Received: September 21, 2025 Accepted: November 23, 2025

REVIEW OF THE LITERATURE

Equity-Oriented Mentorship for Internationally Educated Nurses: A Rapid Review

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Journal of the Society of Internationally Educated Nurses, Vol. 2(1), 1 | 2025
DOI: https://doi.org/10.31542/kvekym90 | © 2025 under CC BY-NC | ISSN 2819-6481

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DOI: https://doi.org/10.31542/kvekym90 | ISSN 2819-6481

Abstract:

Internationally educated nurses (IENs) represent a critical proportion of the global nursing workforce and are central to addressing current and projected shortages. While mentorship is widely recognized as a facilitator of workforce integration, much of the existing literature has treated it as symbolic support rather than as equity-oriented infrastructure. This review examines how mentorship for IENs has been designed, implemented, and evaluated, with particular attention to equity, diversity, and inclusion (EDI) considerations.

We conducted a rapid review following Joanna Briggs Institute guidance and reported according to PRISMA standards. Searches of peer-reviewed and grey literature from 2010 to 2025 identified 51 relevant sources, including empirical studies, program evaluations, and policy reports. Data were extracted and synthesized thematically, with attention to micro-level (identity and lived experience), meso-level (organizational and regulatory structures), and contextual (mentorship models and design) factors.

Findings demonstrate that while mentorship is consistently valued by IENs and employers, most programs lack sustained equity-oriented design features. Effective initiatives included culturally congruent mentor–mentee pairing, structured orientation supports, protected time for mentors, and organizational accountability mechanisms. Programs situated within multi-stakeholder partnerships and supported by explicit equity frameworks were associated with stronger integration outcomes, including increased retention, reduced professional isolation, and enhanced career satisfaction. However, mentorship was often undermined by systemic barriers such as licensure delays, underemployment, and racialized power dynamics.

Mentorship has significant potential to serve as an equity-oriented strategy for IEN workforce integration and retention. For mentorship to move beyond symbolic support, programs must be embedded in organizational policy, resourced adequately, and evaluated against equity-focused outcomes. This review contributes actionable principles for designing and sustaining mentorship that recognizes the intersectional realities of IENs, advancing both workforce stability and justice in nursing.

Keywords: Internationally Educated Nurses, Mentorship, Equity, Diversity, Inclusion, Workforce Integration, Nurse Retention, Rapid Review

Introduction

The global nursing workforce is approaching a critical inflection point. The World Health Organization (WHO) projects a deficit of 4.5 million nurses by 2030, a gap exacerbated by pandemic-related burnout, population ageing, and increased service complexity (WHO, 2024). In response, high-income countries such as Canada, have intensified recruitment efforts targeting internationally educated nurses (IENs) to mitigate this shortage and sustain healthcare delivery (Health Canada, 2024; Registered Nurses of Ontario [RNAO], 2024). In Canada, several provincial health authorities sent hiring delegations to the Philippines, Middle East, and Francophone countries, including Tunisia, Cameroon, Morocco, Algeria, Lebanon and Haiti, and recruited a few thousand IENs to address the staffing shortages in their respective jurisdictions (Dubois, 2023; Froese, 2023; Giguère, 2023; Government of Alberta, 2023; Government of Manitoba, 2023; Government of Saskatchewan, 2023; Pauls, 2023; Saskatchewan Health Authority, n.d.)

However, recruitment without robust retention strategies offers limited effectiveness. Many IENs navigating the Canadian healthcare landscape encounter extensive licensure delays, complex bureaucratic procedures, and significant financial burdens (Hawkins & Rodney, 2015; Primeau et al., 2021; Salami et al., 2018). These challenges are compounded by profound cultural and linguistic dissonance, along with pervasive experiences of overt and covert racism within healthcare organizations, resulting in significant distress, professional isolation, and marginalisation (Randall & De Gagne, 2023; Bélanger-Hardy et al., 2023). Such structural barriers precipitate professional deskilling, characterized by employment in roles below their professional qualification level, and subsequent underutilization of their advanced skills,

contributing to reduced job satisfaction and compromised patient care (Gotehus, 2021; Salami et al., 2018).

Within this landscape, mentorship emerges as a critical retention strategy. Traditional mentorship frameworks, however, often neglect the specific equity, diversity, and inclusion (EDI) considerations necessary to address the complex racialized and migratory experiences of IENs (Njie-Mokonya et al., 2024; Ramji & Etowa, 2018). EDI-informed mentorship programs, grounded in social justice and anti-racist frameworks, reconceptualize mentorship as a reciprocal, culturally safe partnership. Such programs can serve as buffers against systemic exclusion, fostering professional identity reconstruction and facilitating the integration of IENs into new professional contexts. Moreover, they enhance organizational commitment by providing targeted psychosocial and career scaffolding tailored to IENs' unique needs (Gill-Bonanca, 2024; Ramji & Etowa, 2018).

Despite emerging evidence indicating significant benefits of EDI-informed mentorship for mentees, mentors, and healthcare institutions, the literature remains fragmented, and robust empirical validation is inconsistent (Eriksson et al., 2023; Smith & Cantillon, 2024). This rapid review critically synthesizes existing research on EDI-oriented mentorship specifically for IENs, aiming to: (1) comprehensively map the scope and characteristics of mentorship programs documented in published literature; (2) identify and highlight exemplary models that demonstrate strong EDI integration or hold potential for future EDI development; and (3) distill the foundational tenets of a prospective, integrated IEN retention framework.

This synthesis is especially pertinent within the Canadian context, as demographic shifts, the increasing reliance on global nursing talent, and persistent issues of systemic racism

necessitate targeted, transformative mentorship interventions. This rapid review, therefore, is crucial not only for addressing immediate workforce needs but also for laying the foundational groundwork for a sustainable, equitable, and resilient nursing workforce, aligning with broader national healthcare equity objectives (RNAO, 2024).

Methods and Materials

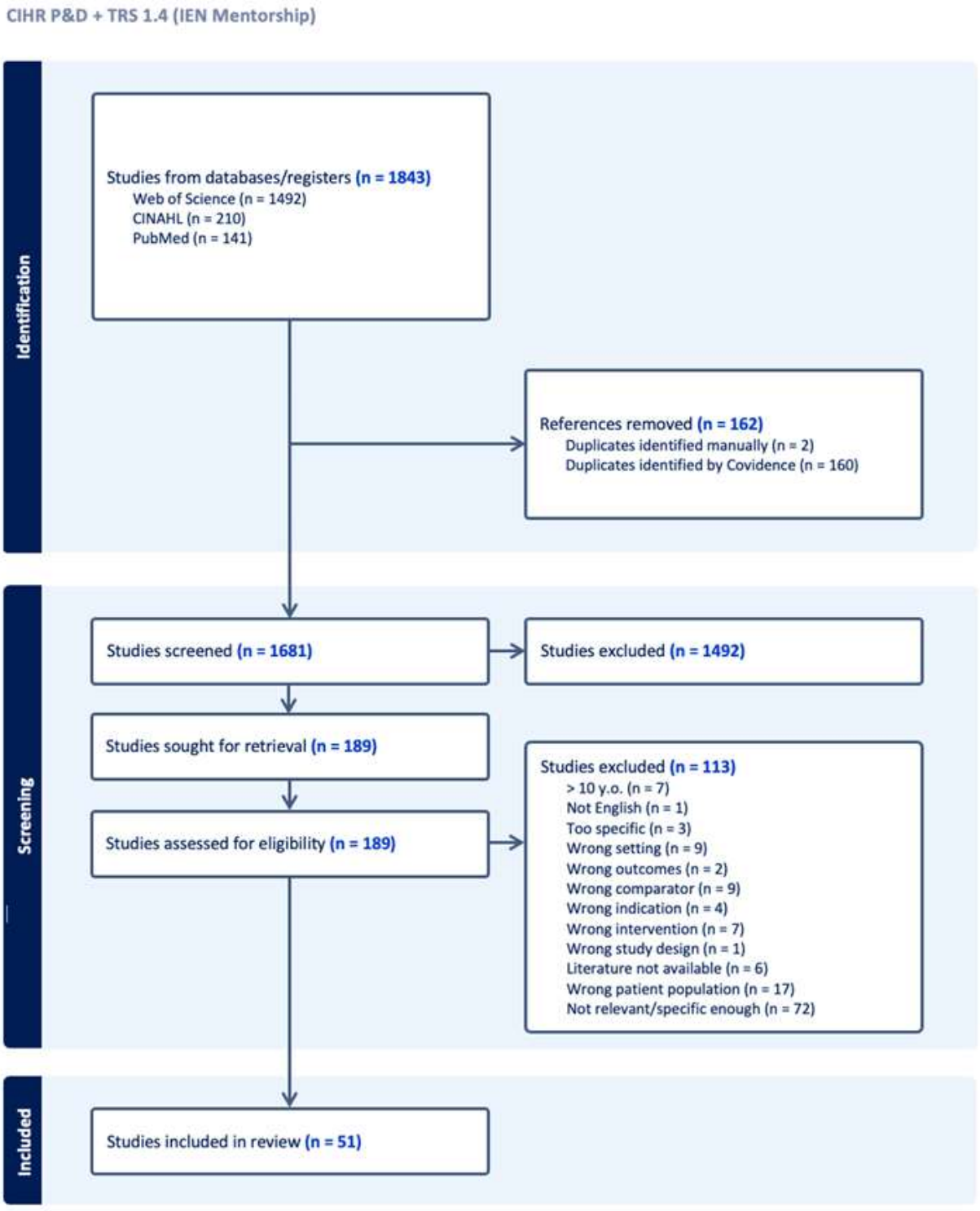
This rapid review was conducted in alignment with the Joanna Briggs Institute Manual for Evidence Synthesis (2024). The work was completed within a one-year project timeline, necessitating pragmatic methodological adaptations to balance rigour with feasibility—such as limiting the number of databases to three core databases and grey literature found on the first ten pages of a Google search of relevant terminology. A protocol establishing the research question, eligibility criteria, and analytic plan was drafted by the team. Databases were searched using strings that combined mentorship and career-support terminology with equity concepts and internationally educated or racialized nursing populations. To enhance clarity and reproducibility, the full search string for PubMed is provided below and reflects the strategy used to identify literature related to mentorship, equity-oriented supports, and internationally educated nurses:

> (("Mentorship"[Title/Abstract] OR "Career Development"[Title/Abstract] OR "Support Programs"[Title/Abstract]) OR ("Equity, Diversity, and Inclusion"[Title/Abstract] OR "EDI"[Title/Abstract] OR "Anti-racism"[Title/Abstract] OR "Culturally Competent Mentorship"[Title/Abstract]) OR ("Exemplary Practices"[Title/Abstract] OR "Best

Practices"[Title/Abstract] OR "Effective Models"[Title/Abstract])) AND ("Internationally Educated Nurses"[Title/Abstract] OR "Minority Nurses"[Title/Abstract] OR "Underrepresented Groups"[Title/Abstract]).

