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Student nurse mentoring : an evaluative study of the mentor's perspective

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Student nurse mentoring: An evaluative study

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Abstract

An evaluative study aimed to capture the 'mentor voice' and provide an insight into the mentoring role from the perspective of the nurse mentor. Participants from each of the four fields of nursing practice were asked to comment on the satisfying and frustrating aspects of their mentoring role. The narrative data gleaned from the evaluation was qualitatively analysed and subsequently organised in to key themes around the student-mentor relationship and the clinical environment. Given that the landscape of nurse education is set to change; in terms of new standards from the professional bodies and the political drivers, not to mention the changing profile of the student nurse; it is hoped that the findings may to help shape the relationship between the mentor, the student and the Higher Education Institution.

Key words:

- The satisfying and frustrating aspects of the mentoring role from the perspective of the nurse mentor.
- The narrative data was qualitatively analysed (utilising Colaizzi, 1978); key themes were developed around the nurse-mentor relationship and the clinical environment.
- The findings revealed that each of the four fields of nursing practice share the same frustrations and delights, with transfer of knowledge and students progression reported as being particularly satisfying.
- Unsurprisingly, time constraints and the clinical environment were a cause of frustration for the mentors.
- Student characteristics such as lack of initiative, using mobile telephones and asking to leave early were also reported to be unsatisfying elements of the mentor role.

Declaration of interest: none

Ethics and permissions: Ethical approval was not sought as the study is an evaluation of practice. Permission for the evaluation was granted by 5 Boroughs Partnership NHS Trust on 18/12/2014

Introduction

Mentors play a pivotal role in the preparation of nurses (Elcock & Sookhoo, 2007) and the demand on nurse mentors to support learners in practice has never been greater. With the present debate around the imminent Nursing and Midwifery Council (NMC) changes to the current Standards for Nurse Education (NMC, 2010) it could be argued that the need for greater understanding of the mentoring role is paramount.

Much is discussed about the mentoring role as determined by the NMC in the *Standards to Support Learning and Assessment in Practice* (NMC, 2008) and whilst it is broadly accepted that a good mentor should satisfy a range of competencies (organised into to eight specific domains - *see table 1*) in order to undertake and maintain their mentor status, it is argued by the authors that the best and the worst aspects of the mentoring role are yet to be understood.

Chandan and Watts (2012) argue that there is a lack of support for mentors in terms of what they have and what they require from both the HEI's and the Organisations. Perhaps a clearer understanding of the mentoring role as perceived by nurse mentors from each of the four fields of practice: adult, child, mental health and learning disability, would offer some insights into the satisfying and unsatisfying aspects of the mentoring role and thus facilitate a more targeted approach to mentor preparation and mentor updates. Furthermore, a clearer understanding would allow the Higher Education Institutions (HEIs) and University Link Lecturers (ULLs) in collaboration with the Organisations to better prepare and support mentors and allow the practice areas to address any tensions that might exist.

Background

In the UK the clinical practice element of pre-registration nursing programmes is significant and accounts for 50% of the entire programme (NMC, 2010). There is an abundance of support available to students whilst on clinical placement (Casey & Clark, 2011) and this includes the requirement for the HEI to provide academic support in practice (NMC, 2010).

Henderson et al (2007) proposes that whilst collaboration between the HEI and healthcare establishments is essential for student support in practice, it is clear that it is the support received from the mentors that is considered to be the most important (Jokelainen et al. 2013). Similar studies (Wilkes, 2006) have suggested that even in a far from perfect clinical placement, the mentor has the power to make the leaning experience a positive one for the student. Thus, student success on placement is reliant on effective mentoring and those staff who undertake the mentoring role (Papastavrou et al., 2010).

Whilst originally an innovation in the early 1970s, the role of the nurse mentor was formally embedded in the UK in the 1990's in response to formal nurse education moving to the HEIs. As pre-registration nurse education moved into the university setting it was clear that there was a need to ensure that supervision, teaching and assessment required a level of formal support out in clinical practice (DH, 2001). However, it wasn't until 2006 that the NMC formally acknowledged that nursing students on placement should be allocated a mentor; hence the NMC *Standards to Support Learning and Assessment in Practice* (NMC, 2008).

However, it is without doubt that the mentor role is multifaceted and complex (Pellatt, 2006, Bray & Nettleton, 2007). It is perhaps this complexity that leads to the mentor role being not being prescriptive and having a level of subjectivity despite standards and guidance to ensure equity for students.

