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Effective Mentoring

Introduction

One of the key mechanisms for facilitating learning for healthcare profession students while on practice placements is mentoring. This mechanism is pretty much 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 firm indication of the criteria that healthcare professionals have to meet to use the title ‘mentor’, and details 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.

Chapter outcomes

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

- 1 Distinguish between mentoring and similar roles that support learning for healthcare profession students and learners.
- 2 Explain a range of reasons for requiring mentors for facilitating students’ acquisition of professional competence and the associated knowledge base in practice settings.
- 3 Identify and evaluate a number of factors that can enable effective mentoring, including the characteristics 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.

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'; and 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 that is related to facilitating professional learning in healthcare 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 upon 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. A study conducted by Carnwell et al. (2007), for instance, to explore the likely differences in the roles of mentors, lecturer-practitioners and link tutors indicate that mentors tend to focus principally on individual students, lecturer-practitioners on the 'learning environment', and link tutors 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 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 tutor. Thus, 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 the 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 defined similarly by the NMC (2008a: 45) as a registrant who has met the outcomes of Stage 2 (i.e. 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 other earlier studies (e.g. White et al., 1993). At that time, Spouse (2001a) found that the terms 'mentorship', 'preceptorship' and 'supervision' were being used synonymously, while White et al. (1993) had earlier found that

mentors themselves were unclear about their roles due to insufficient educational preparation.

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 (which form the major focus of this book). However, research on mentoring (e.g. by Kerry and Mayes, 1995) indicate 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 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'.

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), mentor is defined differently in nursing in other countries, such as in Canada (Billay and Yonge, 2004), and even in the UK in the medical profession (General Medical Council (GMC), 2010), in that it refers to qualified healthcare professionals being mentored by more experienced mutually selected colleagues. Also, in some UK professions, e.g. psychologists, the term 'protégé' is used when referring to the mentee (e.g. Barnett, 2008).

Preceptor

As the term most closely related to mentor, the NMC (2006a) identifies *preceptors* as first-level registrants who have 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 the nature of their working relationship and the 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 throughout 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.

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 aren't (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.

More recently, wide availability of preceptorship has been gaining momentum since publication of the Darzi Report (DH, 2008a), and healthcare trusts have since created new roles such as Preceptorship Co-ordinator to establish this mechanism. Dedicated government funding is now available on a recurring basis to provide preceptorship to all newly qualified nurses (e.g. Bayley and Bayliss-Pratt, 2010). Neither the Darzi Report nor the NMC (2006a) identify the specific content of preceptorship programmes, which are therefore adaptable according to local needs.

However, drawing partly on the successful implementation of preceptorship in Scotland through the 'Flying start' (Scottish Government, 2010) 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' (2010a: 6). The DH presents a framework for effective preceptoring, within which it also identifies the 'attributes' of an effective preceptor – see Box 1.1.

Box 1.1 Attributes of the effective preceptor

- Gives constructive feedback
- Sets goals and assesses competency
- Facilitates problem-solving
- Utilises active listening skills
- Shows understanding and ably engages in reflective practice in the working environment
- Demonstrates good time-management and leadership skills
- Prioritises care
- Demonstrates appropriate clinical decision-making and evidence-based practice
- Recognises their own limitations and those of others
- Knows what resources are available and how to refer a newly registered practitioner appropriately if additional support is required
- Is an effective and inspirational role model and demonstrates professional values, attitude and behaviours
- Demonstrates a clear understanding of the regulatory impact of the care that they deliver and the ability to pass on this knowledge
- Provides a high standard of practice at all times

Source: DH (2010a)

The College of Occupational Therapists (COT) (2009: 8–9) suggests four preceptorship standards that should be addressed in these programmes, namely working with clients, working with colleagues, written communication and 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 (2009a) is 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 on the NMC’s register, which can subsequently be followed up by regular re-validation 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 healthcare professional who has undertaken relevant educational preparation to develop skills in assessing students' level of attainment related to the stated practice competencies (e.g. 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. It also applies to the clinician's education role in relation to other learners (for example junior staff)' (Chartered Society of Physiotherapy (CSP), 2004: 20).

Clinical supervision

Clinical supervision 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 further develop 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.

Clinical supervisor

Clinical supervisor 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.

Practice teacher

The title or role of practice teacher was initially specifically adopted in recognition of the additional 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 (Shardlow and Doel, 1996).

