Third Edition

Mentoring and Supervision in Healthcare

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Effective Mentoring

Introduction

Chapter Outcomes

On completion of this chapter, you should be able to:

1. Distinguish between mentoring and similar roles that support learning for healthcare students and learners.
2. Explain a range of reasons for requiring mentors to facilitate students’ acquisition of professional competence.
3. Identify and evaluate a number of factors that can enable effective mentoring, including the characteristics and roles of effective mentors, and the ability to build sound mentor–mentee ‘working’ relationships.
4. Analyse the likelihood and effects of poor or adverse mentoring, and the actions that can be taken where it is likely to occur.
5. Analyse a number of approaches, guidelines and frameworks for enabling informed and systematic mentoring.

One of the key mechanisms for facilitating learning for healthcare profession students while on practice placements is mentoring. This mechanism is well established now and is indeed a very important component of pre-registration education programmes, albeit using a handful of different titles by different health and social care professions. Policy documents such as Standards to Support Learning and Assessment in Practice (NMC, 2008a) provide a firm indication of the criteria that healthcare professionals have to meet to use the title ‘mentor’ and detail the capabilities that they need to fulfil the role effectively.

The first chapter of this book focuses on mentoring as a concept in its own right, defines and differentiates it from similar and overlapping roles and titles, examines the
various reasons for mentoring and explores how to mentor effectively. It also examines poor mentoring and how it can be redressed.

The chapter thus examines a wide range of perspectives on mentoring itself and also focuses on the NMC’s (2008a: 50) domain ‘establishing effective working relationships’. The related mentor competence is: ‘Demonstrate effective relationship building skills sufficient to support learning, as part of a wider inter-professional team, for a range of students in both practice and academic learning environments’. The NMC’s outcomes for this competence are:

- Demonstrate an understanding of factors that influence how students integrate into practice settings.
- Provide ongoing and constructive support to facilitate transition from one learning environment to another.
- Have effective professional and interprofessional working relationships to support learning for entry to the register.

The Concept of ‘Mentoring’

‘Mentoring’ as a concept and practice for facilitating learning in healthcare settings has evolved consistently since the 1970s and was formally implemented in pre-registration nursing and midwifery education in the 1980s. Slightly different titles and terminologies are used by different healthcare professional groups for this role, and different definitions have been offered over time as research and expert opinions have influenced the forms in which it is currently utilised.

It is generally well documented, for example in the Shorter Oxford English Dictionary (Brown, 2002: 1747), that the term ‘mentor’ originates from the Greek classical story The Odyssey, in which King Odysseus called on a trusted friend named Mentor to act as the guide and advisor to his young son Telemachus when he left for another country to fight a war. The word ‘mentor’ also relates to the Latin word ‘mens’, that is, pertaining to or occurring in the mind (Simpson and Weiner, 1989: 614). The term has gradually evolved to signify a designated person who dedicates some of their time to help individuals to learn during their developmental years, to progress towards and achieve maturity and establish their identity. It has been implemented as a formal role in nurse education to direct focus on enabling students to gain safe and effective clinical practice skills during practice placements. This section disentangles the concept of mentor from similar titles by exploring the differences and similarities between them.

Distinguishing between the mentor’s and related roles

The mentor role is just one of several that support learning in practice settings and therefore there is some overlap in certain aspects of such roles, such as in the
characteristics of the appropriate personnel who support learning, but there are distinct boundaries as well. For instance, a study conducted by Carnwell et al. (2007) to explore the likely differences in the roles of mentors, lecturer–practitioners and link lecturers indicate that mentors tend to focus principally on individual students, lecturer–practitioners on the ‘learning environment’, and link lecturers on knowledge acquisition and fulfilling course requirements.

Activity 1.1 Different education support roles and functions

To begin with, make notes on what you think are the meanings and functions of the following roles: mentor, preceptor, clinical supervisor, assessor and other similar roles that you have encountered, and the differences between them.

You are likely to have identified a variety of roles that enable or support learning for students and other learners in practice settings, which might include practice facilitators and even the university-based course director. In addition to the above roles for supporting learning, other roles such as buddy and coach are also emerging (the latter is discussed later in this chapter). All the same, although there are common elements in the definitions, scope and remit of mentor and similar roles, there are also differences. The most popular learning support roles are examined next.

Mentor

Beside the helping function during developmental years indicated by dictionary definitions of the term ‘mentor’, as a result of research by Phillips et al. (2000) on behalf of the then English National Board for Nursing, Midwifery and Health Visiting, the Department of Health (DH) (2001a: 6) redefined ‘mentor’ as ‘a nurse, midwife or health visitor who facilitates learning, supervises and assesses students in the clinical setting’. Prior to this, the mentor was a registrant who facilitated learning, and the assessor was another registrant who assessed students’ competencies.

Mentor is similarly defined by the NMC (2008a: 45) as a registrant (i.e. qualified nurse or midwife whose name is on the NMC’s live register) who has met the outcomes of Stage 2 (being those of a qualified mentor) and who facilitates learning, and supervises and assesses students in practice settings. The DH’s (2001a) definition resulted from a range of issues related to mentoring and assessing pre-registration student nurses and midwives during practice placements that had been identified by Phillips et al.’s (2000) research and contemporary smaller studies such as Spouse’s (2001a), which revealed that the terms ‘mentorship’, ‘preceptorship’ and ‘supervision’ were being used synonymously.

Going beyond definitions of mentor, the NMC (2008a) identifies a range of day-to-day functions of the mentor in terms of 26 outcomes that are grouped under
eight domains (these form the major focus of this book), which essentially is a framework for effective mentoring. The NMC’s functions of mentors build on existing knowledge of the subject area such as research by Kerry and Mayes (1995) that indicates that definitions of mentor need to include:

- nurturing
- role modelling
- functioning (as teacher, sponsor, encourager, counsellor and friend)
- focusing on the professional development of the mentee and
- sustaining a caring relationship over time.

A subsequent concept analysis of the mentor role by Billay and Yonge (2004: 573) across several health, non-health and social care professions indicates that its defining attributes include ‘being a role model, being a facilitator, having good communication skills, being knowledgeable about the field of expertise, and needing to understand the principles of adult education’. A more recent concept analysis of mentoring by Hodgson and Scanlan (2013) reveals that mentoring is associated with increased job satisfaction and staff retention, which is beneficial for the mentee, mentor, organisation and nursing profession, as ultimately the patient benefits. Mentoring empowers mentors and mentees, which ‘enhances employees’ motivation and professional development … [and] … a culture and workplace is created in which nurses want to come to work’ (ibid.: 392).

It has to be noted at this point that although the term ‘mentor’ is clearly defined in UK policy documents, in particular by the NMC (2008a) and the DH (2001a), it is defined differently in nursing in other countries, such as in Canada (Billay and Yonge, 2004), and in various countries the term ‘preceptor’ is used to signify a role that in the UK is referred to as ‘mentor’; and in some countries, the formal mentor role does not exist.

Even in the UK, in the medical profession (NHS England, 2014a), ‘mentor’ refers to qualified healthcare professionals being mentored by more experienced mutually selected colleagues. Also, in some UK professions, for instance psychologists, the term ‘protégé’ is used when referring to the mentee (for example, Barnett, 2008).

Preceptor

In the UK, the term ‘preceptor’ is identified by the NMC (2006a) as a first-level registrant who has had at least 12 months’ (or equivalent) experience within the same area of practice as the practitioner requiring support, and will normally have completed a mentor or practice teacher educational preparation programme. The NMC indicates that the preceptor and the preceptee should agree between themselves about the nature of their working relationship and the specific desired outcomes. It should be noted, however, that preceptorship is not clinical supervision, which in the UK refers to structured peer support for, and by, registrants during their careers.
The preceptor role emerged from the realisation that for newly qualified nurses, the transition from being a student to becoming a registered healthcare professional is a major leap in responsibility and accountability. It is partly based on an earlier study by Kramer (1974) who found that the first few months after qualifying were often marked by dramatically conflicting value systems, between the aims of pre-registration education and the reality of day-to-day nursing. This led to high attrition rates among newly qualified nurses. Various studies reveal such concerns even today (e.g. Marks-Maran et al., 2013).

The NMC (2006a) recommends preceptorship for all newly qualified registrants, for RNs changing their area of practice and for qualified nurses from other European Economic Area states and other countries. It indicates that for preceptorship to be effective it should last approximately four months, and recommends that the preceptor should:

- facilitate the transition of the ‘new registrant’ from student to a registrant who is confident, effective and up to date with their practice and knowledge
- provide feedback to the preceptee on those nursing or midwifery interventions that they are performing safely and effectively, and those that they are not (if any)
- facilitate the preceptee to achieve the standards, competencies or objectives set by the employer for new registrants.

Structured preceptorship programmes are devised locally by trusts or their departments and are normally of four to six months’ duration, and often include the specialism-specific competencies in the induction programmes for the particular practice setting, which, when achieved, the preceptee can incorporate into their professional portfolio.

Lately, drawing partly on the successful implementation of preceptorship in Scotland through the Flying Start (NHS Education for Scotland, 2014a) pilot schemes, which started in 2006, the DH (2010a: 11) redefines preceptorship as:

A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of lifelong learning.

