Enabling Learning in Nursing and Midwifery Practice

A Guide for Mentors

Edited by

Sue West
Canterbury Christ Church University

Tim Clark
Canterbury Christ Church University

Melanie Jasper
Swansea University

John Wiley & Sons, Ltd

Enabling Learning in Nursing and Midwifery Practice

Enabling Learning in Nursing and Midwifery Practice

A Guide for Mentors

Edited by

Sue West
Canterbury Christ Church University

Tim Clark
Canterbury Christ Church University

Melanie Jasper
Swansea University

John Wiley & Sons, Ltd

 John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester,
West Sussex PO19 8SQ, England
Telephone (+44) 1243 779777

Email (for orders and customer service enquiries): cs-books@wiley.co.uk
Visit our Home Page on www.wiley.com

Other Wiley Editorial Offices

John Wiley & Sons Inc., 111 River Street, Hoboken, NJ 07030, USA

Jossey-Bass, 989 Market Street, San Francisco, CA 94103-1741, USA

Wiley-VCH Verlag GmbH, Boschstr. 12, D-69469 Weinheim, Germany

John Wiley & Sons Australia Ltd, 42 McDougall Street, Milton, Queensland 4064, Australia

John Wiley & Sons (Asia) Pte Ltd, 2 Clementi Loop #02-01, Jin Xing Distripark, Singapore 129809

John Wiley & Sons Canada Ltd, 6045 Freemont Blvd, Mississauga, ONT, L5R 4J3

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Anniversary Logo Design: Richard J Pacifico

Library of Congress Cataloging-in-Publication Data
Enabling learning in nursing and midwifery practice : a guide for mentors / edited by Sue West, Tim Clark, Melanie Jasper.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-470-05797-1 (alk. paper)
1. Mentoring in nursing–Great Britain. 2. Nursing–Study and teaching (Preceptorship)–Great Britain. 3. Midwifery–Study and teaching–Great Britain. 4. Midwives–Training of–Great Britain. I. West, Sue, 1955- II. Clark, Tim, 1953- III. Jasper, Melanie.
[DNLM: 1. Education, Nursing. 2. Learning. 3. Mentors. 4. Midwifery–education. WY 18 E562 2008]
RT86.45.E53 2008
610.73–dc22

2007030202

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN 978-0-470-05797-1

Typeset in 11/13pt Bembo by SNP Best-set Typesetter Ltd., Hong Kong

Printed and bound in Great Britain by Bell & Bain, Glasgow.

This book is printed on acid-free paper responsibly manufactured from sustainable forestry in which at least two trees are planted for each one used for paper production.

Contents

Preface

The book is intended for practitioners in nursing and similar disciplines who have, or will be, developing the role of offering mentorship, support and preceptorship to students and newly qualified practitioners. The demand for high-quality staff has rarely been so acute in health- and social-care settings. There are concerns that those entering these settings might struggle to develop the necessary skills, knowledge and attitudes needed and the role of someone to guide and support students and new practitioners has been identified as being crucial. With current Government targets to increase the numbers of health- and social-care practitioners, there is an increased need for informed mentors and preceptors. This, therefore, potentially affects all health- and social-care institutions that have the need to replace and develop their staff.

We seek to help busy practitioners understand the principles that underpin effective learning and assessment strategies within the practice setting and provide practical guidance on ways that individuals and teams can meet the challenge of increasing student numbers in busy health- and social-care environments. The book will also assist students to gain the most from their practice experiences and, given the focus of many preregistration programmes on preparation of senior students to support more junior colleagues in practice, the book should provide both a valid source of reference and provide practical guidance.

The book is therefore intended to provide a text for students and practitioners to support learning in practice and for experienced mentors and preceptors that are seeking to update their skills and understanding. The development of inter-professional programmes has provided a renewed demand for texts that provide a contemporary view on teaching and learning in the real world setting of busy practice.

The contributors to the book are as follows and offer the following interest areas:

Professor Margaret Andrews is pro-Vice Chancellor (Dean, Faculty of Health and Social Care) at Canterbury Christ Church University. She has been involved in health professional education in a variety of capacities for the

last 22 years. Her main research and publication interests are generally concerned with the education of health professionals in both practice and academic settings and, in particular, the practice learning environment, mentorship, student support and interprofessional learning. She has published on a variety of topics.

Gill Beer was Principal Lecturer and Placement Coordinator at Canterbury Christ Church University. Having gained her Registered Nurse Tutor qualification, she focused her career towards postregistration, initially teaching enrolled nurse development/conversion courses. For many years, she designed mentoring modules and lead the 'mentoring' team. This led to her current role as Academic Placement Coordinator. This involves ensuring that placement opportunities meet the curriculum needs, and that students receive a high quality and equitable experience.

Dr Tim Clark is a Senior Lecturer in research at Canterbury Christ Church University. He completed his PhD in 2005 with a study of the development of competence in newly qualified nurses. He has completed research into learning styles, competence and assessment in practice. Before entering nurse education in 1986, he had a background in general and mental health nursing and still works in clinical practice on a regular basis.

Sheila Daykin was a Principal Lecturer at Canterbury Christ Church University. She has also been very involved in programme development, management and teaching, particularly in relation to postregistration modules, courses and programmes for nurses and midwives. She has a particular interest in work-based learning, mentoring and supervision. In the 1990s, she completed a Post-Graduate Diploma in Health Psychology and MSc in Nursing at City University in London. She is also a qualified and practising Humanistic Counsellor.

Emily Hurt is currently Faculty Liaison Librarian for Health and Social Care at Canterbury Christ Church University. She has worked in health libraries for the past five years, and completed a Post-Graduate Diploma in Information and Library Management in 2004. She is a member of the Continuing Professional Development panel for the Health Libraries Group. She has a strong interest in enabling student access to information, and is always looking for new ways to deliver information skills training.

Professor Melanie A. Jasper PhD, MSc, BNurs, BA, RN, RM, RHV, NDNcert, PGCEA, is Head of School of Health Science, Swansea University. Having graduated from the University of Manchester in 1977, she practised as a health visitor and midwife until becoming nurse educator at the University of Portsmouth in 1990. She was privileged to start her career in nurse education at

the beginnings of the move of nurse education into higher education, an exciting time for developing degree, masters and doctoral programmes aimed at developing high-quality practice underpinned by sound theoretical and research-based knowledge and skills. Having completed her Masters in Nursing at the Royal College of Nursing in 1994, she went on to develop her understanding of reflective writing strategies in nursing education as a doctorate, awarded in 1999. In 2003, she joined Canterbury Christ Church University as head of a multidisciplinary department of Health and Social Welfare Studies, before moving to her current role as Head of School of Health Science at Swansea University in 2007. She was appointed Editor of the Journal of Nursing Management in 2002, expanding her own writing career, which includes four books and numerous journal articles. She has been invited to present keynote lectures at conferences, particularly relating to reflective practice, reflective writing, portfolio and professional development, and on leadership.

Judith Parsons is currently Senor Lecturer in Community Nursing at Canterbury Christ Church University and programme director of the Post-Graduate Certificate in Practice Education. She has always maintained an interest in interprofessional education and recently worked as project lead for the Department of Health funded Modernizing Pre-registration Education for Allied Health Professionals. This project facilitated the provision of interprofessional preregistration placements for health and social care professionals at Canterbury Christ Church University.

Stevie Penfold was a Senior Lecturer at Canterbury Christ Church University. She has worked as an RGN for many years and has worked both in the NHS and private sectors, including nursing homes. She then worked for 12 years in intensive care nursing. For the past 15 years she has worked in education and is involved in the academic development of students for both theoretical and practice-based work in the University.

Sue Riddell is Principal Lecturer and Teaching Fellow at Canterbury Christ Church University. She began her working life as a nurse in Cambridge before moving into nurse education. She has been at Christ Church for over seven years having previously taught in Aberdeen, Chelmsford and Pembury (Tunbridge Wells.) Currently, the majority of her time is allocated to working within the Learning and Teaching Enhancement Unit as a Teaching Fellow and Learning and Teaching Coordinator for the Faculty of Health and Social Care.

Andrew Southgate RGN MSc was one of the first Practice Placement Facilitators in Kent. He has spent the last five years working collaboratively with mentors, managers and university lecturers to improve the quality of placements in a large,

multisite, acute Trust. Major elements of this role include facilitating developments in the placement learning environment and in the quality assurance process. He was the Trust lead for the successful QAA Major Review in 2005. Key achievements include leading the development of the trust-wide interprofessional education audit tool, devising a tool to evaluate the students' experience of mentoring and developing placements that were not traditionally accessed for preregistration nursing students.

Sue West RGN BSc MSc PGCLT (NMC) is a Senior Lecturer and Mentorship Coordinator at Canterbury Christ Church University. Sue is responsible for the modules that prepare practitioners to be mentors and also leads the project group responsible for ensuring the ongoing support, information and updating meets mentors needs and professional requirements. Sue is particularly interested in how mentors help students develop their expertise and is currently exploring this for her doctorate studies.

Sue Westerman leads the Learning Technology Team at Canterbury Christ Church University. She primarily advises on and supports e-learning in health- and social-care education, and has over six years experience supporting the higher education and health sectors. Sue gained her MA in Online and Distance Learning from the OU in 2005. She is particularly interested in issues surrounding learner support, digital literacy and, with a BA in History, the history of technologies in education.

Note on the NMC Code of Professional Conduct:

At the time of going to press, the Nursing and Midwifery Council Code of Professional Conduct is being reviewed by the NMC, with the intention of publishing a new Code in January 2008. This will be found on the NMC website (www.nmc-uk.org) from that time. We will be establishing a website for the book to explore any ongoing changes – this will be available at www.wiley.com/go/west.

Introduction

The real voyage of discovery consists not in seeing new landscapes, but in having new eyes.

Marcel Proust

This book is about looking at the ways we support and mentor students and new staff in practice settings. To many this will be a familiar landscape, but one that is changing and sometimes challenging. Indeed the environment is sometimes so hostile that some lose their way. The idea of mentoring is one way that a practice area can provide a guide to navigate the journey through this sometimes difficult landscape.

The embryo for this book was formed during the planning of a mentoring programme, conferences and learning materials. We wanted to write both an academically sound and a useful book, one that you can dip into for up-to-date references and one that can also provide you with some practical solutions to difficult issues.

The **aims of the book** are therefore to:

- explore the context of learning in practice;
- place mentoring in contemporary practice;
- help the reader to integrate theory and practice in relation to mentoring and supervising students in practice;
- increase the reader's knowledge of the principles of effective mentoring and preceptorship;
- help the reader to acquire knowledge of specific interventions in establishing a mentoring relationship, and the impact upon practice;
- promote understanding of the importance of assessing practice and managing the mentoring process.

HOW THE BOOK IS SET OUT

The book is set out in 13 chapters to provide you with two main things. Firstly, it provides you with some understanding of the theory behind what you do when you are learning or teaching in practice settings. The context of practice settings places huge demands on students, mentors and all those involved in support. Knowledge of the influences on learning is needed to provide a firm foundation to build our understanding. The material is contemporary and based on a firm evidence base. There are a range of references, drawn from research and the broader literature, in each chapter. The book can therefore be used as a **source of references** to support those learning on mentoring, preceptoring or supervision courses and modules. It is also useful for more experienced mentors who need to develop and keep updated in their practice teaching roles.

Next, the book provides a **practical guide** to support the processes of mentoring and assessing in practice settings. There is sometimes a difference between the rhetoric of 'what the papers say' and the reality of what happens in the 'real world' of practice. This book provides a bridge between the theoretical foundation and the practical processes of developing and supporting people in the challenging environment of practice. The authors have identified not only what the issues are but, also, they provide some strategies for making a difference.

A number of themes are drawn throughout the book. We do not see the reader as an empty vessel who can be filled remotely from the fount of our knowledge and experience. Learning is an active process and, where appropriate, we will provide a box with **practical points** for consideration for you to use. These may include short exercises and activities. We want you to get the most out of this book and spending some time thinking about these points will help you to become more engaged in the process. Whilst we may provide some suggestions following the activities, we do not always seek to provide definitive answers to issues that are open to a wide range of interpretations.

Similarly, we have identified a number of **points for reflection** for you to consider. Although reflection is a theme that naturally draws through the book, the chapter on reflection provides a tool kit for mentors and learners to develop the practical skills of reflection. The chapter develops the need for active reflection and shows that this, by definition, cannot be a passive response as heard in the saying 'sometimes I sit and think . . . and sometimes I just sit'. You will need to be active in the process to gain full advantage.

We are conscious we have already introduced a number of terms that may be unclear, unfamiliar or often overused and therefore the meaning may be lost. To

clarify the meanings we take for some of the key terms we include a **glossary** to provide operational definitions. These tems are printed in bold text when they are first used.

There is other **supporting information** in the Appendices to supplement the text. Lists of some other **further reading** are also included, which you may find useful.

The contributors to the book draw from a wide range of experience in education and practice. Many are staff from Canterbury Christ Church University where the Faculty of Health and Social Care has embraced the notion of interprofessional education and has developed an innovative programme that provides interprofessional learning to a number of different professional disciplines in a programme leading to professional qualifications. The programme prepares practitioners in adult, mental health, and child nursing, medical imaging, midwifery, occupational therapy and social work.

We hope you will enjoy our book and look upon mentoring and preceptorship with new eyes.

CHAPTER 1
CONTEMPORARY ISSUES IN MENTORING PRACTICE

Margaret Andrews

Faculty of Health and Social Care, Canterbury Christ Church University

LEARNING OUTCOMES

By the end of this chapter it is expected that the reader will be able to:

- **Identify the role of the mentor in current contemporary nursing and midwifery practice**
- **Compare the ways in which the role of the mentor has evolved over the last 10 years**
- **Broadly outline the Nursing and Midwifery Council (NMC) *Standards to Support Learning*, with particular attention to the concept of the sign-off mentor**
- **Acknowledge the complexities of mentoring and the need for more formal, structured approaches to mentoring practice.**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

ACTIVITY 1.1 REFLECTING ON CURRENT PRACTICE

Before you continue with this chapter take a few minutes to consider what type of support you currently provide to students (or others) in your practice setting. Write down three ways in which you help students to learn; for example demonstrating procedures or new equipment, supervising. ■

INTRODUCTION

The purpose of this chapter is to introduce the **concept** of mentorship in contemporary health practice, and to outline some of the complexities surrounding policy change in the National Health Service (NHS) and health professional education and how this impacts on mentoring for preregistration students. The chapter is meant to both challenge and be challenging; to challenge particular current policy and at the same time confront the reader.

The key to successful practice learning lies in the level of support and guidance students receive from practitioners and academics, suitably qualified to assess their **competence**. There is some general confusion and tension surrounding the shift of responsibility for practice learning and practice assessment, from the academic to the practitioner, which came about in the early 1990s. With this came the demise of the clinical teacher and the renaissance of the concept of mentorship in the health professions. Student expectation of their mentors has changed over the last 10 years and as a result contemporary mentoring practice has evolved to encompass the broader elements of learning and teaching.

At the end of the preregistration programme students must be fit for practice, fit for purpose and fit for award. It is unlikely that they will meet these requirements if they do not have a knowledge base that allows them to practise in an informed way; therefore the responsibility on those who are assigned to supporting and guiding students in this is immense. Gone are the days when students only require friendly or emotional support in practice settings, they demand and deserve good quality, appropriately delivered practice learning that challenges the professionals delivering it and develops practice, based on sound theoretical principles. This is a challenge to us all; it is not an optional one, but a requirement of contemporary professional practice.

The notion of mentorship for health professional students is not new and has existed in a variety of forms for a number of years. In nursing, the introduction of the diploma

of higher education and the first Project 2000 (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1986) programmes, acted as the driver for ensuring that mentorship became a mainstream activity within the preregistration curriculum. Although there is now some acknowledgement that mentoring is a complex activity, it was introduced in a quiet way, with little fuss. Burnard (1990) eloquently points out that mentorship 'slipped into the folklore of nurse education almost unnoticed and quickly became part of the educational language of the eighties and nineties' (p. 352). Little thought was given at this time to how mentoring would work in practice or, indeed, how it was to be sustained. These aspects have become more important as students' expectations of mentors have increased, alongside the growing numbers of students. In most cases, mentors have a role in assessing students' practice competence; it is not the intention to present the arguments for and against this as they have been rehearsed elsewhere (Andrews and Wallis, 1999; Neary, 2000; Pellatt, 2006), though Duffy's (2004) work on failing students will be of interest to mentors. Duffy clearly feels that the distinction between unsafe practice (in relation to students) and the determination of failure need further exploration, especially in relation to students who are thought of as 'borderline'. In order to safeguard professional standards, and in turn the public, it must be recognized that some students need to fail, but mentors, for a variety of reasons, may be reluctant to do this.

Much has been written about the support mechanisms for students in practice settings, with both qualified staff and students favouring the mentoring approach. There is common agreement that supporting students in practice is an important part of the overall educational process, yet there is little consensus in the literature as to what constitutes support. Since the 1980s there has been a growing body of literature about mentorship in preregistration education and it has been highlighted as the most common, and preferred approach to student support (Andrews and Wallis, 1999; Andrews and Chilton, 2000; Neary, 2000; Pellatt, 2006).

The nature and purpose of mentorship in this context is related to the role of the clinician in providing student support and guidance, and, in many cases, encompasses the activities associated with learning, teaching and the assessment of practice. Although in more recent years, nursing has embraced mentorship alongside other developments, other professions have offered alternatives. There is, however, a common acceptance that the mentoring (or equivalent) of students in practice settings and all that this entails is firmly the responsibility of practitioners.

There are a number of challenges for the future around the support of students in practice settings, including the plethora of language used across the professions to denote someone who takes on a mentoring role, the interchangeable nature of the terms, the lack of acknowledgement of the **interprofessional** context and the changing nature and pace of health-care delivery.

DEFINING THE TERMS

There is no common view amongst health professionals and the associated regulatory and professional bodies about the most appropriate role title to call someone who is responsible for supporting, guiding and supervising preregistration students in practice. A range of terms are in common use including mentor (nursing, midwifery and teaching), supervisor/mentor (radiography) practice educator (occupational therapy) and practice supervisor/teacher (social work). Mentorship is a term used more often in midwifery, nursing and teacher education than any of the other professions, with little of the supporting literature found in the associated professional journals relating directly to the other health professions (Mulholland *et al.*, 2005).

The English National Board for Nursing, Midwifery and Health Visiting/Department of Health (ENB/DH) (DH, 2001) defined a mentor as an individual 'who facilitates learning and supervises and assesses students in the practice setting' (p. 6). More recently this is 'a registrant who has met the outcomes of stage 2 (of the standards for mentors) and who facilitates learning, and supervises and assesses students in practice settings' (NMC, 2006, p. 44). In five years there has been little shift in emphasis except in relation to the more general acceptance of defined standards associated with the role.

In contrast, over the same five-year period the role of the practice educator in nursing as depicted in the ENB/DH (DH, 2001) *Preparation of Mentors and Teachers* guidance document has been replaced by the practice teacher within the 2006 NMC standards' document. The practice educator was defined as someone 'who makes a significant contribution to education in the practice setting, co-ordinating student experiences and assessment of learning' (ENB/DH, 2001, p. 6). Practice educators were also responsible for leading the development of practice and providing support and guidance to mentors and others, to enable students to meet learning outcomes and **competencies**. The term **practice teacher**, appearing in the 2006 NMC standards document, denotes someone who has fulfilled the requirements to be a mentor, having received further preparation to achieve 'the knowledge, skills and competence in both their specialist area of practice and in their teaching role, meeting the outcomes of stage 3 (of the new standards), and who facilitates learning, supervises and assesses students in a practice setting' (NMC, 2006, p. 45).

Many preregistration programmes are developed on either a partial or full interprofessional model, which demands an interprofessional approach to practice mentoring. The lack of acknowledgement amongst the professional and regulatory bodies for common terminology to denote individuals who support students in practice settings makes the notion of interprofessional mentoring more difficult to grasp and implement. For example

the College of Occupational Therapists (COT) make reference to a practice placement educator, indicating that this is a practice-based staff member who is involved in the day to day management of a student on placement and who is responsible for the assessment of a student against agreed learning outcomes. Practice educators also facilitate the student's achievement of learning outcomes and are responsible for monitoring and evaluating the student's learning outcomes in partnership with the university (COT, 2003). This is more akin to the role of the mentor in nursing and midwifery. Whatever the differences in role title across the professions, there is general agreement about the nature of the role associated with supporting, guiding and assessing students in practice settings.

In the latter part of 2006 the NMC introduced the notion of the 'sign-off' mentor, as part of a much wider reform of the standards to support learning and assessment in practice. The 'sign-off' mentor is responsible for making the final assessment of practice on the last placement and confirming with the NMC that the required **proficiencies** for entry to the register have been achieved (NMC, 2006, p. 9). To be a 'sign-off' mentor individuals must meet additional criteria to those for mentors and be on the same part of the register as the students they are assessing. (The role and preparation of the sign-off mentor will be considered more fully in Chapter 13.)

ACTIVITY 1.2 PREPARING FOR THE FUTURE

Read Chapter 2 of the NMC (2006) *Standard to Support Learning and Assessment in Practice* (which you can obtain from the NMC web site, www.nmc-uk.org) and consider in more detail 2.1, the NMC standard for mentors. ■

The whole question of the role of mentorship in interprofessional learning programmes is a particularly thorny one. The new standards to support learning and assessment in practice (NMC, 2006) indicate that for nurses undertaking advanced nursing practice there are additional requirements relating to practice teachers. There is concern that the standard associated with practice teachers will present some difficulty. This is because of the wide spread of nurse practitioners, most of whom are nurses and entered advanced practice by learning knowledge, skills and competence that were previously the domain of other professional groups, especially medicine. At present, assessment is undertaken by doctors, who currently practise those skills. For example, nurses who undertake preparation to prescribe are required by legislation to be assessed by a Designated Medical Practitioner (DMP). A DMP is a registered practitioner who provides

supervision and support, assesses application of theory to practice and signs off satisfactory completion of the period of learning and assessment (in practice). The new standards will throw what, to date, has been a recognized model of interprofessional mentoring into question, as on the introduction of the standards, assessment must be by an individual from the same profession.

There are several preregistration, interprofessional programmes in the United Kingdom and others that have an interprofessional flavour, less overt but still evident. In the main, the interprofessional elements are integrated into the theoretical components rather than practice learning. Students do undertake placements where they are exposed to interprofessional working but there is no strong evidence to suggest that practitioners are confident enough to accept readily the responsibility for learning experiences of students from professions other than their own. This is especially so in relation to making judgements about competence, even in relation to generic skills. This raises an interesting dilemma – should interprofessional students continue to be supported and assessed using uniprofessional models? Although, in the main, the associated professional bodies support the concept of interprofessional learning, they have yet to address interprofessional assessment clearly within their practice standards or guidance. This could be done by identifying a common terminology, developing multiprofessional standards for the learning and assessment of students in practice, together with universal preparation programmes for all mentors.

THE PRACTICE CONTEXT

Until recently, the overall picture in the NHS was one of growth, both in the numbers of patients receiving care and in the number of health-care professionals employed. In the early part of this decade the Department of Health (DH) predicted a need for an increasing number of health professionals together with changes in the way they are prepared (DH, 2000). In the NHS plan (DH 2000), the Government set out the policy for modernizing the NHS; a radical programme of reform was planned which included additional health-care personnel, and new roles and responsibilities for nurses, midwives and therapists together with improved training and increased numbers of nurses and other health-care professionals in training. This trend continued until 2005/2006, four years short of the time period for the NHS plan. More recently, in the light of financial pressures, the numbers of health professionals entering training are reducing (2006/2007). The picture currently is one of regression, with many nurses and other health professionals working with the threat of posts being made redundant alongside the 'freezing' of key posts. There is no indication that this trend will not continue, at least in the short term, although the forecast for workforce capacity by 2010/2011 shows a shortfall

of 14 000 whole time equivalent (WTE) nurses (Mooney and Donnelly, 2007). If the present recession does continue there will be a shortage of practitioners to support the future nursing and midwifery students in practice. Current restraint in employment practice may be a false economy if the future workforce is ill prepared to deliver the services that patients need. In addition, the toll this has on attrition, because students are left feeling unsupported, unsure and unsafe, is a financial cost that the NHS can ill afford.

Against this backdrop there is an increasing reliance on practitioners to provide care in an increasingly complex health context and at the same time to take a more active role in the learning, teaching and supervision of students in practice settings. It is clear that if mentors are to support students in a chaotic workplace then the process and tools they use must be fit for the situation they find themselves in and assist rather than hinder the mentoring process. In addition, given the time constraints on practitioners, the support mechanisms for students must be easy to integrate with professional practice and not antagonistic to it. As far back as 1999 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting stressed the importance of dedicated time for teachers and mentors so that they could remain confident and **competent** in their teaching and mentoring roles.

The NMC has, for some time, expressed concern about the perceived variation in competence and fitness to practise at the **point of registration**, particularly in relation to student nurses. This led in 2006 to the publication of the *Standards to Support Learning and Assessment in Practice*, the NMC standards for mentors, practice teachers and teachers (NMC, 2006). The standards indicate that at least 40% of a student's placement time should be spent directly with their mentor and that achievement of competency at key points in the programme must be confirmed by a 'sign-off mentor'. Sign-off mentors will meet additional criteria and, when supervising students in their final placement, will have protected time for providing feedback to students.

The shift in responsibility for ensuring that students are fit for practice is now more clearly towards practitioners. The literature in midwifery, nursing and social work suggests that many practitioners have difficulty taking responsibility for student learning, especially making decisions about appropriate standards of practice (Burgess, Phillips and Skinner, 1998; Sharp, 2000; Duffy and Watson, 2001; Duffy, 2004). This may be as a result of lack of support from higher education colleagues or because practitioners are not necessarily educationally prepared to be the final arbiter of entry to the profession. A number of other reasons have been put forward for inconsistency in approach, such as lack of time to directly supervise students, short length of placements and a sense of personal failure (Mulholland *et al.*, 2005).

The new standards, implemented in September 2007, reinforce the position of the practitioner (mentor) as the arbiter of entry to the profession, making it clear that the

responsibility lies with the sign-off mentor. The NMC standards do acknowledge some 'norms' for the time commitment for mentors, with 40% of the overall time being dedicated to student supervision. In addition to this, in the final placement, students will receive one hour per week from the sign-off mentor. The NMC indicates clearly that 'clinical commitment should be reduced for mentors when they are supporting a student' (NMC, 2006, p. 30). However, there is little to suggest how this will be brought about given the current staffing challenges in the NHS. This is an important issue and one that will require sensitive discussions between educationists, NHS employers and professional bodies. Implementing the new standards for the sign-off mentor affects students qualifying from 2010, and therefore allows for a period of further discussion regarding the time commitment.

ACTIVITY 1.3 APPLYING NEW LEARNING

Consider how you will arrange and manage your working practices to meet the mentor standards (Appendix 1.A) to support learning and assessment in practice. ■

CHAPTER SUMMARY

Having sound mentorship is vital to the development of competent future practitioners and therefore developing good mentors is crucial. The health-care arena is complex and challenging and students need flexible, adaptable mentors who can guide them through the complexities of the practice domain. However, the role of the mentor needs to be easily integrated into 'the job' of being a health practitioner rather than being an 'add on'. Higher education has a crucial role to play in the development of suitable mentors and in providing unobtrusive educational support for them.

Whether in the future mentoring roles are dictated by custom and practice or by guidance from professional and regulatory bodies remains equivocal. What is clear is the urgency for educational bodies to monitor and regulate practice across the professions to reduce ambiguity and confusion and to prepare students for working and studying in an interprofessional context. Most of all, there should be some uniformity in the role titles for practitioners undertaking support roles in practice settings to ensure that all involved have a similar understanding, irrespective of the particular health-care profession.

Currently, there is much discussion regarding the achievability of the NMC (2006) standards within the timescale identified, particularly in relation to specialist practice programmes with non-NHS nurses, whose employers are unwilling or unlikely to employ additional staff as practice teachers. For students undertaking specialist practice qualifications within the NHS, the spread of practitioners is wide with a scarce resource of practice teachers to assess them and limited plans to commission further preparation programmes. For students undertaking preregistration programmes and their mentors the issues are different but no less challenging, especially in relation to the increased responsibilities for 'sign-off' mentors.

The literature pertaining to mentors and mentorship is prolific in nursing- and midwifery-related journals and within this there is little that challenges the assumption that having a mentor improves practice learning, despite there being little research evidence. The research literature usually highlights the supportive and approachable nature of the role rather than the effect on learning. Of course, it may be that when students feel more 'comfortable' and supported in a practice area, they learn more and it is less to do with the direct transference of knowledge. Perhaps no one person can provide all that a student needs in practice and students would be better served by a mentoring team, rather like a supervisory team for students undertaking further studies.

Policy for health professional education tends to be developed centrally by single professional and/or regulatory bodies. What is needed for the future is more joint working across the professional groups so that there is a greater understanding of the context of contemporary health care and education. This is especially relevant at a time when NHS trusts are struggling to recruit staff because of financial pressures, making individual roles more complex. There may be a glimmer of hope on the horizon for more strategic, joint working amongst professional and regulatory bodies with the prospect of a single Professional, Statutory and Regulatory Body (PSRB), but this may be some time off.

Many practitioners underestimate the responsibility and commitment required in the support and guidance of students in practice and many employers fail to acknowledge the necessary 'space' that is required in the working day to help mentors to undertake the role in a way they would wish to. The fundamental aspect that has been present since the introduction of mentoring for students, but has never been addressed adequately, is the one of resource. The role of the mentor is a complex one which requires a high level of commitment and ability and although it may be part of the job of being a health-care practitioner, it does require dedicated time, but it is often the more experienced practitioners who have the least time. The effect of this is twofold. Firstly, students do not get the opportunity to learn from the very people from whom they should be learning and, secondly, inexperienced practitioners are trying to learn new skills whilst passing on others to students.

Despite the inherent difficulties, mentors remain enthusiastic about mentoring and students are clear that having a good mentor eases their journey through the practice arena. It is incumbent upon all health professional practitioners and educators to ensure that we provide the best quality learning experience for students and are actively engaged in developing the right conditions in the workplace for mentors and learners to flourish.

REFERENCES

Andrews, M. and Chilton, F. (2000) Student and mentor perceptions of mentoring effectiveness. *Nurse Education Today*, **20** (7), 555–62.

Andrews, M. and Wallis, M. (1999) Mentorship in nursing: a literature review. *Journal of Advanced Nursing*, **29** (1), 201–7.

Burgess, R., Phillips, R. and Skinner, K. (1998) Practice placements that go wrong. *Journal of Practice Teaching*, **1** (2), 48–64.

Burnard, P. (1990) The student experiences: adult nursing and mentorship revisited. *Nurse Education Today*, **10** (5), 349–54.

College of Occupational Therapists (2003) *Standards for Education: Pre Registration Education Standards*, College of Occupational Therapists, London.

Department of Health (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*, The Stationery Office, London.

Department of Health (2001) *Preparation of Mentors and Teachers: A New Framework for Guidance*, English National Board for Nursing, Midwifery and Health Visiting & Department of Health, London.

Duffy, K. (2004) *Failing Students: A Qualitative Study of Factors That Influence the Decisions Regarding Assessment of Students' Competence in Practice*, Nursing and Midwifery Council, London.

Duffy, K. and Watson, H.E. (2001) An interpretive study of the nurse teacher's role in practice placement areas. *Nurse Education Today*, **18**, 158–64.

Mooney, H. and Donnelly, L. (2007) Workforce plans predict 'bitter opposition' and 'volatility'. *Health Service Journal*, **00**, 5.

Mulholland, J., Mallik, M. and Moran, P. *et al.* (2005) *Making Practice-Based Learning Work*, Occasional Paper No.6, June 2005, The Higher Education Academy, London.

Neary, M. (2000) Supporting students' learning and professional development through the process of continuous assessment and mentorship. *Nurse Education Today*, **20** (6), 463–74.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, Nursing and Midwifery Council, London.

Pellatt, G.C. (2006) The role of mentors in supporting pre-registration nursing students. *British Journal of Nursing*, **15** (6), 336–40.

Sharp, M. (2000) The assessment of incompetence: practice teacher's support needs when working with failing Dip S W students. *Journal of Practice Teaching*, **2** (3), 5–18.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) *Project 2000, a New Preparation for Practice*, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for Practice*, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London.

APPENDIX 1.A

Competencies for Mentors (Adapted from NMC 2006, pp.18–19).

Establishing effective working relationships

- Develop effective working relationships based on mutual trust and respect
- 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

Facilitation of learning

- Use knowledge of the student's stage of learning to select appropriate learning opportunities to meet their individual needs
- Facilitate selection of appropriate learning strategies to integrate learning from practice and academic experiences
- Support students in critically reflecting upon their learning experiences in order to enhance future learning

Assessment and accountability

- Foster personal growth, personal development and accountability through support of students in practice
- Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team
- Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance ad capabilities for safe practice or be able to understand their failure and the implications of this for their future
- Be accountable for confirming that students have met, or not met, the NMC competencies in practice; as a sign-off mentor, confirm that students have met, or not met, the NMC standards of proficiency in practice and are capable of safe and effective practice

Continued

Evaluation of learning

- Contribute to evaluation of student learning and assessment experiences – proposing aspects for change as a result of such evaluation
- Participate in self and peer evaluation to facilitate personal development, and contribute to the development of others

Creating an environment for learning

- Support students to identify both learning needs and experiences that are appropriate to their level of learning
- Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs
- Identify aspects of the learning environment which could be enhanced – negotiating with others to make appropriate changes
- Act as a resource to facilitate personal and professional development of others

Context of practice

- Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated
- Set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care
- Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained

Evidence-based practice

- Identify and apply research and evidence-based practice to their area of practice
- Contribute to strategies to increase or review the evidence-base used to support practice
- Support students in applying an evidence base to their own practice

Leadership

- Plan a series of learning experiences that will meet students' defined learning needs
- Be an advocate for students to support them in accessing learning opportunities that meet their individual needs – involving a range of other professional, patients, clients and carers
- Prioritize work to accommodate the support of students within their practice roles
- Provide feedback about the effectiveness of learning and assessment in practice

CHAPTER 2
A GOOD PLACEMENT EXPERIENCE: THE STUDENT'S PERSPECTIVE OF THEIR NEEDS IN THE PRACTICE SETTING

Sue West

Canterbury Christ Church University

LEARNING OUTCOMES

This chapter provides an opportunity to:

- **Examine the placement experience from the student perspective**
- **Consider the factors that promote and inhibit learning**
- **Explore the potential consequences of unmet student needs.**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

I have had lots of nice experiences, some bad ones, and, one really excellent one. In my excellent placement everything came together. The whole team were really into looking after patients, and, you could work with anyone and still learn. My mentor was really interested in me as an individual and not just another learner.

Second year student

INTRODUCTION

As a practitioner who is committed to the education and support of those who facilitate learning in practice, I have found that the most powerful learning experiences for mentors are those that directly involve students, or in which student reflections have been used to encourage debate. For this reason, when planning a resource for mentors, it seemed appropriate to include a chapter that, although not written by students, provides some insight into their perspective, using their own words. These words are direct extracts from a phenomenological study that sought to understand the experience of learning from the student's perspective (West, 2005). This chapter does not intend to provide an in-depth analysis of the points made, but asks the reader to consider the student's view of the practice learning experience, the factors that either promote or inhibit their learning, the potential implications of unmet needs and question whether any of these views may be replicated in their workplace.

CLARIFYING THE CONTEXT: LEARNING AS INPUT, PROCESS AND OUTCOME

In Chapter 4 the concept of learning will be explored in depth; in this chapter, I would like you to consider learning as a process that occurs in three distinct yet overlapping stages. Biggs (1999) refers to these as *input*, *process* and *output*. When applied to the placement context, input refers to the overall structure that has been put in place to enable learning. This includes the preparation students are given prior to being allocated to the workplace and the objectives they can anticipate achieving. It also refers directly to the mentor's performance as a facilitator of learning and their knowledge base. The latter relates to both professional expertise and the ability to apply principles and concepts to learning.

Process is influenced by the way an individual student selects and learns from the input. It incorporates all of the variables that can occur within any given learning situation. This would include the student's response to their mentor, the way that the mentor has planned, managed and guided the learning experience, as well as their reaction to members of the team and the wider workplace environment.

Output refers to the end product of the learning experience. Within professional education a high quality student performance is anticipated. This chapter suggests that

if the structure and process are not fully in place, the learning experience may produce anxious, worried students who doubt their ability to become registered practitioners.

INPUT: AN EFFECTIVE STRUCTURE FOR THE PLACEMENT LEARNING EXPERIENCE

ACTIVITY 2.1 AN EFFECTIVE PLACEMENT EXPERIENCE

Before reading any further please take a few minutes to list the components of an effective placement learning experience. ■

Chapter 8 provides an extensive commentary on the factors that contribute to an effective learning experience. In my study (West, 2005), an effective learning experience was found to depend on:

- preparation for the placement
- allocation to the right placement at the right time
- a helpful mentoring relationship
- a student-friendly assessment process.

PREPARATION FOR THE PLACEMENT EXPERIENCE

In 1999, the *Making a Difference* (Department of Health, 1999) and *Fitness for Purpose* (United Kingdom Central Council, 1999) reports established the need for students to undertake education programmes that would prepare them for professional practice. One of the recommendations of these reports was that students should experience earlier and longer placements to strengthen the practice component of professional education. To feel adequately prepared for allocation to practice in the early stages of their education, students considered that there were two issues of equal importance that needed to be addressed. The first related to skills development and the second to preparation for the real world of practice.