Registrant

Both NMC and HPC refer to healthcare professionals who are currently on their respective registers as 'registrants'. Nurse and midwife registrants already have a teaching role towards others in the practice setting by virtue of the competencies that they have achieved as part of pre-registration education programmes, as well as through NMC's (2008b) code of practice, as other healthcare professionals usually do as well.

Supervision

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 very specific meaning in the field of counselling, in which it refers to counselling situations wherein one or more highly experienced counsellor helps a less experienced or more junior counsellor develop their practice.

Hawkins and Shohet (2006) refer to supervision as interpersonal interaction between the identified supervisor and the supervisee, wherein the general goal is to enable the supervisee to become more effective in helping people. The British Association for Counselling and Psychotherapy (2010) 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 provided 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.

Supervisor

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.

Roles of practice education facilitators, personal tutors and link tutors

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). More firmed-up roles such as those of facilitators of learning who are fully or partly employed by universities include practice education facilitator (PEF), personal tutor and link tutor.

Practice education facilitator and practice educator

The 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, co-ordinating student experiences and assessment of learning'. The PEF thus leads the development of practice and provides support and guidance to mentors and others who contribute to the student's learning in practice settings, and achievement of practice competencies.

The educational preparation for the PEF role is usually at postgraduate level. The post is generally funded directly by Strategic Health Authorities (SHA) (SHAs will cease to exist from 2012, and part of their functions will be taken over by the NHS Commissioning Board (DH, 2010b)) and generally entails practice-based teaching 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 failing to progress with their practice placement competencies. For students on practice placements, PEFs might also organise dedicated group discussion sessions away from the practice setting for particular categories of students for reflection and peer support purposes.

There are small differences in the way that the role and title are implemented in different healthcare professions. The College of Radiographers (2006: 7), for instance, adopts the Higher Education Academy (2005: 6) definition of practice educator, which is: 'the identified practitioner in practice placement who facilitates student learning face to face on a daily basis and generally has responsibility for the formative and/or summative assessment of competence'. Thus, the practice educator role in radiography and other AHPs is largely similar to the mentor role in nursing and midwifery, and educational preparation for the practice educator role can take either the experiential learning route or a taught programme of six days' workshops spread over several months (e.g. COT, 2006). In physiotherapy it is a more generic term referring to physiotherapists who teach in practice settings.

As for the PEF role in nursing, in a workshop conducted by the NMC (2009b) on the role of PEFs in the context of the review of pre-registration

nursing education, several key priorities were identified, including due regard, accountability and essential skills clusters, and a number of issues as well. 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.

Nonetheless, 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'.

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 pre-registration 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 tutor and student and, where concern is expressed, considering evidence and developing an action plan with the student.

Link tutor

The link tutor 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 tutor 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 tutor 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. The HPC (2008) *Standards of Proficiency – Operating Department Practitioners*, for instance, details the competencies that operating department practitioner (ODP) students have to be competent in to register with the HPC as an ODP.

Furthermore, 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 HPC's (2009) *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 15 allied healthcare professions (e.g. HPC (2008) noted above), that it currently regulates, namely (HPC, 2010):

- 1 Arts therapists
- 2 Biomedical scientists
- 3 Chiropodists/Podiatrists
- 4 Clinical scientists
- 5 Dietitians
- 6 Hearing-aid dispensers
- 7 Occupational therapists
- 8 Operating department practitioners
- 9 Orthoptists
- 10 Paramedics
- 11 Physiotherapists
- 12 Practitioner psychologists
- 13 Prosthetists/Orthotists
- 14 Radiographers
- 15 Speech and language therapists

In addition to the role of the radiography healthcare profession which was referred to earlier in this chapter, the HPC identifies the 'practice placement educator' as 'A person who is responsible for a student's education during their period of clinical or practical experience' (HPC, 2009: 61). It indicates under the standard 'Practice placement educators must have relevant knowledge, skills and experience,' that they should have the knowledge, skills and experience to support students, and provide a safe environment for effective learning. The HPC, however, does not currently set specific requirements about the qualifications and experience that practice placement educators must have to fulfil the role effectively.

Mentoring in physiotherapy has been formalised as clinical educators through the Accreditation of Clinical Educators (ACE) Scheme (CSP, 2004). An evaluation of the ACE Scheme (CSP, 2007) after several hundred physiotherapists had been accredited, suggests that it gives greater recognition to the senior clinicians responsible for student placements; participants believed that they were more reflective and that accredited status had a positive impact on their students, colleagues and patients; and that student placements were planned with more confidence and that staff development was more structured. Formal education preparation for such mentor equivalent roles for all health and social care professions seems imminent.