It identifies a preceptor as: ‘a registered practitioner who has been given a formal responsibility to support a newly registered practitioner through preceptorship’ (DH, 2010a: 6). The DH presents a framework for effective preceptoring, within which it also identifies the ‘attributes’ of an effective preceptor, which are similar to those of mentors, as discussed later in this chapter.

The College of Occupational Therapists (COT) (2013) suggests four standards for preceptors namely: (1) working with clients; (2) working with colleagues; (3) written communication; and (4) health and safety policies. Professional development needs to be achieved in conjunction with NHS Knowledge and Skills Framework (NHS KSF).
(DH, 2004a) dimensions along with indicators that progress through the four levels that can then form the basis for developmental activities for individual occupational therapists, which is also congruous with competencies that they will require for their future careers.

Furthermore, the NMC (2014) has been exploring the appropriateness and feasibility of whether the point of completion of the preceptorship programme can comprise the point of ‘validation’ for the healthcare professional when they have their name and qualification entered in the NMC’s register, which can subsequently be followed up by regular revalidation (currently known as PREP: post-registration education and practice) at re-registration points.

**Assessor**

The term ‘assessor’ remains in use and is often used to denote a role similar to that of the mentor but solely with the assessment component (DH, 2001a). It usually refers to an appropriately qualified and experienced health or social care professional who has undertaken relevant educational preparation to develop skills in assessing students’ level of attainment related to the stated practice competencies (for example, National Vocational Qualifications (NVQ) assessor).

**Clinical educator**

The role of the clinical educator is akin to mentoring and is generally used by some healthcare professions such as medicine and physiotherapy for facilitating student learning during practice placements. In physiotherapy, for instance, a clinical educator is: ‘A qualified practitioner who directly supports a student’s learning during clinical education/practice-based learning. Also applies to the clinician’s education role in relation to other learners (for example junior staff)’ (Chartered Society of Physiotherapy (CSP), 2004: 20).

**Practice teacher**

The title or role of practice teacher was initially specifically adopted in recognition of the additional educational preparation required for mentoring students on specialist community public health nurses (SCPHN) courses. A practice teacher is therefore: ‘A registrant who has gained knowledge, skills and competence in both their specialist area of practice and in their teaching role, meeting the outcomes of stage 3, and who facilitates learning, supervises and assesses students in a practice setting’ (NMC, 2008a: 46). It refers to specialist areas of practice where they support students undertaking a specialist qualification or at a level beyond initial registration.

Practice teachers therefore facilitate learning and assess post-qualifying students on their achievement of specialism-specific specialist or advanced practice competencies. However, practice teaching, practice learning and student supervision are terms that are also used for mentoring student social workers, during practice placements for instance (Parker, 2010).
Clinical supervisor and clinical supervision

Clinical supervisor is a term used in the context of clinical supervision signifying the provider of peer support to the clinical supervisee. It may be used to identify mentoring-type roles in some healthcare professions or vocations.

Clinical supervision itself refers to a peer-support role based on a clinically focused professional relationship between healthcare professionals in which one party is the clinical supervisor and the other the supervisee. The clinical supervisor undergoes educational preparation for this role and utilises clinical knowledge and experience to assist peers to develop further their own knowledge, competence, values and practices.

Waskett (2010: 12) notes that ‘many nurses do not have regular, protected access to confidential conversations about the everyday challenges of their work’, and amongst the various models of clinical supervision that are available for a systematic approach to this activity is Waskett’s 4S model, comprising: structure, skills, support and sustainability.

Supervisor and supervision

The term ‘supervisor’ tends to be used in the context of management of workers to ensure designated tasks are completed, and to a specified standard, rather than in relation to the facilitation of learning. It refers to individuals in the organisation who have authority in the interest of the employer to recruit staff for specified posts, assign duties, oversee the quality of their work and take relevant professional development or disciplinary actions as appropriate.

In this book, the term ‘supervision’ is used in accordance with its dictionary meaning, which is to direct or oversee the performance, action or work of another, which in this instance refers to the mentor directing and overseeing the mentee’s learning. The term does, however, have a very specific meaning in the field of counselling, in which it refers to counselling situations wherein one or more highly experienced counsellors help a less experienced or more junior counsellor develop their practice.

In a comprehensive exploration of the concept and applications of supervision in health and social care professions, Hawkins and Shohet (2012) refer to supervision as a joint endeavour in which the identified supervisor helps the supervisee to improve the quality of their work and continuously develop themselves and their practice. The British Association for Counselling and Psychotherapy (BACP) (2013) indicates that all counsellors, psychotherapists, supervisors and their trainers have an obligation to use regular and ongoing supervision to enhance the quality of the services they provide, and to commit to updating practice by seeking training and other opportunities for continuing professional development, which is also accessed independently of any managerial relationships. An effective interpersonal relationship is essential in both of the above-mentioned interpretations of supervision, and a thorough investigation of mentoring shows that the underpinning principles of supervision apply to mentoring as well.
Practice education facilitator and practice educator

The practice education facilitator (PEF) role in nursing and midwifery also emerged largely from the study of mentors by Phillips et al. (2000). It is defined by the DH (2001a: 6) as a ‘role of the teacher of nursing, midwifery or health visiting who makes a significant contribution to education in the practice setting, coordinating student experiences and assessment of learning’. The PEF thus leads the development of practice learning and provides support and guidance to mentors and others who contribute to the student’s learning in practice settings, and achievement of practice competencies (see, for example, Sykes et al., 2014). An alternative title has been implemented for PEFs who are based in non-NHS nursing homes as Care Home Education Facilitator (CHEF) (NHS Education for Scotland, 2014b).

The educational preparation for the PEF role is usually at postgraduate level, for a post that was previously funded mostly directly by the pre-2013 Strategic Health Authorities, most of whose functions were taken over by NHS England (2014b) in 2013. It generally entails practice-based teaching and supporting practice learning four days a week, and university-based work one day a week. This is a very important role as PEFs are also called upon to attend to students during practice placements when busy clinical staff are unable to dedicate sufficient extra attention to students who are struggling or are failing to make progress with their practice placement competencies. For students on practice placements, PEFs frequently also organise dedicated group discussion sessions away from the practice setting for particular categories of students for reflection and peer support purposes.

However, there are small differences in the way in which the role and title are implemented in different health and social care professions. The College of Social Work (2012: 12) for example, defines a practice educator as one who: ‘… takes overall responsibility for the student’s learning and assessment, utilising information from his/her own assessment and other sources’, which suggests that the practice educator role in social work (as well as in other AHPs) is largely similar to the mentor role in nursing and midwifery.

As with the mentor preparation programme (NMC, 2008a), some AHPs are fast moving towards the title of ‘accredited practice educator’, educational preparation for which can be through the taught route based at a higher education institute (HEI), or an experiential learning route (Society and College of Radiographers, 2014). The Society and College of Radiographers keeps a ‘Register of Practice Educators to the Society and College of Radiographers’, but this is not a requirement by the HCPC at this point in time.

A study by Carlisle et al. (2009: 715) on the impact of the PEF role in Scotland revealed that the PEF role is ‘accepted widely across Scotland and is seen as valuable to the development of quality clinical learning environments, providing support and guidance for mentors when dealing with “failing” students, and encouraging the identification of innovative learning opportunities’. However, McArthur and Burns (2008), amongst others, have evaluated the role of PEFs and found that whilst various staff think that PEFs should work with students, the PEFs themselves feel that their main role is in supporting mentors, as also noted by Sykes et al. (2014).
MENTORING AND SUPERVISION IN HEALTHCARE

Personal tutor

Each pre-registration student is allocated to a nurse lecturer who acts as a personal tutor to the student. This role normally lasts for the duration of the three-year undergraduate course and involves:

- supporting, advising and monitoring students’ progress throughout the educational programme
- accessing students’ practice records for required information, within an ethos of confidentiality and professional accountability
- liaising with the mentor, link lecturer and student and, where concern is expressed, considering evidence and developing an action plan with the student.

Link lecturer

The link lecturer is usually a university lecturer whose responsibility is to assist clinicians in named practice settings. They assist mentors to interpret students’ practice competencies and are available to support mentors when required. They might also assist in the development of the practice setting as a more effective learning environment for all learners. Students tend to receive a visit by the link lecturer early in the placement, especially first year students, to ascertain which learning objectives are realistically achievable. Further visits are arranged as required.

Some of the functions of the personal tutor and the link lecturer have increasingly become part of the PEF’s remit but they continue to provide an essential complementary function.

Mentoring activities in allied health and social care professions

The role of practice educator in AHPs was examined briefly in the above paragraphs. Naturally, enabling students and learners to acquire skills for safe and effective practice prevail in all health and social care professions. In addition to knowledge gained from research and the planned activities of professionals to enable learning, professional and regulatory bodies provide informed guidance on how this can be achieved. For instance, several healthcare profession organisations publish separate profession-specific standards for mentors, such as the College of Operating Department Practitioners’ (CODP) (2009) Standards, Recommendations and Guidance for Mentors and Practice Placements.

The HCPC’s (2012a) Standards of Education and Training Guidance provides guidance on the design of pre-qualifying AHP education curricula, which is supported by specific standards of proficiency (SOP) for each of the 16 allied healthcare professions (HCPC, 2013) that it currently regulates, including chiropodists/podiatrists, clinical scientists, dietitians, radiographers, etc.

