessors and standard of assessment. The organisers of clinical placement expected that assessments were conducted according to the script developed. The script for mandatory clinical assessments was clearly stated in a guideline. However, the guideline for field evaluation was vague. Hence, CIs/ CMs could adopt their own assessment method and their expectations instead of following the script of assessment. When the time of clinical

placement approached, the organisers of clinical placement proceeded to preparation for assessment. They first assigned CIs/ CMs to be assessors for the coming clinical placement.

The students may need to participate in assessment. We may need to make arrangements beforehand such as AOM (administration of medication). The students may need to administer medications in the ward. Who will be the assessor? When will the assessment be conducted? We may help them to make some contact. (O3, hospital coordinator)

Assessors were explicitly assigned to students to conduct the mandatory clinical assessments. In contrast, organisers of clinical placement were less involved in the assignment of assessors for field evaluation.

I think that it would be difficult if only the clinical mentor can perform this type of assessment (field evaluation)...The students could ask the other nurses to sign it (conduct field evaluation) for them. (O4, ward manager)

Other ward nurses could substitute for CMs as assessors for field evaluation when CMs were not available. A ward manager reflected the perceived importance of field evaluation. The implementation of field evaluation varied between ward nurses due to variance in expectations towards students. It further influenced the implementation of the next three phases of assessment. Setting the scene for assessments not only included assignment of assessors but also included preparation of CIs/ CMs and students. Briefing sessions were used to prepare CIs/ CMs and students. The purpose of preparing CIs/ CMs was to ensure they facilitated and judged whether students acted according to the assessment script.

The other part of the workshop is related to clinical assessment. It included some concepts related to clinical assessment and what the tutor should do in clinical assessment in specific programme. The tutor will also know how to conduct the clinical

assessment and what they can do when there is problem encountered. (O1, practicum coordinator from university)

Nurse educators also believed that CIs and CMs would learn about the standard of assessments in the briefing session.

I hope the mentors at least have a similar standard that required the students to achieve. We will provide this information to the mentors through the pre-briefing (pre-practicum briefing). We may give them some examples from previous practicum... Different people may have different views on the standard. There could be some variance of the standard. As a CC (course coordinator), I am trying to align their standard at a similar level. (O2, practicum course coordinator)

The practicum course coordinator believed that the briefing session could standardise the CIs' and CMs' interpretation of the script. However, CIs and CMs still showed variation in interpretations of the script, which will be discussed in the fourth phase of 'performing the drama of assessment'. Apart from preparing the CIs and CMs, nurse educators could also prepare their students for assessment before clinical placement. The purpose of preparing students was to facilitate students to act according to the assessment script. Students were informed about the arrangement of clinical assessments in the briefing sessions.

So we conduct a practicum briefing and talk about our expectations of that practicum, venue of placement, assessment required for that practicum and arrangement of assessors. (O1, practicum coordinator from university)

Preparation for field evaluation was also included in the briefing session. A practicum course coordinator described an example of a student who was considered to have failed to demonstrate an appropriate attitude during clinical placement. She believed that sharing of

these undesired cases could remind students to meet their CMs' expectation in field evaluation.

A student is late to work. (the clinical partners expect the student to) say sorry for the late to work at least. That student may think she said it. She thinks she has apologised but the others (the clinical staff) feel that she hasn't done it or her apology was not sincere. This is a kind of deficit in interpersonal skill. I usually save the scenario and remind the students in the next year. (O2, practicum course coordinator)

I also feel that we can use these scenarios in the pre-briefing (pre-practicum briefing). We may give more focus on these aspects during the briefing session. These case scenarios could be used for the students to discuss. I believed the situation encountered is more or less the same. I don't think we should learn our lesson. The students should learn their lesson. I believe the students could think about how they should handle the case scenario. We can also discuss with them. When the students face the similar situation or the same situation in the practicum, they will know how to handle it. (O2, practicum course coordinator)

The scope of field evaluation was broad and covered some competencies that were not included in the theoretical course. Competence of communication and participation in teamwork were required by NCHK (Nursing Council of Hong Kong, 2016). The practicum course coordinator hoped that her students could learn from previous mistake made by others and avoid making similar mistakes in future clinical placement. Apart from preparing students through giving information, students were also required to attend skills laboratory sessions by their practicum course coordinator before clinical placement.

Although the students have attended the courses related to the nursing skill, we still arrange some lab session to let them to practice before the practicum. (O2, practicum course coordinator)

The purpose of skills laboratory practice sessions was to prepare students with the skills required for their assessments. CIs/ CMs and students learned about the script of assessment and their own role in the drama of assessment. When CIs/ CMs and students were prepared for assessment, the phase of setting up the scene for assessment was completed. The drama of assessments could then proceed to the phase of audition.

7.3.2. Audition

The second phase of assessment, 'audition', started at the beginning of the clinical placement. In the phase of audition, CIs and CMs conducted field evaluation to gain the first impression of their students. Students' first impression depended on whether they could meet their CIs'/ CMs' expectations. As discussed in Chapter 6, CIs and CMs perceived that attitude was an important expectation of students. The judgment of assessment of attitude was based on observation of students' behaviour.

The mentor usually assesses if the students are cooperative or not. That means if the students listen to their instruction or not. (O4, ward manager)

Students were expected to be obedient to authority in clinical placement. A ward manager perceived that being obedient reflected the students' attitude towards authority. The behaviour "listen to instruction" was perceived as reflecting the attitude of being obedient. CIs and CMs, therefore, observed if students followed their instruction. The field evaluation not only concerned the attitude towards authority but also towards patients.

The students talked to patient as if talking to themselves "Hey Lady, take the medication." They didn't talk to that patient. The students talked in a low voice and did not talk to the patient. The conversation was in a tone of a robot. It is a procedure

performed for the patient but not for you. Therefore, I need to teach them about the attitude. (M4, clinical mentor)

Although the students described in the quotation were perceived as showing lack of competence in communication with patients, this CM perceived that students' behaviour presented an impression of not caring and students had a problematic attitude towards patient. This CM further suggested that even small change in behaviour could reflect students' attitude.

I could be able to know one's personality even that person does not speak a word. It could be. How should I say? Some people may not talk loudly to express their anger. They may throw away things forcefully. This response reflects the attitude and personality of that person. That person does not need to speak a word...The behaviour reflects the attitude. (M4, clinical mentor)

Impression of students was developed based on observation of students' behaviour and perceived students' attitude. Inferences were made according to impressions of students. Students with a positive impression were classified as "good students" by their CIs and CMs and vice versa. The label of "good students" and "bad students" influenced how CIs and CMs provided feedback. The feedback given could then shaped students to be either "good students" or "bad students" in the rehearsal of assessment. Different types of feedback were identified from data: details of feedback will be discussed in Chapter 8.

7.3.3. Rehearsal of assessment

CIs/ CMs and students engaged in the rehearsal phase of assessment after a preliminary impression of students had been developed in the phase of audition. Rehearsal of assessments was a practice opportunity of skills required by mandatory clinical assessment.

CIs and CMs first needed to arrange the scene for their students to rehearse the designated skill required by mandatory clinical assessment.

If the students need to have assessment, the nurses will look for some opportunities of practice for the students. (O4, ward manager)

When the opportunities of practice were available students performed the designated skill as if performing in actual assessment. CIs and CMs supervised their students to practise as if conducting the actual assessment.

Um...I barely remember that my mentor supervised my practise once before the assessment. That means she supervised my practice once before assessment. (S3, year 5 student)

The actions of CIs/ CMs and students during practice served as rehearsal of assessments. Both performed their roles according to the script of the assessments that was set by organisers of clinical placement. Students performed the skill as they learnt previously in theoretical course and the preparatory skills laboratory session before clinical placement started. CIs and CMs then judged if the performance of students matched the script. When students' performance did not match the script, CIs and CMs provided feedback to facilitate their students to perform the script of assessment.

The feedback provided by CIs and CMs could be influenced by students' performance in rehearsal and impression of students. When students were designated "good students" in the phase of audition, they tended to receive constructive feedback from their CIs/ CMs in the rehearsal of assessment. Thus, "good students" received more support and could be more capable of performing the drama of assessment according to the assessment script. In contrast, CIs/ CMs could be less supportive to "bad students".

Learning is also important. But I still afraid of...if the nurses have a bad impression toward the students, they will be less likely to teach me. They may make me more difficult to pass the assessment. I still worry about it. (S1, year 5 student)

With less support from CIs/ CMs, “bad students” could be less likely to fulfill the role in the script of assessment. Hence, students could continue to play their role as either “good students” or “bad students” when they performed the drama of assessment.

Impression of students developed in the phase of audition influenced the interaction between CIs/ CMs and students in the rehearsal of assessment. However, impression were not fixed and could be changed during clinical placement. CIs/ CMs could then adjust their feedback and students could then shift to play another role in rehearsal of assessment when there was a perceived change in impression.

The phase of audition and rehearsal of assessment occurred in a recurring cycle before the clinical assessment was conducted. Students could change their practice according to the feedback received and adjust their practice in subsequence rehearsals. The cycle of audition and rehearsal of assessments ended when the drama of assessment was due.

7.3.4. Performing the drama of assessment

After students were prepared by the rehearsal of assessment, CIs /CMs and students proceeded to the fourth phase of assessment, performing the drama of assessment. CIs and CMs had a dominant role in the drama of assessment. They were not only responsible for

assessing students, but also ensuring the drama of assessment that was conducted in an appropriate manner.

I would not intentionally ask the students to handle the difficult cases during assessment. They just need to carry out the very basic concept (complete the procedure for the ordinary case). It let me know that the students are able to manage the basic principles. (M3, clinical instructor)

In Chapter 4 both CI and the ward manager stated their belief that the selection of a case reflected the expected ability of students. They believed that it was more appropriate to let students practise on typical cases instead of complicated cases. However, a year 4 student reported that she was asked to handle a complicated case during mandatory clinical assessment.

The “miss” (clinical instructor) told me to perform the dressing for the most complicated wound so that I could pick a simple wound for the assessment on the next day. She chose the most complicated wound for me. It was a bed sore (wound). The old man looked like “cooked shrimp” (the gesture of the patient with extensive contracture). He was connected with a few lines (IV fluid) and a ryles tube. That patient needed to have suction frequently. It was a complicated situation. That patient could not provide any response...I thought that the “miss” would choose another case on the next day. She did not allow me to choose another one. She told me that my performance was OK. Therefore, she asked me to perform the dressing for that patient. The assessment was in a mess. It was really terrible. It was lucky that a nurse worked on that shift. She knew that I needed to have assessment. She had breakfast earlier and helped me to settle that old man before the assessment. (S4, year 4 student)

This student reported getting extra help from a nurse instead of assigning her to perform the skill on a typical case in the actual assessment. Once the case for assessment was

selected, the drama of assessment started. Students then performed the skill on patient that was similar to the rehearsal of assessment under their CIs' / CMs' supervision.

I was assessed for the skill of changing dressing. That was the AT (aseptic technique) assessment...I performed the task properly. My assessor commented on every step of my performance. (S1, year 5 student)

CIs and CMs served as the audience when students performed the drama of assessment. They monitored their students and judged if their students performed the drama of assessment according to the script of assessments. The judgment on students' performance of assessments was seen to vary between CIs and CMs. Students reported that CIs and CMs had inconsistent standards of assessments, specifically with a different emphasis or focus in assessments.

As each mentor may have different ... main points (of assessment). (S2, year 4 student)

A year 5 student provided an example about the inconsistent in standards of assessments between CIs and CMs.

The clinical mentors want to "hea" (lay back) the assessment...From my observation, those mentors want to complete the assessment once so that they do not need to conduct the assessment again. However, the clinical instructors from the school require you to achieve a certain level of standard in order to pass the assessment. They think that maintaining the standard is more important than pass the assessment... they will help you to pass the assessment. On the other hand, the clinical mentors want to simply complete the task of assessment. They don't need to bother you or they are not bothered. (S1, year 5 student)

The quote above described the perceived inconsistent standard of assessments between CIs and CMs, despite training for assessment being provided to standardise the assessments.

CMs could treat assessment as simply a task to be completed while CIs could perceive

assessment as a way to ensure standard of students' performance. A year 5 student further suggested that CIs could conduct assessments in more detail.

Er...I guess the standard should be more or less the same. It is required to perform 3 checks 5 rights. If the assessment is conducted by the nurse, she will not ask me about the case in detail. I heard from the other students. They (clinical instructors) asked about the cases and perform the assessment for the patients. (S6, year 5 student)

The above quotation suggests that CIs adopt a higher standard of assessment than CMs, which could be related to how CMs perceived the meaning of clinical assessment. CMs could treat clinical assessment as a form of rituals. Students, therefore, could perceive unfairness of assessment due to the difference in implementation of clinical assessment.

I think that the assessment was not fair. The assessment was conducted by different people. It could be inconsistency in the standard. It was such a big difference. (S1, year 5 student)

The perceived variation in standards of assessment was also related to CIs'/ CMs' impression of students. CIs/ CMs could lower the standard of assessment when they perceived their students as good, i.e. presenting a positive impression.

If the patients or the ward staff feel that you are OK, that means having a good relationship with them. Or the ward staff feel that you are good to the patients. "All the things. Do the things is for the goodness (good sake) of the patient." They would have more positive comment on your (the students) practice. (M5, clinical instructor)

The quote above suggests a perceived 'halo effect' in assessment, where CIs/ CMs rate the students as having better performance when these students were perceived as being "good students", i.e. having positive impression. The positive impression could be developed by fulfilling CIs'/ CMs' expectations, such being polite and obedient. Some CIs may assume that

students presenting a positive impression should have better performance. Even students presenting positive impressions could not achieve the standard of assessments, CIs may still “save” these students by rating them as pass in the clinical assessments. When students failed the assessment, they would need to retake the courses CIs could override the requirement of assessment and prevent students with positive impressions facing such negative consequence.

Speak with others politely. That means the students do not challenge the mentor. Their performance should not be in a mess. They should be willing to learn. They should not offend the others. I believed that each clinical instructor is willing to save this kind of student. (M3, clinical instructor)

In contrast, some CIs appeared to be aware of the influence of impression on assessments. A CI reported that she had to maintain fairness of assessment regardless of the impression of students.

You may like some students. You may feel that some students did not listen to you at all. You will have negative feelings toward these students. Therefore, I will try to be neutral. (M2, clinical instructor)

Students with a positive impression could also have favourable result in mandatory clinical assessment even though their CIs/ CMs adopted the appropriate standard of assessment. As discussed in rehearsal of assessment, students presenting a positive impression received more support from their CIs and CMs. It meant that they had a higher chance to pass the clinical assessment. On the other hand, a ‘horns effect’ could also be identified during the drama of assessments. CIs/ CMs could rate students presenting negative impression to have less favourable performance. It could also be related to less guidance received by students

who were perceived as presenting negative impression, and thus were more likely to fail the clinical assessments. Impression, therefore, played an important role in the drama of assessment.

Apart from CIs, students were also aware of the influence of impression. A CI reported a case that failed in mandatory clinical assessment for twice. Other students informed this CI that this student was trying to present a more positive impression to enhance the chance to pass the clinical assessment.

After that student was failed... I did not know about it. "Miss, do you know that this student waits for you when you go to the toilet? She scrubbed her hands in front of you. She had been staring at the door for a minute and waited for you. We were looking at her in the back."(report from other students)... She intentionally let me to know her good behaviour. (M3, clinical instructor)

When students failed a single attempt of clinical assessment, they would have to repeat the phases of audition and rehearsal of assessment before they could participate in the next attempt of clinical assessment. Hence, students could rectify their impression by showing CIs'/CMs' expected behaviour to help them to pass their assessment

Inconsistent standards of assessments could possibly result in inconsistent standards of care quality among future qualified nurses. Incompetent students could pass the assessments by maintaining a positive impression when CIs and CMs lowered the standard of assessments. When the standard of assessments was inconsistent, it was difficult to judge whether the competency of students met the expected standard. In contrast, competent students could

fail an assessment when they were perceived to have poor impression, which could then hinder them qualifying and graduating.

Assessments were conducted in the above-mentioned four phases. Students had a passive role in assessment as they had no control of any phase of assessment, which is reflected in how a practicum coordinator described handling a complaint about assessment.

The students may not agree with the result sometimes. That means she is failed but she does not agree with the result. She may complain the case to me. She thinks the assessor is not fair or pinpoint her... The way to handle it is based on the same principle actually... I will talk to that assessor and know more about what happened during the assessment and the reason that make the student to have such perception...OK. After listen the stories from both sides, I will explain to the student. As I believe that assessor. That means she must have a rationale to support her to make such decision. This is why the assessor fail that student. (O1, practicum coordinator from university)

Both organisers of clinical placement and CIs/ CMs had dominant roles and were in control throughout assessment. Students were expected to act according to the script that was set by the organisers of clinical placement and expected by their CIs/ CMs. CIs/CMs served as the audience and directors who monitor and shaped their students to act according to the expected script. Impression of students served as the product from the second phase of the drama of assessment, which then influenced the subsequent interaction within clinical mentoring.

7.4. The use of impression

The impression of students was found to influence the interaction between CIs/ CMs and students within clinical mentoring and assessment. CIs and CMs used the impression of

students for three purposes: facilitating interaction with students, arrangement of clinical mentoring activities and signing off students. These three purposes further described how CIs and CMs use assessments during clinical mentoring.

7.4.1. Facilitating interaction with students

The impression formed of students influenced the interaction between CIs and CMs and students. A CM working in operating theatre reported that the impression formed from observing students' behaviour in operating theatres.

Some of the students may find a seat at once when they go into the theatre... I usually don't say no to the student. I won't say a word because of taking a seat in operating theatre. It is uncommon to see colleagues to sit in the operating theatre. Yup. I know some of the students may not get used to stand for such a long time. That's why I let student to sit but it will give other a poor impression. (M1, clinical mentor)

Not to sit in the operating theatre was a norm in operating theatre. As discussed in Chapter 6, students were expected to be obedient and should follow the rules in clinical area. When students were unable to fulfill their CIs'/CMs' expectation, negative impression was then perceived by CIs and CMs. This CM further suggested that the negative impression related to "sit in the operating theatre" reflected her students' learning attitude and was interpreted as meaning the student was not willing to learn.

I think it is very personal. If the student is interested in it, she will be interested and more actively participate into the practicum. Or She would like to know more about the interested area. If the student sits in the theatres, it may indicate that she is not interest in it. (M1, clinical mentor)

The behaviour of “sitting in operating theatre” had no relationship with students’ actual clinical performance. However, CIs and CMs interacted with their students based on the impression perceived especially in the early period of the clinical placement.

The impression is always the first thing adopted to assess you instead of your performance. (M5, clinical instructor)

Negative impression influenced the interaction between CIs/ CMs and students. A CM reported that she felt angry when her students talked back as “talk back” was not an unacceptable behaviour of students.

The student was using an assessment form. She should not ask some questions from what she perceived. Her perception of questions was different from the original meaning of the assessment form. It was not the meaning of the assessment form. When I asked her why she asked the patient like this, she felt that “why not? Why I can’t ask by my own way?” I felt a bit angry actually as she talked back suddenly. I just wanted to teach her. She then asked me “Why did she ask in a wrong way? I had to tell her that it was not the actual meaning of the question. It was not the same meaning as she thought. Some students may understand it and shut up. Some students may insist to argue with you (M4, clinical mentor)

CIs and CMs could interact with students under the influence of negative emotion. The interaction between CIs/ CMs and students with perceived negative impression became poor.

Some students may have poor attitude. We would also tell other colleagues. “Um...you feel uncomfortable when that student speaks to you.” Other colleagues may use some strong tone to blame that student afterwards. It is easier to put the blame on that student. “Hey. What has happened to you?” (W1, junior registered nurse)

As reported by the junior RN, students with perceived negative impression were managed in the same way as students with poor performance. The interaction with students could be changed when students were perceived to perform better. One example mentioned in Chapter 5 that a nursing officer perceived a student with fashionable appearance as insincere in the beginning of clinical placement. The nursing officer, therefore, made a complaint about “the fashionable student” as she perceived a negative first impression of “the fashionable student”. After “the fashionable student” became conservative in her appearance, the nursing officer praised that student’s performance. Thus, the impression of students influences how CIs and CMs interact with students during clinical placement. The interaction with students varied according to CIs and CMs’ perceived impression of their students.

7.4.2. Arrangement of clinical mentoring activities

Impressions of students influenced CIs and CMs’ arrangement for clinical mentoring activities. CIs and CMs assigned tasks to their student based on the field evaluation.

Before assessing the ability of the students... I would not let the students to perform some tasks easily. (W1, junior registered nurse)

CIs and CMs learned about the strength and weakness of their students through field evaluation. The impression of students that formed in field evaluation was perceived to correlate to students’ actual clinical skill competency. CIs and CMs perceived that they used their perceived impression of students to adjust task assignment and facilitate their students to improve performance.

If there is an evaluation in the midterm, the students will be clear whether they are on the right track. No matter their performance is very well or not up to standard, they can spend the rest of the practicum to improve their own problem or strengthen their skill.

(M2, clinical instructor)

CIs and CMs also judged whether students were capable of performing the assigned task, based on the mandatory clinical assessments. Students reported in Chapter 6 that they were given more practice opportunities after they passed the mandatory clinical assessment.

Thus, the impression formed in mandatory clinical assessment carried the meaning of being competent that students were capable of performing particular tasks without supervision.

As discussed in Chapter 6, CIs and CMs assigned students to practice advanced skills when students were able to present attitudes and behaviours that met their CIs'/ CMs' expectation. CIs/ CMs thus perceived their students as having passed the assessments. In contrast, students could also continue practising basic skills when they were perceived as unable to pass the assessment. The cycle of assessments and task assignment repeated throughout clinical placement. When clinical placement proceeded, CIs/ CMs were required to assess whether students were suitable for being signed off.

7.4.3. Signing -off students

CIs and CMs were required to sign off their students when students passed the field evaluation and mandatory clinical assessment during clinical placement. Passing both types of assessments meant that the competencies of students fulfilled the requirement of the particular practicum course.

There is impact as it (the result of the assessment) judge whether the student to pass the practicum or not. It depends on the assessment. (S4, year 5 student)

Both field evaluation and mandatory clinical assessments were conducted concurrently during clinical placement. As discussed in section 7.3, mandatory clinical assessments were highly valued by CIs/ CMs and students. As the mandatory clinical assessments were one-off assessments, the performance of students could have deteriorated after students passed the mandatory clinical assessments.

The student needs to complete the assessment in my ward. Complete the AOM (administration of medication) assessment. I will also talk about the meaning of that assessment during evaluation especially for AOM. There were 2-3 students who completed the AOM assessment in my ward. After assessment, everything is completed. Completely let everything go... That is "Do you still remember the medications assessed during the assessment?" (student said) "I can't remember." "What is the indication of this medication?" "I don't know." (M6, clinical mentor)

When students showed a deterioration in their performance, they were not eligible for signing off at the end of clinical placement. Field evaluation could then serve as supplementary measure for CIs and CMs to monitor their students' daily performance.

As the students may just need to take a single exam (clinical assessment) throughout the year, we found that the student is so relaxed after the exam (clinical assessment). The students will start to "hea" (lay back) or daydream in the clinical (in the practicum). As the students feel that there is nothing that can suspend their practicum, it would be good to monitor the students' performance all along. (O2, practicum course coordinator)

The practicum course coordinator further suggested that field evaluation served as a way to verify the competencies of students. Students whose clinical performance was considered as unable to meet their CIs'/ CMs' expectation could also fail in field evaluation.

I have suspended a student from the practicum this time. I actually wanted to suspend this student in week one. However, I still hope to give him some time to see if he can make some improvement. Therefore, this student is suspended in week three...Also, he was far below the standard...We have told him that there were so many problems identified when he performed the dressing; or help others to transfer the patient; or he think he was just handling a task but not taking care of a patient. He did not treat the one as a human. He treated patient as manikin. I think that he did not pay any attention to his behaviour. (M2, clinical instructor)

When students were failed in either type of assessment, they would not be signed off by their CIs and CMs and could face different consequences.

I think if I fail one's practicum, that student may need to spend one more year. An extra year. It will be a big impact to a student. (M2, clinical instructor)

This is the standard of the nursing school. If the student cannot meet the standard, they will be "dead" (have to quit the nursing school). (M6, clinical mentor)

The consequence for students was that they could either be required to attend that clinical placement again or even be suspended from their study when they failed in either field evaluation or mandatory clinical assessment. Hence, CIs and CMs used field evaluation as a strategy to ensure students performed as if in the beginning of the clinical placement.

Students could then remain alert and keep presenting the impression that was desired by their CIs/ CMs.

If the nurses have a bad impression toward the students, they will be less likely to teach me. They may make me more difficult to pass the assessment. I still worry about it. (S1, year 5 student)

When students presented the desired impression until the end of clinical placement they could pass the field evaluation and become eligible to be signed off from clinical placement and move one step forward to be qualified nurses.

7.5. Conclusion

An impression of students was formed through various official and unofficial methods and assessments by CIs and CMs. These impressions influenced the subsequent interactions between CIs/ CMs and students in both the assessment and the mentoring process. Variation in the implementation and interpretation of standards of assessment was reported when CIs and CMs assessed their students, which could result in discrepancies between impressions and actual competency and assessment result. Students were treated differently based on the biased impression formed and included adopting different standards of assessment and providing different types of feedback by CIs and CMs. The influences of impression formed ultimately affected the effectiveness of clinical mentoring. The impression formed of students guided the CIs/ CMs to provide feedback in the interaction within clinical mentoring: findings data on feedback will be discussed in the next chapter.

8. Feedback in clinical placement

8.1. Introduction

This chapter presents and discusses study findings relating to feedback provided by CIs and CMs to students in clinical placement from CIs' / CMs' perspective. As stated in Chapter 4, CIs and CMs were expected by both hospital-based organisers and nurse educators to provide constructive feedback to enhance students' learning. However, the data showed that CIs and CMs provided different types of feedback to achieve different purposes which were different from the official guidelines. Three purposes of providing feedback were identified from the data that included managing students' performance and conduct, ventilation of negative emotions and presenting an impression of being responsible mentor or instructor to other staff. The audience of feedback determined which purpose of feedback was. Three types of feedback from CIs and CMs were identified from the data, namely constructive feedback, minimal feedback, and destructive feedback. These three types of feedback identified from the data asserted different effects on students' competence and confidence.

8.2. Purposes of providing feedback from clinical instructors' / mentors' perspectives

As discussed in Chapter 4 and 6, CIs and CMs were expected by students and by the organisers of the clinical placement to provide feedback to improve students' practice. However, feedback provided by CIs and CMs could achieve other purposes than just improving students' performance. Data indicated that feedback to students by CIs / CMs could be used to achieve three purposes namely, management of students' performance

and conduct, ventilation of CIs'/ CMs' negative emotions and presenting an impression of being responsible.

8.2.1. Management of students' performance and conduct

Managing their students' performance and conduct was identified from data as one of the purposes of providing feedback by CIs/ CMs. Feedback was perceived as a mean to correct students' practice and improve their performance by all participants. When CIs/ CMs perceived the performance of their students as failing to meet their expectations, feedback was provided to manage their students' performance.

The students' performance could then be improved in order to meet the CIs'/ CMs' expectations. A year 5 student (S3) perceived that the feedback provided by his CM could guide him to improve his practical skill.

The nurses usually tell me about their experience and a lot of recommendations to me. How I can improve my performance in the next practice. How to perform the task faster or proper. (S3, year 5 student)

This student also perceived that feedback could facilitate him to improve the speed of his work. Although speed of work was not a criterion adopted by the university to assess the students' performance, working faster was an expectation from this student's CMs. As discussed in Chapter 5, working faster was an expectation of people working in hospital settings. Hence, this student could perceive working faster as an indicator of improvement in his performance. CIs and CMs could also provide feedback to manage their students' conduct. Feedback was perceived to promote the behaviour that was desired by CIs/ CMs.

As noted in the previous chapter, students could be rewarded with learning opportunities when CIs and CMs perceived their performance had met their expectations. Offering learning opportunities could be a form of feedback provided by CIs'/ CMs' to promote students' engagement in desired behaviour.

When you are able to measure the BP faster...the nurses usually say if the students can complete the tasks quickly, there will be chances for learning. (S3, year 5 student)

Completing work faster was the desired behaviour from CMs' perspective. This year 5 student (S3) further suggested that learning opportunities served as an incentive for the students to enhance the efficiency of their work. On the other hand, CIs and CMs could also use feedback to inhibit perceived undesirable behaviour of the student.

When you have completed all the tasks, the staff prepared for the handover. It could be after 8 pm. Almost the end of the P shift. The nurses working for the night shift may not be back yet. Those nurses (of the P shift) may sit there and played with their phone or chat with each other at the (nurse) station. Whatever. I was reading the case there. I wanted to copy the new words or new cases to see if there is something to learn. The nurse then asked me why I stay there and read the case. "Do you have nothing to do? You go and find something else to do." (S1, year 5 student)

In this example, reading the kardex was perceived as undesirable behaviour by the nurses. The year 5 student (S1) avoided reading the kardex after feedback from the nurses was received. Another example identified from data illustrated that the student who received feedback was not the only audience of feedback. Other students could also be considered as audience of feedback. A CI (M3) blamed students publicly to warn other students working in the same setting not to make the same mistake as their classmates.

As I mentioned earlier, I may intend to expose the weakness of the student to have the effect of “execute one as a warning to one hundred” (let other know the consequence of poor performance). (M3, clinical instructor)

The above-mentioned quotes illustrated that CIs and CMs either promoted or inhibited students’ performance and behaviour through providing feedback.

8.2.2. Ventilation of negative emotion

As shown in data, the emotions of CIs and CMs were affected by students’ performance in clinical practice. CIs and CMs experienced positive emotion when their students could meet their expectations.

When the students have better performance...let’s think about it...I feel happy about it. (W1, junior registered nurse)

According to the data, feedback was not provided by CIs/ CMs to ventilate positive emotion. On the other hand, negative emotions were experienced by CIs/ CMs when students were unable to meet their expectations.

A bit anger. She may think that it was an extremely serious mistake. She then told me that the mistake I have made. She also told me that she was not satisfied with my attitude and my practice. (S4, year 5 student)

The negative emotions experienced by this student’s CI may reflect that students’ suboptimal performance was linked to failure in mentoring. It further implied that CIs/ CMs failed to fulfill their role as mentor. Hence, CIs/ CMs tended to provide feedback to students to ventilate negative emotion when students did not perform as expected.

The negative emotion experienced by CIs/ CMs could also be related to their sense of responsibility for the students' performance. Students believed that their CIs and CMs were considered as the responsible person for their performance.

If I have done something wrong, my mentor will have to bear the responsibility. (S2, year 4 student)

Similar belief was also reported by other nurses. It explained why other nurses reported to CIs/ CMs when they perceived student as having poor performance.

We would push (refer) the student to IC. We then tell the IC about the performance of that student. "You handle the student then." The IC would manage the student. The IC would be the one who blame the student. (W1, junior registered nurse)

The action described by this junior RN suggested that CIs and CMs were the first person to be held responsible for managing the students' suboptimal performance. CIs and CMs could then feel stressed when their students did not perform according to their expectations. They had to deal with the consequence of students' suboptimal performance. For example, students were expected to relieve the workload in the ward. When students were unable to complete their task on time, CIs and CMs were then required to complete the unfinished task.

The students may not be able to complete it. Or the students could not complete the task on timely. This is what the mentor unhappy about. The mentors would be able to manage this by themselves as they are experienced nurses. They would be able to manage it. After the situation is over, they may tell me the feedback and they felt unhappy at that time. (O3, hospital coordinator)

The negative emotions of CIs and CMs resulted from the extra workload bore by them in a limited amount of time. Feedback served as a way that CIs and CMs ventilated their negative emotions.