The titles 'practice placement educator' and 'practice placement co-ordinator' are also utilised in various AHP documents with reference to designated health-care professionals who provide support and information to clinical educators (akin to the mentor role in nursing and midwifery), and also monitors the standards of practice placement being experienced by students (HPC, 2009).

Hinton (2009) reports on her experiences of mentoring ODP students in which she indicates that it is an activity that is beneficial for students as well as for ODP mentors. On the other hand, 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' (2007: 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.

Furthermore, Lloyd-Jones et al. (2007) report on the successful implementation of inter-professional learning (IPL) across the whole curriculum of healthcare profession courses, on campus and in practice settings, and also that it figures in assessment strategies.

On the other hand, Lakasing and Francis (2005) argue that because many nurse 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 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. On the other hand, 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 as a 'sterile debate' by Megginson et al. (2006: 5).

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 Box 1.2.

Box 1.2 Why we need mentors

(a) 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
- To provide the appropriate knowledge base for nursing interventions
- For questioning
- For protection from poor practice
- To build confidence
- For sharing learning, i.e. learning from each other
- Is an NMC requirement
- To keep own skills and knowledge up to date
- For linking theory to practice
- For developing one's work skills in teaching and explaining
- To provide structured learning programmes during practice placements

(b) In personal life

- For the development of one's self
- To share experiences
- For encouragement
- To build up confidence
- For honest opinions and views
- As a role model (may be a parent figure, etc.)
- For socialisation
- For support and guidance

Another advantage 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 current medical mentoring definition of mentor, which suggests that the mentor is selected by the learner for support and guidance. However, student mentors identify various reasons for the mentoring role. There are also various research and policy reasons for the requirement for this role. The most significant ones for healthcare are now discussed.

Firstly, 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 United Kingdom 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 (e.g. 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), 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’ (2006: 1055).

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, e.g. the USA, medical mentoring refers to mentoring medical students, in the UK the mentoring relationship is confidential between two doctors, the mentor and the mentee (GMC, 2010: 4; Viney and McKimm, 2010: 107), 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, often but not always working in the same organisation or field (the mentee), 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 that which was 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, and the findings of various research studies on these novel programmes were captured eventually in the UKCC's (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).

Thirdly, 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.

Fourthly, 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 and others to develop their competence' (e.g. NMC, 2008b: 5). 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 which was constituted by Bandura (1986, 1997), and which centres on learning skills by

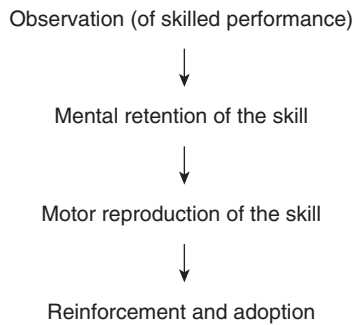


FIGURE 1.1 The four processes of learning

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).

In more detail, the four processes of learning that the learner goes through are:

1 *Observation of skilled performance*

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 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 (e.g. 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 the mentor's have been identified by various agents, some of which are still developing, and include *practice facilitator*, *buddy*, *coach* and *co-tutor*. The term 'coach' tends to surface sporadically in nursing. This, however, is a term and title that is more closely linked to sports, which involves training individuals to enhance their physical performance so that they are able to take part in competitions in specific

sports; and in the context of life coaching. In both instances, coaching implies one-to-one guidance and support for enhancement of one or more specific skills, as also identified by Coleman and Glover (2010) in the context of leadership skills. Nonetheless, it is also increasingly associated with more experienced healthcare managers and executives enabling more junior staff (at times referred to as pupils) to develop skills that can enhance their management and leadership performance in the organisation. The GROW (also referred to as GROWing – which stands for Goal, Reality, Options, Will/Wrap up) model is advocated (e.g. Connor and Pokora, 2007) as a framework for effective coaching.

Who can be a Mentor?

Despite all the reasons for mentoring discussed so far, it shouldn't 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 as 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 inter-professional 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 CPD needs in accordance with *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (NMC, 2008b).

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

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, including the use of learning contracts.

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 using a scale known as CLES+T (Clinical Learning Environment, Supervision and Nurse Teacher), it emerged that the supervisory relationship (8 items on the scale out of 34) between mentor and mentee is the most important factor contributing to clinical learning experiences. 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 actively to 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 to extend their skillbase. Effective communication skills are essential within all teaching and learning situations. So what is communication?