In addition to the role of the radiography practice educator that was referred to earlier in this chapter, the HCPC identifies the ‘practice placement educator’ as:
‘A person who is responsible for a student’s education during their period of clinical or practical experience’ (HCPC, 2012a: 61). It indicates that ‘Practice placement educators must have relevant knowledge, skills and experience’ to support students and provide a safe environment for effective learning. The HCPC, however, does not currently set specific requirements about the qualifications and experience that practice placement educators must have to fulfil the role effectively. But some AHPs have formalised mentoring/clinical educator activities, as for example physiotherapy has done through the Accreditation of Clinical Educators (ACE) Scheme (CSP, 2014).

The titles ‘practice placement educator’ and ‘practice placement coordinator’ are also utilised in various AHP documents with reference to designated healthcare professionals who provide support and information to clinical educators (akin to the mentor role in nursing and midwifery), and also monitor the standards of practice placement being experienced by students (HCPC, 2012a).

Hinton (2009) reports on her experiences of mentoring Operating Department Practitioners’ (ODP) students in which she indicates that it is an activity that is beneficial for students as well as for ODP mentors. In contrast, Mallik and McGowan (2007) completed a scoping exercise on the nature of practice education in five healthcare professions, namely dietetics, nursing, occupational therapy, physiotherapy and radiography, and concluded that although there are areas of good practice, ‘these do so against the provision of well-supported, clearly supervised and adequately quality-assured practice education’ (ibid.: 58). They recommend that such issues should be resolved by the various healthcare professions and need to be recognised and rewarded, and that collaborative work across the professions should be enhanced for achievement of more well-rounded practice education.

On the other hand, Lakasing and Francis (2005) argue that because a number of healthcare profession lecturers are not active clinicians, this tends to create a theory–practice gap that mentors have to redress during student practice placements, unlike medical academics who are also practising doctors. They indicate that mentors should therefore be provided with protected time and extra remuneration to enable them to fulfil this demanding role more effectively. Where extra funding is made available for mentoring activities, the money can be utilised to employ additional pro rata staff to allow the mentor protected time for more effective mentoring.

Lack of funding for mentorship in general medicine in the USA was also identified in a study by Luckhaupt et al. (2005). However, Barton (2006) reports on a study that explored the experiences of doctors mentoring students on nurse practitioner courses, and concludes that medical mentors (clinical educators) experience conflict in that as the students acquire new clinical skills and roles, this also amounts to the mentors feeling that their traditional medical authority is being challenged. This led to a renegotiation of professional boundaries between nurse practitioners and doctors.

In summarising this section on mentor and similar roles, it is clear that there are areas within these roles that overlap, and there are distinctions between them when current national policy and professional bodies’ definitions are considered. However, as these roles evolve and different models of implementation are applied in different
settings, endeavouring to disentangle the educational philosophy underlying these roles – such as differentiating between coaching and mentoring – is seen by Megginson et al. (2006: 5) as a ‘sterile debate’.

Why Do Learners Need Mentors?

The mentor role is widely implemented and utilised and it may now appear to be an obvious facility afforded to learners. A more detailed examination of why we need mentors for mentoring students and learners reveals a number of reasons.

Activity 1.2 Why mentors?

The idea of this activity is to explore the variety of reasons why mentors are required in healthcare professional education, particularly in the context of the prevailing definition of the term. Therefore, consider and make notes on the question, Why do we need mentors (and preceptors) in: (a) nursing, midwifery and allied health professions; and (b) personal life? List as many reasons as you can think of.

When students on mentoring courses are asked to cite as many reasons as they can think of for requiring mentors, they tend to be able to identify several. The reasons given include the need to ensure safe practice by learners, to enable students to achieve their course practice competencies, and to listen and act as a sounding board for any worries or fears or the mentee’s ideas on care delivery. Further reasons cited by students for mentoring learners in: (a) nursing, midwifery and allied health professions, and (b) personal life are listed in the box below.

Why we need mentors

In nursing and other health professions

- For guidance and support
- To structure working environment for learning
- For constructive and honest feedback
- For debriefing related to good/bad experience during placement
- As a link person with other areas
- As a role model
- To assess competence
- As a friend and counsellor
- For encouragement
One of the advantages of mentoring is that students who have been on placement in the particular practice setting might apply for a post in that setting after qualifying, i.e. they can have recruitment benefits. Furthermore, van Eps et al. (2006) explored the benefits of mentoring in a study that evaluated students’ perceptions of mentorship and concluded that mentorship does enable the development of competent practice, especially if it is founded on supportive longer-term mentor–mentee relationships.

It could be argued that everyone could benefit from having a ‘mentor’ in their personal lives, at times referred to as a ‘soulmate’. This privileged role is self-selected by both parties and could be fulfilled by a friend, partner, parent or senior peer. It is consistent with the definition of mentor in current medical mentoring, which suggests that the mentor is selected by the learner for support and guidance. In addition to the reasons for mentoring identified by student mentors and the above-mentioned benefits, there are also various research and policy reasons for the requirement for this role. The most significant ones for healthcare are now discussed.

First, mentoring has become an increasingly popular concept in a wide range of settings, for example:

- In schools and other educational institutions – for initial teacher training.
- In business – to support personal development of business skills, human resource strategies, and business development and self-employment. Further guidance on business mentoring in the UK is available from the Institute of Directors.
• In support of young people who are, or are at risk of becoming, disaffected or excluded from society – to raise achievement, self-confidence, personal and social skills.
• Medical mentoring – as for a doctor or medical student receiving guidance from an identified more senior or experienced colleague on a range of work-related matters.
• Management mentoring – incorporates coaching, and is discussed later in this chapter.

Thus, mentoring has already been implemented quite effectively in non-healthcare professions and social contexts. For instance, mentoring has worked successfully in initial teacher training (see, for example, Furlong and Maynard, 1995; Kerry and Mayes, 1995) for some time. The concept has developed continuously in this context since then, and international journals such as *Mentoring & Tutoring: Partnership in Learning* report on the latest developments and research on various aspects of the concept. Harrison et al. (2006: 1055), for instance, conducted an analysis of mentoring new teachers in secondary schools and found that: ‘best practice for “developmental mentoring” involves elements of challenge and risk-taking within supportive school environments with clear induction systems in place and strong school ethos in relation to professional development’.

Furthermore, Barnett (2008: 3) notes that mentoring new teachers results in benefits for the mentor as well in terms of professional stimulation and collaboration, personal fulfilment, friendship and support, motivation to remain current in one’s field and networking opportunities; and benefits to the institution include more satisfied staff and greater scholarly productivity.

As for medical mentoring, whilst in other countries, for example the USA, medical mentoring refers to mentoring medical students, in the UK the mentoring relationship is confidential between two qualified doctors, the mentor and the mentee (NHS England, 2014a; Viney and McKimm, 2010), and is more akin to clinical supervision in nursing, midwifery and AHPs, which was explained earlier in this chapter. For this, doctors adopt the Standing Committee on Postgraduate Medical and Dental Education’s (SCOPME) definition of mentoring, which is:

> the process whereby an experienced, highly regarded, empathic individual [the mentor], by listening and talking in confidence, guides another individual [the mentee], often but not always working in the same organisation or field, in the development and re-examination of the mentee’s own ideas, learning, personal and professional development. (McKimm et al., 2007: 15)

A second reason for the need for mentoring is the one identified when nurse education moved into the higher education sector en masse during the 1980s and 1990s with the restructured Project 2000 pre-registration curricula and a change in emphasis in certain aspects. The findings of various research studies on these novel programmes were eventually captured in the United Kingdom Central Council for Nursing,
Midwifery and Health Visiting’s (UKCC) (1999) *Fitness for Practice* publication. This publication documented the strengths of these programmes, but one of the prominent findings of these studies was that at the point of registration students were not clinically as skilled as those who emerged from pre-Project 2000 programmes. This reinforced the need for wider availability of competent clinically based mentors to enable students to learn clinical skills so that they are ‘fit for practice’.

The *Dearing Report* on learning in higher education, and other related national reports, also strongly advocates that higher education courses should enable students to become fit for practice, fit for purpose and fit for award (National Committee of Inquiry into Higher Education (NCIHE), 1997).

Third, the findings of Kramer’s (1974) study mentioned earlier indicated the need for preceptors for newly qualified nurses. The notion was extrapolated to pre-registration students and is also a reason for the introduction of the term ‘mentor’ in the UK in the 1980s as a means of supporting student nurses with their learning during practice placements.

Fourth, the standards or codes of professional (or good) practice for nurses, doctors, social workers and AHPs usually indicate that qualified practitioners have a duty to facilitate students’ learning during practice placements so that students develop their competence under supervision (for example, NMC, 2015: clause 9.4). Similar requirements feature in healthcare professionals’ job descriptions, which are also guided by the *NHS KSF* (DH, 2004a).

Mentoring of course also provides registrants with an opportunity to teach, which in itself is a feature of their own professional development and can constitute a stepping stone in their own career trajectories.

Yet another reason for mentoring is the concept of work-based learning, which constitutes practice-based development of skills and (practical) knowledge. Its main features are reflected in the social learning theory that was constituted by Bandura (1986, 1997), and which centres on learning skills by observing skilled professionals perform them first. Social learning theory therefore also involves mentors being role models, and comprises four processes of learning (see Figure 1.1).

