Mentorship: exploring the concept and its place in nursing

Author: Debbie Roberts

Introduction:

This section will introduce the historical and chronological development of mentoring in nursing practice. The notion of having someone that student’s call upon to help them to learn in clinical practice is not new: students have always done this on an informal basis, but this section describes mentoring in relation to what the Global Standards for the initial education of professional nurses and midwives (WHO 2009) and the NMC Code (2015) says. The nature and purpose of mentorship in this context is related to the role of the clinician in providing student support and guidance, and in many cases encompasses the activities associated with learning, teaching and assessment of practice. Introduced within the UK in the 1990’s as part of a curriculum review (Project 2000), as a mechanism to support student nurses to learn in clinical practice; the section will outline the shift in requirements of nurses to have a qualification in mentoring in the UK, and describe how mentoring is more widely linked in in some areas to personal and professional development. Associate or team mentoring has been a pragmatic response by the profession to an increasing number of students being present in the clinical placement at any one time, and will discuss the nature of team mentoring. The section will provide some defined examples of mentors and mentorship and readers will be encouraged to consider these in relation to themselves. Preceptorship and coaching are also explained.
Aims:

- To provide an overview of the historical roots of mentoring
- To provide a definition of mentor and the process that supports mentorship
- To outline the development of mentoring for nurse education
- To examine who becomes a mentor and why they take on the role
- To introduce models of supporting learning in clinical practice.

Historical overview:

You may know that the notion of mentoring originally stems from Greek mythology? In Homer’s Odyssey, King Odysseus asked his trusted friend: Mentor, to protect, advise and support the development of the King’s young son (Telemachus) while the King was away fighting the Trojan War. The role of mentor here is seen as one of empowerment and nurturing over a sustained period of time.

Mentoring also has historical roots within nursing. Metcalfe (2010) suggests that Nightingale was a nursing mentor. According to Metcalfe Nightingale was herself mentored by an influential matron of St. Mary’s Hospital in Paddington, England: Rachel Williams. Metcalfe goes on to suggest that Nightingale also received mentorship from William Farr a statistician of the day that helped her to produce the now iconic polar area charts on preventable mortality in the Crimean War (Metcalf 2010).

Within the UK the need for qualified nurses to have formal preparation to become a mentor in order to teach students was introduced as part of the initiative for nurse education to move from a hospital based process to one of being situated within Higher Education; known as Project 2000, introduced in the 1990’s by the then professional governing body for nursing; the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). It is from this point on that a formal and binding
requirement existed for qualified nurses to have a specific qualification in order to support, supervise and assess student nurses in clinical practice. Although some would argue that nurses have always undertaken this role.

For more information about the development of mentorship in England nursing locate the paper by Fulton (2015), listed in the references. He points out that other countries of the UK may have a similar history. In his paper: The archaeology and genealogy of mentorship in English Nursing, Fulton describes the move away from the empowering role of the mentor described in Greek mythology to one of mentorship being more closely aligned with obedience and surveillance. Scotland has also devised a national approach to mentor preparation; you can see this document by using the following link: [http://www.nes.scot.nhs.uk/media/2071831/national-approach-to-mentor-preparation-2nd-edition.pdf](http://www.nes.scot.nhs.uk/media/2071831/national-approach-to-mentor-preparation-2nd-edition.pdf) You can see that this approach aims to standardise the preparation of mentors across Scotland; this work is returned to later.

More recently, two important reports examining the future of nurse education have been produced: Quality with Compassion: the future of nursing education (2012) (a report produced and published by The Royal College of Nursing) and Raising the Bar Shape of Caring: A review of the future Education and Training of Registered Nurses and care Assistants (a report published by Health Education England). Lord Willis acted as independent Chair for both of these reports and calls for similar recommendations in both documents; particularly around the need for more robust research to strengthen the evidence base to support what works in terms of pre-registration nurse education. Within the 2012 Quality with Compassion report, Lord Willis stresses the importance of the role of mentors in helping students to apply theory to practice and suggests that in order to undertake this important role, mentors require dedicated time to be provided by their employers.