The nurse felt frustrated and vent the anger on the student. There are one or two nurses in my ward who treat students like this. (W2, healthcare assistant)

CIs and CMs also experienced negative emotion when students' performance was not as expected. The suboptimal performance was perceived by CIs and CMs as failure in clinical mentoring and could then present an impression of incapable CIs / CMs to their co-workers and organisers of clinical placement despite their effort of clinical mentoring. Hence, feedback was used as a defending their capability in clinical mentoring by CIs and CMs when they managed suboptimal students' performance.

8.2.3. Presenting an impression of being responsible

CIs and CMs were expected to train their students to be skilled workers by their co-workers and organisers of clinical placement through offering practice opportunities and supervision of students' practice. As illustrated in quote from W1 in section 8.2.2, CMs perceived themselves to be the person responsible person for providing feedback to rectify students' performance when students did not perform as expected. W1 recalled her previous experience of handling a student whose performance was unable to meet the expectations. W1 described how she made a report on the student's performance to the "ward-in-charge" who was the CM of the student. The "ward-in-charge" then blamed her student for the suboptimal performance publicly. The act of blaming students was a form of feedback to manage the individual student's performance. When the "ward-in-charge" blamed the

student publicly, such act served an additional purpose that presented an impression of taking mentoring responsibility seriously to co-workers in the clinical area. It meant that the audience of the feedback was widened and not only limited to individual students. When CIs and CMs provide feedback in front of other nurses and healthcare workers, the act of providing feedback publicly/ in front of others presented an impression of being a responsible professional.

There was a colleague sharing her previous experience. She did not want to be blamed when she was a student. I think of my experience at that moment. I reflected from my way of mentoring. Whether it is right to apply this way of mentoring to my students. I hope I try not to do so... It also let the nurses of the ward to know that I am not lenient to the students. (M3, clinical instructor)

From the above quote, blaming students publicly could also be used to show a public performance of mentoring. The CI (M3) intentionally showed other nurses that she upheld more stringent expectations towards her students. She used this as a way of demonstrating that she was a responsible CI and required her students to achieve higher level of performance. It reflected that being stringent to students with suboptimal performance were linked to an impression of being responsible which could be related to the Chinese culture. The audiences of feedback were not limited to individual students with poor performance and co-workers in the clinical area. When CIs conducted group mentoring, other students in the group witnessed the scene of blaming publicly. This public feedback served as a warning to other students. The students who had suboptimal performance was then labelled by other students in the group and this resulted in ostracism of those students. The details of ostracism will be discussed in section 8.3.3.2. Apart from the above mentioned three purposes, data showed that CIs and CMs provided different types of

feedback in clinical mentoring. The different types of feedback will be discussed in the next section.

8.3. Types of feedback

All participants reported that CIs and CMs provided various types of feedback to their students throughout clinical placement. Three types of feedback were identified from the analysis namely, constructive feedback, minimal feedback and destructive feedback. These feedback types portrayed interaction between CIs/ CMs and students and various mentoring behaviours. As described in the data, the use of these different types of feedback depended on the purpose of providing feedback and audience of feedback. Interestingly, CIs and CMs were not aware that the use of minimal feedback and some types of the destructive feedback. The details of each type of feedback will be discussed in below.

8.3.1. Constructive feedback

As discussed in Chapter 4, constructive feedback was a preferred type of feedback that was preferred by the university. The data showed that constructive feedback was mainly used by CIs and CMs to improve students' performance and promote students' behaviours that were desired by CIs and CMs. Constructive feedback was provided by CIs and CMs through discussion with their students and offering practice opportunities.

8.3.1.1. Discussion with students

CIs and CMs used discussion to provide feedback to their students. Discussion with students described in the data referred to top-down conversation between CIs/ CMs and students.

You need to discuss with the student. You need to discuss with the student about how to improve. (O4, ward manager)

The ward manager (O4) perceived that the aim of discussion with students was to “improve” their performance. CIs and CMs first initiated the discussion with students and informed their students about their perception of students’ performance.

For the second attempt, the clinical instructor told me that it (expired lotion) was the main reason. I also asked her if there is another reason. What should I improve apart from that reason? She also told me about the skill. How I should open the dressing material. Also, the attitude toward the patient. Yup. These were the comments from the clinical instructor. (S4, year 5 student)

Some CIs/ CMs also guided their students to learn about their performance through self-reflection by asking them to evaluate their own performance.

They (Clinical instructors and clinical mentors) used to ask me how I felt about my performance. (S6, year 5 student)

Some CIs and CMs praised their students for satisfactory performance when they perceived their students’ performance was good enough to meet CIs’/ CMs’ expectation. None of the participants reported to what extent the improvement required for students to get praise.

I think the students need to be praised but I won’t praise them without any reason. If I think the students show a huge improvement, of course it could not be perfect; I may compare their performance in week one to week four. If the students show a huge improvement, I will praise them “ You have done a good job. There is a big

improvement." I think the feeling of satisfaction could keep them to perform better.
(M2, clinical instructor)

Praise for satisfactory performance served as a form of encouragement offered in a top-down discussion. As discussed in Chapter 5, students expected their CIs and CMs to give them encouragement. Praise for satisfactory performance was not frequently reported in the data, which is a noteworthy finding. Students who participated in the interviews reported that they felt that they did not receive enough encouragement. The content of discussion focused on improvement of students' practice.

She was calm. She did not give me any encouragement as well. She just told me how I could improve my practice and what I should perform better. (S4, year 5 student)

This student (S4) described his CIs as providing feedback in the form of instructions to guide him to improve his practice of aseptic technique within the discussion. A similar situation was also reported by a HCA.

The nurses...our nurses usually tell the students "Hey, it should not be performed like this. You should do this and this." (W3, junior healthcare assistant)

The junior HCA (W3) witnessed a CM providing instructions for improvement for her students. The content of this instruction was to tell that student how to behave as the CM desired. Instructions also included the reflections on CIs' / CMs' previous clinical experience.

I always ask the students not to trust other for everything. Do not do what others ask you to do. You need to check with the kardex...I think this is from my previous experience...The students may make the same mistake as the mistake that I made previously. I think it would be better to remind my students. (M2, clinical instructor)

CIs and CMs perceive that students had suboptimal performance due to lack of clinical experience. They, therefore, shared their previous clinical experience with their students and expected their students to learn from the sharing in the discussion. This claim echoed the purposes of providing feedback as discussed in section 8.2.

Discussion was a relatively simple form of feedback. The above examples of discussion between CIs/ CMs and students shared one characteristic that top-down communication was commonly identified from such discussion. In the discussion, students knew whether their CIs and CMs were satisfied with their performance and receive instruction that facilitated them to practice as their CI/ CM expected.

8.3.1.2. Offer practice opportunities

Offering practice opportunities was identified from the data as another type of constructive feedback. CIs and CMs described how they offered students repeated practice opportunities when they perceived their students' performance was suboptimal.

For our industry, practice makes perfect. The more the practice, the more familiar with the procedure. (O3, hospital coordinator)

Students, therefore, were asked to practice the same skill repeatedly so that their performance could meet their CIs' / CMs' expectation through repeated practice. In contrast, students were punished by depriving them from practice when their performance was perceived as unsatisfactory by their CIs/ CMs. Details of punishment will be discussed in section 8.3.3.3.

As discussed in section 6.2.2, students could not only become more familiar with the technical procedure through repeated practice also in order to be capable to complete the procedures efficiently. When students were able to meet their CIs'/ CMs' expectations regarding performance of a basic skill, their CIs and CMs perceived that they became competent and ready to practise advanced nursing skill.

When you are not able to perform the basic tasks well, it would not be possible to perform the difficult tasks. (W1, junior registered nurse)

Based on the quotation from this junior RN, offering opportunities to practise advanced nursing skills depended on perceived competency of students. Students were rewarded opportunities to practise more advanced nursing skill when they were perceived as competent in their practice of basic nursing skill whereas students with suboptimal performance were offered repeated opportunities of basic skill. Discussion and offering practice opportunities were used when students were perceived to have both satisfactory or less than satisfactory performance. Constructive feedback was proactively provided by CIs and CMs to reinforce their students to practise according to their own wishes under a supportive learning atmosphere. In comparison to constructive feedback, CIs and CMs could also provide feedback in a withdrawal manner.

8.3.2. Minimal feedback

As reported by students, they received minimal feedback from their CIs and CMs. The data illustrated that minimal feedback was commonly provided by CIs and CMs when they perceived that their students practice had met their expectations. A year 5 student (S3) described minimal feedback from a CM.

I barely remember that my mentor supervised my practice once before the assessment. That means she supervised my practice once before assessment. She told me that I did not have any problem in my practice. Then I perform the procedure on the day of assessment. (S3, year 5 student)

CIs and CMs provided the minimal feedback by informing their students that their performance was able to meet the expectation. In comparison to constructive feedback, no other content was included in minimal feedback such as instruction for further improvement and praise for the satisfactory performance. Minimal feedback was commonly found in data when CMs conducted field evaluation.

How did the mentor assess the items stated in the iPod (touch)? The mentor would supervise me for one more time and tell me about the result. The good mentor would tell me about the result. Some mentors may tick the item without talking anything... As it was too busy in surgical ward, the mentor could only help me to tick the items in night shift. Yup. She was not free to tick the items in the morning and afternoon shift as she was the ward in-charge... The mentors are busy. They are not able to supervise you. (S2, year 4 student)

It was noteworthy that CMs tended to provide minimal feedback from the data. The quote from this student revealed that CMs may only be able to give minimal feedback due to their heavy workload. Receiving minimal feedback could be related to the difficulty for CMs to spend time with a student to conduct field evaluation. As discussed in Chapter 6, in this scenario CMs may either adopt other nurses' opinions as a method of assessment or even omit the assessment. When CMs did not conduct the assessment, they were then unable to provide feedback in detail. The tendency of providing minimal feedback by CMs could also be related to the CM's willingness to be a mentor. Some students reported in the interview that some CMs showed a withdrawal gesture in clinical mentoring. They were unwilling to

mentor students. Hence, these CMs provided minimal feedback as a form of formality. Minimal feedback had little educational value as its contents was quite simple. Students could only know whether their performance met their CMs' expectation or not. Although students may not have benefited from minimal feedback, this year 4 student (S2) still considered her CMs who provided minimal feedback as a "good mentor". Minimal feedback was provided in a neutral and less supportive learning atmosphere. Feedback could be provided by CIs and CMs to manage their students' performance vigorously and show an impression of being responsible mentor.

8.3.3. Destructive feedback

Destructive feedback was a form of negative feedback identified from the data analysis in comparison to the first two types of feedback discussed in the previous sections. Three types of destructive feedback were identified from the data namely blame, labelling and ostracism, and punishment. CIs/ CMs and other ward staff reported that they used blame initially and they gradually applied more than one type of destructive feedback when they perceived their students to have made no improvement after feedback was previously given. In contrast, CIs and CMs reported that they were unaware of ostracism of students. Students who were perceived as having serious problem in performance revealed in the reports that they experience ostracism during clinical placement. Details of each type of destructive feedback will be discussed as below.

8.3.3.1. Blame

Blame was described by all participants as the commonest form of destructive feedback used by CIs/ CMs when they perceived their students as failing to meet their expectations. Blame in clinical mentoring was a complex concept that could be explored through its characteristics, context when CIs/ CMs blamed their students, students' acceptance of being blamed.

Characteristics of blame

Similar to discussion as a method of feedback, blame served as a top-down verbal communication from CIs/ CMs to students. The difference between discussion and blame were related to the tone of communication and learning atmosphere developed through such communication. A year 5 student (S3) reported that his CM expressed her thoughts about his performance in a strong tone.

For blame, the nurse may say "Hey! How could you perform like this? You can do this and that..." The tone is very strong and straight to you. (S3, year 5 student)

The strong tone of the communication between this student and his CM cultivated a hostile learning atmosphere whereas discussion between CIs/ CMs instructed students in supportive learning atmosphere. The above quotation indicated that this student's CM questioned and demanded this student to obey her order. It reflected that this student's CMs regarded herself in a superior hierarchical position within the relationship between her and this student. This year 5 student's CM asserted her power to coerce him to obey her order by using her higher hierarchical status. Blame was then perceived as a warning to students

that emphasised the seriousness of the poor performance and urge students to avoid undesirable behaviour in future practice.

Context of blame

The data also illustrated that CIs and CMs blamed their students in different contexts, namely in public or in private. The context of blame indicated the seriousness of poor performance. Another year 5 student (S6) reported that her CM blamed her in private when she was unable to fulfill the expectation of completing the assigned task at speed.

I could be blamed when I completed the task slowly...Er...in a quiet place. I was blamed in a private place. (S6, year 5 student)

Blaming students privately served as a mild form of blame and served as the first alert for students to aware of the problem in their practice. The severity of blame escalated when students either committed serious mistakes or involved in a serious incident. CIs and CMs could then blame students publicly. A HCA (W3) witnessed a nursing officer blaming a student publicly. In that incident, a student tried to feed a patient who was restricted from drinking plain fluid due to high risk of choking and aspiration and was blamed publicly for the mistake.

I said "Wah! Nurse. Does the student feed the patient medication?" (the nurse said) "Yes. I asked him to feed that patient." The student may not know that the patient must not drink plain water. Who knows! Our nursing officer noticed it suddenly. After it...I think that this incident was very serious. However, the tone of the nursing officer was not good too. It made the student feeling upset. But...how should I say? This incident was very serious. The student may not know about the seriousness of the incident. When the nursing officer spoke to the student, it was quite awful. I feel that the words

were unpleasant. *“Do you want to make the patient die from suffocation. (W3, healthcare assistant)*

The HCA described the nursing officer’s tone and words were unpleasant when she blamed that student in public. This HCA further suggested that blaming students publicly was related to perceived seriousness of the incident. It implied that blaming students publicly was acceptable if the incident was perceived as very serious, such as a threat to patient safety.

Most accounts of blaming in public were given by students or ward staff. A CI (M3) was the only interviewee who admitted that she blamed students in public. She agreed that blaming students in public was a destructive way to manage students’ behaviour. Despite this, she still perceived that it was necessary to blame her students in public.

There is another reason. “I offered the opportunity to you and you did not treasure it. Do you want me to blame you in the public?” I would let the student know beforehand. “Do you know that you may have a chance to meet people who may blame you in the public? Completely not giving any face to you. I would let you to experience it. It’s better for me to blame you now instead of letting others to blame you later.” I know that the students do not feel well about it. I also know that it may have negative effect to the students. (M3, clinical instructor)

This CI justified blaming students in public as a form of experiential learning that students should have experienced it before they became professional nurses.

Students’ acceptance of being blamed

Although all participants agreed that blame was an unpleasant form of feedback, it was interesting that students seemed to accept being blamed. The acceptance of blame

appeared to be based on students' perception of the reason for being blamed. Most of the students who participated in the interviews reported that they could accept blame from their CIs and CMs especially when they perceived that there was a rational reason or explanation for them being blamed such as making a mistake.

It was not big deal. As I made mistake, I let her to "beat me up" (blame me). (S5, year 4 student)

A year 5 student (S3) suggested that being blamed was a reasonable act as he perceived his CMs were doing it for his own good.

When the mentor blames me, he/she can let me know that it was for my good sake. (S3, year 5 student)

Students perceived that they could benefit from being blamed rationally, such as receiving guidance for improving their performance alongside the blame. Receiving blame with a rational reason and guidance meant that students' competency could be improved. However, students could perceive that they had been blamed without a rational reason or explanation.

It was my classmate's experience. He met the same "miss" (female nurse) in the practicum. My classmate is quite tall. He prepared for the intravenous infusion. He pulled the drip stand at a very high level. He then moved the drip stand and the solution to the patient. That nurse blamed the student. "Why do you adjust the drip stand so high? You are tall but I am not. What's the point to hang the IV fluid so high? I can't reach it. Are you going to administer the infusion? (Students are not allowed to administer infusion)" She acted like that. Her tone was not so good all the time. (S3, year 5 student)

This student reported that being blamed for height of the drip stand which was not desired by the ward nurses was an example of irrational blame. He further described what irrational blame was.

Instead of trying to insult me or find some other excuses to blame you. For example, the mentor blamed me because he/she feels unhappy or just some minor mistakes. The mentor is trying to “pick the bone inside the egg” (being picky) and blame you. (If it happens,) I feel that it is not fair. (S3, year 5 student)

This student perceived irrational blame as a form of unfair treatment. Here the difference between rational and irrational blame to students seemed to be related to reciprocity. Students were benefited from rational blame as the guidance included in blame facilitated them to improve their practice while their CIs and CMs ventilated their emotion at the same time. For irrational blame, students perceived that they did not benefit in exchange of being used for ventilation of emotion.

Some students also reported feeling unhappy and upset after being blamed by their CIs and CMs.

I will feel unhappy if the mentor blames me. However... I will not argue or fight for anything as I think that I just work here for a short period of time. Therefore, I will take it. The mentor is responsible for rating my performance in the assessment. I may think like that. I prefer not to make any trouble. I will tolerate it. The mentor could be stressed. So she tried to find somebody to blame. I have no way to resist as a student. There is no way to resist. (S1, year 5 student)

This year 5 student (S1) suggested that any response by him toward being blamed could cause negative impact on his assessments. Hence, he perceived that he still had to accept

being blamed, even with bad feeling in order to avoid trouble. It reflected that students perceived themselves in a subordinate level and inferred that they lacked of the ability to resist the irrational blame.

Blame was a vertical communication from CIs/ CMs to students which served multiple purposes. Some students could feel upset after being blamed. However, interestingly all students still perceived being blamed as a form of beneficial feedback if CIs/ CMs provided guidance for improving their practice at the same time. When CIs and CMs were persistently dissatisfied with their students' performance, the level of destructive feedback could then escalate. Ostracism of students was reported by students and other co-workers in the ward.

8.3.3.2. Labelling and ostracism

Labelling and ostracism was another type of destructive feedback described by students in this study. It was related to more serious problem in students' performance. The process of ostracism first started with labelling the student who was perceived to have poor performance. As discussed in Chapter 7, student with perceived unsatisfactory performance were labelled as a "bad student" by their CIs and CMs when students were perceived to have serious problem in performance. The negative comments about the labelled students were then shared between nurses and other ward staff.

We may discuss about it. For example, there could be a nurse "Hey, this student is very lazy." Or how the student performs...or the student...when the patient waved hand to call the student, the student walked away directly. We would talk about that. It is not because of student. As we work together, we would talk about it. "Hey, this person works like this." or that person may leave you some work. Or the performance of that

person is not good. Ask others to keep an eye on that person. (W3, junior healthcare assistant)

The comment shared by CIs/ CMs focused on their perception on students' character instead of the actual performance. A HCA (W3) described the purpose of sharing the negative comments about the labelled student was to draw other nurses' attention and enhance monitoring of the performance of that student. Similar phenomenon was also identified in group mentoring conducted by CIs.

These two students were very interesting. They stayed together all the time as both of them had poor performance. They may think that they found a "lifebuoy" for each other²³. I knew that they saw each other as buoy actually. Therefore, I tried to ask the other students to break them up as I was afraid that they would hold each other back... I asked the other students to separate them. Otherwise, both of them would be failed. I would stop them to pair up. I would ask a student with better performance to pair up with them as the smart student would voice out if there is any problem. (M3, clinical instructor)

As shown in the above quote, this CI assigned another student who was labelled as "smart student" to supervise the student with poor performance and report to her if undesired behaviour was detected. The actions of this CI also shared the comments of student who was perceived to have poor performance with "smart students". This CI further justified this action indicating that it was to enhance supervision of students who she perceived to have unsatisfactory performance. The "smart student" was recruited to participate in the ostracism when she tried to separate the pair of students with perceived poor performance.

²³ The lifebuoy in this quote was a metaphor of helping each other. As two students perceived with poor performance were ostracised by other students during group mentoring, these two students sought help from each other instead of their clinical mentors and other students within the group. Hence, these two students considered each other as "lifebuoy" as they were the one who help themselves in difficult times.

Those negative comments could influence how other nurses and students perceived and formed an impression of that student. It could further affect their interaction with the student who was perceived as “bad student”. A year 5 student (S3) reported that one of his classmates reported being labelled who was judged as having poor performance after his classmate spilled milk on the floor resulting in being ostracised by ward staff.

I remembered in those few weeks...He told me that the nurses may not eat with him. He may need to take the break alone...um...He could be blamed for some minor mistakes.
(S3, year 5 student)

A junior RN (W1) suggested that having contact with the student who was labelled as having poor performance could result in negative consequences at work for them and describes colleagues suggesting ostracising that student.

Some colleagues may tell you not to talk to that student anymore. Not to get into trouble. (W1, junior registered nurse)

A year 5 student (S4) described being ostracised after he failed in his assessment twice. He pointed out the difference in interaction with his classmates during group mentoring.

We may talk to each other in the beginning. For example, “aiya, you are responsible for that patient. You may need to manage another patient at the same time. If you are not free, I will help you to perform that task.” However, it was impossible to be like that in the later period of the practicum. Even if I offer to help them proactively, they may turn down my offer. Yup...they may do good to me. I could be able to focus on the assessment. On the other hand, I feel that they may be afraid of how the mentor (clinical instructor) look at them. They also thought that I may not have the ability to complete the practicum. It would be better to perform the task by themselves. (S4, year 5 student)

This student perceived that the subsequent discouraging and isolating responses from his classmates reflected that the message conveyed by their CI which implied he was incompetent. This student also perceived that his classmates believed that they should not let an incompetent person to perform a task for them. This student also explained his perception of why his classmates avoided having contact with him. They feared contact with a 'bad' student could lead CIs to form a less favourable impression of them. Thus, the behaviours of his fellow students led to his further exclusion from normal activities. This year 5 student was isolated for the rest of the clinical placement. Students who were perceived with poor performance were labelled and ostracised instead of receiving assistance to improve their performance. Hence, these students were unlikely to show improvement in their competency throughout the clinical placement.

8.3.3.3. Punishment

CIs, CMs and nurse educators reported that they applied punishment in order to inhibit undesirable student behaviours. Different levels of punishment were identified in the data by all participants. CIs and CMs could first deprive the practice opportunities of students perceived with poor performance. Punishment could further proceed leading finally to the suspension of the student from clinical placement. Initially when students were perceived to have poor performance, they could be deprived from practising advanced nursing skill.

We may continue supervision or to let the students to perform some other tasks. It really depends on the students. It depends on the performance of the students. If the performance is not good...the student spends a lot of time to handle the basic tasks, the student will have the very basic package in the practicum. (O4, ward manager)

Being limited to practising basic nursing skills throughout clinical placement was seen as a form of punishment when students' CIs and CMs perceived that they had no improvement in their performance of basic nursing skills. Students were deprived from learning new nursing skills. Students could also be suspended from practice temporarily for a short period of time which served as a form of punishment. A CI (M2) described that she suspended her student when the student repeatedly made the same mistakes in a shift.

That student made the same mistake one day. I punished her for making the same mistake again. I did not allow her to perform any procedure on that day. She followed me and observed others on that day. I did not allow her to perform any task as I wanted her to have some reflection about herself. I will use this method to let the student to think about her performance. (M2, clinical instructor)

Students could also be punished by restricting them in providing care for a particular patient. A year 5 student reported that he was assigned to take care of two patients in the beginning of the clinical placement. He was no longer allowed to take care of a patient after he failed to report the abnormality found during napkin changing for that patient.

For the time that I finished changing napkin, I did not report to her (about the abnormal findings). She felt that it was my weakness. She did not allow me to perform any nursing procedure for this patient. (S4, year 5 student)

The level of punishment could be escalated from deprivation of practice to suspension of clinical placement when students were perceived to have poor performance persistently. CIs and CMs described also being likely to have provided other type of destructive feedback such as blame or ostracism before they decided to suspend the student with poor performance from clinical placement.

The nurses actually reported my performance (to the school). They did not tell me about it at all. They did not think that they need to teach me...I feel ok about that. It may be able to let me know what I have missed and how I can improve my performance. However, they did not do anything. They just treated me like "life release"²⁴. I think that they may not be able to manage their own staff and they did not want to bother. They wanted to get me out (of the ward). (S5, year 4 student)

As reported by this year 4 student, she was "life released" by her CM when her CM decided to suspend this student from clinical placement. Being "life released" meant that this year 4 student's CM had already given up facilitating her to improve her performance. CIs and CMs could perceive that a student who was pending suspension from clinical placement, was unable to improve his/ her performance regardless of feedback provided. Suspending a student from clinical placement was perceived by a CI (M3), as a being a responsible behaviour taken on behalf of the nursing profession.

She (A student) was assessed for the wound (dressing). She was a "double loss" (no knowledge and skill) one...I must suspend the student from practicum. I also worried that the student did not quit the programme as I think it was a waste of her time and her money. That student was not suitable to work in this industry. (M3, clinical instructor)

This CI perceived that this type of student did not have the necessary knowledge, skill and competencies to pursue a career in nursing. Thus, CIs and CMs may perceive that like the CI (M3) that they are acting professionally as gatekeeper when suspending students in order to keep incompetent students away from practice. This action was perceived as a way to protect the nursing profession, allowing them to present an impression of being responsible for the nursing profession.

²⁴ Life release refers to a Buddhist practice that save the life of animals which are going to be slaughtered by setting these animals free. "Life release" in this quote means leave S5 unattended in clinical mentoring

Receiving both constructive feedback and destructive feedback in clinical placement were reported / described as resulting in variable impacts on students.

8.4. Impacts of feedback

CIs and CMs expected their students to behave according to their expectations after they had given students feedback. The impacts of constructive and destructive feedback were described by CIs, CMs, ward staff and students as being reflected in both students' competencies and confidence. Various impacts on students' competence and confidence from both constructive feedback and different types of destructive feedback will be discussed in below.

8.4.1. Impact on students' perceived level of competence

Students were believed by CIs and CMs to show changes in competence after they received feedback. For example, students could show improvement in competency after discussion and the offering of practice opportunities. The improvement of competencies was identified by CIs and CMs through preventing students making the same mistake in future practice.

She (Clinical instructor) told me about how I could improve my performance. She was trying to make me to perform better as she could observe that I was messy when I handled the case. For example, turning. My performance was not good. I should have better preparation before the assessment...I would think about the prevention of the similar incident happened in the future. (S5, year 4 student)

This year 4 student reported that the suggestion provided in the discussion helped her to understand her weaknesses when she performed a dressing for a bedbound patient. She could put her patient in a better position when she performed the dressing next time. Students could also improve their competency after their CI/ CM offered them additional practice opportunities. The junior RN (W1) found that one of her students failed to perform an ECG in the correct way for a patient. She offered several opportunities for her students to perform an ECG afterwards.

I asked her ...next time...to think about how to perform ECG and practise it... (The performance) so far is OK. I think that the student could really achieve the outcome. For an instance, I gave that student 5 minutes. She was really able to give me that paper (ECG) within 5 minutes. I had checked the leads. They were in right position. (W1, junior registered nurse)

This junior RN reported that this student developed the competency of performing ECG after repeated practice. Based on the above quotations, students believed they were able to enhance their competency through constructive feedback. However, as noted earlier, students could also receive minimal feedback in clinical placement providing no suggestions for improvement. Minimal feedback may not offer any opportunity to enhance students' competence.

No one would give you opinion in usual practice. When you perform dressing, they (the nurses) may supervise you once. If it (the performance) is OK , you will perform the task on you own. No one would supervise you on dressing anymore. I may not be alert about something at that time. (S5, year 4 student)

This year 4 student recalled her experience before she participated in the assessment of dressing technique. Her CM informed her that her performance of dressing technique was

acceptable. No further suggestion was given to her. This student, was therefore, unaware of the issue of positioning when she performed a dressing. Thus, students could not improve their competencies when only minimal feedback was given.

Destructive feedback could result in various impacts on students' competence. CIs and CMs believed students could show improvement in their competencies after they were blamed by their CI/ CM.

The students usually perform better after being blamed. Of course. It also depends on the acceptance of the students. (M3, Clinical Instructor)

On the other hand, the junior HCA witnessed a student who did not show improvement in his performance after this student was blamed in the public.

I don't think that he performed better. The performance was not better. (W3, junior healthcare assistant)

CIs and CMs believed that the impact of being blamed was improved performance. The CI (M3) suggested that the improvement in performance was related to an acceptance of being blamed. She perceived that students who accepted to being blamed could improve their performance. However, a year 5 student (S3) reported that he was unable to improve his performance as no guidance for improvement was given when he was blamed.

When the mentors blame me, I may just remember how the mentors blame me. The mentors blame me for different things together. They may forget to teach the students. They forget that they should teach the students. (S3, year 5 student)

This student believed that he was unable to improve his competence as CIs/ CMs did not offer any guidance during blame. This may explain why CIs and CMs perceived that their

students' performance improved after being blamed. The guidance given during blame might be the factor that enhanced students' competence rather than the acceptance of being blamed. When students showed no improvement in their competence, their CIs/ CMs used more vigorous destructive feedback. Students who were then ostracised and punished more frequently consequently showed further deterioration in their competence as no practice opportunity and guidance for improvement was received. Competence and confidence were closely related to each other. Different types of feedback were described by CIs, CMs and students as not only affect students' competency but also as affecting students' confidence.

8.4.2. Impact on students' level of confidence

Feedback from CIs and CMs was described by CIs, CMs and students as influencing the students' level of confidence. Students suggested that they could become more confident after they received constructive feedback. Students also perceived that they were more confident when they developed their competency through repeated practice.

I did not feel confidence for the task with uncertainty. After I had practiced for a number of times, I felt more confidence. I think that it is also an improvement. (S6, year 5 student)

This year 5 student pointed out that she felt more confident about herself due to the improvement in her competency. As mentioned in the section on constructive feedback, students could receive encouragement from their CIs/ CMs when their CIs/ CMs perceived improvement in their competency. This could also enhance students' confidence. A CM (M1)

suggested that students could feel valued in the clinical area when they received constructive feedback. This served as an assurance of the students' ability.

I always give positive feedback to my students. It helps the students to know that they are not useless. (M1, clinical mentor)

Improvement in competency and confidence were closely related to each other. Students reported that felt they could improve their competency through repeated practice, and this increased their confidence as they received encouragement from their CIs and CMs. Hence, students with higher confidence could also show better competency. As a result, CIs and CMs described rewarding these students with opportunities to practice more advanced nursing skills. These students could then keep improving both competency and confidence throughout clinical placement.

On the other hand, some students were described as receiving minimal feedback and could be required to repeatedly practise basic nursing skills. CIs/ CMs expected that these students should be more confident about themselves once they were capable of performing these tasks independently.

When the students become independent on the sixth week, the students feel more confident about themselves. (M5, clinical instructor)

Students could still feel confident even if they kept practising basic nursing skill. A year 5 student (S3) reported that he performed basic nursing skill most of the time during clinical placement. Being competent in basic nursing skill could also reflect how students perceived their contribution during clinical placement. When this student was able to help other nurses to complete the basic nursing care, he reported feeling useful and valued for having

made a valuable contribution in clinical areas. Confidence could then be built up when students were satisfied with their contributions during clinical placement, despite losing the opportunity of further development of competence.

I feel happy if I can help the nurses. Yes. It could also save time for the tasks. I could help the nurse. (S3, year 5 student)

Students' confidence were closely related to students' competence regardless the complexity of clinical skill competence. Constructive feedback was described as benefiting both students' competence and confidence. It was interesting that destructive feedback was reported by ward staff and students as also sometimes benefiting students' perceived competence. However, destructive feedback was also described by CIs, CMs and students as diminishing their students' confidence.