![Figure 1.1](image-url)
In more detail, the four processes of learning that the learner goes through are:

1 **Observation of skilled performance**
   - The individual observes a skilled performance (‘modelling stimulus’).
   - The observed behaviour is seen as useful and distinctive.
   - Observer’s level of arousal pertaining to the skill is raised.
   - Observer is keen to learn the skill.
   - Observer has previously felt positive reinforcement for learning skills.

2 **Mental retention of the skill**
   - Step-by-step performance of the skill is mentally assimilated.
   - Mental rehearsal of modelled behaviour.

3 **Motor reproduction of the skill**
   - Observer carries out observed behaviour or skill, and self-evaluates it in terms of performance.

4 **Reinforcement and adoption**
   - The behaviour is reinforced by external reward such as praise or through self-reinforcement, and is likely to be adopted.

According to Bandura (1986), we do not possess any inherent behaviour patterns at birth except reflexes, and therefore learning occurs by observing other people, which is the essence of social learning theory and which therefore includes learning from social situations. In healthcare, learners (mentees and preceptees) learn and acquire practical skills from mentors and other healthcare professionals through the four processes identified in Figure 1.1.

Bandura’s (1986) social learning theory had previously been termed ‘observational learning’ or ‘modelling’, and was built on behaviourist learning theory (see Chapter 2). It is a component of work-based learning, a concept that is examined in some detail in Chapter 4 in the context of learning in practice settings.

Yet another reason for mentoring is that it can be effective in management mentoring, which is an activity wherein trainee managers are mentored by named highly experienced managers to enable those less experienced to develop their management skills (for example, Megginson et al., 2006). Waters et al. (2003), for instance, report on a very successful tailored mentoring programme for newly appointed nurse managers where mentees can choose their mentors.

### Activity 1.3 Management mentoring

All nurses and the majority of healthcare professionals have a management and organisation of care role. Some healthcare professionals opt to develop their careers as clinical managers. Explore with a band 6 colleague how management mentoring is utilised informally, and possibly formally, to enable healthcare professionals to develop as clinical managers.
Brooke and Ham (2003) also report on a successful programme that enables managers to develop their leadership skills. A small number of healthcare professionals have had experience of management mentoring, which on occasion is referred to as ‘management coaching’. This is a longer-term role than mentoring pre-registration students on practice placement. The management mentor role can initially take the form of a coach that advises the mentee to explore utilisation of particular management techniques, and takes a more directive approach. When the mentee has developed substantial management skills, the role can become more akin to a mentor’s, i.e. less directive; and much later mentor–mentee activities become more akin to those of ‘buddies’, i.e. equals.

**Mentoring and coaching**

Other learning support roles that utilise aspects of mentoring have been identified by various agencies, some of which are still developing, and include practice facilitator, buddy, coach and co-tutor. The more developed terms ‘coach’ and ‘coaching’ tend to surface sporadically in nursing. Coaching itself is defined as ‘the art of facilitating the performance, learning and development of another’ (Downey, 2003: 21, cited in Byrne, 2007); and the Chartered Institute of Personnel and Development (CIPD) (2013: 1) indicates that:

> Coaching targets high performance and improvement at work and usually focuses on specific skills and goals, although it may also have an impact on an individual’s personal attributes (such as social interaction or confidence). The process typically lasts for a relatively short period.

‘Performance’, ‘specific skills’ and ‘goals’ are key common words used in determining a common understanding of the term coaching, which in turn usually incorporates a more directive and prescriptive approach. This term and title, however, is more closely linked to sports, which involves training coachees using individually tailored programmes aimed at enhancing their physical performance so that they are able to take part in competitions in specific sports. Other prominent areas include life coaching (enabling the coachee to live a healthier and more fulfilled life); health coaching (enabling individuals with long-term conditions such as chronic obstructive pulmonary disease (COPD) to self-care; and business coaching (guiding someone who is starting their own business for the first time and helping them to succeed).

Reporting on the findings of an audit of a new role termed ‘clinical coach’, whereby an appointed academic coaches underachieving (referred to as ‘marginal’ or ‘at risk’) student nurses during practice placements, Kelton (2015) indicates that a systematic approach to clinical coaching can significantly enhance students’ successful completion of the placement. Clinical coaching entails the appointed clinical coach providing additional support and guidance to the identified student. Another application of coaching in healthcare is management coaching, to guide more junior registrants to develop their management and organisation of care skills, whereupon the coaches are very experienced more senior healthcare managers enabling coachees to develop skills through one-to-one guidance and
support that can enhance their management and leadership performance in the organisation (for example, Haidar, 2007; Coleman and Glover, 2010). It also applies to more senior managers such as the Executive Nurse receiving coaching from independent appropriate personnel.

Furthermore, there are endeavours to institute management and leadership coaching for healthcare students on their final practice placement at the end of their course when in addition to consolidating their patient or service user care skills, they also learn the practicalities of organising and managing care in the practice setting (for example, Eades et al., 2005), that is they begin to learn management skills. Management activities are identified by Gopee and Galloway (2014), some of which the third year student can learn, include:

- delegation of duties
- supervising care delivery
- organising transfers of patient care
- receiving/giving reports on patient/service users care needs and progress
- working with multidisciplinary team (MDT) members
- doing the off-duty/facilitating self-rostering
- managing space, i.e. extra beds/patients on trolleys
- ensuring the health and safety of staff/patients/visitors.

The competencies that student nurses or midwives have to learn have been identified by the NMC (2010a) for instance, and the GROW model (also referred to as: GROWing – which stands for Goal, Reality, Options, Will/Wrap up) is advocated (for example, Connor and Pokora, 2012) as a framework for effective coaching. There are several other books on coaching, and short courses and modules are available from various organisations.

Who Can Be a Mentor?

Despite all the reasons for mentoring discussed so far, it should not be taken for granted that all qualified healthcare professionals wish to undertake mentoring work, for all or even some of the time. Some healthcare professionals feel that continuous allocation of students to them all year round can be detrimental to their own effectiveness with their workloads, and they would like some space for reflection and to focus on their own professional development.

In the selection of mentors, it is important to ensure that they have the necessary skills and expertise for mentoring, which according to Neary (2000a) include coaching, counselling, facilitating, setting standards, assessing and giving feedback. Other writers and researchers identify similar lists of skills. Such lists initially appear simplistic but a whole range of expertise is required to undertake the mentorship role, and this can usually be developed through appropriate educational preparation.

In some professions, such as in medicine in the UK, the very definition of mentor suggests that students should be able to select their mentor. However, in reality, in
healthcare professions, students on practice placement do not usually have the opportunity to select their mentors due to various factors such as RNs’ increased workload. Nonetheless, there are situations when mentees are encouraged to or have the option to choose their mentor, such as if they go back to a particular practice setting for a second placement later in their course.

There are occasions when RNs may be able to select one individual to whom they can relate throughout an entire programme as a personal mentor or a ‘buddy’. On the other hand, the NMC (2008a) also identifies the criteria for who can be mentors for nursing and midwifery students, which are as follows:

- Be registered in the same part or sub-part of the register as the student they are to assess and, for the nurses’ part of the register, be in the same field of practice (adult, mental health, learning disability or children’s nursing).
- Have developed their own knowledge, skills and competence beyond registration, and have been registered for at least one year.
- Have successfully completed an NMC-approved mentor preparation programme, or a similar previous programme.
- Have the ability to select, support and assess a range of learning opportunities in their area of practice for students undertaking NMC-approved programmes.
- Be able to support learning in an interprofessional environment – selecting and supporting a range of learning opportunities for students from other professions.
- Have the ability to contribute to the assessment of other professionals under the supervision of an experienced assessor from that profession.
- Be able to make judgements about [the] competence of NMC students on the same part of the register, and in the same field of practice, and be accountable for such decisions.
- Be able to support other nurses and midwives in meeting continuing professional development (CPD) needs in accordance with The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC, 2008b). [The NMC (2008b) Code has since been superseded by NMC (2015) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.]

These criteria clearly imply that not all registrants are suitable for mentoring, at least not for all categories of learners. The competencies and outcomes for mentors are discussed next.

**How to Mentor**

In a systematic review of mentoring, Jokelainen et al. (2011) concluded that mentoring comprises two main themes. These are, first, facilitating student learning and, second, strengthening students’ professionalism (professional attributes and identities). Four subthemes were deduced as well as a number of categories under each subtheme. Thus, the principles and methods of mentoring incorporate a number of factors that are essential for effective student learning. They include meeting NMC’s (2008a) standards for mentors that are identified under eight domains, these being:
1 establishing effective working relationships
2 facilitation of learning
3 assessment and accountability
4 evaluation of learning
5 creating an environment for learning
6 context of practice
7 evidence-based practice
8 leadership.

The first domain, ‘establishing effective working relationships’, encompasses:

• how effective working relationships are developed and maintained
• effective mentor–mentee communication
• characteristics of the mentor
• actions by the mentor that support learning.

Each of the other domains is addressed separately in subsequent chapters as detailed in the introduction to this book.