The word ‘communication’ originates from the Latin word *communicare* which means to impart, share, convey or exchange information (Brown, 2002: 463). It is ‘a complex, ongoing dynamic process in which the participants simultaneously create shared meaning in an interaction. The goal of communication is to approach, as closely as possible, a common understanding of the message sent, and the one received’ (Sullivan and Decker, 2009: 122). Furthermore, the factors influencing communication are:

- Past conditioning.
- The present situation.
- Each person’s purpose in the communication.
- Each person’s attitudes towards self, the topic, and each other.

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 cues 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.

The normal communication process is 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:

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

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 Box 1.3).

Box 1.3 The six-category intervention analysis as a specialised communication skill

Authoritative intervention

- Prescriptive: giving advice
- Informative: imparting information
- Confrontational: directly challenging

Facilitative intervention

- Supportive: understanding and encouraging
- Cathartic: allowing the release of emotions
- Catalytic: encouraging deeper exploration

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.

Another specialised communication skill involves communicating in one of three ways, or from one of three ego states (how we act, feel and behave) (Berne, 1975). It is known as transactional analysis and is illustrated in Figure 1.2.

In transactional analysis, every item of communication is uttered from one of the three ego states and received from one of the three ego states. Resolution of the interpersonal or psychological problem is achieved when both individuals communicate from adult ego states.

Transactional analysis is also a therapeutic technique that normally requires formal training. To extend communication skills to the arena of assessment of practice objectives, the mentor could find that they have to utilise specialised communication skills in helping and counselling the student who fails an assessment. This would entail aspects of counselling and helping skills that are relevant for the particular assessment situation, which is discussed in Chapter 7 of this book.

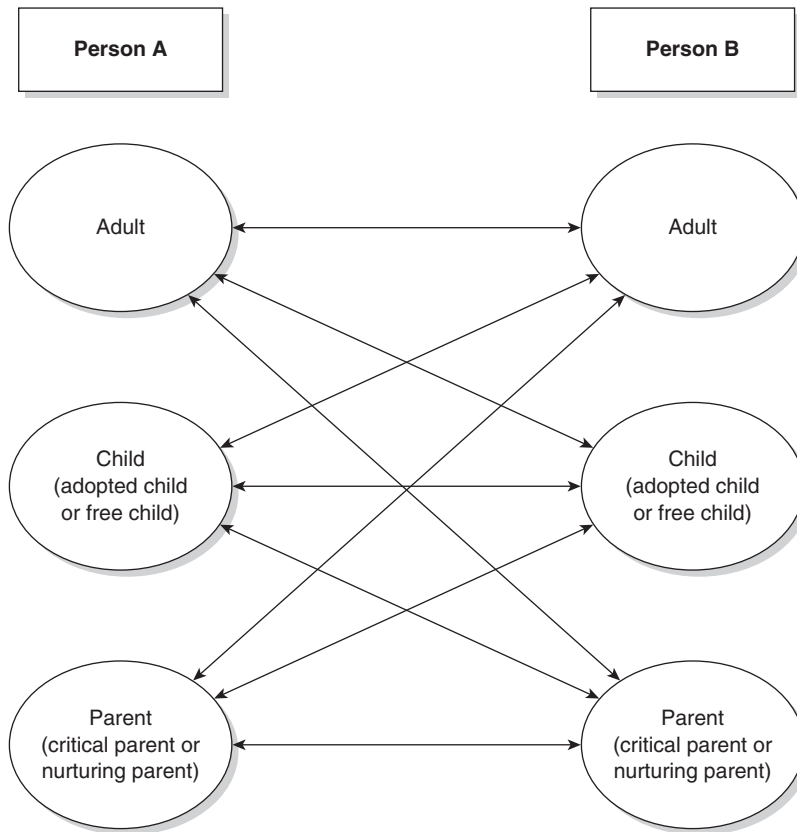


FIGURE 1.2 Utilising specialised communication skill: Transactional analysis

Characteristics of mentors and enabling functions

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 pre- or post-registration 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 Box 1.4.

Box 1.4 Characteristics of the person who needs to act as mentor

- Patient
- Open-minded
- Approachable
- Have a good knowledge base
- Knowledge and competence is up to date
- Has good communication skills, including listening skills
- Provides encouragement
- Is self-motivated
- Shows concern, compassion, empathy
- Has teaching skills
- Provides psychological support
- Counsellor
- Tactful
- Diplomatic, fun and fair
- Willing to be a mentor
- Versatile, adaptable, flexible
- Allows time and commits self to it
- Confident
- Enthusiastic
- Advisor
- Is honest and trustworthy
- Trusting
- A role model
- Non-judgemental
- Resource facilitator
- Able to build working relationship

In 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 Box 1.4 above. At the final interview of this longitudinal three-year study, students identified 12 activities (akin to roles and responsibilities) that would make them good and effective mentors, including:

- Form a relaxed relationship with their student.
- Ascertain what the student requires as an individual to meet the desired learning outcomes.
- Think carefully about the duty rota in terms of arranging shifts to allow student and mentor to work together at some point each week.
- Allow the student some independence by giving more guidance at the beginning of the placement, then standing back and letting the student show initiative and self-motivation afterwards.