When mentors feel unsupported, students sense a lack of belonging which can negatively impact on their learning experience (Hutchings, Williamson & Humphreys, 2005). Indeed, Hartigan-Roger et al., (2007) suggest that the evaluation of a learning environment is more positive when students feel they have access to a supportive mentor and this subsequently

leads to an improved clinical experience. Pearcy and Elliot (2004) support this notion and suggest that when mentors have a positive attitude towards the student and their own role then placement learning will improve.

The problem is that mentors are often challenged by personal and organisational conflicts (Chandan and Watts, 2012) with dual and often competing responsibilities such as managing a clinical workload in addition to being accountable and responsible for student learning and assessment. Mentors need to be empowered, and Grossman (2012) argues that their voice should be heard. Jokelain et al (2013) in a cross culture phenomenographical study, attempted to establish how mentors conceptualised their role. They found that mentors considered assessment and enabling students to achieve their goals and competencies to be the most pertinent. It was interesting that the mentors reported feeling constrained by the confinement and pressure of the placement environment.

Current situation

The shortage of clinical placements for pre-registration student nurses (Merrifield, 2015) and the limited numbers of mentors means that it is vital that there is an exploration of how mentor experiences can be optimised. And whilst mentor preparation programmes in UK are mandatory (NMC, 2008), the sustainability of these programmes are currently being questioned (Health Education England, 2016). It is anticipated that the new NMC *Standards to Support Teaching and Learning in Practice will be published* in 2017/18 along with new *Standards for Pre-registration Nurse Education* expected soon, therefore, it is timely to think about the way forward.

The study was evaluative in design and aimed to capture the mentoring 'voice' from a population of 169 Stage 2 mentors (participants) across each of the four fields of nursing practice. The mentor sample comprised of the following: Mental health 74% (n=125), Adult 15% (n=25) Child 6% (n=10) and Learning disability 5% (n=9).

Data collection

An evaluative questionnaire was designed and circulated to the participants over the course of nine months. Mentors who had attended a mentoring update workshop were asked to comment on the best and the worst aspects of their mentoring role. Participants were invited to comment on the following:

- *What gives you the most satisfaction about your role as mentor?*
- *What causes most frustration?*

Data analysis

The narrative data was qualitatively analysed using a descriptive thematic analysis (Colaizzi,1978). The appeal of thematic analysis was determined by the authors as having greater utility in terms of investigating and evaluating the experiences of the participants.

See figure 1.

After reading and re-reading the narrative data, the significant statements were extracted and meanings subsequently formulated. The formulated meanings were then organised into two core clusters; each with three key themes (*see figure 2*).

All data was included in the analysis to generate an exhaustive list of phenomenon. A summary of the findings was made available to the participants for validation; no changes were made.

Study findings

Core Cluster (1): Mentor-student relationship

Theme one: Transfer of own knowledge

The study findings revealed that 79% (n=135) of mentors across each field of practice consistently reported that the most satisfying aspect of their mentoring role was around the transfer of their own knowledge to the students and facilitating the students development and on-going progression. There was a sense too from the narrative data that mentors also enjoyed giving feedback and making a positive contribution to the students learning experience and career aspirations.

Mental health participant:	*"working with the students and observing them progress"*
Adult participant:	*"sharing knowledge and skills"*
Child participant	*"assessing, guiding, building competence"*
Learning disability participant:	*"helping the students achieve their goals"*

These finding were not surprising and support previous studies (Mosley & Davies, 2008 and Jokelain et al.,2013). The participants further expressed that they felt that their mentoring role promoted clinical quality and often made them feel valued.

Theme 2: keeping up to date

The participants recognised that having a student often kept them up-to-date with their own knowledge and also facilitated practice reflection. This was a theme that was not reported by the child field participants and was most frequently reported by the mental health mentors. This is perhaps not significant given the disproportionate numbers of participants from each field.

Mental health participant:	*"rethinking my attitude or practice by listening to a student's 'fresh' approach/thoughts"*
Mental health participant:	*"helps me reflect and keep on top of my knowledge"*
Adult participant:	*"Keeps me up-to-date on current issues"*

Learning disability participant: *"two- way parting of knowledge"*

Theme 3: student attributes

Participants from each of the fields of practice commented that they enjoyed having students who possessed certain personal qualities such as enthusiasm, keenness and had fresh ideas.