Effective working relationships

In a study conducted by Johansson et al. (2010) to measure the quality of teaching and learning in practice settings, it emerged that the supervisory relationship between mentor and mentee is the most important factor contributing to effective clinical learning experiences. Eller et al.’s (2014) study of effective mentor–mentee relationship concluded that there are eight components to this, including open communication and accessibility, mutual respect and trust, and role modelling.

However, for two individuals who are usually initially unknown to each other, adopting the mentor–mentee roles presupposes that they are able to communicate with each other, develop a rapport and cultivate a ‘working’ relationship at the very least. The word *rapport* means ‘a state of deep spiritual, emotional or mental connection between people’, including understanding and empathy (Brown, 2002: 2465), and *relationship* refers to ‘the state or fact of being related, an emotional association between two people’ (Brown, 2002: 2520).

The requirement for effective working relationships is recognised by the NMC (2008a). But how are relationships formed between two designated parties? According to Rogers and Freiberg (1994), counsellors and helpers build a trusting and working relationship by ensuring first of all that certain key conditions prevail. These conditions are:

• *Acceptance (or unconditional positive regard)* – of the individual for who they are, that is, for their individual strengths and weaknesses; and mutual respect.
• *Genuineness* – as a person, honesty.
• *Empathic understanding* – being able and willing to view situations from the other person’s perspective.
These key conditions are explored in some detail in the context of student-centred learning in Chapter 3. Rogers and Freiberg (1994) emphasise that ‘trust’ underpins these key conditions, which they suggest in reality permeate all mutually beneficial relationships. It is akin to a ‘psychological contract’ between the mentor and mentee, or between patient and carer, or colleagues and friends. The two parties also have to be willing to spend time together to maintain this relationship and to work towards the achievement of practice objectives, for instance. Although the mentee has to actively seek out relevant learning opportunities, the mentor also needs to take actions that support the mentee’s learning, for example by familiarising themselves adequately with the mentee’s educational programme.

Effective mentor–mentee communication

The skills and techniques of communication are some of the most important tools the practitioner undertaking the mentoring role has to utilise. The healthcare professional is normally already a skilled communicator in healthcare settings through initial educational preparation, and therefore it is important to establish which other communication techniques they need to develop in order to extend their skill base. Effective communication skills are essential within all teaching and learning situations.

Various modes of communication are available to the mentor to choose from, including:

- written, for example handwritten, typed, emailed, faxed, printed
- oral (spoken), for example face to face, one-to-one, in groups, by telephone
- non-verbal, for example body posture, eye contact, tone of voice.

Oral (spoken) communication is always accompanied by non-verbal messages, vocal and non-vocal. In fact, non-verbal hues are more powerful than verbal messages. Furthermore, Argyle (1994) suggests that non-verbal signals of a friendly attitude (as opposed to an unfriendly attitude) are:

- **proximity**: closer, leaning forward if seated
- **orientation**: more direct, but side to side for some situations
- **gaze**: more gaze for each other, and mutual gaze
- **facial expression**: more smiling
- **gestures**: head nods, lively movements
- **posture**: open arms stretched towards each other rather than arms on hips or folded
- **touch**: more touch in an appropriate manner
- **tone of voice**: higher pitch, upward contour, pure tone
- **verbal contents**: more self-disclosure.

After reflecting on a former framework for non-verbal communication referred to as SOLER (which stands for: ‘sit squarely’; ‘open posture’; ‘lean towards the other’; ‘eye contact’; ‘relax’), Stickley (2011) suggests that the framework (or model) can be enhanced
by using the acronym SURETY (which stands for ‘sit at an angle’; ‘uncross legs and arms’; ‘relax’; ‘eye contact’; ‘touch’; ‘your intuition’). This latter model incorporates the function of touch as a means of non-verbal communication, and intuition. Normal communication processes however are often presented as the information processing theory in the context of cognitive learning theory, which is discussed in Chapter 2.

Generic and specialist communication skills

In addition to general communication skills, the mentor is likely to need to develop specialist communication skills to manage more complex mentee issues. Scammell (1990) suggests a communication continuum that spans generic communication at one end to specialist communication at the other, with the associated specific purposes and specific skills for each component on the continuum. These components and their associated purposes and skills are as follows:

<table>
<thead>
<tr>
<th>Component</th>
<th>Purpose</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary communications</td>
<td>initial contacts with others; brief encounters</td>
<td>simple interpersonal or social skills, e.g. ability to listen, etc.</td>
</tr>
<tr>
<td>Secondary communications</td>
<td>ongoing relationships – verbal, non-verbal, written; informal support groups</td>
<td>interpersonal or social skills, knowledge of how groups work, etc.</td>
</tr>
<tr>
<td>Advice giving</td>
<td>to offer factual information; to teach, instruct, supervise</td>
<td>when to give advice, ability to impart knowledge of subject area, etc.</td>
</tr>
<tr>
<td>Primary counselling</td>
<td>support for friend or work colleague</td>
<td>listen non-judgmentally, help with problem-solving, etc.</td>
</tr>
<tr>
<td>Secondary counselling</td>
<td>therapeutic counselling for specific mental health problems</td>
<td>advanced accurate empathy, self-disclosure, etc.</td>
</tr>
</tbody>
</table>

Primary and secondary communication occurs between mentor and mentee when exchanging information and establishing a working relationship. Beyond this level, the mentor may need to give direct advice to the student, especially when teaching, as well as when advice is requested. This, however, does not go as far as counselling, for which the individual requires more extensive training.

Primary counselling is a specialised communication skill that the mentor needs to develop to deal with difficult mentoring situations. Secondary counselling will be required for more intense psychological problems, which the mentor can deal with by directing the student to appropriate support services, or, if trained, by using a systematic approach such as Heron’s (1989) six-category intervention analysis (see the box below).
Heron’s (1989) six-category intervention analysis therefore entails six possible actions that the counsellor can choose from. In difficult mentor–mentee situations, for every interaction, the mentor may decide which of the six categories is most appropriate. For instance, for a student who frequently claims to be feeling unwell, physically or psychologically, the mentor might use the prescriptive category of helping, and advise the mentee to consult the occupational health department. They might also give further information about where the department is, and the likely outcomes of this situation. In other situations, the mentor might use another one of the categories, for example cathartic, to enable the mentee to elaborate in detail how they feel about a patient whom they have looked after but who has passed away rather suddenly, for instance.

Ways in which the mentor can usefully apply Heron’s model of intervention towards their mentees are discussed in Chapter 7.

**Mentors’ characteristics and roles that support learning**

In addition to effective communication skills and the ability to form effective mentor–mentee relationships, various researchers have examined the characteristics and roles of mentors that play crucial parts in enabling the mentee’s learning during practice placements.

**Characteristics of mentors**

**Activity 1.4  Characteristics of an effective mentor**

Make a list of what you consider to be the characteristics of a registrant who is effective in their mentoring role for either undergraduate or postgraduate students. Consider their characteristics from such perspectives as personal qualities, approach/actions and skills.
Responding to Activity 1.4 must have been straightforward as all healthcare professionals who have undertaken preparatory educational programmes that include practice placement will have encountered mentors. Some mentors may have been excellent, while there might have been reservations about others. Most of the characteristics identified by groups of student mentors are listed in the box below.

<table>
<thead>
<tr>
<th>Characteristics of the person who is an effective mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient</td>
</tr>
<tr>
<td>• Open-minded</td>
</tr>
<tr>
<td>• Approachable</td>
</tr>
<tr>
<td>• Has a good knowledge base</td>
</tr>
<tr>
<td>• Knowledge and competence is up to date</td>
</tr>
<tr>
<td>• Has good communication skills, including listening skills</td>
</tr>
<tr>
<td>• Provides encouragement</td>
</tr>
<tr>
<td>• Is self-motivated</td>
</tr>
<tr>
<td>• Shows concern, compassion, empathy</td>
</tr>
<tr>
<td>• Has teaching skills</td>
</tr>
<tr>
<td>• Provides psychological support</td>
</tr>
<tr>
<td>• Counsellor</td>
</tr>
<tr>
<td>• Tactful</td>
</tr>
<tr>
<td>• Diplomatic, fun and fair</td>
</tr>
<tr>
<td>• Willing to be a mentor</td>
</tr>
<tr>
<td>• Versatile, adaptable, flexible</td>
</tr>
<tr>
<td>• Allows time and commits self to it</td>
</tr>
<tr>
<td>• Confident</td>
</tr>
<tr>
<td>• Enthusiastic</td>
</tr>
<tr>
<td>• Advisor</td>
</tr>
<tr>
<td>• Is honest and trustworthy</td>
</tr>
<tr>
<td>• Trusting</td>
</tr>
<tr>
<td>• A role model</td>
</tr>
<tr>
<td>• Non-judgemental</td>
</tr>
<tr>
<td>• Resource facilitator</td>
</tr>
<tr>
<td>• Able to build working relationship</td>
</tr>
</tbody>
</table>

Drawing on their study of students’ perspectives on the qualities of the effective mentor, Gray and Smith (2000) list several characteristics, many of which are also identified in the box above. In another study of the personal characteristics of mentors, Huybrecht et al. (2010) concluded that the perceived characteristics of mentors include:

- ability to give feedback
- make time available for mentee
- positive attitude
- transferring of enthusiasm onto students in spite of workload, lack of time, etc.
- closer follow-up of new developments
- teaching ability
- sharing of experiences.