Skills development

It is important for students to have a small repertoire of skills that enables them to be *useful* when they enter the workplace. Many higher education institutions now use skills laboratories as a way of developing some fundamental skills prior to exposure to practice

(Hilton and Pollard, 2005). Although students considered this to be an effective way of addressing initial clinical skills teaching, they also required a mentor to help them to transfer these initial, taught skills safely to patient care and support their acquisition of new and increasingly complex skills throughout their education programme.

ACTIVITY 2.2 SKILLS ACQUISITION

Please take time to consider how mentors in your workplace currently help students to develop their clinical skills. Is the same approach used regardless of the student or are different strategies adopted? ■

When considering how students are helped to develop their skills it can be seen that no one approach would suit all students; each student is a unique individual whose ability will vary according to their individual characteristics and previous experiences. Some students will enter your workplace confident and assured, others will feel anxious about their level of clinical skills or grasp of theoretical concepts. This uncertainty and anxiety can impact on their performance and can increase the pressure they feel during their time with you (Chesser-Smyth, 2005).

Preparation for the real world of practice

As mentioned earlier, as well as having useful skills, students also wanted to feel ready for the cultural reality of clinical practice. One first year student doubted whether it was possible and whether she could have been fully prepared for what it is like in practice. She said 'the running around, getting bogged down in politics and who likes who and not knowing who anyone is and what to do and not to do . . . and going through your head all of the time is I don't know, I just don't know' (first year). Although, being adequately prepared for placements was a specific issue for students within their first placement, it continued to be an ongoing issue throughout their programme. Higher education staff will provide students with formal preparation for the placement experience, but facilitating the transition to the workplace is an essential component of the mentor's role (Nursing and Midwifery Council, 2006).

ALLOCATION TO THE RIGHT PLACEMENT, AT THE RIGHT TIME

Allocation to placements was seen as a positive experience for students as long as they were allocated to the right placement at the right time. Early in their programme, the

'right placement' was one in which the work and learning pace was compatible. For example students who are allocated to the more acute placements in their first year tended not to understand what was going on and felt out of their depth. When the pace was too fast they were overwhelmed by information and this inhibited their ability to learn. In an ideal situation students would be allocated to an environment that had been chosen to meet their individual needs. However, within modern health-care environments this may not be possible. In these circumstances the mentor's role becomes even more significant. It is crucial that mentors are conversant with the student's objectives and can help them focus on aspects of practice that are appropriate to their level and stage of learning. Chapter 4 discusses some of the main learning theories and helps the mentor see how these can be used to optimize the learning experience.

A HELPFUL MENTORING RELATIONSHIP

The role of the mentor has been a topic within the literature since the seminal work of Darling (1984). There has, however, been renewed interest following the recommendations in *Making a Difference* (Department of Health, 1999) and *Fitness for Purpose* (United Kingdom Central Council, 1999) to address the skills' acquisition of preregistration students and the support required to enable them to link theory with practice.

Clearly the mentor's role is significant within the placement learning experience. The mentor can influence whether students feel accepted as part of the team and are able to translate skills and understanding within the context of patient care. Hilton and Pollard (2005) found that the first priority for students when allocated to a placement is to become part of the team. According to Lloyd Jones, Walters and Akehurst (2001), a mentor openly recognizing a student enables them to feel valued as individuals. This can ease their acceptance within the wider health-care team and have a positive effect on their self esteem (Begley and White, 2003).

If students lack clarity regarding the mentor and student relationship or the method of supervision, they can feel that they are left 'hanging around waiting to be noticed', or, as found by Grey and Smith (1999) 'getting on with the work' normally allocated to unqualified members of the team, rather than those they perceived were needed when qualified. The significant role the mentor plays in the development of competent practitioners is well documented within the literature (Grey and Smith, 1999; Chow and Suen, 2001; Spouse, 2001). When talking about the mentors they had worked with, students discussed the difference of individual mentors and their approach to their role:

It seems like there is a huge variation in how they do their job, one of us has had a fantastic experience from a mentor who really knows how to make you learn, the rest of us have had some very nice mentors, and, then there are the busy ones who don't have time and leave you to it!
First year

It is apparent that there is some inconsistency in the way that the mentorship role is undertaken. Students do recognize the pressures within professional practice and felt 'sorry for mentors' (first year) but, never the less, considered that their learning was dependent on being allocated the 'right' mentor.

The right mentor was one who:

- made time for students
- checked student performance
- set boundaries for the shift
- knew what students were learning
- could explain what they were doing
- asked questions and challenged students
- acted as positive role models.

Each of these characteristics will be discussed briefly here and will be explored in more depth in the remaining chapters of the book.

Making time for students

How much time a student should, or needs, to spend being directly supervised by their mentor will depend on the student, their previous experiences and the context of the placement. First years appear to be more tolerant of working with other members of the health-care team than those who are further on in their programme. While those in their final placements are particularly anxious not to be left to their own devices and want time with their mentor that will enable them to feel confident of their skills and abilities at the point of registration.

It is important that at the beginning of a learning relationship the parameters of a working relationship are negotiated and clarified. The Nursing and Midwifery Council (2006) suggests that this working relationship should ensure that the mentor: works with their student for 40% of the placement allocation; structures the learning experience to ensure that there is continuity in their absence; spends time with the student helping them critically reflect on their practice and progress; helps them identify

learning needs and develop action plans; clarifies expectations; and implements sound assessment strategies.

Checking student performance

Students particularly want mentors to find the time to check their performance and provide them with detailed, constructive feedback. They need the reassurance that the skills and knowledge they have learned within their studies have translated safely to patient care. One student discussed her supervision on a 'good placement where the team were supportive of everything (the student) did. The mentor watched (the student) ask questions and obviously just kind of checked on the first time (the student) did anything'. This was a confidence boost for this student who then knew that she was 'safe to go off on her own'. Checking the quality of the student's clinical skills was one aspect of structuring the placement experience so that the student could feel confident in the practice setting. It was important to students that their mentors structured their learning and in doing so 'set them up to do well'.

Set boundaries for the shift

A positive experience is described as when the student is 'organized for the morning'; (the mentor) 'will say well you will be in this bay with these patients, what are you going to do first and what are you going to tell me and when?' (first year). This helped the student to understand her parameters and reinforced the significance of their role in patient care.

Knowing what is being learnt

The mentor who knew what her student was learning was able to bring theory to life and demonstrate the purpose of what they had been taught within their education programme. A second year student explained how she and her mentor 'were caring for a patient and she discussed with me how she uses what she knows about physiology when planning interventions and then she talked about how things like politics and ethics influence care, and, you think right, it is there really' (second year).

The ability to explain

Students acknowledged that the way theory is applied in practice is not always obvious to them. They 'learn a lot and it's hard to focus at times but good mentors show in really small ways that most of it is used in practice' (second year). Students want mentors that can articulate their **tacit knowledge** so that it becomes 'visible; one who knows what to do and is able to explain it' (third year). The mentor who can also ask the right kind of questions during the placement experience ... 'helped (the student) see what (they) know too' (first year).

Asking questions and challenging

It is important to students that mentors 'have the interest to ask you questions' (second year). They recognize that there are different kinds of questions that could be posed and particularly valued the mentor who 'will ask you a question that helps you make a connection' (third year). Students who had not regularly been exposed to questioning in practice found the notion anxiety provoking and were 'scared of looking stupid' (first year). This was in contrast to those who had experienced it; for them if it did not make them 'feel stupid, it just made (them) think, perhaps (they) had better read and find out more' (first year). Chapter 5 provides the opportunity to explore the development of the kind of effective interpersonal relationships between mentor and student that can promote positive feelings, enable students to feel safe and reduce the likelihood of negative responses such as fear and anxiety.

The right level of challenge was something that all students talked about either having experienced, or wanting to experience; having their skills and understanding challenged helped them value the theoretical component of their programme. However, not all mentors were seen as able, or willing, to challenge students within the practice setting. Some were seen as too nice or reluctant to embarrass students, but it is apparent that students wanted more than niceness and pastoral support from their mentors.

I thought I would be asked a lot more questions in placements than we are. My mentor was lovely with the patients and really gentle with them and me and I learned loads about nursing from watching her and her approach to care, she was quite inspirational at times. But part of me still wanted to be pushed a bit too. I mean she was really willing to tell me anything I wanted to know, but she just never asked me anything.

First year

A positive role model

The final characteristic of an effective mentor was seen as one who is a 'really positive role model' (first year). For these students a positive role model included effective interpersonal skills and whether or not they had 'a positive attitude' (third year), 'were really enthusiastic about what they do' (third year) and organized care to 'make time for patients' (first year), 'know their patients … be involved with them' and did 'things in a way that makes a difference for patients'.

A STUDENT-FRIENDLY ASSESSMENT PROCESS

The last issue for the students in this study (West, 2005) was the need to experience an effective assessment process. Rust, Price and O'Donovan (2003) noted that assessment plays a central role in learning for those on a professional education programme. This

is of particular importance within the practice setting, where the decisions made maintain the standard of the professional registers. The form and structure that assessment takes can influence student learning. Entwhistle and Marton (1984) found that students direct their learning towards their perceptions of the demands placed on them. Certainly, the students within this study indicated that when their mentors challenged their understanding, it increased their motivation and desire to respond. Chapter 10 provides an opportunity to consider how a student-centred approach to assessment can be integrated within the overall learning experience.

PROCESS: SOME OF THE VARIABLES WITHIN THE LEARNING EXPERIENCE

In this part of the chapter we will explore some of the variables that occur within the learning situation and the student's response. When examining evaluations of the learning experience, it is interesting to note that two students can experience the same placement at the same time but with very different perceptions and outcomes. Within their learning experiences it is a consistent issue to be recognized as unique individuals, rather than 'just another student'.

THE NEED TO BE SEEN AS AN INDIVIDUAL

So, why is it so important for us to be aware of each student as an individual and what are the potential implications for the learning situation? Before you read any further in this chapter, please take some time to undertake the activity in the box below.

ACTIVITY 2.3 THE CHARACTERISTICS OF INDIVIDUAL STUDENTS

Think about some of the people you have helped learn recently. What characteristics did they have that had the potential to influence the learning experience in either a positive or negative way? ■

Table 2.1 illustrates some key findings from the literature in relation to individual characteristics, and the sources, so that these can be examined further. Later, when you think about developing learning relationships, you may like to explore how the skills

TABLE 2.1

Student Characteristics and Potential Effects on Learning

Characteristic	Potential effects on learning	Source
Age	Mature students may be less tolerant of ambiguity Mature students may be more self-directed than school leavers	Sutherland (1999) Johnson and Romanello (2005) Roberts (2006) O'Shea (2003)
Family commitments	There may be additional pressures on students with children and other family commitments	Longhurst (1999)
Previous work experience	The mentor will need to recognize their previous work experience The student may require less help with clinical skills and more support with theory	Roberts (2006)
Learning style and preferences	Alignment between preferred learning methods and personal learning style	Hand (2006) Chapter 6 of this book
Specific learning needs (dyslexia etc.)	The student may need more time and help to grasp new concepts	Morris and Turnbull (2006) Seekleman (2002)

discussed can help you find out about your student as an individual to provide a foundation for your work with them.

ALIGNMENT BETWEEN OBJECTIVES AND OPPORTUNITIES

It was a significant issue for students that they could see a clear alignment between their individual learning needs and the opportunities made available to them. Regardless of stage of education, learning was seen as exposure to something new. Although students could see potential for building their confidence during 'routine practice', anxiety was expressed if it was seen to inhibit access to a new experience or prevented them filling the perceived gaps in their competence. It was particularly important that there was a

visible difference between the experiences and expectations for students at different levels. When this did not happen, they believed it was because: it was difficult for mentors to differentiate between students; mentors were overwhelmed by 'workload and staffing issues'; and were 'too busy to stop and plan'.

STUDENT RESPONSES

Instead of discussing their concerns, some students displayed characteristics inherent within the rest of the workforce and 'put their heads down and worked'. They considered that this enabled them to be part of the team and show that they could 'cope'. These students considered that, if a placement is 'good, it's good and you learn and if it's not you just work and wait for the next one and hope it's better'.

Other students saw themselves as adults who needed to take responsibility for their own learning. As one noted, you 'have to push yourself, we are not at school and nobody is going to feed us' (first year). Within his theory of adult learning, Knowles (1998) found that people who are self-directed and take the initiative for their own learning learn more effectively than those who wait passively to be taught. He believed that a desire to be self-directed is a natural part of adult maturation and is based on the assumptions that adults will learn what they see is relevant to them as individuals, bring experience to the learning situation, are self-motivated and ready to learn. Knowles' (1990) theory puts the student in the centre of the educational process and assumes that positive motivation is achieved because students are there, want and are able to learn. These students also considered the learning relationship from the mentor's perspective and thought it must be easier to mentor a student who 'is keen to learn and is enthusiastic about practice' but were also conscious of external issues within the wider placement environment that influenced their learning.

Within the literature a number of issues have been found to influence whether or not learning occurs in the workplace; the culture of the learning environment (Morton-Cooper and Palmer, 2000), the preparation of mentors, the level of support and opportunity to reflect (Spouse, 2001), and the characteristics (Chow and Suen, 2001) and attitudes of mentors (Lofmark and Wikblad, 2001).

For these students, the way that care was organized either promoted or inhibited learning. Learning was promoted in a ward where 'everyone gets in and does patient care', whereas learning was inhibited in an environment that took a more task-orientated approach to patient care. Students believed that the approach taken was influenced by the workload and found that when 'it's really busy you don't really have time to learn' and found themselves 'running behind, doing what (they) were told'. Issues related to

the learning environment and steps that can be taken to enhance it will be discussed in Chapter 8.

OUTPUT: THE END RESULT OF THE LEARNING EXPERIENCE

Although for many students, the placement learning is a positive experience that enables them to develop their professional expertise, for others their attempts to learn within the practice context can leave them struggling through periods of vulnerability and doubting whether they will ever emerge from their experiences as competent, registered practitioners. Within my study (West, 2005), first year students demonstrated a real commitment to becoming qualified nurses. The second and third years illustrated what a challenging journey the learning process can be if the framework is not consistently able to support it.

They considered themselves 'lucky' if they were allocated to the 'right placement, the right mentor' and the 'right practice experience', as this was a recipe for success. Conversely, they felt 'unlucky' when this did not occur and this led to a state of anxiety in which they experienced learning as 'worrying'. They talked about 'worrying about getting it right, worrying about knowing, worrying about being a pressure, worrying about patients', and 'worrying about leaving the cover of being a student'.

When talking about worrying and about getting it right, specifically related to an inability to judge their performance, students at all stages of their education sought structure within the learning experience. They wanted very clear outcomes to work towards and constructive feedback that would not only boost their confidence by enabling them to see what they were doing well, but would also provide them with specific guidance regarding where focused development was required. When this structure and feedback was not available, students felt that that they were left to their own devices. This left them anxious about their level of achievement.

When a lack of clarity is experienced within the placement students 'worried' about what they should know and be able to do at different stages of their programme. They wanted to see a clear differentiation between the expectations for students at different stages of their education programme. When this was absent, their development was limited; they were unable to judge whether or not they had progressed and their anxiety levels were increased. As one second year noted 'I always feel that I should know more than I do, but am never sure what'. This was exacerbated occasionally because when the clinical area was really busy they would suddenly find themselves working outside of what was normally expected and this left them feeling out of their depth. The main strategy initiated by students to cope with the potential for getting out of their depth

was avoidance. They tended to focus on what they were comfortable with and keeping busy so that mentors would not ask for more.

Students are very aware of 'busyness' within the workplace and can see themselves as 'just another pressure on top of all of those other pressures'. They observed 'unhealthy' behaviours within the workplace that they considered contributed to the stress and pressure experienced by health-care teams and felt 'guilty' for wanting to take breaks or leave at their allotted time.

One student discussed her education so far and said that 'some of my placements were really good and some were awful, but what really worries (me) is that it's not about now. What if in another 18 months I still do not feel competent to practice. I will be frightened to leave the cover of being a student'.

Within the *Standards to Support Learning and Assessment in Practice* the Nursing and Midwifery Council (2006) have stated their intentions to address some of the concerns regarding fitness for practice through strengthening the role of the mentor and enhancing the assessment of competence. The remaining chapters of this book provide ideas and tools that can help the mentor undertake their role in facilitating and assessing placement experiences that will contribute to the development of students who are ready to commence their role as registered practitioners.

CHAPTER SUMMARY

This chapter has presented the students' view of the factors that can inhibit the input, process or output of their practice learning experience. These include the structure of the experience, the skills and abilities of the mentor, the individual student and their response to the experience and its context. Some of these factors are within and others outside of the mentor's direct control.

Students are aware of the challenges faced by mentors in busy and complex health-care environments and are reluctant to be an additional pressure. They, never the less, look to their mentors to provide structure to their placement and offer a balance of support, challenge and feedback that will enable them to not only contribute to, and feel useful in, the workplace but also develop their skills, confidence and competence.

REFERENCES

Begley, C. and White, P. (2003) Irish nursing learners changing self-esteem and fear of negative evaluation during their pre-registration programme. *Journal of Advanced Nursing*, **42** (4), 390–401.

Biggs, J. (1999) *Teaching for Quality Learning*, Open University Press, Buckingham.
Chesser-Smyth, P. (2005) The lived experiences of general student nurses on their first clinical placement: a phenomenological study. *Nurse Education in Practice*, **5** (6), 320–7.
Chow, F. and Suen, L. (2001) Clinical staff as mentors in pre-registration undergraduate education: learners' perceptions of the mentors' role and responsibilities. *Nurse Education Today*, **21** (5), 350–8.
Darling, L.A.W. (1984) What do nurses want in a mentor? *Journal of Nursing Administration*, **14** (10), 42–4.
Department of Health (1999) *Fitness for Purpose*, Department of Health, England.
Entwhistle, N. and Marton, F. (1984) Changing canceptions of Learning, in *The Experience of Learning* (eds F. Marton, D. Hounsell and N.J. Entwhistle), Scottish Academic Press, Edinburgh.
Grey, M. and Smith, L. (1999) The professional socialisation of diploma of higher education nursing learners (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, **29** (3), 639–47.
Hand, H. (2006) Promoting effective teaching and learning in the clinical setting. *Nursing Standard*, **20** (39), 55–63.
Hilton, P. and Pollard, C. (2005) Enhancing the effectiveness of the teaching and learning of core clinical skills. *Nurse Education in Practice*, **5** (5), 289–95.
Johnson, S. and Romanello, M. (2005) Generational diversity: teaching and learning approaches. *Nurse Educator*, **30** (5), 212–16.
Knowles, M. (1998) *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*, Prentice Hall, Prentice NJ.
Lloyd Jones, M., Walters, S. and Akehurst, R. (2001) The implications of contact with the mentor for pre-registration nursing and midwifery learners. *Journal of Advanced Nursing*, **35** (2), 151–60.
Lofmark, A. and Wikblad, K. (2001) Facilitating and obstructing factors for development of learning in clinical practice: a learner perspective. *Journal of Advanced Nursing*, **34** (1), 43–50.
Longhurst, R.J. (1999) Why aren't they here? Learner absenteeism in a further education college. *Journal of Further and Higher Education*, **23** (1), 61–80.
Morris, D. and Turnbull, P. (2006) Clinical experiences of learners with dyslexia. *Journal of Advanced Nursing*, **54** (2), 238–47.
Morton-Cooper, A. and Palmer, A. (2000) *Mentoring, Preceptorship and Clinical Supervision*, Blackwell Science, Oxford.
Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, Nursing and Midwifery Council, London.
O'Shea, E. (2003) Self-directed learning in nurse education: a review of the literature. *Journal of Advanced Nursing*, **43** (1), 62–70.
Roberts, D. (2006) Learning experiences of seconded pre-registration nursing learners. *Nursing Standard*, **20** (36), 41–5.
Rust, C., Price, M. and O'Donovan, B. (2003) Improving learners' learning by developing their understanding of assessment criteria and processes. *Assessment and Evaluation in Higher Education*, **28** (2), 147–64.
Seekleman, J. (2002) Nursing learners with learning disabilities. *Journal of Nursing Education*, **41** (8), 334–9.

Spouse, J. (2001) Bridging theory and practice in the supervisory relationship: a sociological perspective. *Journal of Advanced Nursing*, **33** (4), 512–22.

Sutherland, P. (1999) A study of the learning of mature adult learners on a professional course. *Journal of Further and Higher Education*, **23** (3), 381–9.

United Kingdom Central Council (1999) *Fitness for Purpose*, UKCC, London.

West, S. (2005) A phenomenological study of the perceptions of the experience of learning related to blood pressure monitoring from the perspective of nursing learners. Unpublished Masters thesis. Canterbury Christ Church University College.

CHAPTER 3
THE REFLECTIVE MENTOR: FACILITATING LEARNING IN THE PRACTICE SETTING

Melanie Jasper

School of Health Science, Swansea University

LEARNING OUTCOMES

By the end of this chapter you will have:

- **Developed yourself as a reflective mentor**
- **Explored how you learn from practice experiences to create your own practice knowledge and theory base**
- **Developed an understanding of reflection as a learning strategy for yourself and others**
- **Considered ways of facilitating reflective learning**
- **Tested strategies for helping others to learn reflectively.**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

INTRODUCTION

The primary role of the mentor, as we have already seen, is to ensure that the student under their care gains the optimum learning experience in their journey towards competence as a professional practitioner. Key to this is both the relationship formed with the student, and the organization and provision of learning experiences and opportunities that will aid the student in achieving their goals.

This chapter is designed to help you develop your skills as a reflective practitioner so that these, in turn, can be used to develop the professional practice of your mentees. Hence, the chapter aims to help your own development as well as that of your students.

BEING A REFLECTIVE MENTOR

Gillie Bolton suggests that reflection is:

an in-depth consideration of events or situations outside of oneself; solitary, or with critical support. The reflector attempts to work out what happened, what they thought or felt about it, why, who was involved and when, and what these others might have experienced and thought and felt about it. It is looking at whole scenarios from as many angles as possible: people, relationships, situation, place, timing, chronology, causality, connection, and so on, to make situations and people more comprehensible. This involves reviewing or reliving the experience to bring it into focus.

Bolton, 2005, p. 9

This talks about the processes of exploring our experiences in order to learn from them in a reflective way. It involves us in using our experiences as a source for learning, and acknowledging that much of what we know, and how we know it, arises from our everyday lives – as a professional practitioner this will primarily be drawn from our working environment. Reflective learning, and the knowledge and understanding developed from this, constitutes another strategy for our development to complement the more formal processes of theoretical learning and instructed, observational practice. Reflective learning involves deliberative, cognitive processes which actively set out to explore an experience for what can be learnt from it. It requires commitment from the person doing the reflecting, and acknowledgement that the process is about expanding one's horizons and challenging previously held beliefs or ways of doing things. Learning from reflection is not always a comfortable or stress-free process. It may force you to

hold a mirror up to yourself and reveal an image that you don't like very much. But, it is worth remembering that the processes are there to help you learn, to take you forward in your life and help you develop in a continuous and continuing way. Although the focus of this is your experiences and therefore as close to you as anything can be, the object of the process is to learn and think positively as a result, rather than to criticize and think negatively about yourself and your actions.

ACTIVITY 3.1 YOURSELF AS A REFLECTIVE PRACTITIONER

Take a few minutes to consider your attitude towards reflective practice and reflection as a learning activity, as this will help you determine how you can use them in your role as a mentor.

- What part does reflective practice play in your role as a professional practitioner?
- How do you develop your knowledge and skills base?
- How do you learn from your everyday practice?
- What part does reflection play in your professional portfolio?
- How important do you see reflective practice as part of the way you practice? ■

Bolton talks about 'reviewing' or 'reliving' the experience to bring it into focus. This activity is also about re-viewing, or seeing something differently, maybe from another perspective or another point or view, in order for us to make sense of it in a different way. Thus, in reflecting on an experience not only do we come to a deeper understanding of it, we may also understand it differently. In turn, this results in learning from the experience and considering alternative ways of approaching and doing things.

ACTIVITY 3.2 YOUR EXPERIENCE AS A MENTOR

Use some time to reflect on your experiences as a mentor:

- What would you consider to be successful mentoring?
- What aspects of the mentoring role are you most comfortable with/do you most enjoy?
- What aspects of the mentoring role do you find most challenging/difficult/not enjoy?
- What have you learnt about yourself as a mentor as a result of your experiences?

Now think about a successful mentoring relationship with a student:

- What made the relationship successful?
- What were the student's attributes that contributed to this success?
- What was it about you that made it successful?
- What have you learnt about yourself as a mentor?
- What strategies for mentoring can you identify that contributed to this success?

Now try the same questions in relation to a mentoring relationship that you felt dissatisfied with.

Try to summarize what contributes to positive mentoring and student behaviour within the mentoring relationship as a result of your experiences. ■

I hope that Bolton's idea of 're-viewing' something has become clear to you as a result of the activity you have just done. Time, distance away from the relationship and being focused on specific questions helps to enable you to put an experience into perspective in relation to wider questions, and learning that can result from the process.

Clearly, the mentor needs to be constantly assessing their relationship with the student to ensure that it is a facilitative and positive one, and adjusting the learning experiences the student is exposed to in order to maximize the range of learning opportunities available. In common with the practice environment, opportunities for learning are subject to constant change and flux – whilst the primary work of the environment may be predictable, it changes on a daily, if not hourly, basis. Hence, a mentor needs to be constantly aware of what is going on in order to identify and expose the student to appropriate opportunities for their own particular needs. Reflective practice is the experienced health-care professional's way of dealing with the uncertainty of the everyday clinical- or social-care environment – it enables them to draw from their experiences in order to respond to whatever the situation is in front of them. It enables them to adjust their practice from what they have done before to respond to the unique set of characteristics that each different client presents. It enables them to deliver individualized care from a set of generic principles that are adapted and altered to suit that person's needs. The skills and knowledge arising from being a reflective practitioner also enables the mentor to respond to the unique needs of each student as an individual. This will be dependent on where they are in their programme, their previous knowledge and skills and their learning objectives whilst they are under your mentorship.

PRACTICE AS A LEARNING ENVIRONMENT

Initial preregistration education for health- and social-care practitioners is designed as a building block for students to be safe and competent practitioners at the point they register with their professional body. Underpinning this competence is a knowledge, skills and attitudes base formed of subject-specific information together with decision-making, critical and reasoning skills that enable the practitioner to utilize their knowledge to develop their practice. In the United Kingdom, all preregistration students develop these primary attributes for practice through the complementary experiences offered in a higher education setting and in real-life practice environments. Whilst academic staff take responsibility for assessing the theoretical knowledge base of the student, the responsibility for competence to practice lies with the practice environment, and ultimately this falls to the mentor who supervises the student. Hence, practice is not only an environment where a service is delivered to clients, it is also a learning environment where future and qualified practitioners continually utilize the opportunities provided to them as experiences to facilitate their professional development. It is not only preregistration and unqualified personnel who learn from practice – all practitioners will constantly be updating and adding to their knowledge and skills and therefore developing proficiency and expertise throughout their working lives.

Often this learning is an unconscious activity that we are not aware of – we absorb knowledge, skills and ideas without being aware that we are doing it. However, the skilled, reflective practitioner has developed the capacity to select from the environment and focus on experiences that they will consciously use as learning experiences. This capacity arises by being constantly aware and 'present' in the environment, by noting things as they happen and by recalling and using these in a constructive way in order to learn from them and change the way we do things.

The basis of reflective practice is the Experience Reflection Action (ERA) triangle (Jasper, 2003) shown in Figure 3.1. Essentially, the ERA triangle summarizes the basic processes of reflective practice by linking them together in a unique relationship that suggests that if one element is missing from the triangle, the concept of reflective practice does not exist. Reflective practice is founded on the premise that we learn from our experiences – hence experience in practice is the starting point, or apex, of the triangle. Any experience that we have can be explored in order to learn from it. By using reflective processes to explore these experiences we can come to a new understanding about them, which enables us to predict action that we may need to take. One view of learning is that it results in changes to our actions. This feeds back into our experiences, coming back to the top of the triangle, emphasizing that the process is designed to contribute to the forward movement and development of our practice. The final stage, taking action, is crucial to the notion of reflective *practice*. Without this 'doing' element, you may be engaging in reflection, but not reflective practice. Practice is about an activity; it is about applying the knowledge you have to a situation, so for reflection on an experience to become reflective practice there needs to be an outcome that involves some sort of action taken.

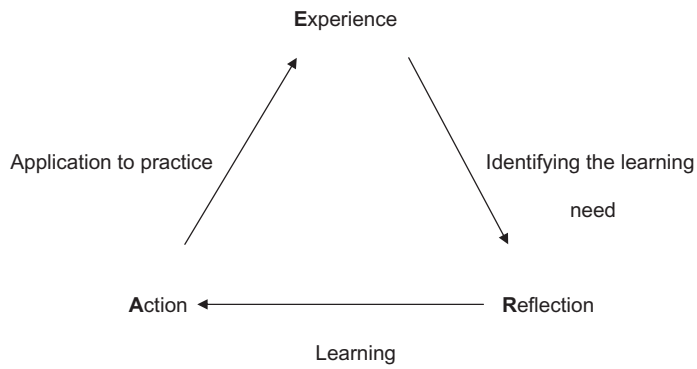


FIGURE 3.1

The ERA Triangle (Adapted from Jasper, 2003, p. 2).

IDENTIFYING THE LEARNING NEED

Superimposed on the basic triangle I have added three processes that contribute to the ERA triangle as a learning activity. As a mentor, you will be focused on enabling students to achieve objectives, hence any reflective activity you do, either for yourself or with your student, needs to concentrate on a particular objective. Each experience a person has can be used in a multitude of ways in terms of the learning that might occur, and as a mentor you may want to identify that objective before starting the reflective process with your student. Consider Activity 3.3 for instance.

ACTIVITY 3.3 IDENTIFYING THE RANGE OF LEARNING OPPORTUNITIES IN A PRACTICE INCIDENT

You are a staff nurse on a busy acute medical ward and have a first year nursing student with you on their second clinical placement. A 60-year-old patient who has been diagnosed as having lung cancer suffers a cardiac arrest and is successfully resuscitated by the team. This is the first time your student has witnessed a cardiac arrest.

- As the student's mentor, you want to ensure that he learns the most he can from this experience, bearing in mind the stage of his education and experience in practice to date.
- What different aspects of the experience could you use as learning opportunities?
- Why might you use these at this stage in the student's programme?
- How could you use them? ■

The aspects I identified were:

- Normal anatomy and physiology of the heart
- Pathology relating to cardiac arrest
- Identification and recognition of cardiac arrest

- Initial action to be taken – calling the team, instigating CPR, environmental safety, etc.
- Basic life support before the team arrives
- Assisting the team
- Protecting other people in the environment, including relatives and friends
- Understanding the processes involved in advanced life support
- Pharmacology of the drugs used
- Care of the patient following successful resuscitation
- Care of the family/friends following resuscitation
- Ethical issues relating to resuscitation, including informed consent, do-not-resuscitate policies, advanced directives (living wills) and so on
- Maintenance of equipment.

You may have thought of more aspects, but these serve to illustrate how many opportunities for learning can be identified from one incident. Whilst this may appear to be going into a lot of detail, it is important to remember that learning is about in-depth understanding of a topic in order for a student to become a safe and competent practitioner. Trying to cover all of these aspects in one learning activity is unlikely to result in the depth of learning that you want to achieve.

The reason I have identified these aspects for a beginning student is that they all relate to basic knowledge and information that a student might be expected to have acquired during his first year's experience (except maybe the pharmacology). They do not involve the more advanced attributes that you might expect of a third year student, such as decision-making, being involved in the process of resuscitation itself, taking responsibility, record-keeping, administering drugs or patient education and health promotion.

Answers to the third question in Activity 3.3 will be considered in the next section.

The mentor's task here is to be identifying for themselves the learning opportunities that arise from an incident and ensuring that the focus of activity for the student is appropriate and relevant to their needs. Your role is to guide the student in making the most of the experiences available in terms of what they may need to learn. As the experienced practitioner, you have greater understanding of the whole complexity of the experience, and can help the student to break it down into manageable chunks that can be rebuilt into the whole once initial understanding is achieved. One way of iden-

tifying the aspect of an experience to focus on is to use the Significance Outcome Describability Action (SODA) process (Jasper, 2006) shown in Table 3.1. This asks you to consider: the significance of the experience; the outcome in terms of learning and development; the describability of the experience in terms of its cohesiveness; and the action that might result from having explored it.

Once you have identified the objectives to be achieved and the potential learning that might arise from exploring an experience, you can move onto to the reflective part of the process.

ACTIVITY 3.4 IDENTIFYING LEARNING EXPERIENCES IN YOUR PRACTICE ENVIRONMENT

You may like to follow up on the previous activity by reflecting on your own practice environment and making a list of:

- The experiences that may be available to students
- The aspects that these experiences can be broken down into
- What you would expect from students at different stages in their programme
- The outcomes that may be achieved as a result. ■

Practitioners are often introduced to the processes of reflection through the use of a model or framework that provides a guided structure for exploring an experience (e.g. Bulman and Schutz, 2004; Johns, 2004; Rolfe, Freshwater and Jasper, 2001; Gibbs, 1988; Kolb, 1984). These provide a useful way of exploring an experience from a particular viewpoint and are excellent in providing questions that draw the reflector down a certain pathway. However, caution must be observed in trying to use just one framework for all reflective purposes – this would be like prescribing the same painkiller for every type of pain. Models and frameworks need to be selected on the basis of what outcome you want to achieve (for a more in-depth discussion see Jasper (2006)).

As a mentor, there is no reason why you should not design your own reflective activities for students, guided by what you want to achieve as outcomes. Look again at your answers to Activity 3.3 for the scope you have in directing a student's reflective activity.

TABLE 3.1

Selecting Experiences for the Focus of Reflection Using SODA (Adapted from Jasper, 2006, pp. 54–55)

Criteria	Features	Examples	Questions to ask
Significance	It must stand out in some way	First experience; unusual occurrence; emotional response; rare opportunity Relates to a specific learning outcome or competence	Why is it significant? Why does it stand out? What is important about it?
Outcome	It needs to provide a developmental opportunity	Increased understanding; identifies a knowledge deficit or need; results in new knowledge; develops insight	What do you/your student want to achieve? What might you learn to influence your practice? What might you learn about yourself?
Describability	It must be sufficiently complete in itself for you to be able to describe it	Identifiable boundaries; remember sufficient detail; awareness of consequences of exploring this issue/ incident; ethical issues	How can you describe it? What are its boundaries? What may be the consequences of exploring it for you/others? What are the ethical/ professional issues involved?
Action	It needs to result in some action being taken	Getting more knowledge/ information; developing a new skill; changing your practice; seeking further help	What action might need to be taken? Who else can help? What resources do I need?

LEARNING

As a mentor you could use different strategies for each one of these aspects. Some, such as ensuring your student has a good grasp of anatomy and physiology, can come from a simple question and answer technique. Others might involve information gathering, such as the student finding out policies and procedures and reporting back to you or searching out evidence to inform their practice. Many of these aspects will be learnt from observing the actions of others, and role modelling, where learning strategies will involve discussing courses of action, developing communication skills and dealing with other people in an empathetic and caring way. Your mentoring role involves establishing different ways of exploring issues to enable learning to take place. It also involves developing an understanding of your student and their preferred learning styles (see Chapter 6) in order to tap into strategies that are most likely to facilitate their learning.

What you will also need to determine, from the outset, is what evidence you can rely on that will demonstrate that the student has learnt and understood from the incident and that this learning is now embedded within their knowledge base. It is not sufficient to simply expose a student to an experience, knowledge or skill – you need to be reassured that this has resulted in understanding, development and change. This is especially important if you are responsible for signing off your student as competent, as you will be accountable for your judgement and decisions relating to them. There are various ways that you might do this in relation to the example developed in Activity 3.3.

ACTIVITY 3.5 DEVISING TEACHING, LEARNING AND ASSESSMENT STRATEGIES

Using the list that you drew up from Activity 3.4 (or the one that I wrote following Activity 3.3) construct a table that shows what teaching and learning strategy you could use for each one. Then, in another column, identify how you could tell that the student has learnt it so that you have the confidence in them.

For example:

- Anatomy and physiology of the heart – read textbook and complete worksheet – short pen and paper quiz.
- Care of the family – reflective discussion with mentor following the event – reflective review in student's portfolio and observation of the student's communication skills and interaction with relatives. ■

The skill of the mentor at this stage is to be able to vary teaching and learning strategies and assessment methods so that they are not only appropriate for the outcome desired, but also interesting and multifocused for the student. The reflective activity at the beginning of this chapter was designed to help you identify your self-perceived strengths and weaknesses as a mentor. If you return to these now, you should be able to identify:

1. activities that you have confidence in using and can build upon with your students;
2. activities that can act as staff development for you in becoming more confident in a range of techniques and strategies for the future;
3. your own learning needs as a mentor.

Whilst these are focused on you as a mentor, at the end of each reflective activity with a student you should be able to devise a similar list that outlines the action that is needed. This brings us to the third corner of the ERA triangle and moves us into the process of translating learning into action and application to practice.

APPLICATION TO PRACTICE

Probably the most effective way of embedding and reinforcing learning in the practice setting is for the student to have to apply it immediately. Therefore, if students can practise new skills and techniques, firstly under supervision and later by themselves once you are assured of their competence, they are more likely to retain the information as part of their knowledge base for future practice. The mentor's role now extends to providing opportunities for revision and practice to ensure that the new learning is part of the student's repertoire for practice.