Darling (1984) reports on a study that explored various components of the mentor role. One of the most significant outcomes of the study was the

identification of the characteristics of mentors that enable learning, which Darling identified as follows:

- **Role model** Consciously practises nursing to a very high standard and conducts self in a way that the mentee can look to, value and adopt.
- **Energiser** Is enthusiastic about the whole of nursing, inspires interest and motivates mentee.
- **Envisioner** Is clear about how patient care could be even better, and is enthusiastic and dynamic about innovations.
- **Investor** Invests an appropriate amount of time in the mentee, and imparts own knowledge and experience.
- **Supporter** Encourages, gives time, is always willing to listen and makes himself or herself available in times of need.
- **Standard prodder** Always questioning standards of care and competence and is clear about own standards.
- **Teacher-coach** Teaches patient care-related knowledge and competence skilfully, gives guidance, allows time to practise and encourages the student to learn through experience.
- **Feedback giver** Provides positive feedback, points out weaknesses and discusses further learning.
- **Eye opener** Inspires interest in wider issues, political, financial, etc., and departmental initiatives that can impact on the practice setting or specialism.
- **Door opener** Suggests available healthcare provisions and learning opportunities related to practice objectives.
- **Ideas bouncer** Encourages mentee to generate and verbalise new ideas, listens to them and helps mentee to reflect on them.
- **Problem solver** Helps the mentee to think systematically about problems and ways of resolving and preventing them.
- **Career counsellor** Available to offer own views and guidance in career planning.
- **Challenger** Enables the mentee to think more critically about their decisions, and challenges views, opinions and beliefs.

Each mentor characteristic can be explored in detail as a concept in its own right, and to illustrate this, the next section explores the characteristic of ‘role model’ and then of ‘challenger and supporter’.

The mentor as the role model

A role model

Consider the terms *model* and *modelling*. Next, consider what a role model is. Consider also why healthcare professionals need to be role models, who for, and what it is about a person that makes him or her a role model.

Think
Point 1.1



In response to Think 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 1.5 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 or thing, a perfect exemplar of excellence’ (Brown, 2002: 1806), that is, someone whose practice standards, attitudes and beliefs the observer can emulate. Individuals choose their role models, such as someone who is good at time management, at self-organisation, or in 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.

Thomas (2005) reports that there are mixed views about nurses being role models of healthy habits when off duty. Faugier (2005a) suggests that role models are those whom we look up to, emulate and admire as professionals. However, in society in general, she suggests, people base their character identities, values and lifestyles on celebrities and characters in television programmes. This highlights how crucial the latter’s public behaviours are. All teachers in the practice setting (e.g. mentors) should therefore be aware of their impact as role models on students’ learning of skills and professional attitudes.

The mentor as a challenger and supporter

There are various examples of situations that present high or low challenge for learners in practice settings, and the 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 hasn’t 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.



Think
Point 1.2

Mentoring support and challenge

Consider the characteristics of ‘supporter’ and ‘challenger’ identified by Darling (1984) and think of learning situations where you need to provide the mentee with a high level of challenge and support, and other situations where you afford low levels of each.

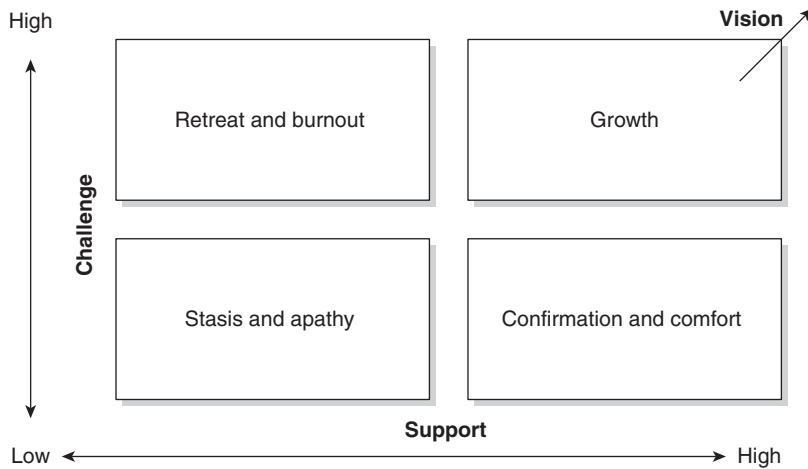


FIGURE 1.3 Effects of support and challenge on the mentee's development

Daloz (1989) explored these two functions further and concluded that high support and challenge can lead to growth and achievement of vision, while low support and low challenge can result in stasis and apathy, as illustrated in Figure 1.3.