8.5. Conclusion

Both organisers of clinical placement and students expected their CIs and CMs to provide constructive feedback so that students could complete the clinical placement successfully to become qualified nurses. However, the data presented in this chapter showed that CIs and CMs provided feedback for more purposes than simply to improve performance. Three types of feedback were identified from the data, namely constructive feedback, minimal feedback and destructive feedback. These forms of feedback were identified as having had variable impacts on students' competence and confidence. In summary, the data presented that the process of clinical mentoring was conceived of as being framed by various expectations of organisation and CIs/ CMs. Within the interactions of clinical mentoring, CIs and CMs described making social judgments about their students through assessments and

managing their students through feedback while students described themselves as subordinates and tried to prevent negative impacts from feedback and achieve their own expectations of clinical placement. In the next chapter, the process of clinical mentoring will be further discussed.

9. Discussion

9.1. Introduction

This study aimed to explore the social process of mentoring in order to understand how the process played out within the context of pre-registration nursing clinical placements in hospital settings in Hong Kong. A theoretical framework describing the process was abstracted from a comparative analysis of the perspectives of five participant groups based on a constructivist grounded theory approach (Charmaz, 2014). The four categories that emerged from the data analysis to describe the social process of mentoring were: expectations, impression, social judgment and feedback. These categories illustrate how CIs/CMs and students interacted during the process of clinical mentoring within hospital placements. The interactions between CIs/CMs and students were influenced by various contextual factors, including the ward staff, ward culture and environment, policies guiding mentorship, clinical placement, ward organisation, and the organisational cultures of both the hospitals and the educational institutions. In this chapter the key study findings will be discussed in relation to relevant theory and empirical literature. Implications of this study will also be identified and recommendations will be suggested to enhance the organisation and implementation of clinical mentoring in nursing education. Study strengths and limitations will be addressed in a later section. This study can contribute to knowledge of clinical mentoring and enhance the quality of clinical mentoring in future.

9.2. Summary of findings

The findings of this study were used to construct a theoretical framework that illustrated the social process of mentoring in pre-registration clinical nursing placements in hospital settings in Hong Kong. The theoretical framework was based on comparative analysis of various

interactions in clinical mentoring by the key participants and an analysis of the related guidelines and policies. This theoretical framework consists of two parts, outer rings showing the contextual influences and a central model describing the core interactive process that took place between CIs/ CMs and their students (see Figure 9.1).

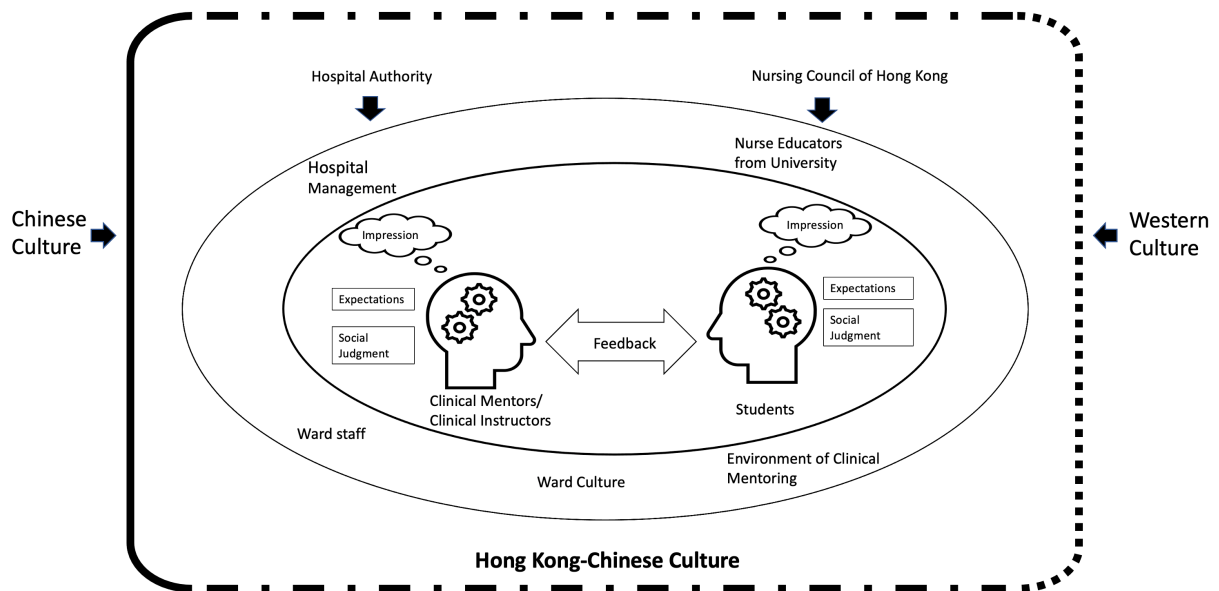


Figure 9.1: Theoretical framework showing the social process of clinical mentoring

The social process of clinical mentoring was a dynamic process that was co-constructed as a core interactive process between CIs/ CMs and students and embedded in the Hong Kong-Chinese culture. It occurred in multiple interactions between students, CIs/ CMs and those participants who influenced clinical mentoring including hospital management, nurse educators and ward staff. The context of clinical mentoring was framed by various guidelines and policies developed by the Hospital Authority and NCHK. These served as a first level of contextual influence. The second level of contextual influence was constituted by the guidelines for CIs/ CMs and students which were developed by the hospital management and nurse educators. These were based on the guidelines and policies set by both the

hospitals management and the nurse educators from the university. Other second level contextual influences included arrangements regarding placement allocation, ward cultures and interactions with other staff, including ward staff, ward managers and nurse educators. These two levels of contextual influence shaped the initial interactions between CIs/ CMs and students and continuously influenced later interactions. The interactions between CIs/ CMs and students constituted the core of the social process of clinical mentoring in placement settings. By comparing different accounts of clinical mentoring interactions given by the five participant groups, four categories emerged which illustrated how CIs/ CMs and students acted within each interaction during the process of clinical mentoring (See Figure 9.2).

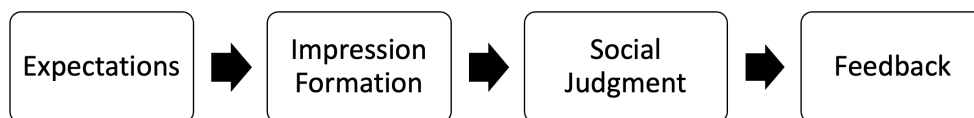


Figure 9.2: Core interaction process in clinical mentoring

Expectations

All participants had preconceived expectations of others in mentoring interactions. These expectations were related to self-presentation, and also to the expected roles and behaviours which were perceived as appropriate or inappropriate, both in the clinical placement setting and in the interactions between CIs/ CMs and student. Self-presentation reflected expectations about appearance and etiquette, while expected roles reflected the expected fulfilment of responsibilities and level of competence anticipated of the other by participants. The analysis identified that these expectations were shaped by multiple factors including previous experiences, and the organisational cultures of both the hospital and the

university. These expectations acted as unspoken standards by which the performance of the others was initially judged. From the reports of participants in the clinical mentoring process, in the next phase of the social process they formed an impression of the other actor(s) in the process.

Impression formation

CIs/ CMs gained an understanding about their students and the environment of the interaction through various means before they made a social judgment about their students. For example, CMs knew their students and the environment in which the interaction took place through observation of the student's appearance and behaviour, in the context of their environment. They also sought comments from bystanders to the interaction, such as ward staff, to inform their impression of students. For example, students wearing "fashionable" glasses were perceived to reflect an impression of "arrogance" and a "poor" learning attitude by some CMs. The appearance of these students was considered to not be compatible with the impression of a "good student" as "good students" should be humble and show deference to their CIs/ CMs (Goffman, 1956). CIs/ CMs then made a social judgment based on their impression of the students and put a label on them (Matsueda, 2017). The social process of social judgment formation could then lead to students being labelled as "good" or "bad" students (Becker, 1974). Typification refers to a way of perceiving the world by structuring our understanding of it through the use of types and typologies (Kim and Berard, 2009). Different types or typologies are formed based on general conceptions of particular groups of people which have been formed within a specific cultural setting (Kim and Berard, 2009). These ignore individual differences in order

to label individuals as belonging to a particular type. A similar phenomenon was found in this study. CIs/ CMs developed their perception of students based on generalised ideas of the characteristics of “good” and “bad” students, and typified students into “good students”, “average students” and “bad students”. Typification was also found in previous studies in healthcare (Hargreaves, 2005; May and Kelly, 1982). Hargreaves (2005) described the characteristics of a nurse who was typified as a “good nurse”, while May and Kelly (1982) described the characteristics of psychiatric patients who were typified as “problem patients”. The taken for granted typification or stereotyping of individuals as “good nurse” or “problem patients”, shared similar characteristics to labelling and could result in social judgements influencing later interactions (Johnson, 1997). The characteristics of “good” and “bad” students and the ways in which this typification of students influenced the interaction within clinical mentoring will be further discussed in section 9.3.4.

Social Judgment

In the phase of social judgment, CIs/ CMs compared the impression they had formed of the student with their preconceived expectations and used this comparison to interpret the meaning of students’ behaviour. When CIs/ CMs judged that their impression of students was incompatible with their expectations, a negative impression of students was formed and a negative label was then assigned. Students who were then perceived, for example, as “being arrogant” or having a “poor learning attitude” were considered to be unable to meet the CIs’/ CMs’ expectations and were thus labelled as ‘bad’ students. The label assigned served as a form of typification in that CIs/ CMs perceived students as either “good students”, ‘average students’ or “ bad students” based on generalised perceptions of these three categories. Assigning labels to students was the first step in making a social

judgement. Based on the label assigned CIs/CMs then judged whether their students were worthy enough to become qualified nurses. The classification of worthiness was also similar to the findings in Supples (1993) that nurses who complied with their managers' remedial practices tended to be perceived to be more worthy. This phenomenon was similar to the students who were able to present CIs/CMs' with the desired impression of a 'good' student in this study. The process of social judgment identified in this study was similar to the description of social judgement by Johnson (1997). The social judgement made by CIs/CMs further influenced how they managed students' performance in later interactions within clinical mentoring. On the other hand, students who were perceived to fulfil CI/CMs expectations were then labelled as 'good' students. This label, once assigned, guided the CIs/ CMs in how to act in forthcoming interactions. The findings showed that the first impression of a student had a significant influence on both early interaction and on subsequent interactions during clinical mentoring. It is noteworthy that this opinion and impression was formed often before the students had undertaken or been observed actually practising nursing.

Feedback

Feedback was provided to students by CIs/ CMs based on the social judgment of the student formed from first impressions. The purpose of providing feedback was to influence the students to act according to the CIs'/ CMs' expectations. CIs/ CMs considered both their social judgment of the students, and the social situation in which the interaction took place when they decided how they provided feedback. They tended to provide either constructive feedback or minimal feedback to students who were labelled as "good students", while students who were labelled as "bad students" tended to receive either minimal feedback or

destructive feedback, such as blame. Blame was the most common type of destructive feedback used to manage students following a negative social judgment. Baron (1988) defined destructive criticism as a form of feedback that the supervisors provided to their subordinates when the subordinates' performance was perceived as poor. Typically destructive feedback was provided after some delay. Supervisors who provided destructive feedback tended to be angry and unable to control their tempers when they managed their subordinates' performance issues. Thus feedback was generally inconsiderate in tone (Baron, 1988). Destructive feedback also attributed poor performance to internal poor character traits in the individual being criticised. This also echoed typification of good and bad students in that the perception of good and bad students were based on generalised stereotypes instead of actual performance. The threatening tone and the strong emotion of CIs/CMs communications were compatible with the characteristics of destructive criticism described by Baron (1988). Supervisors used destructive criticism to embarrass and blame those subordinates who were perceived to have poor performance (Baron, 1988). Similarly, CIs/ CMs used blame to inform students about their perceived unsatisfactory performance, and to stress the requirement for the student to fulfil their expectations in future. Baron (1988) found that destructive feedback elicited an emotional reaction from recipients which tended to worsen their performance.

Similarly, Audia and Locke (2003) found that destructive feedback was not effective in improving performance. Some students in this study did learn how to address their perceived weaknesses in clinical practice through experiencing blame. We could also consider the management of students' performance as reflecting the fact that both hospitals and university adopted a control-based form of management which has been seen as contributing to a blame culture (Khatri et al., 2009). Control-based management refers to

a type of management philosophy that assumes employees are incapable of controlling their own behaviours and standards of performance. Under control-based management the management of the organisation perceives a need to provide constant guidance, and feedback to discipline and control their employees (Khatri et al., 2009). Blame thus serves as a form of informal discipline designed to manage the day-to-day performance of the employee (Cooke, 2016). The management of students' performance will be further discussed in section 9.3.3.

In this study it was found that some students only understood that their CIs/ CMs were emotionally upset by their performance without understanding how to improve their performance as predicted by Baron (1988). The feedback provided varied according to the social situation in which the interaction took place. For example, CIs/ CMs blamed students in public when they perceived that the students' poor performance was a threat to their role and image as a mentor. They blamed their students in public to either show an impression of being a responsible mentor to the ward staff (bystanders of the interaction) or to give a warning to other students. The analysis showed that all participants who engaged in the interactions in clinical mentoring described their experiences of these interactions in ways that fitted the model of this process of expectations-impression formation-social judgment-feedback. The data also suggested that CIs/ CMs used this process to manage poor performance.

Several impacts were identified as resulting from feedback provided by CIs/ CMs by relevant participants, mainly students, nurse educators and some young CIs/ CMs. Most of these reported impacts were related to students and concerned their confidence and competence. The impacts on CIs/ CMs that were described related to their competence in clinical

mentoring as perceived by ward staff, ward managers and nurse educators. Such perceptions could influence the CIs'/ CMs' relative power in clinical mentoring, in regard to both ward staff and students. The impacts of feedback further influenced both CIs'/ CMs' and students' expectations and changed interactions that occurred in the later period of clinical mentoring. This phenomenon could be explained by the concept of self-fulfilling prophecy (Merton, 1948). The concept of the 'self-fulfilling prophecy' refers to the ways in which "one's expectation about a person eventually lead that person to behave in ways that confirm those expectations" (Tauber, 1997, p. 14). Thus CIs/CMs early labeling of students as 'good' or 'bad' could create a self-fulfilling prophecy. One of the examples in this study was related to how CIs/ CMs managed students to whom they had attributed a negative social judgment. CIs/CMs adopted a more stringent standard in their subsequent judgments of students and provided more destructive feedback and less constructive feedback during the rest of the period of clinical placement. Learning opportunities were also restricted for these students. Due to insufficient guidance and fewer opportunities for practice, these students' performance was then shaped by their limited practice opportunities and this reinforced the label of "bad student". On the other hand, CIs/ CMs adopted more lenient standards towards students who were judged to be "good students". These students tended to receive more constructive feedback, had a better clinical mentoring experience and were given more opportunities to practise valued skills. Students judged as "average students" tended to receive minimal feedback and opportunities to practise routine tasks instead of being given the opportunities to learn new skills offered to 'good' students. This further reinforced the differentiation between 'good', 'bad' and 'average' students".

In summary, both CIs/ CMs and students jointly engaged the interactive process of expectations-impression formation-social judgment-feedback. This process was influenced by various contextual factors such as mentoring guidelines and policies developed by NCHK, Hospital Authority²⁵ and the university, hospital and ward cultures. Thus, as a result of these cultural influences, the actual process of clinical mentoring differed from the description of clinical mentoring stated in the official documents, guidelines and policies.

The theoretical framework (Figure 9.1) showing the process of clinical mentoring illustrates how CIs/ CMs and students interacted in the context of clinical mentoring in pre-registration nursing placements in Hong Kong. Four factors were identified from the data and analysis, namely the influence of context, procedural rituals, perception and management of poor performance, error and mistakes, and the influence of impression formation and impression management on outcomes. Analysis of these factors enhanced the understanding of the social process of clinical mentoring in this specific context. The analysis showed that the Hong Kong Hospital Authority and the hospital institutions asserted dominant control over the social process of clinical mentoring. These contextual factors further influenced the participants' expectations and their interactions.

Secondly, CIs/ CMs and students had to engage in formal clinical assessments as required by NCHK and the university as stated in Chapter 1. As shown in Chapter 4 and 7, CIs/ CMs and students were expected to act according to a set of formalised rules and procedures during mandatory clinical assessments. These were developed by the university within the

²⁵ Hospital Authority is a government subsidised organisation that manage all public hospitals in Hong Kong.

framework set out by NCHK. The analysis illustrated that in order to pass the mandatory clinical assessments, students needed to present the desired impression to their CIs/ CMs. They could not pass by solely illustrating their clinical competency, knowledge and understanding. Thus, these mandatory clinical assessments involved a ritualised performance of competence.

Thirdly, feedback was provided in various forms by CIs/ CMs in each interaction. The findings suggested that CIs/ CMs provided minimal or destructive feedback more often than constructive feedback in their interactions with their students. Students reported in the interviews that they expected their CIs/ CMs to provide constructive feedback when their performance was satisfactory. However, minimal feedback was commonly provided when students' performance was perceived as satisfactory. Destructive feedback served as a common way for CIs/ CMs to manage students' poor performance, despite its negative impacts on students and on subsequent interactions during clinical mentoring. This tendency to use minimal and destructive feedback was related to CIs'/ CMs' perceptions of how to handle errors and mistakes and also to their concern with the impression they presented to the bystanders of the mentoring interactions (ward staff and ward manager). On the other hand, some students learned to manage the impression that they presented to their CIs/ CMs to avoid receiving destructive feedback.

In summary, the complete social process of clinical mentoring can be analysed using a dramaturgical approach (Goffman, 1959, 1967). The perspective of dramaturgy is used to illustrate the meaning of interpersonal interaction through the metaphor of drama and performance (Goffman, 1959). Goffman's work focused on exploring social interaction in

everyday life and his use of the metaphor of a drama helped to identify some key principles of social interaction including performance, definition of the situation, region of social interaction and impression management (Jacobsen and Kristiansen, 2014). These principles were also found in this study. It became clear when analysing the data that the social process of clinical mentoring was constructed through social interactions and these interactions could be better understood by using dramaturgical metaphors. I began to look at Goffman's dramaturgical perspective after analysis of the data revealed that CIs/ CMs and students described consciously acting the part of a 'good' mentor or student and also described following a script that was framed by various contextual factors. The context of clinical mentoring provided several sets of cultural scripts for these actors to follow. Both CIs/ CMs and students adopted different strategies to perform the daily interactions involved in clinical mentoring (Goffman, 1959) and attempted to manage the impressions they gave to both their counterparts in the interaction and bystanders. This phenomenon was particularly dominant in students. CIs/CMs consciously encouraged their students to act and present the 'right' impressions in social interactions within clinical placements. These included being deferential and obedient and acting as helping hands on the ward (Goffman, 1956). These impressions reinforced what Goffman calls the 'interaction order' i.e. the tacit rules of interaction in a particular social setting (Goffman, 1967). CIs and CMs then responded according to the impression presented. These findings during analysis led me to go on to develop my analysis using the principles of dramaturgy. Thus, I applied the principles of dramaturgy outlined by Goffman (1959) to the social process of clinical mentoring which offered me a useful analytic framework for understanding the participants' behaviours within clinical mentoring. From Chapter 7, it appeared that some students consciously created, and intentionally presented the impression desired by CMs/CIs in order

to please their CIs/ CMs, and achieve their goal of passing their clinical placement. CIs/ CMs were aware of, and accepted, that their students could be just acting the part of a “good student”, and provided feedback according to the part played. When students acted the part of a “good student”, this enabled the CIs/ CMs to provide the type of feedback reserved for “good students”, and also allowed mentors to present the impression of being a “good mentor” to bystanders. The student’s behaviour illustrated the ‘face-work’ described by (Goffman, 1967). Goffman first developed the concept of ‘face’ from his use of a dramaturgical perspective on social interaction. ‘Face’ reflected the impression presented in interactions and refers to the work individuals undertake to present a positive self-image (Goffman, 1967). Individuals adopted face-work as strategy to maintain an acceptable ‘face’ through managing the impressions they presented (Goffman, 1967). One of the example of impression management was related to how CIs/ CMs managed the impression they presented toward the ward staff. An impression of being a stringent mentor was presented to the bystanders when CIs/ CMs provided destructive feedback to students who were perceived as “bad students”. Acting as a stringent mentor was also designed to give the impression of being a “good mentor” to bystanders. These behaviours served as examples of impression management in that CIs/CMs intentionally tried to avoid negative consequences by applying strategies within the interaction designed to dramatise the role of a ‘good’ mentor (Goffman, 1967). The pattern of behaviour reflected the interaction order and constructed the interaction rituals of clinical mentoring (Goffman, 1967). Based on the findings from the analysis four discussion themes will be presented in the following sections in order to enhance understanding of the interaction process in clinical mentoring.

1. The dominant control of clinical mentoring by the Hospital Authority and hospitals

2. Mandatory clinical assessment rituals
3. Managing poor performance, errors and mistakes
4. Understanding the influence of impression and impression management in clinical mentoring using a dramaturgical approach

9.3. Discussion of themes

In this section theoretical consideration of the four discussion themes identified in section 9.2 will be presented and compared with relevant literature. Understanding of contextual factors enhances the understanding of the social process of clinical mentoring in pre-registration nursing education in this setting.

9.3.1. The dominant control of clinical mentoring by the Hospital Authority and the hospitals

Clinical mentoring was organised in a partnership between the Hospital Authority, the hospitals and the university. Both the Hospital Authority and the university developed different official guidelines and policies to guide CIs/ CMs and students to fulfil their roles in the context of clinical mentoring. CIs/ CMs and students described their roles as a continuum which reflected two distinct ends of the expected roles in clinical mentoring, namely a pragmatic and an ideal end (see Figure 9.3).

Personnel Involved in Clinical Mentoring	Expected Roles in Clinical Mentoring	
	Pragmatic end	Ideal end
Students	Prioritising Helping Hands for the Clinical Workload	Prioritising Learning
Clinical Mentors & Clinical Instructors	Prioritising Clinical Nurse Duties	Mentorship of student

Figure 9.3: Continuum of expected roles in clinical mentoring

The pragmatic roles in clinical mentoring prioritised the operation of the ward over student learning and were commonly reported by study participants. Several studies explored the work role of learners in clinical placement (Bukhari, 2012; Melia, 1987; Ousey, 2007).

Bukhari (2012) explored how the qualified nurses adapted to the new working environment through a preceptorship programme. The findings of Bukhari (2012) illustrated the problems associated with the transitional role of a new worker in unfamiliar working environment.

This was a different situation to that of students learning to be professionals and it is therefore difficult to apply this study to the pragmatic roles expected of pre-registration nursing students identified in this study. However, both Melia (1987) and Ousey (2007) found a similar phenomenon to the current study in that students served as workers giving basic nursing care in their studies. A mentor in Ousey (2007) justified this practice suggesting that taking up the role of providing basic nursing care was a way to learn about care. Students were seen as being able to practice their skill at the same time as relieving the ward workload (Melia, 1987). These claims were also found in this study. Melia (1987) further explained that performing basic nursing skill to relieve the ward workload was part of the professional socialisation of students as this represented the daily tasks that were completed by the ward nurses. Both Melia (1987) and Ousey (2007) studies confirmed that students' roles were those of workers on the ward. However, these two studies were unable to explain how much the students learned when they had to fulfil the role of a worker delivering basic care at the same time.

In contrast, the ideal roles in clinical mentoring focused on the clinical education of students. The two ideal roles in clinical mentoring were briefly described in the official guidelines of clinical mentoring produced by the university. In the findings, hospital

managers and students both reported that students served as “helping hands” with the clinical workload by performing basic nursing care. Similar findings of students acting as helping hands were also reported in previous studies (Jack et al., 2018; Morrell and Ridgway, 2014; Sinclair et al., 2015). Hospital managers in this study justified this role with two explanations. Firstly, they believed that CMs were able to spare some time for clinical mentoring when students relieved the clinical workload and secondly they believed that students could learn through repetition, regardless of the complexity or simplicity of the clinical tasks. Some students in this study reported similar findings to previous studies and complained that they repeatedly performed the basic nursing care tasks normally performed by healthcare assistants (Morrell and Ridgway, 2014; Sinclair et al., 2015).

Similarly, CMs also reported that their clinical nurse duties were at a higher priority than their mentoring duties when they encountered role conflict. Hospital managers reported that CMs had to fulfil both clinical nursing duties and mentoring duties. Fulfilling their clinical nurse duty was considered by all participants as the primary duty of nurses rather than acting as CMs. Their major responsibility was to maintain the operation of the ward through the organisation and delivery of care. This echoed the findings in previous studies that found that heavy workloads hindered CMs' ability to conduct clinical mentoring (Coyne and Needham, 2012; Gillespie, 2017; Levett-Jones et al., 2009). Some students reported that they were left unattended in clinical placement as their CMs were engaged in clinical duties. Hospital managers in this study showed acceptance of the phenomenon of mentors having insufficient time for clinical mentoring, by allowing the use of less qualified substitutes for CMs, instead of increasing the support to the CMs' workloads. Thus, clinical mentoring responsibilities could be delegated to HCAs, and other nurses or students could be left to

practice without supervision. Clinical mentoring conducted by unqualified clinical staff was also reported in a previous study (Hasson et al., 2013). Insufficient clinical mentoring not only failed to facilitate students to learn through practice (Walsh, 2020) but also increased the risks to patient safety (Reid-Searl et al., 2010).

On the other hand, CIs were expected to conduct clinical mentoring solely as stated in the official guidelines from NCHK and university. However, CIs reported that completing their clinical nurse duty efficiently and effectively when in placement areas was a means to illustrate their clinical competency and build up a trustful relationship with ward staff. This was necessary in order to seek learning opportunities for their students. The findings of this study illustrated that appropriate learning opportunities were controlled by the ward managers and senior ward staff. This was different from findings of previous studies that the assignment of practice opportunities was based on CMs' willingness to participate in teaching (Chapman and Orb, 2001). In this study CMs, CIs and students all followed an unspoken rule of exchange. In order to obtain opportunities to learn the more prized technical nursing skills, it was necessary to earn credit by completing basic clinical nursing duties. Thus, access to ideal roles in clinical placement was only achieved through fulfilling the pragmatic roles in clinical placement. This phenomenon was a more a prominent issue for CIs and students than for CMs who were members of the ward team. CMs were members of the ward staff, thus were not required to build up trusting relationships to gain the permission to access learning opportunities. They were more likely to offer students learning opportunities, especially when they were senior ward staff. CIs and students however, were outsiders on the ward, and were required to seek permission for learning opportunities, and earned these by being ward staff's helping hands. The ward staff's

authority and control over learning opportunities was granted by the hospital managers. A ward manager reported that she instructed her ward staff to limit the quantity and the complexity of clinical tasks assigned to either students or CIs when they were not able to complete the routine clinical tasks efficiently. Granting permission for learning opportunities was contingent on creating an impression of trustworthiness. As reported in Rebeiro et al. (2015), the impression of trustworthiness allowed students to be accepted as part of the healthcare team. The findings of this study showed that CIs also shared similar experiences. The impression of trustworthiness could not only be developed from actual clinical competency but also from showing a conservative appearance and acting to conform to implicit standards of hospital etiquette. This included being polite and greeting others in the way that was considered appropriate. The impact of the impressions of students formed by CIs and ward staff will be discussed further in section 9.3.4. The above discussion revealed that the hospital management asserted dominant control over the roles of CIs, CIs and students in clinical mentoring.

Apart from their control over the performance of the clinical mentoring role, hospital managers reported that they also asserted control over which hospital settings could be used for clinical mentoring. Hospital managers decided the availability of placements in different clinical settings. They controlled access to clinical placement areas and could limit access when disruption of the ward operation by clinical mentoring was anticipated, due to factors such as ward renovation or expected staff shortages. This served as a means to protect clinical workload and prevent the occurrence of insufficient clinical mentoring (Finlay et al., 2003; Hellowell et al., 2018).

Jokelainen et al. (2011a) reported that a supportive learning environment could facilitate clinical mentoring. The characteristics of a supportive learning environment included planning of placement learning, ensuring implementation of placement learning and assuring individual support in placements (Jokelainen et al., 2011a). Hospital managers in this study tried to maintain a basic level of clinical mentoring without disruption of clinical care delivery. Other aspects that contributed to a supportive learning environment according to Jokelainen et al. (2011a), such as acceptance of students and CIs, and offering suitable practice, remained unaddressed. This suggests that hospital management focused solely on the arrangement of clinical mentoring such as ward allocation and ward orientation. However, they did not monitor whether clinical mentoring was conducted effectively, and neglected the quality of mentoring (Walsh, 2020). Nurse educators in this study had little involvement in creating a supportive learning environment in the clinical areas. Unlike in the United Kingdom, no educational audits of clinical settings were conducted by either nurse educators or hospital management. Educational audits could facilitate nurse educators to make appropriate allocation decisions and identify supporting strategies that enhance the quality of the clinical placement (Hutchings et al., 2005). Nurse educators participating in the study suggested that students could raise their concerns about the lack of educational value of practice placements through the practicum course evaluation. Nurse educators could then report these concerns in meetings with the hospital managers. There was no other strategy to manage such a situation, even when students reported the situation was not improved. University staff were simply informed by the hospital of the arrangement of placements and clinical mentoring. The findings of this study showed how the two organisations, hospitals and university, interacted when they organised clinical mentoring. The actions of hospital managers reflected the fact that clinical

mentoring was predominantly controlled by the hospitals. In contrast to the situation in this study, several studies have been conducted to illustrate conceptual models of collaboration between healthcare organisations and university for the provision of healthcare education placements (Bivall et al., 2020; Kirke et al., 2007; Nisbet et al., 2021; Svensson et al., 2009). However, none of these studies described how healthcare providers and university applied those models and jointly organised clinical placements.

9.3.2. Mandatory clinical assessments rituals

Mandatory clinical assessments, outlined in the background chapter (Chapter 1) were the mandatory summative assessments required by NCHK to ensure students acquired the clinical competencies that are essential to become registered professional nurses. As described by the CIs/ CMs and students, they followed the formal rules set down by the university to conduct these mandatory clinical assessments. These rules provided a brief framework to guide how CIs/ CMs and students should behave during the mandatory clinical assessment (see Appendix 19). Students reported that they were asked to perform some tasks that were neither necessary nor supported by evidence such as scrubbing the dressing trolley as preparation for an aseptic procedure and not kneeling down to get material placed in the lower cupboard. These acts carried the symbolic meanings of contamination and were performed as rituals of mandatory clinical assessment but had no relationship with breaking aseptic principles (Gusfield and Michalowicz, 1984). Besides this, the symbolic acts performed during assessments also served as a kind of face-work (Goffman, 1967). Students showed deference and fulfilled the CIs'/CMs' expectations by closely following the CIs'/ CMs' instructions. This established the interaction order expected by CIs/ CMs in that students were expected to defer to the authority of CIs/ CMs. When

these expectations of deference were fulfilled students were more likely to pass the assessment.

The mandatory clinical assessments were used as summative assessments of practice. Students were required to pass one mandatory clinical assessment in each practicum course. Students participating in this study had to complete three mandatory clinical assessments in three separate practicum courses during their pre-registration nursing programme. As reported by CIs/ CMs and students, the required clinical skills demanded in the first mandatory clinical assessment were easier and the complexity of the required clinical skills increased in the later mandatory clinical assessments. Mandatory clinical assessment was considered an important ceremony for the students to move up in the hierarchy of the nursing profession (Gusfield and Michalowicz, 1984; Laurent, 2019). All participants agreed that students were perceived as competent after they passed the mandatory clinical assessments. Passing each mandatory clinical assessment developed an impression that the student was progressing in competence. It meant that students were a step closer to gaining membership of the profession of nursing (Buckenham and McGrath, 1983). Hence, both CIs/ CMs and students prioritised practice of the clinical skills necessary to pass mandatory clinical assessments over all other learning activities. Passing the mandatory clinical assessments carried the symbolic meaning of being a competent nurse. From the data, it appeared that CIs/ CMs allowed their students to practise independently without limitation once the mandatory clinical assessment was passed and were more willing to offer more advanced learning opportunities, due to their impression that the student had proved their competence. When students passed all three mandatory clinical

assessments one by one, it was seen as reflecting the transition from “novice” to “professional” nurse (Benner and Benner, 2001).