Year limits (2010-2025) and an English-language filter were applied. Although a librarian was not consulted, two reviewers with systematic-search training piloted and iteratively refined the strategies to maximise specificity and minimise post-search screening burden.

All retrieved records were exported to EndNote for de-duplication and then uploaded to Covidence. Titles and abstracts were screened independently by two reviewers (R.R. and V.F.). The same reviewers evaluated full texts, resolving disagreements through discussion; a third reviewer (N.P.) verified final inclusion decisions. Data extraction and quality appraisal were likewise performed in duplicate. The compressed yet transparent approach aligns with current guidance permitting predefined methodological concessions in rapid reviews, provided that search strategies and selection procedures remain reproducible. The screening and selection process is summarized in Figure 1 (PRISMA flowchart).


CIHR P&D + TRS 1.4 (IEN Mentorship)
Identification
Studies from databases/registers (n = 1843)
Web of Science (n = 1492)
CINAHL (n = 210)
PubMed (n = 141)
References removed (n = 162)
Duplicates identified manually (n = 2)
Duplicates identified by Covidence (n = 160)
Screening
Studies screened (n = 1681)
Studies excluded (n = 1492)
Studies sought for retrieval (n = 189)
Studies assessed for eligibility (n = 189)
Studies excluded (n = 113)
> 10 y.o. (n = 7)
Not English (n = 1)
Too specific (n = 3)
Wrong setting (n = 9)
Wrong outcomes (n = 2)
Wrong comparator (n = 9)
Wrong indication (n = 4)
Wrong intervention (n = 7)
Wrong study design (n = 1)
Literature not available (n = 6)
Wrong patient population (n = 17)
Not relevant/specific enough (n = 72)
Included
Studies included in review (n = 51)

Eligibility

Eligible evidence encompassed empirical and grey-literature sources published in English between 2010 to 2025. The publication window of 2010–2025 was a deliberate methodological decision, reflecting the period when contemporary recruitment surges, evolving licensure reforms, and equity-focused mentorship models became more visible in the evidence base. We accepted qualitative, quantitative, and mixed-methods journal articles, program evaluations, government or professional-association reports, dissertations, and other grey documents so long as they (a) centred on internationally educated nurses (IENs) and (b) described, evaluated, or recommended a mentorship, preceptorship, or institutional support initiative (e.g., funded transition programmes, leadership-development schemes). The initiative ideally had to embed at least one explicit equity, diversity, or inclusion (EDI) element—such as anti-racism training, culturally-congruent pairing, or policies targeting systemic barriers. Studies where mentorship was peripheral or absent were excluded.

The publication window was a deliberate rapid-review concession, balancing comprehensiveness with feasibility and ensuring that included programmes reflect contemporary recruitment surges and evolving EDI discourse. Restricting to English was likewise pragmatic, given resource constraints and the predominance of English-language dissemination in Canadian and international nursing literature.

Data Collection

Data extraction was undertaken in duplicate by two reviewers (R.R. and V.F.) under the supervision of the principal investigator (N.P) to minimise transcription error and interpretive bias. Using a spreadsheet, each reviewer independently recorded study characteristics

(country, design, sample), programme descriptors (mentorship structure, duration, EDI components), stakeholder groups involved (mentors, mentees, institutional sponsors), outcome measures, and authors' stated implications for practice or policy. After completion, spreadsheets were cross-checked; discrepancies were reconciled through discussion and, where necessary, by reference to the source text.

To develop the analytic themes, we used a combined deductive–inductive thematic analysis process. Deductive codes were initially derived from the focal points established in the protocol, including (a) the personal and professional identity of IENs, (b) organisational and regulatory structures shaping integration, and (c) the role of mentorship. As reviewers coded each included study, inductive codes were added to capture unanticipated concepts. Coding spreadsheets were then compared, discrepancies were resolved through discussion, and conceptually related codes were grouped into higher-order categories. Through constant comparison across study contexts and designs, these categories were refined into the final themes presented in the Findings section.

Methodological Quality and Limitations

Methodological quality across the 51 studies was varied. Many relied on small, convenience samples, retrospective or cross-sectional designs, and rarely tracked outcomes beyond the short term (i.e., one year). Only a handful incorporated longitudinal follow-up, disaggregated results by intersecting sociodemographic factors, or used explicit intersectional frameworks, leaving compounded barriers (e.g., race, gender, class) under-examined. Additionally, some older studies may not reflect current regulatory contexts. These limitations

underscore the need for more rigorous, equity-attentive investigations that employ larger, representative samples and longitudinal designs.

Findings

Overview of Studies

This rapid review draws on 51 publications (2012-2025) encompassing primary qualitative inquiries, quantitative surveys and audits, mixed-methods pilot evaluations, and secondary syntheses or policy commentaries. Studies predominantly originate in Canada, with the remainder spanning the United States and various parts of Europe. Designs range from interpretative phenomenological analyses with <15 participants to a 15-year NCLEX trend analysis of national data, yet converge on three persistent focal points: (i) the individual nurse's struggle to sustain a coherent professional identity amid deskilling and racialized labour markets; (ii) organisational and regulatory architectures—especially licensure regimes and bridging programmes—that can either entrench or alleviate this displacement; and (iii) mentorship, whose presence, quality, and cultural safety mediate outcomes across the first two domains. The post-2020 literature is notably more explicit about equity, diversity, and inclusion, often embedding intersectional or anti-racist frameworks, whereas earlier work centres on credential mechanics. Taken together, these studies offer a dense, yet uneven, foundation to organise findings around the micro-level experience of IENs, the meso-level actions of organisations and regulators, and the cross-cutting contextual role of mentorship.

The Internationally Educated Nurse: Personal and Professional Identity

Across many of the studies, internationally educated nurses (IENs) describe a profound rupture in their professional biographies the moment they encounter host-country labour markets. Meticulously trained and often highly experienced in their countries of origin, they arrive to discover a chasm between that expertise and the entry points on offer: frequently a care-aide post (Hawkins & Rodney, 2015), a licensed practical nurse (LPN) credential (Salami et al., 2018), or, more insidiously, prolonged unemployment while licensure records idle in opaque regulatory queues (Lee & Wojtiuk, 2021; Newton & Pillay, 2012; Primeau et al., 2021). This enforced "deskilling" is more than an economic demotion; it destabilises the very epistemic foundations of their professional self-concept (Gotehus, 2021). Salami et al. (2018) recount baccalaureate-prepared nurses who endured years of cognitive dissonance as they reconciled intimate knowledge of critical care with the routinised tasks of LPN roles, while Gotehus (2021) shows how Filipino RNs in Norway navigated the existential tension of performing advanced procedures unofficially, thereby preserving clinical competence—yet being remunerated and titled as unskilled labour. Such structural incongruence corrodes confidence, elicits a corrosive doubt whereby nurses question their identity.

That renegotiation is never neutral; it is refracted through intersecting axes of race, gender, language, and migratory status. Intersectional scholarship illuminates how racialised nurses compound the devaluation of foreign credentials: Gotehus (2021) shows that Filipino nurses in Norway are systematically funnelled into lower-status assistant roles, where stringent language and licensure barriers erode recognition of their clinical expertise and authority. Quantitative evidence from Primeau et al. (2021) sharpens the point: Black IENs reported the

lowest career satisfaction in Canada's health system, a finding that aligns with literature on racialised surveillance in workplace assessment and promotion. Self-Determination Theory–informed commentaries (Randall & De Gagne 2023) further demonstrate that racism and linguistic bias thwart autonomy, competence, and relatedness—the psychological nutrients that sustain professional thriving. Yet across these hostile terrains, agency persists. Nurses cultivate underground economies of knowledge—informal groups for licensure tips, informal study circles for NCLEX preparation, peer-mentoring dyads that diffuse emotional labour (Hawkins & Rodney, 2015). Some quietly reframe multilingualism from deficit to asset, leveraging language fluency for complex patient communication (Nije-Mokonya et al., 2024); however, there is insufficient recognition of such contributions. Notably, whenever such personal strategies are coupled with even minimal structural scaffolding (i.e. occupation-specific English modules, high-fidelity simulation, or extended clinical preceptorships), the alchemy of resilience converts into measurable success, exemplified by the 89–100% exam pass rates reported by Atack et al. (2012).