From their concept analysis of mentoring, Hodgson and Scanlan (2013) identified the characteristics of effective mentors as: approachable, knowledgeable, honest, friendly, patient, experienced, enthusiastic, willing to spend time with the mentee, have a strong belief in the mentee’s capability, they challenge, support and encourage a
mentee, but also expect the mentee to be willing to learn, be career committed, competent, and have strong self-identity and initiative.

**Roles of mentors and enabling functions**

In addition to personal characteristics of mentors, other researchers explore the ‘roles’ of mentors. The roles of mentors refer to what mentors do to enable or facilitate mentees’ learning. Deducing from an earlier substantial study on various aspects of mentoring, Darling (1984) identified fourteen roles of mentors that enable learning. These roles are being a(n):

- role model
- energiser
- envisioner
- investor
- supporter
- standard prodder
- teacher–coach
- feedback giver
- eye-opener
- door-opener
- ideas bouncer
- problem solver
- career counsellor
- challenger.

Taking a broader perspective, Hall et al. (2008) explored mentors’ perceptions of their role in teacher training in the USA and found that it comprises nine roles and responsibilities for supporting learning of individuals engaged in teacher training. These roles are:

- parent figure
- trouble shooter
- scaffold
- counsellor
- supporter
- instructional model
- coach or guide
- source of advice
- a sounding board for concerns about teaching.

### Activity 1.5  Ascertaining mentorship potential

Consider Hall et al.’s (2008) or Darling’s (1984) roles of the mentor, and identify situations from the past when you needed to be in these mentoring roles, or will be in forthcoming mentoring opportunities.

1. For each role, do a self-rating of yourself as a mentor using the numbers 1 to 4, with 1 indicating development or learning need and 4 indicating skilled.
2. Next, focus on one or two of the roles on which you rate yourself as low, and consider why this is (e.g. lack of opportunity), and how you can develop your competence in that role.
The above exercise based on roles of the mentor is also referred to as ‘measuring mentorship potential’ (MMP) (Darling, 1984). Of course, the teacher mentor has to be a role model in teaching in the first place, and in healthcare the mentor has to be a role model as a healthcare professional, i.e. as a clinician, as well. Alternatively, with reference to research mentors in medicine, Tobin (2004) identified seven roles of the physician-researcher: as teacher, sponsor, advisor, agent, role model, coach and confidante.

Each of these mentor roles can be explored in detail as a concept in its own right, and to illustrate this, the next section explores the features of being a ‘role model’ and then of ‘challenger and supporter’ that were identified by Darling.

**The mentor as the role model**

Various research studies indicate that mentors should be role models for their mentees (for example, Tobin, 2004; Billay and Yonge, 2004; Darling, 1984).

In response to Reflection Point 1.1, you might have felt that a mentor who is a role model is someone who fulfils NMC’s (2008a) standards for mentors, as identified earlier in this chapter. Although the mentor would be a role model predominantly for clinical skills, they should also be a role model as an organiser of care, a researcher and a teacher within the parameters of their post.

As with most nascent and tentative concepts, a concept analysis or a STEP (social, technical, economic and political) analysis can enable further clarification of the concept, and a systematic understanding of various facets and components of the concept. Alternatively, a SWOT (strengths, weaknesses, opportunities and threats) analysis can be undertaken. Such an analysis can help the individual decide whether any problem-solving, avoidance or developmental actions need to be taken.

**Activity 1.6  STEP analysis of role model**

Using the headings ‘social’, ‘technical’, ‘economic’ and ‘political’, conduct a STEP analysis of ‘the mentor as a role model’.

Being a role model is a feature of Bandura’s (1997) social learning theory, which stipulates that substantial learning occurs as a result of observation of appropriate
professionals. Bahn (2001) suggests that role modelling is consistent with social learning theory, as substantial socialisation occurs in clinical learning environments. It is also a significant component of ‘work-based learning’, which is discussed in Chapter 4.

There can also be bad role models, that is, how not to come over as a healthcare professional. Bad role models can therefore not be seen as a model at all, considering what the word ‘model’ means. A role model is ‘an exemplary person, a perfect exemplar of excellence’ (Brown, 2002: 1806), that is, someone whose practice standards, attitudes and beliefs can be emulated by the observer. Individuals choose their role models, such as someone who is good at time management, at self-organisation or at how they interact with colleagues.

Donaldson and Carter (2005) report on an evaluation of the perceptions of undergraduate students on role modelling within the clinical learning environment. They indicate that students stressed the importance of good role models whose competence they could observe and practise. Constructive feedback was needed on their practice from their role models to develop their competence and build up their confidence, and to convert observed behaviour into their own behaviour and skill set.

Faugier (2005a) suggests that role models are those whom we look up to, emulate and admire as professionals, but in society in general, she suggests, people base their character identities, values and lifestyles on celebrities and characters in television programmes. All teachers in the practice setting (for example, mentors) should therefore be aware of their impact as role models on students’ learning of skills and professional attitudes.

Thomas (2005) reports that there are mixed views about nurses being role models of healthy habits when off duty, and therefore a certain level of self-awareness of one’s public behaviour is necessary to keep their credibility as role models intact.

The mentor as a challenger and supporter
During their practice placements students are likely to encounter patient or service user situations that they find challenging, and being a ‘challenger’ is one of the roles of the mentor identified in Darling’s (1984) research, and other situations that they will find much less challenging especially in the latter part of their pre-registration programme as they acquire various clinical skills. How much support (also a mentor role according to Darling) should the mentor provide to the student when the latter encounters very challenging situations?

Mentoring support and challenge
Consider the mentor’s roles as ‘supporter’ and ‘challenger’, and think of patient or service user care situations (or clinical interventions) in your workplace that, say, a second year student will find highly challenging, and others that will be much less challenging. Often mentors have to comment on the level of initiative that their students take.

(Continued)
mentees show. So think for yourself (or discuss with a peer) if the mentee encounters highly challenging patient or service user care situations, what level of support you would provide your mentee.

What is the result if the student consistently encounters situations that are of ‘low challenge’ to them?

Of course, students have to be supervised all the time, either directly or from a distance. There are various examples of situations that present high or low challenges for learners in practice settings, and the level of support required. Asking a third year student nurse consistently to perform clinical skills for which they have already been signed as competent would provide a lesser challenge to them, and lesser support might be required. But if the same student has not yet learnt how to provide care in epidural pain control, for instance, then this would present a higher challenge and the student is likely to need a high level of support.

Daloz (1989) explored these two mentor roles further and concluded that high challenge and high support can lead to growth and achievement of aspirations (or vision), while low support and low challenge can result in stasis and apathy. However, high challenge and low support, according to Daloz leads to ‘retreat and burnout’ (see Figure 1.2).

Mentor actions to support learning

The roles and responsibilities of the effective mentor are regularly researched to ascertain the more contemporary nature and perceptions of this function. For example, Carnwell et al. (2007) explored NHS and HEI managers’ perceptions of

![Figure 1.2: The effects of support and challenge on the mentee's development](image-url)
learning support roles. They found that the mentors’ primary role is in clinical practice, their primary skills constituting clinical expertise, teaching clinical skills and student support, and their primary focus is the individual student, that is student supervision and the assessment of students’ clinical skills. However, they also identified potential for role conflict, particularly if the mentor is relatively recently qualified and therefore still developing their own repertoire of clinical skills.

Activity 1.7  Actions that support learning

In addition to having the characteristics of an effective mentor, think of and make a list of a number of actions that can be taken by mentors that support learning.

No doubt a range of components that support learning can be identified. One of the key functions of the mentor is to help the student integrate into the practice setting, which entails managing the practice placement, receiving the student and conducting initial, mid-placement and final interviews, and preferably using learning contracts. ‘Acceptance’ of the mentee (Rogers and Freiberg, 1994) signifies that the mentor accepts the student for their current levels of knowledge and competence, which may be extensive or minimal.

As for managing the placement, the designated mentor would have been nominated before the student starts on the placement, and would need self-preparation time beforehand. Time would also have been set aside for receiving the student and introducing them to the team, and associate mentors may have been identified.

Seeing the practice placement from a student’s viewpoint suggests that they might be experiencing different feelings in anticipation of the placement. They are likely to appreciate any prior information sent to them, which might include any preparatory reading that the student can do. On the first day, they tend to appreciate an introduction to the clinical area, making them feel comfortable about learning, a professional but friendly environment, student involvement and continuity of mentorship. These perspectives are consistent with ‘empathic understanding’ identified as a key condition of effective working relationships by Rogers and Freiberg (1994).

Furthermore, the NMC (2008a) indicates that to enable effective learning, at least 40 per cent of the student’s placement time must be spent working with the mentor. Similar rules apply to the practice teacher role. Moreover, the NMC (for example, 2008a) has identified the need for ‘protected time’ for mentoring, as has the Department of Health (1999).

Adverse Effects of Poor Mentoring

A common experience in nursing in the twenty-first century is that nurses working in many practice settings feel that they are managing their workload with ongoing staffing
MENTORING AND SUPERVISION IN HEALTHCARE

constraints. Indeed, Phillips et al. (2000) noted that mentors fulfil their mentoring role as one of several other roles they have during any span of duty. Despite ‘protected time’ for mentoring having been advocated for over a decade (DH, 1999), the implementation of this mechanism remains slow for many mentors due to the demands on their time. When working within these constraints, knowingly or unknowingly, the mentor may be taking (or omitting) actions that discourage learning.