The transference of knowledge from one sphere of learning to another is extremely complex. We can all remember practitioners whose knowledge base is superb but could not translate this into effective, efficient and safe caring for patients. Similarly, there are many practitioners who avoid 'book work' and prefer instead to learn 'on the job'. Of course, there is no right and wrong way of approaching learning, but we need to remember that all professional practitioners today are educated within higher education institutions and need to demonstrate both the ability to deal with complex theory and to practice safely and competently. They need to achieve a minimum competence in knowledge skills, such as understanding theory, sourcing and evaluating evidence, making decisions and being able to write convincingly at the appropriate academic level for their qualification before they can be admitted to the professional register. Equally important

is their ability to underpin their practice by applying their academic work to professional practice. It is here that the mentor plays an important role in assessing competence (see Tim Clark's chapter relating to aspects of competence – Chapter 9) and providing a range of learning opportunities that can enable the student to practise and test out their new skills in safety.

Often, these learning opportunities are to be found outside the immediate practice area in which you work. The mentor is not expected to provide all the learning that a student requires – rather, they are asked to organize, arrange and facilitate the learning experience to ensure that all outcomes are achieved. Sometimes, other professional practitioners will be able to provide learning experiences to broaden the base of the student's practice context. In addition, these other practitioners can help you in assessing the student's achievements and competence.

ACTIVITY 3.6 IDENTIFYING RESOURCES IN THE PRACTICE ARENA

In Activity 3.4 I asked you to identify the range of previous experiences available in your own practice environment. Take a look at these again and consider whether:

- You need to provide these yourself
- They could be provided in different practice environments
- They could be provided by other members of the interprofessional team
- What added value would result from broadening the student's experience in this way. ■

MAXIMIZING YOUR OWN OPPORTUNITIES FOR DEVELOPMENT

Being reflective is a complex activity which involves commitment and deliberation if it is to bring results in terms of learning, changing practice and personal and professional development. There is a complicated interplay between the present, the past and a predicted future, which is constantly subject to adjustment and reconfiguration as new

information is added into the equation. This chapter has concentrated on reflective activity of the mentor in an attempt to maximize learning opportunities for the student. However, reflection clearly has applications beyond the relationship between yourself and your learners, for instance in planning and fulfilling your own development.

Both your employer and the Nursing and Midwifery Council (NMC) are likely to want to see evidence of your competence in your professional roles. The NMC, at a minimum, asks for a signed notification from you, triennially, to confirm that you meet the Post-Registration Education and Practice (PREP) students and continuing professional development standards (NMC, 2004). Additionally, you will need to demonstrate, if asked, how you meet the *Standards to Support Learning in Practice* (NMC, 2006). The NMC requires every registered practitioner to maintain a professional profile which documents how you achieve these standards. Similarly, your employer will have an appraisal system, and as part of this you may be required to produce your professional portfolio as evidence of your continuing competence in your roles. The introduction of the knowledge and skills framework within the *Agenda for Change* emphasizes the need for practitioners to be working towards evidencing skills acquisition within their role.

Reflective activity can play a large part within your portfolio, as this helps to show how you are making the links between knowledge and practice, and how you are using new knowledge to inform your practice. Conversely, reflective writing can also show how you are picking up on experiences within your practice and developing these further by exploring them. I cover strategies for portfolio use within professional development in more detail in *Professional Development, Reflection and Decision-making* (Jasper, 2006).

Similarly, other forms of reflection can help you in your role as a mentor. For instance, verbal dialogue with your colleagues in relation to your mentoring experiences can help to share strategies for learning and enable you to work through problems and challenges from an informed perspective. This can become formalized through clinical supervision sessions or groups where reflective activity is used to stimulate discussions, or in action learning sets where experiences are used as the focus for developmental work.

CHAPTER SUMMARY

Successful mentoring occurs when the mentor and student can work together within a positive relationship to plan and achieve learning outcomes. Part of this success comes from the flexibility that arises when a mentor uses reflection as a way of thinking through the issues and challenges and developing unique solutions for the particular student they are working with at the time. Effective practice learning results when the specific learning needs of the individual student are diagnosed and plans devised to meet those needs.

Whilst it is important that all students entering the professional register achieve the basic standards as competent, the ways in which they learn in practice are individualized and depend to a large extent on unique student characteristics. The reflective mentor will work together in partnership with each student to ensure that the strategies and experiences selected maximize the student's potential to achieve their outcomes.

However, reflection has a greater part to play for the mentor than only enabling them to help others learn. Reflection is a tool for professional development for the mentor themselves, and can be utilized in a variety of ways to ensure that their own development and learning is part of their ongoing practice.

REFERENCES

Bolton, G. (2005) *Reflective Practice – Writing And Professional Development*, 2nd edn, Sage, London.

Bulman, C. and Schutz, S. (eds) (2004) *Reflective Practice in Nursing*, 3rd edn, Blackwell Publishing, Oxford.

Gibbs, G. (1988) *Learning by Doing. A Guide to Teaching and Learning Methods*, Further Education Unit, Oxford Polytechnic, Oxford.

Jasper, M. (2003) *Beginning Reflective Practice*, Nelson Thornes, Cheltenham.

Jasper, M. (2006) *Professional Development, Reflection and Decision-Making*, Blackwell Publishing, Oxford.

Johns, C. (2004) *Becoming a Reflective Practitioner*, 2nd edn, Blackwell Publishing, Oxford.

Kolb, D. (1984) *Experiential Learning as the Science of Learning and Development*, Prentice Hall, Englewood Cliffs NJ.

Nursing and Midwifery Council (2004) *The PREP Handbook*, NMC, London.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, NMC, London.

Rolfe, G., Freshwater, D. and Jasper, M. (2001) *Critical Reflection for Nursing and the Helping Professions – A User's Guide*, Palgrave, Basingstoke.

CHAPTER 4
HELPING PEOPLE LEARN

Stevie Penfold
Canterbury Christ Church University

LEARNING OUTCOMES

By the end of this chapter readers will have:

- **An overview of theoretical perspectives and their influence on learning**
- **A structure to enable learners to develop personally and professionally**
- **Considered how to develop and build on clinical skills, with a view to developing critical thinking and depth of knowledge with learners.**

INTRODUCTION

As has been seen in the previous chapter, the needs of learners are very diverse and consequently the mentor must devise different strategies to enable learning. This presupposes that mentors have the tools to encourage this, so the purpose of this chapter is to provide an insight into how learning takes place, and to provide a structure to assist learners in their development within a practice setting. In addition, the context in which educational theory is applied will consider **situated practice** and the progression of the learner. Teaching methods will include support of the novice learner, who may initially require **scaffolding**. Mentors themselves may draw on **concept** formation and the sociological influences on learner development, to further enrich their role.

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

EVERYDAY TEACHING AND LEARNING

Health professionals are expected to support their practice by having a base of evidence or research, to inform their actions. It seems, then, that fundamental to the teaching of students, knowledge of theories of teaching and learning will provide a similar base on which to draw when organizing teaching. Yet there should be caution against placing too great an emphasis on theoretical approaches as there will be no one theory which is a 'fit all' for learning (Woolfolk, 1998). In fact, practitioner mentors have to ensure that learning occurs experientially in the workplace as the professional bodies require practitioners who are 'competent and capable of safe and effective practice' (NMC, 2006). Therefore, it is clear that those who sign off learners as **fit for practice** and who achieve professional registration as a result, are accountable for their decisions.

Previously, the focus of traditional definitions of teaching was to transfer knowledge. This was mainly teacher-led, with the activities planned for students generally guided by the teacher, who was the expert, although there was some interdependence where questioning occurred (Myles, 1987). Learning was assumed when a change occurred in behaviour. The stimulus–response theory shaped curriculum design when educational application was centred around the achievement of learning objectives measured by observable changes in behaviour (Quinn, 2000). However learning can also be recognized when a change occurs in the knowledge, skills and attitude of an individual, due to perceptual alterations as a result of sensory and intellectual experience. This can be due to personal development or directed by a teacher.

Teaching may be seen as the provision of specific, theoretical and practical information via direct or indirect means, which enables learning to take place. Direct teaching involves selected material being given to the student as a presentation, advance organizer or cued learning. Indirect teaching occurs by facilitating the reorganization of knowledge, skills and attitude, by exposure to problem solving and practical immersion in a **practicum**.

ACTIVITY 4.1 TYPES OF TEACHING ACTIVITIES

In the past, you will have attended courses or been taught in practice. Think back on the teachers who taught you. Identify some of the methods that were used. Which of these were successful and why was this? Also, were there any teaching methods you did *not* find useful? ■

Your list may include formal lectures, seminar activities, workshops or demonstrations of new clinical skills. Following completion of the exercise, you will have a clearer idea of some of the successes experienced in the past and also an insight into the kind of teaching you found useful and what was not very helpful. We tend to have preferred ways that we like to learn and these are discussed more fully in Chapter 6.

A further definition of teaching sees the aim as primarily 'to make the student learn' (Ramsden, 1992, p. 5). Traditionally, teaching and learning were seen as interdependent activities with the student under the guidance of an 'expert', where knowledge was imparted in a prescriptive manner (Myles, 1987). But now it is recognized that putting a student in the frame for learning, by using a 'system of activities', devised to promote learning, may also include the deliberate creation and control of those conditions within which learning occurs (Curzon, 1997, p. 18). It is the involvement of students in constructing their own learning that facilitates their development. There is a distinct difference between teaching and learning. On the one hand, teaching means to 'instruct', 'to impart knowledge or skill', a role Carl Rogers (1983) found was 'a vastly over-rated activity', and as a result preferred the teacher to adopt the role of facilitator of learning (Knowles, Holton and Swanson, 2005, p. 84).

A facilitator of learning provides the support for a student to learn by certain attitudinal qualities. A facilitator tries to form a non-judgemental relationship, which seeks to understand the level of the student, respects the individual's differences and uses open communication, based on trust and acceptance. This sets the scene to provide a basis for the mentoring role. Facilitation is a core role of a mentor. So knowing about a number of theories to broaden understanding of how learning can occur will encourage mentors to apply these theories, and therefore enhance specific learning opportunities. The challenge the facilitator faces today is to recognize opportunities for learning and to have the ability to manipulate the learning environment so that the student can achieve the expected competencies.

In addition many client groups are more acutely ill with convalescence taking place at home, supported by community health professionals. More importantly, the patient is no longer a passive recipient of care, but is more educated and involved both in decision making and in the management of their care. What has *not* changed is that the patient still remains the focus of care, and so the central theme of any practitioner's development must be the consequences of care delivery being beneficial to the patient's well being.

BEHAVIOURIST THEORY

When thinking about the way learning takes place, one way is to become *involved, to do, or acquire a skill*. This lends itself to **behaviourism**, a theory that recognizes that

learning has taken place by a change in behaviour. However, no evidence of mental or cognitive ability is required. Most behaviourist studies relied on research with animals, which was then applied to humans. Pavlov's experiments with dogs in 1927 is well known; it involved using a stimulus–response reflex, such as a normal response to food (salivation) and linking this to introduced stimuli, which then initiated a response without the original stimulus being used. This is termed **classical conditioning**. The most important principle to arise from this was that a stimulus created a response. Other stimuli were based on the animal learning of connections between actions, which then led to a reward or **reinforcer**, therefore making it more likely that the action would be repeated, and possibly more quickly (Skinner, 1938; Thorndike, 1913). To put this into a learning context, students will have practice leaning outcomes identified by the university for the stage of the course they are undertaking. Successful repetition and achievement of the learning acts as a reward (Bigge and Shermis, 1999) and it is hoped the behaviour will then be repeated in the future (Thorndike's law of exercise).

Some examples of classical conditioning are seen in people who are treated for phobias by being gradually introduced to their fears and anxieties under safe conditions. The person is exposed to their fears until their anxiety decreases (Ormrod, 1999; Quinn, 2000). As emotional responses to particular situations can be learned, a mentor may see conditioned behaviour in the student reluctant to take on new and complex tasks because they are nervous of failure, particularly if there has been a previous failure. Conditioned responses are also seen in students who associate a particular environment, situation or person with humiliation or frustration, thus causing them anxiety. This in turn affects their capacity for learning. This is supported by several authors who previously identified how important a supportive environment is to stimulate learning (Fretwell, 1980; Orton, 1981; Ogier, 1989). It is recognized today that learning is influenced by being a participant within a community, becoming part of that community and developing the knowledge and skills of that community (Murphy, 1999).

Conditioned behaviours can be used in a positive and effective way to encourage the formation of new habits that are critical for patient/client safety. As a mentor you will be aware of certain practices that are very important. One such practice is hand washing as a preventative measure to stop the transference of infections when caring for clients. Therefore there is a need to develop appropriate, habitual practices. One way is to link one activity to another, for example touch patient–clean hands. Another example is resuscitation. Resuscitation is taught using a behaviourist approach. Specific actions, which should be carried out speedily and effectively, will entail practicing sequences or patterns to accomplish specific outcomes. The practitioner benefits from feedback to help 'shape' their performance.

ACTIVITY 4.2 USING A BEHAVIOURIST APPROACH

Consider how you would use a behaviourist approach in your area of practice. What skills would lend themselves to following set patterns? Are there any disadvantages to this method? ■

A mentor will probably see changes in behaviour reflected in students as they begin to develop their skills. Perhaps Activity 4.2 has identified certain actions that a professional is expected to learn and the outcome will be seen as changes in a skill or attitude. It will be a mentor's role to oversee and assess developing competence, to enable learners to perform actions effectively and efficiently. However, there will be instances when feedback on poor or inappropriate performance is necessary to develop self awareness in the learner and this is a skill which a mentor will need to develop (Quinn, 2000).

An important factor necessary for progress is the giving of feedback. Giving praise if an action is correct and identifying areas for improvement when necessary are important for learning to develop. However, it is also important to be aware of, and sensitive to, the learner's needs. Giving feedback on a learner's performance should always be done in an empathetic and constructive manner. Do not be tempted to focus on the negative side only, but include positive feedback as well.

The most effective way to give critical feedback is to use the **sandwich method** (Hinchliff, 1999). Start by focusing on the learner's positive points; for example 'you assessed the wound very well and prepared the patient well'. Follow this by identifying an area in which you think the learner can improve. This can be in knowledge, skill or attitude – 'I do think however, that you could have taken off the dressing more carefully by easing off the edges, and you could have explained what you were doing to the patient, as it seemed as if you were concentrating on the wound. Although some good points were that you made her comfortable when you had finished and were able to answer her questions confidently.' This finishes on a positive note, but the message for **formative feedback** is clearly given (Hinchliff, 1999).

Points to consider when giving feedback are:

- Having a sense of humour and giving minimal criticism whilst maximizing the student's own evaluation of performance is important (Hinchliff, 1999).
- Be honest.

- Be constructive, never destructive, as the whole point of constructive criticism is to enable the learner to improve.
- Remain calm and try to be objective when giving the feedback. Try not to become angry, aggressive or defensive.
- Terms that are objective should reflect the action of the person rather than the person themselves. When speaking to your learner, describe the behaviour they need to change and your reaction to it. 'When you interrupted me just now I felt really angry. You must not interrupt when I am in the middle of a conversation with relatives.'
- Allow time for the learner to digest the information and time to clarify and discuss any points that are unclear. This is important. It is often an area neglected by the mentor when they are perhaps busy, or even embarrassed by an uncomfortable situation.
- Learners are often all too aware that they are not achieving. Be prepared for the learner having high anxiety levels, which in turn can affect future performance. If this occurs, set some small achievable goals that can help with restoring confidence and motivation.
- Feedback is most effective when it gives guidance, not only on what learners have not done but also how they can improve their performance.
- Many students have internal reinforcers; for example the pleasure of mastering a skill or the feeling of success in completing a task. Motivation is influenced by reinforcement.
- Finally, the most important point to remember is that consistent, positive feedback can only be effective if the learner sees the value in the learning being undertaken. It should always be given immediately or as soon as possible after the event. But it also is important to remember that what is reinforcement for one may not be appropriate for another.

ACTIVITY 4.3 SHAPING BEHAVIOUR

How would you use positive or negative reinforcement if you wanted to shape behaviour in a particular student?

Is there any difference in guiding a first year learner, or a third year learner? Would your teaching be more direct when supporting a learner in the first year rather than in the third year? ■

Activity 4.3 highlights that it is important when giving feedback to different levels of learner that the stage of the course and of their personal development is considered. Initially, skills learning may be a priority for a first year student within a practicum and it may be at a superficial level. Similar to behaviourism, it may be a passive process because the learner responds to a stimulus in order to act, rather than thinking through or planning a response to a situation. As the learner develops in experience, however, it is necessary to question the knowledge and understanding of their actions and the consequences and outcomes of certain responses.

However, another feature of behaviourism is that some behaviour is learned through watching others, particularly when learning complex skills.

SOCIAL LEARNING THEORY

Bandura (1986) proposed that when people are born they have no behaviour patterns and therefore most behaviour is learned from observing others and modelling on them accordingly. **Social Learning Theory** involves interaction between a role model and a learner and the environment. This guided participation in learning takes place by observing many different models, and is useful when applied in any health-care setting, to develop professional skills and attitudes. Vygotsky saw it as essential for learning the language of a culture (Rogoff, 1999).

However, there must be four conditions present if this is to be a successful method of learning:

1. attention
2. retention
3. motor reproduction
4. motivation.

ATTENTION

Frequently the relationship between mentor and learner is based on the degree of interpersonal attraction between them. The relationship between them is developed by the frequency of contact and the degree of interest the mentor takes in helping the learner to process information. In addition, in order to replicate an action correctly, the learner must focus attention on what is to be learned. As a result, focus may need to be provided in a health-care environment where there are many distractions that compete for

the student's attention. Therefore the role of mentor would be to direct the student's learning. This should be done by being approachable and critically analysing actions, procedures and nursing actions. Giving the rationale for actions rather than describing what is being done will promote understanding more effectively.

RETENTION

Observational learning must be reinforced by rehearsal and repeated exposure to the experience for the person to retain this in their long-term memory. The mentor may also need to provide the theory–practice links by questioning to develop understanding. Other ways to help a student may be to provide visual clues or codes to remember theory (Ormrod, 1999); 'Ride Your Green Bike' is an example used to remember how to place ECG leads. Colour coding for equipment or writing in charts using colours for record keeping are other examples.

ACTIVITY 4.4 MAKING LINKS WITH THEORY AND PRACTICE

Give an example of a theory or practice issue that may require you to provide the links for your student.

An example could be that of linking early mobilization following a birth, or operation, and the prevention of deep vein thrombosis or pulmonary embolism. ■

MOTOR REPRODUCTION

The person must have the ability and dexterity to carry out the actions that have been observed. The ability of a learner will increase with practice and they should be able to evaluate their performance in terms of accuracy and speed. Feedback from the mentor, informing the learner of progress, should be linked to their level of performance. Above all, for performance to improve, it is essential to have the opportunity to practice skills. Therefore guided practice, or scaffolding, can be provided by a skilled practitioner who works with the student, simplifying tasks by breaking them down into smaller, more manageable and understandable components. Thus, practice takes place under supervision (Wood, Bruner and Ross, 1976). For a learner it is a useful method to learn simple components of practice, particularly for those at a novice stage in learning. This could

apply to managing simple dressings, then leading on to more complex practice such as managing a sinus wound, perhaps in a more critical environment (Bahn, 2001). Once a learner is seen to become adept and competent, the scaffolding can be withdrawn (Vygotsky, 1987). A criticism of working with a practitioner, who is responsible for the learner, is the assumption that the practitioner is competent and safe in their practice. The NMC has addressed this in their guidelines for supporting learners in practice (NMC, 2000). Mentors are required to update their knowledge and skills as a part of their role development.

MOTIVATION

Lastly, the behaviour to be learned can only occur if the learner can see the value of what they are learning and its relevance to their development. The mentor can relate the learning to the assessment that the student must aspire to achieve by the end of the placement. For this to occur, three aspects of motivation need to be involved:

1. External, arising from some positive feedback that the action is valued, for example praise by the mentor for teamwork which has been effective.
2. Internal, where the person benefits by the action, thus contributing to a sense of pride and achievement, giving more responsibility to the student as they become more competent.
3. The student sees another receiving praise or negative feedback and learns vicariously by working with others that certain actions stimulate a response.

ACTIVITY 4.5 ROLE MODELLING

How and when would you use role modelling to develop your learner's clinical skills? ■

COGNITIVE APPROACHES TO HELPING LEARNERS

A professional health-care worker has specific standards to uphold. Teaching a skill is not sufficient in itself as simple acquisition of a skill needs to be transformed into under-

standing of the stages, sequencing and consequences of a learner's actions. From this arises a need to consider theories involving thinking and problem solving.

Cognitive theories are the oldest approaches to learning, first recorded as being used by the Greek philosophers Aristotle, Plato and Socrates (Hernshaw, 1987). Their views acknowledged the importance of acquisition of knowledge to structure a society and the acquisition of skills to perform roles in that society competently. Discussion using reasoning on values and moral issues, led to the development of knowledge. This is not so different to the knowledge required by mentors today. Practice in health- and social-care environments is evolving rapidly and consequently the responsiveness to change is another element for practitioners to consider.

Gestalt theorists considered how perception affects the process of learning and assumes that learning takes place by visualizing the world as a whole, in patterns or *Gestalten*, and not in fragments or pieces (Ormrod, 1999). **Gestalt theory** advises that knowledge should be grouped into elements that encourage proximity, similarity, closure and *pragnanz*.

To put this into context in a health-care situation:

Law of Proximity: Items or stimuli that are close together tend to be formed into patterns, and this can be a useful method to develop insight into practice placements when learners need to experience the difference between different disciplines.

Law of Similarity: similar items or stimuli are grouped together in one's perception. A practical application would be in learning about specific disease processes and the responses to their treatment or care.

Law of Closure: In a health-care context, pieces of information are gained over a period of time and finally, the last piece of information provides the under-standing or insight into a particular problem. This may arise when students are prepared in the classroom where their skill, knowledge and understanding may be limited, but once in practice they are able to relate the theory and understand the relationships.

Finally, **Law of *Pragnanz***: the pattern must be practical and must make sense. Memory depends on the re-alignment of information by mentally restructuring pieces of information to make a whole, which is understood and thus retained in the memory (Ormrod, 1999). However, it may be necessary for a mentor to provide the means for the student to understand and make relationships between separate facts. The Gestalt approach to learning sees perception as a critical link between what is stored in memory and the present stimulus. To put this into context for health and social work professionals, patterns need to be established for their students to learn. These can be created by beginning with what the learner already knows. A concept map which links several like areas could be designed for each practicum.

Bruner, Goodrow and Austin (1956) found that to develop understanding of a concept, certain attributes of the concept, or characteristics relating to it needed

to be linked together to make the concept understood in its totality. Using **concept maps**, and **schemata**, will enable teaching of simple to more complex areas, which are related (Quinn, 2000). See Appendix 4.A for a suggested concept map on respiration.

Quinn suggests that a concept is:

a relatively abstract representation of objects, episodes, actions or situations which contains slots or variables into which specific instances can be fitted in a particular context

Quinn, 2000, p. 79

Concept maps are a method of providing a Gestalt or overview of certain speciality topics. Taking the concept map of breathing as a model, the topic is divided under several headings. The learner identifies an area of practice that needs developing and the mentor has the means to base their teaching on a specific aspect. Teaching should always start from the known to the unknown, linking each step with the one before, grouping together facts and aspects which have natural relationships or connections, employing subcategories which link with the main ideas. The map, however, must also show the relationships between the parts and the whole. The Activities of Living (Newton, 1991) lend themselves to deconstructing certain elements of practice, involving theory, skill and attitude. Students may be assisted when working at a novice level, but should be able later to both understand and discriminate using reasoning to make new links between old materials and new. The concept map can provide the language of the speciality. This may need interpretation by the mentor initially. Choice of learning activity can be agreed between mentor and student. Using learning contracts will enable evaluation of any learning that has resulted.

Interpretation of data will be the next stage of development. Again the mentor will engage with the student in a practice situation to link theory with practice. Understanding how categories emerge, how data reflects deterioration or improvement in a patient's illness, will develop during constant exposure and practice. Finally, the ability to make inferences and predictions as a result of data and the actions required, will lead to applications of the principles, which Taba (1966) suggests arises as ability expands.

Piaget (1926) identified learning as part of a natural process of maturation. Learning is dependent on the cognitive and biological maturation of an individual. As the individual matures, perception and understanding develop as experience and knowledge are gained. Learners develop through a continuum using simple concrete thought leading to more abstract principles. However, at every level the individual strives to construct his own knowledge. Earlier in this chapter, it has been discussed that this process can be accelerated by the mentor providing scaffolded instruction, a method by which the

mentor provides assistance for both the skill to be learned and the rationale behind its application (Vygotsky, 1987, cited in Woolfolk, 1998, p. 47).

CONSTRUCTING LEARNING

The mentor can be the facilitator for developing learning in many different situations. So it is not only the individual who processes their perspective of new information, but as the mentor is involved, it becomes a collaborative or shared approach to construct new knowledge. Theorists refer to this as **constructivism**, which is not one theory but a combination of the research by Vygotsky, Piaget (1980), Bruner (1960) and Ausubel (1963), (Woolfolk, 1998). Vygotsky (1987) views shared or social construction of knowledge as collaborative *development*, where the learner is in an interactive role, being guided by others. Knowledge is constructed by the student being exposed to the language and culture, and by exploring the individual's beliefs and experiences within that culture. Here coaching, role modelling, guided discovery and exposure to a specific environment may be used to develop learning. However, environment is a broad, neutral term according to Benner and Wrubel (1989). Far better to refer to learning being 'situated', which has connotations of a situation having a past, present and future, all of which can influence an individual.

Some interpret the idea of **situated learning** as meaning that our thoughts and actions are located in space and time (Lave and Wenger, 1999). But, 'situated' could be interpreted as people being dependent for meaning on the social structure within which they are working. A simple definition is that situated learning is 'enculturalation' or adopting the norms, behaviours, skills, beliefs and language of a particular area (Woolfolk, 1998, p. 280). The use of language, in particular, is seen as vital for building and processing information (Vygotsky, 1987). Both Vygotsky and Piaget agree that learning develops through shared language. Language delivers the knowledge of the speciality. Within complex organizations, such as hospitals, each department will have its own culture, norms and language. Mentors can act as translators to help learners understand, make sense of and integrate into this new environment. An example would be a specialized clinical area, which has medical abbreviations in common usage, such as an intensive care unit or a radiography department.

Constructivist thinking stresses the importance of knowledge being context-bound (Knowles, Holton and Swanson, 2005), but it is also a process wherein the learner *expands* and *deepens* knowledge (Joyce and Weil, 1996). Savery and Duffy (1996) suggest anchoring learning to a larger problem and giving the learner the responsibility and ownership to develop a process to learn. However, they also emphasize that there should be the opportunity to reflect on the learning with a practitioner to establish what has been learned (cited in Knowles, Holton and Swanson, 2005).

APPLICATION OF KNOWLEDGE FOR PRACTICE

Organizing information for better understanding and retrieval is dependent on the knowledge of a particular discipline. 'Knowing that' or **declarative knowledge** is based on knowing rules, regulations, mathematical calculations, formulae or abbreviations, all of which can be learned from books, papers or verbally from colleagues. Often it is the knowledge required for the working of a discipline.

However, 'knowing how', or **procedural knowledge**, is having the ability to carry out skills necessary for that domain of practice. An example of procedural knowledge is being able to translate the needs of a client into actions that meet the needs of the client, and requires intellectual or problem solving skills (Gagne, 1985).

As a mentor, declarative and procedural knowledge is useful to guide the novice student. Safety aspects of care and treatment can be contained within guidelines issued by professional bodies. A mentor therefore has a range of resources towards which they can guide the learner to make links between action and a rationale for that action. This form of knowledge may also change in new situations and is often domain specific, so what may be a norm for one discipline may not be for another.

Conditional knowledge is a combination of the two previous categories and uses cognitive strategies to apply these to situations (Box 4.1). This appears to be knowledge at a level of 'expert', whereas declarative and procedural knowledge are more concrete and therefore may be seen as more the level of a beginner or novice student. To develop conditional knowledge the learner needs experience, although by role modelling or by reflection-in-action, this skill can be developed more quickly (Woolfolk, 1998).

BOX 4.1 SCENARIO INCORPORATING THE THREE MODES OF KNOWLEDGE

Mary has just arrived on the medical ward to take over her patients for the shift. She notices that Bill, in the corner bed of the six-bedded bay, is breathing noisily. On closer examination she realizes that he is unconscious and makes the diagnosis that he is about to have a respiratory arrest, or other life-threatening event. Observations taken confirm this (declarative knowledge – domain specific). She calls for the support team and alerts other members of staff, who alert the relatives (conditional, procedural and declarative knowledge are all evident). She draws the curtains. The patient requires resuscitation (procedural knowledge). ■

Newly qualified, trained nurses, those who have recently moved into a new speciality and new nurses from other parts of the world, will need a period of time to settle in and establish knowledge of the norms and culture of the environment in which they are working before being able to synthesize the knowledge and skills in order to teach new students competently.

ACTIVITY 4.6 USING DIFFERENT TYPES OF KNOWLEDGE

Give examples from your practice of the three types of knowledge. How could you direct/support a student in learning each one?

In your role as mentor, think of these aspects of knowledge in relation to your own domain.

Write these down, reflecting how you can explain these to your student – giving examples from your practice. ■

PRACTICAL TIPS FOR TEACHING AND FACILITATING LEARNING

When planning to meet a learner's needs, it should be borne in mind that all practitioners have a distinct teaching role as well as one to facilitate learning. The NMC (2006) states that 'nurses must communicate effectively and share knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients' and a nurse has a duty to facilitate students of nursing, midwifery and health visiting and others to develop their competence. A proactive approach to teaching is one where structured activities are devised by a mentor so that learning occurs. Repetition of the activities and constant exposure to similar situations will enable both the development of insight and also competence in actions.

Many mentors are uncertain what to teach. There are three areas suggested by Hinchliff (1999, p. 138):

1. must know
2. should know
3. could know

and an additional category will be discussed

4. could know later

ACTIVITY 4.7 PRIORITIES FOR CLINICAL LEARNING

What skills and knowledge *must, should, could* a first year student develop in your clinical area? ■

MUST KNOW

This can be interpreted as those core things that are practice or domain specific, which Greaves (1989) recommended as the most important aspect within a speciality. For example what would you like all practitioners to learn about your ward, department or workplace? What do you do especially well? What is different about your speciality in relation to others? Is there anything special in this particular working environment that no other area in the hospital/community has? It would therefore be useful for you to specify learning outcomes for your workplace in relation to what a learner must know.

Example 1: The general medical ward has five side-rooms into which all patients with neutropenia are admitted. No other ward in the hospital will admit these patients as this is the designated ward. Therefore, all students, whether on placement for a day, a week or even for a month, must learn about neutropenia whilst on this ward. This may be done by: (i) reading the ward protocol for management of care; (ii) reading about neutropenia in articles or books, either in the ward or in the university library; and (iii) if there is a need to gain more experience in this type of nursing, to work with the patient, under supervision, to gain experience of how the patient feels.

Transferable skills are those for patients requiring isolation techniques. Consideration of the necessity for isolation, and the psychological and social issues arising as a result, can be raised as discussion.

Example 2: Safety precautions required to be implemented when working in a radiology department.

SHOULD KNOW

Mentors can use the documentation relating to a learner's progress on a course to plan their teaching. It usually pertains to skills and experiences they should achieve and relates to the stage of the course they are on. Normally, there are elements of **formative and summative statements**, which the students will need to have assessed and signed by mentors as proof of reaching a certain stage of efficiency.

Example: First year students should be able to take a blood pressure and know the normal range.

COULD KNOW

The learning here is the 'icing on the cake'. Students in a placement may have the opportunity to accompany a patient to theatre, sit in on a multidisciplinary meeting, to visit other hospital departments, to work alongside physiotherapists or other health practitioner – a very valid experience, but every student will not have the same opportunities. This learning is not critical for the student's development, but will enrich learning.

Example: A first year student could know the major treatments of hypertension.

COULD KNOW LATER

An additional category which can be added is that of could know later. This would relate to the enthusiastic student who wants to learn everything and be exposed to advanced skills on their first placement. It may be appropriate to wait for in depth exposure until the student has more theory, experience and coping skills.

Example: A first year student could know later about fourth heart sounds.

CHAPTER SUMMARY

The perspectives that have been examined in this chapter have been of those cognitive theorists who are associated with Gestalt, particularly Bruner's concept of cognitive maps, and some of the strategies that may be useful for mentors to involve when teaching students. Increasingly, it becomes evident that whilst behavioural theories are still reflected in some skills development it is very difficult to separate out behaviour without the application of some element of cognitive activity. Adults as learners are more likely to engage in meaningful learning and the kind of assistance that can be provided by mentors in the way of scaffolded learning can provide guidance for the more complex learning activities that a health professional is expected to achieve. Mentors working with their learners can help to make sense of the world of health care in the practicum and learning can therefore be applied within specific contexts as situated learning. Theories of learning now focus on the interaction of the learner with the environment and the perspective of social constructivism can provide the focus for learning and development of a competent practitioner. Mentors who facilitate learning need to be clear what learners know, what they *should* know and what they *could* know. An idea of what they could know later allows for enthusiastic learners and can act as a further motivator.

REFERENCES

Ausubel, W.P. (1963) *The Psychology of Meaningful Verbal Learning*, Grune and Stratton, New York.

Bahn, D. (2001) Social learning theory: it's application in the context of nurse education. *Nurse Education Today*, **21**, 110–17.

Bandura, A. (1986) *Social Foundations of Thought and Action*, Prentice Hall, Englewood Cliffs NJ.

Benner, P. and Wrubel, J. (1989) *The Primacy of Caring*, Addison Wesley Publishing Company, California.

Bigge, M.L. and Shermis, S.S. (1999) *Learning Theories for Teachers*, 6th edn, Longman, New York.

Bruner, J. (1960) *The Process of Education*, Harvard University Press, Cambridge.

Bruner, J., Goodrow, J. and Austin, G. (1956) *A Study of Thinking*, John Wiley & Sons, Ltd, New York.

Curzon, L.B. (1997) *Teaching in Further Education: An Outline of Principles and Practices*, Cassell, London.

Dewey, J. (1963) *Experience and Education*. London: Collier Macmillan.

Fretwell, J.E. (1980) An enquiry into the ward learning environment. *Nursing Times*, **76** (26) (Occasional paper), 69–75.

Gagne, R.M. (1985) *The Conditions of Learning and Theory of Construction*, 4th edn, Holt, Rinehart and Winston, New York.

Greaves, F. (1989) *The Nursing Curriculum: Theory and Practice*, Chapman and Hall, London.

Hernshaw, L.S. (1987) *The Shaping of Modern Psychology: A Historical Introduction from Dawn to Present Day*, Routledge and Kegan Paul, London.

Hinchliff, S. (1999) *The Practitioner as Teacher*, Bailliere Tindall, Edinburgh.

Joyce, B. and Weil, M. (1996) *Models of Teaching*, Allyn and Bacon, Boston MA.

Knowles, M., Holton, E. and Swanson, R. (2005) *The Adult Learner*, 6th edn, Butterworth Heinemann, London.

Lave, J. and Wenger, E. (1999) Legitimate peripheral participation, in *Learners, Learning and Assessment* (ed. P. Murphy), Paul Chapman OU, London.

Murphy, P. (1999) *Learners, Learning and Assessment*, Paul Chapman OU, London.

Myles, A. (1987) The Curriculum in Nursery Education, in *The Curriculum in Nursing Education* (eds P. Allan and M. Jolley), Chapman and Hall, London.

Newton, C. (1991) *The Roper-Logan-Tierney Model in Action*, Macmillan, London.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers*, NMC, London.

Ogier, M.E. (1989) *Working and Learning: The learning Environment in Clinical Nursing*, Scutari, London.

Ormrod, J.E. (1999) *Human Learning*, 3rd edn, Prentice Hall, Englewood Cliffs NJ.

Orton, H.D. (1981) Ward learning climates and student nurse responses. *Nursing Times*, **77** (23) (Occasional paper), 65–8.

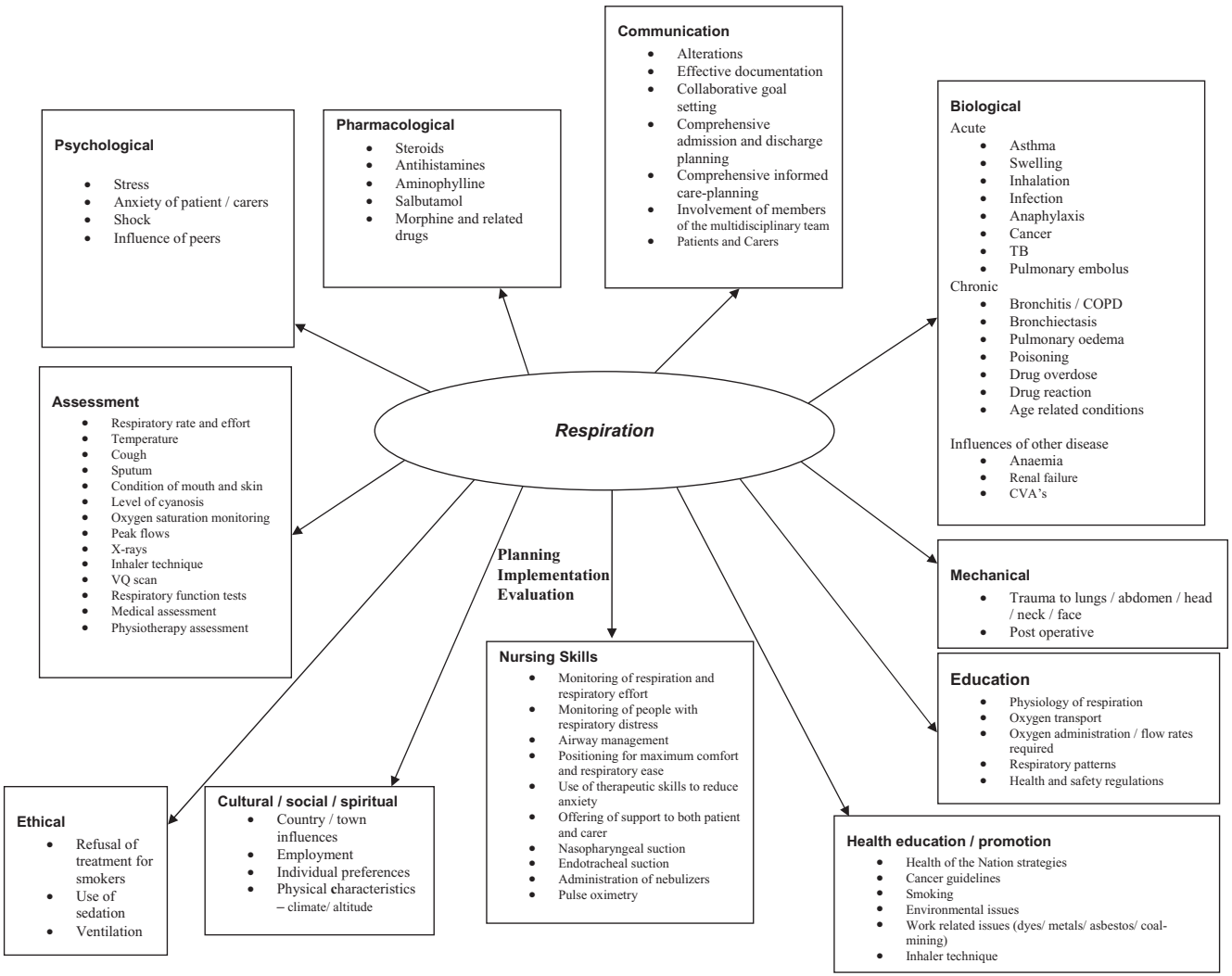
Piaget, J. (1971) *Science of Education and the Psychology of the Child*, Longman, New York.