Organization: Regulatory, Academic, and Employment Environments

Internationally educated nurses (IENs) often feel "deskilled," but that individual shock begins within the organisations that control licensure and onboarding. Two decades of research describe Canada's registration process as a costly maze—financially, emotionally, and chronologically—shouldered almost entirely by migrants. Covell et al. (2016) depict regulators as gatekeepers whose legislation and rules change by province and specialty; Salami et al. (2018), Hawkins (2015) and Montegrico (2021) add evidence of rising exam fees, shifting cut-scores, and ever-expanding document lists that disproportionately hinder internationally

trained applicants. Even when bridging programmes exist, they cluster in large cities and high-profile disciplines, leaving rural regions and allied fields without support (Covell et al., 2016; Gill-Bonanca, 2024). The result is a systemic bottleneck that prolongs professional limbo and nudges nurses toward precarious work or deskilled work, as described by Salami et al. (2018).

Organisational innovation, however, can flip this script. High-touch transition models that weave together occupation-specific English training, simulation labs, structured exam prep, and extended clinical immersion consistently outperform piecemeal approaches (Atack et al., 2012; Harries et al., 2019; Lee & Wojtiuk, 2021; Shen et al., 2014). Ontario's 15-week preceptorship, backed by dedicated mentor manuals, doubled national registration success rates (Atack et al., 2012). In Wales, adding a full-time OSCE coach and custom simulation suite lifted pass rates from 14 % to 100 % across successive cohorts (Harries et al., 2019). Hamilton Health Sciences' Community Collaboration Employment Model—an employer–university–community partnership—combined individual learning plans, language workshops, and on-site simulation to move majority of participants into salaried posts over 12 years (Lee et al., 2021). These programmes share three design pillars: executive sponsorship that protects mentorship time, equity-minded data systems that track IEN progress and adapt support, and feedback loops that treat IENs as co-designers rather than passive recipients (Ramji & Etowa, 2018).

Where these structures are missing, inequity spreads. Bélanger-Hardy et al. (2023) document mentorship deserts in rural hospitals and among mid-career nurses; Ramji & Etowa (2018) show that inclusive rhetoric collapses without accountability metrics. Primeau et al. (2021) link lower career satisfaction in Atlantic Canada to minimal employer investment in inclusive orientation, while Njie-Mokonya et al. (2024) report that absent leadership, IENs are

dropped into understaffed wards, reduced to ad-hoc translation, and judged by unwritten cultural norms. The organisational verdict is clear: equity does not emerge by chance—it is built through deliberate governance, resources, and continuous co-design.

Context: Mentorship—Its Presence and Its Absence

Mentorship emerges as the linchpin that connects an internationally educated nurse's individual resilience to the organisation's capacity for equitable integration. Empirical work depicts a wide continuum of practice: at one pole are carefully structured preceptorships such as the model documented by Atack et al. (2012), which pairs nurses with trained mentors, sets explicit learning objectives, and builds in regular feedback cycles; at the other pole lie mentorship vacuums, where nurses must piece together ad-hoc guidance through peer groups and informal advice (Hawkins & Rodney, 2015; Salami et al., 2018). Shiju et al. (2024) quantify this heterogeneity, noting that only a few studies on IEN integration even describe mentorship approaches tailored to migrants' realities.

Where mentorship is effective, several design principles recur. Programmes that allocate protected time and formalise the mentor role—whether in the guise of full-time OSCE facilitators in Wales or Hamilton Health Sciences' Clinical Integrators—ensure mentors have both authority and resources commensurate with their tasks (Harries et al., 2019; Lee et al., 2021; Smith & Cantillon, 2024). Cultural and linguistic congruence also matters: when preceptors understand the nuances of a mentee's first language, psychological safety improves and clinical risk disclosures surface earlier (Eriksson et al., 2023; Harries et al., 2019; Sriram et al., 2024). Reciprocal development models, such as the "80/20 late-career" arrangement that allows seasoned nurses to devote a portion of their workload to mentoring, simultaneously

prolong experienced staff's careers and transmit tacit knowledge (Bélanger-Hardy et al., 2023). While this model does not specifically focus on internationally educated nurses, this could potentially be a retention strategy that allows senior internationally educated nurses to pair with new hire internationally educated nurses. Group-based or circle configurations further enrich the process by making power and race dynamics explicit, opening conversations that traditional dyads often avoid (Sriram et al., 2024). Conversely, programmes that rely on goodwill without workload relief tend to evaporate under clinical pressure (Doodlesack et al., 2024), and schemes that valorise perfectionist "exemplar" mentors invite burnout, whereas facilitator-style mentors sustain satisfaction over time (Smith & Cantillon, 2024). Collectively, these findings underscore that mentorship is not a decorative add-on: when it is culturally safe, well resourced, and deliberately designed, stories of deskilling become narratives of professional re-anchoring; when it is absent, discrimination, attrition, and distress proliferate to the detriment of nurses, employers, and patients alike.

To consolidate the diversity of mentorship models identified in this review, Table 1 offers a comparative summary outlining the structure, strengths, and limitations of each approach.

Table 1 - Comparative summary of the structure, strengths, and limitations of each approach

Model / Framework	Description	Strengths	Challenges
Structured Preceptorships (e.g., Atack et al., 2012)	A 15-week full-time clinical placement with structured preceptor support, occupation-specific language training, and simulation exercises. Preceptorship was part of a formal academic bridging program.	High pass rates, clear guidance, language and cultural integration, long-term support	Resource-intensive, may be inaccessible in rural areas; loss if income for participants while attending program; time-intensive; additional expense for participant (tuition and other program costs)
80/20 Late-Career Mentorship (Belanger-Hardy et al., 2023)	A mentorship model where late-career nurses spend 80% of time in clinical roles and 20% mentoring, allowing knowledge transfer and leadership development.	Knowledge retention, promotes leadership among senior nurses, formalised structure	Not widely implemented or tailored to IENs, sustainability concerns
Informal Peer Mentorship (Gotehus, 2021; Hawkins & Rodney, 2015)	Informal support networks developed organically among IENs, often compensating for lack of formal support with peer guidance and shared experiences.	Builds community and resilience, accessible, supports emotional well-being	Lacks institutional support, depends on personal initiative, inconsistent outcomes
Simulation-Based OSCE Support (Harries et al., 2019)	Structured OSCE (Objective Structured Clinical Examination) preparation programs with dedicated facilitators and high-	Boosts exam readiness, improved confidence, high pass rates	Costly to maintain, not always culturally responsive

	fidelity simulation environments.		
Culturally Congruent Mentorship Circles (Sriram et al., 2024)	Group-based mentorship settings that prioritize racial and cultural alignment and address systemic barriers through open peer dialogue.	Promotes psychological safety, supports open discussion of racism, peer solidarity	Requires skilled facilitation, potential for group dynamics issues
Clinical Integrators Model (Lee et al., 2021)	A hospital-based model combining mentorship, simulation, and individualized learning plans under a multi-organizational collaboration.	Strong integration into workforce, tailored learning plans, real-time tracking	High dependency on multi-organizational coordination, scalability concerns
Facilitator vs. Exemplar Mentor Models (Smith & Cantillon, 2024)	Mentorship styles focused on either setting a high standard (exemplar) or guiding collaboratively (facilitator), highlighting trade-offs in mentor stress and effectiveness.	Facilitator model reduces burnout, enhances mentor satisfaction, improves mentee trust	Exemplar model increases stress, risk of burnout without support or time

Discussion

Reframing Mentorship Through an Equity Lens

This rapid review set out to examine whether mentorship can transform the migration-licensure-practice pipeline for internationally educated nurses (IENs) into an equitable pathway of belonging and professional advancement. The collective evidence—drawn from 51 empirical sources—suggests that mentorship is indeed a potent lever for integration, but programmes should be anchored in equity, diversity, and inclusion (EDI) principles. Across the studies, five challenges recurred with striking regularity: long-drawn-out credential-recognition processes, language-proficiency gaps, professional de-skilling, workplace racism, and affective burdens such as moral distress and homesickness. When mentorship initiatives addressed these inter-locking barriers holistically—for example, through culturally congruent mentor–mentee pairings (Sriram et al., 2024), structured language-practice opportunities (Newton et al., 2012), and explicit anti-racist pedagogy (Randall & De Gagne, 2023)—mentees reported smoother acculturation, higher job satisfaction, and reduced turnover intent (Gill-Bonanca, 2024; Lee et al., 2024). Conversely, loosely structured or assimilationist models often reproduced existing hierarchies, reinforcing critiques that "support" without critical reflexivity can entrench inequity rather than dismantle it (Laing & Smyth, 2025).

Reframing "Deskilling" as an Avoidable Policy Artefact

Escalating exam fees, ever-thickening documentation demands, and shifting cut-scores do not simply "happen" when nurses cross borders; research shows they function as deliberate gatekeeping mechanisms. By raising costs and complexity, licensing statutes consistently filter

opportunity along lines of nationality, accent, and racialised identity, siphoning professional capital from migrant women and racialised men to the domestic workforce regulators were created to protect (Neiterman & Bourgeault, 2015; Salami et al., 2018; Montegrico, 2021). Thus, the recurring pattern of Filipino, Caribbean, Nigerian, and Eastern-European nurses being forced into lower-paid licensed practical nurse roles—or into prolonged unemployment or underemployment—is not an unfortunate aberration but the system operating exactly as designed (Covell et al., 2016; Gotehus, 2021).