You might find it useful to read these two reports which can be found via the following links:

The two reports together with a further project undertaken by the National Nursing Research Unit (Robinson, Cornish, Knutton, Corben and Stevenson. 2012) and the Royal College of Nursing on Mentorship (2016) all agree that mentorship is vital to nurse education but also indicate that perhaps the mechanism by which mentorship is delivered and sustained are not yet ideal. Indeed a review of standards for nurse education within the UK is underway and it is anticipated that the competencies for graduate nurses are likely to be changed.

What is a mentor and what is the process of mentoring?:

Mentorship is open to many interpretations. There are many terms which are sometimes used interchangeably, for example, mentor, buddy, and preceptor; but these titles are not necessarily describing the same role; however, they all involve one individual supporting another in order to learn. Some of the variations in title are aligned with geographical definitions; for example, in Australia the term preceptor is used to describe a one to one clinical learning experience between an experienced registered nurse and a novice (Amos 2001).

Exercise: before moving on try to write a few ideas about your own definition of mentorship and then see if any of the elements you have identified appear within the definitions provided here.

The social science literature contains many different definitions of a mentor which demonstrates how this concept and role is open to interpretation.

The following are some examples of definitions:
“Mentoring is a two way circular dance that provides opportunities for experience, giving and receiving each other’s gift without limitations and fears” (Huang, Huang and Lynch 1995 p xii).

“Mentoring is the art and science of guiding another through purposeful actions of leading and directing to a new place of cognition” (Metcalfe 2010 p167).


Mentorship: “the supervisory relationship of the student nurse with a qualified nurse who monitors and evaluates their skill development in the clinical area” (Fulton 2015 p39).

Interprofessional mentorship: “learning that takes place between providers and students who are from different disciplines or health professions” (Lait, Suter, Arthur and Deutschlander 2011 p211).

What is interesting about these definitions is that they focus on different things: some appear to concentrate on the learner or mentee’s development, some focus on the relationship itself and others emphasise the reciprocal nature of the mentee mentor relationship.

The Global standards for the initial education of professional nurses and midwives (WHO 2009) highlights the diversity of initial preparation of nurses and midwives and calls for the standard to be agreed globally at Degree level; although there is an acknowledgement that many countries will be working towards this standard. The global standards aim to provide an opportunity for investment in the capacity required to raise the standard of initial education of nurses and midwives; with curriculum being firmly rooted in universities. It is important to remember that Universities cannot achieve this standard alone; students also need to learn from the experience of being in a clinical environment in order to learn to be a nurse and hence close working relationships are required with clinical practice and qualified nurses (and others) who support students to achieve clinical learning
standards. The principles enshrined within the Global standards are quite clear that the interaction between the student and the client should be the “primary focus of quality education and care” (p19), further emphasising the importance of clinically based mentors. Clinical learning is woven throughout many of the global standards. Students should be provided with “supervised clinical learning experiences” (standard 3.2.4) in order to develop “clinical reasoning, problem solving and critical thinking” (Standard 3.1.7).

Exercise: Download the Global standards for the initial education of professional nurses and midwives from the following website: http://www.who.int/hrh/resources/standards/en/

Look at pages 20-29 which contain the various outcomes related to programme graduates; in particular look at section 4.2: Clinical faculty. There are three aspects to this section; think about your role as a mentor and how you might be meeting these standards.

Mentoring within nursing can occur through direct supervision, indirect or arm’s length supervision “or through subtle coaching to allow the mentee to achieve a new direction in his or her life.

Effective mentors are able to lead others by modeling professional behaviour and personal balance” (Metcalfe 2010: 167). According to NHS Education for Scotland (2013: 13) “Mentors are required to be facilitators of learning, effectively enabling the development of individuals by focusing on the experience of learning and making explicit the steps involved in the learning process and guiding students towards achievement. The elements involved in this process include communication, collaboration, guidance, participation, problem solving, supporting decision making and support and challenge”.

Within this book, a mentor is considered to be a clinician that supports and guides the clinical learning of a student; such support includes role modelling, teaching and assessing student practice. Mentors support learners in a variety of different contexts, for example, the learner may be an
undergraduate student on an initial pre-registration programme, a post graduate student on an initial pre-registration programme; internationally recruited qualified nurse working towards qualification and registration with the NMC in the UK; student health visitors, student district nurses; a qualified nurse working towards Advanced status and many others.