Piaget, J. (1926) *Language and Thought of the Child*, Routledge and Kegan Paul, London.

Quinn, F. (2000) *Principles and Practice of Nurse Education*, 4th edn, Stanley Thornes, London.

Ramsden, P. (1992) *Learning to Teach in Higher Education*, Routledge, London.
Rogers, C. (1983) *Freedom to Learn for the 80s*, Charles Merrill Publishing Co., London.
Rogoff, B. (1999) Cognitive development through social interaction: Vygotsky and Piaget, in *Learners, Learning and Assessment* (ed. P. Murphy), Paul Chapman OU, London.
Savery, J.R. and Duffy, T.M. (1995) Problem Based Learning: An Instructional Model and Its Constructivist Framework. *Educational Technology*, **35** (5), 31–7.
Skinner, B.F. (1938) *The Behaviour of Organisms: An Experimental Analysis*. New Jersey: Prentice Hall.
Taba, H. (1966) Thinking Inductively, in *Models of Teaching*, 5th edn (eds B. Joyce and M. Weil), Allyn and Bacon, London.
Thorndike, E. (1913) *Educational Psychology: The Psychology of Learning*. New York: Teachers College Press.
Vygotsky, L.S. (1987) *Thought and Language*, MIT Press, Cambridge MA.
Wood, D. Bruner, J. and Ross, S. (1976) The role of tutoring in problem solving. *British Journal of Psychology*, **66**, 181–91.

APPENDIX 4.A A CONCEPT MAP ON RESPIRATION



CHAPTER 5
DEVELOPING EFFECTIVE LEARNING RELATIONSHIPS IN PRACTICE

Sheila Daykin
Canterbury Christ Church University

LEARNING OUTCOMES

Humanistic and adult learning theories of education emphasize the crucial contribution made by effective relationships between teachers and students to student learning. The interpersonal relationship that exists between teacher and student is seen as a significant variable affecting learning and a major influence on the prevailing climate in health- and social-care practice learning environments (Quinn, 2000).

This chapter will:

- **Examine learning relationships in the context of health- and social-care practice**
- **Explore aspects of the literature to identify what constitutes effective learning relationships between students and mentors**
- **Critically consider the development of effective learning relationships in the context of professional practice**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

This chapter will explore the development of effective learning relationships between prequalifying students and their mentors and supervisors, in the context of health- and social-care practice, and provide opportunities to consider how student–mentor relationships develop and are sustained in professional practice. It will focus on the attributes and qualities of mentors that have been identified as supporting effective relationships with students. This chapter proposes that it is impossible to consider student and mentor relationships in isolation from the practice environments in which the relationships develop and exist. This is on the basis that mentoring in health-care settings literally takes place 'on the job,' and, as such, means that a mentor's first priority is usually, and quite rightly, focused towards effective relationships with health- and social-care service users and their families, rather than students. This chapter will also consider ways in which mentors may engage with students effectively as part of their wider role as a nurse or midwife.

Throughout the chapter there are opportunities to undertake reflective activities. These activities are not intended to produce definitive responses. Their intention is to encourage mentors to think about issues and to discuss their views with other mentors and colleagues – there are no 'right' answers!

ACTIVITY 5.1 REFLECTION ON RELATIONSHIPS

Reflect on the teachers you have encountered throughout your life so far and the types of relationships you have had with these teachers. Jot down your responses to the following:

- What kind of relationships helped you to learn?
- What kind of relationships hindered your learning? ■

Health- and social-care practice learning environments can be both complex and challenging. This is not to say that classroom learning environments are bereft of both complexity and challenge. Nevertheless, classrooms don't usually require students and teachers to cease what they are doing and assist a patient to the WC, offer comfort to a distressed relative or answer the telephone. Classroom interruptions are more likely to be prompted by late arrivals or a false fire alarm, than a need to engage with a client and their family; variables that assist or hinder the learning process may, to a great extent, be controlled.

In sharp contrast, the potential distracting variables in practice are seemingly limitless. Nevertheless, practice environments offer a multitude of rich learning possibilities that can never be replicated in the most well-equipped classroom, skills laboratory or virtual learning environment. Practice learning environments can present challenges for students and mentors. The challenges may be grounded in the organizational context, the immediate working environment and team and also the individual student and mentor.

Health- and social-care environments are seemingly in a constant state of change, time-pressured and delivering increasingly complex services to informed service users and their families in a variety of contexts. Currently, some health- and social-care professionals are being redeployed or unemployed, as services are reconfigured, right-sized or cease to exist. In some areas, newly qualified practitioners are finding difficulty in securing employment or taking jobs that may not be their first choice in terms of speciality or geographical location. Staff numbers and budgets are decreasing in some areas, and workloads and performance expectations are increasing. The health- and social-care professions need to develop new skills and competency as their roles and responsibilities change, expand and extend. Government targets may sometimes compromise professional values and pose ethical dilemmas. Individual practitioners may be stressed and their morale low.

Alongside these challenges professional bodies have published standards and expectations that, quite appropriately, focus on the importance of effective mentoring and supervision of prequalifying students in health and social care (Nursing and Midwifery Council, 2006; Health Professions Council, 2005), not least to ensure that students develop as safe, competent practitioners.

ACTIVITY 5.2 THINK ABOUT YOUR OWN PRACTICE

Consider your own practice area and:

- List any specific, current issues in your own practice area that you feel may get in the way of developing effective relationships with students
- Share your list with two colleagues in your workplace and brainstorm ideas as to how you may resolve *one* issue on your list
- Turn the results of your brainstorm into an action plan and start to work to resolve the issue ➤

An example may help you with the above:

Jason has been a mentor for three years and recently three students have independently told him that they found the first few days of placement very stressful. When he explored this further with colleagues and other students he discovered that the first day of placement was the problem. Students were routinely told to arrive at 7.00 a.m. on their first day. The placement was usually very busy responding to immediate client needs until about 10.30 a.m. Although mentors were usually on duty, they had very little time to spend with the students who were frequently 'left hanging around and trying to look busy.' Mentors said they felt guilty because they had no time to show their mentee around or explain what they were doing. Subsequently Jason also had discussion with the university placement manager and other mentors in the unit and the following was agreed:

- All students must contact the unit prior to commencement of a placement and speak to their allocated mentor or associate mentor
- First day start times would then be negotiated to ensure that the mentor or associate mentor could be available to spend approximately one hour with the student during their first day
- The placements office would gain permission from students to provide the unit with student contact details prior to commencement of the placement ■

THE EFFECTIVE MENTOR

Despite the myriad of challenges presented by practice learning environments, the literature strongly suggests that an effective mentor has the potential to be a major factor in determining an effective or ineffective learning experience for students of health and social care.

It is important to note at this point that much of what has been written about the effectiveness or otherwise of the mentor–mentee relationship over the last 20 or more years tends towards the anecdotal and speculative rather than based on research findings (Higgins and McCarthy, 2005; Burns and Patterson, 2004; Fawcett, 2002; Ragins and Cotton, 1999; Gray and Smith, 2000; Stewart and Krueger, 1996; Vance, 1982). Dorsey and Baker (2004) identify that 'the science of mentoring is in its infancy.' This view is

echoed by Sambunjak, Straus and Marusic (2006) in their systematic review of mentoring in academic medicine, which they conclude by urging those responsible for training health professionals to engage in more detailed evaluation of all aspects of mentoring activity.

Much has been written about the attributes and role of the effective mentor. Darling (1984) identified three absolute requirements for successful mentoring: mutual attraction, mutual respect and subscription of time and energy to the task. These requirements are also echoed in more recent literature (Royal College of Nursing, 2005; Health Professions Council, 2005; Nursing and Midwifery Council, 2006). Darling (1984) also identified fourteen attributes students particularly valued in a mentor. In order to help you to think about these attributes the example of facilitating a student to learn about the administration of medication will be used to consider each attribute in turn below.

ACTIVITY 5.3 ATTRIBUTES OF MENTORS

The attributes that a mentor needs to develop in order to be effective in the role are listed in Table 5.1. Work through the list of attributes and:

- Firstly, identify those attributes that you feel you have and use regularly and confidently when working with students
- Secondly, identify those attributes that you feel you have but could develop and use more fully when working with students
- Thirdly, identify those attributes that you feel you need to develop
- Discuss your findings with a trusted mentor or colleague and check out whether they agree with your self-assessment, and identify any professional development which may be helpful. ■

Neary (2000) supports Darling (1984), indicating that an effective mentor is one who demonstrates many of the attributes described above, and is willing to give time and energy to the role. It is relatively recently that recognition of the need for mentors to have time set aside to enable them to undertake their mentoring role has been formalized (Nursing and Midwifery Council, 2006). It could be argued that the current requirement that mentors must be given one hour a week for each student nurse in the

TABLE 5.1

Attributes of Mentors

Attributes	Examples related to facilitating a student to learn about the administration of medication
Role Model	A mentor who the student can look up to, respect and admire. In relation to administration of medicines a mentor who is a positive role model consistently demonstrates up-to-date knowledge and skill in all aspects of administration of medication. This knowledge is used in such a way as to put the patient at the centre of care. They take opportunities to discuss medication issues with patients and their families as appropriate, they obtain informed consent and respect their wishes.
Envisioner	A mentor who gives a picture to the student of what could be done, is enthusiastic about opportunities and encourages the students to see beyond the here and now. An example in relation to medication may be the issue of patient education. Modelling and suggesting ways in which patients can be actively involved in self-administration whilst in hospital, and safe storage of medication in the community setting.
Energizer	A mentor who is enthusiastic about the administration of medicines and is able to transmit this enthusiasm to students. It may be the energizer points out that the administration of medication can provide regular contacts with patients, which they can use to assess patients holistically. The administration of a depot injection each month may be the only contact with a health professional and this contact can be a crucial opportunity to reassess the patient, and thus moves the students thinking beyond the task to the potential that the task offers.
Investor	A mentor who makes time for the students; spots potential and capabilities; trusts the student; and delegates responsibility. An example is the mentor who prebooks specific time during the week when they will participate in administration of medicines with the student and provide feedback.
Supporter	A mentor who listens; is warm, caring and encouraging in times of need. An example could be demonstrating empathetic understanding when students are nervously undertaking their first injection and incorporating this awareness into their teaching.

TABLE 5.1
continued

Attributes	Examples related to facilitating a student to learn about the administration of medication
Challenger	A mentor who questions opinions and beliefs; forces students to examine choices critically whilst empowering the student towards fulfilment of their potential. For example a student may express the belief that a patient is over requesting analgesia. An appropriate challenge from the mentor could encourage the student to explore the bases of their own professional values and opinions.
Standard Prodder	A mentor who is clear about what level of achievement is required at different stages of a programme and takes cognisance of this when planning learning experiences. For example does the mentor know at what stage of the particular programme students are formally introduced to basic pharmacological principles, terminology and legislation in the university? What is the level of achievement expected at the end of the first year of a particular programme, and how is reliability and validity of assessment achieved?
Teacher and Coach	A mentor who guides the students to problem solve and helps them establish priorities to develop and refine new skills, and inspires personal and professional development. For example many students at the beginning of their programme of study may not know what they need to know and have great difficulty in identifying their specific learning needs (see Heron, 1999 later in this chapter). An effective mentor may initially help the student to identify specific areas to focus on such as safe storage of medication and infection control procedures, otherwise students may be overwhelmed in the face of a perception that there it too much for them to assimilate.
Feedback Giver	A mentor who can offer both positive and constructive feedback, and also help students to explore things that go wrong. For example if the mentor observes that a student does not engage verbally with patients whilst administering medication, posing a question such as 'How did you feel you interacted with the patients during the drug round?' enables the student to reflect, and identify the improvements needed themselves. If the student fails to recognize their shortcoming then statement such as 'I noticed you sometimes forgot to speak to patients' is much less accusatory than a statement such as 'You didn't speak to the patients enough.'

TABLE 5.1
continued

Attributes	Examples related to facilitating a student to learn about the administration of medication
Eye Opener	A mentor who motivates interest in new developments and research related to drug developments and related issues such as concordance with prescribed medication and the psychosocial aspects of long-term dependency upon medicines, and thus directs the student into seeing the bigger picture.
Door Opener	A mentor who encourages students to try out new ideas and suggests and identifies resources for learning. For example students may not fully appreciate the role of the pharmacist and the contribution they can make to the well-being of patients and the community generally. Facilitating time with a pharmacist could provide a greater awareness of services available.
Idea Bouncer	A mentor who is willing to discuss and debate issues and encourage the student to clarify their thinking and stimulate new thoughts. For example if a patient refuses medication, is it appropriate to try and persuade them? Can persuasion be justified solely on the basis of being in the patient's best interest? Such questions posed to students by mentors and encouragement given to explore and discuss the literature and with other health professionals may extend the students thinking.
Problem Solver	A mentor who is tolerant of the shortcomings of students and willing to help them to solve their problems. For example a student who is struggling with understanding drug calculations could be offered the opportunity to practice and work though examples of calculations on paper before being required to calculate directly in practice.
Educational Counsellor	A mentor who is trusted; understands the student's need to achieve and supports and guides them towards success. For example if a student is struggling with some aspects of the administration of medicines then the mentor is willing and able to maintain integrity and transparency in managing the situation, able to negotiate a learning contact and action plan with sensitivity to the students situation, whilst being mindful of the need for the student to demonstrate safe practice.

final part of their programme is probably insufficient. Nevertheless, it is a very welcome step in the right direction.

Neary also identifies that an effective mentor is both up-to-date and innovative in practice, and an active learner themselves. A need for competence in core skills of mentoring, which are identified as coaching, counselling, facilitation, giving feedback and networking, were also identified (Neary, 2000). Neary further established mutual attraction and mutual respect as absolute requirements of a successful relationship. It may be that these two requirements implicitly suggest that mentoring works best when there are opportunities for both mentees and mentors to choose each other. The reality in health- and social-care settings is that most students are allocated to mentors before they meet. However, if mutual attraction and choice is significant there should be the opportunity to change mentors.

Wallace and Gravells (2005) identify many of the attributes and skills discussed by Darling and Neary within the context of a facilitative relationship. They identify an effective mentor as someone who is competent in building rapport, listening, questioning, reflecting back and summarizing. They suggest that it is essential for a mentor to be able to demonstrate in their behaviour that they care about the mentee and their development, encourage openness in the relationship and are at ease with the mentee. They also identify qualities of being non-judgemental, trusting, having integrity, able to maintain confidentiality, and able to be honest and congruent when working as a mentor.

Gillespie (2002, 2005) conjectured that effective student–teacher relationships are based on, and grounded in, student–teacher connection; a relationship that embodies trust, relatedness, connectedness, mutuality, a sense of community, understanding, acceptance and collaboration. Gillespie is attempting to describe what goes on in 'the space between' the mentor–mentee relationship. Gillespie proposes that if the connection between the student and teacher is embedded in knowing, trust, respect and mutuality, then it can provide a 'transformative space in which students are affirmed, gain insight into their potential, and grow toward fulfilling personal and professional capacities: student–teacher connection emerges as a place of possibility' (Gillespie, 2005).

In summary, it seems that the effective mentor is someone who has a particular view of the nature of human beings and how they should be treated, has certain personal attributes, up-to-date knowledge and skills related to their professional practice and a genuine desire to give time and energy to the role of mentor.

THE PHASES OF THE MENTOR–MENTEE RELATIONSHIP

A number of theorists have speculated on the stages or phases and possible duration of mentor–mentee relationships. Kram (1983) identified four phases of the mentor–mentee

relationship process, these being initiation, cultivation, separation and redefinition. Kram suggested that the first phase of initiation was when mentor–mentee established the relationship and developed ways of working. It was suggested that this phase spanned a six to twelve-month period. The cultivation phase could last for up to five years as the main work was undertaken. Eventually the relationship was no longer required and therefore the mentor–mentee either separated or redefined the nature of their relationship. Haynor (1994) and Kram (1983), considered that mentor–mentee relationships may generally span up to a ten-year period. Nevertheless, Short and Wachs (2002) suggested that the complexity of health-care practice learning requires students to have more short-term mentoring relationships, some of which may be occurring simultaneously. The requirements of some health- and social-care prequalifying education demand a wider range of contacts and the term 'mentor' is often used to determine the current key person in the particular placement experience who is supervising and assessing the student. This wider range of contacts is seemingly more akin to networking rather than traditional, long-term mentor–mentee relationships.

FACILITATION

Rogers (1994) proposed that it was not generally possible to teach anyone anything and that the best we can hope to do is to provide an environment in which students wish to learn. Rogers is not suggesting that teachers are redundant, but is dismissing some of the teaching methods in vogue at the time of his writing. These teaching methods did, according to Rogers, regard learners as passive, empty vessels, into which teachers poured knowledge. Whereas Rogers believes that real and meaningful learning is a not just about absorbing facts but is a whole-person experience that brings about some emotional or affective impact on the individual, which results in a change in behaviour.

Rogers favours the term 'facilitation' rather than teaching and regards the role of the facilitator as primarily respecting the students' autonomy, self-directedness and need for empowerment, and providing the right environment for students to have the freedom to learn. This right environment, in Rogers' view, rests mainly within the context of the student–facilitator relationship (Rogers, 1994).

This relationship, according to Rogers, is fundamentally based on genuineness, trust, acceptance and empathetic understanding. Genuineness on the part of the facilitator is about presenting yourself as a real person, and displaying normal reactions when you are with students, rather than adopting a role based on some notion of the ideal mentor, nurse or midwife. Trust and acceptance is avoiding being judgemental about students, and respecting them as a person. Empathetic understanding is the ability of the mentor to put themselves in the students' shoes.

ACTIVITY 5.4 THINKING ABOUT FACILITATION

Consider the ideas regarding the role of the facilitator proposed by Rogers above. Thinking about your work with students to date, and your observations of your colleagues working with students, consider the following:

- Is it possible for mentors working in health- and social-care to present themselves as genuine when working with students?
- Being non-judgemental may be laudable, but how does this equate with needing to assess and make judgements about students?
- How easy is it to empathize with students?

You may find it useful to discuss your responses to the above with other mentors and colleagues. ■

Heron (1999) proposes a model of facilitation that may offer mentors some ideas about the dimensions of facilitation, the modes of facilitation and their use that also takes into account the unique style of the individual facilitator and the mentee's stage of development and training. Although Heron based his model largely on the facilitation of groups, his ideas may be useful when considering the facilitation of an individual, particularly as many mentors in health and social care facilitate students at distinct stages of their educational journey.

Heron identified the six dimensions of facilitation as planning, developing understanding, confronting, feeling, structuring and valuing. Heron suggests the role of a facilitator is to work with the group or individual to negotiate and agree together how the group or individual will:

- Achieve their objectives (planning dimension)
- Understand the significance of their experiences and actions (developing understanding dimension)
- Raise and extend their thinking about their experiences and actions (confronting dimension)
- Handle feelings and emotions (feeling dimension)

- Structure and share their learning (structuring dimension)
- Create a climate of personal value, integrity and respect (valuing dimension)

ACTIVITY 5.5 USING HERON'S 6 DIMENSIONS

Consider the six dimensions of facilitation proposed by Heron (1999) and identify how you might use the dimensions when working with students. In order to prompt your thinking you might wish to consider the following questions:

- How do you work with students in order to develop their learning contract at the start of a placement?
- How do you ensure that students cannot only 'do' things in practice but that they also have knowledge and understanding of *why* they do things?
- How do you structure a student's experience during a placement to ensure that their knowledge and understanding is developed and increased rather than remaining static?
- How do you know how your students are feeling?
- Give examples of evidence that supports the notion that students are valued and respected in your area of practice. ■

Heron (1999) also identified three possible modes of facilitation – hierarchical, cooperative and autonomous – that a mentor may use, depending upon the stage of development of a group or individual and also the unique style and personality characteristics of the facilitator. Heron suggested that all three modes operate concurrently but suggests hierarchy early on, cooperation mid-term, and autonomy later on. The three modes are described below.

THE HIERARCHICAL MODE

In this mode the facilitator largely directs the learning process for the student and exercises significant power in the learning situation. The facilitator leads from the front and may regularly think and act for the student. The facilitator generally decides on the

learning outcomes, interprets and explains what is happening and what needs to be done. They manage the student's feelings and emotions, and direct the structure of the learning. They praise the students for what is they deem to be success. The facilitator tends to take responsibility for all dimensions of the learning process.

THE COOPERATIVE MODE

In this mode the facilitator and student share power in the learning process. They encourage and guide the student to become more self-directing. They work with the student to agree the learning outcomes and how things will be learnt. They help the student to understand what is happening and what needs to be done. They work with the student to decide how learning is structured and encourage students to evaluate and assess themselves. They share their own views and opinions on issues, and encourage students to do the same. Facilitation is cooperative.

THE AUTONOMOUS MODE

In this mode the facilitator respects the autonomy of the student, gives them freedom to find their own way and make their own judgements. Students evolve their learning outcomes and strategies to learn and to deal with others. Learning is unprompted, self-directed practice and the facilitator's role is to delegate to the students. This is not an abdication of responsibility, but rather a process of creating conditions where students are self-directing in their learning.

ACTIVITY 5.6 FACILITATION AND THE MENTOR

Consider the modes of facilitation proposed by Heron above and your experiences of working with students.

- In your experience, do all students move from a state of dependency to independence as they move through a placement or through different stages of their programme?
- How might a mentor support the student in each of the modes in order to move towards them becoming competent practitioners?
- As a mentor, how confident and comfortable do you feel in each of the modes? Which mode best suits your teaching style? ■

Work has been undertaken in relation to the effect of gender on the relationship (Luckhaupt, Chinn and Mangione, 2005; Parker and Kram, 1993) and also the issues of mentees choosing their mentors or being allocated to them by others (Tracey and Nicholl, 2006). It is probably true to say that health- and social-care mentors and students are allocated to each other prior to the commencement of the placement and neither side has a choice. They usually meet as strangers and changing mentors or mentees is not usually condoned, although a number of informal arrangements seem to exist.

DYSFUNCTIONAL MENTOR–LEARNER RELATIONSHIPS

Scandura (1998) identified some aspects of dysfunction in mentor–mentee relationships. These included some level of aggression, ranging from disregard or ignoring each other through to hostility. Scandura (1998) and Darling (1985) pointed out potential dangers if the mentor has managerial control or power over the mentee, and certainly this could be an issue when assessment of competence is a requirement of the mentor's role. Scandura (1998) also points out the potential dangers of sexual overtones that might occur in mixed sex relationships, and that male mentees are less satisfied with female mentors. Luckhaupt, Chinn and Mangione (2005) have suggested that female mentors spend more time making social relationships than male mentors.

Darling (1985) identifies five types of toxic mentors: avoiders (example of mentor behaviour is that they ignore the student); dumpers (example of mentor behaviour – uses the relationship to express their own dissatisfaction with their work and colleagues); blockers (example of mentor behaviour – restricting the responsibility they give to the student); destroyers; and criticizers (example of mentor behaviour being negative about the performance of the student and others in their professional environment). Darling suggests that this toxicity occurs due to a mentor's lack of the required attributes and skills and being stressed and 'burnt out'. Mentors may not always take on the role willingly, not particularly enjoy working with students generally or in specific circumstances, or they mentor students reluctantly only because it is a requirement of their current job specification.

ACTIVITY 5.7 WHEN THINGS GO WRONG

- Reflect on whether a dysfunctional mentor–mentee relationship has occurred or could develop in your area of practice.
- Discuss with your colleagues how this was or could be managed.
- Find out if there is a policy or agreed protocol in place to help you manage a breakdown of a relationship between a mentor and student in your area of practice, and familiarize yourself with this.
- Find out whether the students you mentor know what to do if they are unhappy with their mentor. ■

CHAPTER SUMMARY

This chapter has explored the development of effective learning relationships between prequalifying students and their mentors and supervisors. It has focused on the qualities and attributes of mentors that have been identified as supporting effective relationships with students, in health- and social-care settings. Consideration of the mentor–mentee relationship tends to focus on the teaching and learning aspects of the relationship. Nevertheless, it is important to accept that there are other possible strands. These can include that of assessing students, and this has recently become a stronger aspect of the role. For example the Nursing and Midwifery Council (2006) have identified that the sign-off mentor will take on a much more important role judging competence at the end of preregistration preparation. Combine this with practice situations where mentors and students are also work colleagues who may regularly share the joys and tribulations of hectic and demanding work. Emotional and sometimes distressing situations may result in mentors–mentees regularly commiserating, supporting and comforting each other, which may form strong bonds between them. Strong affinities and friendships can develop and this may also make the assessment of students challenging.

This chapter has identified some of the complexity inherent in mentoring students of nursing and midwifery in health- and social-care settings. The ability to maintain sufficient objective distance to enable mentors to assess students, whilst maintaining the benefits proposed in this chapter of a relationship that supports learning and is largely therapeutic in nature, is a complex skill set for mentors to develop.

REFERENCES

Burns, I. and Patterson, I.M. (2004) Clinical practice and placement support. *Nurse Education in Practice*, **5**, 3–9.

Darling, L.A. (1984) What do nurses want in a mentor? *Journal of Nursing Administration*, **14** (10), 42–4.

Darling, L.A. (1985) What to do about toxic mentors. *Journal of Nursing Administration*, **15** (5), 43–4.

Dorsey, L.E. and Baker, C.M. (2004) Mentoring undergraduate nursing students: assessing the state of the science. *Nurse Educator*, **29** (6), 260–5.

Fawcett, D.L. (2002) Mentoring – what it is and how to make it work. *Association of Operating Room Nurses Journal*, **75**, 950–4.

Gillespie, M. (2002) Student–teacher connection in clinical nursing education. *Journal of Advanced Nursing*, **37** (6), 566–76.

Gillespie, M. (2005) Student–teacher connection: a place of possibility. *Journal of Advanced Nursing*, **52** (2), 211–19.

Gray, M.A. and Smith, L. (2000) The qualities of an effective mentor from the student nurse's perspective; findings from a longitudinal qualitative study. *Journal of Advanced Nursing*, **32**, 1542–9.

Haynor, P.M. (1994) The coaching, precepting, and mentoring roles of the leader within an organizational setting. *Holistic Nursing Practice*, **9** (1), 31–40.

Health Professions Council (2005) Standards of Education and Training, HPC, London.

Heron, J. (1999) *The Complete Facilitators Handbook*, Kogan Page, London.

Higgins, A. and McCarthy, M. (2005) Psychiatric nursing students' experiences of having a mentor during their first practice placement: an Irish perspective. *Nurse Education in Practice*, **5**, 218–24.

Kram, K.E. (1983) Phases of the mentor relationship. *Academy of Management Journal*, **26** (4), 608–25.

Luckhaupt, S.E., Chinn, M.H. and Mangione, C.M. (2005) Mentorship in academic internal medicine. *Journal of General Internal Medicine*, **20** (11), 1014–18.

Neary, M. (2000) *Teaching, Assessing and Evaluation for Clinical Competence*, Stanley Thornes, Cheltenham.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, NMC, London.

Parker, V.A. and Kram, K.E. (1993) Women mentoring women: creating conditions for connection. *Business Horizons*, **36**, 42–51.

Quinn, F.M. (2000) *Principles and Practice of Nurse Education*, Nelson Thornes, Cheltenham.

Ragins, B.R. and Cotton, J.L. (1999) Mentor functions and outcomes: a comparison of men and women in formal and informal mentoring relationships. *Journal of Applied Psychology*, **84** (4), 529–50.

Rogers, C. (1994) *Freedom to Learn*, Maxwell Macmillan, New York.

Royal College of Nursing (2005) *Guidance for Mentors of Student Nurses and Midwives*, RCN, London.

Sambunjak, D., Straus, S.E. and Marusic, A. (2006) Mentoring in academic mentoring: a systematic review. *Journal of the American Medical Association*, **296** (9), 1103–15.

Scandura, T.A. (1998) Dysfunctional mentoring relationships and outcomes. *Journal of Management*, **24** (3), 449–67.

Short, J.D. and Wachs, J.E. (2002) Mentoring: career enhancement for occupational and environmental heath nurses. *Journal of American Occupational Health Nursing*, **50** (1), 135–41.

Stewart, B. and Krueger, L. (1996) An evolutionary concept analysis of mentoring in nursing. *Journal of Advanced Nursing*, **12**, 311–21.

Tracey, C. and Nicholl, H. (2006) Mentoring and networking. *Nursing Management*, **12** (10), 28–32.

Vance, C.N. (1982) The mentor connection. *Journal of Nursing Administration*, **12** (4), 7–13.

Wallace, S. and Gravells, J. (2005) *Mentoring in Further Education*, Learning Matters Ltd, Exeter.

CHAPTER 6
LEARNING STYLES IN PRACTICE

Tim Clark

Canterbury Christ Church University

LEARNING OUTCOMES

By the end of this chapter you will have:

- **An understanding of what learning styles are**
- **Considered the factors that promote and inhibit the development of learning styles**
- **Explored the student perspective of their preferred ways of learning in a practice experience**
- **Explored the potential consequences of student needs in relation to their preferred way of learning.**

INTRODUCTION

As adults we usually have a preferred method of learning and this seems to be fairly consistent in most people. It follows, therefore, that awareness of your preferred style of learning will help to maximize the way you are able to learn. Similarly,

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

awareness of your student's style may help you to understand how best to arrange teaching to help their learning. As a practitioner who is committed to the education and support of learners in practice settings, you may have already noticed that there are sometimes differences in the way they prefer to learn. For example you may have noted that some students prefer to use a very ordered and step-like approach to their learning, whilst others need to understand a general process before they understand the small steps. This preferred way of learning has been described as learning style.

Kolb first identified that individuals learn in different ways (Kolb, 1984). The existence of different **cognitive** or **learning styles** has been the focus of a significant body of research and a number of different approaches have been described (Riding and Rayner, 1998; Fleming, 2001; Mansouri *et al.*, 2006). This chapter will explore some of these and will consider the implications for a mentor supporting a range of students, some of whom may have different preferred learning styles. For example some individuals need to practically apply procedures in order for deep learning to occur whilst others may learn better by reading a book. In any large body of students there are going to be a number of different learning styles, and it is therefore essential to ensure that the variety of teaching methods suits all learning styles. Most health- and social-care programmes have a significant amount of time in practice settings and it may be very useful to think about your own preferred style and how the students' learning style may vary. The increasingly technical and demanding context of health care requires practitioners who are fit for practice and have a range of skills, including the ability to learn how to learn (Department of Health, 1999).

The report of the National Committee of Inquiry into Higher Education (1997) emphasized the need to develop learner centred approaches and suggested that students should be aware of their learning styles. Learning style preferences influence the way a student responds to the learning opportunities within any educational experience and affects their ability to direct their own learning (O'Shea, 2003). Whilst there may be a tendency to try to always teach to a student's preferred style, there is some discussion as to whether it is always of benefit to match learning and teaching styles. In our experience, supported in the literature, using opposite or alternative styles can be useful to take the student out of their comfort zone and stimulate their development (Quinn, 2000). This will need to be carefully considered however; as Rassool and Rawaf (2007) point out, a mismatch between teaching and learning styles has been found to have serious consequences, resulting in a reduction in motivation and a negative impact on test results. Careful exposure to different approaches should help develop a more versatile approach to learning. This is especially important given the pace of developments in practice and the changing profiles of those entering nursing and midwifery practice (Nursing and Midwifery Council, 2005).

CLARIFYING THE CONTEXT: WHAT ARE LEARNING STYLES?

Learning styles are the preferred ways we perceive and interact to the various elements in any learning situation. Although the concepts of cognitive style and learning style have been used interchangeably, the term learning style is preferred as this reflects both the student's preferred way of learning, major learning interests and awareness of learning context. Various styles have been identified and it must be emphasized that no particular style is *better* than others. If a learning situation is compatible with an individual's learning style, the learning potential is more readily obtainable. Clearly this learning situation is very important and, as a significant proportion of learning takes place in practice contexts, the style adopted will make a difference. Research indicates that there are differences in the learning styles of nurses in different disciplines, with these styles developing in the course of the student's studies (Sutcliffe, 1993; Clark, 1995).

Knowing your learning style can accelerate your learning as you undertake activities that best fit your preferred style. You can also use it to also help avoid repeating mistakes by undertaking activities that strengthen other styles. The following are some example of learning styles. There are several competing theories about how people learn, and websites where you can assess your natural learning style. If you want to follow this up, there are references at the end of this chapter.

ACTIVITY 6.1 HOW DO YOU LIKE TO LEARN?

Before you read any further take a few minutes to consider how you like to learn. Make some notes; it may help to think of a recent learning experience. ■

Your notes might include how and where you like to learn. Do you need to be quiet or can you not stand learning in a quiet environment? You may find you need to make notes for yourself, or talk over your ideas to yourself. You may need a logical and rational approach to solving problems, or just get in there and try things out in practice. Do you like to focus on the 'here and now' or do you prefer to analyse experiences thoroughly before you take any actions? There are many different and complex components of learning styles. Some of these are explored in the following sections, including

some ways of identifying your own approach to learning. Practitioners who provide effective learning are likely to have integrated a number of learning and teaching strategies. These strategies are influenced by the teaching style adopted and this is likely to be influenced by their own learning style.

LEARNING STYLES – WHICH ONE ARE YOU?

Most of us have elements of more than one learning style. Think about your strongest style and your weakest style to identify how you learn. We also have some learning preferences that influence the ways we perceive, process and organize information. By thinking about your preferred style, you can try and apply this to learning new things. If you are able to use your natural style, you are likely to find learning much easier and quicker.

When we gather information about the world around us we employ all our senses. But some of us employ one sense more than others; consider the activity in Appendix 6. A and see what sort of strategy you prefer when doing something. The **VARK system** assesses how much people rely on:

Visual – sight,

Auditory – hearing,

Reading/Writing, and

Kinaesthetic – movement, which also includes touch and temperature.

Students sometimes say things such as, 'I'm an auditory learner' meaning that they are more comfortable absorbing information which they've heard or discussed; or 'I'm a practical learner' if they prefer to learn through practical classes and hands-on activities, rather than by reading books and listening to lectures. In fact, each of us uses all available senses to absorb information. But you may find it helpful to confirm what your strengths are with regard to perception. If you want to do this, visit the VARK web site (www.vark-learn.com), fill in the test, and check your results. Let us consider some ways we use our senses to help us get the most of our learning opportunities.

If you are a **visual learner**, you will remember things best when you've seen them. You normally like a stimulating and orderly environment. To make the best of your visual sense you probably like to use diagrams and charts to help you make sense of things. Often visual learners like reading, and may be good at spelling. If you recognize yourself as a visual learner try using the tips in Box 6.1. to help you when you are

BOX 6.1 STUDY TIPS TO HELP PEOPLE WHO ARE VISUAL LEARNERS

- Write things down to help you learn them
- Draw pictures, charts and maps to help you understand things
- Use mind-mapping (for more information see the Further reading)
- Use planners, organizers or goal-setting charts
- Highlight important points with colour (but not in books which you've borrowed!)
- Try visualizing ideas and facts in your mind
- Try changing places in the room while you're studying, to get a different perspective
- Use models if they're available
- When you need to revise, read over and recopy your notes
- Use demonstration in a simulated or natural setting ■

working or studying. The same ideas can of course be used when you are working with students who are visual learners.

If you are what's called an **auditory learner**, you will learn best when you're listening (e.g. in a lecture) and when you're involved in discussion. You will remember things best when you've heard them. Study tips for auditory learners are listed in Box 6.2.

If you mostly use **reading and writing** as a strategy, university education is ideal for you. You are already comfortable reading text and writing notes and essays. As you prefer to see 'words', when you are studying graphs, charts and diagrams, convert them into words as you will be more able to make sense of them and remember them.

If you learn best by doing you are what's called a **kinaesthetic learner**, you will learn best when you're moving around. You will remember things best when you've done them rather than just read about them. You may have trouble with spelling. In lectures you may make lots of notes but tend never to look at them again. Study tips for kinaesthetic learners are given in Box 6.3.