If health systems are serious about equity, this regulatory burden must flip. Regulators—not migrants—should be required to justify each procedural hurdle by proving it is the least exclusionary route compatible with patient safety. Routine, transparent equity audits that disaggregate outcomes by race, gender, and immigration class would expose the financial, temporal, and psychological costs now silently absorbed by internationally educated nurses and their families, turning invisible barriers into actionable targets for reform.

Mentorship as Infrastructure, Not Benevolence

Mentorship is not a charitable add-on; it is the structural engine of equitable integration. Programmes flourish when mentors are paid, given protected time, and assessed on clear outcomes—as demonstrated by Hamilton Health Sciences' Clinical Integrators, Wales's OSCE-driven simulation overhaul, and Alberta's language-rich preceptorship, all of which post exceptional registration results because they are explicitly funded, staffed, and evaluated (Atack et al., 2012; Harries et al., 2019; Lee et al., 2021). Smith and Cantillon's interpretative phenomenological study of Irish mentors deepens this point: when mentors adopt a facilitator identity—emphasising confidence-building and collaborative learning—they experience lower

stress and greater sustainability than metric-based "exemplar" mentors who chase perfection and shoulder accountability alone (Smith & Cantillon, 2024). Their participants also highlighted chronic gaps in formal preparation and protected time, underscoring that resourcing, not charisma, is the decisive variable. Valuing relational labour monetarily therefore elevates work that has long been feminised and racialised while giving mentees dependable, high-quality guidance, including the intercultural communication and team-socialisation support that Smith and Cantillon flag as a "hidden curriculum."

Programmes built on goodwill and "found time" collapse as soon as staffing ratios tighten. Doodlesack et al. (2024) report how informal check-ins vanished during pandemic surges, erasing mentorship precisely when internationally educated nurses needed it most, while Smith and Cantillon show that exemplar-style mentors burn out quickly without structural backing. Embedding mentorship expectations into collective agreements and staffing algorithms thus serves a dual justice aim: it professionalises caregiving labour—and nudges mentors toward the lower-stress facilitator model—and it shields mentees from the boom-and-bust cycle of short-term pilots. When relational work is counted, budgeted, and protected, mentors grow in self-awareness and professional confidence, mentees thrive, and organisations gain a sustainable pathway to equity.

Intersectionality as the Analytical Engine

Aggregate metrics often mask patterned disadvantage. National pass-rate and retention curves can appear stable, yet disaggregated data show that Black internationally educated nurses (IENs) report the lowest career-satisfaction scores (Primeau et al., 2021); qualitative studies deepen the picture: Filipino IENs describe navigating licensure alone and enduring

systemic devaluation of their credentials (Hawkins & Rodney, 2015), while many baccalaureate-prepared nurses pursue licensed practical nurse roles as a quicker, cheaper—but deskilling—route into the workforce (Salami et al., 2018). These findings confirm that exclusion is patterned, not incidental, and intersectionality is essential for decoding how race, gender, language, and migration status interact multiplicatively rather than additively.

Operationalising intersectionality means engineering supports that neutralise compound disadvantage rather than cater to an "average" nurse. Race-matched mentorship with anti-racist curricula (Smith & Cantillon, 2024), gender-responsive scheduling that recognises caregiving obligations (Randall & De Gagne, 2023), and licensure preparation that frames multilingualism as an asset (Gotehus, 2021) are not boutique extras; they are precision tools for equity. By clarifying expectations, normalising difference, and distributing resources transparently, intersectional design raises psychological safety and performance for the entire workforce, while directly targeting those who have been most marginalised.

Organisational Accountability Through Data Governance

Equity rhetoric without measurement is merely performative. The staying power a bridging programme (Atack et al., 2012), Wales's OSCE-focused simulation overhaul (Harries et al., 2019), and Hamilton Health Sciences' Community Collaboration Employment Model (Lee et al., 2021) lies in their use of real-time dashboards that track applicant flow, exam pass rates, promotion trajectories, and exit-interview themes by race, gender, and immigration class. By converting moral aspiration into visible metrics, these systems make inequities impossible to ignore; red-amber-green indicators on quarterly reports demand corrective action rather than polite acknowledgement.

Accreditation agencies should embed such dashboards into their standards. If eligibility for public funding or recognition programmes were contingent on demonstrable progress in internationally educated nurse (IEN) integration metrics, equity work would shift from pilot-project periphery to the heart of continuous quality improvement. Hard-wiring accountability in this way would replace rhetorical commitments with sustained, data-driven cycles of action and evaluation.

Toward a Praxis of Reciprocal Recognition

Regulators, employers, educators, and researchers each hold a distinct lever in advancing equity for internationally educated nurses. Regulators should adopt a principle whereby every fee increase, documentation demand, or exam cut-score must be defended with data that it is the least exclusionary option consistent with patient safety (Neiterman & Bourgeault, 2015; Salami et al., 2018). Employers should embed paid, protected mentorship into workload formulas, valuing relational labour as rigorously as medication reconciliation or infection control (Atack et al., 2012; Smith & Cantillon, 2024). Educators must hard-wire anti-racist and gender-responsive pedagogy into bridging curricula, reframing multilingualism as a clinical asset rather than a deficit (Gotehus, 2021; Randall & De Gagne, 2023). Researchers, finally, must move beyond merely cataloguing inequities and start building—and rigorously testing—solutions. A priority should be the co-creation of an equity-oriented mentorship framework, then subjecting it to realist evaluation, cost-utility analysis, and long-term cohort tracking to furnish decision-makers with actionable evidence (Primeau et al., 2021).

In such an ecosystem, a Nigerian, Filipino, Bangladeshi or Jamaican nurse would never have to ask, “Am I still a real nurse here?” Equitable and standardized pan-Canadian licensure

rules, transparent metrics, and remunerated mentorship would make their expertise visible and indispensable. The result would be a workforce that marries ethical integrity with operational resilience—better equipped to serve an increasingly pluralistic public with competence, humility, and justice.

Strengths and Limitations

A key strength of this work lies in its rapid-review design, which enabled the team to produce a timely synthesis while adhering to core elements of methodological rigour. By canvassing three major databases and accepting diverse research alongside programme evaluations, the review captures the breadth of current scholarship on mentorship for internationally educated nurses and distills cross-cutting lessons that are immediately actionable for policy and practice. Nevertheless, several constraints temper the findings. Searches were restricted to English-language records and confined to three databases without formal librarian input; relevant studies in other languages or older high-quality reports may therefore have been overlooked. Additionally, the heterogeneity of mentorship definitions, programme structures, and outcome measures precluded formal comparative analysis or meta-synthesis. Finally, because most primary studies were cross-sectional or short-term, the review cannot draw firm conclusions about longitudinal effectiveness or patient-level impact. Taken together, these limitations suggest that future work should incorporate broader search parameters, standardised reporting of mentorship interventions, and long-term evaluations to strengthen the evidence base.

Conclusion

Canada cannot meet its promise of a culturally responsive nursing workforce simply by recruiting internationally educated nurses (IENs); it must also cultivate the conditions for them to flourish. Evidence from this review demonstrates that mentorship structured around protected time, cultural humility, and organisational backing accelerates licensure, curbs deskilling, and boosts career satisfaction while enriching team dynamics and patient care. To scale these benefits, however, mentorship must be embedded within a national, equity-oriented mentorship framework—one that sets common standards, funds mentor preparation, and mandates data-driven feedback loops to track both workforce and patient outcomes.

Building such a framework will demand coordinated action. Regulators need to harmonise bridging pathways and justify every licensure barrier; employers must treat relational labour as core clinical work; educators should weave anti-racist, gender-responsive pedagogy into curricula; and policymakers must link accreditation and funding to demonstrable progress on equity metrics. By pairing these structural commitments with participatory programme design that centres IEN voices, health systems can move from fragmented pilot projects to a cohesive, future-proof architecture—one that honours the expertise IENs bring and strengthens the quality and justice of care for all Canadians.

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Appendix A – *Selected Studies for Rapid Review*

Study	Study Design	Mentorship Model/Notes	EDI implications	Notable Program Features	Outcomes	Barriers	Facilitators
Atack, L., Cruz, E. V., Maher, J., & Murphy, S. (2012). Internationally educated nurses' experiences with an integrated bridge program. The Journal of Continuing Education in Nursing, 43(8), 370–378. https://doi.org/10.3928/00220124-20120615-62	Qualitative longitudinal study using interviews and focus groups at three time points (start, end, and 3–6 months post-program)	Clinical preceptorship model: 15-week full-time preceptorship with a staff mentor; preceptorship and faculty manuals were created to guide mentorship for internationally educated nurses (IENs)	- Recognizes structural inequities (language, licensure, education gaps) faced by IENs - Emphasizes tailored support for language acquisition, adult learning, cultural transitions, and socio-professional integration	- One-stop "bundled" bridge program - Occupation-specific English training - High-fidelity simulation - Hybrid learning model - Technology skill-building - Job prep workshops - Extended clinical time	- 89–100% pass rate on registration exam (vs. 49–71% typical) - Successful employment in varied settings (hospitals, retirement homes, agencies) - Improved confidence and critical thinking	- Financial strain - Family/work/life balance - Lack of awareness about IEN programs among employers - Cultural/educational mismatch in teaching style - Accent/language bias during interviews	- Faculty and preceptor awareness training - Integrated English and clinical skills training - Simulation and hands-on practice - Emphasis on patient-centered care and Canadian health system knowledge