Within the UK, it is mandatory for all pre-registration nursing and midwifery students to be supported in clinical practice by a named mentor (NMC 2006), however, mentors can support more than one student simultaneously. Mentors should be available to the student for 40% of their time in practice and mentors may support up to three students at any one time (although invariably nursing works on a 1:1 basis). This emphasises the importance of the student and mentor working alongside each other for the purpose of learning. When the mentor and student do not work alongside each other, the mentor should nominate another individual to supervise the activity that the student undertakes. This requirement for students and mentors to work together in order to provide direct patient care and promote learning in the student has been called into question in terms of whether this is sustainable (for example, see Robinson et al, 2012, and Andrews et al 2010, from the reference list for some of the key arguments).

The development of mentorship:

In the UK the professional body for nursing: The Nursing and Midwifery Council (NMC), devised new standards for mentoring student nurses and midwives in clinical practice in 2006, which were updated in 2008. The standards were introduced with the aim of protecting the public from unsafe nurses through better mechanisms of learning in practice and more rigid assessment of clinical learning. All student nurses studying on approved educational programmes in the UK should be allocated a named mentor for each clinical learning placement (NMC, 2006). Mentors must be on the same part, or sub-part, of the register as the student they are to assess and must be registered for at least one year before taking on this role. The NMC standard defines a mentor as being a
registrant who has successfully completed an accredited mentor preparation programme from an approved Higher Education Institution (HEI). As a mentor you should be prepared to be able to demonstrate to any student that you have achieved and maintained your mentor status.

**Action point:** If you work in the UK, the organisation in which you work should have a record or register of live mentors. Ask your line manager where this record can be accessed and check your details. Glasper (2012) suggests that the record should ideally show:

- **The date of initial preparation for being a mentor.**
- **The date the mentor was last updated and the method by which this was undertaken (e.g. via an on line virtual learning platform, or face to face.**
- **The scheduled date for triennial review (all mentors are expected to be fully updated every 3 years), and the date of completion.**
- **An annotation for sign-off mentors, which is usually a star next the name on the database of mentors.**
- **An annotation for the practice teacher; usually a separate column on the data base (Glasper :371).**

Within the UK, mentorship is seen as an essential element of pre registration nurse education and is one of the mechanisms by which students are made practice ready on completion of their programme as a newly qualified nurse.

From September 2007, all new entrants to mentor and practice teacher preparation programmes must meet the requirements outlined in the NMC’s Standards to support learning and assessment in practice (NMC, 2006). Andrews, Brewer, Buchan et al (2010) draw on the Standards to Support Learning and assessment in Practice and highlight the importance of mentors who are able to use
the standards in their everyday practice and so achieve the criteria to maintain their ‘active’ status on the mentor register.

The role of the mentor:

Within the UK, the NMC (2006) states that mentors:

1. **Organise and co-ordinate student learning activities in practice.** Throughout this book you will find a wide range of practical examples of the type of learning activities that you might be expected to provide to students. Whilst the examples provided are meant to be informative; the idea of this book is that you will use the examples as a springboard to devise and develop learning activities that are appropriate for students in the place where you work. A later section on the learning environment will encourage you to think more about the learning activities that are available to students in your area.

2. **Supervise students in learning situations and provide them with constructive feedback on their achievements.** Providing feedback, on both positive and negative aspects of a student’s performance can be difficult.

3. **Set and monitor realistic learning objectives for students.** In order to do this, it is important that you have a working knowledge of the programme that the students is studying, can offer a range of learning activities that are appropriate for each student depending on the stage in their educational journey and finally have a good grasp of what constitutes a learning objectives, and how to assess whether the student has achieved their objectives. Some learning objectives will be laid down by the professional body as a requirement of progression on the programme; whilst others will be personal to each student.

4. **Assess the total performance of students, including their developing nursing skills, attitudes and behaviour.** This is akin to holistic assessment of patients or clients, and again, some aspects are easier to provide feedback on than others. The total performance of students in clinical areas is becoming increasingly important and under close scrutiny as it
has been suggested that mentors are sometimes reluctant to refer or fail student nurses. For example, see Duffy K (2004) *Failing to Fail*. Nursing and Midwifery Council, London.