Several studies illustrated that some actions performed by nurses, such as the medication round, post-mortem care and hand-over could be seen as rituals in practice (Chapman, 1983; Laurent, 2019; Philpin, 2002; Wolf, 2013). Holland (1999) and Laurent (2019) also described the transition of nursing students to professional nurse as a ritual in nursing practice. However, no study was located that discussed rituals in clinical assessments. Some nursing literature claimed that rituals in nursing practices were repetitive and performed without rationale (Philpin, 2002; Wolf, 2013). However, the three mandatory clinical assessments that included the assessment of aseptic technique, administration of medications and professional nursing care were identified as goal-orientated action in this study (Philpin, 2002). These assessments consisted of both rational and non-rational elements. They served as a rational way to verify if students had acquired these three skills. On the other hand, students were also required to perform some non-rational acts as described above in order to pass the mandatory clinical assessment.

The findings of this study showed that mandatory clinical assessments were highly formalised. CIs/ CMs and students engaged in mandatory clinical assessments as if they were a ceremony in the drama of clinical mentoring. Interestingly, CIs/ CMs facilitated students to pass the mandatory clinical assessment by rehearsing the required clinical skills in coaching sessions. On the day of mandatory clinical assessment, students reported that they performed the clinical skill as instructed in the rehearsal and that this could be different from their usual practice. For example, students intentionally used alcohol to scrub

the trolley during mandatory clinical assessment but they did not perform this action in their usual practice. This implied that students were taught to act in mandatory clinical assessments instead of showing their usual standard of competency to their CMs and CIs. When students passed the mandatory clinical assessment, they were sometimes also able to make use of this opportunity to improve the impression their mentors/instructors had formed of them, by showing their obedience to their CIs/ CMs and fulfilling their CIs'/ CMs' expectations. Being obedient served as another symbolic element of mandatory clinical assessment and implied that being obedient played an important role in managing the impression they gave to others. This could result in the phenomenon of 'failing to fail' (Duffy, 2003) which refers to the phenomenon that occurred when mentors failed to fail students who were considered as incompetent (Duffy, 2003). Some factors related to failing to fail were also found in this study including the consequences for students' of failure in assessment, such as extending the clinical placement and the mentors' conflicting emotional responses towards failing students. Some CIs and CMs in this study reported that they were reluctant to fail their students as students were required to repeat the clinical placement or even quit the programme. They also felt that failing students was in opposition to their supportive roles as CIs/CMs. However, Duffy's (2003) study was limited as it only captured the perspectives of lecturers and mentors. This study was able to supplement the students' perspective on failing in assessment. In addition, Duffy (2003) explored the phenomenon of failing to fail students perceived as incompetent. In this study competent students could also be at risk of failing in the assessment due to presenting an unfavourable impression based on factors unconnected to competence. Details of the influence of impressions will be discussed in section 9.3.4.

9.3.3. Managing performance, errors and mistakes

Feedback was a means for CIs/ CMs to manage their students' performance. Three types of feedback were identified in data from all participants. The use of different types of feedback reflected how CIs/ CMs managed students' performance and also their perceptions of errors and mistakes. Constructive feedback reported in this study served as a type of positive feedback (Clynes and Raftery, 2008). However, it was not a common form of feedback provided by CIs/ CMs in comparison to minimal feedback and destructive feedback. Among the different types of constructive feedback, the findings showed that praise and encouragement were not commonly provided. Foster et al. (2015) found that students considered praise and encouragement as one of the most valued mentors' activities. Praise and encouragement not only enhanced the students' clinical placement experience (Foster et al., 2015), but also enhanced the students' learning in clinical placement as well as the relationship between CIs/ CMs (Saraf et al., 2014; Clynes and Raftery, 2008). As mentioned in Chapter 4, the training manual of clinical mentoring developed by the university provided instructions for CIs/ CMs on how they should provide feedback that could facilitate students to improve their performance. This implied that praise and encouragement was not considered as part of the feedback from nurse educators' perspective. The purpose of providing feedback was to improve students' performance. Hence, it was perceived that the feedback provided should focus on rectification of error and mistakes. This claim was different from previous literature that has indicated that praise and encouragement were considered equally essential and that constructive guidance in practice for students and should be provided during clinical mentoring (Clynes and Raftery, 2008). Another explanation for the lack of praise and encouragement provided could be related to the Chinese culture. Being humble can be considered as showing politeness and accepting

praise in front of others can be considered as an impolite act (Gao and Ting-Toomey, 1998). Hence, students were not expected to take any credit when they performed well. Declining to receive praise was an act that showed deference to authority and reflected that the interactions in clinical mentoring occurred under a very hierarchical culture. Taking credit was considered to indicate the act of being proud/ arrogant and failed to fulfil the expectation of being humble. If one performed well, one should keep a low profile.

Apart from lack of praise and encouragement provided by CIs/ CMs, students also reported that they received minimal/ no feedback during clinical mentoring. A similar phenomenon was also reported in Adamson et al. (2018). Clynes and Raftery (2008) reported that students could have an incorrect interpretation of their own performance when they received insufficient feedback. This ultimately affected the quality of learning in clinical placement. Insufficient feedback could also be explained by the CIs'/ CMs' expectations that students should take the initiative to manage their own learning. They expected their students to explore how to improve their performance themselves. Students, therefore, evaluated their own performance by comparing it with their observations of other ward staff's practice (Clynes and Raftery, 2008). Some students were able to identify their weaknesses and improve their performance in ways that fulfilled their CIs'/ CMs' expectations. However, not all students were able to identify their weaknesses and show improvement in their practice. Plakht et al. (2013) reported that teachers tended to provide higher quality of feedback about the less satisfactory performance when students' self-evaluation was accurate. The improvement of students' performance still relied on the feedback from the teacher (Plakht et al., 2013). Hence, there was insufficient data to explain the reason for this in this study.

Among the three types of feedback, destructive feedback was considered as a common and undesirable form of feedback by both students and nurse educators. The frequent use of destructive feedback to manage students' performance could partly be related to the vague guidelines about feedback provided by university. The procedures for managing students' performance were not stated in any placement guidelines or training manual for clinical mentoring. As stated in Chapter 4, only the worst consequence, which was suspension of clinical placement, was described in the guidelines provided to students. Lack of clear formal guidelines allowed CIs/ CMs to manage students' performance based on their previous experience as nursing students, mentoring experience and ward culture.

Various types of destructive feedback including blame, ostracism and suspension were considered as suitable punishments by CIs/ CMs. As mentioned in section 9.2, destructive feedback shared the characteristics of destructive criticism mentioned in Baron (1988). Destructive criticism refers to inconsiderate verbal feedback from supervisors who regard the cause of the unsatisfactory performance as related to internal causes such as a poor 'character' (Baron, 1988). Destructive feedback found in this study further extended the nature of destructive criticism to include punishment. A ward manager who participated in the interview used the metaphor of parenthood to justify the use of punishment as being good for students. The use of punitive feedback could be related to a wider punitive culture as well as to Confucian beliefs about teaching and learning. Valier (2005) suggested that punitive culture reflects a pattern of retributive and vengeful penalties that may be linked to particular ethnic or national cultures (Valier, 2005). The practice of carrying out punitive acts may be influenced by the culture and history of that nation or ethnic group (Valier, 2005). Different nations have their own cultures with different levels of punitiveness. This

includes their social institutions (including the government) which have varying tendencies to manipulate leniency and mercy versus harsh punishments (Bakken, 2011; Valier, 2005). This reflects the linkages between punishment and power, with harshly punitive regimes becoming the norm in some political cultures (Bakken, 2011). These regimes can influence the wider culture. Thus a punitive culture was found in this study in that university and hospitals which had the power to control clinical mentoring were responsible for the decision to assert the need for punitive (rather than remedial) methods of dealing with students perceived to demonstrate problems with performance. This may reflect the political culture within clinical nursing education. Bakken (2011) however, claimed that Chinese punitive culture was related to the wider political situation in China. He also suggested that Confucianism advocated mercy and humanism, and that it was therefore debatable whether Confucianism contributed to a punitive culture in contemporary China. It is therefore uncertain as to precisely which of these cultural factors contribute to the punitive culture in nursing education in Hong Kong.

Fan suggested that under the influence of Confucianism, people are encouraged to pursue self-perfection by learning throughout their life span (Fan et al., 2004). In order to achieve self-perfection, errors and mistakes were considered as a kind of failure and rectification should be done to turn failure into success (Wang and Murphy, 2004). Such failure reflected the learning needs of students and guided educators/ teachers in future teaching (Schleppenbach et al., 2007). The claims of guidance by errors and mistake in teaching and learning echoed the findings of Sicora et al. (2020) that qualified social workers in China perceived being corrected for the errors and mistakes as giving guidance to learn and improve their professional competence. This explained why CIs/ CMs put the most emphasis on correcting errors and mistakes identified during clinical mentoring and perceived that

“good” mentors should detect errors and then deter them by providing destructive feedback. The frequent use of destructive feedback could be related to the Confucian belief in the responsibility of teacher. As stated in the Confucian classic text ‘Three Character Classic’²⁶, “to teach without rigour—is the teacher’s laziness” (Clark, 2021, p. 47). This implied that teachers were responsible for ensuring students were learning what they were expected to learn. If students failed to do so, teachers could use rigorous strategies including shaming and blame in teaching (Fan et al., 2004). This claim echoed the report from the ward manager that punishment was a means to do good to students. Punishments were used as a means to discipline students’ behaviour and deter students’ errors and mistakes (Bakken, 2011). Students who were perceived to make mistakes were typified as ‘bad students’. They shared similar experience to those of unpopular nurses who were scapegoated for non-performance related issues in a study in the UK (Cooke, 2007). In this study being ostracised was identified as another form of punishment. Ostracism could be related to gossip within the organisation (Soeters and Iterson, 2002). When comments about ‘bad’ students were spread informally between ward staff and students as gossip, then the ‘bad’ students could be treated as outsiders. Destructive feedback was not only used as a strategy to manage students with poor performance but was also reported, particularly by students as being used by mentors/instructors as a mean to ventilate their emotions. Some CIs/ CMs also reported that they felt angry when students made mistakes. This could be related to the linkage made between students’ learning and the responsibility of teacher. The emotion of CIs/ CMs could be related to their feelings of disappointment and their perceptions that their efforts at mentoring were in vain, as well as stress from the

²⁶ Three Character Classic is a book that covers all Confucian values and is used to teach children about these values in the past and nowadays (Clark, 2021).

extra workload involved to provide additional guidance. Feelings of anger could also be related to perceived threats to the CIs'/ CMs' image of being a responsible mentor. Hence, destructive feedback could also be used for ventilation of anger instead of educational purposes.

The impacts of destructive feedback toward students were well reported. CIs/ CMs in this study expected students to improve their performance and make fewer mistakes after destructive feedback had been received. However, the findings showed variation in performance after students received destructive feedback. Some students could improve their performance, but some showed further deterioration in performance. In the study by Raver et al. (2012), the change in performance after receiving destructive feedback depended on the competitiveness of an individual. Individuals with high competitiveness tended to have higher self-esteem and higher confidence (London, 1995; Janssen and Askari, 2019). Hence, students with high competitiveness had a higher intention to put more effort to improve their performance and had a higher tendency to show improvement in performance. On the other hand, students with low competitiveness could give up attempts to improve their performance. Comparing both destructive feedback and constructive feedback, constructive feedback was more beneficial to students as it facilitated students to recognise weaknesses and improved professional confidence (Elcigil and Sari, 2008; Ortiz, 2016). Destructive feedback could also result in emotional impacts on students. Some students reported that they felt angry after they received destructive feedback. This finding was consistent with previous studies (Baron, 1988; Raver et al., 2012). Raver et al. (2012) further revealed that individuals perceived destructive feedback as motivated by an

intention to harm from the feedback-giver. They, therefore, felt anger toward that feedback-giver (Raver et al., 2012).

The use of destructive feedback also affected the relationship between CIs/ CMs and students. Some students in this study reported that their trust in CIs/ CMs decreased when they received destructive feedback constantly. This echoed the findings of Raver et al. (2012). Students who consistently received destructive feedback could also have higher stress levels and this resulted in negative impacts to students' psychological health (Mullen et al., 2018). In summary, destructive feedback was found to have several negative impacts within clinical mentoring and should not be used to manage students' performance.

9.3.4. Understanding the influence of impression and impression management in clinical mentoring by using a dramaturgical approach

CIs/ CMs and students were the main actors and audiences in the interactions during clinical mentoring. Their acting in the drama of mentoring followed a similar pattern and as discussed earlier, could be explained by the dramaturgical model described by Erving Goffman (Goffman, 1959, 1967). The metaphor of the drama facilitated greater understanding of how people involved in mentoring accomplished meaning through their behaviours within the interaction (Charmaz, 2014). The meaning of the various interactions within mentoring could be portrayed using the concepts from dramaturgy of actors, roles, performances, audiences, scenes and setting (Ditton, 1980; Goffman, 1959, 1967). Using a symbolic interactionist perspective, the dramaturgical approach helped to illuminate the meaning of mentoring behaviours and show how people justified their behaviours during

interactions. This also illustrated the interaction order of clinical mentoring and offered explanation as to how interaction rituals occurred during clinical mentoring.

In this study the data showed that impression and impression management mediated the interactions of clinical mentoring. All participants in this study mentioned how they formed impressions of others who were involved in the interactions during clinical mentoring. An impression reflected one's perception of another person. Impressions were subjective and played an important role in the interaction, as an impression guided participants to decide what type of feedback was appropriate in the interaction. The impression presented served to shape the perception that the audience of the social drama gained from the performance (Goffman, 1959). An impression could be changed overtime. However, from the data analysis, the first impression had a potent influence on the interactions between CIs/ CMs and students throughout the period of mentorship.

Impressions of students were first developed by CIs/ CMs when the CIs/ CMs engaged in the initial interactions with their students. First impressions reflected the CIs'/ CMs' perceptions of an individual student based on a combination of observable cues, such as the behaviour and appearance of students, and were also informed by others' comments about the student. Clinical competency could affect first impressions but was often only observed later. Each student presented their own impression to their CIs/ CMs. CIs/ CMs assigned their students into two distinct labels, good student and bad student, according to the impression. The findings showed that CIs'/ CMs' expectations of students were linked to the characteristics said to identify good and bad students (Listed in table 9.1 below). The characteristics of both "good students" and "bad students" listed did not always correspond

with each other. The characteristics of “good students” were explicitly reported by all participants. Not all the characteristics of “bad students” were explicitly described by participants.

	Characteristics of Good Students	Characteristics of Bad Students
Learning attitude	Being obedient Being humble Being an active learner	Talking back Being arrogant Being a passive learner
Etiquette	Being polite Greeting others’ appropriately	Being impolite
Be professional	Being punctual Maintaining a conservative appearance Being clinically competent	Lacking nursing knowledge Present fashionable appearance/ insincere posture Completing tasks ineffectively/ inefficiently

Table 9.1: Characteristics of good students and bad students

Two characteristics of good students, such as being an active learner and clinically competent were reported in previous studies (Coyne and Needham, 2012; McIntosh et al., 2014; Peters et al., 2013). Interestingly, the remaining characteristics of good students, such as being obedient and humble, and maintaining a conservative appearance, identified in this study were not found in previous studies. The gestures of deference and demeanour required (Goffman, 1956) could be related to the influence of Chinese culture on clinical mentoring in this setting. However, the findings did not show if any of these characteristics were more important than others in the labelling of students. The characteristics concerning active learning attitude, etiquette, outlook and clinical competency were stated in the placement guidelines developed by university. The other characteristics which were not listed in those guidelines were part of the ‘hidden curriculum’ of the clinical placement that students were expected to achieve (Hafferty et al., 2015).

Some characteristics of “good students” were easier to identify by CIs/ CMs before students practised clinical skills in the initial interaction of clinical mentoring. Students who demonstrated the above-mentioned positive characteristics were then labelled as ‘good’ students. The first impression of students tended to develop based on superficial traits such as appearance and has been noted previously. It could offer an explanation as to why there was often discrepancy between actual performance and impression. This discrepancy could also be related to the biased comments received from ward staff and other nurse educators. On the other hand, CIs/ CMs could label students as bad students when they were perceived as unable to fulfil the characteristics of “good students” and were instead perceived to exhibit the characteristics of “bad students” listed in table 9.1. Students who were labelled as “bad students” tended to be unclear about the “hidden curriculum” and failed to act like “good students”. The criteria for making such judgments were vague as it was based partly on CIs’/ CMs’ personal preference. Previous studies have mainly focused on the CIs’/ CMs’ perceptions of “good students” and have not addressed how they formed perceptions of “bad students” (Coyne and Needham, 2012; Levett-Jones et al., 2009; Morrell and Ridgway, 2014; Sinclair et al., 2015).

From the findings, the impression of students could be changed throughout the period of clinical mentoring. For example, a student with “fashionable outlook” was perceived as arrogant and labelled as “bad student” by the ward sister even when she was considered as clinically competent by her CI. The ward sisters impression of the student being arrogant was changed after the student accepted the suggestion from her CI to change to a conservative appearance. This suggested that students needed to avoid any unconventional appearance and dress to conform to the expected image of nursing students when working

in the clinical area. However, it was not common for students to convert their first impression, even if students subsequently changed their behaviour or appearance. Among the various impressions, formed over the duration of the placement, the first impression was the more influential in shaping the interactions between CIs/ CMs and students than the impressions developed later. This was related to the power of the labelling effect (Matsueda, 2017). When students were labelled as good students, they received more learning and practice opportunities. This further enhanced the “good students” to learn and improve their performance. In contrast, “bad students” received more destructive feedback and had less support in learning. The first impression guided the CIs/ CMs to provide feedback that was compatible to the label assigned. This then shaped and constrained those students labelled as ‘bad’ to act according to the label. The act of labelling students reflected the interaction order of clinical mentoring.

As discussed in section 9.3.3, the feedback provided by CIs/ CMs was heavily influenced by their impressions of students. Students and CIs/ CMs assumed that their audience would react according to their expectations after their act of feedback. For example, students reported that they and their classmates tried to increase their chances of receiving constructive feedback and avoid destructive feedback by intentionally managing the impression they presented to their CIs/ CMs. This was consistent with the description in Goffman (1956) that actors in the social drama demanded their audiences respond as expected by the actors. Two patterns of acting within the interaction of mentoring were identified from the data, namely feedback and impression management. They served different functions and influenced the interactions within mentoring relationship in different ways.

The act of providing feedback, which emerged from the data analysis, was similar to the act of performance described in dramaturgy. The actors in the drama of mentoring developed their impressions of their audience and provided feedback to their audience according to the impressions formed. The purpose of feedback was to manipulate their audiences' behaviour within the interaction. CIs/ CMs in this study provided different types of feedback to manage their students' performance. However, it was rare for students to provide feedback to other participants. The act of performance management by CIs/ CMs was similar to the act of idealisation mentioned in Goffman's work on dramaturgy (Goffman, 1959). Idealisation referred to behaviour that "socialised, moulded and modified to fit into the understanding and expectations in which it is presented" (Goffman, 1959, pp 22-23). The intention of CIs/ CMs was that students who received feedback would be socialised, moulded and modified according to their CIs'/ CMs' expectations. However, feedback was not always able to achieve this expected purpose. CIs/ CMs would then adjust the feedback provided from time to time. The influence of feedback was thus asserted on the audience of the drama directly and explicitly.

Using the dramaturgy model, we can see that the response from the audiences depended on the impression presented by the actors (Goffman, 1959). The findings showed that both CIs/ CMs and students tried to manage the impression they presented during clinical mentoring. Their acts of impression management shared similar functions to the face-work described by Goffman in that CIs/ CMs and students managed the impression they presented in order to save face (Goffman, 1967). When the actors in the drama of mentoring perceived that their own impression was threatened, they could apply an impression management strategy to protect the impression they projected and avoid the

negative consequences of projecting an undesirable impression. The phenomenon of impression management was best illustrated when the CI blamed her students publicly or when a student acted out a performance of diligent hand washing intentionally in front of her CI. These acts of impression management carried symbolic meanings (Goffman, 1967). That CI's act of blaming students in public showed the symbolic meaning of "being responsible" while the act of the student who washed her hands in front of CI was intended to demonstrate the meaning of "being competent". The difference in the acts of impression management performed by CIs and students was related to the different target audiences for their act. The target audience for the CI was not the student but the bystander, such as ward staff who worked in the clinical area, while the target audience of the student was the CI. The influence of impression management, therefore, could be asserted on either the immediate audience within the interaction explicitly or the bystander of the interaction implicitly.

Participants adopted both feedback and impression management to suit their purposes in the interactions. These behaviours of participants constituted the drama of clinical mentoring. The actors in the drama of clinical mentoring performed a play that showed deference and obedience to their next level in the hierarchy within the context of clinical mentoring (Goffman, 1956). These behaviours served as interaction rituals within the context of clinical mentoring. The performance of both CIs/ CMs and students were similar in character even though they were at different levels in the hierarchy. CIs/ CMs followed rules and instructions set by hospital management and nurse educators respectively, whereas students showed obedience and followed instructions from their CIs/ CMs. The drama of clinical mentoring illustrated how CIs/ CMs and students interacted according to

the script provided by hospital management and nurse educators. The purpose of CIs'/ CMs' and students' actions served to preserve the hierarchical relationships within institution and this implicit goal tended to override the goal of improving students' clinical competence.

In summary, four discussion themes were considered above. The dominant control from clinical organisations resulted in inadequate clinical mentoring. Mandatory clinical assessments carried both goal-oriented meanings but also carried symbolic meaning. The dominance of symbolic meanings meant that assessments were conducted in the form of a ritual. Feedback was provided by CIs/CMs after they made social judgment from comparing their expectations of students and impression of students. Minimal and destructive feedback were reported as common types of feedback. This could be influenced by the CIs'/ CMs' perceptions of errors and mistakes. The social process of clinical mentoring could best be explained by using a dramaturgical approach. Based on the above discussion, the current practice of clinical mentoring was not as effective as expected by NCHK and nurse educators as CIs/ CMs placed more emphasis on the symbolic meanings of their actions and these tended to override the educational purpose of clinical placement. Several implications towards clinical mentoring can then be inferred from these findings.

9.4. Implications from this study

Several implications were identified based on the above discussions. The implication of this study included that the current practice of clinical mentoring in Hong Kong failed to foster critical thinking, produced inadequate clinical mentoring, failed to effectively perform its role as a gatekeeper to the profession, and produced negative impacts on students.

9.4.1. Failure to foster critical thinking

Critical thinking is a high order of thinking skill that is expected to be developed in pre-registration nursing education is expected to develop by the NCHK (Nursing Council of Hong Kong, 2016). In this study, the findings showed the social process of clinical mentoring illustrated that students were expected to be obedient by their CIs/ CMs, hospital management and nurse educators. Instead of fostering critical thinking, the findings showed that students were shaped to follow instructions without using their critical thinking faculties. This meant that students were unable to develop competencies in “analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge” (Brunt, 2005, p. 61).

The ability to foster critical thinking skills was influenced by the hierarchical culture of the learning environment and the openness or otherwise of educators (Chan, 2013). Such findings were consistent with the findings in this study. When students lacked critical thinking skills, they might not be competent to make appropriate clinical judgments, which could threaten patient safety. Patient safety could also be threatened by the hierarchical organisational culture as this decreased communication and information flow can be decreased by a hierarchical organisational culture (Singer et al., 2009). Similar to the findings in this study, students may not dare to report any abnormality or deficient practice that was identified. There is a need to change the culture of the clinical mentoring environment and better equip CIs/ CMs to facilitate students’ development of critical thinking skills.

9.4.2. Inadequate clinical mentoring

Inadequate clinical mentoring was found to be related to insufficient supervision, lack of clarity about the focus of clinical mentoring and inadequate mentoring skills. As reported by students, insufficient supervision was commonly found in clinical mentoring conducted by CMs. As discussed in section 9.3.1., all participants regarded the heavy workloads in clinical duty as an explanation for insufficient clinical mentoring by CMs. On the other hand, CIs had to supervise eight students at the same time during clinical mentoring. As reported by the ward manager and CIs, students may not receive sufficient clinical mentoring especially if one of the students was a 'slow learner' and required additional attention. This means that both CIs/ CMs were unable to provide sufficient supervision for their students.

Apart from insufficient supervision, CMs were reported to have little knowledge about what students should learn through clinical mentoring, though nurse educators reported that they provided relevant information before clinical placement started. When CMs were unclear about the focus of clinical mentoring, they relied on their students to inform them about what they needed to learn and practise. This could result in failure to provide appropriate learning opportunities for students to develop their nursing competencies. CIs had no concerns about this issue as they received a pre-placement briefing and received the information needed directly from the nurse educators. Lack of understanding of the focus of clinical mentoring could be related to communication breakdown between the university and hospitals.

Inadequate mentoring skills were a third factor that contributed to inadequate clinical mentoring. This was reflected particularly through CIs'/ CMs' management of their students' less satisfactory performance. As reported by all participants, errors and mistakes were

inevitable during clinical placement. CIs/ CMs tended to use destructive feedback such as blame and punishment to manage their students' performance. Some students reported that they were unable to learn after being blamed and punished. However, some CMs provided minimal or no guidance after they found their students making a mistake. Even though these students were provided with practice opportunities, they did not always understand how they could rectify their mistake through practice. When their performance did not show improvement, CIs/ CMs escalated the level of destructive feedback. Students could then be deprived of opportunities to practise. This meant that these students were deprived of opportunities for learning. Inadequate clinical mentoring affected their learning in clinical placement and ultimately could result in a student's failure to meet the professional standard developed by the NCHK. This could increase the risks to patient safety.

9.4.3. Failure to be adequate gatekeepers for the profession

Failure to be adequate gatekeepers for the profession was the second implications of this study. As discussed in section 9.3.2, the ritualised nature of mandatory clinical assessments shown in this study showed these to be incapable of serving their purpose of acting as a summative assessment of clinical skills. Students were reinforced by their CIs/ CMs to perform symbolic acts when practising the tasks of mandatory clinical assessment and when conducting the actual mandatory clinical assessment. These symbolic acts were unrelated to the evidence-based practice. Students could pass the mandatory clinical assessments by showing these symbolic acts instead of actual clinical competency and understanding. In addition, CIs/ CMs were influenced by their impression of students when they conducted mandatory clinical assessments. Students could pass assessment through presenting their

CIs/ CMs with the preferred impression through acceptable greetings, social behaviour, and appearance and by showing obedience. Demonstrating these behaviours from the start of clinical placement influenced CIs/ CMs to provide more support and adopt a more lenient standard during assessment. On the other hand, students who presented a less desirable impression, for example, by asking questions in an undesired way, presenting a less acceptable appearance or demonstrating less satisfactory performance, received less guidance and support. They could then need to fulfil a more stringent assessment requirement. Students could then either pass or fail the mandatory clinical assessments based on the impression they gave instead of their actual competency. This meant that CIs/ CMs had failed to act as adequate gatekeepers by ensuring the students had the required clinical competency and understanding. When less competent students then became qualified nurses, this could further risk patient safety.

9.4.4. Negative impacts on students from destructive feedback

The frequent use of destructive feedback may result in negative impacts on students. Destructive feedback shared similar characteristics to bullying in the workplace (Hollin, 2016). Bullying in the workplace has been defined as behaviour that is characterised by intent, repetition, and a power imbalance between the perpetrator and the victim (Hollin, 2016). According to the findings, some CIs/ CMs adopted various types of destructive feedback intentionally to manage their students' performance. CIs/ CMs had power to control the outcomes of clinical placement for students and this reflected the power imbalance in clinical mentoring. Different types of destructive feedback such as blame and ostracism could be categorised as workplace bullying (Hollin, 2016). Several negative impacts from workplace bullying were found in students who persistently received

destructive feedback in this study such as increased stress, depressed mood and low confidence and these have also been recorded in other studies (Al Omar et al., 2019; Clarke et al., 2012; Lever et al., 2019) and were also identified in this study. On the other hand, the performance of students who persistently received destructive feedback hardly improved due to insufficient guidance and support. These students may then leave nursing education due to their unsatisfactory performance and the other negative impacts of the clinical placement experience (Clarke et al., 2012; Hoel et al., 2007). This could mean that the nursing students leave nursing education prematurely and the resources of nursing education were wasted.

9.5. Recommendations from this study

The aim of this study was to explore the social process of clinical mentoring in the context of pre-registration nursing placements in hospital settings in Hong Kong. Several recommendations arising from this study are presented below, concerning regulatory policy, clinical education and practices, clinical environment and research.

9.5.1. Recommendations for regulatory policy

The study findings showed that clinical mentoring was framed by official guidelines and policies from the NCHK. Several recommendations are suggested to enhance policies on the implementation and monitoring of clinical mentoring.

- The NCHK should review and revise the current policy on clinical placements and examine the reaccreditation policy. The revised policies should establish clearer standards for clinical placements and clinical mentoring to guide nurse educators and hospital management when organising clinical placements, similar to the standards

for practice learning and accreditation developed in the United Kingdom by the Nursing and Midwifery Council (2018, 2020). The revised policies and guidelines should also mandate mentorship training and regular mentor updates for both CMs and CIs and ensure the students' supernumerary status offers some protected learning time.

9.5.2. Recommendations for clinical education and practices

The following recommendations are suggested to enhance the quality of clinical mentoring by improving the mentoring skills and implementation of clinical mentoring and fulfil the purpose of clinical education.

- Better collaboration and communication between nurse educators and clinical partners at all levels should be established by the nursing education institutions. Communication breakdown between CIs/ CMs and the nursing education institutions was commonly found in clinical placement. The required information and support relied on different hospital organisers of clinical placements to cascade information to frontline staff. An online platform for CIs/ CMs could be established to serve as a more accessible and direct, two-way communication channel to share required information and provide necessary support during clinical placement.
- Current mentorship training should be enhanced by the introduction of appropriate mentoring skills, reinforcing communication skills, fostering critical thinking skills, enhancing the awareness of impression management and the limitations of ritualised mandatory clinical assessment. Training related to developing supportive and effective learning relationships should also be included in mentorship training for

CIs/ CMs to enhance the development and maintenance of trusting relationships with students.

- A formal clinical assessment guidance and feedback system for students should be established by the nursing education institution. This could enhance the fairness and quality of clinical assessment and ensure objective and constructive feedback is provided to students during and after the clinical placement (McAllister, 2008).
- Clearer guidelines for the management of students' clinical performance should be devised in partnership with hospital-based organisers. These guidelines should focus on how to facilitate student learning and improvement instead of removing students with less satisfactory performance from practice.
- A workplace bullying prevention programme should be introduced for students by the nursing education institution. The programme should provide understanding of bullying and advice for students on how to act when they encounter bullying in clinical settings (Bowllan, 2015). Nurse educators should also establish a reporting channel and a system for managing suspected bullying cases during clinical mentoring.
- Rewards should be provided to both CIs and CMs to recognise their contribution in clinical mentoring and facilitate them keeping their knowledge up-to-date. Access to free continuing education should be offered by the nursing education institution.

9.5.3. Recommendations for clinical learning environment

The recommendations for clinical learning environment include suggestions for fostering a more positive and supportive organisational culture that facilitates the implementation of quality clinical mentoring.