How do you see the role as a mentor trying to develop students? A lot of what you do involves kinaesthetic learning although most people use all four approaches to some

BOX 6.2 STUDY TIPS TO HELP PEOPLE WHO ARE AUDITORY LEARNERS

The key thing is to make use of sound:

- Talk things through as you learn them, with a friend or a member of your tutorial group
- Get a friend to read aloud to you
- When you have to learn facts, try reciting them to yourself, or even singing them aloud
- Find out if you study best in silence or with music playing in the background
- Realize that some people aren't as good as you at remembering what they are told ■

BOX 6.3 STUDY TIPS TO HELP PEOPLE WHO ARE KINAESTHETIC LEARNERS

- Move around as you learn and revise
- Work through problems physically
- Mentally review what you've been studying while you're swimming or jogging
- Use models and machines when you can
- Take plenty of breaks while you're studying ■

extent. You will need to make the most of their strengths as a learner, and practise strategies that will allow them to build up the weaker areas. If you want to explore how people learn, there are dozens of interesting websites. You might want to use the links at the end of this chapter to get started.

PROCESSING INFORMATION

Once you've acquired information by listening, reading or doing, you then process it mentally by thinking about it and memorizing it. You will have a natural preference for how you grasp and order information, deal with facts and process the information.

ACTIVITY 6.2 DEALING WITH INFORMATION

Answer the following questions:

When you receive information do you prefer to deal with:
abstract concepts and generalizations, or
concrete, practical examples?
When you order information would you rather receive facts:
in a logical, sequential way to build up a picture one step at a time, or
with an overview straight away to show the big picture first, then the details?
When you engage with information do you prefer:
to act quite quickly, or
use reflection? ■

You may feel that you do have a preference and this can reflect a different learning style. Researchers have sought to describe clearly identifiable, qualitative distinctions in student learning styles. The most basic of these use the classifications of **deep learning** and **surface learning** (Entwistle and Ramsden, 1983; Marton and Säljö, 1984). A third classification is **strategic learning** (Entwistle, 1992). These differences have been explored using the Lancaster Inventory (Entwistle, Thompson and Tait, 1992).

How we tend to organize and present information is also influenced by our preferred style of learning. You are likely to have a preference for how you organize information. You may seek to make sense of information by concentrating on developing a holistic overview where you seek to understand the whole thing before you can appreciate the details. This is described as a holist approach. Alternatively you might need to adopt a step-by-step approach which develops a detailed and logical analysis, so you understand the parts before you can a full picture; this is known as a **serialist approach**. This approach to recognizing these trends have been considered using questionnaires that identify learning style preferences.

QUESTIONNAIRES THAT EXAMINE LEARNING STYLE

There are a number of learning style questionnaires, the following are two that have been used in health and social care settings; the Lancaster Inventory (Entwistle, 1992; Entwistle and Ramsden, 1983) and the *Learning Style Questionnaire* (Honey and Mumford, 1992, p. 200).

LANCASTER INVENTORY

Noel Entwistle has developed a learning style inventory that identifies the tendency to use deep, surface and strategic strategies and the use of holistic or serialist approaches (Entwistle, Thompson and Tait, 1992). This was developed from research into a self-assessed questionnaire that identifies learning preference, and might be useful for you to consider on a personal level and to understand in your role as a supporter of students in practice settings.

In studying learning styles it has been found that the different disciplines within nursing have differences in their preferred style with variations between 'medical' nurses using more holist approaches and 'surgical' nurses more likely to adopt a serialist approach. This tendency to use learning style or preferences that fit with our type of practice has significance when we work in areas where we have a wide range of patients and little ability to control the setting.

It may be interesting to note that different occupations have differences in their preferred style. In a study of student learning style Mansouri *et al*. (2006) identified that midwives were more likely to adopt a deep approach to learning, whilst nurses tended to adopt a surface approach. The better educational outcome is associated with using deep or more strategic approaches to learning.

Deep learning is based on high levels of intrinsic motivation, pursuing new ideas and materials through a variety of strategies in the search for understanding. Using a deep approach has been demonstrated to have a positive influence on the sort of learning outcomes for new teachers (Gordon and Debus, 2002). The deep approach is the ideal model for learning, although student performance may not necessarily be recognized in the award of high marks during assessment. The deep approach to learning within a practice context would involve:

- concentration on developing an understanding of the problems in clients and patients;
- the use of research evidence to expand knowledge of the evidence base of practice;

- using organizing principles to integrate ideas from different concepts;
- evaluation of the process of practice as well as the outcome;
- relating practice decisions to their evidence base.

Surface learning occurs when the student simply puts in the minimal effort to avoid failure. There is a focus on assessment requirements and an early move to completing the assessment without developing the knowledge skills or attitudes. In a practice context this would mean:

- the use of known evidence in an unquestioning way;
- the use of simple repetition of care without any variation or real consideration of individual needs;
- evaluation on the basis of basic care given rather than quality of care given;
- limited reflection on decisions.

Strategic learning is focused towards the product of learning rather than the process and the achievement of high grades. Concentration is towards planning to use time and effort efficiently to achieve specific, predetermined outcomes. Organizational behaviours and activities commonly referred to as study skills become increasingly important in the pursuit of a specific goal. The element of competition among students as a key motivator is very strong. In a practice context this would mean:

- concentration on developing care that gains approval by mentors or tutors;
- developing ideas that match tightly the care requirements;
- the use of research to acquire and reflect on information;
- using strategies to produce outcomes that match assessment criteria;
- A focus on the outcome of the caring process as opposed to the process of caring.

If students move towards surface and strategic learning styles in reaction to assessment systems, there can be a reduction in the learning experience. Opportunities for creative thinking can be reduced or even lost if the focus of learning moves towards assessment and attainment is measured only against stated performance criteria. What can emerge is a student who seeks to please staff by judging what is the preferred style or practical outcome required. In this learning framework students are unlikely to engage their minds

deeply in an active, yet considered, reflective exploration for new ways of doing things; they will stay within the guidelines of what output is required to satisfy the instructor or mentor and the stated assessment criteria. In the search for more effective care, assessment strategies that encourage students towards the opposite of this characteristic, namely a deep approach to learning, can offer considerable gains in learning. Of course students do need to meet the learning outcomes, but they also need to be thoughtful practitioners who can understand the complexities of the practice situation. If we only teach and learn enough to pass an assessment of what we think we will be assessed on, it is unlikely we will ever learn enough to safely care for patients.

LEARNING STYLE QUESTIONNAIRE

Another approach to identifying your own style and that of students has been developed by Peter Honey and Alan Mumford, who are best known for their learning style questionnaire (Honey and Mumford, 2000). This is a self-administered questionnaire that determines your preferred learning style that identifies four main learning style preferences: **activist**, **theorist**, **reflector** and **pragmatist**. You can find out your preferred style by completing a full assessment, but look at Table 6.1 and compare the responses to the activity to get an idea of which one best fits you.

So do you have a preferred style? As stated earlier, there is no one preferable style and although we may prefer one way of learning we may use more than one approach. Honey and Mumford suggest about 35% of people have one preferred style, 25% had two, 20% three and 19% have no preferred style. Rassool and Rawaf (2007) support the presence of dual styles in nursing and Lesmes-Amel, Robinson and Moody (2001) also recognized this to be true in general practice registrars.

The implication of the different styles can be seen when we think about the implications of trying to adapt the learning experience for students.

Activists: as activists like to be involved in new experiences, they clearly need to be kept stimulated. They are open minded and enthusiastic about new ideas but get bored with implementation so will need to be involved in new experiences, problems and opportunities. They enjoy doing things and being thrown in the deep end with a difficult task. However, they tend to act first and consider the implications afterwards. They like working with others but tend to hog the limelight. They may learn best when working with others in team tasks. They learn least when listening to lectures or long explanations as they have difficulty absorbing and understanding data. They benefit from team work as they will not enjoy reading, writing or thinking on their own. They also have difficulty following precise instructions to the letter.

Reflectors: as reflectors like to stand back and look at a situation from different perspectives and to collect data and think about it carefully before coming to any conclusions, they enjoy observing others and will listen to their views before offering

TABLE 6.1

Learning Preferences

Activists (Do)	Theorists (Conclude)
Immerse themselves fully in new experiences	Think through problems in a logical manner, value rationality and objectivity
Enjoy the here and now	Assimilate disparate facts into coherent theories
Open minded, enthusiastic, flexible	Disciplined, aiming to fit things into rational order
Act first, consider consequences later	Keen on basic assumptions, principles, theories, models and systems thinking
Seek to centre activity around themselves	
Reflectors (Review)	Pragmatists (Plan)
Stand back and observe	Keen to put ideas, theories and techniques into practice
Cautious, take a back seat	Search new ideas and experiment
Collect and analyse data about experience and events, slow to reach conclusions	Act quickly and confidently on ideas, gets straight to the point
Use information from past, present and immediate observations to maintain a big picture perspective	Are impatient with endless discussion

their own. Therefore reflectors learn best when observing individuals or groups at work. They need the opportunity to review what has happened and think about what they have learned and so prefer doing tasks without tight deadlines. Reflectors learn less when they are acting as leader or role-playing in front of others. They don't like being thrown in at the deep end and doing things with no time to prepare as they hate being rushed or worried by deadlines.

Theorists: theorists adapt and integrate observations into complex and logically sound theories. They think problems through in a step-by-step way. They tend to be perfectionists who like to fit things into a rational scheme. They tend to be detached and analytical rather than subjective or emotive in their thinking. They therefore learn best when they are put in complex situations where they have to use their skills and knowledge. They do best in a structured situation with clear purpose and where they are offered interesting ideas or concepts even though they are not immediately relevant. They value the chance to question and probe ideas behind things. Theorists learn less

when they have to participate in situations which emphasize emotion and feelings or where the activity is unstructured or briefing is poor. They also do not learn well when they have to do things without knowing the principles or concepts involved or when they feel they're out of tune with the other participants, for example with people of very different learning styles.

Pragmatists: as pragmatists are keen to try things out and want concepts that can be applied to their job, they tend to be impatient with lengthy discussions and are practical and down to earth. Pragmatists learn best when there is an obvious link between the topic and the job. They value the chance to try out techniques with feedback where they are shown techniques with obvious advantages, such as saving time. Pragmatists prefer it when they are shown a model they can copy such as a respected role model. They learn less when there is no obvious or immediate benefit that they can recognize or there is no practice or guidelines on how to do it. Pragmatists are very practically orientated so learn least when the event or learning is 'all theory'.

ACTIVITY 6.3 EXPECTATIONS OF LEARNING STYLE

Given the descriptions, what might you expect the learning style to be of the students with whom you are involved? ■

According to Rassool and Rawaf (2007) the most dominant style in nurses was reflector, followed by activist, theorist and then pragmatist. However, the most common pairing of learning styles is between reflector/theorist, a finding in common with a study of general practitioners (Lesmes-Amel, Robinson and Moody, 2001).

ACTIVITY 6.4 HELPING DEVELOP LEARNING STYLE

Take a few moments to consider how you might help students use and develop their learning style in your workplace:

Are there opportunities to help develop the different approaches to learning?

What can you do to challenge and develop learning styles in your practice setting? ■

Effective teaching and learning in practice settings demands students who engage effectively with those mentoring them (Lloyd Jones, Walters and Akehurst, 2001; Hand, 2006). Practice experience has a significant influence on learners' socialization into their chosen profession (Grey and Smith, 2000). Learning style preferences influence the way in which they understand and respond to an educational experience and this therefore impacts on the outcomes of the experience and mastering of the necessary knowledge, skills and attitudes for practice.

CHAPTER SUMMARY

Within this chapter we have given the opportunity to read, and think, about learning styles for practitioners and for learners in the workplace. Completing the activities will have provided the chance to consider your own style and to think how this might impact on how you support student learning.

Learning styles are complex and they influence how we access, process and use information. Each learner is likely to have an individual style, some of whom will have a style similar to your own preferred way of learning and it will be easier for you to understand and package the learning for them. Those who do not have a style similar to your own will require some extra thought as to how you can help them make the most of the learning opportunities available; this will take time, patience and skilled support if they are to meet their goals. Those involved in teaching in any environment need to think about their own learning style as this is likely to have a subconscious effect on their approach to teaching.

REFERENCES

Clark, T.J. (1995) A Longitudinal Study of the Cognitive Styles of Nursing Students in the Common Foundation Programme of the Diploma of Higher Education (Nursing Studies) Course. Unpublished MA dissertation. University of Kent.

Department of Health (1999) *Fitness for Purpose*, Department of Health, England.

Entwistle, N., Thompson, S. and Tait, H. (1992) Guidelines for Promoting Effective Learning in Higher Education, Centre for Research on Learning and Instruction, University Of Edinburgh.

Entwistle, N.J. (1992) Influences on the quality of student learning implications for medical education. *South African Medical Journal*, **81**, 596–606.

Entwistle, N.J. and Ramsden, P. (1983) *Understanding Student Learning*, Croom Helm, London.

Fleming, N.D. (2001) *Teaching and Learning Styles: VARK Strategies*, Honolulu Community College, ISBN 0-473-07956-9.

Gordon, C. and Debus, R. (2002) Developing deep learning approaches and personal teaching efficacy within a preservice education context. *British Journal of Educational Psychology*, **72** (4), 483–511.

Grey, M. and Smith, L. (1999) 'The professional socialisation of diploma of higher education nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, **29** (3), 639–47.

Hand, H. (2006) Promoting effective teaching and learning in the clinical setting. *Nursing Standard*, **20** (39), 55–63.

Honey, P. and Mumford, A. (1992) *The Manual of Learning Styles*, 3rd edn, Peter Honey, Maidenhead.

Honey, P. and Mumford, A. (2000) *The Learning Style Questionnaire: 80 Item Version*, Peter Honey, Maidenhead.

Kolb, D.A. (1984) *Experiential Learning: Experience as the Source of Learning and Development*, Prentice Hall, Prentice NJ.

Lesmes-Amel, J., Robinson, G. and Moody, S. (2001) Learning preferences and learning styles: a study of Wessex general practice registrars. *British Journal of General Practice*, **51** (468), 559–64.

Lloyd Jones, M., Walters, S. and Akehurst, R. (2001) The implications of contact with the mentor for pre-registration nursing and midwifery students. *Journal of Advanced Nursing*, **35** (2), 151–60.

Mansouri, P., Soltani, F. and Rahemi, S. *et al.* (2006) Nursing and Midwifery students' approaches to study and learning. *Journal of Advanced Nursing*, **54** (3), 351–8.

Marton, F. and Säljö, R. (1984) Approaches to learning, in *The Experience of Learning* (eds F. Martin, D. Hounsell and N.J. Entwistle), Scottish Academic Press, Edinburgh.

National Committee of Inquiry into Higher Education (1997) *Higher Education in the Learning Society The Report of the National Committee of Inquiry into Higher Education*, HMSO, Norwich.

Nursing and Midwifery Council (2005) *Statistical Analysis of the Register 1 April 2004 to 31 March 2005*, NMC, London.

O'Shea, E. (2003) Self-directed learning in nurse education: a review of the literature. *Journal of Advanced Nursing*, **43** (1), 62–70.

Quinn, F. (2000) *The Principles and Practice of Nurse Education*, 2nd edn, Croom Helm, London.

Rassool, G.H. and Rawaf, S. (2007) Learning style preferences of undergraduate nursing students. *Nursing Standard*, **21** (32), 35–41.

Riding, R. and Rayner, S. (1998) *Cognitive Styles and Learning Strategies: Understanding Style Differences in Learning and Behaviour*, David Fulton, London.

Sutcliffe, L. (1993) An investigation into whether nurses change their learning style according to subject area studied. *Journal of Advanced Nursing*, **18** (4), 647–58.

Sutherland, P. (1999) A study of the learning of mature adult students on a professional course. *Journal of Further and Higher Education*, **23** (3), 381–9.

Tracy and Rose, C. (1995) *Accelerated Learning*. Simon & Schuster, London.

FURTHER READING

Honey, P. and Mumford, A. (2000) *The Learning Style Helpers' Guide*, Peter Honey, Maidenhead.VARK is an extension of the concept of VAK, which comes from the following:

Bandler, R., Grinder, J. and O'Stevens, J. (1981) *Frogs into Princes: Neuro Linguistic Programming*, Real People Press.

Dunn, R. and Dunn, K. (1978) *Teaching Students Through Their Individual Learning Styles: A Practical Approach*, Reston Publishing, Virginia.
Biggs, J. (1999) *Teaching for Quality Learning*, OU Press, Buckingham.
Knowles, M. (1998) *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development*, Prentice Hall, Prentice NJ.
Mezirow, J. (1990) *Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning*, Jossey Bass, San Francisco CA.
www.support4learning.org.uk/education
www.learning-styles-online.com/
www.bbc.co.uk/keyskills

APPENDIX 6.A WHAT SORT OF LEARNING APPROACH DO YOU LIKE?

This chart helps you determine your VARK learning style; read the word in the left column and then answer the questions in the successive three columns to see how you respond to each situation. Your answers may fall into all three columns, but one column will likely contain the most answers. The dominant column indicates your primary learning style.

When you . . .	Visual	Auditory	Kinaesthetic and tactile
Spell	Do you try to see the word?	Do you sound out the word or use a phonetic approach?	Do you write the word down to find if it feels right?
Talk	Do you sparingly but dislike listening for too long? Do you favour words such as *see, picture*, and *imagine*?	Do you enjoy listening but are impatient to talk? Do you use words such as *hear, tune*, and *think*?	Do you gesture and use expressive movements? Do you use words such as *feel, touch*, and *hold*?
Concentrate	Do you become distracted by untidiness or movement?	Do you become distracted by sounds or noises?	Do you become distracted by activity around you?

When you . . .	Visual	Auditory	Kinaesthetic and tactile
Meet someone again	Do you forget names but remember faces or remember where you met?	Do you forget faces but remember names or remember what you talked about?	Do you remember best what you did together?
Contact people at work	Do you prefer direct, face-to-face, personal meetings?	Do you prefer the telephone?	Do you talk with them while walking or participating in an activity?
Read	Do you like descriptive scenes or pause to imagine the actions?	Do you enjoy dialogue and conversation or hear the characters talk?	Do you prefer action stories or are not a keen reader?
Do something new at work	Do you like to see demonstrations, diagrams, slides or posters?	Do you prefer verbal instructions or talking about it with someone else?	Do you prefer to jump right in and try it?
Put something together	Do you look at the directions and the picture?	Do you prefer verbal instructions or talking about it with someone else?	Do you ignore the directions and figure it out as you go along?
Need help with a computer application	Do you seek out pictures or diagrams?	Do you call the help desk, ask a neighbour or growl at the computer?	Do you keep trying to do it or try it on another computer?
Numbers of positive responses			

Adapted from Tracy and Rose (1995). *Accelerated Learning*. Simon & Schuster, London.

CHAPTER 7
USING INTERPERSONAL SKILLS IN MENTORING

Sue Riddell

Canterbury Christ Church University

LEARNING OUTCOMES

By the end of this chapter you should be able to:

- **Recognize the interpersonal skills necessary for the development of effective mentoring relationships**
- **Be aware of the context of the use of these skills and how it is different from the health care professional–client relationship**
- **Reflect on your own interpersonal skills, identifying areas of strength and weakness**

INTRODUCTION

If we acknowledge that developing effective mentoring relationships is essential, then the next step is to identify and improve the use of those skills needed to do so. These are the same interpersonal skills that each health- and social-care professional should already possess – skills that are used in the day-to-day work of interaction with clients,

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

colleagues and members of the multidisciplinary team. The students who look to you for guidance will be as varied in terms of age, ethnicity, sexuality, culture and life experiences as the clients that you care for. It is only the context of the relationship that is different. Instead of trying to help a client come to terms with a health or personal welfare issue, you are enabling a student to make sense of new learning.

Sometimes clients are unclear about the best way forward and need you to be directive in your helping; whereas in other situations the client needs your assurance that he/she is making progress in the right direction. A student is no different. During the early days of a placement in particular, he/she may need clear direction about how to utilize the opportunities available for learning. Having learned from them, the student may then require confirmation from you that his/her professional competence is developing as it should. There is clear overlap of the interpersonal skills required for interacting with both the client and the learner.

The aim of this chapter is to put into context within the mentor–student relationship the interpersonal skills that you already have. In order to achieve this attending, listening and responding skills will be reexamined and adapted, considering examples from within the practice setting. It is also hoped that you will increase your self-awareness through the process of engaging with the activities within the chapter, becoming more skilled in the formation of effective mentoring relationships.

PHASES OF THE RELATIONSHIP

The relationship, and therefore the required interpersonal skills, will be considered in three phases. The first phase is similar to the orientation phase described by Sundeen *et al.* (1998) when considering nurse–client interactions; a time when a contract is developed between the parties which identifies the structure for the duration of the relationship and the expectations that each party has of the other. Once the learner has identified his/her learning needs and together you have devised a programme to meet these, the relationship enters the maintenance or working phase.

> *... when interaction is maintained for the purpose of accomplishing the mutually agreed-on tasks (work)*
>
> *Sundeen et al., 1998, p. 178*

During the final phase of the relationship a mentor will need specific interpersonal skills to carry out effective assessment of the learner's competence. This might be a challenging time, particularly if failure is a possibility, so assertive skills are amongst those required.

FIRST IMPRESSIONS

Your first meeting with a student is likely to set the tone for your relationship. Both you and the student will be seeking cues as to the likely nature of your relationship. First impressions are very significant and your non-verbal communication sends much stronger messages than what is actually said.

ACTIVITY 7.1 FIRST ENCOUNTER

Think back to the most recent learner for whom you have provided mentorship.

Can you remember the first encounter – when, where it took place, what was going on around and how you were thinking, feeling and behaving?

Write a short paragraph describing that scene. ■

Normally, you will have received advanced notice of a student arriving in your place of work so you will be able to make some arrangements for that first meeting. Occasionally, they may turn up unexpectedly, whilst you are attending to a multitude of other things. Unfortunately, many students experience negative reactions from mentors when this happens, even bordering on hostility at times. This does not endear them to the placement and may cause anxiety and distress. How do you demonstrate to a student through your body language that they are welcome and you want to help them, whilst others are making simultaneous demands on your time?

Sometimes the first interaction may not be face-to-face. It is just as important over the phone or via an e-mail that you convey a sincere welcome to a new learner in your tone of voice or the words you write. It may be easy to understand the anxiety of a junior student but it is also important to recognize the anxiety that a more senior student may feel because of the expectations that they believe you will hold about their skills and level of competence.

The first, and most important, thing to do when you first meet is to stand still. Health-care professionals are always on the go, busy moving from one place to another, usually carrying something and with eyes focused somewhere in the distance. This behaviour is often subconscious but, nonetheless, a deterrent to communication. Standing still and turning your body towards another person demonstrates your attention to them. This is a common courtesy that shows respect. Imagine trying to hold a conversation on the move and how that might feel to the student.

Facial expression is probably the most striking component of a first visual impression. A smile is very important to let a learner know that they are welcome. Shaking hands may feel too formal for you and an embrace would not be appropriate at a first meeting! So greeting the learner with a smile and a welcome by name is the likeliest scenario. 'Hello! You must be Anna Jones? Welcome to the rehabilitation unit. My name is Gill Everest and I am going to be your mentor whilst on this placement'.

Names are very personal and important to us. Ensure whenever possible that you know the name of the learner you are expecting and the stage of training that they are at. Demonstrating interest in the learner in this way will make them feel valued. In turn this will encourage them to engage in a relationship with you that is more likely to be rewarding for you both.

ACTIVITY 7.2 REFLECTION ON FIRST ENCOUNTER

Look at the account you have written about your first meeting with a learner.

What were the good and bad points about it?

In what way might you improve on this in future? ■

As far as possible you should plan the initial meeting ahead of time. This will help to create a positive first impression that might make all the difference to the direction in which your relationship develops.

In a busy place of work it is not always easy to find an environment conducive to talking but it is part of demonstrating your respect for the student to try hard to give them some uninterrupted time for you to get to know each other, discuss previous experiences, learning needs and any other issues relevant to his/her time with you. If you have set aside a specific length of time for this meeting, you should let the learner know this at the beginning. This will allow them to make sure that they tell you the most important things before the meeting comes to an end. It also demonstrates that you value them sufficiently to have set aside a period of uninterrupted time, however short that might be.

ATTENDING AND LISTENING

Attending and listening are two key skills in developing good relationships. Attending means demonstrating through your physical presence and non-verbal communication

that you want to engage with the other person. Listening is about hearing and seeking to understand what they are thinking, feeling and their past experiences. During the first proper discussion that you have with the student, when you are able to sit down and spend time together, it is important that you listen and hear their needs.

Egan (2002) outlined five aspects of non-verbal communication, summarized by the acronym SOLER, that convey your attention to others: face **S**quarely, **O**pen posture, **L**ean towards, maintain **E**ye contact and **R**elax. The following is an adaptation to show relevance in a mentoring relationship.

S: face the learner squarely. Some feel that this may appear confrontational but the intention is that the orientation of your body is towards rather than away from the learner when you are talking to them. If you are busy, it may be tempting to have a conversation over your shoulder whilst you carry out your duties and if you are seated you might continue with work in front of you on the table whilst talking to the learner – or to the table!

O: open posture. This means no folded arms whilst talking and preferably no crossed legs if you are sitting down. Crossed arms and legs can signify a lack of involvement and although many people find it comfortable, the message conveyed to others is often one of reticence or indeed a level of aggression. An anxious learner may perceive that you would rather be somewhere else.

L: lean towards the other. This may seem rather intense, but it becomes more obvious when you consider striking the opposite pose and leaning back in your chair, away from the learner (laid back!) This may suggest that it is all too much bother for you.

E: eye contact. Good eye contact is a significant way of conveying your interest. This will be easier if you are talking together in a quiet area but somewhat more challenging if you are surrounded by the hustle and bustle of a busy work environment where it is easy to be distracted. Staring intently is likely to cause panic in the learner so ensure that your level of eye contact is comfortable to you both.

R: relaxed. An apprehensive learner needs you to be calm and comfortable not fidgeting and hesitant.

It will not be possible to adopt these five aspects of attentive non-verbal communication all the time, but an awareness of them will enable you to consider and adapt the principles. In this way your learner will feel that you want to help them and is more likely to engage with you in a productive relationship.

However calm the exterior, our non-verbal communication is likely to leak our true feelings. The learner may appear fidgety, anxious and avoid making eye contact with you or they may over-compensate by loud and brash behaviour. They will look for

cues from you to help them settle and relax. If your behaviour suggests that you have little or no time for them, the anxiety will increase and indeed may create hostility in the learner if persistent.

ACTIVITY 7.3 NON-VERBAL ATTENDANCE

When you next sit down with a learner to discuss their learning needs, consciously use positive non-verbal attending. Remind yourself after each five minutes and correct your posture accordingly. ■

QUESTIONING

The first meeting will be one for orientation and for you to find out what this learner wishes to gain from working with you and for you to tell them about the learning opportunities available. You will also want to learn a little about their previous placement and mentoring experiences as these may influence the way they behave whilst with you.

Effective questioning skills are essential for good mentoring (Parsloe and Wray, 2000); they are important at the start of the relationship, to develop a rapport and to assess the learner's needs. During the ongoing relationship they are necessary to continuously review progress and check learning. In the assessment stage questions are critical to being able to make an accurate judgement with regard to competence.

ACTIVITY 7.4 QUESTIONS TO ASK

Write a list of the questions that you may ask a new learner.

Consider what you need to know about them in order to best meet his/her learning needs. ■

The type of question you ask is important, but so too is the way in which it is asked. Being a learner can be a very stressful time and questions that threaten self esteem or, at worst, may humiliate by exposing an area of deficit in the learner's knowledge or skills, can add to the anxiety and may cause distress. In such a state, the learner will be unable to take on board new material and so enters a cycle of anxiety-provoked inability to learn. Hence the type of question and the nature of the asking are important.

Egan (2002) offers some words of caution when using questions, which he categorizes as a probing technique. In itself that word conveys the intrusive and therefore threatening potential of questions. Although he is analysing the use of questions in a different context, the two principles that Egan offers may sometimes be applied within mentoring also:

- Do not ask too many questions – whilst wanting to discover what knowledge, skills and experiences the learner has, you do not want them to feel interrogated, as if sitting under a single light bulb in an empty, dark room!
- Ask open-ended questions – they allow the learner more freedom when answering.

You need to be sure that you have gleaned the necessary information so that together you can plan a learning programme. This questioning skill will be the same one that you might use when carrying out an assessment of a client when you first meet. In the same way that you would plan care with a client, so you will help a student to make a plan of learning. You should use questions effectively to discover their 'learning intent' (Boud and Walker, 1990). Stuart (2003) suggested that it is possible that students enter a placement with no real idea of what it is they wish to learn. The mentor must help them to identify the intent and so plan activities which will be of interest and useful to the learner. Closed and open questions both have a purpose here.

Dickson, Hargie and Morrow (2000) point out that it is normally the individual of higher status or the person in control of the relationship who poses the questions. One way to help restore some balance and give some power to the learner is by using open questions. These allow the respondent to make choices in what they disclose and how much they choose to share. This is particularly important when the relationship is new and you are working on developing a rapport. Listen to the difference between 'Did you enjoy your last placement?' and 'Tell me about your last placement.' If they did not get on well on the last placement, the closed question forces them to either lie or to share more information with you than they may feel comfortable doing at such an early stage in your relationship. Conversely, the second open question, gives the learner control over what they choose to say.

ACTIVITY 7.5 REFLECTION ON QUESTIONS

Look at the questions you listed in Activity 7.4.
How many of them are closed and how many are open questions?
Could you rephrase your closed questions into open ones? ■

There will be instances where a categorical answer to a closed question is what you need but, if this is not the case, try to use open questions which help to share the power between yourself and the learner.

If asking questions is important, then so too is listening to the answers. Most work environments in health and social care are busy, sometimes frenetic. Being preoccupied with the work that you feel you should be doing does not provide an ideal environment for effective listening. However, if you do not listen properly to the words, feelings and non-verbal messages of the learner, you will not hear them. Your way of responding will convey back to the learner whether you have listened effectively and they will judge the likelihood of a successful relationship.

When your non-verbal attention is good and your questioning is skilful, the learner will be encouraged to talk. Their words will help you to build your own picture of how the learning experience appears to them. From a humanistic perspective, this is empathic understanding. If you are able to appreciate how the world looks to a learner, using the same listening skill that you use to try to put yourself in the shoes of your clients, then you will be an empathic mentor. But you must be cautious: remembering how you felt as a learner is only half the task and indeed may be distracting on occasions. Arguably the more important aspect is to listen to what the learner says that they feel like and respond to what you *actually* hear, not what you *expect* to hear. Although a number of learners experiencing the same learning environment may share the same feeling of anxiety, the degree of anxiety and the reasons for it may be different. We each form our reactions to situations based on our past experiences and as these are many and varied, so too will our reactions be. Active listening is the key to understanding the needs of your learners and without it you may fail to provide them with a satisfying learning experience.

ACTIVITY 7.6 SUMMARIZING

Following your next interaction with a student, summarize what they have said back to them at the end, to check for accuracy. This will enable you to discover how well you have listened and picked up on the messages. This will be an indication of you listening skills and empathic understanding. ■

RESPONDING

As your relationship with the learner enters the maintenance phase, you will begin to understand what it is that they need from you. This will vary according to such things as the environment, the stage of training and the character of the learner. When you are sure you have understood the message that your learner is conveying, you must respond in an appropriate manner. Heron (2001) identified a range of styles of interventions, ranging from prescriptive to supportive. An unsure, junior learner may need a prescriptive or informative intervention when developing new skills, whereas a more confident, senior learner may respond to interventions that are challenging and require them to analyse and evaluate what is happening with the client (Heron, 2001). However, these are not exclusive; a senior learner may require directive interventions at times whilst a junior learner should be encouraged from the beginning to think in an analytical way about their work.

Broadly, Heron's six categories of interventions can relate to helping learners in the following ways:

Prescriptive interventions are used to direct behaviours, so the mentor would be instructing the learner in what they should do. **Informative interventions** will be used when the mentor wants to tell the learner something, to impart new knowledge that is relevant to the learner's needs. According to Heron (2001), a **challenging intervention** will tell uncomfortable truth, but do so with love. The most important factor when challenging a learner is that the relationship is psychologically safe and the learner will know that the mentor will not be judgemental or think less of the learner as a result of whatever truth needed to be told. Therefore challenging interventions are only perceived by the learner as safe when there is trust and respect within the relationship.

Cathartic interventions will encourage learners to explore how they feel about something; this may be in relation to such things as the placement experience as a whole, their own capabilities or a particularly emotional client situation. As with challenging interventions, the relationship will need to be established and a good rapport developed in order for cathartic interventions to be effective. **Catalytic interventions** are useful in encouraging a learner to problem solve, to seek out their own solutions to questions and become an independent learner. **Supportive interventions** are positive strokes that make the learner feel good about themselves, affirming his/her worth and value.

ACTIVITY 7.7 INTERVENTION STYLE

When you next talk to a learner, consider how you use the different styles of intervention and think how you might broaden your use of these styles to encompass a greater range. Note how the learner responds to the different styles and draw conclusions about how this influences your relationship with them. ■

Sometimes you may feel it is important to give clear, authoritative instructions to your learner about how to behave in a particular setting, or how to execute a particular skill. On another occasion, you may believe that the most important thing is that the student finds their own style of working and therefore how you respond to a question might be very different – open and facilitative. It is likely that you have a preferred way of responding but paying attention to adjusting your style will enable you to react flexibly to the differing needs of students.

During the maintenance phase of the relationship it is essential that a mentor does not forget that they provide a significant role model. All the time that you are carrying out your work, you are likely to be observed and frequently imitated by learners. The learner should be able to watch you work and know that you are demonstrating best practice. This includes observation of how you interact with patients, clients and members of the multidisciplinary team. A learner should see you use the same skills in those relationships as you do with them. It would seem unjust to be kind and caring in your communication with others, but abrupt and judgemental with a learner.

FEEDBACK

The *Standards to Support Learning and Assessment in Practice* (NMC, 2006) requires that a mentor should 'develop effective working relationships based on mutual trust and respect'. When we have a trusting relationship, we hope that this means it is an honest one too. As a mentor you are likely to have a significant role in assessing the competence of learners, whether that is formatively or summatively. Over the period of a placement you should certainly be giving a learner feedback on their progress, which may be formally recorded or not.

ACTIVITY 7.8 GIVING FEEDBACK

Recall the last occasion when you, as their mentor, watched a learner undertaking a piece of work. What feedback did you give them about their performance? ■

Supportive feedback may feel good for both the mentor and the learner, but if it is not entirely honest it will not facilitate development. Rogers (1983) believed that genuineness and congruence is a core condition for a helping relationship. In simple terms this means that what you think inside your head is the same as the words that come out of your mouth. You do not *think* that a learner's performance is poor, but *tell* them that it was alright. This is not a comfortable area in any relationship but it is likely to be in the learner's best interests (and that of future clients) that you point out to them the aspects that they need to improve on, alongside praising them for their strengths. As a mentor, you not only have an accountability to your profession to ensure that the next generation is knowledgeable and does the job well, but you also owe it to the learner to be honest with them, so that they can put right any mistakes or focus their development in necessary areas in order to become a knowledgeable professional.

In a busy working environment it is often easy to forget to give informal feedback, but it is this that can keep a learner going. Behavioural psychologists discovered, many years ago, that positive reinforcement will encourage repetition of good performance (Skinner, 1971). Parsloe and Wray (2000) suggested that feedback is the fuel of improved performance, that it can provide motivation. However, they warn that motivation may go backwards if you get the feedback wrong, believing that successful mentoring depends in the most part on good quality communication, which in turn is dependent on the

correct choice of words and method. As an extreme example, you hopefully would never leave a brief written note for a learner saying, 'You've failed your assessment'.

Feedback is not helpful if it is non-specific and bland. Clear, detailed feedback is much more useful, particularly when it is a critical comment which provides the learner with a focus for future development. The skills needed by the mentor here include some aspects of breaking bad news and some from assertiveness.

ACTIVITY 7.9 GIVING NEGATIVE FEEDBACK

If you have never had to provide quite substantial negative feedback to a student, what aspects of it would cause you concern?

If you have had to do this, reflect on what went well and what things you would do differently next time ■

Although a large proportion of feedback is likely to be quick and informal whilst working alongside a learner, to tackle more difficult feedback, or to undertake a considered assessment, it is important to set aside time and sit down together in a quiet, uninterrupted environment. A mentor must never humiliate a learner by telling them off in front of others. Sadly, learners do experience this sometimes and it is a very unpleasant and demotivating experience. Taking urgent action to prevent unsafe or even dangerous practice occurring is usually quite easily done by quickly taking over from the learner or getting them to stop what they are doing immediately, allowing the mentor to seek clarification of their intention and firmly but gently correcting the error. This avoiding action should not be accompanied by reprimand – verbal or non-verbal.

Once in a suitable place, ideally where you both are seated, you can tackle the negative feedback. Ensure that your non-verbal communication is positive and attentive as described earlier in this chapter. The best way to begin is probably with an open question such as 'How do you think that you have developed during this placement?' or 'Talk me through what you were doing just now.' Remember that open questions give the respondent control over how they answer. Many times a learner will identify for themselves areas that they struggle with, or mistakes they have made. Indeed, sometimes, they can be rather too hard on themselves. It will be your role as mentor then to affirm those aspects that you agree with and challenge those that you do not. Health-care professionals generally do the work they do because they want to care for others and

this normally encompasses 'being nice' to everyone. So agreeing with someone's negative comments about themselves is quite difficult, but it can be done through non-verbal actions such as nodding in agreement instead of a verbal statement. Alongside the negative, always try to find positive comments to make too, so that the learner is not left feeling that they are all bad.