5. **Provide evidence, as required by programme providers (Usually universities) of student achievement or lack of achievement.** Therefore, just as with any documentation relating to the people in your care; as a mentor you are expected to document your activity with students and make judgements about their progress in a professional manner. The documents about student learning should be clear and factual.

6. **Liaise with nurse teachers to provide feedback, identify any concerns about the student’s performance and agree action, as appropriate.**

7. **Provide evidence of, or act as, a sign-off mentor with regards to making decisions about the achievement of proficiency.**

The standards tell you what the professional requirements currently are within the UK, but for a more detailed understanding of the real world of mentoring you could obtain the paper by Jokelainen, Turunen, Tossavainen, Jamookeah and Coco (2011) (from the reference list below) who undertook a systematic review of 23 papers of mentoring spanning over twenty years. Their paper is useful because it provides a detailed overview of the systematic review process adopted by the authors and presents two main themes as being evident within the literature: facilitating student learning and strengthening students’ professionalism and four further sub themes are also identified. Interestingly, the authors suggest that mentoring is a complex role integrating learning and practice, personal and professional development that bridges the theory practice gap of working life. Furthermore, they go on to say that the nursing professionals acting as mentors be pedagogically competent; in other words they should know how to teach.

For another very different description of mentoring, see the paper by Mills, Francis and Bonner (2008), (in the reference list below) who undertook a study with seven mentors. The paper describes rural nurses’ experiences of mentoring in Australia and suggests that nursing has its own symbolic
language that mentors teach their mentees through chatting together. The ‘nurse chat’ can take place through planned face to face, accidental face to face and planned distant mechanisms and if the mentor and mentee share similar values, the chatting is influential in developing an ongoing strong bond of deep friendship. What is interesting here is that the language can be used in a subconscious way; so mentors may not even be aware that they are using such language; but in doing so, they are passing on what might otherwise be hidden. Mills et al (2008: 27) refer to this process as “cultivating and growing rural nurses”.

**Associate mentors:** These are people that can also support clinical learning: they may be working towards qualified mentor status, be from another discipline to that of the learner or be a second level nurse. Associate mentors can undertake formative assessments intended to support clinical learning; but it should be the mentor that undertakes any summative assessments of student practice.

**Sign off mentors** are expected to have met extra criteria to undertake the role, supporting pre-registration midwifery students during all placements and nursing students during final placement. These experienced mentors assess students to ensure they have achieved all prescribed NMC (2004, 2009, 2010) proficiencies for registration, that they are fit to practice, and fit for purpose. Only sign off mentors are able to confirm to the NMC that the student has met the relevant standards of proficiency; and they are accountable to the NMC for their decision.

All sign off mentors must meet set criteria which include:

- **Currency and capability in the field of practice the student is being assessed in;**
- **Has a working knowledge of the students’ programme and practice assessment requirements;**
- **Has an in-depth understanding of their accountability to the NMC for their assessment decisions;**
Sign off mentors are required to spend 1 h of protect time with each final placement student to give feedback and to facilitate learning (NMC, 2008).

Rooke (2014) examined sign off mentors, new mentors and lecturers’ understanding of the sign off mentor role at one Higher Education Institute in the UK. The participants were 114 new sign off mentors from midwifery and a range of fields of nursing practice; 37 preparation for mentorship students and 13 nurse lecturers. The sign off mentors considered the professional accountability elements of the role to be daunting but acknowledged that they were the best placed, most appropriate individuals to assess practice. The additional responsibility of being a sign of mentor was seen as a challenge for the majority of the participants. The study also found that “participants felt the role remains unrecognised and poorly understood within healthcare organisations leading to a lack of appreciation of the time required to do the role effectively” (Rooke 2014 :47). These themes are not dissimilar to a phenomenological study conducted by Hutchinson and Cochrane with six sign off mentors (2014); where participants highlighted several aspects associated with accountability and the importance of making a decision as to whether a student was fit to practice as a qualified nurse. The language used by the participants demonstrates the enormity of the personal and professional impact of the role (look at the data extracts presented in the paper for examples).

Why do individuals become mentors?

Exercise: Before reading this next section it might be useful to stop and think about your own journey to becoming a mentor; reflect on what influenced your decision to become a mentor and how you became a mentor. Compare your own journey to the following section.