- Nurse educators and hospital management should review and integrate their clinical placement policies and guidelines together based on the regulatory policy and standards developed by NCHK. This could help to cultivate a more open and less hierarchical learning environment, standardise the procedures for organising clinical placements and minimise variations in the clinical learning environment.
- Hospital management should address the hierarchical organisational culture and attempt to move towards a more professional and supportive nursing culture by following the Magnet hospital model and work towards Magnet recognised hospital accreditation (Anderson et al., 2018). Magnet recognised hospitals are required to fulfil 14 characteristics that foster positive organisational culture, promote job satisfaction and staff retention (Royal College of Nursing, 2015). As discussed in section 9.3.1, clinical mentoring was controlled by hierarchical organisations, mainly the Hospital Authority. The Magnet hospital model emphasises autonomy of nurses and nurses as teachers (Royal College of Nursing, 2015). It decentralises organisational structures and encourages active participation of nurses in decision making at all levels. The supportive organisational culture advocated as part of the Magnet programme could optimise the use of facilities and resources for educational purposes (Victorian Government, 2016).
- Educational audit of the clinical learning environment, as used in the UK (Nursing and Midwifery Council, 2018, 2020), should also be introduced and conducted periodically by nurse educators to assess the suitability of clinical settings for students' learning and clinical mentoring by having sufficient and appropriate learning opportunities (Victorian Government, 2016).

- Hospital management should invest more resources such as increasing staffing and adjust the CM's workload to provide better support to clinical mentoring. This should include better arrangement of duty rosters to facilitate CMs and students to work together more frequently and have sufficient protected time for clinical mentoring.
- Recognition should be provided to CMs to enhance their job satisfaction from clinical mentoring. Hospital management could recognise clinical mentoring as part of nurses professional development and include it as an element to be assessed in annual performance and development reviews and promotions.

9.5.4. Recommendations for Future Research

Recommendations for future research focus on further research exploring the process of clinical mentorship in other nursing institutional settings; examining ritualisation in the assessment process in pre-registration nursing education, and research exploring the impacts of minimal and destructive feedback.

- This was a small grounded theory study focused specifically on clinical mentoring of nursing students studying in one university in Hong Kong. A similar qualitative study should be replicated in other nursing education institutions in Hong Kong, including the nursing schools, to explore if there are any differences attributable to the contextual influences of specific institutions in order to assess the transferability of these findings.
- Mandatory clinical assessments were found to be conducted in the form of rituals in this study. An ethnographic study of the organisational cultures of institutions involved in nurse education is suggested to explore if similar cultural phenomena identified in this study are found in other settings/ contexts.

- The study found that minimal feedback and destructive feedback to students was used commonly during clinical mentoring. The impacts of these two types of feedback were not explored in this study as this issue was not a study aim. Further research using Stake's interpretivist case study approach (Stake, 1995) is suggested to explore how CIs/CMs manage their students' performance during clinical mentoring, the factors contributing to the choice and use of various types of feedback as well as the impacts of different styles of feedback (Yazan, 2015).

9.6. Strengths of this study

The findings of this study reflect the strengths of using constructivist grounded theory to achieve the study aims. As stated in chapter 3, strategies for rigour in constructivist grounded theory proposed in Charmaz and Thornberg's (2000) framework which included credibility, originality, resonance and usefulness, were adopted to ensure the quality of this study. This study had high credibility as the findings achieved intimate familiarity with the social process of clinical mentoring through systematic comparison between categories that emerged from the interview and documentary data. Strong logical linkages between categories and analysis were supported by reflections and memos. This study also produced some unique findings demonstrating originality and resonance. The findings of this study illustrated various interactions in mentoring from multiple participants' perspectives at different times and different stages of the mentoring process. These findings offer new insights about clinical mentoring that build on previous studies, which focused solely on a single perspective. It has considered clinical mentoring as a static rather than a dynamic process and thus the study has also provided resonance through illuminating the participants' experience of the mentoring process.

Apart from exploring the social process of clinical mentoring, study findings about the behaviours within interactions were able to demonstrate usefulness. The study was able to reveal the symbolic meanings of the behaviours within interactions by using a symbolic interaction lens. For example, student's fashionable appearance carried a meaning of "being arrogant", whilst CIs/ CMs blaming students in public reflected an image of "being responsible". This helps us to clarify the participants' understandings of their behaviours within the interaction process during clinical mentoring and helps us to understand the contextual influences affecting clinical mentoring. Using a constructivist perspective to understand the various interactions involved in clinical mentoring provided useful and original insights into how clinical mentoring was conducted.

9.7. Limitations of this study

Several study limitations were identified. The choice of study settings could have affected the credibility of the study. This study was a small study and was conducted by a single researcher and limited to one educational setting in Hong Kong. All students, CIs and nurse educators and documentary sources were sampled from the same university. The recruitment of participants for interviews and documentary data from other nursing institutions was not possible as the request was rejected by relevant gatekeepers from these universities in the initial stages of the study. Thus, these study findings only represent the views of participating students, CIs and nurse educators from a single university, although multiple clinical sites were included. The resonance of this study to other universities in Hong Kong is therefore uncertain. As mentioned in Chapter 1, this study only covered university educated nurses. Although university programmes are the dominant form of pre-registration education in Hong Kong, nursing schools may have different

organisational cultures and clinical mentoring processes, thus this study may not have resonance for these settings. In addition, the findings may not have had resonance outside Hong Kong-Chinese culture.

Another limitation related to resonance concerns the possible influence of my role as a senior lecturer in a university during the period of data collection. This role could have affected participants' willingness to participate in this study as well as what they shared. My professional relationship with some participants interviewed in this study could mean that some participants provided socially desirable responses, especially hospital management and nurse educators. Some key informants were reluctant to comment and express their views about organising clinical placement and managing conflicts in clinical mentoring. On the other hand, some participants also gave free and frank responses. No limitations concerning originality and usefulness were identified from this study.

9.8. Conclusion

This study was the first in-depth qualitative study that explored the process of clinical mentoring in the context of undergraduate pre-registration nursing education in Hong Kong. Findings from this study were used to construct a theoretical framework (see figure 9.1) to explain the social process of clinical mentoring conducted within the context of pre-registration nursing clinical placements in hospital settings in Hong Kong by using a constructivist grounded theory approach. The study provided new insights which add to the previous knowledge of clinical mentoring, including that clinical mentoring was a dynamic process that was constructed by various interactions between different people. It also highlights the influence of different organisational and national cultures on clinical

mentoring in this context. The dynamics of the interactions in this setting were sometimes different from the dynamics of clinical mentoring reported by previous literature although there were some areas of overlap. This study illustrated the importance of the clinical learning environment which included both the organisational environment and culture, and the attitudes and behaviours of co-workers. This study also contributes knowledge about how CIs/ CMs and students manage the impression they present and how these impressions influence the interactions of clinical mentoring. This study has added new insights to the current literature by applying the theories and concepts of impression management and dramaturgy to the clinical mentoring in hospital settings (Goffman, 1959; Goffman, 1967). The related organisations including the NCHK, the Hospital Authority and nursing education institutions could use the insights from the findings to review the current policy and improve the practice of clinical mentoring. Different qualitative studies have been suggested to further explore organisational culture in clinical mentoring and examine rituals in nursing education.

9.9. Final reflection

Further to the description of my background in About the Author, I started this study when I was a senior lecturer in nursing at a university in Hong Kong. Once the study received ethical approval, I was able to invite appropriate participants to share their experience due to my professional relationships. I consider that because of this trusting relationship, participants talked about their experience and spoke frankly about their thoughts and experiences in the interview. At an organisational level, the various organisers of clinical placement only focused on the functional procedures of clinical placement and clinical mentoring, rather than human aspects of clinical mentoring such as psychological support and maintaining

trusting relationships. This further influenced how CIs/ CMs conducted clinical mentoring. I realised that many CIs'/ CMs' beliefs and expectations meant that their perception of what constituted 'good' mentorship could result in the provision of unhelpful, even harmful clinical mentoring to many students. This phenomenon was especially prominent when they managed students' performance. I found some evidence that this phenomenon could be starting to change when I talked to the younger CMs and junior RN in the interviews. They understood the support that the students needed based on their recent past experience and struggled between the traditional mentoring that their seniors wanted and the mentoring that they believed could accommodate students' needs such as reassurance. I was glad to see some signs of change even though the progress could be uncertain and slow. I also hope that some lessons could be learnt from the reports from all participants i.e. learning is a dynamic process that the learning process for each student is unique. Nurse educators and clinician should also learn to avoid doing any harm to our students. Errors and mistakes can indicate the opportunity to learn rather than simply a reason to ask students to quit. Finally, I hope CIs, CMs and students could enjoy their participation in clinical mentoring in the future.

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Appendix 1 – Summary of the included literature

Research articles

	Name of Authors Title Country of the study	Methodology, Method of Data Collection & Data analysis method	Sample Size, Sampling Strategy and Setting	Summary of Main Findings	Strength and Limitations of the Study
	<p>Levett-Jones, T., Lathlean, J., Higgins, I. & Mcmillan, M. 2009.</p> <p>Staff-student relationships and their impact on nursing students' belongingness and learning. <i>Journal of Advanced Nursing</i> 65, 316-324.</p> <p>Australia and United Kingdom</p>	<p>Mixed method study</p> <p>Online survey. No information about the questionnaire was stated</p> <p>In-depth interview</p> <p>Constant comparison method</p>	<p>Sample size, sampling method and response rate of online survey was not reported</p> <p>18 third year undergraduate nursing students: 6 students from UK, 12 students from Australia Sampling method was not stated</p> <p>All participants were recruited from a large regional university in New South Wales, a small metropolitan university in Queensland and a large metropolitan university in southern England</p>	<ul style="list-style-type: none"> • Receptiveness of nursing staff • Inclusion vs exclusion • Legitimization of the student role • Recognition and appreciation • Challenge and support 	<p>Strength</p> <ul style="list-style-type: none"> • In-depth interview generated comprehensive and rich data <p>Limitations of method used</p> <ul style="list-style-type: none"> • The result of the survey was not covered in this paper • Unable to assess for sampling bias due to lack of information

	<p>Bradbury-Jones, C., Irvine, F. & Sambrook, S.</p> <p>2010.</p> <p>Empowerment of nursing students in clinical practice: spheres of influence. <i>Journal of Advanced Nursing</i> 66, 2061-2070.</p> <p>United Kingdom</p>	<p>Longitudinal phenomenological study</p> <p>In-depth interview conducted annually at the end of each academic year. Attrition rate of participants was not stated.</p> <p>Principally use the approach of van Manen but also influenced by Moustakas, Todres and Giorgi and Giorgi method</p>	<p>13 first-year nursing student from a university in UK</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> • Being empowered as first year of students: being valued as team member and a person, importance of time, knowledge and confidence • Being empowered as second year of students: knowledge and confidence, importance of mentors and issue of time • Being empowered as third year of students: knowledge and confidence, self-empowerment and careful strategy in negotiating empowerment 	<p>Strength</p> <ul style="list-style-type: none"> • Longitudinal study design enhanced the understanding of development of empowerment of nursing students throughout their studies <p>Limitations of method used</p> <ul style="list-style-type: none"> • Participants were recruited from single site • Unable to assess for sampling bias due to lack of information • Unclear about the data analysis method used
	<p>Warne, T., Johansson, U., Papastavrou, E., Tichelaar, E., Tomietto, M., Den Bossche, K. V., Moreno, M. F. V. & Saarikoski, M.</p>	<p>Cross-sectional survey</p> <p>Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale</p>	<p>1903 pre-registration nursing students</p> <p>Purposive sampling. Recruitment procedure and response rate was not mentioned.</p>	<ul style="list-style-type: none"> • 44% of respondents were satisfied with their clinical placement • 42% of respondents were neutral to their clinical placement 	<p>Strength</p> <ul style="list-style-type: none"> • Various factors including teaching and learning, relationship and environment of

	<p>2010.</p> <p>An exploration of the clinical learning experience of nursing students in nine European countries. <i>Nurse Education Today</i>, 30, 809-815.</p> <p>Cyprus, Belgium, England, Finland, Ireland, Italy, Netherlands, Spain and Sweden</p>	<p>Cronbach alpha coefficient among European sample ranged from 0.83 to 0.96</p> <p>Online Survey: link of the questionnaire was sent to respondents through email</p> <p>Descriptive statistics and ANOVA (P<0.01)</p>	<p>17 traditional nursing schools among 9 European countries</p>	<ul style="list-style-type: none"> • Higher levels of satisfaction toward clinical placement when the duration of clinical placement was longer (P=0.006) • Less satisfied with role of nurse teacher (nurse educators from education institution) (P=0.001) 	<p>clinical placement were assessed</p> <ul style="list-style-type: none"> • High reliability of questionnaire <p>Limitations of method used</p> <ul style="list-style-type: none"> • Unclear about the sampling used due to insufficient information • Potential sample bias • Validity of questionnaire was not stated. • The validity of questionnaire was questionable.
	<p>Allan, H. T., Smith, P. & O'driscoll, M.</p> <p>2011.</p> <p>Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the</p>	<p>Ethnographic case study that involved 2 stages</p> <p>Stage 1: literature review and interview with 10 stakeholders</p> <p>Stage 2: Four higher education institutions were treated as four cases</p>	<p>5-days observation of registered nurses, students and other healthcare workers for students' learning experience in accident & emergency department, medical and surgical wards</p>	<ul style="list-style-type: none"> • Supernumerary status prevent student from learning • Being supernumerary: students became aimless and was difficult to cope with the fast pace at work. The performance of newly qualified nurses 	<p>Strength</p> <ul style="list-style-type: none"> • Participants with diverse background were included <p>Limitations of method used</p> <ul style="list-style-type: none"> • The finding of stage 1 was not

	<p>theory-practice gap? <i>Journal of Clinical Nursing</i> 20, 847-855.</p> <p>United Kingdom</p>	<p>Active participant observation</p> <p>Focus group interview Individual and joint interview</p> <p>Thematic analysis</p>	<p>Student nurses, mentors, nurses from various levels, nurse educators in either focus group, joint interview and individual interview</p> <p>Sampling method was not stated</p> <p>Four higher education institutions and arrange of clinical practice setting in acute NHS Trust</p>	<p>was similar to that of second/ third year students</p> <ul style="list-style-type: none"> • Negotiating supernumerary status reflected at the handover: task allocation • Negotiating supernumerary status as new aspects of hidden curriculum • Negotiating supernumerary status reflected the failure of integration of theory and practice 	<p>covered in the article</p> <ul style="list-style-type: none"> • Potential sampling bias: all student nurses were recruited from single site • The details of data collection was not described
	<p>Gidman, J., Mcintosh, A., Melling, K. & Smith, D.</p> <p>2011.</p> <p>Student perceptions of support in practice. <i>Nurse Education in Practice</i>, 11, 351-355.</p> <p>United Kingdom</p>	<p>Mixed method research design.</p> <p>Stage 1: Survey Self-developed questionnaire to rate different aspects related to support in placements. Pilot test was performed</p> <p>Descriptive statistics</p>	<p>Two groups of student nurses studying in adult pre-registration nursing programmes in the Cheshire and Merseyside region of England</p> <ul style="list-style-type: none"> • Starter students (practice experience less than 6 months) 	<p>Stage 1:</p> <ul style="list-style-type: none"> • Starters and finishers had similar views on important element of placement, responsibilities and qualities of mentors, teaching and support, own responsibilities, challenge in placement except source of support 	<p>Strength</p> <ul style="list-style-type: none"> • The findings differentiated the support needed by starters and finishers <p>Limitations of method used</p> <ul style="list-style-type: none"> • Validity and reliability of the questionnaire was not stated.

		<p>Stage 2: focus group interview</p> <p>Thematic analysis</p>	<ul style="list-style-type: none"> • Finisher students (in final 3 months in their programme) <p>Stage 1: 2 groups: 174 starter students and 98 finisher students Response rate was not stated</p> <p>Convenience sampling</p> <p>Stage 2: 2 groups with 15 starter students and 2 groups with 20 finisher students</p> <p>Purposive sampling</p>	<p>Stage 2:</p> <ul style="list-style-type: none"> • Major difficulty encountered: Personal issues, uncertainty of student nurse role, competence and assessment • Source of support: mentors, peers and newly qualified nurses and being part of a team 	<ul style="list-style-type: none"> • Unclear about the reliability and validity of questionnaire due to lack of information • Weak sampling method • The topics discussed in focus group interview was not stated • Findings only reflect the situation encountered by nursing students in UK
	<p>Jokelainen, M., Jamookeah, D., Tossavainen, K. & Turunen, H.</p> <p>2011.</p> <p>Building organizational capacity for effective</p>	<p>Phenomenological study</p> <p>Semi-structured focus group interviews</p> <p>Phenomenological data analysis method</p>	<p>22 nurses from Finland 17 nurses from UK</p> <p>Purposive sampling</p> <p>Nurses who mentored pre-registration nursing students during placement learning in healthcare centres, care</p>	<ul style="list-style-type: none"> • Organisation as optimizer in the provision of mentorship: develop clear strategy for placement learning provision, provide sufficient human and financial resources and contribute the 	<p>Strength</p> <ul style="list-style-type: none"> • In-depth description of the role of organisation in clinical placement <p>Limitations of method used</p>

	<p>mentorship of pre-registration nursing students during placement learning: Finnish and British mentors' conceptions. <i>International Journal of Nursing Practice</i>, 17, 509-17.</p> <p>Finland and United Kingdom</p>		<p>homes, medical, surgical and emergency wards, and outpatient clinical from general, private or university hospitals</p>	<p>professional development of mentors</p> <ul style="list-style-type: none"> • Creator of a positive culture in placements: promote a development-oriented work image, establish mentorship-favourable placement, highlight student-centered atmosphere and strengthen goal-directive student mentorship • Provider of well-prepared placement: Control the current working condition for placement, coordinate the placements for stakeholders, arrange suitable procedure for students, organise placement learning opportunities for students 	<ul style="list-style-type: none"> • Inappropriate to use focus group interview in phenomenological study: unable to reveal individual experience • The procedure of data analysis was not stated
	<p>Skaalvik, M. W., Normann, H. K. & Henriksen, N.</p>	<p>Cross-sectional survey</p>	<p>511 nursing students studying undergraduate nursing programmes in</p>	<ul style="list-style-type: none"> • Higher satisfaction of clinical experience in hospital setting than 	<p>Strength</p> <ul style="list-style-type: none"> • Study illustrated the impacts of

	<p>2011.</p> <p>Clinical learning environment and supervision: Experiences of Norwegian nursing students-A questionnaire survey. <i>Journal of Clinical Nursing</i>, 20, 2294-2304.</p> <p>Norway.</p>	<p>Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale</p> <p>Mann-Whitney U tests and chi-square test</p>	<p>five Norwegian Higher Education Institutions</p> <p>Response rate: 41.6%</p> <p>Convenience sampling</p>	<p>that in nursing homes (P<0.001)</p> <ul style="list-style-type: none"> • Pedagogical atmosphere and supervisory relationship enhance the students' clinical experience in both settings (P<0.001) 	<p>different clinical settings on students' clinical experience.</p> <p>Limitations of method used</p> <ul style="list-style-type: none"> • Weak sampling method • Low sample representativeness (4.5% of the nursing student population in Norway) • Unable to assess the quality of questionnaire: validity and reliability of the questionnaire was not stated.
	<p>Courtney-Pratt, H., Fitzgerald, M., Ford, K., Marsden, K. & Marlow, A.</p> <p>2012.</p>	<p>Mixed Method research design</p> <p>Modified quality clinical placement inventory (QCPI) for supervising ward nurses and clinical</p>	<p>163 supervising ward nurses (employees of hospitals)</p> <p>22 clinical facilitators (employed by university)</p>	<ul style="list-style-type: none"> • Majority of respondents rated the placement as high quality • Building up confidence and competence was highly rated by nursing students (Mean=4.4/5) 	<p>Strength</p> <ul style="list-style-type: none"> • Mixed method study provided more comprehensive data

	<p>Quality clinical placements for undergraduate nursing students: A cross-sectional survey of undergraduates and supervising nurses. <i>Journal of Advanced Nursing</i>, 68, 1380-1390.</p> <p>Australia</p>	<p>facilitators, and nursing student (5-point Likert scale) was reviewed by expert panel</p> <p>Open-ended questions about most helpful and unhelpful experience</p> <p>Survey: Questionnaires were distributed in feedback session</p> <p>Descriptive statistics</p> <p>Coding of open-ended responses and emerging of codes was completed by two researchers</p>	<p>178 second year undergraduate nursing students</p> <p>Response rate: 89%</p> <p>Convenience Sampling</p>	<ul style="list-style-type: none"> • Welcoming and belongingness was highly rated by supervising ward nurses and clinical facilitators (Mean=4.22/5) • Relationships, organizational structure and ward setting, and knowledge and experience were found influencing the quality of clinical placement 	<p>Limitations of method used</p> <ul style="list-style-type: none"> • All respondents were recruited from one hospital only • The reliability and validity of the questionnaire was not stated. Reliability testing of questionnaire was not conducted and review process by expert panel was not described • Weak sampling method • Sample size of each group was small
	<p>Coyne, E. & Needham, J. 2012.</p> <p>Undergraduate nursing students'</p>	<p>Generic qualitative study</p> <p>Semi-structured interview</p> <p>Thematic analysis</p>	<p>7 student nurses who completed 4-week clinical placement in a renal dialysis unit and an ambulatory day oncology unit</p>	<ul style="list-style-type: none"> • Knowledge and preparedness for specialist placement: lack of specialty knowledge that reduced ability and increased nervousness, being 	<p>Strength</p> <ul style="list-style-type: none"> • Participants were able to provide comprehensive and rich data

	<p>placement in speciality clinical areas: Understanding the concerns of the student and registered nurse. <i>Contemporary Nurse</i>, 42, 97-104.</p> <p>Australia</p>		<p>13 registered nurses who mentored the student nurses in renal dialysis unit and ambulatory day oncology unit</p> <p>Convenience sampling</p>	<p>welcomed and oriented and being notified and prepared for mentoring</p> <ul style="list-style-type: none"> • Teamwork and being included: influenced by the personality of students, culture of registered nurses working in specialty area • Customising learning needs: getting students to identify the learning objectives and expectations, need for close contact with university, appropriate assessment in specialty area 	<p>Limitations of method used</p> <ul style="list-style-type: none"> • Weak sampling method • Short duration of interview (15-30 mins)
	<p>Halcomb, E. J., Peters, K. & Mcinnes, S. 2012.</p> <p>Practice nurses experiences of mentoring undergraduate nursing students in Australian general practice. <i>Nurse</i></p>	<p>Exploratory qualitative study</p> <p>Semi-structured telephone interview</p> <p>Thematic analysis</p>	<p>12 practice nurses (Registered nurses) from four Australian states who had mentored students previously were recruited.</p> <p>Convenience Sampling</p>	<p>Three themes to describe mentoring experience</p> <ul style="list-style-type: none"> • promoting practice nursing • mentoring future co-worker • reciprocity in learning. • Practice nurses' enthusiasm positively influenced the student 	<p>Strength</p> <ul style="list-style-type: none"> • In-depth understanding of experience was gained through semi-structured interview <p>Limitations of method used</p> <ul style="list-style-type: none"> • Potential sample bias

	<p><i>Education Today</i>, 32, 524-528.</p> <p>Australia</p>			<p>nurses in their future career.</p> <ul style="list-style-type: none"> The qualification of interviewed practice nurses may not be optimal for mentoring. 	<ul style="list-style-type: none"> Findings reflected the perception of mentoring in Australia
	<p>Hasson, F., Mckenna, H. P. & Keeney, S.</p> <p>2013.</p> <p>Perceptions of the unregistered healthcare worker's role in pre-registration student nurses' clinical training. <i>Journal of Advanced Nursing</i> 69, 1618-1629.</p> <p>Northern Ireland</p>	<p>Generic qualitative research design</p> <p>Semi-structured interview</p> <p>Inductive content analysis</p>	<p>59 healthcare assistants (HCA) working</p> <p>Purposive sampling</p> <p>Four major acute NHS hospitals</p>	<p>Four themes were identified</p> <ul style="list-style-type: none"> close working relationship roles in student learning approach to teaching justification and consequence <ul style="list-style-type: none"> Participants were either delegated by the registered nurse (RN) or mentor to supervise and provide feedback to student nurses informally. It could be related to blurred boundary between the role of HCAs and RNs in patient care. when the RNs were busy with clinical duty. 	<p>Strength</p> <ul style="list-style-type: none"> Findings represented the view from HCAs from various specialties <p>Limitation of method used</p> <ul style="list-style-type: none"> Unclear strategy used to ensure credibility

	<p>Jokelainen, M., Jamookeeah, D., Tossavainen, K. & Turunen, H.</p> <p>2013.</p> <p>Finnish and British mentors' conceptions of facilitating nursing students' placement learning and professional development. <i>Nurse Education in Practice</i>, 13, 61-67.</p> <p>United Kingdom and Finland</p>	<p>Phenomenological design</p> <p>Focus group interview</p> <p>Phenomenological data analysis method</p>	<p>17 mentors from UK 22 mentors from Finland</p> <p>Sampling method was not mentioned</p>	<ul style="list-style-type: none"> • 2 approaches to facilitate in 4 stages of mentoring: pedagogical approach and human approach • 4-stages of mentoring: students in focus, placement fit for purpose, co-working and spurring and ongoing assessment of achievements • Pedagogical approach: goal-based guided co-working and evaluating achievement of learning outcomes • Human approach: positive encouraging partnership and developing professional competences 	<p>Strength</p> <ul style="list-style-type: none"> • Maximize the diversity of data <p>Limitations of method used</p> <ul style="list-style-type: none"> • Sampling method was not stated • Inappropriate to use focus group interview to reveal individual experience • Unclear data analysis
	<p>Peters, K., Halcomb, E. J. & Mcinnes, S.</p> <p>2013.</p> <p>Clinical placements in general practice:</p>	<p>Generic qualitative research</p> <p>Semi-structured telephone interview.</p> <p>Information about the</p>	<p>12 practice nurses who had experience of mentoring at least one undergraduate nursing students in four Australian states</p>	<ul style="list-style-type: none"> • Appropriate students' preparation for placement • Seeking greater consultation in the organization of clinical placements: overload 	<p>Strength</p> <ul style="list-style-type: none"> • Diverse background of the participants <p>Limitations of method used</p>

	<p>Relationships between practice nurses and tertiary institutions. <i>Nurse Education in Practice</i>, 13, 186-191</p> <p>Australia</p>	<p>topics discussed in interview was not stated</p> <p>Thematic analysis</p>	<p>Convenience sampling and snowball sampling</p>	<p>by excess students, feeling being overlooked</p> <ul style="list-style-type: none"> • Uncertainty and lack of support: lack of training before mentoring, lack of ongoing support and communication throughout the placement 	<ul style="list-style-type: none"> • Potential sampling bias • Unsure about the thickness of the data: short duration of interview (11 to 26 mins), topics discussed unknown • Unable to observe for social cues in telephone interview
	<p>Stayt, L. C. & Merriman, C. 2013.</p> <p>A descriptive survey investigating pre-registration student nurses' perceptions of clinical skill development in clinical placements. <i>Nurse Education Today</i>, 33, 425-430.</p> <p>United Kingdom</p>	<p>Cross-sectional survey</p> <p>Self-developed questionnaire: 16 questions using 5-point Likert-type scale and a space for open comment</p> <p>Online survey</p> <p>Descriptive statistics for 16 quantitative questions and thematic analysis for open comment</p>	<p>421 undergraduate nursing students studying in Higher Education Institutions in South of England</p> <p>Response rate: 53%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • More than 30% of respondents rated that they “always” have opportunity to practice various clinical skills • More than 42% of respondents were assessed various clinical skills frequently • Shortage of staff and heavy workload were perceived as factors that minimize the supervision and assessment 	<p>Strength</p> <ul style="list-style-type: none"> • Open-ended comment provided additional information to enrich the quantitative findings <p>Limitations of method used</p> <ul style="list-style-type: none"> • The validity and reliability of the questionnaire was not stated. The

					<p>quality of questionnaire was questionable.</p> <ul style="list-style-type: none"> • The content of the questionnaire included basic nursing skill only • Potential sample bias: weak sampling method, low response rate, high rate of missing data (23%) in frequency of assessment, 41% of respondents were first year nursing students
	<p>Annear, M., Lea, E. & Robinson, A. 2014.</p> <p>Are care workers appropriate mentors for nursing students in residential aged care? <i>BioMed Central Nursing</i>, 13, 1-16.</p>	<p>Action research: describe cycle of reflection, planning, action and evaluation</p> <p>6 focus group interviews for student group and mentor group prior, every week of the four-week placement and after the placement</p>	<p>10 second year undergraduate nursing students who attend four-week placement in a residential aged care facilities (RACF)</p> <p>17 facility mentors: 5 care workers and 12 nurse mentors</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> • Identification of the issues: perceived carer mentors as inappropriate mentor, lack of respect to carer mentors • Action planning and taking action: development of assessment guide 	<p>Strength</p> <ul style="list-style-type: none"> • Actions and reflections during the clinical placement in RACF were tracked through repeated interviews

	Australia	Thematic analysis		<ul style="list-style-type: none"> Evaluation and critical reflection: change in perception of carer mentors in the end of placement 	<p>Limitations of method used</p> <ul style="list-style-type: none"> Participants were included in single site The findings from nurse mentors was not reported
	<p>Black, S., Curzio, J. & Terry, L.</p> <p>2014.</p> <p>Failing a student nurse: A new horizon of moral courage. <i>Nursing Ethics</i>, 21, 224-238.</p> <p>United Kingdom</p>	<p>Hermeneutic phenomenological study</p> <p>Individual reflective interview. An interview guide was developed using reflective cue questions</p> <p>Gadamerian-based approach of data analysis</p>	<p>19 mentors who worked in 7 different healthcare organisations in inner city and rural locations in the southeast of England</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> Experiencing moral stress: guilt emerged from failing students, consequences faced by failed students, unpleasant physical and psychological feeling toward failing students Demonstrating moral integrity: protect the public, professional response, element of conscience and a personal moral code Ensuing moral residue: being brave, prevention of future harm 	<p>Strength</p> <ul style="list-style-type: none"> Thick data was obtained through reflective interview <p>Limitations of method used</p> <ul style="list-style-type: none"> The reflective cue questions were not stated. The background information of the participants was not stated
	<p>Helminen, K., Tossavainen, K. & Turunen, H.</p> <p>2014.</p>	<p>Survey</p> <p>Self-developed questionnaire</p>	<p>276 nursing students and 108 Nursing teachers from five universities in Finland</p>	<ul style="list-style-type: none"> Nursing teachers tended to contact students in the beginning of the clinical placement ($P < 0.001$). 	<p>Strength</p> <ul style="list-style-type: none"> Survey was an effective method to collect data in

	<p>Assessing clinical practice of student nurses: Views of teachers, mentors and students. <i>Nurse Education Today</i>, 34, 1161-1166.</p> <p>Finland</p>	<p>The questionnaire was validated by 5 expert groups with pilot testing completed. Data related to validation was not available</p> <p>Descriptive statistics and chi-square test</p>	<p>225 mentors from partner hospitals were recruited</p> <p>Response rate:73-84%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Students tended to focus on learning skills related to assessment (P<0.001). • Mentors rated by nurse teachers that mentors lacked courage to fail students (P<0.001). • Both mentors and students agreed that nursing teachers should involve in final assessment discussion. Majority of nursing teachers and students in this study did not support 	<p>short period of time</p> <p>Limitations of method used</p> <ul style="list-style-type: none"> • The details of questionnaire, such as the validity and reliability of the questionnaire, items included in each part of the questionnaires, was not stated. • Weak sampling method
	<p>Mcintosh, A., Gidman, J. & Smith, D.</p> <p>2014.</p> <p>Mentors' perceptions and experiences of supporting student nurses in practice. <i>International Journal of Nursing Practice</i>, 20, 360-365.</p>	<p>Mixed method research design.</p> <p>Stage 1: Survey</p> <p>Self-developed questionnaire that ask respondents to rate the perceived support that student needs and support sources, mentor responsibilities and qualities, student</p>	<p>Stage 1:</p> <p>61 mentors who had experience of supporting students on a pre-registration nursing programme (adult branch) from one acute Trust and community Trust in the North West of England completed the questionnaires</p>	<p>Stage 1</p> <ul style="list-style-type: none"> • Major responsibility as supporting learning (57%) • Personal attributes as important qualities of mentor (64 %) • Willingness to learn as major students' responsibilities (62%) 	<p>Strength</p> <ul style="list-style-type: none"> • Assessment in placement served as a process to verify if the student become competent in practice. It also hindered the learning of the skills that did not