Activity 1.6 Ascertaining mentorship potential

Consider Darling's (1984) characteristics or roles of the mentor as detailed in Box 1.5, and identify situations where you needed to use these skills in relation to mentoring learners or of forthcoming opportunities for mentoring.

- 1 For each characteristic, do a self-rating of yourself as a mentor using numbers 1 to 4, 1 indicating development or learning need and 4 indicating skilled.
- 2 Next, focus on one or two of the skills on which you rate yourself as low, and consider why this is (e.g. lack of opportunity) and how you can develop this characteristic.

The above exercise based on characteristics or roles of the mentor is also referred to as 'measuring mentorship potential' (MMP) (Darling, 1984). The characteristics or attributes of the effective preceptor, on the other hand, were identified earlier in this chapter.

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 learning support roles, and 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 being the individual student, that is student supervision and 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.

Taking a broader perspective, Hall et al. (2008) explored mentors' perceptions of the role in teacher training in the USA, and found that it comprises being:

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

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.

Activity 1.7 Actions that support learning

In addition to having the characteristics of an effective mentor (e.g. Box 1.5), 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 possibly 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 would 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 (e.g. 2008a) has identified the need for 'protected time' for mentoring as has the Department of Health (1999). Mentoring can be made even more efficient by the use of learning contracts.

Using learning contracts

Learning contracts are very much a feature of adult education (or andragogy, which is discussed in Chapter 2) and involve negotiated learning between teacher and student. As the word *contract* implies, a learning contract is a written and signed agreement between teacher (mentor in this case) and learner resulting in the latter's active involvement in decisions over practice objectives and other components of learning. Therefore, it is often a feature of practice modules whereby the mentor and student agree on specific practice objectives and on each party's responsibility in the achievement of the objectives.

The use of learning contracts was advocated by Knowles et al. (1998) in the context of adult learners needing to exercise some self-direction in their learning. The agreed set of objectives in the learning contract includes those of the course curriculum and those of the student and the mentor. Therefore, the learning contract affords the student some control over their learning, motivates them to learn and to engage with the placement experience. It is also a medium for identifying the student's pace of learning, to explore the means of theory and practice integration, and can be supported by ascertaining the student's preferred learning style.

However, the requirements and objectives set by the course curriculum have to be met. A learning contract section or pro forma may already have been included in the student's placement competencies booklet. Basically, the mentor and student discuss and agree on what the student is aiming to learn, how the learning will take place and how this will be evaluated. This is usually written down by the student and, when agreed, both mentor and student sign and date it. Learning pathways based on patient journeys can be incorporated as a strategy for achieving particular objectives. An example of a learning contract is presented in Box 1.5.

Box 1.5 A learning contract

Name of student:			Cohort:	
Placement:			Mentor's name:	
<i>Learning needs</i>	<i>Objectives</i>	<i>Resource and strategies</i>	<i>Target date</i>	<i>Evidence</i>
What do I want to learn? – Topic area	What do I want to have achieved at the end of this learning? – Specific objectives	How will I learn, and who will support me? – learning strategies	Date of achieving the objectives	How will I know I have achieved my intended learning?
Assessment of a new patient	Able to assess the health and social care needs of newly admitted/ referred patient / service user	Mentor, social worker	30-09-2010	Mentor reviews and agrees with my assessment and care plan

(Continued)

(Continued)

Teach patients	Able to teach a type 2 diabetic patient how to control their dietary intake	Mentor, dietician. Consult diet sheets, guidelines. Read up on type 2 diabetes	30-09-2010	Mentor observes my teaching and signs me as competent in this skill
Pre-contract				
Signature of student:			Date:	
Mentor's signature:			Date:	
Name of link teacher / practice education facilitator:			Name of personal tutor:	
Comments on achievement of contract objectives				
Signature of student:			Date:	
Mentor's signature:			Date:	

Crucial components of the learning contract are also the specific resources (human and material) that are required to enable the student to achieve the agreed objectives, and also the specific dates by which each objective will have been achieved. An alternative to a learning contract is a learning agreement (Open University, 2001; RCN, 2002), which has similar features but might not include signatures of those involved, nor rigid 'achieve-by' dates.