Career progression: in the UK career progression is linked to role descriptions and pay bands through the Knowledge and Skills Framework (DH 2003a) and Agenda for Change (DH 2003b). For
many nurses holding a mentor qualification is a pre requisite for progression to senior staff nurse or junior sister roles; even though it could be argued that not all nurses are necessarily suited to the mentorship role; and may feel pushed into taking on the role in order to aid career progression (Andrews, Brewer, Buchan et al 2010). In some cases seniority or length of service is one of the main reasons cited for becoming a mentor (Chen and Lou 2014). Whilst Nettleton and Bray (2008) acknowledge that for most mentors there is an expectation for individuals to become mentors; but that in reality, individuals have very little choice about becoming a mentor. Robinson et al (2012) on behalf of the National Nursing Research Unit and the NHS Education for Scotland (2013) both identify the desirable qualities that mentors should possess and point out that commitment and passion for the role of facilitating learning is paramount.

In an interesting study from Australia, McCloughen, O’Brien and Jackson (2014) found that being a mentor and having the need for a mentor commenced in childhood. In their study of thirteen nurse leaders who had been both a mentor and a mentee; the participants started to identify and form relationships with people that they saw as mentors around them. Mentorship was described by the participants as an evolutionary journey. The connections with mentors made in childhood further evolved during their youth and into the early nursing careers of the participants; “when they continued to be exposed to and impacted by mentorship” (p304) in this case the mentorship was seen as essential to leadership development. This is an interesting idea because the authors are arguing that there is a natural and evolutionary process of becoming a mentor beginning with being in the company of people who act as mentors (although we may not use this term to describe our relationship with them); learning from mentors to one of becoming a leader mentor. So it is possible that our ideas about the human qualities expressed by mentors are formed early in our childhood and that early and sustained exposure to such individuals shapes our understanding of what it means to be mentored and to be a mentor.

Becoming a mentor:
Formal preparation.

Most but not all countries require mentors to undergo some form of formal or official preparation in order to become a mentor; although the point at which individuals should be allowed to undertake the role is disputed. Robinson et al (2012) provide a very useful summary of some of the key arguments in terms of whether mentorship is incumbent upon all qualified nurses or whether mentorship should be preserved as a specialist function and therefore should remain in the domain of those who are wholly committed to the role. Their report shows that if formal education is a prerequisite for mentors then it needs to be actively supported by senior managers in order to release staff to fully engage in the process (Robinson et al 2012). Andrews, Brewer, Buchan et al (2010) also acknowledge that “not only is there a need for large numbers of active mentors but the system relies on a regular stream of ‘mentors in waiting’ to replace those who move onto other roles” (p253).

Scotland decided to take a national approach to the preparation of mentors; bringing together a range of key stakeholders from academia and the health service to develop a standardised core curriculum. The document provides guidance for three key areas of mentor preparation including identification and selection of those who undertake mentorship training; the nature of the supervisory role of mentors and their requirements for ongoing professional development in the role. Here is a link to the core curriculum framework which you might like to compare to your own preparation:


The NHS Education for Scotland (2013) curriculum also points out the importance for mentor preparation to take place in both classroom and clinical practice.
Despite formal preparation or training programmes, there is evidence to suggest that many mentors (particularly newly qualified nurses) can become overwhelmed by the responsibilities and as a result feel poorly prepared for the enormity of the role (see the following for examples: Andrews and Wallis 1999, Andrews and Chilton 2000, Andrews et al 2010; all in the further reading list).

Within the UK nurses must have been qualified for a year before they can undertake the preparation to become a mentor course. The formal preparation course to become a mentor is currently set at a minimum length of ten days, at least five of which should be protected learning time spent in clinical practice spread across a three month period. This time should involve classroom and clinically based learning activities and should include the experience of mentoring a student under the supervision of a qualified mentor (Veeremah 2012, NHS Education for Scotland 2013). Given the agreement within the literature of the importance of mentorship to nurse education; it perhaps surprising that the period of mentorship preparation is set at such a low minimum requirement (10 days), compared to the length of time spent in initial pre-registration nurse education.