	<p>United Kingdom</p>	<p>responsibilities, challenges for mentors and support for mentor</p> <p>Descriptive statistics</p> <p>Stage 2: Two focus group interviews were conducted.</p> <p>Data reduction, display and conclusion drawing was used to analysis the data collected from focused group interview</p>	<p>Response rate: 46.9%</p> <p>Convenience sample</p> <p>Stage 2: Two focus group interviews were conducted with 6 mentors from the acute Trust and 7 from the community Trust</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> • Agreed practice education facilitators as main support (33%) <p>Stage 2</p> <ul style="list-style-type: none"> • Peers and other health care assistants as alternative source of support for students • Not all of registered nurses wanted to be mentor as it was an add-on commitment of the existing roles. • Students were expected to take initiative in their learning. They also became task-orientated and assessment focused. • Students should be treated as part of the health care team 	<p>required in assessment.</p> <p>Limitations of method used</p> <ul style="list-style-type: none"> • The validity and reliability of the questionnaire was not stated. The quality of questionnaire was questionable. • Weak sampling method in stage 1 • The topics discussed in focus group interview was not stated • Unclear about qualitative data analysis
	<p>Morrell, N. & Ridgway, V. 2014.</p> <p>Are we preparing student nurses for</p>	<p>Phenomenological study</p> <p>Written diary about the first 4 weeks of the final clinical placement. No information about</p>	<p>8 adult branch student nurses of a UK higher education</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> • Being an extra pair of hands • Late completion assessment documentation • High staff expectation • Mentor importance 	<p>Strength</p> <ul style="list-style-type: none"> • Cost effective way to collect personal experience <p>Limitations of method used</p>

	<p>final practice placement? <i>British Journal of Nursing</i>, 23, 518-523.</p> <p>United Kingdom</p>	<p>number of diaries collected</p> <p>Interpretative phenomenological analysis</p>		<ul style="list-style-type: none"> • Lack of knowledge • Lack of support and stress • Simulated practice • Achievement of tasks and confidence 	<ul style="list-style-type: none"> • Small sample size • Not sure if data saturation was reached
	<p>Rooke, N. 2014.</p> <p>An evaluation of nursing and midwifery sign off mentors, new mentors and nurse lecturers' understanding of the sign off mentor role. <i>Nurse Education in Practice</i>, 14, 43-8.</p> <p>United Kingdom</p>	<p>Evaluation survey design</p> <p>Phase 1, 2 and 3: questionnaire include open and multiple-choice questions. No testing of questionnaires was conducted</p> <p>Descriptive statistics for quantitative data and thematic analysis for qualitative data</p>	<p>Phase 1: 114 registered nurses and midwives who attended "sign off" Mentor preparation session</p> <p>Response rate: 95%</p> <p>Phase 2: 37 registered nurses and midwives who completed a Mentor Preparation programme</p> <p>Response rate: 44%</p> <p>Phase 3: 13 nursing and midwifery lecturer</p> <p>Response rate: 28%</p> <p>Convenience sampling for all phases</p>	<ul style="list-style-type: none"> • The main role of sign-off mentors was perceived as protection all groups of respondents • Benefit: fitness for practice, accountability, enhancement of the student experience and professional development • Challenge: time, workload, responsibility and assessment 	<p>Strength</p> <ul style="list-style-type: none"> • Survey was an effective way to measure knowledge about the role of sign-off mentor <p>Limitations of method used</p> <ul style="list-style-type: none"> • The details, validity and reliability of questionnaire was stated. The quality of questionnaire was questionable. • Weak sampling method • Low response rate in phase 2 and 3 • The findings reflected the

					perception of sign-off mentors who had no experience of assessment
	<p>Wilson, A. M. E. 2014.</p> <p>Mentoring student nurses and the educational use of self: A hermeneutic phenomenological study. <i>Nurse Education Today</i>, 34, 313-318.</p> <p>United Kingdom</p>	<p>Hermeneutic phenomenological study</p> <p>In-depth interview</p> <p>Data analysis method was not stated</p>	<p>12 nurses who had mentored at least one student</p> <p>Purposive and snowball sampling</p> <p>These nurses worked in various healthcare settings which ranged from home nursing to intensive care in southern England</p>	<ul style="list-style-type: none"> • Mentoring was considered as “the educational use of self” • Tool of mentoring: mentor • Meaning of mentoring: being a role model and building up a relationship with students and the nursing educator • The human aspects of mentors including time constraints, emotional and physical burnout, were ignored. 	<p>Strength</p> <ul style="list-style-type: none"> • Personal feeling towards mentoring and difficulties encountered by mentors was revealed. <p>Limitations of method used</p> <ul style="list-style-type: none"> • Low representativeness of participants due to snowball sampling • Unclear data analysis method
	<p>Dimitriadou, M., Papastavrou, E., Efstathiou, G. & Theodorou, M. 2015.</p>	<p>Descriptive, correlation survey</p> <p>Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale</p>	<p>357 second year undergraduate nursing students</p> <p>Response rate: 94%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Highest satisfaction in supervisory relationship with mentors and the role of nurse teacher-enabling integration of theory and practice (Mean of all dimension 	<p>Strength</p> <ul style="list-style-type: none"> • Correlation between different dimensions of clinical placement

	<p>Baccalaureate nursing students' perceptions of learning and supervision in the clinical environment. <i>Nursing & Health Sciences</i>, 17, 236-242.</p> <p>Cyprus</p>	<p>(Cronbach's alpha of 4 subdimension ranged from 0.82 to 0.96)</p> <p>Descriptive statistics and one-way ANOVA, Pearson correlation</p>		<p>ranged from 3.54 – 4.18)</p> <ul style="list-style-type: none"> • No statistical difference in satisfaction between team supervision and individual supervision (ANOVA 28.569, $P < 0.001$) • Strong correlation: premise of nursing on the ward and premise of learning on the ward (Pearson correlation: 0.666, $P < 0.001$) • Weak correlation: leadership style of ward manager and role of nurse teacher (Pearson correlation: 0.356, $P < 0.001$) 	<p>Limitation of method used</p> <ul style="list-style-type: none"> • Weak sampling method
	<p>Foster, H., Ooms, A. & Marks-Maran, D. 2015.</p> <p>Nursing students' expectations and experiences of mentorship. <i>Nurse</i></p>	<p>Mixed method exploratory sequential design</p> <p>Stage 1: semi-structured focus group interviews</p> <p>Framework method of analysis</p>	<p>All final year nursing students from one university in south west London</p> <p>Stage 1: 12 nursing students</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Positive rated mentorship's experience • Mentors as good role (98.1%) • Most valued mentors' activities: explaining and teaching, support and supervision, assessment 	<p>Strength</p> <ul style="list-style-type: none"> • Mixed method study provided more comprehensive data <p>Limitations of method used</p>

	<p><i>Education Today</i>, 35, 18-24.</p> <p>United Kingdom</p>	<p>Stage 2: Online Survey Self-developed questionnaire from the finding in stage 1 Likert-type questions and open-ended questions. Pilot testing was completed</p> <p>Data analysis for quantitative data was not stated</p>	<p>Stage 2: 53 nursing students</p> <p>Response rate: 45%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Option of being mentors should be provided for the nurses • Support for mentors: regular mentor updates, study days for mentors and assessment of mentors 	<ul style="list-style-type: none"> • All respondents were recruited from one university • Small sample size • Weak sampling method • One focus group interview in stage 1 • Low response rate in stage 2 • The validity and reliability of the questionnaire was not stated. • Unclear about the use of framework method of analysis
	<p>McInnes, S., Peters, K., Hardy, J. & Halcomb, E.</p> <p>2015.</p> <p>Primary care clinical placements: The views of Australian registered nurse</p>	<p>Mixed method Second part: Online Survey for students/ paper-formed survey for mentors</p> <p>Questionnaire for students:</p>	<p>45 pre-registration nursing students from graduate entry/ Master of Nursing or combined degree/ Master of Nursing program in single university in Australia</p> <p>Response rate: 19.7%</p>	<ul style="list-style-type: none"> • Clinical placement in primary care setting was positively rated (Mean 79.85) • Student respondents were highly satisfied with their relationship with the nurse mentors (No statistic provided) 	<p>Strength</p> <ul style="list-style-type: none"> • High reliability of questionnaire <p>Limitations of method used</p> <ul style="list-style-type: none"> • Small sample size and unclear sampling method

	<p>mentors and pre-registration nursing students (part 2). <i>Nurse Education in Practice</i>, 15, 443-449.</p> <p>Australia</p>	<p>Clinical Learning Environment Inventory-19 (CLEI-19) Cronbach alpha of subscale ranged between 0.92 and 0.94</p> <p>Quality Clinical Placement Inventory (QCPI) Cronbach alpha 0.955</p> <p>Questionnaire for mentors Self-developed questionnaire to evaluate clinical placement. This questionnaire was reviewed by experts in nursing, primary and research to ensure face and content validity</p> <p>Descriptive statistics for quantitative data and content analysis for qualitative data</p>	<p>22 primary care registered nurse mentors</p> <p>Response rate: not specified</p> <p>Sampling method was not specified</p>	<ul style="list-style-type: none"> • High score in welcoming and belongingness (Mean 4.29) • Mentors' perceived barrier of clinical placement: lack of payment for placement (45.5%), lack of time (41.8%), space limitation (27.3%) • Mentors' perceived enabler of clinical placement: own personal desire to mentor nursing student (77.3%), enthusiasm of the GP (68.2%) and patient perception (63.6%) 	<ul style="list-style-type: none"> • Student respondents were recruited from single university • The validity and reliability of the questionnaire was not stated
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	<p>Sinclair, W., Mcloughlin, M. & Warne, T. 2015. To Twitter to Woo: Harnessing the power of social media (SoMe) in nurse education to enhance the student's experience. <i>Nurse Education in Practice</i>, 15, 507-511.</p> <p>United Kingdom</p>	<p>Data retrieved from a planned 1-hour Twitter chat which #WeNurses</p> <p>Pre-chat reading to guide the interested participants to provide related opinion</p> <p>Data analysis method was not stated</p>	<p>900 tweets and 836 134 impression from 107 contributors</p>	<ul style="list-style-type: none"> • Discrepancy in the role of students: as learner or part of the workforce • Negative attitude of clinical mentors related to poor placement experience • Relationship with mentors was essential to the placement experience • Lack of communication between clinical area and university 	<p>Strength</p> <ul style="list-style-type: none"> • Participants were less likely to provide socially acceptable response <p>Limitations of method used</p> <ul style="list-style-type: none"> • Potential sampling bias: only message hashtag WeNurses included • Data analysis method was not mentioned • The finding was fragmented • Unclear data analysis method
	<p>Skela-Savič, B. & Kiger, A. 2015. Self-assessment of clinical nurse mentors as dimensions of professional development and the capability of developing ethical</p>	<p>Non-experimental quantitative research design</p> <p>Self-developed structured questionnaire (Cronbach alpha coefficient ranged from 0.78 to 0.828)</p>	<p>143 clinical mentors from twenty healthcare settings in Slovenia</p> <p>Response rate: 49%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Time of research and learning was positively related to increased professional self-confidence ($R^2=0.188$ $P \leq 0.05$), responsibility of development of ethical values in nursing students ($R^2=0.145$ $P \leq$ 	<p>Strength</p> <ul style="list-style-type: none"> • Benefit of mentors' participation in research activities was illustrated • High reliability of questionnaire

	<p>values at nursing students: A correlational research study. <i>Nurse Education Today</i>, 35, 1044-1051.</p> <p>Slovenia</p>	<p>Descriptive statistics, bivariate analysis, factor analysis, correlation analysis and linear regression analysis</p>		<p>0.05) and application of ethics into practice ($R^2=0.212$ $P\leq 0.05$)</p> <ul style="list-style-type: none"> • Respondents' level of education was positively related to responsibility of development of ethical values ($r=0.187$) 	<p>Limitation of method used</p> <ul style="list-style-type: none"> • Weak sampling method
	<p>Antohe, I., Riklikiene, O., Tichelaar, E. & Saarikoski, M.</p> <p>2016.</p> <p>Clinical education and training of student nurses in four moderately new European Union countries: Assessment of students' satisfaction with the learning environment. <i>Nurse Education in Practice</i>, 17, 139-44.</p>	<p>Online Survey.</p> <p>Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale (Cronbach's alpha of 4 subdimension ranged from 0.85 to 0.95)</p> <p>Descriptive statistics and chi-square test</p>	<p>418 nursing students who studying undergraduate nursing programme</p> <p>Response rate: 50%</p> <p>Convenience sampling.</p>	<ul style="list-style-type: none"> • The majority of the respondents were satisfied with their placement (Mean 3.87) • Higher level of satisfaction (4.13) when the respondents supervised individually • Students' motivation significantly related to level of satisfaction ($P<0.001$) • Frequent communication with nurse teachers were reported (51%) • Majority of respondents (80%) rated the background of supervisors (mentors) as very important. 	<p>Strength</p> <ul style="list-style-type: none"> • Study addressed the influence of supervisory relationship on the students' satisfaction of placement. • High reliability of questionnaire <p>Limitation of method used</p> <ul style="list-style-type: none"> • Weak sampling method • Low response rate

	Czech Republic, Hungary, Lithuania and Romania			<ul style="list-style-type: none"> Both university nurse educators and clinical supervisors were important in teaching core concepts of the nursing process (36%). Cooperation between nurse educators and supervisors and the relationship with supervisors influenced level satisfaction 	
	<p>Dahlke, S., O'connor, M., Hannesson, T. & Cheetham, K.</p> <p>2016.</p> <p>Understanding clinical nursing education: An exploratory study. <i>Nurse Education in Practice</i>, 17, 145-152.</p> <p>Canada</p>	<p>Mixed method Survey.</p> <p>Self-developed questionnaire including 12 quantitative questions and an open-ended question about the support and challenge in working with student nurses</p> <p>(KMO 0.81 and Cronbach's Alpha 0.881)</p> <p>Mean for the quantitative data and</p>	<p>15 Clinical faculty (Teaching staff employed by university who conduct clinical instruction)</p> <p>Response rate: 50%</p> <p>17 preceptors who provide clinical instruction to undergraduate nursing students in a university</p> <p>Response rate: unable to determine</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> Similar scores from both clinical faculty and preceptors in confidence (clinical faculty= 42.07, preceptors =35.65), knowledge (clinical faculty= 7.5, preceptors =8.6)and information survey (clinical faculty= 7.8, preceptors =8.7). Communication and enthusiasm could facilitate clinical instruction. Physical space and heavy workload inhibited their 	<p>Strength</p> <ul style="list-style-type: none"> High validity and reliability of questionnaire <p>Limitations of method used:</p> <ul style="list-style-type: none"> Small sample size Weak sampling method Low response rate Authors used various terms including "clinical instruction", "preceptorship" and "mentorship" interchangeably.

		interpretive descriptive analysis		<p>communication with students.</p> <ul style="list-style-type: none"> • Support on questioning technique, conflict resolving skill and handling of students with progress concern should be given 	<ul style="list-style-type: none"> • The generalizability of this study is questionable.
	<p>Dobrowolska, B., Mcgonagle, I., Kane, R., Jackson, C. S., Kegl, B., Bergin, M., Cabrera, E., Cooney-Miner, D., Di Cara, V., Dimoski, Z., Kekus, D., Pajnikihar, M., Prlić, N., Sigurdardottir, A. K., Wells, J. & Palese, A.</p> <p>2016.</p> <p>Patterns of clinical mentorship in undergraduate nurse education: A comparative case analysis of eleven EU and non-EU countries. <i>Nurse</i></p>	<p>Case study design.</p> <p>Self-developed questionnaire that included quantitative and qualitative items</p> <p>Pilot testing was completed</p> <p>Data was analysed at country level. Two researchers provided synthesis of core content from the data</p>	<p>13 nurse educators who were members of “Understanding Development Issues in Nursing Educator Network Careers (Udine-C)” working in Higher Education Institution (HEI)/ universities</p> <p>Purposive and convenience sampling.</p>	<ul style="list-style-type: none"> • Variation in implementation of clinical mentorship, requirement on experience, education received • Most countries had a formal evaluation of the CMs except for Ireland and Czech Republic. 	<p>Strengths</p> <ul style="list-style-type: none"> • This article illustrated the ambiguity of the “mentorship” and “preceptorship” terms. • It also illustrated variations in how educational institutions from different countries recruited and managed the clinical mentors <p>Limitations of method used</p> <ul style="list-style-type: none"> • Weak sampling method

	<p><i>Education Today</i>, 36, 44-52.</p> <p>Croatia, Czech Republic, England, Iceland, Ireland, Italy, Poland, Serbia, Slovenia, Spain and United States of America</p>				<ul style="list-style-type: none"> • Extremely small sample size for survey • The validity and reliability of questionnaire was not stated • Unclear data analysis method
	<p>Fuentes-Pumarola, C., Ballester-Ferrando, D., Gelabert-Vilella, S., Bosch-Farre, C., Malagon-Aguilera, M. C., Rascon-Hernan, C., Bonmati-Tomas, A. & Fernandez-Pena, R. 2016.</p> <p>Nursing student and professor perceptions and assessments of the achievement of practicum competencies: A mixed method approach. <i>Nurse Education Today</i>, 45, 199-205.</p>	<p>Mixed method</p> <p>Stage 1: survey. Self-developed questionnaire</p> <p>Descriptive statistics</p> <p>Stage 2: 2 semi-structured focus group interviews</p> <p>Content analysis</p>	<p>Stage 1: 163 4th year undergraduate nursing students from University of Girona</p> <p>Stage 2: 5 4th year undergraduate nursing students and 5 practicum professors from University of Girona</p> <p>Convenience sampling</p>	<p>Stage 1</p> <ul style="list-style-type: none"> • Placement in mental health and intensive/emergency setting were rated higher than placement in surgical setting • Practical activity was rated as the most helpful methodology to achieve various competencies <p>Stage 2</p> <ul style="list-style-type: none"> • Difference in perceived importance of acquired competencies between professors and student 	<p>Strength</p> <ul style="list-style-type: none"> • Differences in perception of clinical placement between professors and students were illustrated <p>Limitations of method used</p> <ul style="list-style-type: none"> • Weak sampling method • Respondents recruited from one university in Spain • Validity and reliability of the

	Spain			<ul style="list-style-type: none"> • Discrepancy between learning in classroom and clinical practice • Relationship with mentor was key indicator of clinical placement experience 	<p>questionnaire was not stated.</p> <ul style="list-style-type: none"> • Majority of student respondent attended placement in specialty area
	<p>Gale, J., Ooms, A., Sharples, K. & Marks-Maran, D.</p> <p>2016.</p> <p>The experiences of student nurses on placements with practice nurses: A pilot study. <i>Nurse Education in Practice</i>, 16, 225-234.</p> <p>United Kingdom</p>	<p>Online Survey</p> <p>Self-developed questionnaire included 4-point Likert-style and opened questions. Information related to questionnaire validation was not stated.</p> <p>Data analysis method was not stated</p>	<p>9 nursing students who participated in 4-6 weeks clinical placement in general practice (GP) led service</p> <p>Response rate: 52.9%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Respondents had positive placement experience in GP led service • Clinical placement in GP led service could facilitate respondents to become professional nurses • The placement experience in GP led service was better evaluated than that in hospitals 	<p>Strength</p> <ul style="list-style-type: none"> • The placement experience in GP setting was evaluated in four aspects, student engagement, value, impact and sustainability <p>Limitations of method used:</p> <ul style="list-style-type: none"> • Weak sampling method • Extremely small sample size • The validity and reliability of questionnaire was not stated

					<ul style="list-style-type: none"> • Unclear data analysis method
	<p>Hunt, L. A., Mcgee, P., Gutteridge, R. & Hughes, M.</p> <p>2016.</p> <p>Manipulating mentors' assessment decisions: Do underperforming student nurses use coercive strategies to influence mentors' practical assessment decisions? <i>Nurse Education in Practice</i>, 20, 154-62.</p> <p>United Kingdom</p>	<p>Interpretivist grounded theory</p> <p>Semi-structured interview</p> <p>Constant comparison method</p>	<p>15 mentors 8 practice education facilitators 8 Link lecturers</p> <p>Theoretical sampling</p> <p>The participants worked in the field of adult, child, mental health and learning disabilities in hospitals and community locations of NHS and private sectors</p>	<ul style="list-style-type: none"> • Students' response toward failed in assessment: improve performance, reject the criticism and manipulate the mentors to sway the assessment outcome • Four types of coercive students: ingratators, diverters, disparagers and aggressors • Different types of coercive students manipulate the guilt and fear of mentors • Recognizing the locus of fail 	<p>Strength</p> <ul style="list-style-type: none"> • The findings illustrated the process of failing students <p>Limitation of method used:</p> <ul style="list-style-type: none"> • Difficult to assess the methodology used: This article covered the theme about assessment only. • Perspective of students was not included
	<p>Kajander-Unkuri, S., Leino-Kilpi, H., Katajisto, J., Meretoja, R., Räisänen, A., Saarikoski, M., Salminen, L. & Suhonen, R.</p>	<p>Comparative survey: survey that was developed to compare the assessment rating between students and mentors</p> <p>Questionnaire included the demographic data,</p>	<p>42 student-mentor pairs</p> <p>Student nurses who attended the final clinical placement in four polytechnics in different geographical location in Finland</p>	<ul style="list-style-type: none"> • 68.3% of students rated their overall competence better than the rating by their mentors • Congruent rating in competence from student group and mentor group: 	<p>Strength</p> <ul style="list-style-type: none"> • High validity and reliability of questionnaire <p>Limitation of method used:</p> <ul style="list-style-type: none"> • Weak sampling method

	<p>2016.</p> <p>Congruence between graduating nursing students' self-assessments and mentors' assessments of students' nurse competence. <i>Collegian</i>, 23, 303-312.</p> <p>Finland</p>	<p>the generic Nurse Competence Scale (NCS) (Cronbach alpha 0.84 to 0.93) and Command of nursing functions (Cronbach alpha 0.87 to 0.94). The questionnaire was reviewed by expert panels to ensure content validity</p> <p>Descriptive and inferential statistics</p>	<p>Response rate: 92.3%</p> <p>Mentors of the recruited students were also recruited</p> <p>Response rate: 98%</p> <p>Convenience sampling</p>	<p>therapeutic interventions (P=0.02), helping role (P<0.001), diagnostic functions (P=0.001) and ensuring quality (P=0.009)</p> <ul style="list-style-type: none"> • 61% of students rated their nursing skills better than the rating by their mentors • No congruent rating in nursing skill from students and mentors at group level • No congruent rating in overall competence and nursing skill at individual level between students and mentors 	<ul style="list-style-type: none"> • Small sample size
	<p>Mccallum, J., Lamont, D. & Kerr, E.-L.</p> <p>2016.</p> <p>First year undergraduate nursing students and nursing mentors: An evaluation of their experience of</p>	<p>Mixed method descriptive and comparative survey</p> <p>Self-developed questionnaire included questions in 4-point likert scale and open-ended question</p>	<p>First year undergraduate nursing students from Scotland: 69 students from specialist area and 147 students from general area</p> <p>Response rate: 46.2%</p>	<ul style="list-style-type: none"> • Students (62%) attended specialist hub placement more positively rate their placement than students practice in general area • Students in both area valued learning 	<p>Strength</p> <ul style="list-style-type: none"> • Response from open-ended question enrich the findings in quantitative questionnaire <p>Limitations of method used</p>

	<p>specialist areas as their hub practice learning environment. <i>Nurse Education in Practice</i>, 16, 182-187.</p> <p>United Kingdom</p>	<p>Online survey</p> <p>Descriptive statistics for quantitative data and thematic analysis for qualitative data</p>	<p>Mentors: 13 mentors from specialists' area and 26 mentors from general area</p> <p>Response rate: 6.7%</p> <p>Convenience sampling</p>	<p>opportunity and support</p> <ul style="list-style-type: none"> • Mentors from both areas valued more on the belongingness and support received from the organization 	<ul style="list-style-type: none"> • Small sample size • Weak sampling method • Low response rate • Information about the open-ended questions, the validity and reliability of the questionnaire was not stated.
	<p>Papastavrou, E., Dimitriadou, M., Tsangari, H. & Andreou, C. 2016.</p> <p>Nursing students' satisfaction of the clinical learning environment: a research study. <i>BMC Nursing</i>, 15, 1-10.</p> <p>Cyprus</p>	<p>Descriptive correlational study</p> <p>Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale (Cronbach's alpha of 4 subdimension ranged from 0.82 to 0.96)</p> <p>Descriptive statistics, Spearman's rho correlation coefficient and chi-square test</p>	<p>463 undergraduate nursing students in three universities</p> <p>Response rate: 70.3%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • High level of satisfaction in clinical placement experience (Mean= 4.1) • High level of satisfaction in their clinical placement was correlated to frequency of communication and having a named mentor (P<0.001) • Respondents reported less satisfied in practicing in paediatric unit (P=0.02) • Respondent from private university reported to have less 	<p>Strength</p> <ul style="list-style-type: none"> • High reliability of the questionnaire <p>Limitations of method used:</p> <ul style="list-style-type: none"> • Findings only reflect the situation encountered by nursing students in UK • Weak sampling method

				satisfactory experience (P=0.04)	
Gillespie, M. 2017. Student nurse preferences for their first clinical experience: a thematic analysis. <i>British Journal of Nursing</i> , 26, 104-108. United Kingdom	Mixed method study Survey: self-developed questionnaire distributed before and after the placement in care home. Further information related to the questionnaire was not stated Focus group interview Thematic analysis	122 student nurses from one Scottish university participated in survey Response rate: not specified 7 student nurses participated in focus group Sampling method was not stated	<ul style="list-style-type: none"> • Care home: less relevant to learning and lack of challenge • Opportunity: repetitive and basic, being mundane • Compassion: offer reassurance, support and companionship • Availability of support: mentor as gatekeeper to control learning opportunity, sense of welcoming and supportive environment • Challenge: desirable and daunting 	<p>Strength</p> <ul style="list-style-type: none"> • Able to reveal the collective view on first clinical experience <p>Limitation of method used</p> <ul style="list-style-type: none"> • Unable to assess the sampling method due to lack of information • This article covered the findings from focus group interview only 	
Newton, J., Taylor, R. M. & Crighton, L. 2017. A mixed-methods study exploring sign-off mentorship practices in relation to the Nursing and	Mixed method Study 1: self-developed case report form related to supervision by sign-off mentor Study 2: practice assessment document and case report form	Study 1: 42 nursing students who completed their final placement in 2 cohort within one NHS trust (Cohort 1: 22, cohort 2:20) Response rate 56%	<ul style="list-style-type: none"> • 64% of student respondents from cohort 1 had at least 40% of shift working with SOM. Students from cohort 2 were significantly more likely to work at least 40% of shift working with SOM 	<p>Strength</p> <ul style="list-style-type: none"> • Challenges in conducting assessment were illustrated <p>Limitations of method used</p> <ul style="list-style-type: none"> • Unable to assess sampling method 	

	<p>Midwifery Council standards. <i>Journal of Clinical Nursing</i>, 26, 3056-3066.</p> <p>United Kingdom</p>	<p>related to practice assessment</p> <p>Study 3: self-developed questionnaire that was reviewed by three experts. Pilot test was completed on four mentors</p> <p>Descriptive statistics, Wilcoxon signed-rank test and chi-square test for quantitative data and content analysis for qualitative data</p>	<p>Study 2: Practice assessment document from 28 nursing students recruited in study 1</p> <p>Study 3: 30 sign-off mentors (SOM) working within a single acute NHS trust</p> <p>Sampling method and response rate was not specified</p>	<p>$(\chi^2 (df = 1) = 6.196, p = 0.013)$</p> <ul style="list-style-type: none"> • Only 1 student respondent had weekly meeting with SOM • 70% SOM respondents felt confident about their role • Weekly meeting with students was reported as unrealistic by SOM respondents • No reduction of clinical commitment when 70% SOM respondents mentored final placement students 	<ul style="list-style-type: none"> • Small sample size • 33% missing data in study 2 • Information about reliability and validity of questionnaire was not stated
	<p>Palese, A., Basso, F., Del Negro, E., Achil, I., Ferraresi, A., Morandini, M., Moreale, R. & Mansutti, I.</p> <p>2017.</p> <p>When are night shifts effective for nursing student clinical learning? Findings</p>	<p>Mixed-method study design</p> <p>Phase 1: survey. Self-developed questionnaires included demographic data, rating on feeling, tasks and effect perceived in working in night shift and preferred shift</p>	<p>Phase 1: 352 Nursing students from two Bachelor of Nursing Programme</p> <p>Response rate: 95.1%</p> <p>Convenience sampling</p> <p>Phase 2: 9 nursing students included in phase 1 were recruited through purposive</p>	<p>Phase 1:</p> <ul style="list-style-type: none"> • Participants felt less satisfied (44.7%), bored (23.5%) and less stressed (17.0%) and anxious (10.6%) in comparison between attending day shift and night shift but the rating was not statistically significant (P ranged from 0.114-0.744) 	<p>Strength</p> <ul style="list-style-type: none"> • Mixed method study produced rich and comprehensive data <p>Limitations of method used</p> <ul style="list-style-type: none"> • The validity and reliability of the questionnaire

	<p>from a mixed-method study design. <i>Nurse Education Today</i>, 52, 15-21.</p> <p>Italy</p>	<p>No Information about validity of questionnaire was stated</p> <p>Descriptive statistics and chi-square tests</p> <p>Phase 2: Phenomenological study. Semi-structured interview</p> <p>Content analysis</p>	<p>sampling. 5 of them attended the highest hours of night shift while 4 of them had the experience of attending night shift.</p>	<ul style="list-style-type: none"> • 3.8 tasks were performed in night shift including nursing round, non-nursing task (stock taking) and managing patients' issues • Participants developed relationship with their mentors and other clinical staff, reading guideline/ protocol and writing academic reports during the free time. <p>Phase 2 The effectiveness of clinical learning in night shift served as a continuum. Different types of tasks in night shift were categorized according to its effectiveness in clinical learning.</p>	<p>used was not stated</p> <ul style="list-style-type: none"> • Weak sampling method in phase 1 • Unable to assess sampling method in phase 2 due to lack of information
	<p>Rylance, R., Barrett, J., Sixsmith, P. & Ward, D.</p> <p>2017.</p>	<p>Evaluative study: capture the "mentor voice" across four fields of nursing practice</p> <p>Questionnaire consisted of two open-ended</p>	<p>125 stage 2 mentors from a single NHS trust</p> <p>Response rate: not specified</p>	<ul style="list-style-type: none"> • Mentor-students relationship: transfer of own knowledge, keeping own knowledge up-to-date, student attributes eg enthusiasm 	<p>Strength</p> <ul style="list-style-type: none"> • Narrative data provided detailed description of mentoring