When people are given bad news, which criticism and failure are, there is often an emotional reaction which can be difficult for the mentor to deal with, because it reinforces the belief they may already have that they are a bad person for saying unpleasant things to a learner. In dealing with the emotions, non-verbal attention becomes important again and silence can be powerful and useful too. It is vitally important to listen to the learner's response to what you have said. This is not always easy when you are anxious about what you have to do, but is an important component of assertiveness and demonstrates respect for the learner. If the mentor embarks upon 'making it better' for the learner, they may well find themselves going back on things they have said. Whilst at the same time as demonstrating empathy, it is important to stick to the message and if necessary repeat your feedback. This is another technique often associated with assertiveness, when a respondent tries to throw you off your track by sidetracking into many and various other aspects.

Make sure that you are able to provide the learner with examples of incidents that illustrate the area of weakness that you are describing. Use analytical interventions (Heron, 2001) to help the learner explore how they might improve their performance and thereby feel a little more in control. Do not forget to also provide examples when identifying strengths so that the learner has a clear understanding of which behaviour was good. The use of questions is again significant for the mentor to assess a learner's level of theoretical knowledge and understanding.

It is vital that you continue to show the learner respect and acknowledge any pain you might be causing throughout this type of interaction. When assessment and feedback is positive there should be no difficulty in discussing it with the learner. Negative feedback, or indeed failure, is altogether more problematic. However, this chapter has already identified that honesty is a fundamental component of an effective mentoring relationship, so you owe it to your learner to demonstrate it. Helping the learner to plan their way forward gives closure to the assessment process and provides the mentor with the opportunity for more positive interaction using attending and listening skills again, along with responding and questioning.

CHAPTER SUMMARY

This chapter has sought to identify a selection of interpersonal skills that are used to carry out the role of a mentor. It has been pointed out that these are skills that

health-care professionals should already possess and which are used regularly when interacting with patients and clients. Although the skills have been primarily identified with stages during the relationship with a learner, this is not intended to suggest that they cannot be used appropriately at other stages. Sully (2003) suggests that a student has responsibility for their own learning, whilst the supervisor has responsibility for providing support. To be a supportive mentor it is simply necessary to transfer these skills from the context of relationships with clients to the relationship with learners.

REFERENCES

Boud, D. and Walker, D. (1990) Making the most of experience studies. *Continuing Education*, **12** (2), 61–80.

Dickson, D., Hargie, O. and Morrow, N. (2000) *Communication Skills Training for Health Professionals*, 2nd edn, Chapman & Hall, Cheltenham.

Egan, G. (2002) *The Skilled Helper*, 7th edn, Brookes/Cole.

Heron, J. (2001) *Helping the Client – A Creative Practical Guide*, Sage Publications, London.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*. NMC, London.

Parsloe, E. and Wray, M. (2000) *Coaching and Mentoring*, Kogan Page, London.

Rogers, C. (1983) *Freedom to Learn*, Merrill.

Skinner, B.F. (1971) *Beyond Freedom and Dignity*, Alfred Knopf, New York, cited by Quinn, F.M. (2000) Principles and Practice of Nurse Education, 4th edn, Stanley Thornes, Cheltenham.

Stuart, C. C. (2003) *Assessment, Supervision and Support in Clinical Practice*, Churchill Livingstone, London.

Sully, P. (2003) Managing relationships in practice, in *Supporting Learning in Nursing Practice* (eds S. Glenn and P. Parker), Palgrave Macmillan, Basingstoke.

Sundeen, S.J., Stuart, G.W., Rankin, E.A.D. and Cohen, S.A. (1998) *Nurse–Client Interaction*, 6th edn, Mosby.

CHAPTER 8
THE LEARNING ENVIRONMENT

Gill Beer[1] and Andrew Southgate[2]
[1]Canterbury Christ Church University and
[2]Practice Placement Facilitator, Kent

LEARNING OUTCOMES

At the end of this chapter you will have:

- **Explored some of the factors that have an influence on student learning in practice**
- **Compared and contrasted the changing face of the learning environment**
- **Considered ways of improving the practice learning environment for your learners.**

INTRODUCTION

One of the most influential aspects of student learning is the environment in which we place learners and expect them to learn the art and science of nursing. Within professional education we are actively encouraged to reflect on practice. In this chapter we

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

are asking you to reflect on the learning environment, the changes that have happened within professional education and the workplace, and the consequences of this change. This will enable you to appreciate some of the reasons for the demands placed on your role and consider ways in which you can manage these.

In the early 1980s Joan Fretwell (1980) conducted a seminal piece of research which explored the teaching and learning environment within the ward setting. Fretwell argued that 'unresolved conflicts' within the ward learning environment influenced when, where and how learning would occur. Furthermore, it was suggested that these conflicts would ultimately affect the quality of the learning experience, assuming of course that learning had actually taken place. This chapter will attempt to explore these conflicts by considering some of the changes and developments that have occurred in recent years. Whilst you may question why we are considering work that is over 20 years old, it does give us the opportunity to explore the changes over time and consider if these have been of any benefit to the learner.

ACTIVITY 8.1 LOOKING BACK

Just take a few minutes to either remember some of the comments made about nursing in 'the old days' or perhaps an old documentary or film you have seen about nursing. What do you think are the main differences between then and now and how would these differences affect the learning environment? ■

You may have noted that the ward layout was different (there were single-sex Nightingale wards); there was a focus on task allocation and routine; and the domain was very much controlled by a stereotypical spinster, know as the Ward Sister.

The conflicts highlighted by Fretwell's work (Fretwell, 1980, 1982) work have concluded that: few ward sisters had been prepared for their teaching role; teaching came low down on the sisters list of priorities; clinical teachers had not assumed a dominant teaching role in most hospital wards; there was no dominant teacher in the ward; learners found teachers amongst their peers; there was evidence that students had low learning expectations in respect of repetitive clinical work; and received little or no teaching or supervision whilst they worked.

ACTIVITY 8.2 THEN AND NOW

Do you see any similarities between the findings of Fretwell's work and those discussed in Chapter 2? ■

You may have identified a number of changes that have been implemented since Fretwell undertook her research. Some of the areas that she believed affected the learning were:

- the method of student allocation
- permanent staff
- the nature of the learner
- the nature of the ward (clinical environment)
- teaching by others.

Do you think that these still remain relevant in the twenty-first century within the context of the following developments?

- changes that have occurred in preregistration education (UKCC, 1999; DH, 1999) since Fretwell published her research;
- Government initiatives to strengthen and modernize the NHS workforce (DH, 2000);
- increasing emphasis on the role of the mentor (Nursing and Midwifery Council, 2006);
- impact that the Quality Assurance Agency Major Review process and the Ongoing Quality Monitoring that is a core component of publicly funded health-care programmes.

Furthermore, you may have noticed that Fretwell focused on adult nurse education but major changes to care delivery has encouraged the development of interprofessional learning programmes. Therefore, the learning environment needs to be seen in light of its impact on all health-care learners. Let's explore these areas in more detail.

METHOD OF LEARNER ALLOCATION

LEARNER NUMBERS

Have you considered who decides how many learners are trained each year and, subsequently, how many are sent to your clinical area?

When learners were once part of the local workforce, recruitment of student nurses was based upon the actual labour requirements of each Trust (O'Callaghan and Slevin, 2003). Today, learners are commissioned based on future workforce planning needs both nationally and locally. This may explain why you have more learners in training than local vacancies. Learners are being prepared to work in the NHS, social care and the private/voluntary sector.

TIME SPENT IN PRACTICE

Government and professional bodies have also impacted on the role of the mentor. *Making a Difference* (DH, 1999) set an expectation that all student nurses would spend 50% of the preregistration programme in clinical practice. Furthermore, the English National Board (ENB) (ENB, 2000a) stated that learners needed to access clinical placements earlier in their preregistration programmes and undertake clinical placements for longer periods of time (ENB, 2000a). This, along with the increased commissioned numbers of learners, has led to greater pressure both on clinical placement capacity and the mentors that support and assess practice learning. So, we now have more learners, earlier in their training and for longer periods of time. What effect has this had on your clinical area?

COORDINATION OF PLACEMENTS

Placements in Focus (ENB and DH, 2001) recommended that the responsibility for clinical placements in terms of capacity and quality be delegated to service providers. This has led to the creation of **Clinical Placement Facilitator** or **Practice Placement Facilitator** posts based within Trusts. These roles evolved alongside the introduction of the *Making a Difference* programmes (DH, 1999). A key feature of the role is the link that these post holders have with the organizations involved with both uni- and interprofessional preregistration education, namely the University, the Strategic Health Authority and the Trusts. These and other similar clinical support roles have been highlighted as being key to ensuring the dissemination of good practice within clinical placements, and supporting learners in order to ensure they are fit for practice on registration (Ajiboye, 2000; Downes, 2001; Birchenall, 2001; Lambert and Glacken, 2004). Practice Placement

Facilitators (PPFs) have quite a challenging role. Their local knowledge enables them to be proactive in response to service reconfigurations and compromises to student capacity (James, 2005). They are now responsible for auditing the learning environment, collating student evaluations and coordinating mentorship updates.

Furthermore, in some Trusts the development of practice learning teams, comprising university lecturers and clinical staff, has been useful in developing, enhancing and maintaining the learning environment and providing guidance to learners (Chapple and Aston, 2004). This ensures that learners undertake placements that are relevant and appropriate to their practice and theoretical outcomes. This demonstrates that there have been major shifts in the way placements are allocated and, most significantly, learners no longer attend placements where 'workers' are required.

ACTIVITY 8.3 FOCUS ON YOUR WORKPLACE

Within your own practice area, how many learners do you have? Are they from one specific profession? Who supports their education? What are the challenges? ■

You may feel that you have too many students. Each workplace, in partnership with their academic colleagues, needs to consider the range of learning opportunities available and the capacity they have to support learners. The NMC requires us to be active in this vital aspect of students' professional development.

CLINICAL STAFF

We now need to consider some of the staff who are responsible for the learning experiences.

TEAM LEADERS

It has long been recognized that the person who leads the team is key to setting the ethos of the clinical learning environment. Team leaders (ward managers, superintendent, lead practitioner, etc.) are the professional gatekeepers of the learning environment but with the increasing demands placed on them, they may not always be able to take

responsibility for clinical learning. The team leaders' roles have evolved and they are often accountable for managing their own budgets. Team leaders must have the ability to create a positive learning environment, have a positive attitude towards students (Saarikoski and Leino-Kilpi, 2002) and foster the conditions that produce a conducive learning environment. As a manager and leader, there needs to be a commitment from them for the growth and professional development of their staff, creating trusting relationships with them and finally engaging with and knowing their staff. Team leaders need to create an environment where learners feel they belong. There is an acknowledgement that where this occurs, learners actively participate in care, feel part of the team and have the opportunity to learn. In addition, the team leader needs to create an environment where the dual role of the registered practitioner as an educator and a clinician is enabled.

LEARNER ROLE

For learners to achieve they need to be active in the learning process. This underpins the philosophy of adult learning and recognizes that learning results from interacting with the opportunities available within the placement. However, at times the learner's role may be unclear. Are they supernumerary? At times, the learner's supernumerary status may be compromised when staff shortages, patient care demands or cuts to staffing establishments require staff to be moved around wards and units. Are they workers? Well, they are expected to work under supervision but the definition of supervision ranges from working alongside their mentor to being supervised 'long arm'. Often students are not aware of this 'long arm' supervision and are left feeling anxious, believing that they have ultimate responsibility for clients' care. Are they students? They are university students but do not enjoy the luxury of long holidays and other benefits that most students have. They have to produce academic work whilst balancing their clinical work time and, for some, the family demands of their home life. This role conflict must impact on their learning.

In clinical practice, the manager still has responsibility for the students and the roles they undertake. Within nursing, the NMC places great emphasis on the individual practitioner's own accountability. This reflects the view that as the ward managers' role has evolved, mentors have increased clinical freedom. Having 24-hour responsibility for patients puts a strain on the ward manager who is becoming increasingly absent from the clinical area and therefore undertakes less direct care on a day-to-day basis (Donnelly, 2003). Therefore they have less influence over the management of learners. What might this mean for them in practice and for the team reader's role in mentoring an individual learner?

THE MENTORS

Professional bodies such as the Nursing and Midwifery Council (NMC) and the Health Practitioner Council (HPC) have highlighted the crucial role of the mentor within the learning environment. Each nursing and midwifery student is expected to work 40% of their time with their mentor (NMC, 2006). This relationship needs to be nurtured to enable a humanistic approach to learning. Individual learner needs are identified with the use of learning contracts, and the mentor facilitates the achievement of the learning outcomes. However, the increasing numbers of learners, and the higher turnover of patients, puts an incredible strain on the workload of the mentor.

Furthermore, the type of care provided reflects the philosophy of facilitation – a humanistic, holistic approach to client care prevents task allocation. The consequence of this is that learners need to learn all tasks related to care provision, rather than learning one particular task and performing it on numerous patients. This in turn increases the need for greater supervision and support.

NATURE OF THE LEARNER

Learning occurs within a 'web of relationships' permeated with values about individuality, knowledge and society that reflect larger cultural, economic and political issues (Williams and Calvillo, 2002). Factors such as the age of the learner, their past experience and the clinical placement itself can either facilitate or hinder the support that is available to the learner. With a clearer focus of widening participation, diversity is actively encouraged (Grundy, 2001).

ACTIVITY 8.4 THE STUDENT AS AN INDIVIDUAL

Consider your most recent students. What were their individual differences? You may wish to compare these to the differences of the other members of your team. ■

EFFECTS ON LEARNING

Culture

Culture is often viewed as the customs, civilization and achievements of a particular people (Soanes and Stevenson, 2004). This information needs to be explored in the

initial meeting with the mentor and learner, although the effects of culture on learning are not usually seen as a priority when writing the learning contract. Williams and Calvillo (2002) highlight the changing influences on learners' culture. These include ethnicity, age and gender, place of birth, immigration status, lifestyle, education and career background.

Gender

More learners with young children are entering the profession and some of these are sole breadwinners. Increasing moves towards family friendly practices can conflict with rigid curricula and practice hours leading to challenges associated with managing home life and the responsibilities associated with preregistration programmes. The conflict is increased further when coupled with the reduced capacity for learner placements, and the increased need for learners to travel further a field.

When considering male learners, there is evidence to suggest that male nurses may be less likely to seek emotional support and that it may be perceived that as a result of gender stereotyping they are seen as less likely to require emotional support (Milligan, 2001). Gender stereotyping has been researched by O'Lynn (2004) and appears to be evident within the education system. There are a lack of sufficient role models and exposure to non-feminist models of care. Male learners experience feelings of isolation, less exposure to learning opportunities and lack of support on physical interaction with patients. There is also evidence to suggest that male nurses are expected to undertake more masculine roles in care delivery such as manual handling (Anthony, 2004).

ACTIVITY 8.5 GENDER MATTERS

Consider the gender of your students.

- Do you treat them as equal?
- Do mothers have more sociable shift patterns?
- Are males given the same learning opportunities as women?
- Do they get involved in all activities?
- Do clients treat them any differently?
- Do students without children have to travel further to their placements? ■

Nationality

Mentors are supporting learners in an increasingly multicultural society; with European Union expansion, and the need for adaptation programmes for overseas learners, mentors have to develop a greater range of skills. These include having to facilitate learning opportunities for learners who are experienced registered nurses in their own country. Issues that may arise include inducting these learners into the working practices of the NHS, supporting adjustment into the cultural and societal differences that influence how health care is delivered in the UK and differences in the academic system itself (Burnard, 2005). Intercultural mentoring has been found to be both a rewarding and frustrating role and mentors require additional preparation on how to manage the complexities associated with mentoring overseas learners, such as differences between concepts of time, health and lifestyles (Koskinen and Kerttu, 2003).

ACTIVITY 8.6 BEING A MENTOR IN A MULTI-CULTURAL SOCIETY

Consider a colleague who qualitied outside the UK. How might their needs be different when joining your team? How can their experience help your practice? ■

Education and background

The widening of the entry gate and the establishment of stronger links with Higher Education Institutions (HEIs) has occurred as a result of the UKCC commission into preregistration education (UKCC, 1999). In addition, the development of schemes aimed at managing the education needs of those aged 16 and over in local communities, such as Modern Apprenticeships schemes and Learning and Skills Council's programmes, has resulted in access to preregistration nursing education for students who previously would not have been able to do so (DEE, 2000). Those who have a National Vocational Qualification in Care (NVQ) at level 3, or Level 2 plus additional qualifications, as well as those with the traditional GCSEs and 'A' levels, are now able to access preregistration nurse education. Strategic Health Authorities provide commissions for existing Health Care Assistants (HCAs) to be sponsored to undertake preregistration nurse education. As these learners already have some experience of health care and may have already

achieved some of the clinical practice outcomes required by the end of the Common Foundation Programme as part of the NVQ programme, their presence in the student population can create challenges for mentors. With all these variations in access to care programmes, placement areas may feel overwhelmed with the numbers of learners needing support. Therefore learners are entering nursing with a wide and diverse range of previous experience (Grundy, 2001) and, if mentors are to treat them individually, this places further challenges on the mentor as no two learners are the same.

Furthermore, learners with a range of disabilities are now welcomed into preregistration programmes. These include certain physical, mental health and minor learning difficulties. As long as the practice area makes reasonable adjustments to the environment, learners with dyslexia, hearing impairment and other specific learning needs may be able to achieve the learning outcomes.

ACTIVITY 8.7 SUPPORTING THE STUDENT WITH ADDITIONAL NEEDS

Take some time to talk to colleagues, academic links/placement facilitators about the mechanisms in place (available) to support students with special needs and how you can access them. ■

To check your answers contact your link lecturer from the university or the practice placement facilitator.

Socioeconomic status

Diploma students in England are eligible for a non-means-tested NHS bursary; however, degree students can only apply for a means-tested bursary. This may cause stress and anxiety in practice, as many learners have to take on additional paid employment to remain financially secure. Whilst this is recognized as being a necessity for many learners, there are not always systems in place to allow the number of extra hours worked outside of placement and university time to be monitored, and consequently usual working time directives may be breached. As a result, learning may be compromised through tiredness or restricted by commitments to outside employers.

ACTIVITY 8.8 THE SHIFT DILEMMA

Consider the following dilemma. A very good, hardworking student cannot be allocated night duty or weekend work, as she already has a paid part-time job. You know that the NMC insist that students experience the full 24 hour, 7 days a week student experience.

- What would you do?
- What is the University's policy on this? ■

It might be expected that when learners commence nursing they have family support; however, this may be influenced by the value placed on nursing as a profession or the lack of understanding about academic nursing programmes. In some ethnic groups, nursing is seen as an unsuitable profession and therefore financial support may not be forthcoming. However, in a multicultural society, in order for nurses to deliver care to diverse groups, we need to recruit and support nurses from these diverse backgrounds.

Motivation

Learners' motivation may be influenced by their perception of the value of the placement experience, the registered practitioners supporting them or the input of visiting university lecturers. These can either have a positive or negative impact. As previously mentioned, placement capacity within acute areas has reduced significantly and more non-traditional environments are sought to achieve the NMC learning outcomes, curriculum requirements and the government strategy for healthcare advocate the value of such settings (ENB, 2000b; DH, 2001b). This has resulted in the increased use of care homes (nursing). Evidence suggests that the learners undervalue such experience; implying that these placements only provide basic care rather than seeing these as essential nursing skills. Learners being placed in such settings may feel their learning experiences are of less value when compared to more acute areas. Therefore there are challenges in motivating learners undertaking placements in areas that have traditionally not been accessed. The practitioner mentoring learners with negative perceptions of either the case mix or the environment face special challenges in facilitating learning and working with the learner to view the placement and its learning opportunities in a positive way.

However, learners themselves have highlighted one of their key motivators. They are motivated when the interpersonal relationships that they have with placement staff is good and identify this as being essential for their learning. Learners are also encouraged by feedback on their performance and by being exposed to situations that allow them to develop their problem-solving and decision-making skills.

Whilst most learners evaluate practice positively, some report feeling unwelcome, being ignored, having no support or working to non-specific objectives. Learners may enter the clinical placement with unrealistic expectations both of what the role of the registered practitioner actually is and what can realistically be gained from the placement experience. The mentor therefore needs to be aware that part of their role is associated with socializing learners into the reality of nursing in the twenty-first century. The positive experiences reported by learners that increase their motivation are: appreciation and support; quality of mentorship and patient care; and learner self-directedness.

Stage of training

The stage of the programme that the learner is on when undertaking a placement may influence the learning environment (Matsumura *et al.*, 2004). This study found that staff nurses preferred learners who were more senior, for example third years, as they were more 'useful'. How did this compare to your preferences? Did you agree? They also preferred learners who asked questions and were motivated. Furthermore, the quality of learner preparation by the university before the placements was also shown to affect the staff nurses' interactions with the learners. This preparation is becoming more jointly owned by the learner and the HEI with the increasing use of *electronic ward profiles* (DH, 2001a) and involving senior Trust staff in placement preparation sessions.

HIGHER EDUCATION INSTITUTIONS

When considering the learning environment, we must not underestimate the links with the HEI. There needs to be a positive and harmonious relationship between the university and service providers with good channels of communication between the two. This ensures that the theory and practice elements of the programmes complement each other. The aims of practice learning are set by the university but the distance between the education provider and service can lead to breakdown in communication.

The university also has a role to play in ensuring that there are effective and efficient systems in place to provide learning support for learners when necessary. This could take the form of designated study skills and student support units

NURSING AND MIDWIFERY TEACHERS

Relocation of teachers into universities has changed the complexion of the support for learners in the practice area, reducing the amount of contact that teachers have with learners in the clinical setting. It has been suggested that the move of preregistration education from hospital-based schools of nursing into higher education institutions has resulted in nurse teachers being unsure of their role in the clinical setting, which may be exacerbated by having an identified workload within the university. For some nurse teachers there is the view that classroom teaching takes precedence, which may be dictated by pressures within the university, resulting in clinical credibility being sacrificed for academic credibility. Mitchell (2005) supports this concern, highlighting that despite the fact that regular communication between education and practice is vital, it appears to be compromised by the heavy administrative tasks given to the lecturers, the lack of matching lecturers' clinical expertise to the type of practice area to which they have been allocated and the large number of clinical areas they are expected to support. Clinical support and teaching in the practice area is now undertaken by clinical staff.

MODE OF ATTENDANCE

In order to widen the entry gate, programmes are now much more flexible with more pathways for part-time learners. To embrace the widening entry gate, there are now identified 'stepping off and stepping on' points, where learners can take breaks to suit their personal circumstances. Learners with family commitments may decide to start on a part-time programme, but as these family demands reduce, they may transfer to full-time programmes. The consequences of this may mean that learner may be difficult to track. Again this can present further challenges for mentoring.

CLINICAL ENVIRONMENT

LEARNING OPPORTUNITIES

When providing quality clinical placements, best practice is led by placements that have developed **placement profiles**. These outline the learning opportunities available, and the learning outcomes expected from the placement. By involving placement staff in writing these, their awareness and perceptions of learning opportunities within their individual placement can be made more explicit to them, and they are better equipped to support learning. Mentors can be supported in writing these profiles and identifying

learning opportunities by attending the mandatory mentor updates (NMC, 2006). In addition, specified practice outcomes and the mapping of these to individual placements can highlight to learners and mentors what is to be achieved and how it can be achieved.

ACTIVITY 8.9 THE OUTCOMES FOR YOUR WORKPLACE

How do your students know what the learning outcomes are for your practice area?

How do you know what the learning outcomes are for?

How can this information be accessed by you and your students? ■

Learners experience uncertainty and anxiety when they are unable to be provided with, or unable to recognize, opportunities to develop their competence when undertaking clinical placements. Factors which contribute to this uncertainty are: unavailability of staff due to time constraints; shortage of equipment to meet patient needs; conflict in the expectations between the teachers and clinical staff; and lack of awareness amongst senior staff about the needs of junior students.

Linking relevant learning opportunities and experiences that are outside the boundaries of the traditional placement have been developed. These allow the learner to follow the **patient pathway** through a speciality, or allow the learner to focus upon themes such as management (Donnelly, 2003). Such opportunities include time spent with Clinical Nurse Specialists and in areas that provide valuable learning experiences but which are not suitable for long-term placements, such as cardiorespiratory departments. By developing pathways or 'virtual' learning environments, placement providers are able to expose the learner to the range of contexts in which the registered practitioner functions in the modern NHS (ENB, 2000b). Setting specific objectives and mapping objectives to predetermined outcomes has been found to be useful in developing the learning environment in shorter and non-traditional placements that are now being accessed by learners, such as an out-patients department. In one NHS Trust, patient pathways have been developed which map practice learning and theoretical module outcomes to individual placement areas. Although the impact of these has not been researched, there has been positive feedback from mentors and learners where these have been implemented and they are seen as a valuable resource to support practice learning.

ACTIVITY 8.10 BROADENING THE OPPORTUNITIES

When identifying your placement's potential learning opportunities, have you considered what other professions can offer? What could this include? ■

The introduction of an Interprofessional Learning Programme for eight health-care professions at one university has driven forward developments in ensuring that student nurses and midwives work with, and learn from, other health-care professionals (DH, 2001a). With the advent of interprofessional placements on the horizon, new and exciting challenges lay ahead for mentors as they will be supporting learners from not only nursing but also from other professions such as medical imaging, midwifery, occupational therapy, operating department practitioners and social work. Patient pathways have been developed that incorporate the interprofessional ethos. These can be regarded as instrumental in assisting mentors and learners to make the relevant connections between nursing and the contribution that other health-care professions make to patient care. This process is instrumental in achieving the objectives of the *Priorities and Planning Framework 2003–2006* (DH, 2004).

CARE SETTING

When considering the physical location of the learning environment, practitioners may follow traditional stereotypes and immediately think of acute hospital settings. You may have noticed that television programmes tend to reinforce the notion of health-care practitioners working in the hospital setting. However, for tomorrow's practitioner, this will not be the case. There has been an expansion of intermediate care, as outlined in the *National Service Framework for Older Persons* (DH, 2001b), in an attempt to maximize independence and keep people in their own homes if possible (Trappes-Lomax *et al.*, 2006). Primary care constitutes a 'diverse and fertile source of learning' (Goppee *et al.*, 2004). It is in this area of practice that practitioners can be truly autonomous. There are now: first contact and acute assessment treatment and referral centres; continuing care, rehabilitation and chronic conditions management; and public health protection and promotion programmes.

Learners need to be able to respond to demographic shifts in populations and diversity and have knowledge of the community and facilities in the local area (Redding, 2007).

This could include the local prison, detention centres and low income housing centres; in fact, anywhere care is being delivered in a multiprofessional way. It should be possible to 'follow the patient's journey', rather than take a snap shot in time.

ACTIVITY 8.11 THE CLIENT JOURNEY

Consider one of your clients. When and where does their 'journey' begin? What happens to them? What type of practitioners do they see? What are their roles? How can you expose your student to this type of experience? ■

COMMUNITY SETTING

There are new challenges when placing students in primary care. Often this is with a community practitioner on a one-to-one mentoring basis. Whilst this attention may be desirable, it has a separate set of challenges to be considered.

ACTIVITY 8.12 ONE-TO-ONE MENTORING

What may be the advantages and disadvantages of one-to-one mentoring in the community? ■

You may have considered that such close mentoring brings with it the opportunity for close assessment and more individual teaching. However, local feedback has suggested that this close contact can be too intense and can lead to minor irritation between the mentor and the learner. Often the learner and mentor are confined to a car, with office space unable to accommodate additional students. Perhaps the community practitioner could consider ways of sharing the learner, such as team mentoring. Other concerns are raised when health-care learners are working in non-traditional care settings such as prisons. Who assesses the learner? Are there always NMC recognized practitioners available?

WARD PLACEMENT

The aim of ward layout is to provide a safe environment for patient care where the nurse in charge can observe junior staff and monitor their activities. With traditional Nightingale wards, the nurse in charge was able to observe junior staff and monitor their activities; however, it is harder, if not impossible to do this in wards based on bays. This impacts upon the supervision of learners and the ability of the team leader to monitor mentors' skills. Furthermore, learners and mentors in wards based upon bays cannot always be aware of activities taking place elsewhere on the ward, so valuable learning opportunities may be missed.

WORK ALLOCATION/CARE DELIVERY

When considering the effect of the learning environment on the quality of learning, there has always been a belief that the use of a model of care was crucial for providing a good learning environment (Fretwell, 1980). However, it has been found to have no impact upon the quality of care delivery (Tiedeman and Lookinland, 2004). The study concluded that the standard of education, the competency of the nurse, the nature of support systems and the motivation and leadership qualities of the ward manager were the factors most likely to influence the quality of care.

However, the type of nursing employed within the placement has been shown to affect who makes the decisions relating to nursing care. A functional approach leads to all decision-making, communication with others and responsibility for care being the sole domain of the ward manager. Where team nursing is advocated, coordination of care becomes the responsibility of team leaders. Staff management, patient care and communicating with others become the responsibility of the team leaders, who are also accountable for care decisions. In primary nursing, the primary nurse is accountable for all care decisions. where team or primary nursing is employed the role of the ward manager is regarded as one of a teacher, a role model and manager. therefore the type of nursing can impact upon learner and mentor motivation. From a mentor's perspective, team nursing has the lowest level of job satisfaction, and therefore placements where this style of care is adopted may adversely affect the learners' experience.

Another significant factor affecting the learning experience is the type of patient found in the clinical area and the category of their need, such as surgical, medical or gynaecology. However, Government targets, such as reducing waiting times in accident and emergency departments, have led to patients being transferred out of the departments to wherever a bed is available. Patients then may be nursed on a ward that does not reflect their 'speciality' for admission. The staff may be less confident and skilled in

managing the patient's specific care needs and therefore learning opportunities for the learner can be reduced.

CHAPTER SUMMARY

This chapter has reflected on the learning environment experienced by our learners. In particular, the factors that have an influence on learning in practice have been considered and some of the changes and advances since Fretwell's seminal work in the 1980s have been explored. The reader should now be able to consider their own practice area and challenge some of these issues, and perhaps implement improved strategies for better learning.

The learning environment is subject to constant change. These are due to locally and nationally defined changes to the provision of care and service delivery, resulting in service reconfiguration. Further changes have resulted in the diversity of learners entering the learning environment and the programmes they are undertaking. It is certainly challenging times for mentors, who may wish to consider whether we have resolved the conflicts found by Fretwell, or are they still with us today?

REFERENCES

Ajiboye, P. (2000) Learning partners. *Nursing Standard*, **14** (51), 53.

Andrews, M., Bromwich, J., Jacobs, L. et al. (2003) Occasional Paper No1. *The Practice Placement Coordinator Project: Influence and Impact on Practice Education*, Canterbury Christ Church University College, Canterbury.

Anthony, A. (2004) Gender bias and discrimination in nursing education: can we change it? *Nurse Education*, **29** (3), 121–5.

Birchenall, P. (2001) Education facilitation: a developing role. *Nurse Education Today*, **21**, 249–50.

Burnard, P. (2005) Issues in helping students from other cultures. *Nurse Education Today*, **25**, 176–80.

Chapple, M. and Aston, E.S. (2004) Practice learning teams: a partnership approach to supporting students. *Clinical Learning Nurse Education in Practice*, **4** (2), 143–9.

Department for Education and Employment (2000) *Raising Standards in Post-16 Learning*, The Stationary Office, London.

Department of Health (1999) *Making a Difference: Strengthening the Nursing and Midwifery and Health Visiting Contribution to Health and Healthcare*, DH, London.

Department of Health (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*, The Stationery Office, London.

Department of Health (2001a) *Working Together; Learning Together – A Framework for Lifelong Learning*, DH, London.

Department of Health (2001b) *The National Service Framework for Older Persons*, DH, London
Department of Health (2004) *The NHS Plan: Priorities and Planning Framework 2003–2006*, DH, London.
Donnelly, A. (2003) Creating virtual placements for student nurses. *Nursing Management*, **10** (4), 19–20.
Downes, M. (2001) Support for student training: a new role as demonstrators. *Nursing Times*, **97** (7), 39.
English National Board for Nursing. Midwifery and Health Visiting (2000a) *Education in Focus. Strengthening pre Registration Nursing and Midwifery Education*, ENB, London.
English National Board for Nursing. Midwifery and Health Visiting (2000b) *Education in Focus. Strengthening pre Registration Nursing and Midwifery Education Curriculum Guidance and Requirements: Adult Branch*, ENB, London.
English National Board for Nursing. Midwifery and Health Visiting and Department of Health (2001) *Placements in Focus. Guidance for Education in Practice for Health Care Professions*, ENB, London.
Fretwell, J. (1980) An inquiry into the ward learning environment. *Nursing Times*, **76** (16), 69–75.
Fretwell, J. (1982) *Ward Teaching and Learning: Sister and the Learning Environment*, RCN, London.
Goppee, N., Tyrrell, A., Raven, S. et al. (2004) Effective clinical learning in primary care settings. *Nursing Standard*, **18** (37), 33–7.
Grundy, L. (2001) Pathways to fitness for practice: National Vocational Qualifications as a foundation of competence in nurse education. *Nurse Education Today*, **21**, 260–5.
James, R. (2005) Reducing overcrowding on student practice placements. *Nursing Times*, **101** (48), 28–32.
Koskinen, L. and Kerttu, T. (2003) Characteristics of intercultural mentoring – a mentor perspective. *Nurse Education Today*, **23** (4), 278–85.
Lambert, V. and Glacken, M. (2004) Clinical support roles: a review of the literature. *Nurse Education in Practice*, **4** (3), 177–83.
Matsumura, G., Callister, L.C., Palmer, S. et al. (2004) Staff nurse perceptions of the contributions of students to clinical agencies. *Nursing Education Perspectives*, **25** (6), 297–303.
Milligan, F. (2001) The concept of care in male nurse work: an ontological hermeneutic study in acute hospitals. *Journal of Advanced Nursing*, **35** (1), 7–16.
Mitchell, M. (2005) The role of the link teacher in the context of nurse education. *Nursing Times*, **101** (50), 33–6.
Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice: NMC Standards for Mentors, Practice Teachers and Teachers*, NMC, London.
O'Callaghan, C. and Slevin, E. (2003) An investigation of the lived experiences of registered nurses facilitating supernumerary student. *Nurse Education Today*, **23** (2), 123–30.
O'Lynn, C. (2004) Gender based barriers for male students in nursing education programmes prevalence and perceived importance. *Journal of Nursing Education*, **43** (5), 229–36.
Redding, D. and Anglin, L. (2007) How many is too many? Collaboration of multiple nursing organizations for professional development. *The Journal of Continuing Education in Nursing*, **38** (3), 132–9.
Saarikoski, M. and Leino-Kilpi, H. (2002) Association between quality of ward nursing care and the students assessment of the ward as learning environment. *Nursing Times Research*, **4** (6), 467–75.

Soanes, S. and Stevenson, A. (eds) (2004) *Concise Oxford English Dictionary*, University Press, Oxford.

Tiedeman, M.E. and Lookinland, S. (2004) Traditional models of care delivery: what have we learned? *Journal of Advanced Nursing*, **34** (6), 291–7.

Trappes-Lomax, T., Ellis, A., Fox, M. et al. (2006) Buying time: a prospective, controlled trial of a joint health/social care residential rehabilitation unit for older people on discharge from hospital. *Health and Social Care in the Community*, **14** (1), 49–62.

United Kingdom Central Council for Nursing. Midwives and Health Visitors (1999) *Fitness for Practice*, UKCC, London.

Williams, R.P. and Calvillo, E.R. (2002) Maximizing learning among students from culturally diverse backgrounds. *Nurse Educator*, **27** (5), 222–6.

CHAPTER 9
THE DEVELOPMENT OF COMPETENCE IN NEWLY QUALIFIED PRACTITIONERS

Tim Clark
Canterbury Christ Church University

LEARNING OUTCOMES

At the end of the chapter you will:

- **Have an overview of what competence is and the factors influencing competence in practice**
- **Have a structure to enable their students to develop personally and professionally**
- **Consider the issues that help to develop confidence with students**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

INTRODUCTION

This chapter is about competence and explores some of the issues for mentors and preceptors helping to develop competence in those they are supporting. In Chapter 2, one learner stated that:

some placements were really good and some were awful, but what really worries (me) is that it is not about now. What if in another 18 months I still don't fell competent to practise? I will be frightened to leave the cover of being a student.

This quote raises a number of key issues including:

- the variability of quality of placements;
- the stress invoked;
- the reality of the consequence of future practice;
- lack of confidence in competent performance and;
- the reticence at leaving the relative safety of student hood.

Unless the learner can safely manage, or be managed through these issues, they are likely to struggle when they become qualified staff. Newly qualified staff therefore have some very discrete needs and yet it often falls to the same people who act as mentors to also support these and other new or inexperienced staff.

In some ways the needs of these staff appear very similar to students and as such some people treat them in the same way. One major difference is that qualified staff are considered to be competent to practise. Given their experiences as students, there have been concerns regarding how well staff are prepared for their new role as qualified staff (Gerrish, 2000). She indicates that some of the problems in the preparation of students have not significantly changed over the years (Gerrish, 2000).

The focus for new staff is on developing competence, but whilst this would appear to be straightforward, there is a lack of clarity in what is meant by the central terms such as **competence**, and how this can be developed. For new staff this comes at a time of transition from the role of student to the role as a qualified practitioner. The process of socialization causes pressures on the new practitioner (Gray and Smith, 1999) and they therefore require the support of a more qualified colleague to assist with this period of development. The Nursing and Midwifery Council (NMC) does not enforce a period of preceptorship although it 'strongly recommends that all new registrants have

a period of preceptorship to make the transition from student to accountable practitioner' and to enable the development of their confidence they should have access to protected learning time and a **preceptor** (NMC, 2006). Whilst no formal qualifications are associated with being a preceptor, they are expected to have at least one year's experience in the clinical area and have undergone mentor preparation.