Veeramah (2012) conducted a study to evaluate the effectiveness of the preparation programme from one approved education institution in the South East of England. The 346 invited participants had all completed their mentor preparation course between September 2007 and January 2010; data were collected by postal questionnaire asking 11 closed questions and two open-ended questions from 199 participants (57.5%). The results indicate that all participants had acted as a mentor to at least one student since undertaking their preparatory course. They were asked the extent to which the course equipped them with the appropriate level of knowledge, understanding and skills to fulfil the role and responsibilities of a mentor. One hundred and seven (53.8%) said ‘to a large extent’, 85 (42.7%) mentioned ‘to some extent’, 1 was ‘not sure’ and 6 (3.0%) stated ‘to a little extent’ (Veeramah 2012. p415). Results regarding protected time in which to complete the theoretical and practical components of the course varied: 42 (21.1%) said ‘to a large extent’, 84
(42.2%) stated ‘to some extent’, 7 (3.5%) were ‘not sure’, 27 (13.6%) and 39 (19.6%) mentioned ‘to a little extent’ and ‘not at all’, respectively (Veeramah 2012. p415).

Informal preparation: whilst formal educational or other planned programmes are an important aspect of demonstrating competency to be a mentor for nursing students; the idea of informally becoming a mentor should not be underestimated. The study by McCloughen et al (2014) suggests that the seeds of being a mentor should be sown very early on in initial pre registration nurse education so that the identity of being a nurse emerge in parallel with that of being a mentor. They go on to point out that the influences of “supportive attitudes and behaviours, and environments and cultures in which acts of professional generosity are promoted should not be underestimated” (p308).

Remaining on the live register of mentors.

Undertaking an initial formal preparation programme to become a mentor is only the first part of the mentoring journey. Within the UK there are other formal requirements after initial preparation. Whilst these requirements are specific to mentors working in the UK, the principles of maintaining knowledge and skills is not unique to this group of nurses; so even if you are working to support student learning outside of the UK, no doubt you will still want to ensure that you remain confident and competent to be a mentor and support student learning in the best way possible. Within the UK, mentors must also undertake an annual update which should include opportunities for formal discussions with other mentors around the validity and reliability of judgements they have made about student performance (NMC 2009). Similarly, mentors must also undergo a triennial review (every three years) in order to maintain their live status on the register of mentors (NMC 2008). Whilst the nature of the triennial review is determined by local arrangements, mentors should be able to provide evidence that they have remained active as a mentor and supported at least two students, completed annual updates, and had opportunities for group exploration of borderline or
difficult cases so as to be confident about the judgements they have made in the intervening period (NMC 2008).

Preceptorship: Mentoring newly qualified nurses.

It has long been recognised that nurses who are newly qualified require support during the period of transition between being a student and being a registered nurse. There are a range of support processes specifically aimed at such newly qualified nurses and whilst this period is known in the UK as preceptorship, some countries refer to mentorship. Chen and Lou (2014) provide a literature review of programmes supporting newly qualified nurses under the term mentorship. Interestingly, they suggest that the primary aim of such mentorship programmes is to reduce high turn-over rates and prevent people leaving the profession. They also point out that mentorship and preceptorship share similar characteristics of a supportive role and of the development of knowledge and skills in mentees/preceptees.

Mentoring: working together.

It is important for students to engage in the ‘real work’ of the clinical placement.

Exercise: Before embarking on mentoring a student it is a good idea to think about what the ‘real work’ of your particular area is; you may find it useful to undertake this exercise with other members of your team in order to construct an agreed vision of what the work entails. What does the work of the qualified nurse consist of in your area? How do qualified nurses communicate with other disciplines/professions in your area? Are there particular skills, or nursing interventions that could provide unique learning opportunities for students whilst they are learning in your area?

These aspects are considered later in more detail. Mentors should be available to students; but it is important to think about what this means.

What does being available really mean?
Exercise: Start to think about how you can let a student know that you are available?

Start to think about how as a mentor you intend to work with different students; for example a student on their first clinical placement will have different requirements to a student that has previously worked for many years as a healthcare support worker prior to undertaking their pre registration nurse education programme. Think also about the requirements of students as they progress through the programme of study? What might students need from you as a mentor and or from the placement as they progress?

Mentoring: Knowing the student.