Bélanger-Hardy, É., Palmer, K. S., Kokorelias, K. M., Chan, C., & Law, S. (2023). Easing the nursing shortage: Tools for retaining nurses through mentorship. Nursing leadership, 36(2), 17–26. https://doi.org/10.12927/cjnl.2023.27206	Rapid Review – Conducted by CanCOVID for Health Canada to examine the impact of mentorship on nurse retention across early-, mid-, and late-career stages. Included reviews of systematic reviews, grey literature, and programs like SPEP.	- Models highlighted: 80/20 Mid-and-Late Career Nurse Mentorship Program (senior nurses work 80% at bedside, 20% on initiatives), Supervised Practice Experience Partnership (SPEP). - SPEP supports IENs with up to 140 hours of mentorship and preceptorship; both mentors and preceptors. - Other models: staged mentorship, student-peer, and traditional 1:1 formats.	- Call to recruit mentors with shared diverse backgrounds (e.g., racialized or immigrant mentors). - Highlighted need to support Black and Indigenous nurses (not yet widely addressed in literature). - Recognizes structural barriers in rural vs. urban mentorship access.	- Five tools for success: (1) Reciprocal relationships among stakeholders, (2) Administrative structures and support, (3) Effective features like trained mentors and longer duration, (4) Personal and professional development, (5) Targeted support for IENs.	- Improved retention rates, especially among early-career nurses. - Increased self-confidence, resilience, and leadership skills for both mentees and mentors. - Positive outcomes for IENs transitioning to Canadian workforce (e.g., SPEP participants retained in hospitals).	- Lack of culturally aligned mentors for IENs. - Insufficient rural/remote program infrastructure. - Short program durations limit trust-building. - Mid-career nurses underserved despite high turnover. - Employers unaware of mentorship benefits or unsure how to implement programs effectively.	- Administrative buy-in and dedicated resources (time, tech, training). - Structured programs with mentor training (e.g., communication, feedback). - Integration into onboarding or preceptorships. - Peer/community support in group mentorship showed higher retention intentions

Cubelo, F., Parviainen, A., & Kohanová, D. (2024). The impact of bridging education programs on internationally educated nurses becoming registered nurses in high-income countries: A mixed-methods systematic review. International Nursing Review. https://doi.org/10.1111/inr.13038	Reviewed 13 peer-reviewed and 4 grey literature sources (total n=17).	- Mentorship was often informal or embedded within clinical placements and academic modules. - Noted absence of standardized mentorship structures across BEPs (briding education programs). - Some programs incorporated peer mentoring or culturally safe practice supports, but no consistent mentorship model across sites.	- BEPs recognized as critical EDI interventions by addressing systemic barriers like language, credential recognition, cultural unfamiliarity, and racism. - Called for more culturally congruent mentorship. - Programs attempted to bridge gaps in healthcare norms and patient safety expectations in Canada.	- BEPs included clinical practice placements, academic upgrading, cultural competence training, regulatory exam preparation (NCLEX-RN/CPNRE), and soft skills development (e.g., communication). - Some programs provided mental health and resilience workshops. - Use of simulation labs and interprofessional learning in a few programs.	- Improved clinical confidence, communication, familiarity with Canadian healthcare system. - Participants reported greater employability and success in licensing exams. - Enhanced integration into work environments, but challenges remained in achieving equitable career advancement.	- Limited access to formal mentorship. - Licensing exam costs and preparation pressure. - Racism and discrimination in clinical placements. - Emotional toll of navigating unfamiliar systems. - Variability in program quality, access to placements, and support structures across institutions.	- Supportive faculty and preceptors, including culturally safe teaching approaches. - Bridging cohort model provided peer support. - Targeted language and exam support. - Access to community mentors, though informal.

Covell, C. L., Neiterman, E., & Bourgeault, I. L. (2016). Scoping review about the professional integration of internationally educated health professionals. Human Resources for Health, 14(1), 38–38. https://doi.org/10.1186/s12960-016-0135-6	Scoping Review — Used updated Arksey & O'Malley's six-stage scoping framework. Included 407 sources (academic + grey literature).	- Bridging programs and workplace integration supports were common themes, often involving informal or formal mentorship. - Professional recertification often included mentored clinical placements and supervised practice. - However, mentorship was inconsistently reported or evaluated.	- Highlights structural inequities in professional recognition. - Emphasizes systemic barriers such as credentialing delays, lack of access to networks, and unfamiliarity with Canadian norms. - Allied health professionals were underrepresented, indicating equity concerns in research focus.	- Programs spanned pre-immigration readiness, early arrival orientation, bridging education, and recertification support. - Programs often integrated language training, simulation-based learning, and regulatory preparation. - Dominated by medicine and nursing fields.	- Professional integration remains inconsistent, especially outside of medicine and nursing. - Increased volume of literature signals policy attention, but effectiveness of interventions remains largely unassessed.	- Lack of effectiveness data on integration programs. - Credentialing challenges and workplace exclusion. - Allied health professions lack visibility in both research and programs. - Fragmented data and programming across provinces and professions.	- Increased funding and policy attention enabled the expansion of bridging programs. - Growth in early arrival supports. - Sustained research and publication activity points to strong institutional engagement.

Doodlesack, A., Dubosh, N., Grossestreuer, A. (2024). A novel nurse-inteRN mentorship program to improve nurse-physician communication and teamwork in the emergency department. International Journal of Emergency Medicine, 17(1), 163. https://doi.org/10.1186/s12245-024-00740-z	Pilot mentorship program evaluation using a pre- and post-program survey (12 questions) assessing perceptions of communication, collaboration, and benefit. Quantitative data analyzed using Fisher's exact, Wilcoxon, and marginal homogeneity tests.	- Nurse-InteRN Mentorship Program (1 year, pilot). - Nurses voluntarily served as mentors; interns (first-year residents) were assigned one or two mentors. - Focused on communication feedback, quarterly meetings, and ongoing informal check-ins.	- Differences in professional culture and power dynamics noted. - Nurses showed more interest in providing feedback, suggesting asymmetry in collaboration expectations. - Gender mismatch, burnout, and COVID-19 impacted participation and engagement.	- Applied Kern's six-step curriculum development framework. - Included orientation-based introduction, quarterly meetings, flexible communication platforms (text, phone, Zoom). - Supported by group social events to build rapport.	- Perceived benefit decreased post-program among both nurses ($p=0.016$) and interns ($p=0.035$). - No significant improvements in teamwork or communication scores. - Nurses rated interns' communication skills lower than interns rated themselves.	- Pandemic burnout, high nursing turnover, inconsistent mentor availability. - Lack of program structure, unclear expectations, power imbalances. - Variation in mentor/mentee engagement reduced consistency.	- Strong initial stakeholder support (nursing/residency leadership). - Mandatory participation by interns ensured full cohort inclusion. - Needs assessment and field testing of surveys enhanced program alignment with perceived gaps.

Eriksson, E., Högstedt, D., Engström, M., & Jansson, I. (2023). Preceptors' experiences of supervising internationally educated nurses attending a bridging program: An interview study. Nurse Education Today, 131, 105975–105975. https://doi.org/10.1016/j.nedt.2023.105975	Qualitative descriptive study based on semi-structured interviews with 15 registered nurse preceptors	- Preceptorship model within a 1-year bridging program for IENs from outside the EU/EEA/Switzerland - Preceptors had to tailor mentorship to IENs' prior clinical knowledge and linguistic/cultural integration needs	- Cultural and linguistic barriers required adaptive, individualized mentorship - Preceptors reported needing more support and background information to effectively supervise IENs	- Emphasis on language support, interprofessional relationship-building, and tailored supervision - Bridging program involved both theoretical and clinical education	- Mixed feelings: joy and professional satisfaction, but also frustration and challenge - Need for stronger training and system support to handle diversity in experience and communication	- Insufficient information about students' backgrounds and training - Limited university and managerial support - Language barriers affected integration with patients and teams	- Preceptors' commitment and adaptability - Focus on person-centered care and team integration in clinical training

Gill-Bonanca, K. (2024). Mentorship: A strategy for nursing retention: Embed mentoring into your organizational culture. American Nurse Journal, 19(8), 6-. https://doi.org/10.51256/ANJ082406	Practice-based expert commentary with evidence synthesis from multiple empirical studies and national surveys	- Focus on structured mentorship for newly hired and early-career nurses - Can be one-on-one or group mentoring - Emphasis on sustained relational support beyond skill acquisition (unlike preceptorships) - Cites models from Academy of Medical-Surgical Nurses (AMSN), Robert Wood Johnson Foundation, and others	- Mentorship supports inclusive work cultures, improves psychological safety, and helps retain nurses from underrepresented or marginalized backgrounds - Emphasizes matching based on shared values and interests, allowing for culturally responsive relationships - Acknowledges that mentorship can reduce feelings of isolation for novice or diverse nurses, particularly in large or rural institutions	- Defined timelines (typically 6–12 months) - Mentor/mentee matching based on interpersonal fit or tools (e.g., MBTI) - Mentor training in adult learning, communication, and relationship-building - Dedicated program coordinator role - Protected time for mentoring activities - Incorporates ongoing check-ins, resource sharing, and evaluation tools	- Reduced turnover by 2% to 15% - Improved self-confidence, job satisfaction, and stress reduction among mentees - Increased sense of belonging, engagement, and commitment - Real-world results include 90% retention (Children's Mercy), 70% (UVM Medical Center), and 87–94% (Marie Curie, Northern Ireland)	- Time constraints and scheduling conflicts between mentors and mentees - Lack of organizational support or unclear expectations - Hesitancy in open dialogue when mentors and mentees work on the same unit - Absence of standardized matching best practices	- Leadership buy-in and creation of a "mentoring culture" - Protected time and formal scheduling support - Strong interpersonal mentor qualities (approachability, commitment, communication skills) - Use of validated toolkits and structured evaluation plans

Gotehus, A. (2021). Agency in deskilling: Filipino nurses' experiences in the Norwegian health care sector. Geoforum, 126, 340–349. https://doi.org/10.1016/j.geoforum.2021.08.012	Qualitative study, 22-in depth interviews with Filipino nurses	- No formal mentorship models identified - Informal learning through peer interactions and taking on RN duties unofficially - Skills maintained by performing nursing tasks while officially employed in lower roles	- Systemic inequities in migration, licensure, labour markets - Racialization and gendered labour expectations --> deskilling - Expertise undervalued, invisible	- Norway's licensure process required: - Norwegian language proficiency - Bridging courses - National exams - No formal integration or mentorship pathways specific to internationally educated nurses.	- Many participants remained in health-care assistant roles despite being qualified RNs. - Some regained RN status after significant personal effort. - Demonstrated strong personal agency but continued to be constrained by systemic deskilling.	- Language barriers (requirement for fluency in Norwegian). - Costly and unclear licensure processes. - Visa precarity, temporary contracts, and lack of bridging supports. - Cultural expectations and family remittance obligations.	- Peer support and informal knowledge sharing. - Individual strategies like resilience and adaptation. - Performing unofficial RN work to preserve skills and identity. - In some cases, union advocacy helped navigate systemic constraints.