Think
Point 1.3

The learning contract

What would logically happen after both parties have signed the learning contract? Do you feel that it should be constantly reviewed to monitor the student's progress with its content, or only reviewed on the 'target date'?

Learning contracts may be seen by some as a chore. Others may prefer to write something treating it as a mere formality. But the benefits of learning contracts have been reported by Ghazi and Henshaw (1998), for instance, who found that learning contracts help to improve student performance in assessments and student attendance at lectures. Donaldson (1992), Northcott (1989) and others reported similar benefits.

An important step involved in constructing a learning contract is the mentor facilitating self-assessment of clinical skills and knowledge by the student and identifying inherent learning needs. Naturally, when a contract has been drawn up, then on the 'achieve-by' date there will be a need to ascertain whether the activities identified in the contract were undertaken and the objectives achieved. The review time will of course have been determined at the beginning when the content was being discussed and documented.

The mentor will have developed knowledge and understanding on the use of learning contracts as part of the mentor preparation programme, along with how they can deliver these functions in the context of other roles that they have to fulfil.

Rogers and Freiberg (1994) indicate that learning contracts endow the student some freedom to learn aspects that they wish to learn and pursue areas that they find particularly interesting. A learning contract is also a medium for resolving any doubt that there may be about specific purposes of the learning experience. It clarifies the activities that the student would

engage in and provides motivation and reinforcement through the achievement of objectives.

Having determined that a contract can be a very useful educational tool, no doubt you'll be wondering what happens if the student does not take all the actions that they had agreed to take or does not achieve all the specified objectives.

There are mixed views in the literature about whether learning contracts are legally binding. Mazhindu (1990) argues that they are, while Neary (2000a) suggests that this isn't the case. It is useful to note the NMC's (2009c) stance on documentation and record keeping as it indicates that written as well as electronically kept records comprise evidence of actions taken (or omitted). For learning contracts to be effective, they need to be skilfully constructed. Guidelines for constructing them are provided by educational researchers Knowles et al. (1998), as well as by Bailey and Tuohy (2009) more recently, and an example of a well-constructed learning contract is presented in Box 1.6 above.

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 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; NMC, 2008a), 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 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, advertently or inadvertently, may be seen as discouraging or disabling learning.

The following case study presents an example of poor mentoring.

Case Study - 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 1.6).

Box 1.6 The 'galaxy of toxic mentors'

Types	Features
Avoiders	Mentors who are not available or accessible, also referred to as ignorers or non-responders.
Dumpers	Throw people into new roles or situations and let them flounder, either to sink or to swim, often deliberately.
Blockers	Actively avoid meeting the mentee's needs either by refusing requests, by controlling through withholding information, or by blocking the mentee's development by over-supervising.
Destroyers/ Criticisers	Set out to destroy the mentee by subtle attacks to undermine confidence, and open and public verbal attacks and arguments, questioning of abilities and deliberately destroying confidence.

Based on extensive experience in management and the processes of 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 this development. While the focus is on looking for, and developing, 'talents' in employees, the reality is that the mindset of some individuals can stifle development. These authors grouped the problematic or disabling traits, termed 'three mental poisons', as the functioning of rigid minds, ego minds and Machiavellian minds (see Box 1.7). Such ways of thinking are not always obvious, nor easily detected, but do affect learning adversely.

Box 1.7 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 thinking
- Continually blocks the openness of more creative thinking
- Loyal to traditional thinking and rejects novelty (seen as complexity)
- 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
- Pays little attention to what others think and say
- Unsociable and do 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), and 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 (e.g. problem-solving skills). Heirs and Farrell (1986) suggest that it is the organisation's managers' responsibility to identify individuals who fall into any of these categories. Their '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.

Other actions that can be taken if ineffective mentoring is detected is to implement co-mentoring, which involves two mentors jointly mentoring the student. A temporary non-allocation of a mentee 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 alternative strategies which are 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 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, personal views and beliefs. In mentoring, it would depend on the mentor's beliefs about nursing, pre-registration 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 or characteristics of the mentor constitute such a model, the NMC's (2008a) eight domain standards for mentoring is 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 Box 1.8.