This chapter explores the issues surrounding competence in newly qualified staff and suggests key features influencing the development of this in practice. This is based on research completed with newly qualified nurses (Clark, 2005, 2007). The suggestion is made that new practitioners deal with the process of transition into professional practice by adopting a cloak of competence. Appropriate preceptorship, when present, enables the development of confidence and competence in practice.

WHAT IS COMPETENT PRACTICE?

Professional bodies such as the NMC require all new practitioners to be competent in their area of practice. What does this mean to you as a practitioner? What do you understand by the term competence?

ACTIVITY 9.1 COMPONENTS OF COMPETENCE

List the features you feel are the components of competence. ■

What was on your list? Some people find it quite difficult to think about these 'everyday' ideas, but most people might include knowledge and skills. The fact is that we often tend to take these ideas for granted. There is some debate about what we mean by the idea of competence. We need to be clear what it is before we can really know how best to develop it. The definition of competence has been difficult as it is both nebulous and open to interpretation and is defined in different ways by different people (Watson *et al.*, 2002). The effect is that there is considerable confusion between competence as the ability to perform or to 'do something' (Eraut, 1994a) and the possession of certain qualities (Short, 1984). There is also a lack of clarity between competence and other concepts such as expertise, ability and/or capability (Eraut, 1994b). We may also think that competence means more than just adequate performance; it is something more than the normal standard.

So competence may comprise the practitioner's general attributes that are crucial to effective performance, such as knowledge, skills and attitudes and the level of performance. Whilst these reflect the elements essential for competent nursing, there may be difficulties due to the 'theory–practice gap'; that is, there are known to be differences between 'what theories say should happen' and 'what people actually do in practice'. This difference between theoretical knowledge and actual performance may be significant and this makes it difficult to be sure what we need to be judging. Is it what people say they do, or what they actually do? Ascertaining the meaning of competence and competency in nursing is, therefore, fraught with difficulty. Nevertheless, the newly qualified are expected to have reached a standard of autonomous practice for which they can be held to account and the NMC (2006) uses 'competence' to describe safe and effective practice in the absence of direct supervision.

The understanding of competence has been complicated by interchangeably using different terms in the literature such as competence, competency, capability and performance. This is supported by Manley and Garbett (2000) who suggest that there appears to be a distinct difference between competence and competency although the words are sometimes considered to have the same meaning.

ACTIVITY 9.2 DEFINITIONS

Which of the following definitions most closely fit with your views expressed in activity 9.1?

'Competence and competences are job related, being a description of an action, behaviour or outcome that a person should demonstrate in their performance. Competency and competencies, on the other hand, are person-orientated, referring to the person's underlying characteristics and qualities that lead to an effective and/or superior performance in a job.' (McMullan *et al.*, 2003, p. 284) ■

The distinction is subtle and has become blurred over time (McMullan *et al.*, 2003) and the definition of competence has therefore been difficult (Black and Wolf, 1991; Philips *et al.*, 1994).

ACTIVITY 9.3 REFLECT ON THE FOLLOWING QUOTE

Bradshaw (1998) poses a number of challenging question. Consider the following quote and consider what she is asking.

'As a registered general nurse, how do I know with confidence that I have the necessary and adequate knowledge and skill needed to perform my duties and responsibilities? Conversely, how do I know that I do not have the necessary knowledge and skill so that I am aware of what my limitations are? How do I know what I know? How do I know what I do not know? What is the objective standard against which my knowledge and skill is measured as competent and by which I can improve my knowledge and skill to reach further competency? What is the basic level and standard of competence expected of me . . .?' (p. 348)

Although Bradshaw is focusing on nursing, is there relevance to other professions; a number of colleagues in other disciplines have suggested it is true for them. Consider your experience:

Do you have necessary and adequate knowledge and skills?
How do you know this?
Are you clear as a practitioner what the basic level and standard is?
Who sets these standards?
Are they really objective?
If you can't judge yourself, who should? ■

Clearly the role of an individual to provide appropriate feedback and guidance is crucial in guiding the development of competence and to influence what Gerrish has described as 'fumbling along' (Gerrish, 2000). As identified in Chapter 1, students in the UK have used the mentorship model since the 1980s and this has been supplemented by the role of preceptor for newly qualified staff or those moving into a different area of practice.

PRECEPTORSHIP

Newly qualified practitioners are recommended by the NMC to undergo a period of preceptorship (NMC, 2006), who clearly define what they and their preceptor should do:

The preceptor should:

- *facilitate the transition of the 'new registrant' from a student to a registrant who is;*
  onfident in her practice,
  sensitive to the needs of patients/clients,
  as effective team member, and
  up-to-date with her knowledge and practice.
- *provide honest feedback to 'new registrants' on those aspects of performance that are being undertaken well;*
- *provide honest and objective feedback on those aspects that are a cause for concern and assist 'new registrants' to develop a plan of action to remedy these;*
- *facilitate 'new registrants' to gain new knowledge and skills, and*
- *be aware of the standards, competencies, or objectives set by the employer that the 'new registrant' is required to achieve and support them in achieving these.*

The role of the preceptor is therefore wide ranging and a significant influence on the development of new staff. The benefits of preceptorship are well documented and there is consensus that these benefits include improvement to the care given to patients as well as benefits to the preceptee and preceptor (O'Malley *et al.*, 2000). Ohrling and Hallberg's (2000) phenomenological study of the lived experience of preceptorship concludes that the preceptor role is a conscious and energy demanding one and highlights the need for time to be set aside. The importance of preparation for the role has been identified by Kaviani and Stilwell (2000) who emphasize the role of educators and suggests that nurses should not be assumed to be automatically suitable as preceptors simply because of their knowledge and skills; the ability to teach clinically was seen as equally important.

Hardyman and Hickey (2001) completed a large, longitudinal study of what new nurses expected from preceptorship; 97% of respondents wanted a preceptor in their first nursing job and wanted the preceptor to teach them clinical skills and help them make a smooth transition into their new role. Armitage and Burnard (1991) suggested that preceptorship has an important role to play in bridging the theory–practice gap helping new nurses to translate knowledge, principles and theories into practice and make sense of new clinical skills.

Myrick and Yonge (2001) identified that the preceptor significantly influences the preceptorship experience, with sensitivity and caring about the preceptee and valuing their contribution to the workplace all found to enhance the experience of preceptorship and helped to create an environment conducive to critical thinking.

Whilst the roles of mentor and preceptor have been found to be difficult to define, and indeed many sources tend to use the terms almost interchangeably, there does seem to be an important distinction to be made. Whereas students (as mentees) need to be taught the knowledge, skills and attitudes for professional practice within a number of differing contexts, newly qualified staff (as preceptees) are already trained. They are therefore peers of their colleagues and could be assumed to have gained some knowledge, skills and attitude albeit at a minimal level. However, Duffy (2004) has identified that some nurses 'fail to fail' students for a variety of reasons and the consequences of this may be that some nurses qualify who have not actually got the required knowledge skills and attitudes. In my research I found that newly qualified nurses did not feel confident enough to describe themselves as ready for professional practice at the point of registration (Clark, 2005).

ACTIVITY 9.4 PERSONAL EXPERIENCES

What is your experience? Try to remember when you first qualified.
Did you feel ready for professional practice?
Why were you ready?
Why were you not ready? ■

The NMC, similar to other professions, require newly qualified staff to identify that they have met the requirements for qualification and are ready to register. Whilst university systems are robust, there is a potential for individuals to sometimes avoid the points of scrutiny within preregistration courses. There are anecdotal accounts suggesting some students have forged assessor's signatures, forged placement records to allow them to avoid some placements completely, plagiarized peers work or accessing tailor made work from Internet sites. Clearly the absence of appropriate professional attitudes alongside serious fraudulent activities should render such individuals as inappropriate to join a profession. They do not warrant the title and privileges of professional qualification. The various 'gates' described in Chapter 10 are clearly important filters to ensure inappropriate people do not gain professional qualification and be considered competent. Therefore, the professions and society require practitioners to be competent, but what do we mean by competent?

ACTIVITY 9.5 OWN DEFINITION

Try to write your own definition of competence.

If you are not a nurse or midwife does your own professional body clearly define what they mean by competence? ■

The operational definition we have used sees safety as the minimum level of competent practice. Competence is seen as a concept involving a relationship between the practitioner and the practice setting that has a prime and central purpose of delivering a range of often complex professional services. Within this environment, professional competence develops in settings that provide a range of learning opportunities and have differing work cultures. The development of professional competence comprises the acquisition of certain knowledge and skills and the development of an attitudinal approach that is congruent with the professional and traditional values within the area (Clark, 2005).

Competence is characterized by the presence of the components of appropriate knowledge skills and attitudes to enable safe care to be given within a defined practice situation. These broad components interrelate within a profile of:

- skills (practical, technical, interpersonal, organizational, ability to transfer into other settings)
- knowledge (up to date, critical thinking, reflection)
- attitude (values and beliefs, professional attitudes, confidence)
- practice situation (adequate resources, ethos of support, reasonable workload).

Clark, 2005

ACTIVITY 9.6 KEY COMPONENTS

Consider the above definitions.

As a mentor or preceptor can you list the core practical, technical skills you feel a new practitioner needs in your clinical setting?

What is key knowledge that underpins these skills?

What are the key values and attitudes needed in this area?

What constraints does the practice setting impose on the process? ■

There is a need for clarity regarding the nature of the knowledge, skills and attitudes and the constraints that exist in the real world of the practice situation. They are key features for a preceptor to be aware of and determines the focus of the preceptorship. According to the NMC (2006):

Preceptorship is about providing support and guidance enabling 'new registrants' to make the transition from student to accountable practitioner to:

- *practice in accordance with the NMC code of professional conduct …*
- *develop confidence in their competence as a nurse, midwife or specialist community public health nurse;*

To facilitate this the 'new registrant' should have:

- *learning time protected in their first year of qualified practice; and*
- *have access to a preceptor with whom regular meetings are held.*

These NMC guidelines provide the key features of the preceptors' responsibility in developing newly qualified staff and these are now explored further.

WHAT ARE THE KEY FEATURES?

Whilst it is generally accepted that knowledge, skills and attitudes are all relevant, how these are developed is not so clear. In a phenomenological study of the factors that influence the development of competence (Clark, 2005, 2007) an understanding of competence was developed that encompassed the key areas from newly qualified nurses and their preceptors' perspectives. Using some of the research findings, the NMC requirements for preceptorship are considered.

FACILITATING THE TRANSITION

Whilst making the journey to professional practice, the new nurse is caught in a period of transition between the role of student and trained nurse. This is made more obvious as, until registration is confirmed, the nurse is in a position of limbo and cannot be properly afforded the title nurse. Certain privileges, such as title and uniform, are not available initially and the new nurse clearly desires to progress and socialize into his or her new role.

The process of socialization into the role of a trained nurse is a strong driver and new practitioners seek to do this and gain the approval of their peers (Clark, 2005, 2007). They need to show that they are able to do the tasks demanded of them and therefore this often means not leaving the ward until all the major duties had been performed. In my study this meant not leaving the ward often up to three-quarters of an hour after the end of the shift. It also meant rarely taking the required breaks during the shift (Clark, 2005). This was, however, influenced by the local hospital or ward culture. Nurses quickly adopted the local 'rules' and accepted the ethos of the area. As a preceptor it may be possible to acknowledge and influence this by agreeing modified 'rules' to ensure the new practitioner takes a reasonable load and manages to take breaks and mealtimes. It is unreasonable to expect new staff to be as efficient and effective as more experienced staff, and due allowance needs be made for this factor. Nurses are supposed to care; sometimes they are not so good at showing this to their colleagues.

There is also an expectation that new practitioners will be caring and are also supposed to have the skills and knowledge for safe practice. The new nurses adopted this mantle even though they did not feel ready for practice (Clark, 2005). To hide their deficits they appear to don 'a cloak of competence', covering the areas of their practice from overt scrutiny where they feel less than confident. The practice areas where appropriate support was given, often including preceptorship, allowed the nurses to share their concerns with their peers more readily. Given the feedback from these interested colleagues, a greater level of self-awareness was achieved, crucially allowing them to develop their confidence. The preceptor clearly has a role in providing both feedback and developing confidence; these ideas are explored further below.

Although all nurses were under some stress, part of the use of the cloak of competence was to mask from full view the extent of their stress so to show a level that they felt was acceptable to the ward staff. The new staff believed they had to be seen to be coping. In interviews they expressed some of the emotional labour they were working under, and the impact that had on their working and home lives, often disrupting both. Staff were often philosophical about this rationalizing this was a state that everyone needed to get through, it would pass and they recognized that other staff had their own rather more significant stressors (Clark, 2005).

It is a difficult thing to balance the need to be accepted into a new setting and acknowledging to those around you that you are both lacking in knowledge, skills and confidence. Part of the rarely stated philosophy of nursing is that 'nurses cope'. It is rare for nurses not to dutifully accept everything that is demanded of them. This is a subtle but powerful factor in the transition from a student to trained staff culture. There are symbolic signs of this cultural change.

Part of the defining image of general nurses is of a young, often female, person in an identifiable uniform. The transition to trained nurse from student is marked for some

with a change of uniform, or at least a different colour belt. The uniform forms an important function in that it is both protective and denotes to those who understand the relevance of the various colours, belts and epaulettes, the seniority and role of the wearer. Uniforms, by definition, also seek to make the wearer the same as everyone else with in the same grade. New staff may not feel they have the required skills or knowledge, but they *appear* the same as all the other staff. The uniform adds to the 'cloak of competence' and therefore affords some form of anonymity for the wearer. The function of the nurses' uniform has therefore both a practical and a symbolic function and this latter function is to provide a mask or cloak that may be used to disguise the competence of new nurses. However, the transition does not need to be a covert activity; if a preceptor is available and close enough, they can provide feedback to the new practitioner.

PROVIDING FEEDBACK

This is a key role for preceptors. As Bradshaw (1997, 1998) reminded us earlier, it is very difficult for practitioners to fully recognize their own competence. A crucial role, therefore, is to help practitioners to develop their self-evaluation skills.

DEVELOPING SELF-EVALUATION SKILLS

The awareness of personal values and the development of professional attitudes congruent with the profession are an important aspect of competent practice (Clark, 2005). The philosophy of care adopted by a practice area has an influence on the decision of an applicant to apply for a post. The context of practice is ideally selected to fit with personal requirements and can include factors such as the preferred approach to care and congruence with cognitive and learning styles. Those areas that have a well articulated ethos and philosophy of care make it easier for staff to make an informed choice to apply for a post there. Some areas are less clear about their approach to care; sometimes this is enforced as the area is used as a broad base where patients from a range of specialties are cared for. This could lead to dissonance in staff who want to care for surgical patients and end caring for medical or orthopaedic cases (Clark, 2005).

Preceptors have a role in ensuring that the philosophy is articulated and understood. They also have a responsibility to try to ensure the new nurse has the opportunity to care for a reasonable range of patients. The preceptor can often tailor the workload for new staff, gradually developing the number and complexity of cases used. It is therefore possible to select patients most congruent with the ethos of the area to allow new practitioners the opportunity to practise in a way that fits with their preferred approach.

As seen in Activity 9.3 above, it is difficult for new practitioners to set a standard that they can use to evaluate their own practice. Although reflection is a powerful tool to develop practice (as discussed in Chapter 3) the new practitioner is helped by a process that involves discussing with others aspects of practice. The preceptor has a key role in providing constructive feedback and, as the NMC (2006) remind us the, '"new registrant" has a responsibility to . . . seek feedback on their performance from their preceptor and those with whom they work' making them active in the process.

TIMELY AND CONSTRUCTIVE FEEDBACK

As well as the presence of appropriate knowledge, skills and attitudes, the central issue of an ability to practise safely was identified in my study (Clark, 2007). However, it was clear from the observations that some aspects of safe practice, such as hand hygiene, were not adhered to fully. Therefore, although staff have the ability to practise safely, there is a need to be observed to be practising safely. Unless the preceptor has the opportunity to observe some aspects of practice and provide feedback, there is likely to be limited development of practice.

Although the new staff were seen to have possession of up to date knowledge and interpersonal skills, some concerns were expressed regarding the breadth of knowledge. The educational programmes in the United Kingdom focus on depth of knowledge and this has resulted in the perception in staff that new nurse have 'islands of knowledge', where they knew some material in depth (if they had completed an assignment on a topic) but had very limited knowledge in other areas (Clark, 2005). The challenge then for preceptors is to help new practitioners to identify material that will enhance and build bridges between the 'islands of knowledge'. There is a need to focus learning in relation to clinical priority. It is therefore good practice to ensure new practitioners have a more focused area of involvement initially until knowledge is built up. Chapter 11 gives a range of resources and suggestions regarding the use of the Internet and electronic sources of information to enhance knowledge that can be accessed in practice settings.

All new practitioners in my study felt they did not have sufficient knowledge on drugs and clinical science despite this being a perceived area where advanced skills were sought (Clark, 2005). Whilst the ability to learn material should make any learning transferable, this is dependent on the staff having the time and energy to do this. With the pressure of work for the new practitioners, extra learning was difficult (Clark, 2005). The NMC has identified that the 'new registrant should have learning time protected in their first year of qualified practice' (NMC, 2006), although it is not clear how this can be always guaranteed. It is clear that the preceptor will need to facilitate this time and help to identify resources that relate specifically to the clinical setting.

FACILITATING NEW KNOWLEDGE AND SKILLS

The presence of core and specialist skills for practice are especially valued by new practitioners, indeed the development of these skills appeared to be a key motivator in some new staff as they were seen as a marker of transition to qualified practice. The ability to use technical skills, such as giving of intravenous drugs, is a factor as it makes the new nurse more dependent on colleagues and increases their colleagues' workload (Clark, 2005). It is important that the mentor plans an appropriate and reasonable timeframe for the development of these skills, especially as there is a limited knowledge base in some areas.

The contexts of care differed in their orientation towards supporting new staff to develop new skills and knowledge. This has been seen in earlier research regarding learning environments (Orton, 1981; Ogier, 1982, 1986) where some areas were seen as being more orientated to learning than others. Irrespective of workload, some areas manage to maintain an ethos of support for their new staff. I christened these wards in my study as 'learning friendly' areas and they all tended to provide a good level of support for the practitioner within the practice situation. This was appropriate support from a named individual who arranged programmed activities and negotiated the level of input. Importantly they provided of a source of feedback for the new practitioner regarding their performance. They also provided a source of challenge and 'pushed' the nurse on, sometimes beyond their immediate comfort zone. They were responsive to the level of stress within the practitioner and acted as a 'buffer' between the nurse and the pressures due to the level of stress within the practice situation, being sensitive to when new learning was possible.

The use of reflection as a strategy is also important as a tool to facilitate new learning and is seen as an important aspect of practitioner development (see Chapter 3). The use of reflection is seen in new nurses and is a part of their preparation in preregistration programmes, but there is a difference between the rhetoric of 'what should be' and the reality of 'what is'. This is seen in a number of incidents where reflection seemed to be a more academic activity with a lack of actual changes to practice occurring as a result of reflection (Clark, 2005). This may be an example of the difference between 'theories in use' and 'theories in action' described by Schön (1987).

There is a clear parallel here with clinical supervision, another concept sometimes more talked about than acted on. Preceptorship provides a vehicle to allow structured supervision and reflection on critical aspects of practice, good practice being regular contact and opportunity to discuss openly issues using structured frameworks. The NMC (2006) state that a 'new registrant who is receiving preceptorship has a responsibility to . . . reflect on their practice and experience'. It is likely that the use of reflection will enhance the ability of new nurses to make the links between the pockets of knowledge

that they may have assigned to the various mental pigeon holes developed in university and previous clinical placements.

PROMOTING TRANSFERABILITY

The ability to transfer knowledge and skills appears to be context dependent; despite having experience in, for instance, critical care settings as a student, new nurses can not automatically transfer this into a less-acute environment (Clark, 2005).

This may be due in part to absence of appropriate confidence. Although confidence in itself is seen as a double-edged sword, where being over confident poses different but equally dangerous problems to being under confident. Appropriate confidence is based on a realistic awareness of abilities and capabilities. In the absence of good reflective skills, it would appear that the new practitioner needs the feedback of a preceptor to clarify when reasonable confidence is present. The preceptor could explore these issues within the relative safety of a supervision relationship.

SUPPORT TO ACHIEVE STANDARDS

New practitioners need to be allocated a feasible workload if they stand any chance of achieving reasonable standards of practice. The NMC recognizes that errors are more likely at times of undue pressure and, given the extra stress endured in learning new knowledge and skills, the preceptor can usefully influence the rate of progress and workload. The preceptor has a role in clarifying what skills can be developed in the area and ensures a planned schedule of skill development is identified. The preceptor may need to act as an advocate to prevent undue pressure being applied to progress unreasonably. This is sometimes generated from the new practitioner themselves, especially in those more confident.

Although the notion of **eu-stress** is important as a 'good stress' that motivates and shows that coping is needed, it is clear that undue stress does impact on performance (Cox, 1986). As the performance in question is giving competent and safe care, it can be assumed stress may negatively affect performance. Under the influence of stress, the ability to make decisions, reflect and transfer knowledge is affected.

The preceptor has an important role in clarifying the required standard for new practitioners in a defined area of practice; the NMC describes newly qualified as 'minimally competent' at the point of registration. Preceptors therefore also have a role in helping to acknowledge limitations in new staff. 'New registrants' also have a responsibility to 'identify specific learning needs and develop an action plan for addressing these needs' (NMC, 2006).

ACKNOWLEDGING LIMITATIONS

One of the things that third year nurses say causes them concern as they approach the end of their courses is that they start to know how much they don't know! It is not always easy to acknowledge limitations; for example it is said that it is easier to get a confession to committing murder than it is to acknowledge bad driving. It is perhaps more difficult to know that you do not know everything, yet assume that people think you should know more than you feel you do. It is important for you as a mentor or a preceptor to recognize this, as there is a significant effort involved in trying to hide your limitations.

In the poem *Knots*, Laing (1970) depicts the challenge facing someone who is unsure of what they need to know and the emotional consequences of pretending to know what they think they should know. The strategy adopted is to pretend to know everything. It is clear a lot of practitioners do not feel ready for professional practice and that their preferred type of practice is often in an area where much more generic practice is required. There is a problem of 'not knowing what you don't know'. In the absence of clear guidance from a preceptor, the new nurse may be unsure of what they need to know. In an effort to be seen to be competent, it is not surprising that they pretend to know more than they do, belying their weaknesses in knowledge and skills. Although their limitations may be real, part of development will involve building their confidence.

BUILDING CONFIDENCE

One of the defining differences between 'learning friendly' areas and other placements is the use of positive preceptor/preceptee relationships; these are significant in building confidence. In positive relationships time and effort are made available, it is seen as legitimate activity on all sides and ideally time will be ring-fenced for this (NMC, 2006).

The effective preceptor has a good understanding of the new practitioner's needs. Although there are often Trust-wide objectives set, these are localized and tailored to the individual preceptees. If they are interpreted into short-term targets, this will have a big effect on confidence as the preceptees constantly feel themselves progressing. If a negotiated level of contact is established, this ensures an agreed, contracted amount of time for working together. The contact time can be used to offer feedback on performance and setting of future goals. What is seen as the most positive factor is the gradual reduction of direct contact over the life of the preceptorship, the stepping down of more direct contact being jointly agreed. There are times when direct assistance is likely to

be requested, and it is seen as a measure of the relationship that preceptees can ask for this increased support on demand.

The preceptor helps to identify the technical and specialist skills available and often acts as an advocate for the preceptee, encouraging colleagues to also be involved in developing them. Although the preceptor can not on their own control the culture of the ward, they can sometimes act as a mediator when there are potential conflicts in the clinical areas. Although the choice of who is admitted to the ward is beyond normal control, the actual allocation of patients within the ward can be often very effectively tailored by the preceptor, providing an increasingly challenging experience. As the competence of the nurse develops, more demanding and complex cases and situations can be introduced whilst the good mentors provide alternative 'escape hatches' or 'safety nets' that are seen as being there if need be, but because it is there you are less likely to use it.

The NMC have identified that **sign-off mentors** will be introduced with a special role to ensure fitness to practise at the end of each significant progression point, including the point of qualification. These mentors will be experienced staff and should be given ring-fenced time to allow them to fulfil this added and demanding role. It may be that with the introduction of sign-off mentors there will be a reduction of those staff that qualify despite not really being ready for professional practice. However, this will not remove the need for good preceptorship within any new role as there will always be the need to develop staff.

Currently many new staff lack confidence regarding their readiness to practise in a competent way and this leads new practitioners to a state of dissonance where their behaviour may not met the expectation of competent practice. To ease this dissonance, new practitioners may shield their behaviour from other peoples' scrutiny by using a 'cloak of competence'.

ADOPTING A 'CLOAK OF COMPETENCE'

The idea of the cloak as garment to be wrapped around one as a means of cover or screening is compelling. The cloak of competence is something that is drawn around us to both protect us and give others the idea that we are competent. However there is a danger that this cloak could also be used as a disguise or a means of camouflaging incompetent performance. In this way new nurses envelop themselves in a cloak of competence in their need to deny themselves the reality of their position, one that is too uncomfortable to openly acknowledge.

The potential to need such a cloak is dependant on the impact that culture plays in the practice setting. Newly qualified staff need to 'unlearn' the student culture and learn

or relearn the new culture of working as a new practitioner. This is a challenging transition to make in relation to new skills, relationships and responsibilities. There are very different cultural contexts to negotiate, from university student culture to professionally qualified practitioner. The reality shock is significant; it is not perhaps surprising that nurses need significant support during their transition.

The newly qualified nurse is expected to be competent at the point of registration; however the nurses themselves do not generally share this belief. Newly qualified nurses' perceptions of their own limits impact on their self-esteem and confidence. Despite the belief that their behaviour masked awareness of their status, few people positioned very near them would fail to recognize their limits; clearly a crucial opportunity for preceptors.

The newly qualified nurse is presented with a constantly changing and challenging environment. The practice situation is volatile – clinical areas are under constant pressure as increasingly complex patients are admitted – and this may exert excessive pressure on the new nurses. In the past the type of patient to be found on a particular ward was often clearly defined; the increased demands on current bed spaces, however, often dictates that any patient can be admitted to any ward. This makes for unpredictable working for those staff who are struggling to consolidate their knowledge, skills and attitudes.

The consequence of this is that newly qualified nurses are challenged by needing to demonstrate competent practice for a much wider variety of increasingly technically demanding cases. The technical care needs are compounded by the requirement for liaison with larger numbers of medical teams. This is compounded by the limited preparation new nurses have for this role.

CHAPTER SUMMARY

My studies have shown that there are challenges to the notion of competence; there are aspects of practice that are less than optimal in terms of performance in newly qualified staff. These were especially significant given the importance of the central issue of patient safety. If less than ideal practice is exposed, when our 'cloak of competence' is seen to slip, our professional credibility becomes vulnerable. Although the cloak has allowed some movement in professional practice, perhaps there remains a central and core purpose in that the cloak ensures that some of these aspects of practice are not exposed. The cloak provides a message to others to indicate the wearer has the capability to perform certain skills. Most nurses can recount the discomfiture of wearing their uniform for the first time and realizing their limitations. However, just because someone is capable, does not mean that optimum performance can be expected on all occasions.

This is true of many other complex skills including driving a motor vehicle. Although accidents can and do happen, core skills must be completed to a safe level. The concern is for those who are capable but choose not to perform to a safe level; the preceptor has a crucial role in identifying and challenging these practitioners.

The other notion of the cloak as a mask needs to be considered in relation to the issue of confidence. Although the cloak of competence may enable practitioners to 'appear' to be confident, this masking must be considered with caution if the practitioner either takes on more than they can manage or is over confident in their own ability.

The alternative to using a cloak of competence would involve exposing ourselves to a different and perhaps more vigorous scrutiny. To withstand this level of scrutiny will demand a greater clarity of the key skills that practitioners need but that have not yet been fully identified. It would also require a better fit between the skills of the practitioner and the sort of job they are required to do. There also needs to be greater awareness of the impact that organizational culture imparts on practitioners.

The journey to professional practice is described in Chapter 10 as passing through a number of points of scrutiny from the university and in practice, although these, in turn, have been found sometimes to be less than perfect. To protect the vulnerability of new nurses, they attempt to mask themselves in a cloak to hide what they believe to be their imperfect practice. The discussion here explores the imperative that nurses need to present themselves as ready for professional practice when they often do not feel ready for this role. Indeed, there are challenges to the notion of competence in new nurses with aspects of practice that are less than optimal in terms of performance. However, if no one is close enough to the newly qualified staff, there will be no one to see how performance is developing. Preceptorship, when offered, did make a significant difference, resulting in other staff and managers as well as the new staff themselves judging that competent practice had been developed (Clark, 2005). It is therefore a crucial aspect of staff development.

KEY POINTS

- Competence is a complicated concept that can only be partially achieved in preregistration programmes.
- Part of the socialization into a profession encourages the new practitioner to mask their performance from their peers.
- A period of preceptorship can enable the new practitioner to develop their knowledge, skills and attitudes through the support, feedback and challenge offered by a more experienced colleague.

- Competent practice is possible with good preceptorship.
- The NMC has clear guidelines for the role of preceptor and the role of the 'new registrant'.

REFERENCES

Armitage, P. and Burnard, P. (1991) Mentors or preceptors? Narrowing the theory practice gap. *Nurse Education Today*, **11** (3), 225–9.

Black, H. and Wolf, A. (eds) (1991) *Knowledge and Competence: Current Issues in Training and Education*, Department of Employment, London.

Bradshaw, A. (1997) Defining 'competency' in nursing (Part 1): a policy review. *Journal of Clinical Nursing*, **6**, 347–54.

Bradshaw, A. (1998) Defining 'competency' in nursing (Part 2): an analytic review. *Journal of Clinical Nursing*, **7**, 103–11.

Clark, T.J. (2005) *The development of competence in newly qualified nurses*. Unpublished Doctoral Thesis, University of Kent.

Clark, T.J. (2007) Fit for practice? An exploratory study of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies*, **44**, 1210–20.

Cox, T. (1986) *Stress*, MacMillan, Basingstoke.

Duffy, K. (2004) A grounded theory investigation of factors which Influence the assessment of students' competence in practice. NMC website: www.nmc.org.

Eraut, M. (1994a) *Developing Professional Knowledge and Competence*, The Falmer Press, London.

Eraut, M. (1994b) Concepts of competence. *Journal of Interprofessional Care*, **12**, 127–39.

Gerrish, K.A. (2000) Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing*, **32** (2), 473–80.

Gray, B. and Smith, P. (1999) The professional socialisation of diploma of higher education in nursing studies students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, **29** (3), 639–47.

Hardyman, R. and Hickey, G. (2001) What do qualified nurses expect from preceptorship? Exploring the perspective of the preceptee. *Nurse Education Today*, **21**, 58–64.

Kaviani, N. and Stilwell, Y. (2000) An evaluative study of clinical preceptorship. *Nurse Education Today*, **20**, 218–26.

Laing, R.D. (1970) *Knots*, Penguin, Harmondsworth.

McMullan, M., Endacott, R., Gray, M. *et al.* (2003) Portfolios and assessment of competence: a review of the literature. *Journal of Advanced Nursing*, **41** (3), 283–94.

Manley, K. and Garbett, B. (2000) Paying Peter and Paul: reconciling concepts of expertise with competency for a clinical career structure. *Journal of Clinical Nursing*, **9**, 347–59.

Myrick, F. and Yonge, O. (2001) Creating a climate for critical thinking in the preceptorship experience. *Nurse Education Today*, **21**, 461–7.

NMC (2006) *Nursing and Midwifery Council Circular 21/2006*, NMC, London.

Ogier, M. (1982) *An Ideal Sister*, RCN, London.

Ogier, M. (1986) An ideal sister 7 years on. *Nursing Times, Occasional Paper*, **82** (2).
Ohrling, K. and Hallberg, I. (2000) Nurses lived experience of being a preceptor. *Journal of Professional Nursing*, **16** (4), 228–39.
O'Malley, C., Cunliffe, E., Hunter, S. and Breeze, J. (2000) Preceptorship in practice. *Nursing Standard*, **14** (28), 45–9.
Orton, H. (1981) *Ward Learning Climate*, RCN College, London.
Philips, T., Edwards, H., Robinson, J. and Schostak, J. (1994) *Education, Dialogue and Assessment; Creating Partnership for Improving Practice*. English National Board, London.
Schön, D. (1987) *Educating the Reflective Practitioner: Towards a Design for Teaching and Learning in the Professions*, Jossey-Bass, San Francisco, CA.
Short, E.C. (1984) Competence re-examined. *Educational Theory*, **34**, 201–7.
Watson, R., Stimpson, A., Topping, A. and Porock, D. (2002) Clinical competence assessment in nursing: a systematic review of the literature. *Journal of Advanced Nursing*, **39** (5), 421–31.

FURTHER READING

Bedford, H., Phillips, T., Robinson, J. and Schostak, R. (1993) *Assessing Competencies in Nursing and Midwifery Education*, English National Board for Nursing, Midwifery and Health Visiting, London.
Gray, M. (1998) *A Longitudinal Investigation into the First Year Experiences of Being a Staff Nurse: The Transition from Diplomate to Staff Nurse. Final report to the National Board for Nursing, Midwifery and Health Visiting for Scotland*. Napier University, Edinburgh.
Jasper, M.A. (1996) The first year as a staff nurse: the experiences of a first cohort of Project 2000 nurses in a demonstration district. *Journal of Advanced Nursing*, **24**, 779–90.
Lankshear, A., Brown, J. and Thompson, C. (1996) *Mapping the Nursing Competencies Required in Institutional and Community Settings in the Context of Multidisciplinary Health Care Provision (An Exploratory Study)*, English National Board for Nursing, Midwifery, and Health Visiting, London.
Runciman, P., Dewar, B. and Goulbourne, A. (1998) *Project 2000 in Scotland: Employers' Needs and the Skills of Newly Qualified Project 2000 Staff Nurses*, Queen Margaret College, Edinburgh.

CHAPTER 10
ASSESSMENT OF PRACTICE: PRINCIPLES, PROCESS AND RESPONSIBILITIES

Sue West

Canterbury Christ Church University

LEARNING OUTCOMES

This chapter provides an opportunity to:

- **Examine the principles and models of assessment and how these can impact on assessment in practice**
- **Explore the notions of reliability and validity with regard to practice assessment**
- **Think about ways that students can be engaged in the assessment process**
- **Consider management of the 'failing student'**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

INTRODUCTION

Measuring the competence of health-care students is a crucial aspect of the mentor's role that must be carried out effectively to gate-keep the professional register, protect the public and maintain the standard and credibility of the profession. The problems of assessment in practice have been widely explored within the literature (Phillips *et al.*, 2000; Calman *et al.*, 2002; Norman *et al.*, 2002; Neary, 2000) and a number of factors found to influence it. These have included the design of the assessment model and tool and the mentor's understanding of its criteria and use, the inability of the criteria to measure meaningful outcomes for professional practice, workload issues and competing demands on the mentor's time and the level of support offered or available to the mentor. In her influential report, Duffy (2004) demonstrated that failing students might be time consuming and place an emotional burden on practitioners.

This chapter will briefly discuss the control mechanisms within the journey to professional practice, it will explore the principles and processes that underpin an effective assessment event to help the reader understand its individual components and will then consider the management of the 'failing student'.

THE JOURNEY TO PROFESSIONAL PRACTICE

The pathway to the register is controlled by three major gateways that either allow access or deny it. The first is controlled by higher education sanctions, the second is an academic gate and the third, and most significant from the perspective of this chapter, is a practice gate. For various reasons the pathway may not always be straightforward.

THE UNIVERSITY PATHWAY

The university has several roles. At key points in a programme of study, the university formally considers the progress of students in an examination board. In health-care programmes this usually considers both academic work and assessment of practice. Following assessment in the practice setting examination boards will decide, based on documentary evidence, whether or not students can be offered a second or, dependent on conventions, a third assessment opportunity. This may contribute to the practitioner's concern that 'it is pointless to fail a student' (Duffy, 2004) but might also reassure the mentor that the burden is not entirely on their shoulders. At the end of the student's course the university is also charged with confirming that each student has met all theoretical and practice requirements and is a 'fit and proper' person to enter the profession.

Sometimes, if there is evidence of inappropriate student attitudes or behaviour a decision is made to remove them from the course. There have, however, been some challenges to these decisions and this may have led to increased reticence about interrupting students from the course in this way. As funding 'follows' students this may influence the decision whether to discontinue or interrupt a student, as there may be a desire to retain students to ensure the university does not lose the funding.

Universities currently agree contracts to meet workforce needs and therefore decisions may be influenced by the need to recruit and retain students to meet these targets. Could this pathway therefore be controlled by a 'leaky gate'?

ACADEMIC PATHWAY

The academic pathway provides a number of gateways to professional practice. Duffy (2004) acknowledged that students are more likely to 'fail' theory than practice. However, despite this difference there are still limits to the ability of some students and the ability of the university to identify them. There has been an increase in identified plagiarism cases in many universities and some now use sophisticated computer software to identify deliberate attempts to copy others' work. 'Off the peg' essays can be bought on the Internet, and indeed 'tailor-made' essays written specifically for the selected assignment brief can be bought. Clearly the academic gateway may be 'leaky'. Clark (2005) identified a number of areas where there was limited evidence of knowledge for practice such as drugs and clinical science and that there were 'islands of knowledge' indicating depth in isolated areas rather than breadth of knowledge.