Harries, H., Giles, L., Condon, L., & Williams, M. (2019). Objective structured clinical exam: how clinical nurse educators can support internationally educated nurses. Nursing Management (Harrow, London, England), 26(5), 19–23. https://doi.org/10.7748/nm.2019.e1845	- Descriptive case study documenting the evolution of three models used to support 37 IENs through OSCE preparation. - Draws on program evaluation, reflections from educators, and narratives from IENs.	- No formal mentorship, but embedded clinical educator-led coaching and simulation-based support. - Progressive shift from ward-based mentoring to dedicated facilitators and simulation rooms. - Peer support among IENs enhanced confidence.	- Recognized emotional and systemic burden of migration, exams, and failure risk. - Authors advocated for pastoral care, emotional safety, and culturally aware preparation to address stress and inequities. - Highlighted importance of fairer assessment practices.	- Three models: - Model 1: Supernumerary placements + limited prep (14% first-time pass rate). - Model 2: Simulation blocks, uniforms, mock exams (pass rate improved). - Model 3: Full-time facilitator and OSCE simulation suite (100% pass).	- Pass rates rose from 14% to 100%. - Improved nurse confidence, preparedness, and timeliness to practice. - Feedback showed preference for classroom-based OSCE prep over clinical-only models.	- High-stakes stress, cost of retakes (£500–£1,000), lack of early clarity on OSCE expectations. - Cultural mismatch between real practice and exam format. - Emotional toll of migration and isolation.	- Dedicated educator/facilitator roles. - Simulation fidelity (uniforms, filming, timed conditions). - Peer-led coaching and support. - OSCE-aligned mock exams and feedback loops.

Hawkins, M., & Rodney, P. (2015). A Precarious Journey: Nurses from the Philippines Seeking RN Licensure and Employment in Canada. Canadian Journal of Nursing Research, 47(4), 97–112. https://doi.org/10.1177/0844562115047004 08	- Qualitative, in-depth interviews with 47 nurses educated in the Phillipines and living in Canada	- Participants reported navigating complex licensure systems largely alone - Relied on peer advice or informal community support - Lack of mentorship noted as a structural gap	- Study reveals systemic racism, classism, and gendered deskilling - Highlights inequities in immigration and licensure processes - Canadian systems devalue foreign nursing education and experience	- No singular program studied - Bridging and licensing programs were described as fragmented, costly, and inconsistent across provinces - Some temporary care aide roles offered limited entry points but often led to further deskilling	- Most nurses experienced deskilling and downward occupational mobility - Only a small number were able to re-enter nursing after long delays - Significant emotional, financial, and professional toll	- Expensive and opaque licensure process - Discriminatory evaluation of foreign credentials - Family and care responsibilities disproportionately affected women - Psychological impact of persistent exclusion	- Peer support and informal community-based networks - Personal resilience and determination - In a few cases, supportive employers or clear guidance from regulatory bodies helped

Hopkins, N. M., & Stephens, J. M. L. (2021). Education Strategies Supporting Internationally Educated Registered Nurse Students With English as a Second Language in Canada. Canadian Journal of Nursing Research, 53(2), 162–170. https://doi.org/10.1177/0844562120917254	- Literature synthesis, reviewed studies and commentary published from academic databases and grey literature	- No formal mentorship program evaluated - Article advocates for educational and instructional strategies, not mentorship per se - Highlights importance of faculty support and culturally responsive teaching	- Emphasizes language barriers and their compounding effect on IENs' integration - Identifies cultural dissonance and lack of critical thinking alignment as challenges - Advocates for pedagogies that center diversity and inclusion in teaching practices	- Recommends inclusion of evolving case studies, simulation, role-play, and multiple-choice test practice in bridging programs - Suggests integration of experiential techniques to build communication and cultural competence	- Literature suggests these strategies enhance language proficiency, critical thinking, and cultural adaptation - However, effectiveness not yet empirically confirmed—authors call for further research	- Communication difficulties, particularly in clinical practice - Differences in critical thinking approaches and cultural expectations - Gaps in faculty preparedness to address linguistic and cultural needs	- Use of experiential learning strategies like simulation and role-play - Peer support and inclusive instruction help mitigate challenges - Practice with Canadian-style testing formats supports exam readiness

Laing, D., & Smythe, A. (2025). The challenges and needs of international nurses who are assimilating to healthcare systems in the United Kingdom: Experience from the field. International Nursing Review, 72(1), e13078-. https://doi.org/10.1111/inr.13078	- Reflective practice paper drawing on experiential knowledge from delivering training to IENs - Not a primary empirical study, but includes qualitative insights from practice settings	- Describes acculturation and communication skills training designed for IENs - Emphasis on two-way learning between IENs and local staff - No formal mentorship structure, but supports continuous relational learning	- The training revealed "hidden work" IENs perform to adapt to UK systems - Highlights how dominant cultural norms are often unacknowledged - Emphasizes emotional labor, professional identity negotiation, and feeling silenced in clinical environments	Training emphasized: - Encouraging cultural visibility and expression - Surfacing everyday challenges (e.g., managing accents, clinical norms) - Creating safe, non-judgmental spaces for expression - Encouraging active listening from UK staff	Nurses reported: - Feeling more seen and heard - Ability to express identity without fear - Increased relational confidence - Staff also reported increased awareness of cultural assumptions and reflective practice	- Isolation, emotional suppression, and internalized pressure to “fit in” - Navigating hierarchical power structures - Lack of recognition for emotional and cultural labor IENs perform - Fear of making mistakes or speaking up	- Relational trust built through shared reflection - Encouraging open and reciprocal conversations between IENs and UK staff - Emphasis on the value of cultural contribution, not just assimilation

Lee, R., & Wojtiuk, R. (2021). Transition of internationally educated nurses into practice: What we need to do to evolve as an inclusive profession over the next decade. Nursing Leadership, 34(4), 57–64. https://doi.org/10.12927/cjnl.2021.26689	- Commentary based on authors' lived experience, programmatic insights from CARE Centre for IENs, and synthesis of existing literature and reports.	- Emphasizes the need for assigned buddies, consistent preceptors, and workplace mentors. - Suggests job shadowing, virtual mentorship, and peer-to-peer support beyond preceptorship. - Notes many IENs report lack of mentorship or unclear support systems.	- Calls for systemic change to support diversity, equity, and inclusion. - Critiques hiring biases against IENs (e.g., preference for Canadian grads). - Urges organizations to move beyond "one-size-fits-all" orientation models. - Advocates for culturally inclusive policies.	- CARE Centre's Supervised Self-Directed Evidence of Practice Program. - Suggests customized IEN orientation, multicultural education for staff, and use of Livingston's Racial Equity Framework. - Highlights collaborative partnerships with academic and community orgs.	- Improved integration when mentorship and orientation are structured. - Successful programs recognize IENs' prior clinical experience. - Without support, many IENs leave nursing or remain underemployed due to systemic and financial barriers.	- Lack of credential recognition, support, or consistent preceptorship - Discriminatory hiring practices - Insufficient cultural awareness by nursing staff - Limited academic support to update skills post-lapsed licensure - High financial burden and policy fragmentation	- Supportive preceptors, buddies, and mentors - Cultural education for teams - Tailored orientation and workplace integration plans - Community partnerships (e.g., CARE Centre) - Advocacy for fair salary recognition based on prior experience

Lee, R., Beckford, D., Jakabne, L., Hirst, L., Cordon, C., Quan, S., Collins, J., Baumann, A., & Blythe, J. (2021). Multiorganizational partnerships: A mechanism for increasing the employment of internationally educated nurses. Nursing Leadership, 34(3), 51–62. https://doi.org/10.12927/cjnl.2021.26593	- Descriptive report on the IEN Integration Project at Hamilton Health Sciences, including focus groups, environmental scan, and continuous program evaluation from 2009–2021 using intake questionnaires and external evaluators (NHSRU, McMaster University).	- Clinical Integrators (CIs)—experienced nurses (often IENs themselves) acted as informal mentors. - Ongoing mentorship from the Project Manager. - Peer networking based on American Academy of Medical–Surgical Nurses model. - Job coaching, job shadowing, and professional workplace exposure included. - Emphasis on supportive work culture and transition to Canadian patient safety standards.	- Addresses barriers to equity in employment of IENs: credential recognition, cultural communication, hiring bias. - Partners include Hamilton Centre for Civic Inclusion for cultural awareness training for IENs and leaders. - Aims to create a diverse and sustainable nursing workforce to reflect growing population diversity and regional health needs.	- Community Collaboration Employment Model (CCEM): partnerships between employer, education, and community organizations. - Individualized Learning Plans for each IEN. - Interventions included language support, cultural training, simulation labs, and job search coaching. - On-site simulation lab, workplace language workshops, and orientation. - Project evaluated and adapted continuously since 2009.	- From 2009 to 2021, 1,783 IENs accessed the project; 996 enrolled, and 591 obtained employment in or outside HHS. - Project credited with increasing confidence, exam success, and employment outcomes. - Participants noted improved readiness, support, and integration into Canadian system.	- Credentialing and registration challenges. - Cultural and language barriers (e.g., pronunciation, team roles, public speaking). - Employer reluctance to hire IENs. - Lack of awareness of IENs' prior experience. - Limited guidance on integration from regulatory and workforce bodies.	- Multiorganizational support from CARE Centre, Mohawk College, HCCI. - Cultural awareness and simulation training. - Mentorship from CIs and Project Manager. - Access to HHS orientation, e-learning, and career progression supports. - Ongoing evaluation and feedback for adaptive program delivery.