	<p>Student nurse mentoring: an evaluative study of the mentor's perspective. <i>British Journal of Nursing</i>, 26, 405-409.</p> <p>United Kingdom</p>	<p>questions: What gives you the most satisfaction about your role as mentor? What causes most frustration?</p> <p>The development of questionnaire was not stated</p> <p>Descriptive thematic analysis</p>	<p>Sampling method was not stated</p>	<ul style="list-style-type: none"> • Clinical environment: time constraint, appropriateness of clinical location and support from colleagues and money 	<p>Limitations of method used</p> <ul style="list-style-type: none"> • The aim of this study was to describe the mentoring role from mentors' perspective instead of evaluation of mentoring • Potential sample bias: single source of population and unknown sampling method • Validity and reliability of the questionnaire was not stated
	<p>Thomson, R., Docherty, A. & Duffy, R.</p> <p>2017.</p> <p>Nursing students' experiences of mentorship in their final placement.</p>	<p>Heideggerian phenomenological study</p> <p>Unstructured interview</p> <p>Colaizzi's procedural steps</p>	<p>7 final year nursing students from on Scottish university who attended final clinical placement</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> • Being more independent • Need of support • Importance of belongingness • Expectation of feedback • Anticipatory anxiety 	<p>Strength</p> <ul style="list-style-type: none"> • Unstructured interview generated thicker data <p>Limitations of method used</p> <ul style="list-style-type: none"> • Potential sample bias: small sample

	<i>British Journal of Nursing</i> , 26, 514-521. United Kingdom				size, participants recruited from a single university <ul style="list-style-type: none"> • Not clear how data saturation was reached
Adamson, E., King, L., Foy, L., Mcleod, M., Traynor, J., Watson, W. & Gray, M. 2018. Feedback in clinical practice: Enhancing the students' experience through action research. <i>Nurse Education in Practice</i> , 31, 48-53. United Kingdom	Action research 7 interviews with student participants. Either one or two student participants were interviewed in each interview 2 focus group discussion with three to four participants including students, link lecturers and practice education facilitators (PEFs) Thematic analysis	27 nursing students in various year of study 22 mentors who received training about feedback 3 link lecturers 3 PEFs who were responsible for training of mentors Purposive sampling	<ul style="list-style-type: none"> • Feedback as shared responsibility • Relationships and explicit feedback were enabler of feedback • Impact of the feedback training project: ongoing feedback as motivator for students, increased students' confidence and increased awareness of explicit feedback 	Strength <ul style="list-style-type: none"> • Addresses the different perception and influence of feedback in mentoring Limitation of method used <ul style="list-style-type: none"> • Only one cycle of action research process was conducted 	
Jack, K., Hamshire, C., Harris, W. E., Langan, M., Barrett, N. & Wibberley, C. 2018.	Mixed method study Phase 1: online survey. Self-developed questionnaire. No other information about the questionnaire was stated	Phase 1: 1425 undergraduate nursing students Response rate: not specified	<ul style="list-style-type: none"> • Over 60% respondents felt "respected on placement" and "enjoyed" all of their placement • 59% respondents reported lack of contact 	Strength <ul style="list-style-type: none"> • The findings of unstructured interview enriched the findings of survey 	

	<p>"My mentor didn't speak to me for the first four weeks": Perceived unfairness experienced by nursing students in clinical practice settings. <i>Journal of Clinical Nursing</i>, 27, 929-938.</p> <p>United Kingdom</p>	<p>Descriptive statistics</p> <p>Phase 2: Unstructured interview</p> <p>Thematic analysis</p>	<p>Convenience sampling</p> <p>Phase 2: 22 nursing students from the sample of phase 1. Stratified sampling. The details of the sampling method was not stated</p> <p>Undergraduate Nursing students studying preregistration NHS North West Commissioned programme (from nine institutions) and those who discontinued from such programme within 12 months</p>	<p>time with mentors and being used as an extra pair of hands</p> <ul style="list-style-type: none"> • Feel like being ignored and very unsupported • Strong mentors facilitated learning in hostile clinical environment • Oppressive culture in clinical placement 	<p>Limitation of method used</p> <ul style="list-style-type: none"> • Weak sampling method in phase 1
	<p>Kaphagawani, N. C. & Useh, U. 2018.</p> <p>Clinical Supervision and Support: Exploring Pre-registration Nursing Students' Clinical Practice in Malawi.</p>	<p>Mixed method study</p> <p>Phase 1: survey</p> <p>Self-developed questionnaire</p> <p>Cronbach alpha coefficient 0.8</p> <p>One-way tVA</p>	<p>Phase 1: 590 nursing students in Malawi</p> <p>Simple random sampling method</p> <p>Response rate: 84%</p> <p>Phase 2: 144 nursing students from phase 1 participated in 16 focus</p>	<p>Phase 1</p> <ul style="list-style-type: none"> • Not all respondents (42.3%) received clinical supervision provided by either institutions or hospitals • Tendency of providing clinical supervision varied between different institutions ((F 7,582) 5.665, P<0.00A1) 	<p>Strength</p> <ul style="list-style-type: none"> • The perceived reason for not receiving clinical supervision was revealed • Strong sampling method in phase 1 <p>Limitations of method used</p>

	<p><i>Annals of Global Health</i>, 84, 100-109.</p> <p>South Africa</p>	<p>Phase 2: focus group interview</p> <p>Data analysis method was not stated</p>	<p>group interviews. Sampling method was not stated</p>	<p>and hospitals ((F3 586) 3.714, P<0.011)</p> <ul style="list-style-type: none"> • Higher satisfaction of clinical supervision in students studying RN Diploma ((x) -0.1454, p < 0.047) <p>Phase 2</p> <ul style="list-style-type: none"> • Lack of clinical teaching, guidance and support • Job insecurity and lack of remuneration • Lack of human resources and learning support • Role model and student guidance despite pressure 	<ul style="list-style-type: none"> • Details of questionnaire was not provided • Unclear about how clinical supervision was conducted in Malawi • Comparison between findings of survey did not reflected the students experience. • Unclear data analysis method in phase 2
	<p>Tuomikoski, A.-M., Ruotsalainen, H., Mikkonen, K., Miettunen, J. & Kääriäinen, M.</p> <p>2018.</p> <p>The competence of nurse mentors in</p>	<p>Cross-sectional survey</p> <p>Mentors' Competence Instrument Questionnaire</p> <p>Cronbach's alpha for each factor ranged from 0.83 to 0.94</p> <p>Online survey</p>	<p>576 mentors from all five university hospitals</p> <p>Response rate:17.2%</p> <p>Random sampling. No information about the process of randomization was stated</p>	<ul style="list-style-type: none"> • Majority of respondents rated themselves with middle-level (45%) and high level (50%) of competence • High motivation in respondents with high level of competence (P<0.01). They spent more time in mentoring 	<p>Strength</p> <ul style="list-style-type: none"> • High reliability of questionnaire <p>Limitations of method used</p> <ul style="list-style-type: none"> • Low response rate • The findings only reflect the

	<p>mentoring students in clinical practice – A cross-sectional study. <i>Nurse Education Today</i>, 71, 78-83.</p> <p>Finland</p>	<p>Questionnaire was delivered through Webropol online survey tool</p> <p>Descriptive statistics, chi-square test and Kruskal-Wallis test</p>		<p>education and evaluation discussion than respondents with lower level of competent</p>	<p>competence of mentors in Finland</p>
	<p>Bowen, L., Kable, A. & Keatinge, D.</p> <p>2019.</p> <p>Registered nurses' experience of mentoring undergraduate nursing students in a rural context: a qualitative descriptive study. <i>Contemporary Nurse: A Journal for the Australian Nursing Profession</i>, 55, 1-14.</p> <p>Australia</p>	<p>Qualitative descriptive design</p> <p>Semi-structured interview</p> <p>Content analysis</p>	<p>9 nurse mentors who mentored an undergraduate student nurse in two rural hospitals on the mid-north coast of New South Wales</p> <p>Purposive sampling</p>	<ul style="list-style-type: none"> Challenges of mentoring: communication with university, time constraints, diversity of patients' condition, heavy workload and lack of support and recognition for the role of mentor Supporting students and facilitating learning: being role model, demonstration of skill, time management and reflection on practice Supporting registered nurses: support from clinical facilitators, positive learning attitude, availability of learning opportunities, 	<p>Strength</p> <ul style="list-style-type: none"> Participants were able to provide detailed description of their mentoring experience <p>Limitation of method used</p> <ul style="list-style-type: none"> Potential sampling bias: participants were recruited from two rural hospitals

				<p>further mentorship training</p> <ul style="list-style-type: none"> • Reward of mentoring: satisfaction from improved student performance, opportunity to learn from students, expression of appreciation and feedback 	
	<p>Liang, H.-F., Wu, K.-M., Hung, C.-C., Wang, Y.-H. & Peng, N.-H. 2019. Resilience enhancement among student nurses during clinical practices: A participatory action research study. <i>Nurse Education Today</i>, 75, 22-27. Taiwan</p>	<p>Participatory action research design</p> <p>Group discussion before and during resilience enhancement (RE) project, participatory observation in the peer-led group discussion during RE project, reflective diaries, 12 semi-structured after RE project interviews</p> <p>Content analysis</p>	<p>28 senior nursing students</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Increase self-exploration about source and types of stressors before and throughout clinical placement • Improve the development of confidence and competence through • Construct resilience strategies after RE project 	<p>Strength</p> <ul style="list-style-type: none"> • Only study conducted in Chinese population <p>Limitations of method used</p> <ul style="list-style-type: none"> • Findings collected from various methods was combined • One action research cycle was completed • Only positive findings was reported

	<p>Mikkonen, K., Tomietto, M., Cicolini, G., Kaucic, B. M., Filej, B., Riklikiene, O., Juskauskienė, E., Vizcaya-Moreno, F., Pérez-Cañaveras, R. M., De Raeve, P. & Kääriäinen, M.</p> <p>2020.</p> <p>Development and testing of an evidence-based model of mentoring nursing students in clinical practice. <i>Nurse Education Today</i>, 85, 104272.</p> <p>Finland, Italy, Lithuania, Slovenia and Spain</p>	<p>Cross-sectional survey</p> <p>Modified Mentors' Competence Instrument Questionnaire</p> <p>Cronbach's alpha for each factor ranged from 0.83 to 0.94</p> <p>Online and paper-based survey</p> <ul style="list-style-type: none"> • Online questionnaire used in Finland and Spain • Paper-based questionnaire used in Lithuania, Italy and Slovenia <p>Descriptive statistics and chi-square test</p>	<p>1360 mentors working in primary and specialist healthcare organization</p> <p>Response rate: 32%</p> <p>Convenience sampling</p>	<ul style="list-style-type: none"> • Mentors' characteristic influenced the mentors' motivation (Parameter 0.71, $p < 0.001$) and reflection during mentoring (Parameter 0.54, $p < 0.001$) • Mentors' motivation influenced the reflection during mentoring (Parameter 0.32, $p < 0.001$) and mentoring practice • Mentoring practice achieved goal in mentoring (Parameter 0.61, $p < 0.001$) • Reflection during mentoring was related to provision of constructive feedback that could achieve goal in mentoring (Parameter 0.79, $p < 0.001$) • Goal-orientated mentoring enhanced students-entered evaluation (Parameter 0.79, $p < 0.001$) 	<p>Strength</p> <ul style="list-style-type: none"> • Model of mentoring in nursing was identified • High reliability of questionnaire <p>Limitations of method used</p> <ul style="list-style-type: none"> • Weak sampling method • Low response rate • The model focused on mentors only. Factors that were not related to mentor were excluded
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	<p>Mikkonen, K., Merilainen, M. & Tomietto, M. 2020 Empirical model of clinical learning environment and mentoring of culturally and linguistically diverse nursing students. <i>Journal of Clinical Nursing</i>, 29: 653-661. Finland</p>	<p>Cross-sectional correlation study Clinical Learning Environment, Supervision and Nurse Teacher (CLES+T) scale and Cultural (Overall Cronbach's alpha 0.96 and subscale ranged from 0.84-0.91) and Linguistic Diversity Scale (CALDs) (Overall Cronbach's alpha 0.89 and subscale 0.79-0.87) Chi-square test</p>	<p>187 culturally and linguistically diverse nursing students who study in English languages nursing programme The sample was selected through structural equation model. Information about the process of sample selection was not stated</p>	<ul style="list-style-type: none"> • Pedagogical atmosphere was positively related to cultural diversity ($X^2 = 0.66$, $p < 0.001$), orientation ($X^2 = 0.54$, $p < 0.001$) and role of students ($X^2 = 0.25$, $p < 0.001$) • Mentoring relationship was influenced by cultural diversity ($X^2 = 0.32$, $p < 0.001$) and orientation ($X^2 = 0.71$, $p < 0.001$) 	<p>Strength</p> <ul style="list-style-type: none"> • High reliability of questionnaire <p>Limitations of method used</p> <ul style="list-style-type: none"> • Secondary data analysis from previous study • Possible bias in selection of sample
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Literature reviews and Discussion Papers

	Name and Title	Type of review, search strategy, database used and number of included articles	Summary of Content	Strength and Limitations of the review
	<p>Omansky, G. L. 2010. Staff nurses' experiences as preceptors and mentors: An integrative review. <i>Journal of Nursing Management</i>, 18, 697-703.</p>	<p>Integrative review</p> <p>Keywords: staff nurses, student nurses, preceptors, mentor of preregistration students and clinical placement</p> <p>Year of publication: 1981- 2009 Database: ERICC, OVID, Medline, Psycinfo, Science Direct databases and CINAHL</p> <p>Number of included articles: 30 articles including 20 research studies and 10 non-research articles</p>	<ul style="list-style-type: none"> • Role ambiguity: lack of definition of preceptor role • Role conflict: conflict between preceptor role and patient care • Role overload: “mentor-overload” with clinical duty and teaching duty 	<p>Strength</p> <ul style="list-style-type: none"> • Clear strategies in selecting included literature <p>Limitation</p> <ul style="list-style-type: none"> • Confused use of concept: mentorship and preceptorship were used interchangeably
	<p>Warren, D. 2010. Facilitating pre-registration nurse learning: a mentor approach. <i>British Journal of Nursing</i>, 19, 1364-1367.</p>	<p>Narrative review</p> <p>Keywords, search strategy and database: not specified</p> <p>Number of included articles: Not specified</p>	<ul style="list-style-type: none"> • Mentor-student relationship • An effective learning environment • Interprofessional approach • Fitness to practice 	<p>Strength</p> <ul style="list-style-type: none"> • Comprehensive summary about facilitation of clinical learning <p>Limitations</p> <ul style="list-style-type: none"> • Potential bias: no information about the literature search

				<ul style="list-style-type: none"> •The information focused on mentoring in UK
	<p>Kragelund, L. 2011. The windmill of learning processes: a learning and teaching tool for student nurses and mentors. <i>Nurse Education Today</i>, 31, 54-58.</p>	<p>State-of-the-art review: “most current research in a given area or concerning a given topic” (Dochy, 2006)</p> <p>Keywords: nursing education, clinical education, learning in practice, learning processes, psychiatric nursing and mental health nursing</p> <p>Year of publication: 2002- 2004 Database: Medline, Psycinfo and CINAHL</p> <p>Number of included articles: 28 articles and types of articles were not specified</p>	<p>Four types of disjuncture of Windmill model</p> <ul style="list-style-type: none"> • Individual conscious disjuncture: awareness of non-routine situation • Individual non-conscious disjuncture: unaware of non-routine situation • Collective conscious disjuncture: awareness of situation faced by both students and mentors • Collective non-conscious disjuncture: unaware of situation faced by both students and mentors 	<p>Strength</p> <ul style="list-style-type: none"> •Logical discussion about the learning process through Windmill model <p>Limitations</p> <ul style="list-style-type: none"> •The review focused on clinical learning in mental health setting only •Potential bias: literature from limited range of year of publication (3-year period) included and literature used was not updated (2002-2004) •Insufficient evidence to support the four types of disjuncture
	<p>Wells, L. & Mcloughlin, M. 2014. Fitness to practice and feedback to students:</p>	<p>Narrative review</p>	<ul style="list-style-type: none"> • Benefit of effective feedback: enhance fitness of practice, students’ motivation and students’ self- 	<p>Strength</p> <ul style="list-style-type: none"> •Logical analysis on “failing to fail” students

	<p>A literature review. <i>Nurse Education in Practice</i>, 14, 137-141.</p>	<p>Keywords: Feedback, students, clinical placement, failing student nurse, mentors</p> <p>Year of publication: 2003-2013</p> <p>Database: OVID, AMED, EBSCOHost, CINAHL, MEDLINE and BNI</p> <p>Number of included articles: Not specified</p>	<p>esteem, successful personal and professional development of mentors</p> <ul style="list-style-type: none"> • Barrier to effective feedback: time, emotional aspects and harmful effect on mentor student relationship • Consequence of not undertaking effective feedback: incompetent student nurse enter profession, risk at professional reputation and responsibility and legal responsibility 	<p>Limitation</p> <ul style="list-style-type: none"> • Potential bias: unclear about the amount and type of literature included and publication only from UK was included
	<p>Rebeiro, G., Edward, K.-L., Chapman, R. & Evans, A. 2015. Interpersonal relationships between registered nurses and student nurses in the clinical setting—A systematic integrative review. <i>Nurse Education Today</i>, 35, 1206-1211.</p>	<p>Systematic integrative review</p> <p>Keywords: registered nurses, preceptor, buddy nurse, clinical teacher, mentor, student nurse, nursing student, interpersonal relationship</p> <p>Year of publication: 1982-2011</p> <p>Database: MEDLINE, CINAHL and OVID</p> <p>Number of included articles: 7 articles and types of articles was not specified</p>	<ul style="list-style-type: none"> • Educate and value registered nurses (RN) to mentor student nurses • Attitude of RN impact the relationship between RN and student nurses • Having time to build a relationship with student nurses 	<p>Strength</p> <ul style="list-style-type: none"> • Clear review method stated <p>Limitations</p> <ul style="list-style-type: none"> • Confused use of concept: mentorship and preceptorship were used interchangeably • Potential bias: Two included literature were outdated (from 1982 and 1995)

	<p>Elliott, C. 2016. Identifying and managing underperformance in nursing students. <i>British Journal of Nursing</i>, 25, 250-255.</p>	<p>Narrative review</p> <p>Keywords: not specified</p> <p>Year of publication: 2003-2013</p> <p>Database: British Nursing Index and CINHAL</p>	<ul style="list-style-type: none"> • Improve mentor-student relationship • Improve mentor confidence • Improve open and honest communication • Early identification of concerns 	<p>Strength</p> <ul style="list-style-type: none"> • Logical discussion about the related factors and strategies <p>Limitation</p> <ul style="list-style-type: none"> • Unclear selection criteria of literature
	<p>Helminen, K., Coco, K., Johnson, M., Turunen, H. & Tossavainen, K. 2016 Summative assessment of clinical practice of student nurses: A review of the literature. <i>International Journal of Nursing Studies</i>, 53, 308-319.</p>	<p>Narrative review</p> <p>Keywords: nursing student, clinical training, practical training, clinical placement, preceptor, competence, skill, performance appraisal, assessment, evaluation and judgement</p> <p>Year of publication: 2000-2014</p> <p>Database: CINHAL, PubMed, Medic, ISI Web of Science, Cochrane library and ERIC</p>	<ul style="list-style-type: none"> • Acts before final assessment: Orientation for clinical practice, familiarize with assessment form, different treatment environments, observation of student nurses' behaviour, mentors' attitudes and qualifications • Actual final assessment situation: provide proper assessment situation, assure relevant criteria for assessment, assign grade and fail students • Acts after the assessment situation: assure relevant documentation, extra time for failing students and support for mentors 	<p>Strength</p> <ul style="list-style-type: none"> • Clear review strategies stated <p>Limitation</p> <ul style="list-style-type: none"> • Confused use of concept: mentorship and preceptorship were used interchangeably
	<p>Bickhoff, L., Sinclair, P. M. & Levett-Jones, T. 2017</p>	<p>Narrative review</p> <p>Keywords: nursing student, clinical placement, experience and attitude</p>	<p>Students' demonstration of moral courage in clinical placement</p> <ul style="list-style-type: none"> • Just a student • Don't rock the boat 	<p>Strength</p> <ul style="list-style-type: none"> • Clear search and review strategies stated

	<p>Moral courage in undergraduate nursing students: A literature review. <i>Collegian</i>, 24, 71-83.</p>	<p>Year of publication: 2000-2014 Database: CINHAL, Psycinfo and ProQuest</p>	<ul style="list-style-type: none"> • Fear of consequences • Mentor-student relationship • Patient advocate identity 	<p>Limitation</p> <ul style="list-style-type: none"> • Only qualitative studies are included
	<p>Pramila-Savukoski, S., Juntunen, J., Tuomikoski, A. M., Kääriäinen, M., Tomietto, M., Kaučič, B. M., Filej, B., Riklikiene, O., Vizcaya-Moreno, M. F., Perez-Cañaveras, R. M., De Raeve, P. & Mikkonen, K. 2020. Mentors' self-assessed competence in mentoring nursing students in clinical practice: A systematic review of quantitative studies. <i>Journal of Clinical Nursing</i>, 29, 684-705.</p>	<p>Systematic review Keywords: Not specified Year of publication: 2000-2019 Database: CINHAL, PubMed, Scopus, ERIC and Medic databases</p>	<p>Mentors' self-assessed competence</p> <ul style="list-style-type: none"> • Satisfactory: pedagogical practices of mentors with respects, identification of students' need, student-centered feedback and evaluation, personal desire to guide students • Less satisfactory: less likely to be enabler of students in clinical placement, low motivation to mentoring, ability to use evaluation tools • <p>Thematic analysis for descriptive data</p> <ul style="list-style-type: none"> • Mentors' competence in nursing and continuous education • Support student's learning process • Clinical learning and environment and mentoring for students • Mentors' characteristics and attitudes 	<p>Strength</p> <ul style="list-style-type: none"> • Publications in seven languages were included <p>Limitation</p> <ul style="list-style-type: none"> • Summarize of quantitative data instead of synthesizing the data

Discussion papers

	Name and Title	Source and summary of Content	Strength and Limitations of the articles
	<p>Carr, J., Heggarty, H., Carr, M., Fulwood, D., Goodwin, C., Walker, W. & Whittingham, K. 2010 Reflect for success: recommendations for mentors managing failing students. <i>British Journal of Community Nursing</i>, 15, 594-596.</p>	<p>Description of reflective model</p> <p>Five patterns of knowing on managing failing students</p> <ul style="list-style-type: none"> • Empirical knowledge • Personal knowledge • Ethical knowledge • Aesthetic knowledge • Emancipatory knowledge 	<p>Strength</p> <ul style="list-style-type: none"> • Structured discussion about application of five patterns of knowing <p>Limitation</p> <ul style="list-style-type: none"> • Lack of evidence to support the application of five patterns of knowing
	<p>Hewitt, P. 2010 Nursing students on the unit: What's your role? <i>Nursing</i>, 40, 51-52.</p>	<p>Opinion</p> <p>The role of mentors included</p> <ul style="list-style-type: none"> • Friendly welcome • Share your knowledge • Inquisitive mind • Develop skills 	<p>Strength</p> <ul style="list-style-type: none"> • Structured summary about the role of mentor <p>Limitation</p> <ul style="list-style-type: none"> • Mentorship and preceptorship were used interchangeably
	<p>Barker, M., Blacow, L., Cosgrove, S., Howorth, N., Jackson, G. & McMahon, J. 2011. Implementation of 'sign-off' mentorship: different perspectives. <i>British Journal of Nursing</i>, 20, 1252-1255.</p>	<p>Description and opinion of "sign-off" mentor</p> <ul style="list-style-type: none"> • Aim of "sign-off" mentorship • Roles of "sign-off" mentor • Roles of practice education facilitators • Strength and weakness of "sign-off" mentorship • Opinions about "sign-off" mentorships from students and mentors 	<p>Strength</p> <ul style="list-style-type: none"> • Structured summary about "sign-off" mentor • Limitations • "Sign-off" mentorship is not relevant to current practice • Potential bias: unclear about the collection and selection of opinion presented
	<p>Casey, D. C. & Clark, L. 2011. Roles and responsibilities of the student nurse mentor: an</p>	<p>Description of the role of nurse mentor</p> <ul style="list-style-type: none"> • Roles and responsibilities of mentors 	<p>Strength</p> <ul style="list-style-type: none"> • Comprehensive summary about the mentorship in UK

	<p>update. <i>British Journal of Nursing</i>, 20, 933-937.</p>	<ul style="list-style-type: none"> • NMC standards for supporting learning and assessment • Support for failing students • Requirement of mentors • Benefit from mentoring students 	<p>Limitations</p> <ul style="list-style-type: none"> • The information focused on the clinical placement in UK only • “Sign-off” mentorship is not relevant to current practice
	<p>Vinales, J. J. 2015 Exploring failure to fail in pre-registration nursing. <i>British Journal of Nursing</i>, 24, 284-288.</p>	<p>Description of failure to fail students from mentors’ perspective</p> <p>Factors related to failing to fail student nurses</p> <ul style="list-style-type: none"> • Lack of confidence and experienced regardless the training received • Excess expectation • Misunderstand of standard • Not allowing time for students to improve <p>Support for mentors to fail students</p> <ul style="list-style-type: none"> • University support: clinical educators, link lecturers • Backup from NMC standard • Setting up “SMART” action plan 	<p>Strength</p> <ul style="list-style-type: none"> • Logical and comprehensive discussion about the factors related to failing to fail student nurses • Relevant strategies for these factors were provided <p>Limitation</p> <ul style="list-style-type: none"> • The discussion focused on the clinical placement in UK only
	<p>Vinales, J. J. 2015. Mentorship part 1: the role in the learning environment. <i>British Journal of Nursing</i>, 24, 50-53.</p>	<p>Description of mentoring in UK</p> <ul style="list-style-type: none"> • Mandatory requirement of mentors • Definition of mentoring • Roles and responsibilities of mentors • Characteristics of good, bad and toxic mentors • NMC standards of mentoring • Willingness to be mentor 	<p>Strength</p> <ul style="list-style-type: none"> • Comprehensive summary about mentorship in UK <p>Limitation</p> <ul style="list-style-type: none"> • Some information applied to clinical placement in UK only

	<p>Vinales, J. J. 2015. Mentorship part 2: assessing preregistration student nurses. <i>British Journal of Nursing</i>, 24, 174-177.</p>	<p>Description of assessment of clinical placement in UK</p> <ul style="list-style-type: none"> • Types of clinical assessments • Reliability and validity of clinical assessment • Format of assessments • Definition of competence • Roles of “sign-off” mentors • Record of clinical assessment • Challenge associated with clinical assessment 	<p>Strength</p> <ul style="list-style-type: none"> • Comprehensive summary about clinical assessment in UK <p>Limitation</p> <ul style="list-style-type: none"> • “Sign-off” mentorship is not relevant to the current practice
	<p>Anderson, C., Moxham, L. & Broadbent, M. 2016. Providing support to nursing students in the clinical environment: A nursing standard requirement. <i>Contemporary Nurse</i>, 52, 636-642.</p>	<p>Description and opinion of support to nursing students</p> <ul style="list-style-type: none"> • Comparison nursing standard of Australia, Canada, Finland, Ireland, New Zealand, United Kingdom and United States of America • Discussion on enablers and deterrents of mentoring 	<p>Strength</p> <ul style="list-style-type: none"> • The context of discussion covered the nursing standards from various countries <p>Limitation</p> <ul style="list-style-type: none"> • The discussion overemphasized the deterrents of mentoring
	<p>Shellenbarger, T. & Robb, M. 2016. Effective Mentoring in the Clinical Setting. <i>American Journal of Nursing</i>, 116, 64-68.</p>	<p>Description of mentoring from mentors’ perspective</p> <ul style="list-style-type: none"> • Maintain open communication: provide feedback, enhance motivation and gain confidence • Effective use of questioning: use different types of questions to enhance learning and stimulate critical thinking 	<p>Strength</p> <ul style="list-style-type: none"> • Structured and comprehensive summary about the mentoring strategies <p>Limitation</p> <ul style="list-style-type: none"> • Confusing concepts: mixed use of mentorship and preceptorship

		<ul style="list-style-type: none"> • Goal setting: identify gap and area of deficiency, set realistic goals, ensure opportunities to achieve the identified goal • Role modeling and socialization: supportive environment, make decision making process transparent • Reflection: use of debriefing • Overcome obstacles: familiarize the role of mentors and expectations • Transitioning to a professional role 	
	<p>Timmins, F., Cassidy, S., Nugent, O., Lydon, C., Part, S., Keane, L., Dennehy, C., Fenn, H., Prizeman, G., Murphy, F. & Coffey, M. 2017. Reluctance to fail nursing students in practice-implications for nurse managers. <i>Journal of Nursing Management</i> 25, 489-490.</p>	<p>Description of reluctant to fail students from mentors' perspective</p> <ul style="list-style-type: none"> • Review of previous studies about mentors who failed to fail the underperforming students • Discuss the factors of failure to fail the underperforming students • Illustrate the consequence of failing a student • Discuss the role of nurse manager in failing the underperforming students 	<p>Strength</p> <ul style="list-style-type: none"> • Logical discussion about reluctance to fail nursing students <p>Limitation</p> <ul style="list-style-type: none"> • Potential bias: Heavy self-citation of an author's articles
	<p>Foster, S. 2019. Rethinking clinical placements. <i>British Journal Nursing</i>, 28, 405.</p>	<p>Description and opinion of current clinical placement practice in UK</p> <ul style="list-style-type: none"> • Overview of the latest change in the NMC standard for student supervision and assessment 	<p>Strength</p> <ul style="list-style-type: none"> • Thorough discussion on the challenge faced by nurse leader <p>Limitation</p> <ul style="list-style-type: none"> • The discussion focused on the clinical placement in UK only

		<ul style="list-style-type: none">• Comment on the strategy to increase availability and support of clinical placement	
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Appendix 2 – Interview guide for organisers of clinical placement (English)

Interview Topic Guide: Organiser of clinical placement

The questions listed below serve as a reference to guide in the interview.

1. Introduction of interviewer and the study
 - a. Introduce the interviewer
 - b. Purpose of the study
 - c. Rights of the participants
2. Description of your daily work
 - a. Could you briefly describe your key responsibilities?
 - b. What are the key tasks of your daily work?
3. Most recent/ most memorable experiences of organising clinical placement
 - a. Could you describe what you do to organise clinical placement?
 - b. What do you like the most about organising clinical placement?
 - c. What are the challenges of organising clinical placement?
 - d. How do you deal with challenges?
4. Relationship between different parties
 - a. Could you describe the relationship between you and your student?
 - b. How do you maintain the relationship between you, student and ward staff?
 - c. Could you describe how the school/ hospital communicate with you during clinical placement?
 - d. Do you have any difficulty in communication with the school/hospital? Could you describe it if there is any?
5. Learning environment in placement
 - a. What are the main issues you encountered with you students in clinical environment?
 - b. What are the main issues you encountered when you work with the ward staff?
 - c. How the ward environments influence the mentoring?
 - d. Could you describe support provided by the school to you for mentoring?
 - e. How the supports from the school facilitate organising clinical placement?
 - f. Could you describe other support that you would like to obtain from the school/hospital?