Every student is an individual; it is important that as a mentor you understand what programme of learning the student you are mentoring is studying. Whilst all pre-registration nurse education programmes in the UK are at a minimum of degree level, some programmes leading to initial qualification may also be at post graduate or masters level (see the following two examples)

http://www.southampton.ac.uk/healthsciences/postgraduate/taught_courses/pgdip_adult_nursing.page

http://www.salford.ac.uk/pgt-courses/nursing-rn-adult-mental-health-children-young-people

Exercise: Start to think about what students at different academic levels will need when they are your ward or unit for their clinical placement. You need to be prepared to develop students at all levels, with various previous knowledge and skills sets and confidence levels.

At different stages of the programme the student will be expected to learn different things; these may relate to knowledge or skills that the student is expected to be able to demonstrate and which you as the mentor, may be expected to assess whether the student has achieved
the required standard. Within the UK, the NMC (2006) specifies the Standards for pre
registration nursing education, and within the document you can see exactly what the student
has to demonstrate at various points of the programme:

http://www.nmc.org.uk/globalassets/siteDocuments/Standards/nmcStandardsofProficiencyF
orPre_RegistrationNursingEducation.pdf

The emotional aspects of mentoring:

Being a mentor means having to make judgements about the performance of learners whilst
they are with you; and this is not always easy or straightforward; especially when the student
is struggling or failing to meet the required standard. Black, Curzio and Terry (2014) explored
the emotional aspects of being a mentor; they established what it means to the mentors to
experienced distress in three ways:

‘the personal price’, ‘a sense of professional responsibility and accountability’ and ‘having the
strength’”. Read the paper by Black et al (from the reference list below) and look in particular
at the powerful data extracts presented from each theme. It is clear that these mentors did
not feel prepared for the reality of the real experience or the associated distress associated of
failing a student. Despite having undergone the appropriate mentor preparation, they
struggled to deal with their feelings although the participants in the study acknowledge that
failing the student was the right decision to make. Black et al (2014) go on to consider the
potential dissonance between classroom taught theory, and “actually going through this
experience and having to manage it” (Black et al 2014: 232).

Models of supporting clinical learning:

As a result of a literature review of practice education models, Budgen and Gamroth (2008)
identify ten ways or models to support clinical learning: faculty-supervised practicum,
preceptorship, education unit, joint appointment, secondment, affiliate position, internship, co-operative education, work–study and undergraduate nurse employment. Their paper is written from a Canadian perspective where the term preceptor is used instead of mentor, but the issues raised are transferrable elsewhere. The review highlights the key features of the models such as:

“differing ratios of students to teachers; variations in roles and responsibilities among students, faculty and clinicians in relation to supervision; teaching/learning and evaluation; and also, differences in the nature of relationships between practice and academic organizations. All models had inherent benefits and limitations that could be minimized or maximized depending on implementation” (p280).

They produce a useful table showing the key features, benefits and limitations of the different approaches. Download the paper or ask your librarian to help you to obtain a copy of the paper to read about the different models.

As early as 1990, in the United States of America, nursing, academic-service partnerships were being described; often presented as strategic relationships between educational and clinical settings with the aim of promoting practice, education and research (AACN 1990). Similarly, within the UK, the Fitness for Practice report (UKCC 1999), encouraged Higher Education Institutions develop partnerships with health care providers to support students and deliver and monitor learning in practice. Education units appear to have developed as a response to this call. Emanating in Australia (Gonda, Wotton, Edgecombe and Mason 1999) to provide a more flexible model of supporting undergraduate nursing students where both students and academics are accepted as being integral to the clinical team; the concept has been used by colleagues in New Zealand (Fourie and McClelland 2011) and United States of America (Parker and Smith 2012, Randles-Moscato, Miller, Logsdon, Weinberg and Chorpenning 2007), however, to date there are fewer examples of academic-service partnerships within the UK.
New models of placement provision are briefly mentioned by Robinson et al (2012) who describe client attachment models: whereby “students are attached to a client and then mentored by staff in settings along the client’s care pathway) and hub and spoke (students based in a hub e.g. a health centre and then spending time in spokes which are settings associated with the hub”) (p11) but it is perhaps too early to know whether these approaches are proving to be effective, although Robinson et al acknowledge that for any new system to be viable, it is important for all key staff to be engaged in the development of the pragmatics of how the system is developed and introduced.