Montegrico, J. (2021). A 15-Year Trend Study of Internationally Educated Nurses' NCLEX-RN Performance. Nursing Education Perspectives, 42(1), 22–28. https://doi.org/10.1097/01.NEP.0000000000000660	- Correlational study using secondary data analysis of NCLEX-RN results from 2003 to 2017.	- Not applicable (study focused on licensure exam trends and outcomes, not mentorship models).	- Indicates systemic inequities due to variations in nursing education globally.	- None discussed; study focused on analysis of exam performance trends, not programs.	- Overall decline in NCLEX-RN applications and pass rates among IENs. - Philippine-educated nurses had lower odds of passing. - Canadian-educated nurses had higher odds of passing.	- Differences in nursing curricula, standards, and clinical preparation across countries. - Possible lack of exam-specific preparation.	- Not directly examined; however, education systems in Canada may better align with U.S. expectations, facilitating higher pass rates.

Neiterman, E., & Bourgeault, I. L. (2015). Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada. Social Science & Medicine (1982), 131, 74–81. https://doi.org/10.1016/j.socscimed.2015.02.043	- Qualitative study using semi-structured interviews with 179 internationally educated physicians, nurses, and midwives, and 70 policy stakeholders in Canada - Focused on understanding resocialization experiences across professions.	Mentorship is not formally structured; informal learning from peers and preceptors noted. Lack of consistent mentorship programs is a gap.	- Resocialization was shaped by gendered and racialized hierarchies. - Female-dominated professions like nursing and midwifery experienced lower levels of professional autonomy and more deskilling. - Stakeholder assumptions often reflected deficit narratives, reinforcing inequities.	- Variation in access and quality of bridging and orientation programs. - Programs emphasized communication norms, patient safety, and professionalism. - Systemic factors often outweighed program-level intentions in shaping outcomes.	- IEHPs underwent professional identity negotiation, with many experiencing status loss - Physicians were most affected by re-entry barriers, while nurses and midwives often returned through lower-status roles. - Success was often linked to resilience and access to enabling environments.	- Credential recognition issues and lack of regulatory transparency. - Institutional rigidity and limited accommodation of international experience. - Workplace discrimination and lack of tailored supports for IEHPs.	- Gender theory and institutional/organizational analysis. - Intersectional lens to understand how race, gender, and profession intersect in shaping IEHP integration.

Newton, S., Pillay, J., & Higginbottom, g. (2012). The migration and transitioning experiences of internationally educated nurses: a global perspective. Journal of nursing management, 20(4), 534–550. Https://doi.org/10.1111/j.1365-2834.2011.01222.x	A database search of CINAHL, Medline, Scopus and Web of Science, and a hand-search of key nursing journals produced 239 combined hits, with 21 articles meeting the inclusion criteria.	- Mentorship is recommended as a transition strategy - Emphasizes the potential of peer mentorship from experienced IENs - Lack of structured, widespread mentorship programs documented	- IENs frequently face discrimination in host countries - Deskilling due to credentialing barriers and local practice standards reduces IENs' confidence and scope - Cultural and linguistic differences fuel exclusion and outsider status - Highlights that without structural EDI measures, the potential contributions of IENs are underutilized	- No specific programs are detailed—this is a review of global experiences rather than a program evaluation - Suggests orientation strategies and the need for structured transition supports - Recommends mentorship training, particularly from fellow IENs	- Many IENs report demoralization from unmet expectations post-migration - Erosion of professional identity is common due to underemployment and deskilling - IENs often develop personal coping strategies but face systemic barriers to advancement	- Credentialing delays and inconsistencies - Cultural displacement and communication barriers - Racism and workplace discrimination - Inadequate orientation to local clinical practices	- Mentorship by experienced IENs - Personal resilience and adaptive strategies - Language acquisition and peer support networks - Workplace efforts to recognize prior experience

Njie-Mokonya, N., Montoya, L., Abebe, N., & Shorr, R. (2024). Examining Workplace Practices Used to Facilitate Successful Integration of Internationally Educated Nurses Into Acute Care Settings: A Scoping Review. The Journal of Continuing Education in Nursing, 55(4), 195–201. https://doi.org/10.3928/00220124-20231211-02	- Scoping review - Based on Arksey & O'Malley's (2005) five-step framework - Explores literature on integration and education strategies for IENs in acute care settings - Focus on workplace-based, tailored bridging programs	- Highlights the lack of structured mentorship within workplace bridging programs - Stresses the importance of clinical mentorship and supervised transition-to-practice supports - Mentorship is underexplored despite being essential for safe, full-scope practice integration	- Notes social exclusion, power imbalances, and lack of organizational support as barriers - Insufficient recognition of the contributions that IENs bring to organizations is also noted. For example, Xiao et al. (2014) describe instances of IENs being used for translation service in addition to their usual role within the nursing team. - Corporate cultures may undervalue IEN expertise or resist adaptation to diverse workforce needs - Points to	- Emphasis on tailored, context-specific bridging programs in acute care settings - Supports inclusion of clinical mentorship, cultural adaptation modules, and policy-level engagement - Workplace integration programs should move beyond one-size-fits-all prelicensure models	- Better outcomes when programs are tailored to IEN needs and workplace context - Potential for improved scope-of-practice utilization, workforce retention, and patient safety - Lack of tailored programs leads to continued deskilling, frustration, and underemployment	- Fragmented or inconsistent approaches to IEN education - Lack of employer engagement in bridging design - Limited awareness of social/cultural needs of IENs in transition - Absence of funding or structural policy support	- Presence of culturally safe mentorship and clear expectations - Support from unit champions, nurse educators, and leadership - Recognition of IENs' prior expertise and graduated responsibility in care settings - Programs that foster peer collaboration and ongoing feedback

			systemic inequities embedded in traditional orientation and training approaches				

Primeau, M.-D., St-Pierre, I., Ortmann, J., Kilpatrick, K., & Covell, C. L. (2021). Correlates of career satisfaction in internationally educated nurses: A cross-sectional survey-based study. International Journal of Nursing Studies, 117, 103899–103899. https://doi.org/10.1016/j.ijnurstu.2021.103899	Cross-sectional survey-based study	- Focus on self-reported perceptions of career satisfaction - Integration and support were measured through factors like discrimination and goal attainment	- IENs who experienced discrimination reported lower career satisfaction - Career satisfaction varied significantly by race: Black IENs were least satisfied; White and Asian IENs most satisfied - Highlights the need for anti-discrimination policies and inclusive organizational cultures	- Provides insights for developing targeted support based on demographics and geography - Suggests creating environments that support goal attainment and address discrimination	- Satisfaction higher among older, more experienced nurses and those who attained career goals - Male IENs and highly educated newcomers reported lower satisfaction - Career satisfaction highest in Prairie Provinces and Ontario; lowest in Atlantic Canada	- Discrimination based on race and gender - Inability to reach career goals - Underemployment and part-time/occasional work - Regional disparities in support and opportunities	- Full-time employment - Having children (linked with greater satisfaction across groups) - Feeling that one's career goals have been achieved - Living in more supportive regions (e.g., Prairies, Ontario)

Ramji, Z., & Etowa, J. (2018). Workplace integration: Key considerations for internationally educated nurses and employers. Administrative Sciences, 8(1), 1–18. https://doi.org/10.3390/admsci8010002	- Instrumental qualitative case study informed by critical social theory (CST); single-site study at St. Michael's Hospital - 28 participants: IENs, mentors/peers, managers, senior leaders; diverse in gender, origin, years in practice - Semi-structured interviews, focus groups (for member checking), organizational document review, surveys	- Workplace integration is a two-way process involving both IENs and the employer organization.	- Emphasizes equity (not just equality); HR and management must tailor supports; cultural humility, leadership development for managers; need for equity-oriented accountability structures	- Mentorship seen as a key integration tool; IENs take on preceptor and mentor roles; hospital piloted mentorship initiatives (e.g., "super users," clinical fellowships, mentoring IEPs)	- Definition and conceptual framework of workplace integration; advocacy for accountability structures (e.g., tracking IEN progression); recognition that IENs are contributors, not just passive recipients of integration	- Family obligations, multiple job demands - Inflexible scheduling for education - Social closure and racialized exclusion from leadership roles - Uneven application of hiring policies - Lack of follow-up after leadership role applications	- Organizational culture of inclusion - HR tracking of IEN recruitment - Visible senior leadership on equity - Engagement with external community and recognition through awards - Role modeling and peer support