Box 1.8 Approaches, models and frameworks for mentoring

Approaches to mentoring

Classical mentoring	Also known as informal or primary mentoring. A natural, mutual and self-chosen relationship that can usually be terminated by mutual decision.
Reflective practitioner	Based on learning theories, e.g. andragogy, styles of learning and student-centred approaches, the mentor is a critical friend and co-enquirer.

Models or frameworks of mentoring

Apprenticeship model	The mentor as skilled crafts person, and the mentee learns by re-enacting their actions.
Competence-based model	The mentor enables the mentee to learn specific practice objectives, and assesses their competence in them.
Team mentoring model	A team of mentors mentor one or more students jointly, as recommended for nursing by Phillips et al. (2000), for instance. Is akin to team supervision for doctorate students.
Contract mentoring	Formal mentoring that is time- or objectives-restricted, e.g. when on practice placement at another institution.
Pseudo-mentoring	Also known as quasi- or partial mentoring, may be in appearance only, and for a specific task, e.g. dissertation supervision.

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:

- 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 psycho-bio-social 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 – Sheila.

Case Study – Sheila's portfolio

I visited Mr J while his care co-ordinator, who is also my practice supervisor, was on annual leave. At this time he expressed concern about his care co-ordinator 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 co-ordinator. 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 co-ordinator. His care co-ordinator 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

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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 Box 1.9 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, 2010). The 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 need 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 (QAA, 2008), respectively). They tend to be equivalent to 200 to 300 hours of student effort, and are normally completed within four months. 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 (GMC, 2010), 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 other 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 on 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.

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 (e.g. 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 mentoring, definitions of and distinctions between the mentor's and various related learning facilitation roles, such as preceptors, clinical educators, assessors and supervisors, and those of the practice education facilitator, link tutor and personal tutor. All these roles are established to facilitate healthcare learners acquire clinical skills, knowledge and appropriate attitudes.
- A number of reasons for requiring mentors for supporting 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, and includes generic and specialist communication skills; the characteristics of mentors and enabling functions, which include the mentor as a role model for learners, and ascertaining own mentorship potential; the actions that support learning including the use of learning contracts.
- Research findings on detrimental effects of poor, inefficient or adverse mentoring.
- The use of different models or approaches that identify mentors' perceptions of their mentoring role.

Further Optional Reading

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:

- Garvey, B., Stokes, P. and Megginson, D. (2009) *Coaching and Mentoring: Theory and Practice*. London: SAGE.

For management mentoring and other models of mentoring, see:

- Megginson, D., Clutterbuck, D., Garvey, B., Stokes, P. and Garrett-Harris, R. (2006) *Mentoring in Action: A Practical Guide*. London: Kogan Page.

For three very recent articles on clinical supervision, see:

- Waskett, C. (2010) 'Clinical supervision using the 4S model 1: Considering the structure and setting it up', *Nursing Times*, 106 (16): 12–14.

To explore original directives and guidelines related to effective mentoring and supervision see also the health and social care regulatory bodies' (e.g. HPC, GSCC) and professional colleges' (e.g. RCN, COT) websites, such as that of the Chartered Society of Physiotherapy's (2004) *Accreditation of Clinical Educators (ACE)* publication which provides an update on the scheme and the number of physiotherapists who had been accredited through the scheme.

- Chartered Society of Physiotherapy (2004) *Accreditation of Clinical Educators Scheme*. Available at: www.csp.org.uk/uploads/documents/csp_ace_scheme_guidance.pdf. Accessed 4 August 2010.

For details of the link between *NHS KSF* (DH, 2004a) dimensions and indicators for band 5 healthcare staff and precepteeship, see:

- College of Occupational Therapists (2006) *The Preceptorship Training Manual – A Resource for Occupational Therapists*. London: COT.

For details of successful implementation of preceptorship, see:

- Scottish Government (2010) *Flying Start NHS*. Available at: <http://flyingstart.scot.nhs.uk/>. Accessed 20 December 2010.

As preceptorship is being implemented with renewed vigour, it should prove advantageous for you to arrange to meet the main trust-based preceptorship co-ordinator to ascertain their perspective on this enterprise, i.e. their specific plans for implementation, and for dealing with anticipated and unanticipated issues.

For a discussion on the ten most commonly utilised models of practice education roles, essentially reflecting different learning facilitation and student roles, e.g. joint appointments, internship, etc., see:

- Budgen, C. and Gamroth, L. (2008) 'An overview of practice education models', *Nurse Education Today*, 28 (3): 273–83.

For a good section on vicarious learning, see pp. 86–101 of:

- Bandura, A. (1997) *Self-Efficacy – The Exercise of Control*. New York: W H Freeman and Company.