6. Comparison between your previous perception of mentor and your current mentoring experience
 - a. Could you briefly describe your experience of being mentored as a student?
 - b. What do you think about the relationship with your mentors?
 - c. Could you describe the difference between your relationship with your mentors and your students?
 - d. How does your previous experience of being mentored influence your current experience of organising clinical placement?
7. Conclusion
 - a. Ask if there is anything related to the study that they want to discuss
 - b. Thank you for participation

Appendix 3 - Interview guide for organisers of clinical placement (Chinese)

訪問指南：統籌臨床實習相關人士

1. 簡介訪問者及是次研究
 - a. 訪問者簡介
 - b. 研究目的
 - c. 參加者權益
2. 形容一下你日常的工作
 - a. 請簡單形容一下你主要職責範圍
 - b. 哪些屬於你主要日常工作？
3. 最近一次/印象最深刻的統籌臨床實習經驗
 - a. 請你形容一下怎樣統籌臨床實習？
 - b. 你認為怎樣統籌臨床實習是最好的？
 - c. 統籌臨床實習時會遇到哪些困難？
 - d. 你是如果處理哪些困難？
4. 與不同機構及相關人士的關係
 - a. 請你形容一下與學生的關係
 - b. 你是如何維持與學生及病房同事的關係？
 - c. 請你形容一下在實習期間你是怎樣與院校/醫院溝通？
 - d. 你與院校/醫院進行溝通時有遇到困難嗎？如有，請形容一下遇到什麼困難。
5. 實習期間的學習環境
 - a. 你的學生在臨床中會遇到哪些主要問題？
 - b. 你與病房同事工作時會遇到哪些問題？
 - c. 臨床環境怎樣影響帶教？
 - d. 請你形容一下院校在帶教過程中會為你帶來什麼支援？
 - e. 院校提供的支援怎樣幫助你統籌臨床實習？
 - f. 請你形容一下你希望院校/醫院提供哪些其他的支援？
6. 比較你對以前帶教導師的印象與你現在帶教的經驗
 - a. 請你形容一下你作為學生時接受帶教的經驗
 - b. 你認為你與帶教導師有關係如何？
 - c. 請你形容一下你與你的帶教導師的關係及你與你的學生的關係有何分別
 - d. 你之前接受帶教的經驗如何影響你現時統籌臨床實習？
7. 總結
 - a. 詢問受訪者有否其他與是次研究相關議題需要討論
 - b. 感謝參加是次面談

Appendix 4- Interview guide for clinical instructors and clinical mentors (English)

Interview Topic Guide: Clinical instructors and clinical mentors

The questions listed below serve as a reference to guide in the interview.

1. Introduction of interviewer and the study
 - a. Introduce the interviewer
 - b. Purpose of the study
 - c. Rights of the participants
2. Description of your daily work
 - a. Could you briefly describe your key responsibilities?
 - b. What are the key tasks of your daily work?
3. Most recent/ most memorable mentoring experiences of student nurses
 - a. Could you describe what you do in a day of mentoring?
 - b. What do you like the most about mentoring?
 - c. What are the challenges of mentoring?
 - d. How do you deal with challenges?
4. Relationship between different parties
 - a. Could you describe the relationship between you and your student?
 - b. How do you maintain the relationship between you, student and ward staff?
 - c. Could you describe how the school communicate with you during clinical placement?
 - d. Do you have any difficulty in communication with the school/hospital? Could you describe it if there is any?
5. Learning environment in placement
 - a. What are the main issues you encountered with you students in clinical environment?
 - b. What are the main issues you encountered when you work with the ward staff?
 - c. How the ward environments influence the mentoring?
 - d. Could you describe support provided by the school/hospital to you for mentoring?
 - e. How the supports from the school facilitate mentoring?

- f. Could you describe other support that you would like to obtain from the school/hospital?
- 6. Comparison between your previous perception of mentor and your current mentoring experience
 - a. Could you briefly describe your experience of being mentored as a student?
 - b. What do you think about the relationship with your mentors?
 - c. Could you describe the difference between your relationship with your mentors and your students?
 - d. How does your previous experience of being mentored influence your current experience of mentoring?
- 7. Conclusion
 - a. Ask if there is anything related to the study that they want to discuss
 - b. Thank you for participation

Appendix 5 - Interview guide for clinical instructors and clinical mentors (Chinese)

訪問指南：帶教導師

1. 簡介訪問者及是次研究
 - a. 訪問者簡介
 - b. 研究目的
 - c. 參加者權益
2. 形容一下你日常的工作
 - a. 請簡單形容一下你主要職責範圍
 - b. 哪些屬於你主要日常工作？
3. 最近一次/印象最深刻的護士學生帶教經驗
 - a. 請你形容一下怎樣帶教的一天會做什麼？
 - b. 你認為怎樣進行帶教是最好的？
 - c. 帶教時會遇到哪些困難？
 - d. 你是如果處理哪些困難？
4. 與不同機構及相關人士的關係
 - a. 請你形容一下與學生的關係
 - b. 你是如何維持與學生及病房同事的關係？
 - c. 請你形容一下在實習期間你是怎樣與院校/醫院溝通？
 - d. 你與院校/醫院進行溝通時有遇到困難嗎？如有，請形容一下遇到什麼困難。
5. 實習期間的學習環境
 - a. 你的學生在臨床中會遇到哪些主要問題？
 - b. 你與病房同事工作時會遇到哪些問題？
 - c. 臨床環境怎樣影響帶教？
 - d. 請你形容一下院校在帶教過程中會為你帶來什麼支援
 - e. 院校/醫院提供的支援怎樣幫助你進行帶教？
 - f. 請你形容一下你希望院校/醫院提供哪些其他的支援？
6. 比較你對以前帶教導師的印象與你現在帶教的經驗
 - a. 請你形容一下你作為學生時接受帶教的經驗
 - b. 你認為你與帶教導師有關係如何？
 - c. 請你形容一下你與你的帶教導師的關係及你與你的學生的關係有何分別
 - d. 你之前接受帶教的經驗如何影響你現時進行帶教？
7. 總結
 - a. 詢問受訪者有否其他與是次研究相關議題需要討論
 - b. 感謝參加是次面談

Appendix 6 - Interview guide for students (English)

Interview Topic Guide: Nursing students

The questions listed below serve as a reference to guide in the interview.

1. Introduction of interviewer and the study
 - a. Introduce the interviewer
 - b. Purpose of the study
 - c. Rights of the participants
2. Description of student role in clinical placement
 - a. Could you briefly describe your role in clinical placement?
 - b. What are the key tasks you need to achieve in clinical placement?
3. Most recent/ most memorable experiences of clinical placement
 - a. Could you describe what you do in a day during clinical placement?
 - b. What do you like the most about clinical placement?
 - c. What are the challenges of clinical placement?
 - d. How do you deal with challenges?
4. Relationship between different parties
 - a. Could you describe the relationship between you and your mentor?
 - b. How do you maintain the relationship between you, mentor and ward staff?
 - c. Could you describe how your school/hospital communicate with you during clinical placement?
 - d. Do you have any difficulty in communication with your school? Could you describe it if there is any?
5. Learning environment in placement
 - a. How do the ward environments influence your clinical placement?
 - b. What do you like the most about the ward environments during your clinical placement?
 - c. How do the ward environments make your clinical placement difficult?
 - d. Could you describe how the ward environments would help clinical placement?
 - e. How do your school/hospital help you during the clinical placement?
 - f. Could you describe other support that you would like to obtain from your school/hospital?

6. Conclusion

- a. Ask if there is anything related to the study that they want to discuss
- b. Thank you for participation

Appendix 7 - Interview guide for students (Chinese)

訪問指南：護士學生

1. 簡介訪問者及是次研究
 - a. 訪問者簡介
 - b. 研究目的
 - c. 參加者權益
2. 形容一下你在臨床實習中的角色
 - a. 請簡單形容一下你在臨床實習中的角色
 - b. 哪些工作你需要在臨床實習中完全？
3. 最近一次/印象最深刻的臨床實習經驗
 - a. 請你形容一下怎樣臨床實習的一天會做什麼？
 - b. 你認為怎樣的臨床實習是最好的？
 - c. 進行臨床實習時會遇到哪些困難？
 - d. 你是如果處理哪些困難？
4. 與不同機構及相關人士的關係
 - a. 請你形容一下與帶教導師的關係
 - b. 你是如何維持與帶教導師及病房同事的關係？
 - c. 請你形容一下在實習期間你是怎樣與院校/醫院溝通？
 - d. 你與院校/醫院進行溝通時有遇到困難嗎？如有，請形容一下遇到什麼困難。
5. 實習期間的學習環境
 - a. 病房環境如何影響你的臨床實習？
 - b. 你認為在臨床實習期間怎樣的病房環境是最好的？
 - c. 病房環境怎樣令你的病房環境實司更困難？
 - d. 請你形容一下病房環境如何幫助你進行臨床實習
 - e. 院校/醫院提供的支援怎樣幫助你進行臨床實習？
 - f. 請你形容一下你希望院校/醫院提供哪些其他的支援？
6. 總結
 - a. 詢問受訪者有否其他與是次研究相關議題需要討論
 - b. 感謝參加是次面談

Appendix 8 - Participation information sheet (English)

MANCHESTER
1824

The University
of Manchester

A study of positive and negative experiences of supervisory relationships in clinical nurse education placements in Hong Kong

Participant Information Sheet

You are being invited to take part in a student research study for PhD Nursing. This research study aims at exploring the supervisory relationship between nursing students and clinical mentors. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

Ms Fung Pui Ling, Bell
PhD student in School of Nursing, Midwifery and Social Work
The University of Manchester

What is the purpose of the research?

Nursing education involves classroom teaching and clinical teaching. Clinical teaching involves education within a workplace. Literatures reported that supervisory relationship between clinical mentors and nursing students may affect the process of supervision. The literatures also suggested that supervisory relationship could be affected by the personality of clinical mentor and nursing students, culture and environment. There was limited literature exploring how the clinical mentors/nursing students manage the supervisory relationship. Besides, most of these studies were conducted in western countries. These findings were unable to apply to the situation in Hong Kong as the clinical environment and the culture were different. Hence, this study will provide an explanation for the interaction within the supervisory relationship of clinical placement in Hong Kong. The findings of this study are important to clinical mentors in improve their current practice in managing the supervisory relationship. The nursing educators and management of the clinical setting could also adjust the clinical placement arrangement and guidelines based on the findings to enhance the mentor training and facilitate the clinical placement.

Why have I been chosen?

You have been chosen because we are interested in finding out about the supervisory relationship encountered by clinical mentors and nursing students during the clinical placement. We will recruit nursing students, clinical mentors, the organizers of clinical placement in order to build up a picture of the supervisory relationship encountered in the supervision process. There will be around thirty participants recruited to be involved in this study.

What would I be asked to do if I took part?

If you decide to take part, you will be invited to take part in the interview to share your experiences of clinical nurse education. You will be asked to fill in a form about yourself which will include detail such as your education level, working experience and so on. The researcher will start the interview afterwards. The interview will be audio-recorded. The researcher may also write some notes during the interview. You will be asked some questions about the experience related to supervisory

relationship during clinical placement. The researcher may discuss about the positive and not so positive experiences you have had during clinical placement. You can have a choice to refuse to answer any questions that you don't want to. The interview will be like a guided conversation and should last about an hour or so.

What happens to the data collected?

The audio-recording of your interview will be typed into documents. The researcher will analyse both the audio-recording and documents.

How is confidentiality maintained?

We will ensure confidentiality in a number of ways. Your information will be kept in a locked drawer in a locked office and will only be seen by the research team. Your transcript will have only a code number known to the research team. Your identity will not be shown in any report or publication. The research team will be the only personnel that have access to your identity. The transcripts will be kept in an encrypted laptop. The encrypted laptop and related documents will be locked in the cabinet. After the research study is completed, the data will be kept for five years. The documents will be destroyed by paper shredder and the encrypted files will be deleted after five years. However, there are conditions that the confidentiality may be breached. If there is a risk of harm to self or others or if there is a risk that causes concern about reportable professional misconduct, this may need to be disclosed as part of a safeguarding process. The researcher will discuss with you if the incident may require disclosure.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw until the point of publication without giving a reason and without detriment to yourself.

Will I be paid for participating in the research?

No, you will not be paid for participation in the research.

What is the duration of the research?

You are invited to take part in an initial interview. The researcher will analyse the information obtained from the interview. There may be possibility that the researcher may want to clarify these information. She may also ask for consent to have follow-up interview. Each interview will be about 1 hour.

Where will the research be conducted?

The interview will be conducted in the premise of The Open University of Hong Kong or other private venue suitable for you.

Will the outcomes of the research be published?

The findings from this study will be published in professional and academic journals. The findings may also be presented at conferences. At all times your confidentiality will be maintained.

Who has reviewed the research project?

This research study has been reviewed by the University of Manchester Research Ethics Committee.

What if something goes wrong?

If you have any concerns about this study, you should contact the researcher. The researcher will try her best to answer your questions.

What if I want to complain?

If there are any issues regarding this research you should contact the researcher in the first instance *Ms Fung Pui Ling, Bell, Room E1118, OUHK Jubilee College, 81 Chung Hau Street, Homantin, Kowloon, Hong Kong, by emailing: puling.fung@manchester.ac.uk or by telephoning +852 3120 2634.*

However, if you would prefer not to discuss with members of the research team, please contact *Dr. Moria Attree, Jean McFarlane Building, Room 5.343, University Place, Oxford Road, Manchester, M13 9PL*, by emailing: Moira.J.Attree@manchester.ac.uk or by telephoning +44 (0)161 306 7630.

If you wish to make a formal complaint about the conduct of the research you can contact a Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674 or 275 8093

How can I contact you?

You can contact researcher, Ms Fung Pui Ling, Bell through below methods.

Address: Room E1118, OUHK Jubilee College, 81 Chung Hau Street, Homantin, Kowloon, Hong Kong

Email: puling.fung@manchester.ac.uk

Telephone: +852 3120 2634.

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC ref. no. 16135].

關於香港臨床護理教育中的監督關係中的正面及負面經驗

研究簡介

你被邀請參與一個護理哲學博士學生的研究。是次研究的目的是希望探討臨床帶教老師與護士學生的監督關係。在決定參與是次研究之前，你需要明白有關此研究之細節。請細心閱讀以下簡介。有需要時請與其他人進行討論。若有不清楚的地方或需要更多資訊，請向研究員詢問。無論你最後要不要參與是次研究，請花點考慮會否參與本研究。感謝你閱讀本簡介。

誰在進行此研究？

馮珮鈴小姐
曼徹斯特大學護理、助產士及社會工作學院哲學博士學生

是次研究的目的是什麼？

護理教育包含課室教學及臨床教學。臨床教學擁有在工作空間中進行教育的意義。研究指出臨床帶教老師與護士學生的監督關係可能會影響監督的過程。某些研究亦建議監督關係可能會受臨床帶教老師及護士學生的性格、文化及環境所影響。現今對於如何處理監督關係的文獻不多，而且大部分研究都集中於西方國家。這些研究結果未必能夠應用於香港的臨床環境及文化。因此，希望透過是次研究找在香港臨床實習中出監督關係中的互動，從而解釋臨床帶教老師及護士學生如何處理監督關係。是次研究結果將會對如何改善現今監督關係有所幫助。護理教育人員及臨床管理層亦可以因此調整臨床實習的安排及指引，令帶教訓練改善並使臨床實習更完善。

為什麼我會被選中？

你被選中是因為我們有興趣探討臨床帶教老師及護士學生在實習過程中的監督關係。因此，我們會邀請護士學生、臨床帶教老師及臨床實習的策劃人。我們希望透過面談更了解監督過程中的各種關係。整個研究大概邀請三十人。

如果我參加這個研究，我會被要求做些什麼？

如果你決定參與是次研究，你會被邀請參與面談，並分享你在臨床護理教育中的經驗。你會被要求填寫一份關於你個人資料的表格，包括：你的教育程度、工作經驗等。之後研究員會開始進行面談。面談的過程會進行錄音，而研究員亦會在面談中記錄一些事情。你會被問及臨床實習中監督關係。研究員可能會跟你談論一些正面及一些較負面的臨床實習經驗。你有權拒絕任何你不想回答的問題。研究員會引導你以聊天的方式進行面談。整個過程大概歷時一小時。

資料是怎樣收集？

你的面談錄音會被轉化成抄本。研究員會以面談錄音及面談的抄本進行分析。

怎樣將資料保密？

我們會以幾種方法將資料保密。你的資料會貯儲在一個上鎖的辦公室中的已上鎖的抽屜內，而只有這個研究團隊能夠接觸你的資料。你的身份會以一個編號代表，而研究團隊只會知道這個編號。你的身份亦不會出現於任何報告或期刊中。已保密的手提電腦及相關文件會貯放在已上鎖的抽屜內。當研究完成後，資料會保留五年。所有文件將會在五年後以碎紙機銷毀，而電腦檔案亦會被刪除。不過，保密情況可能因某些原因而解除。當出現任何相害自身或他人的風險，或出現需要呈報的專業失德時，研究員可能需要向相關單位呈報以保障。若出現需要呈報事件時，研究員會與你討論。

如果我改變說法或我不想再參與是次研究，我可以怎樣做？

你參與是次研究完全是基於個人決定。如果你決定參加這次研究，你會收到此研究簡介及請你簽署同意書。如果你已經決定，你亦可以不用提供任何理由或不受任何影響隨時離開這個研究。

我會因為今次研究收到報酬嗎？

不會。你將不會因為參與是研究而得到報酬。

是次研究需時多久？

你會被邀請進行首次面談。研究員會對從面談中得到的資料進行分析。研究員可能會要求再次會面以進一步了解。每次面談大約歷時一小時。

是次研究 將在這裡進行？

面談將會在香港公開大學內進行。

研究結果會在這裡公佈？

研究結果將會在專業及學術期刊內公佈。研究結果亦可能會在研討會上公佈。儘管如此，你的身份亦會保密。

誰會對是次研究進行評審？

曼撒斯特大學研究道德委員會已經通過是次研究的評審。

如果我對是次研究有疑問，我可以怎樣聯絡？

你可以與研究員聯絡。研究員會盡力解答你的問題。

如果我想作出投訴，我可以怎樣做？

若你在進行研究過 I 中有任何疑問，你可以先與研究員馮珮鈴小姐聯絡。

地址：香港九龍何文田忠孝街 81 號公開大學銀禧學院 E 座 1118 室

電郵：puling.fung@manchester.ac.uk

電話：+852 3120 2634.

若我不希望與研究員談論該事情，你可以與 *Dr. Moria Attree* 聯絡。

地址：Jean McFarlane Building, Room 5.343, University Place, Oxford Road, Manchester, M13 9PL

電郵：Moira.J.Atree@manchester.ac.uk

電話：+44 (0)161 306 7630.

若你希望對此研究操守作正式投訴，你可以與 Governance and Integrity Manager 聯絡
地址：Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL
電郵：research.complaints@manchester.ac.uk
電話：0161 2752674 或 275 8093

我可以怎樣聯絡研究員？

你可以用以下方法研究員馮珮鈴小姐。
地址：香港九龍何文田忠孝街 81 號公開大學銀禧學院 E 座 1118 室
電郵：puling.fung@manchester.ac.uk
電話：+852 3120 2634

曼撒斯特大學研究道德委員會已批准此研究計劃 [UREC ref. no. 16135].

Appendix 10 – Demographic data collection sheet: organisers of clinical placement

Demographic data sheet (Organiser of the clinical placement)

Participant number _____ Date _____

Sex

Female _____ Male _____

What is your age?

21-30 _____ 31-40 _____ 41-50 _____ 51-60 _____

How many years post registration experience you have? _____

Which type of pre-registration nursing education you have completed?

Vocational training _____ Higher diploma _____ Bachelor degree _____

Have you received any training after registration? If yes, what was the training?

Which specialty do you work in?

How many times have you involved in organising the clinical placement? _____

Appendix 11- Demographic data collection sheet: clinical instructors and clinical mentors

Demographic data sheet (Clinical instructor/ clinical mentor)

Participant number _____ Date _____

Sex

Female _____ Male _____

What is your age?

21-30 _____ 31-40 _____ 41-50 _____ 51-60 _____

How many years post registration experience you have? _____

Which type of pre-registration nursing education you have completed?

Vocational training _____ Higher diploma _____ Bachelor degree _____

Have you received any training after registration? If yes, what was the training?

Which specialty do you work in?

How many students have you mentored?

Appendix 12- Demographic data collection sheet: students

Demographic data sheet (Nursing student)

Participant number _____ Date _____

Sex

Female _____ Male _____

What is your age?

17-20 _____ 21-30 _____ 31-40 _____ 41-50 _____ 51-60 _____

Year of study in this nursing programme _____

How many clinical placements you have had? _____

Which clinical areas you have had your clinical placement?

Appendix 13 - Sample of a memo

Reflection from interview of M3

Background of M3

M3 is a clinical instructor of a university. M3 was very experienced nurse. She was an advanced practice nurse in one of Hospital Authority hospital and also a wound specialist. She has worked as clinical mentor and clinical instructor for many years. She was responsible for mentoring the students from both the Higher Diploma in Nursing and Bachelor of Nursing.

Impression to M3

M3 has a strong traditional Chinese value in her mind. She is also a straight forward person. She is also a pragmatic person.

Summary of the interview

Gatekeeper of the nursing profession

M3 believed that clinical instructor should act like a gatekeeper for the nursing profession. Assessment is a mean to identify students who fail to meet the standard. M3 will try to identify the weakness of the students and fail the one who was unable to meet the standard. It will help to maintain the quality of the nursing profession.

Blame to improve performance

M3 believed that different level of blame could help the students to improve. She may blame the student privately when the student first made mistakes. If the student made the same mistake persistently, she will blame the student in front of others. It serve as a warning to other students. Blame also served as a sign that M3 had done her job.

Subjective judgements in assessment

M3 included some subjective judgements during the assessment. For example, she thought that students should consist of character of nurse. When the student did not have such character, she would find a way to fail this type of students.

Personality

M3 claimed that she was a shy person. She reported that she did not have close relationship with her previous mentors or colleagues. She claimed that she was not comfortable to build up close relationship. In comparison with the interview of M2, M3 emphasized less about interpersonal skill in mentoring

Be Open-minded to students' comment

It could help to manage the relationship with the students. M3 reported that she gave wrong information at a time. She would apologize to the students and tell the students about the right information after confirmation. M3 seems to put herself in a higher position than students. Being open-minded or act humbly is a gesture of building up relationship. However, she felt upset when she handled the challenge by the students.

Difference between clinical mentors and clinical instructors

As M3 had experience as clinical mentor and clinical instructor, she felt that clinical mentor is more task orientated. Clinical mentors focus more on the skill and try to help the students to complete the assessment and clinical placement. After she became the clinical instructor, she put more focus on the knowledge.

Discussion as a mean to knowledge consolidation

In order to help the students to consolidate the knowledge, M3 asked the students to participate in the discussion. She expected the students to search for information first instead of providing the answer. When students put effort in exploration, it helps to consolidate the impression of knowledge. It is consistent with the previous interviews.

Relationship with the ward

Relationship with the ward helps to facilitate the clinical instructors to obtain more learning opportunity and quality of practice. Good relationship with ward helps to get more chance of practice. When the clinical instructors have better relationship with ward staffs, the ward staffs may give some reminders or tips of practice to facilitate the practice in placement. It is also reported by S1 in the later interview.

Students as tool of mentoring

M3 may involve the students in her group mentoring. For example, she asked the active student to motivate the passive students. She also asked some students for comment about the performance of their partner.

Meaning of poor performance

From the wordings used by M3, poor performance or failed in assessment could be described as "death of the student". It seems that good performance or passing the performance are the purpose of mentoring or clinical practicum.

Area that needed to be further explore

Purpose of assessment

Purpose of mentoring

Expectation of students

Appendix 14 - Ethical approval of the University of Manchester

The University
of Manchester



Ref: *ethics/16135*

Dr Speed
Room 6.325, Jean McFarlane Building
University Place
Oxford Road

18 May 2016

Research Governance, Ethics and Integrity
2nd Floor Christie Building
The University of Manchester
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Dear Dr Speed,

Study title: A study of positive and negative experiences of supervisory relationships in clinical nurse education placements in Hong Kong

Research Ethics Committee 4

I write to thank you and Dr Moira Attree for coming to meet the Committee on 13 April 2016. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

This approval is effective for a period of five years. If the project continues beyond that period an application for amendment must be submitted for review. Likewise, any proposed changes to the way the research is conducted must be approved via the amendment process (see below). Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. [Amendments](#)
2. [Breaches and adverse events](#)
3. [Notification of Progress/End of the Study](#)

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a feedback sheet [UREC4 feedback](#)

We hope the research goes well.

Yours sincerely,

A handwritten signature in black ink, appearing to read "K Lythe".

Karen Lythe
Secretary to University Research Ethics Committee 4

Appendix 15 - Informed consent form (English)

Version 6
Date 12/05/2016

APPENDIX B

The University
of Manchester

MANCHESTER
1824

A study of positive and negative experiences of supervisory relationships in clinical nurse education placements in Hong Kong

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

Please initial box

1.	I confirm that I have read the information sheet (Version 6, Date 12/05/2016) about the study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2.	I understand that my participation in the study is voluntary and that I am free to withdraw at any time (from interview up until the point of publication) without giving a reason and without detriment to my service/self.	
3.	I understand that my data will remain confidential.	
4.	I understand that the interviews will be audio-recorded, transcribed, and made anonymous before the interviewed is analysed.	
5.	I know that it will not be possible to identify any individual respondent in the study report, including myself.	
6.	I agree to the use of anonymous quotes.	
7.	I agree that my identity may be disclosed when mal practice is identified from the interview.	

I agree to take part in the study

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher	Date	Signature
_____	_____	_____

This Project Has Been Approved by the University of Manchester's Research Ethics Committee [UREC ref. no. 16135].

Appendix 16 - Informed consent form (Chinese)

Version 6
Date 12/05/2016

APPENDIX B

MANCHESTER
1824

The University
of Manchester

關於香港臨床護理教育中的監督關係中的正面及負面經驗

同意書

如果你同意參與是次研究，請完成同簽署以下同意書。

請簽署以下每一項

1.	我確認我已經閱讀有關本研究計劃的簡介 (Version 6, Date 12/05/2016)。我有機會思考研究的資料，並向研究員提出詢問。研究員亦會提供滿意答案。	
2.	我明白我是自願參與是次研究。我知道我可以在任何時間自由退出是次研究 (從開始面談至研究結果已經發表)。我不需要提供任何解釋，亦不會對我個人有任何影響。	
3.	我明白我的資料將會被保密。	
4.	我明白面談將會被錄音及轉抄成文字。在進行分析前，所有與個人相關資料將會變成匿名。	
5.	我知道沒有人能夠從研究報告中辨認出任何參與者，包括我在內。	
6.	我同意研究員以匿名方式引用我的語錄。	
7.	我同意當面談中發現舞弊時，我的身份可能會被透露。	

我同意參與本研究。

參加者姓名

日期

簽署

研究員姓名

日期

簽署

曼徹斯特大學研究道德委員會已批准此研究計劃 [UREC ref. no. 16135].

Appendix 17 - Disclosure protocol

Disclosure policy _____

Participant number _____ Date _____

Assessment of disclosure

Did the participant report any of the following incidents? Yes/no

- (1) Danger or risk to health and safety of the participants or related parties
- (2) Issue related to misconduct. For example, unprofessional attitudes or behaviour

If yes:

- (1) Inform supervisors about the incidents and discuss the need of disclosure. The decision of disclosure should be based on the following principals.
 - i. Prevention of serious harm, including physical and psychological harm
 - ii. Prevention, detection or prosecution of serious crime
 - iii. Public interest

If yes:

Explain: Our policy have to ensure the health and safety of participants and related parties.

- (1) Ask for consent for disclosure from the participants (The researcher will override the consent when the incident may cause either serious harm to individual or serious crime).
- (2) Discuss with the participant
 - i. The reasons for disclose the information
 - ii. The effect of disclosure or non-disclosure
 - iii. The proposed recipient of the disclosure
 - iv. The need to disclose the confidential information
 - v. The urgency of the decision

If the incident requires disclose,

- (1) Inform the Head of Division of Nursing and Health Studies if the incident is related to nursing students and university employed clinical mentors
- (2) Inform the Head of Division of Nursing and Health Studies and report to respective Hospital Chief Executive if the incident is related to hospital employed clinical mentors.

Follow up:

- (1) Record details of the disclosure, including the details of the incidents, people involved, reason of disclosure and procedure of disclosure made.
- (2) Inform the supervisor and report to the committee at the conclusion of the study.

Appendix 18 – Distress protocol

Distress policy Adapted from the University of Manchester Central Policy

Participant number _____ Date _____

Administer 1st mood rating

Has interview been curtailed because the participant became distressed? Yes/no

If yes:

Ask: Comments or questions about the study? How is the participant feeling? Is their mood at normal levels?

Explain: Our policy is not to send participants away from an experiment feeling unhappy.

Administer 2nd mood rating. Had the participant indicated they are unhappy (levels 8-9), anxious (levels 1-2), or despondent (levels 1-2)? Yes/no

If yes: is this lower than their 1st mood rating? Yes/no

If yes:

- (1) Ask the participants how they are feeling, listen with empathy
- (2) Offer participant magazines and a hot drink
- (3) Return after 10-15 minutes and ask the participant to complete the mood scale again.

Administer 3rd mood rating. Had the participant indicated they are unhappy (levels 8-9), anxious (levels 1-2), or despondent (levels 1-2)? Yes/no

If yes: is this lower than their 1st mood rating? Yes/no

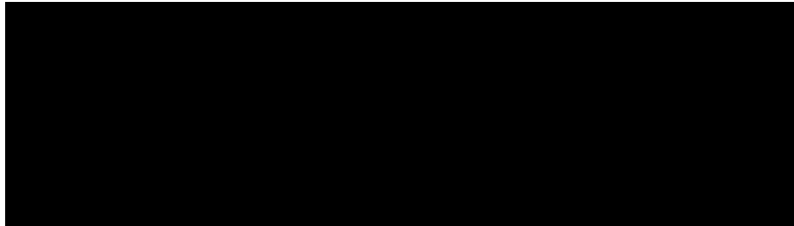
If yes:

- (1) Give participants a copy of the PIS and contact number of counsellor.
- (2) Invite participants to talk about their concerns or low mood to the interviewer.
- (3) Invite the participant to give you their phone number, explaining you will ring the next day to check how they are doing.

Follow up:

- (1) Ring the participant the next day and check how they are doing. If they are in a low mood that they attribute to the study, suggest that they see counsellor
- (2) If the participant wants to leave:
 - (i) Invite them to remain in the room until their mood returns to baseline.
 - (ii) If they wish to leave, offer to accompany them to the bus stop and pay their bus fare home.
- (3) *Inform the supervisors and report to the committee at the conclusion of the study.*
- (4) Ring the participant after 2 weeks. If they are in a low mood that they attribute to the study, suggest that they see counsellor.

Appendix 19 - Sample of assessment form of mandatory clinical assessment



Bachelor of Nursing with Honours in General Health Care Programme

Clinical Assessment : Aseptic Technique

(Perform a nursing procedure involving aseptic technique to a client)

Clinical Practicum : III

Clinical Practicum : IV

Name of Student : _____ Student ID: _____ Year of Intake: _____
 Hospital : _____ Ward : _____ Date of Assessment : _____

Aseptic Technique Procedure Assessed :

 Client's Diagnosis and Condition :

Item	Performance		
	Pass	Fail	Comment
Perform Assessment	[Redacted]		
• Confirm with doctor's prescription (if appropriate) #			
• Assess client's conditions #			
• Identify client #			
• Prepare equipment #			

Assessment Item	Performance		
	Pass	Fail	Comment
Perform Hand Hygiene whenever appropriate #	[Redacted]		
Prepare Client #			
Perform Aseptic Technique			
• Comply with aseptic technique principles #			
• Ensure safety in performing the procedure #			
Perform After Care			
• Client			
• Clinical waste / equipment #			
• Environment			
Observation, Documentation and Report #			
Professional Behaviour and Attitude			

#Critical Item

Assessment Result : [Redacted] Pass [Redacted] Fail

Comments (If appropriate) :

Clinical Assessor's Signature : [Redacted] Clinical Assessor's Name : [Redacted]

Student's Signature : [Redacted]

Remark

(1) 「 Fail 」 : Failed in any "critical item", or failed in more than 50% of the assessment items (i.e. 7 items).