Mental health participant:	*"I enjoy having enthusiastic students"*
Adult participant:	*"having a student who is interested"*
Child participant	*"mentoring students who evidently want to learn"*
Child participant	*"mentoring keen and enthusiastic students"*
Learning disability participant:	*"students with a genuine interest in developing their skills"*

Conversely, participants from each field of practice described a lack of enthusiasm or initiative and unprofessional behaviours as contributing to the unfulfilling aspects of their mentoring role.

Mental health participant:	*"Lazy and unmotivated students"*
Adult participant:	*"students who appear disinterested""*
Child participant	*"a student who is mobile phone happy"*
Learning disability participant:	*"over confident students who don't want to listen"*

It was noteworthy that a number of mentors from each field of practice commented that students often used their mobile phones whilst on their clinical placement; they attributed this type of behaviour to a lack of professionalism.

Although, not investigated further, this type of student behaviour may be reflective of the post-millennial student (born between 1995 & 2012), who is more engaged with their technology than previous students and perhaps doesn't reconcile their actions with unprofessionalism. This is doubtlessly an issue which needs to be explored further if mentors are to support students as their profile changes through time.

There were no differences in the themes discovered between each of the fields in terms of the joys of the mentoring role. Similarly, there were subtle but inconsequential differences between the fields of practice in terms of the most frustrating and unsatisfying aspects of the mentoring role.

Core category (2): Environment

Theme 1: time

Time was considered to be a major factor of tension amongst each field of practice with 48% (n=81) of mentors commenting that time, whether it be time spent completing student paperwork or time spent teaching and supervising students as a frustrating aspect of their mentoring role. There was a sense from the participants that the time spent with students could be time spent with patients/service users and carers/families. This was an unsurprising find and is well supported in the wider literature (Elcock & Sookhoo 20007; Veeramah, 2012)

Mental health participant:	*"time constraints… endless paperwork"*
Adult participant:	*"time constraints…lack of allocated time to do paperwork"*
Child participant:	*"lack of time for discussion/reflection"*
Learning disability participant:	*"amount of time spent on admin and work related to students"*

Theme 2: clinical location

A key theme was around placement constraints, such as when community visits were not suitable for student nurses to attend or a lack of flexibility in shift patterns. Some of the mentors commented that the hub and spoke model and the seemingly short placements did not offer sufficient time to properly assess the student. Similarly, other environmental constraints such as poor access to computers or study space for students was a feature of the mentoring role that they found to be unsatisfactory and was a consistent finding across each field of practice.

Mental health participant:	*"organisational pressures and time constraints"*
Adult participant:	*"telephones"*
Child participant	*"sometimes a visit may be unsuitable for a student to attend"*
Learning disability participant:	*"lack of space, computers"*

Theme 3: colleagues and money

Although the numbers were not vast it was worthy of note that 5% (n=8) of the mental health participants commented that the lack of financial remuneration was a disappointing part of their role and further commented that some colleagues would elect not to mentor students and that this compounded the situation.

Mental health participant:	*"unhelpful attitude from colleagues"*
Mental health participant:	*"other staff not being happy to take students' with them"*
Mental health participant	*"can be frustrating getting some members of the team to spend time with them [students]"*
Mental health participant	*"no extra increment for mentoring students"*
Mental health participant	*"no financial reward for extra responsibility"*

The fact that the comments were generated from the mental health mentors was not considered to be significant, given the high proportion of mental health participants in relation to the other fields.

Limitations

The study was limited to a single Trust and whilst the findings are in keeping with previous studies (Sharples & Kelly, 2007), it may not be representative. In addition, the sample was disproportionate in terms of parity between each of the four fields of practice. Furthermore, the authors acknowledge that the mentoring role is not restricted to the nursing profession

alone (HCPC, 2012) and suggest that a multi-centre, inter-professional study would produce more generalisable results.

Discussion

The study found that nurse mentors derive a significant amount of satisfaction from their mentoring role and in particular the exchange of knowledge that appears to underpin the mentor-student relationship.

The frustrating aspects of their role appeared to be around those students who lacked interest in their placement or learning experience. However, it is acknowledged that the same student may have exhibited different behaviours if they were on a different placement. This was not examined further and would undoubtedly require further investigation before any generalisations could be made.

The environment of care, in terms of time pressures and related paperwork coupled with lack of access to computers and space seemed to cause significant frustration for the mentors and arguably is a barrier to the mentoring role.