Activity 1.8   How the mentor might discourage learning

Think of, and make notes on, a range of actions on the part of mentors that, deliberately or not, may be seen as discouraging or disabling learning.

The following case study presents an example of poor mentoring.

Poor mentoring

Mel Alexis is a second year student nurse on a rehabilitation ward. One day, she finished her shift early, having told the staff nurse in charge that she had a terrible headache, while in fact she was extremely upset regarding her placement.

That morning she had felt that the staff nurse had spoken to her in a very unprofessional manner, as she does to patients as well. This is what bothered Mel the most. She also challenged the staff nurse over her drug administration that morning. A patient was left her morning medication in a pot on the table, but was unable to swallow it as she needed assistance due to her having a weak side and problems with her other hand. As Mel walked past the patient’s room, the patient called her and indicated that she had not taken her tablets yet. As Mel was not the nurse who administered the drugs, she called the nurse to the room for her to administer the drugs. The nurse said that she did not have time to do this but the tablets were correct for the patient.

Mel agreed to assist in giving the medication but noticed three tablets lying on the table beside the pot. Mel asked the nurse what these tablets were and she was advised they were morning medications as well. Mel doubted this as they were not in the medicine pot and asked the nurse why they were not in the pot, but the latter did not give an answer and instead picked them up and put them into the pot. The nurse then told Mel to assist with the medications and Mel made it clear that she did not feel that the medications were correct, as there seemed to be more tablets than the patient usually took in the morning. The nurse told Mel not to question her drug administration, so Mel felt that she had no choice but to assist the patient in taking the drugs.

This event highlighted Mel’s unhappiness with this ward. She had started feeling like this on day one when she was not introduced to any staff members or shown around.
She had had to find things out for herself during her time on this ward and if she asked where something was, the staff said it would be quicker for them to get the item themselves rather than show Mel. As a second year nurse, she was expecting to do many nursing activities but instead she felt that she was being treated like a support worker. Although Mel loves providing basic nursing care to patients, she expected a lot more out of this placement than she was actually achieving. Mel appreciates that on a rehabilitation ward nursing takes on a different role but she feels that she has yet to see what this role is.

Mel says she has always wanted to be a nurse and really loves the job, but this ward has now made her question this and it makes her very sad to feel like this.

In response to Activity 1.8, you may have felt that one of the problems that students experience is the lack of opportunities to work with their named mentor. Other actions on the part of mentors that you might have thought of that can discourage learning are:

- lack of interest in students and in their learning needs
- lack of knowledge about the student’s course
- lack of evidence-based practice or research utilisation
- hierarchical, and a lack of team approach
- not acknowledging student’s previous experience
- negative attitudes
- reluctant to change practice.

There is a possibility that you have yourself witnessed poor mentoring, directly or indirectly. Other problems with mentoring remain prevalent. Earlier research into mentoring and assessing had identified personality characteristics that discourage learning. For instance, Darling’s (1985) qualitative study revealed what she termed the characteristics of the ‘galaxy of toxic mentors’ (see box).

<table>
<thead>
<tr>
<th>The ‘galaxy of toxic mentors’</th>
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<tbody>
<tr>
<td><strong>Types</strong></td>
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<tr>
<td>Avoiders</td>
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<td>Dumpers</td>
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(Continued)
Based on extensive experience in management and decision-making, Heirs and Farrell (1986) explored the mindsets of individual employees who enable an organisation to progress with its aims, and those of people who block such development. While the focus is on looking for, and developing, ‘talents’ in junior employees, in reality the mindset of some employees can stifle development of juniors and mentees. The researchers grouped the problematic or disabling traits of those who block development as ‘three mental poisons’, in terms of the functioning of rigid minds, ego minds and Machiavellian minds (see box). Such ways of thinking are not always obvious, nor easily detected, but do affect learning adversely.

The functioning of rigid minds, ego minds and Machiavellian minds

The rigid mind:
- Personal values are set or stereotyped
- Unable to see the positiveness in others’ thoughts if they conflict with their own thinking
- Continually blocks the openness of more creative thinking
- Loyal to traditional thinking and rejects novelty
- Appears to lack imagination or creativity
- Stifles use of originality and encourages complacency

The ego mind:
- Sees elements of a problem only in terms of self-interest and self-importance
- Fairly ambitious and has a high opinion of own abilities
- Looks after number one to the exclusion of other considerations
EFFECTIVE MENTORING

• Pays little attention to what others think and say
• Unsociable and does not contribute to collective thinking
• Will betray colleagues and even the organisation if it serves his or her ends

The Machiavellian mind:
• Quickly sees the range of likely outcomes of any decision
• Manipulates the feelings and ambitions of others to deceive
• Devious and calculating
• Intimidates and engages in politicking
• Perpetuates worry in the organisation and perpetually currying favour with superiors
• Scheming, cunning and suspicious of subordinates

Source: Heirs and Farrell (1986)

Mentoring was formalised with increased emphasis with the introduction of diploma in higher education programmes in Nursing (Project 2000) (UKCC, 1999). In this context, Gray and Smith (2000) conducted a study to explore students’ experiences of mentoring, and found that whilst effective and good mentoring did prevail, the majority of students also experienced poor mentoring, as some mentors:

• break promises
• lack knowledge and expertise
• have poor teaching skills
• have no structure to their teaching
• ‘chop and change their minds’
• allow students to observe only (i.e., not participate)
• are unclear about their students’ capabilities
• throw students in at the deep end
• delegate unwanted jobs to students
• dislike their job and/or students
• may be disliked by other members of the team
• are distant, less friendly, unapproachable
• intimidate the students
• have unrealistic expectations.

Activity 1.9 Mentors who disable learning

Discuss with a peer or in a small group why any mentor would behave in the negative ways described by Darling or Gray and Smith. Discuss also if and how such behaviours can be changed.
Darling (1985) makes a number of suggestions on how to deal with ‘toxic’ mentors. For instance, if the particular mentor–mentee allocation is unavoidable, then the mentee can try and keep the relationship balanced by building a support network with other students or registrants within the team, and drawing on his or her own personal strengths (for instance, problem-solving skills). Heirs and Farrell (1986) suggest that it is the responsibility of the organisation’s managers to identify employees who block development and learning. ‘Poisonous’ thinking endures, but can be changed gradually through formal and informal meetings. Decisions about delegation of responsibilities and roles need to be applied selectively and overseen with appropriate intensity or leniency.

At times, mentors are ineffective because of a lack of detailed knowledge of their mentee’s educational programme (or course), regarding which the PEF should be able to advise. Other actions that can be taken if ineffective mentoring is detected is to implement co-mentoring, which involves two mentors jointly mentoring the student. Temporary non-allocation of a student to the ineffective mentor is another alternative that might work. Managers can formally or informally ask the mentor how well they feel they are fulfilling their mentoring role. The line manager may be able to confront the ineffective mentor if poor mentoring has been observed, or a complaint received. There can be other alternative strategies, but they will be dependent on local circumstances. Ethical aspects of poor mentoring are discussed in Chapter 7.

**Approaches and Models of Effective Mentoring**

Despite the multiplicity of likely mentor behaviours that could inhibit learning, mentoring remains a necessary role for supporting learning in healthcare professions. A mentor in personal life is also advocated. Due to the humane, personal and suffering-prevention nature of healthcare provision, professional education programmes need to be appropriately structured and carefully monitored. Mentoring students must also be a structured or planned exercise, as discussed earlier in this chapter. An appropriate combination of directive and facilitative approaches may be adopted, depending on the knowledge and competence that the student displays.

The underlying principles on which each mentor bases their mentoring vary according to the personal beliefs and approaches of the mentor towards this role. The underpinning beliefs of the mentor about student learning therefore determine their approach to mentoring, and the model or framework of mentoring they use.

The differences between the terms *approach*, *model* and *framework* are as follows. ‘Approach’ to mentoring is personal to the mentor and is based on his or her own life and professional experiences, and personal views and beliefs. In mentoring, it would depend on the mentor’s beliefs about nursing, undergraduate course design, student and learner populations and their styles of learning.

A ‘model’, however, can be defined as a research-deduced, and therefore informed, set of interrelated components that enable the activity to be addressed.
comprehensively. A ‘framework’ takes this further, whereupon the components of the model are utilised as sections or headings for planning and implementing the activity, and may even have been empirically tested.

All three perspectives indicate a planned and systematic approach to the mentee’s placement experience to make it more effective. Few frameworks for mentoring in healthcare are currently available. Darling’s (1984) roles of the mentor constitute such a model, the NMC’s (2008a) eight domain standards for mentoring are another. Despite the pragmatic nature of frameworks, it is important to examine other approaches and models of mentoring that are available, such as those identified in the box.