Randall, P. S., & De Gagne, J. C. (2023). Supporting self-determination among internationally educated nurses: a discussion. Contemporary Nurse: A Journal for the Australian Nursing Profession, 59(6), 416–421. https://doi.org/10.1080/10376178.2023.2290035	- Discussion paper based on synthesis of extant literature, guided by Self-Determination Theory (SDT).	- No specific mentorship model was evaluated, but authors recommended preceptors from shared backgrounds, regular feedback from IENs, and culturally aware support as informal mentorship strategies.	- Highlights the role of systemic and interpersonal racism, language bias, and cultural insensitivity in undermining IENs' autonomy and well-being. Recommends anti-racist policies, inclusive orientation, and language framing.	- Discusses a 12-month bridging program in Sweden (Högstedt et al., 2021) that enhanced licensure, language, clinical skills, and peer bonding. Recommends local language framed as "additional" vs "second."	When supported across SDT domains (autonomy, competence, relatedness), IENs reported increased confidence, workplace adaptation, and engagement. Lack of support led to distress, isolation, and potential patient safety risks.	- Racism and discrimination from peers and patients - Communication challenges - Lack of licensure support - Limited career mobility - Inadequate orientation - Exploitative contracts	- Recognition of prior credentials - Language training with flexible scheduling - Peer support - Bridging programs - Empowerment through career pathways - Positive framing of multilingualism

Salami, B., Meherali, S., & Covell, C. L. (2018). Downward occupational mobility of baccalaureate-prepared, internationally educated nurses to licensed practical nurses. International nursing review, 65(2), 173–181. https://doi.org/10.1111/inr.12400	- Exploratory qualitative study using a transnational feminist framework; data collected via semi-structured interviews with 14 baccalaureate-prepared internationally educated nurses (IENs) in Canada.	- No formal mentorship program studied. However, lack of mentorship and support was highlighted as a major barrier to RN licensure and successful integration. Participants relied on informal networks for guidance.	- Gendered roles (e.g., motherhood) shaped both migration motivations and constraints. - Systemic barriers, including racism, credentialing inequities, and language testing, contributed to downward mobility. - Highlights the racialization and feminization of deskilling in Canada's nursing labor market.	- Comparison of RN vs. LPN pathways: LPN registration perceived as faster, cheaper, and more accessible. - LPN roles often resulted in underutilization of prior RN skills and qualifications.	- Participants faced deskilling, ambivalent recognition of skills, and professional dissatisfaction. - LPN role helped some regain confidence and relational skills, but many felt unrecognized and stagnant.	- Credential recognition and lengthy application process. - Lack of support for RN registration. - Limited access to bridging programs. - High costs of exams and language testing. - Confusing or misleading information from recruiters.	- Easier LPN registration pathway. - Informal support networks. - In a few cases, experience as LPN enhanced confidence in navigating the Canadian health system (for those who later became RNs).

Shen, J. J., Xu, Y., Staples, S., & Bolstad, A. L. (2014). Using the Interpersonal Skills tool to assess interpersonal skills of internationally educated nurses. Japan Journal of Nursing Science : JJNS, 11(3), 171–179. https://doi.org/10.1111/jjns.12018	- Quantitative observational study using simulated patient encounters to assess IENs' communication skills with a modified Interpersonal Skills (IPS) tool. Conducted with 52 IENs at two U.S. hospitals.	- Not a mentorship study. However, the study underpins the need for structured transition training programs to improve IEN interpersonal competencies. Data drawn from a baseline assessment of the Speak for Success program.	- Highlights communication inequities faced by IENs due to language, cultural, and training differences. - Gender and ethnic differences in communication performance observed (e.g., male IENs scored lower on empathy). - Suggests tailored cultural competence training is necessary.	- Used standardized patients (SPs) to simulate real nurse–patient interactions. - Measured 17 items across 4 domains: interviewing, counseling, rapport, and personal manner. - Based on modified IPS tool validated in other health contexts.	- IENs scored significantly lower in "soft" skills like counseling, rapport, and personal manner. - Domain 1 ("interviewing/collecting information") had the highest scores (mean 3.54/4). - Weakest areas: small talk (2.06), counseling (2.10), closure (2.44), physical exam (2.21).	- Cultural norms that prioritize technical/cure-focused training over psychosocial care. - Possible discomfort with culturally unfamiliar patient interactions (e.g., touch, self-disclosure). - Lack of targeted communication training for IENs.	- Age positively correlated with interpersonal skill performance (more experience, better adaptation). - Non-Filipino IENs scored better on body language and mood/demeanor, suggesting intra-IEN diversity may influence skill variation.

Shiju, M., Hall, H., Lee, C., & Whitehouse, C. (2024). Barriers and enablers of successful workplace integration of internationally educated nurses (IENs) in a host country: A qualitative evidence synthesis. Policy, Politics & Nursing Practice, 25(4), 228–240. https://doi.org/10.1177/15271544241276860	- Qualitative Evidence Synthesis (QES) using thematic analysis (Braun & Clarke, 2006) of 6 qualitative studies (2013–2023); guided by PICo framework.	- Mentorship was cited as a critical enabler in 3/6 studies. - Tailored mentorship facilitated confidence, skills transfer, and smoother integration.	- Highlights systemic racism, cultural dissonance, leadership gaps, and the need for culturally safe mentorship. Emphasizes inclusivity, antidiscrimination policies, and cultural competency.	- Structured onboarding, preceptorship, language/practical skills training, and culturally aware workplace environments.	- Improved workplace integration, confidence, reduced transition stress, enhanced patient care, stronger team cohesion.	- IEN-related: language barriers, cultural differences, scope of practice disparities. - Organizational: poor leadership, inadequate support. - Contextual: racism, discrimination.	- IEN-related: commitment to learn and adapt. - Organizational: structured multifaceted programs (orientation, skills, cultural training), supportive environment, and mentorship.

Smith, C., & Cantillon, P. (2024). Exemplar or facilitator: An exploration of the lived experience of nurse mentors supporting the adaptation of internationally educated nurses. The Clinical Teacher, 21(2), e13702-n/a. https://doi.org/10.1111/tct.13702	- Interpretative phenomenological analysis research design was utilised to explore the experiences of nurse mentors. Semi-structured interviews were conducted with a maximum variance sample of 11 nurse mentors. The data were subjected to an Interpretive Phenomenological Analysis (IPA) sequential analytical approach yielding integrative themes	Explored two mentor identities: 1) Exemplars – standard-bearers focused on perfection and accountability. 2) Facilitators – supporters who build confidence and promote learning collaboratively.	- Intercultural communication challenges and the need to support IENs' socialisation into Irish team-based and culturally embedded care environments. - Exemplar mentors felt more stress, suggesting equity-focused training must encourage a facilitator identity to improve sustainability and well-being.	- Mentorship is required for IENs during adaptation periods. - Many mentors lacked formal preparation or protected time. - Socialisation into team culture is a key, often hidden, curriculum.	- Facilitator mentors experienced less stress and greater sustainability. - Positive learner engagement and gratitude influenced mentor satisfaction. - Mentorship benefits included increased self-awareness and professional growth.	- High workload and staffing shortages. - Lack of time, protected space, and formal support. - Language barriers and unfamiliarity with supporting socialisation. - Cultural disconnects and role strain between mentoring and clinical duties.	- Formal preceptorship training (though not all had it). - Empathy and motivation from both mentors and learners. - Strong team dynamics. - Recognition and appreciation from mentees and institutions.

Sriram, V., Atwal, A., & McKay, E. A. (2024). Exploring aspects of mentoring for black and minoritised healthcare professionals in the UK: a nominal group technique study. BMJ open, 14(12), e089121. https://doi.org/10.1136/bmjopen-2024-089121	- Nominal Group Technique (NGT) – a structured consensus-building method involving silent idea generation, round-robin sharing, open discussion, and ranked voting. - 12 UK-based healthcare professionals from diverse ethnic and professional backgrounds, all with experience in mentoring.	- Sponsorship: active career advocacy and opportunity sharing - Allyship: mentors supporting racial equity and disrupting bias - Surface characteristics: role modeling and demographic identity matters - Peer support: through structured mentoring circles	- Builds consensus on the key components of effective mentoring for Black and minoritised ethnic (BME) healthcare professionals in the UK.	- Psychosocial mentoring is foundational: trust, intimacy, clarity of expectations. - Discussion of race and racism in mentoring is essential, particularly in cross-ethnic pairings. - Mentoring circles (peer group mentoring) complement traditional one-to-one mentoring. - Allies must be authentic, humble, and courageous in challenging systemic norms.	- A consensus-informed mentoring model for BME healthcare professionals was developed. - Key components: psychosocial mentoring, peer support (mentoring circles), race-conscious conversations, sponsorship, and allyship. - Identified mentor characteristics critical for BME mentees' success: honesty, humility, cultural awareness, and strong relational skills.	- Lack of clarity in literature on effective mentorship for BME professionals. - Silence or avoidance of race-related discussions in mentorship relationships. - Risk of inauthentic allyship or performative mentoring. - Potential mismatch in expectations or lack of safe spaces to share.	- Psychosocial safety through trust and open communication. - Use of mentoring circles for additional peer support. - Authentic allyship grounded in humility, honesty, and courage to challenge norms. - Early-career mentoring and network facilitation.