These types of challenges are not uncommon and are frequently experienced by nurse mentors (Wilkes, 2006, Veeramah, 2012).

Conclusion

It is hoped that by better understanding the delights and frustrations of the mentoring role, the findings from this study will help to facilitate the relationship between the mentor, Organisation, HEI and student and support the very interface that the Practice Education Facilitator practices within.

It is anticipated that the findings will enlighten key clinical partners about the mentoring voice in the context of a potentially significant shift in nurse education and an uncertain political landscape; in terms of post bursary funding and administration. Furthermore, given the time

and workload pressures that the mentors reported in this and other studies; it is possible that the findings may serve to inform new models of mentoring.

Indeed, coaching models such as Collaborative Learning in Practice (CLiP) have already been adopted in some clinical areas across the UK and offer an enhanced mentoring approach. Based on 'learning communities' the clinical area typically receives 20 students of whom 3-4 per shift work with a coach, who is a registrant and mentor who then works with the student to help them to identify their own learning needs and develop strategies on how to achieve them. The CLiP model relies on a hierarchy of coaches/mentors and the student to mentor ratio is thus optimised. This and other models such as the *Dedication Education Units* in the USA and the *Clinical Facilitation units* in Australia (RCN, 2015) offer similar 'tiered' levels of mentorship.

Arguably, all are pedagogically sound and fit with the ambitions and demands of modern nursing curricula. However, if students are to be educated to nurse in the 21st Century, perhaps the biggest challenge of all is aligning mentors, Organisations, formal nurse education and patient outcomes with the changing student profile and the uncertain landscape of tomorrow's care system.

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Table Click here to download Table Table 1.docx

Table (1): The Eight Competency Domains (NMC, 2008)

• Establishing effective working relationships
• Facilitation of learning
• Assessment and accountability
• Evaluation of learning
• Creating an environment for learning
• Context of practice
• Evidence-based practice
• Leadership

Figure (i.e. diagram, illustration, photo)
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Figure 1: Colaizzi's (1978) Method of Data Analysis

Step 1	Each transcript is read and re-read
Step 2	For each transcript significant statements were extracted
Step 3	Meanings formulated from these significant statements
Step 4	The formulated meanings arranged into categories, clusters of themes, and themes
Step 5	The findings of the study were integrated into an exhaustive description of the phenomenon under study
Step 6	Returning to findings to the participants for validation
Step 7	Incorporating any changes based on the participants' feedback

Figure (i.e. diagram, illustration, photo)

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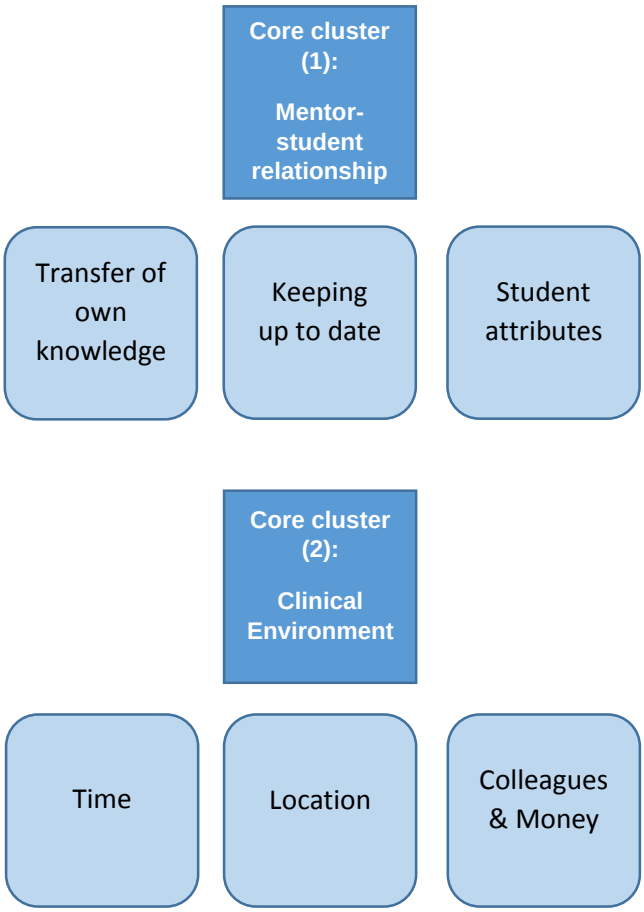
Figure 2: Core and theme clusters