A model is of course useful if it can be used as a framework for action. Kerry and Mayes (1995) tend to use the terms ‘strategies’, ‘approaches’ and ‘models’ interchangeably. They suggest four models of mentoring, namely the:

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**Approaches, models and frameworks for mentoring**

<table>
<thead>
<tr>
<th>Approaches to mentoring</th>
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<tbody>
<tr>
<td>Classical mentoring</td>
<td>Also known as informal or primary mentoring. A natural, mutual and self-chosen relationship that can usually be terminated by mutual decision.</td>
</tr>
<tr>
<td>Reflective practitioner</td>
<td>Based on learning theories, e.g. andragogy, styles of learning and student-centred approaches, the mentor is a critical friend and co-enquirer.</td>
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<table>
<thead>
<tr>
<th>Models or frameworks of mentoring</th>
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<tbody>
<tr>
<td>Apprenticeship model</td>
<td>The mentor as skilled crafts person, and the mentee learns by re-enacting their actions.</td>
</tr>
<tr>
<td>Competence-based model</td>
<td>The mentor enables the mentee to learn specific practice objectives, and assesses their competence in them.</td>
</tr>
<tr>
<td>Team mentoring model</td>
<td>A team of mentors mentor one or more students jointly, as recommended by Phillips et al. (2000), for instance. Is akin to team supervision for doctorate students.</td>
</tr>
<tr>
<td>Contract mentoring</td>
<td>Formal mentoring that is time- or objectives-restricted, e.g. when on practice placement at another institution.</td>
</tr>
<tr>
<td>Pseudo-mentoring</td>
<td>Also known as quasi- or partial mentoring, may be in appearance only and for a specific task, e.g. dissertation supervision.</td>
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MENTORING AND SUPERVISION IN HEALTHCARE

• collegial model – similar to team mentoring or the use of associate mentors
• counselling model – refers to facilitation of learning using humanistic theories (discussed in Chapter 2)
• professional model – similar to the contract model, for example for a student on a practice placement, or in dissertation supervision (i.e., for a specific task)
• process model – also referring to facilitation of learning but enabling the mentee eventually to become an independent practitioner.

Activity 1.10 Application of models of mentoring

In your own experience of mentorship, which of these approaches, models or frameworks apply to learning professional skills in your own practice setting, and why? Which ones suit you most? Make some notes.

It could be argued that often the apprenticeship model applies more to the training of support workers in that an apprentice normally learns skills and crafts at the level of task performance, along with associated practical knowledge, unlike the holistic psychobiosocial approach taken by nurses and midwives. The competence model might apply to nursing but the reader needs to be aware of varying definitions of the term 'competence'. Some definitions see competence as the ability to perform a skill in accordance with agreed procedures and incorporate practical knowledge, while others see it as including theoretical knowledge as well.

The reflective practitioner approach is one that is frequently favoured within health profession circles, and advocates the mentor taking a less directive approach to their practice-based teaching. Consider the following reflective recording in the portfolio of a student social worker called Sheila.

Sheila’s portfolio

I visited Mr J while his care coordinator, who is also my practice supervisor, was on annual leave. At this time Mr J expressed concern about his care coordinator and questioned her supportive abilities. My initial reaction was to explain that different practitioners would use different approaches, and advised him to raise the issue with the care coordinator. In a further conversation by telephone, Mr J reiterated the issue but in a more agitated manner and asked me to speak to the care coordinator. His care coordinator suggested that we visit Mr J to question him about what he actually wanted from the service and what type of support he felt she should offer. She felt Mr J didn’t always engage with services (he frequently missed appointments), and that his drug-addiction problem was the issue he most needed to address, but which she did not specialise in. Mr J was receiving services
from the drug team but, again, he didn’t always attend his appointments. However, it was clear Mr J felt he needed more support. As a result we discussed a referral to an agency which provided outreach support specifically for people with a history of offending and drug/alcohol abuse problems. Mr J was keen to accept this support.

Reflective recordings from clinical situations provide an essential learning vehicle for mentees. The approaches and models presented in the box above titled ‘Approaches, models and frameworks for mentoring’ may not all be seen as frameworks, although they can be systematic and comprehensive. Most of the approaches are relatively recent concepts that await further empirical exploration or testing. Other frameworks and models of good practice are identified as specific sets of actions for specific professions, such as in business mentoring (Institute of Directors, 2014). The Royal College of Nursing (RCN) (2002) presents them as the ‘responsibilities’ of mentors.

Further dimensions of mentoring

To enable healthcare professionals to fulfil their mentor role effectively, especially towards students on pre-qualifying education programmes, they are required to undergo specified educational preparation. They thus have to attend and successfully complete an NMC-approved mentor course. One requirement for such courses is that they address the theory and practice related to the mentor outcomes under the eight NMC (2008a) domains referred to earlier in this chapter.

Fulton et al. (2007) explored the international literature for the content of mentor programmes and concluded that although the NMC domains (they were originally published in 2006) provide an acceptable framework for mentoring, it is reasonable to expect each country to be able to adapt the framework according to their own national and local needs.

The NMC (2008a) indicates that educational preparation for mentors needs to be at a minimum academic level 5 (Quality Assurance Agency for Higher Education (QAA), 2008), although most of these programmes are at degree and postgraduate levels (levels 6 and 7, respectively). They tend to be equivalent to 200 to 300 hours of student learning and are normally completed within four months. Mentor courses may be available with accredited CATS points or without, but in both cases the NMC’s (2008a) standards are met and the level of critical analysis that student mentors engage in has to be at minimum level 5. Continuing learning for mentors subsequent to successful completion of a mentor preparation programme is discussed in Chapter 8.

Furthermore, as noted earlier in this chapter, mentoring is now an activity that is widely applied in various healthcare and non-healthcare fields and can take different forms. Previously, mentoring in nursing, and currently in medicine (NHS England, 2014a), comprised mentors and mentees being mutually selected for their respective roles by the two healthcare professionals for facilitation, guidance, assistance and support with student learning. The notion that students can select their mentor has currency in some situations, such as if the named mentor’s job changes at short notice.
Gilmour et al. (2007) report on a highly successful peer-mentoring programme in which second year student nurses mentor first year students as they embark on their pre-registration university courses. Furthermore, a small-scale study by van Eps et al. (2006) suggests that year-long mentorship programmes yield more beneficial outcomes for students in terms of the variety of skills that they acquire through the longer-term relationship than the usual shorter-term ones.

Long-arm mentoring is another activity that tends to prevail primarily in certain areas of primary and social care where the mentor is not generally based at the same healthcare site as the mentee, and yet all criteria and activities comprising effective mentoring are fulfilled. Electronic or e-mentoring can also be implemented successfully, as demonstrated by Stewart and Carpenter (2009), whereupon the mentor and the mentee communicate entirely through their computers.

Moreover, increasingly, as interprofessional working and interprofessional learning is being systematically operationalised, the concept of interprofessional mentoring is also gaining in popularity and credibility. Lait et al. (2011), for instance, document the findings of evaluative research on the concept of interprofessional mentoring, indicating that:

• students learned about the roles of other professions and how to work together to provide patient-centred care
• interprofessional mentoring can be ‘threaded’ through all clinical placements rather than being offered only once on the three year pre-registration programme, or once a year.

Lait et al. (2011: 213) also point out that the activities that students engaged in varied in complexity and that ‘provider commitment’ is important. Furthermore, Lloyd-Jones et al. (2007) report on the successful implementation of interprofessional learning (IPL) across the whole curriculum of healthcare profession courses, on campus and in practice settings, and also that it figures in assessment strategies.

However, in a study of students’ experiences and staff perceptions of the implementation of placement development teams, Williamson (2009) reports that students indicate a need for more direct, personal and organisational support, and better communication between university and placement areas. Furthermore, research also suggests that the effectiveness of the mentor role also depends on the level of the mentor’s interest in mentoring (for example, Hallin and Danielson, 2009).

Chapter Summary

This chapter has focused on mentoring as a concept and professional role, and has therefore addressed:

• Current and recent perspectives on the concept of mentoring; and definitions of and distinctions between the mentor’s and various other learning facilitation roles, such as preceptors, clinical educators, assessors and supervisors,
practice education facilitators, link lecturers and personal tutors. All these roles are established so as to facilitate healthcare learners to acquire clinical skills, knowledge and appropriate attitudes.

- A number of reasons for requiring mentors to support learning for healthcare students on preparatory education programmes during practice placements, and the criteria for who can be a mentor.
- Effective mentoring, which encompasses effective working relationships; relevant mentor–mentee communication, which includes generic and specialist communication skills; the characteristics of mentors; and ascertaining own mentorship potential.
- Research findings on detrimental effects of poor, inefficient or adverse mentoring, and ways of addressing this issue when it occurs.
- The use of different models or approaches that identify mentors’ perceptions of their mentoring role.

Further Optional Reading

1 For an exploration of research on mentoring and coaching in a wide range of settings in the UK and abroad and discussion on a range of perspectives and issues, see:


2 For details of the successful implementation of preceptorship, see:


3 For an easy-to-follow and yet extensive and well-informed exploration of the concept and practice of supervision, including the qualities needed to be a good supervisor, see:


4 Having examined a range of components of the mentor role in this chapter, whilst also addressing the NMC’s mentor outcomes under the domain Establishing effective working relationships, if you are a student mentor, you should now be in a position to identify a selection of evidence that you can provide to demonstrate your competence on the mentor outcomes under this domain. Please see the companion website where a number of items of evidence are identified under each NMC domain.

To access further resources related to this chapter, visit the companion website at https://study.sagepub.com/gopee