Dedicated Education Development units (DEDU) originated in Australia and New Zealand as a mechanism to facilitate a practice education partnership. The main feature of a DEDU is a focused environment where collaborative teaching and learning opportunities are fostered. Furthermore, such collaborative practice/education partnerships may potentially act as a catalyst to transforming the culture of care thus enabling patient-centred, evidence based effective care to flourish. An independent report on the DEU’s in New Zealand suggest that a DEU presents a model whereby student nurses work alongside registered nurses in a collaborative and supportive environment where clinicians and educators work together (KPMG 2001). Clinical academic partnerships are an important aspect of the DEDU approach; based on the Australian model outlined by Walsh, Kitson, Cross et al (2012) which adopts a broader interpretation of nursing knowledge.

For an example of supporting interprofessional mentorship see the work of Williamson and colleagues (2010 and 2011 in the suggested further reading list), who undertook a large scale longitudinal study to implement practice development teams to promote interprofessional education in clinical practice. Placement development sites were mandated a specifically
interprofessional remit to provide support to students from non-medical healthcare professional education programmes. The study examined student and staff perceptions of the placement development teams and of interprofessional learning and interestingly the study finds mixed reviews.

In addition a new model of supporting clinical learning is emerging in the East of England: the Collaborative Learning in Practice (CLiP) model for pre registration nursing students. This model devised and developed by Lobo, Arthur and Lattimer (2014) is based on principles of coaching originally used in the Netherlands and presents a new way of organising and prioritising clinical learning. Under this model, rather than working individually with a mentor students work together with other students to deliver nursing care; their practice being overseen by a day coach. The day coach supports up to three students at various stages of nurse education; importantly, all other responsibilities are removed from the day coach; their primary role for the span of duty is to support student learning meaning that they have time to teach (Lobo, Arthur and Lattimer 2014). Other key features of this model are that analytical care discussions are woven throughout the day; this is made possible as each ward is equipped with a resource room of a range of information which students can use enabling them to present relevant case studies jointly or individually to their peers and practice staff. The coaches are supported by a clinical educator: described as an experienced mentor with strong facilitating skills who provides on site guidance to coaches, mentors and students (Lobo et al 2014).

For further information about this innovative model, you may wish to look at the following:

https://www.uea.ac.uk/health-sciences/research/impact/collaborative-learning-in-partnership-clip

https://www.uea.ac.uk/documents/20279/0/CLiP+Student+Prep.pdf/eef3d4ba-29c7-4bea-a06f-9a5f9f21a5b2
The educational use of self:

This concept is described by Wilson (2014) from a study of the experiences of twelve UK based mentors. The study demonstrates that being a mentor can be an “intensely personal and meaning laden enterprise” (p314) and the paper presents some useful descriptions of how to be a mentor. It seems that there is a difficult balance to be achieved between wanting to push the student to develop whilst encouraging them to be independent thinkers (Wilson 2014).

“The ‘educational use of self’ reflected common desires of trying to ‘make sure’ students learn, or to ‘get them to understand’. Mentors pursued these goals by organizing, being vigilant, leading by example, engaging students in activity, repetition, problem solving, and inspiring students in some way. They wanted students to ‘stop and think what’s going on’, and to question why they were doing things” (Wilson 2014. p314).

The mentors in Wilson’s study also drew on their own past experiences as students in order to identify with how it feels to be a student in an unfamiliar situation. The impact of time, space and body are explored in Wilson’s paper and provides some interesting and insightful data outlining the reality of being a mentor.

Summary:

This section has provided an overview of the historical background to mentorship and has provided some definitions of the term. As part of the update you should also have developed your own definition of what being a mentor means to you and begun to think about some of the practical aspects of being a mentor where you work. The development of mentorship in supporting the development of student nurses has been described together with an overview of who becomes a mentor and you should have started to relate this to your own journey. Like much of the evidence suggests within the literature, you may feel that you did not really make an active decision to
become a mentor. The various approaches to mentoring and some models to support clinical learning have also been described.

References:


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Nur and Midwifery Council. 2009. Additional information to support implementation of NMC Standards to support learning and assessment in practice. London, NMC.


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