PRACTICE PATHWAY

A number of studies have identified that new practitioners have a limited skills profile and may not feel ready for independent practice at the point of registration (Fraser, Murphy and Worth-Butler, 1998; Lankshear, 1990; Burge and Lancaster, 2004). Watson and Harris (1999) suggested that some student nurses are passing clinical placement without demonstrating sufficient competence and Duffy (2004) suggested that some staff qualify who probably should not, suggesting another 'leaky gate'. This assertion may or may not be supported by your own personal experiences.

In her work Duffy (2004) found that there were a number of reasons why mentors 'failed to fail' student assessments, these included:

- it being much more difficult to fail than pass a student;
- a lack of time;

- leaving it too late in the placement;
- uncertainty regarding the assessment process in use;
- failing students was seen as a pointless process;
- a lack of confidence, experience and support.

In addition, Duffy (2004) found that there is an emotional burden associated with failing a student during their practice experience. It is challenging for mentors to be encouraged to get to know their students as individuals, develop a relationship with students based on empathy, trust and respect and then be charged with making a decision that has consequences for the person and their future.

These findings have significantly influenced the development of the NMC (2006) *Standard to Support Learning and Assessment* in which the NMC has determined that assessment of competence will be enhanced by strengthening the role of the mentor and the networks available to support them in their decision making. In particular, the implementation of experienced or **sign-off mentors** who will be responsible for all summative assessments within midwifery practice, the final summative assessment at progression points in nursing pathways and for supporting less experienced mentors when failing students.

The ideal measure of student competence would consider their overall performance, their ability to apply an appropriate range of skills, attitudes and understanding in a holistic and real context. The aim of the next part of this chapter is to explore the complexities of assessing in practice, the factors that can inhibit or promote an effective assessment process and some of the assessment methods that can inform assessment decisions.

THE PURPOSE OF ASSESSMENT

Assessment has been defined by the Quality Assurance Agency (2000, p. 1) as a 'Generic term for a set of processes that measure the outcome of students' learning in terms of knowledge acquired, understanding developed and skills gained'. Within the practice context, assessment involves collecting sufficient information regarding student performance to ensure that a consistent and acceptable standard has been reached and to enable a sound and defensible decision to be made. The processes for assessment are designed and implemented as part of curriculum development and are planned to ensure that student learning is measured effectively within both the higher education and clinical context so that statutory requirements are met and the standards of the profession are

maintained. To achieve this there is a need to take responsibility for ensuring that the skills and attributes are developed that enable learning to continue outside of the formal structure of educational programmes. According to Boud and Falchikov (2006), assessment is an integral part of achieving this outcome.

If you consider your experiences of being assessed for a moment it is likely that you will think about tasks that you completed to demonstrate your grasp of something new, for instance in an exam or achieving competence in a clinical skill. In an informal manner assessment may influence the level of support given or required, for instance a tutor reading a draft essay and commenting or a colleague suggesting alternative ways of achieving a task. In a more formal situation this may have included a mark, a pass or a fail and may have influenced the opportunities open to you in the future. This illustrates the two main types of assessment referred to as formative and summative.

FORMATIVE ASSESSMENT

Formative assessment is a developmental process and is focused on facilitating student learning. Throughout the placement the student's performance is continuously and systematically appraised so that their progress can be determined (Knight, 2002) and a decision can made regarding the level of support and supervision required to maintain a safe environment for both patient and student.

Within formative assessment the emphasis is on encouraging more understanding by providing feedback in relation to their strengths and weaknesses, gaps in knowledge, skills and attitudes and providing the guidance and support that is essential for this development to be achieved. Highlighting the student's strengths can help them see where learning has taken place, raise their self-esteem and increase their motivation. Identifying areas that require developing can help both mentor and student focus on priorities for learning, inform the development of action plans and the choice of further learning experiences that are facilitated.

SUMMATIVE ASSESSMENT

When undertaking a summative assessment the mentor is providing the student, the higher educational institution, the professional body and prospective employers with evidence of the student's achievement against an agreed set of objectives. This evidence will enable students to progress to subsequent placements and years of study or to qualify and be entered onto their professional register.

Essentially, formative assessment is a diagnostic process that is used by the mentor to promote learning, while summative assessment requires sound judgement that

enables the mentor to defend their decision. Consequently, evidence for this judgement must be clear and unequivocal and must be gained through a timely and thorough process.

SUSTAINABLE ASSESSMENT

Formative and summative assessments are predominantly teacher or mentor led. When learning and assessment are externally driven, Massey and Osborne (2004) suggest that learning can be inhibited and the student disempowered. Empowerment is at the heart of adult education with its focus on learning and growth of the individual. While, professional education seeks to empower health-care practitioners in anticipation that they will in turn be able to empower their clients. If one of the goals is to prepare students for their work role, adopting a more student-centred approach to learning and assessment, can contribute to the process.

Central to the concept of adults as students is the ability to 'self-evaluate' or 'self-assess'. Boud and Falchikov (2006) believe that self-assessment is an attribute that can be encouraged and promoted through student-centred assessment methods. Taking a student-centred approach to assessment does not mean simply asking a student to measure themselves against criteria dictated by the mentor, teacher or assessment tool. This could potentially limit learning and may encourage students to aim continually for the expectations of others rather than developing the ability to consider what a good performance should be and measure themselves against it. This third reason for assessment demands an approach that can empower the student to be an active participant. Throughout this chapter student participation in the assessment process will be considered.

UNDERPINNING PRINCIPLES

A number of principles are integral to assessment of professional practice, these include:

- practicality
- transparency and fairness
- motivation
- validity and reliability.

PRACTICALITY

When developing an assessment process for practice it is essential that the design provides a fair and equitable process for all students and is sufficiently robust to safeguard the quality of patient care. These aims must be balanced by a manageable process (Taras, 2002), one that does not place an unreasonable burden on staff or student. An effective assessment process takes into account the stresses and demands of the clinical area. It is challenging to design a process that achieves a balance between a thorough and meaningful assessment and what can be reasonably achieved in the workplace.

TRANSPARENCY AND FAIRNESS

The process and expectations of assessment should be transparent to all (Rust, 2002) and fair to the student involved. In order to make a fair and accurate decision there are a number of questions that, as a mentor, you will want to be able to answer:

- Do I understand the student's learning outcomes for this placement and how they translate to my area of practice?
- Have I discussed my expectations with others in my team to ensure that I have shared our common expectations?
- Have I clarified my expectations so the student knows what criteria they are working towards?
- Have I planned to provide or facilitate the learning experiences that will enable my student to have sufficient practice in order to meet the learning outcomes?
- Have I provided sufficiently detailed constructive feedback on knowledge, skills and attitudes to guide development?
- Have I allowed them reasonable time to improve?
- Have I ensured that the student understands my feedback so that the final decision will not be a surprise?
- Have I collected sufficient and appropriate evidence through observation, discussion and consultation with my student and others who have worked with them and documented it in the correct way?
- Have I involved the student actively throughout the assessment process?
- Can I make a sound judgement based on all of the above?
- Do both the student and I know when and where to go for additional support?

MOTIVATION

Assessment dominates the students' learning experience; if there is a focus on specific skills and tasks that may be all they learn. It is therefore necessary to focus the student towards the overall patient care experience and not just aspects of it. Setting objectives that are patient-centred and enhance the care experience can be motivating for assessor and student alike. Being enabled to see progression through a continuous system of ongoing and constructive feedback helps both assessor and student see the outcome of learning.

VALIDITY AND RELIABILITY

Reliability and validity are vital considerations within the assessment process. Reliability is the ability of a tool to measure the same thing each time it is used. This means that regardless of the context or the person using the tool the outcome would remain the same (Gray, 2001). Validity relates to measurement – a valid scale will, for example, measure weight accurately. Ideally you would want a consistent measure of weight so you also prefer reliable scales. So, if for example you were monitoring the daily weight of a group of patients with a single set of scales, you would expect that as long as they wore the same clothes and were weighed at the same time the result would be accurate regardless of who recorded it. If, however, the scale consistently weighed 1 kg heavy, your recording would be considered reliable but not valid. However, a tool cannot be considered valid unless it is also reliable (Gray, 2001).

A number of studies (Norman *et al.*, 2000; Watson *et al.*, 2002; West and Clark, 2003) have explored the use of assessment tools in practice. They have questioned their reliability as measurements of clinical competence. Some of the reported reasons for this indicated that assessors:

- found the tools hard to understand;
- had minimal preparation for their use;
- relied on students for advice;
- rarely failed students regardless of their performance for a variety of reasons.

You may be aware of an instance when a colleague has passed a practice assessment when you think they should have failed. This may have been because the performance criteria were vague and open to interpretation. This can result in the expected standard being at the discretion of assessors, each with different expectations. Conversely, if the standard for performance is specific, it is much easier to say whether or not it has been

achieved and is more likely to be fair for students. When designing a tool it is challenging to develop criteria that are broad enough to be achieved in a variety of care settings, specific enough to be understood but not so specific that assessment of practice is turned into a list of tasks.

ACTIVITY 10.1 TASK-FOCUSED ASSESSMENT

What are the potential implications of using an assessment tool that is focused on tasks? ■

According to Neary (2000) it is important that we do not reduce professional practice down to a checklist that should be achieved during placements. If we break down the care of an individual into its component parts there is a risk that patients might be exposed to routine or task-orientated care.

In roles that involve the care and welfare of others it is not enough to be able to undertake a task with technical ability. The focus of professional practice is the individual client whose needs will not necessarily be static or predictable. For this reason assessment of practice should also measure whether the student demonstrates an approach that respects the individual needs, values and beliefs of the person and whether they can apply relevant theoretical concepts in the context of everyday practice.

ASSESSMENT CRITERIA

When an assessment is undertaken in practice judgements are being made about what the student can do, within the context they are doing it and comparing it with an identified standard. There are three main ways of measuring achievement: norm referenced, criterion reference and self referenced.

NORM-REFERENCED ASSESSMENT

Norm-referenced assessment involves comparisons being made between what one student knows and a general expectation for the average student at a particular stage of their education, or more directly with other students in their year or previous year groups.

Although this approach is not formally used within professional education, comparisons can be made within the workplace and these may lead to favourable or unfavourable comparisons. It is important that objectivity is maintained and the focus remains on whether the student has met their outcomes. The trouble with this is the 'halo' or 'horn' influence that bad or good students have, potentially biasing the assessment. This is shown in the following student quote:

We were really lucky, we went to the ward after a couple of really bad students and the staff kept saying you are so much better than the awful students who had just left . . . I don't know if were that good, just better than the ones before. Thank goodness we did not follow some really good ones.' First year student.

West, 2005

CRITERION-REFERENCED ASSESSMENT

Criterion-referenced assessment seeks to avoid this bias and provides clarity within the assessment process for both student and assessor and asks the assessor to compare the student's performance against a set of specific criteria. In theory having a set of criteria should mean that:

- all students can potentially pass their assessment (as long as the criteria are met);
- students can find out what skills, knowledge and attitudes they need to acquire;
- they will be aware if they need to seek support or advice.

ACTIVITY 10.2 ENSURING FAIRNESS AND TRANSPARENCY

Whichever form of criteria is used in your workplace it is likely that to some extent your judgement is influenced by your professional expertise and your view of a 'good' students practice and performance.

What mechanisms to do you have in place to ensure that your assessment is fair and transparent and that your student is aware of your expectations for their performance? ■

SELF-REFERENCED ASSESSMENT

The third method of measuring achievement is self-referenced assessment. This involves the student measuring their ability against their previous performance and the criteria that they have defined for their own achievement. Ecclestone (2002) suggests that encouraging students to meet their own standard alongside other more formal assessment processes can build students' confidence and promote their self-evaluation skills. Regardless of the criteria used there are two main ways that assessment of practice is undertaken, either set assessment events or a process of continuous assessment.

SINGLE EVENT VERSUS CONTINUOUS ASSESSMENT

Assessment can be a single, planned event or, more commonly, a continuous process. A single, planned event can measure the student's ability to meet a defined set of criteria on a preplanned day and can be undertaken in practice or in a simulated environment in the form of an Objective Structured Clinical Examination (OSCE). This could put substantial stress on the student and assessor which can negatively influence either's performance. A little stress will, of course, act as a motivational force and is likely to enhance performance.

Neary (2000) suggests that although there are advantages of preplanned assessment events, they will not measure whether or not a student can meet the changing needs of patients. For this to happen there is a need to observe the student to ensure consistency of their standard of practice. Continuous assessment, as the term suggests, is assessment that occurs over a period of time, normally with formal points by which either formative or summative assessment documentation should be completed. The advantages of continuous assessment are that you and your colleagues can observe the student's performance in the reality of your workplace. During this period of time, through a process of feedback and supported reflection, the student can be enabled to develop to their full potential (Watkins, 2000).

The main criticisms of continuous assessment relates to the objectivity of the assessor over a prolonged period thereby effecting reliability. Another criticism is whether there is sufficient time available for assessor and student to work together so that practice can be observed and understanding and attitudes explored and challenged. If sufficient time is not available this might impact both on validity and reliability of the assessment.

Foster and Hawkins (2004) suggest that assessment practice could move beyond either single events or continuous assessment. They propose a 'Performance of Understanding'

model that specifically focuses on the increase in the student's knowledge base and how this informs their clinical practice and reflection on that practice. This is a partnership model that involves collaboration between higher education and practice. Within a given educational programme or individual course a small number of essential skills are identified and assessed in the placement in a tripartite fashion. This involves a lecturer and mentor simultaneously assessing the student using the same criteria. The collaborative aspect of this approach has the potential to increase the worth placed on learning within the higher education institution and reduce the theory–practice gap.

ACTIVITY 10.3 EVALUATION OF A PARTNERSHIP MODEL FOR ASSESSMENT

Take some time to think about this approach to assessment; what would make you consider it to be:

- reliable and valid?
- practical and feasible?
- beneficial for patient care?
- student centred?
- empowering? ■

FACTORS THAT INFLUENCE ASSESSMENT IN PRACTICE

ASSESSMENT MODELS AND TOOLS

The approach taken to assessment will be influenced by the assessment tool and process written into the students' curriculum. During your time as both student and practitioner you may have experienced several of the diverse range of models for practice assessment that have been described in the literature. Toohey, Ryan and Hughes (1996) described five distinct approaches: (i) the attendance model; (ii) the work history model; (iii) the broad abilities model; (iv) the specific competencies model and (v) the negotiated curriculum model. The main characteristics, potential strengths and weaknesses of each of these models are outlined in Table 10.1.

TABLE 10.1

Summary of Assessment Models (Based on Toohey, Ryan and Hughes, 1996)

Model	Characteristics	Advantages and disadvantages
Attendance	Satisfactory completion based on attendance May or may not be graded	If graded – on a pass/fail basis Minimalist approach May appear to devalue the clinical experience Recognizes the difficulty of assessing learning in the clinical context
Work history	Students document and reflect on tasks they have undertaken and what they learnt from it in a journal or log book Mentors certify task has been completed Journals may or may not be marked	Learning is based on the opportunities availablePromotes reflectionMay not promote an all round performance
Broad abilities	Specific abilities are defined (for example interpersonal or critical thinking skills). These abilities can be achieved in all placement experiences Performance criteria are defined Criteria measured on a pass or not yet pass basis	Abilities are used to inform both the education and practice aspects of the programme Abilities may be expressed so broadly that the assessor may be unsure of standard required Using a 'pass' or 'not yet passed' criteria is more defensible than grading
Specific competencies	Key roles and tasks are defined Placements are planned so that sufficient variety and experience is made available Competence must be demonstrated in either an identified sample in each placement or a full range Assessed in the work place using either pass/fail or a rating scale	More structured Looks for understanding as well as skills Reflects work place performance Higher degree of validity More acceptable to students Achieving the full range of learning experiences is challenging in a changing workplaceIf competence statements are too narrow, student performance can be limited Performance may be context specific Performance is not necessarily transferable

TABLE 10.1
continued

Model	Characteristics	Advantages and disadvantages
Negotiated curriculum	Individual negotiated learning planned and assessed through the use of a Learning Contract	Can engender a high level of student commitment and motivation through increased ownership Time consuming Requires students to be self-motivated and able to negotiate their own learning. Individual learning requires individual expectations for assessment

ACTIVITY 10.4 RELIABILITY AND VALIDITY

Having considered the models in Table 10.1, which model do you currently use in your workplace? How would you rate it in terms of reliability and validity? ■

CONTEXTUAL FACTORS

Phillips *et al.* (2000) undertook an extensive research project during which a significant amount of time was spent observing students and mentors. During this time they collected evidence that reflected the reality of assessing students within the challenging and complex environment of clinical practice. They identified a number of contextual factors that affected the quality and effectiveness of assessment in practice; some of these would be useful to consider in relation to your own practice. They found that:

- Mentors found it difficult to distinguish between students at different levels and stages of their programme.
- Assessment can be an *ad hoc* process that does not involve sufficient planned time for working together, observation and discussion of performance.

- Competing demands, shift patterns, skill mix and workloads inhibited the amount of time that assessors and students worked together.
- Effective learning may not happen unless time is spent with an experienced practitioner who can explain the decisions they make and spend time challenging the problem-solving processes of the student.

ACTIVITY 10.5 PLANNING ASSESSMENT OF AN INDIVIDUAL STUDENT

Are these factors an issue for you? How do you ensure that you are aware of:

- the student's stage of education
- the specific outcomes for their placement
- the level of support and supervision required to ensure safe practice
- the standard of performance and understanding you should expect. ■

The NMC (2006) expect that 40% of a student's time should be spent with their mentor, more if the student is at a 'sign-off' point. The mentor has an additional responsibility of ensuring continuity of the learning experience for the remainder of the practice hours.

ACTIVITY 10.6 MEETING THE NMC (2006) REQUIREMENTS FOR ASSESSMENT

In a normal working week, how do you plan your time to ensure that:

- you meet the responsibilities of your clinical role
- spend 40% of time with your student, working with them, observing their performance and discussing their progress
- ensure that they are supervised and have continuity of learning experience in your absence – the NMC requires that students are aware who will supervise them in the mentor's absence
- there are opportunities for feedback between you, your student and your colleagues that are transparent to all concerned. ■

METHODS OF ASSESSMENT

There are a variety of methods that can be utilised within the assessment process. Within the practice setting observation is the most commonly used method. For practical skills, this can be seen as the most obvious form of assessment and provides the mentor with a clear picture of what the student can actually do and the approach they take to the patient, relatives and the team in which they are working.

ACTIVITY 10.7 OBSERVATION AS A METHOD OF ASSESSMENT

- What factors do you think would affect the reliability of observation as an assessment method?
- What needs to be considered to ensure that observation provides sound evidence of a student's performance? ■

There are a number of suggestions that you may be in response to this activity. For example:

- Student performance may be influenced by the observer; this is termed the 'Hawthorne' effect (Van Wagner, 2007).
- How frequently does practice need to be observed before a decision can be made regarding the consistency of the standard of performance?
- The assessment criteria need to be clear. The assessment can only be considered reliable if all engaged in the assessment process have a shared view of what they are looking for.
- There is an element of personal judgement involved in direct observation and it is possible that the student may disagree with the outcome.
- Observation can be enhanced by the participation of the colleagues who support the student in the mentor's absence.
- The student may have observed unprofessional attitudes or poor skills demonstrated in the workplace.
- Students can be asked to provide feedback on their own performance and use this as a starting point for constructive feedback.

Within the practice setting, observable performance is one aspect of competence. It is also essential to establish whether learning that cannot be directly observed has taken place.

ASKING QUESTIONS

For the students referred to in Chapter 2, a good mentor was one who asked questions and challenged their thinking. If they had a mentor who tested their learning and understanding, they attempted to rise to the challenge. Within the most effective learning environments, questioning is a routine part of the mentor–student relationship. As part of your clinical practice, questions are asked routinely throughout the working day. There are a number of reasons for asking questions; some examples are listed below but these can be added to:

- to check or increase patient and family understanding;
- to identify individual needs;
- to explore previous health issues;
- to explore coping mechanisms;
- to identify problems from their perspective;
- to involve the person and their family in their care;
- to address problems as they arise;
- to explore how they manage their environment and how they react in a given situation;
- to evaluate the effectiveness of care interventions;
- to evaluate progress;
- to understand their thinking and responses;
- to clarify shared goals.

There will be many similarities between this list and the reasons that students will be asked questions during their placement. The way that questions are asked, open or closed, will significantly influence the quality of information gained. For example asking a first-year student 'Have you undertaken a patient assessment before? initiates a very different response from 'Can you tell me about your previous experience of assessing patients?' Asking another, 'Have you spoken to Mrs Williams today?' initiates a different

response from 'Tell me the two most significant things you noticed about Mrs Williams when you were talking to her today?

Example 1 in Table 10.2 demonstrates that the questions asked can promote a different level of thinking. Asking a student a normal range for a pulse asks her to recite facts. Whereas asking her to choose appropriate interventions demands that the student takes the facts, make sense of them in terms of the person's symptoms and suggest appropriate actions. This therefore shows a stronger link between theory and practice.

When discussing the promotion and evaluation of the cognitive skills of health-care students Stuart (2003) reinforced the need to look beyond the student's ability to recall or relate information and to use questioning skills to encourage higher level thinking skills. Stuart (2003) and Nicholl and Tracey (2006) provide excellent examples of how Bloom's taxonomy can be used as a framework to enable this to be achieved. In 1956 Benjamin Bloom developed a classification of intellectual behaviour (Quinn, 2000) with six levels, knowledge being the lowest level and evaluation the highest.

TABLE 10.2

Examples of Questions to Elicit Understanding, Response and Rationale

1. Student understanding	What is the normal pulse for a 58-year-old woman? Mrs Smith is tachycardic, why do you think she has an increased pulse rate? Mrs Smith has a pulse rate of 140 and her blood pressure is 90/50 what interventions are required?
2. Student response	Mrs Smith has just returned from theatre, what will you do if . . . ?
3. Reason for practice	I notice that you avoid Mrs Smith; can you explain why you do that?

ACTIVITY 10.8 USING QUESTIONS

With Bloom's taxonomy in mind, think of an aspect of practice on which you assess students in your workplace.

What questions could you ask a first year, a second year and a third year student related to that aspect of practice?

Discuss with your peers/academic link why you chose these questions and what you are trying to achieve with the student. ■

TABLE 10.3

Examples of Questions to Elicit Different Levels of Thinking

Knowledge	The student can recall facts or observations and memorize principles and procedures
Comprehension	The student can demonstrate understanding of information that they have previously learnt and explain it in their own words
Application	The student use relevant concepts and principles to inform their problem solving
Analysis	The student can break complex issues down into component parts and analyse them to inform their decision making
Synthesis	The student can bring ideas together, develop new solutions to problems, rearrange component parts to form a new 'whole'
Evaluation	The student can make a reasoned judgement based on sound values, principles and concepts.

At first, asking higher order questions can seem difficult for a number of reasons (Myrick and Yonge, 2004). It can take longer to initiate and elaborate responses; mentors are sometimes uncertain what level the student should be functioning at or be uncomfortable dealing with incorrect answers. The student may feel threatened, particularly if this has not been a routine experience for them.

The kind of questions illustrated in Example 2 can be used to establish a student's learning that has possibly taken place but not yet been observed by the mentor. It could also be used prior to an experience to ensure that the student will respond appropriately within a patient care situation. Example 3 demonstrates how questions can be used to challenge values and attitudes and act as a precursor to a reflective discussion.

ACTIVITY 10.9 RATING QUESTIONING AS AN ASSESSMENT TECHNIQUE

Please take a moment to rate questioning as an assessment technique in relation to their validity, reliability and fairness for the student? ■

Asking questions can be a highly valid form of assessing learning. However, it could not really be considered reliable unless all mentors within a given area asked from a standard list of questions. If the questions posed are at an appropriate level for the student and asked in a safe environment, this is a 'fair' process. However, the student who is not routinely questioned or the one who feels 'put-down' by the process may contest this.

BECOMING STUDENT-CENTRED

During this chapter the principles that underpin an effective assessment process and the factors that can impact on assessment in both positive and negative ways have been discussed. Assessment has been considered as a student-centred process that cannot only measure student performance but also help prepare them for their qualified role and ongoing professional development.

Jackson (1997) outlined five criteria that are important in promoting student involvement within higher education that can be adapted to the practice context. These are shown in Box 10.1.

PROMOTE STUDENT CHOICE AND INVOLVEMENT

There are a number of ways that student choice and involvement can be promoted. At the beginning of their placement and at regular review points the student can be enabled to lead the development and review of their learning contract or action plan. This will provide them with the opportunity to actively identify their own learning needs. The

BOX 10.1 PROMOTING STUDENT INVOLVEMENT IN THE ASSESSMENT PROCESS (ADAPTED FROM JACKSON, 1997)

- Promote student choice and involvement
- Developing self-evaluation/assessment skills
- Promote transferability
- Allocate a feasible workload
- Provide timely and constructive feedback ■

student can be encouraged to clarify the requirements of a good performance and the way that this could be measured. The student can be encouraged to clarify the requirements of a good performance, the way that this could be measured and the type of evidence they should provide.

DEVELOPING SELF-EVALUATION/ASSESSMENT SKILLS

Having agreed the requirements of a good performance the student will need time to think, critically consider and discuss their own performance with you.

PROMOTE TRANSFERABILITY

Within the placement experience it is important that students can see how previously learned skills could be further developed and used in your workplace and how the skills and understanding developed within your workplace can be transferred to a variety of settings and contexts.

ALLOCATE A FEASIBLE WORKLOAD

To provide students with the best opportunity for success during the assessment process it is essential to ensure that they have a feasible workload for their stage of education that can enable them to learn as well as work. This means ensuring the student is allocated to an appropriate number of patients, has the time to provide individualized care and develop a depth of understanding in relation to them as individuals, their disease process, their care and its underpinning evidence base.

PROVIDE TIMELY AND CONSTRUCTIVE FEEDBACK

The provision of feedback is seen as the most crucial aspect of any learning and assessment event. To be effective, constructive feedback needs to be an ongoing dialogue throughout the placement period. It should be objective and sufficiently detailed to enable a student response.

MAKING A DECISION

When completing a student assessment any decision should be based on a range of evidence (Stuart, 2003; NMC, 2006) that will enable the mentor to judge overall competence, skills, understanding and attitudes. As a mentor it is important to be aware of the

role personal values, attitudes and preferences can have within the assessment process and the potential for bias, negative or positive, described by Trowell (2006) as 'halo' and 'horn', within the decision making process.

The '**horn**' effect occurs when one negative aspect of a student or their performance is viewed and is generalized into an overall poor assessment a rating. The horn effect is most likely to occur in situations where there is a personality conflict between student and mentor or student and members of the team who may influence the assessment decision. The opposite of the horn effect is called the '**halo**' effect. In this circumstance the mentor views an aspect of the student or their performance in a positive manner and generalizes this to an overall positive evaluation of their competence. Arnold and Pulich (2003) describe the '**similar to me effect**' when performance is rated higher when the person appears to have similar characteristics and ways of working to the mentor and their clinical team.

Philips *et al.* (2000) established that assessment in practice is best achieved through time spent together working, observing and engaged in purposeful conversation. This working together should be meaningful, actively involve the student in planning and evaluating their own learning and reflect the process of assessment recognised within the higher education institution. To do this, mentors will need to have a sound grasp of the placement objectives, the timings for assessment and the documentation and criteria. This will enable the mentor to identify where additional learning experiences are needed to ensure the optimum chance of success and when either mentor or student need additional help from the academic link/placement facilitator/sign-off mentor. This will ensure that when success is not achievable mentor and student are supported through the process of 'failing'.

MANAGING THE FAILING STUDENT

ACTIVITY 10.10 WARNING SIGNS

Before continuing, please take a few moments to think about what factors would first make you question whether or not you are able to pass a student's assessment. ■

Duffy (2004) explored the reasons for nursing students failing their assessment in practice. The main reasons were not directly related to clinical skills and knowledge but were more commonly concerned with the student's personal approach and professional demeanour. Failing students were more likely to:

- regularly arrive late for their shifts;
- lack personal self-awareness;
- have little insight into professional boundaries;
- display poor communication and interpersonal skills;
- appear unmotivated and demonstrate a lack of interest and little participation in the placement learning experience.

What can the mentor do to help a student who is not meeting the required standard? There are three steps a mentor can take when working with a student who is not achieving:

- reflect on your personal role in the assessment process;
- provide every opportunity to progress;
- remember personal accountability.

REFLECT ON PERSONAL ROLE IN THE ASSESSMENT PROCESS

The following points should be considered:

- Did I clarify my expectations?
- Did I follow the agreed process of assessment for the higher education institution?
- Did I ensure the student accessed appropriate learning opportunities?
- Have I let my personal feelings/values influence my decisions?
- Have I asked the student why they are late/appear disinterested and so on or have I made any assumptions?
- Have I spent sufficient time working with and observing the student?
- Have I provided specific feedback to the student on my areas of concern?

- Have I helped the student develop an action plan that would enable them to respond to my feedback?
- Have I discussed my concerns and sought help and support from an experienced colleague (sign-off mentor/lecturer)?

If there is a negative response to any of these questions, addressing the issue concerned will be a priority for the mentor.

OPPORTUNITIES TO PROGRESS

The mentor should provide the student with every opportunity to progress. The process followed will be dependant on the assessment strategies agreed locally but will usually involve:

- early involvement of academic staff and regular tripartite meetings throughout the placement period (Stuart, 2003);
- regular formal and documented feedback;
- development of formal action plans agreed between mentor, student and lecturer;
- recognizing that it will be difficult for the student who may feel threatened by the process and as such will need careful handling in a suitable environment; a student-centred approach that encourages them to explain their perspective and what they feel are their strengths and weaknesses will help them feel that the process is inclusive rather than one-sided;
- ensuring that the documentation is carefully completed following local guidelines.

REMEMBER ACCOUNTABILITY

If having provided appropriate opportunities, offered consistent, precise verbal and documented feedback and held regular meetings, the student has not responded appropriately and met the agreed standard, the mentor needs to be aware of their accountability (NMC, 2006) and fail the student.

The process of failing a student is one that can cause stress to all concerned; the process of failing to fail a student has even more consequences, personally and professionally. A final quote from Duffy's study leaves us with a powerful reminder of these consequences,

. . . To this day I'm personally still worried that I've passed a student that I'm not 100% confident in her abilities, professionalism, the quality of care she delivers to patients.

CHAPTER SUMMARY

This chapter has considered the gateways that safeguard entrance to the professional register and defines the purpose of assessment in both promoting learning and judging performance. The factors that can promote and inhibit an effective assessment event have been explored. These have included the underpinning principles of practicality, transparency and fairness, motivation, validity and reliability as well as some of the models, tools and criteria used. The use of Jackson's (1997) criteria as a framework for involving students throughout the assessment process has been proposed and observation and questioning have been examined as methods of collecting evidence.

The potential for bias and the importance of making sound and defensible decisions is discussed. It is acknowledged that failing a student is a difficult task for a mentor but also one that is sometimes inevitable once all attempts to enable the student to progress have been made. The mentor should not feel isolated in this process and access to support networks can help. This will consist of experienced colleagues, sign-off mentors (NMC, 2006) managers and their academic link. Making contact as soon as concerns are identified can ensure that both mentor and student receive the support and advice they need.

REFERENCES

Arnold, E. and Pulich, M. (2003) Personality conflicts and objectivity in appraising performance. *Health Care Manager*, **22** (3), 227–32.

Boud, D. and Falchikov, D. (2006) Aligning assessment with long-term learning. *Assessment and Evaluation in Higher Education*, **31** (4), 399–13.

Burge, S.M. and Lancaster, T. (2004) Assessment in undergraduate dermatology. *Clinical Experimental Dermatology*, **29** (4), 441–6.

Calman, L., Watson, R., Norman, I. and Redfern, S. (2002) Assessing practice of student nurses: methods, preparation of assessors and student views. *Journal of Advanced Nursing*, **38** (5), 516–23.

Clark, T. (2005) *The development of competence in newly qualified nurses*. Unpublished PhD Thesis, University of Kent, Canterbury.

Duffy, K. (2004) *Failing Students: A Qualitative Study of Factors That Influence the Decisions Regarding Assessment of Students' Competence in Practice*, Nursing and Midwifery Council, London.

Ecclestone, K. (2002) *Learning Autonomy in Post Compulsory Education: The Politics and Practice of Formative Assessment*, Kogan Page, London.

Foster, T. and Hawkins, J. (2004) 'Performance of understanding': a new model for assessment. *Nurse Education Today*, **24** (5), 333–6.

Fraser, P., Murphy, R. and Worth-Butler, M. (1998) *Preparing Effective Midwives; an Outcome Evaluation of the Effectiveness of Pre-reg Midwifery Programmes of Education*, ENB, London.

Gray, D. (2001) *A Briefing on Work-Based Learning*, Learning and Teaching Support Network, York (Assessment Series No. 11).

Jackson, M. (1997) But learners learn more. *Higher Education Research and Development*, **16** (1), 101–9.

Knight, P. (2002) The achilles heel of quality: the assessment of student learning. *Quality in Higher Education*, **8** (1), 107–14.

Knowles, M. (1990) *The Adult Learner: A Neglected Species*, 4th edn, Gulf Publishing, Houston, TX.

Lankshear, A. (1990) 'Failure to fail' the teachers dilemma. *Nursing Standard*, **4** (20), 35–7.

Massey, D. and Osborne, D. (2004) Empowerment and assessment; a dichotomy? *Nurse Education Today*, **24** (5), 357–62.

Myrick, F. and Yonge, O. (2004) Enhancing critical thinking in the preceptorship experience in nursing education. *Journal of Advanced Nursing*, **45** (4), 381–91.

Neary, M. (2000) Responsive assessment of clinical competence: part 2. *Nursing Standard*, **15** (10), 35–40.

Nicholl, H. and Tracey, C. (2006) Questioning: a tool in the nurse educator's kit. *Nurse Education in Practice*, **7** (5), 285–92.

Norman, I., Watson, R., Murrells, T. *et al*. (2002) The validity and reliability of methods to assess the competence to practise the pre-registration nursing and midwifery students. *International Journal of Nursing Studies*, **39** (2), 133–45.

Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, Nursing and Midwifery Council, London.

Phillips, T., Schostak, J., Tyler, J. and Allen, L. (2000) *Practice and Assessment: An Evaluation of the Assessment of Practice at Diploma, Degree and Postgraduate Level in Pre- and Post-Registration Nursing and Midwifery Education*, English National Board, London.

Quality Assurance Agency (2000) *Code of Practice for the Assurance of Academic Quality and Standards in Higher Education Section 6: Assessment of Students*, Quality Assurance Agency, London.

Quinn, F. (2000) *Principles and Practice of Nurse Education, 4th edition*. Stanley Thornes, Cheltenham.

Rust, C. (2002) The impact of assessment on student learning. *Active Learning in Higher Education*, **3** (2), 145–58.

Stuart, C.C. (2003) *Assessment, Supervision and Support in Clinical Practice: A Guide for Nurses, Midwives and Other Health Professionals*, Churchill Livingstone, Edinburgh.

Taras, M. (2002) Using assessment for learning and learning from assessment. *Assessment and Evaluation in Higher Education*, **27** (6), 501–10.

Toohey, S., Ryan, G. and Hughes, C. (1996) Assessing the practicum. *Assessment and Evaluation in Higher Education*, **21** (3), 215–27.

Trowell, F. (2006) Mentoring in palliative nursing: a personal reflection. *International Journal of Palliative Nursing*, **12** (10), 260–3.

Van Wagner, K. (2007) *Hawthorn effect*, http://psychology.about.com/od/hindex/g/def_hawthorn.htm (5 June 2007).

Watkins, M. (2000) Competency for nursing practice. *Journal of Clinical Nursing*, **9** (3), 338–46.
Watson, H.E. and Harris, B. (1999) *Supporting Students in Practice Placements in Scotland*, Department of Nursing and Community Health, Glasgow Caledonian University.
Watson, R., Calman, L., Norman, I. *et al*. (2002) Assessing clinical competence in student nurses. *Journal of Clinical Nursing*, **11** (4), 554–5.
West, S. (2005) A phenomenological study of the perceptions of the experience of learning related to blood pressure monitoring from the perspective of nursing students. Unpublished Masters thesis. Canterbury Christ Church University College.
West, S. and Clark, T. (2003) *Evaluation of the Assessment of Practice Tools: Dip (HE)NS 2000 Curriculum*, Canterbury Christ Church University, Canterbury.

CHAPTER 11
USE OF THE INTERNET TO SUPPORT LEARNING IN PRACTICE

Susan Westerman and Emily Hurt
Canterbury Christ Church University

LEARNING OUTCOMES

The reader will be able to:

- **Gain a picture of how the Internet is used in higher education and the health-care sectors**
- **Be aware of the challenges and benefits surround the use of the Internet to support practice-based learning**
- **Gain some practical ideas on how to use the Internet to support practice-based learning**

INTRODUCTION

People use the Internet and new technologies every day – for finding information, communicating, and seeking entertainment, goods and services. Learners are bringing new expectations of the power

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

of technology into higher education. And the curiosity and innovation of those in higher education is driving them to explore new approaches to learning supported by technologies.

Higher Education Funding Council for England, 2005, p. 1

How practitioners react to this quote from the Higher Education Council will no doubt vary. If they are using the **Internet** to order groceries, book holidays and keep up-to-date with professional practice, they will quite happily accept this scenario. However, if they are not a regular and comfortable user of the Internet, this quote may appear rather disturbing. Whatever the position taken, the increasingly pervasive and integrated use of the Internet in all aspects of life, at home and at work, cannot however be denied.

This chapter aims to give mentors an overview of how the Internet is currently being used in both the higher education and health-care sectors, and provides a brief commentary on the potential benefits and challenges that are associated with its use in supporting learning in practice. The chapter will then offer practical applications and illustrations of how the Internet can be used to support learning in practice, both in terms of information resources and tools that can aid interaction, communication and reflection.

The chapter is not a technical one, but does inevitably make reference to new technologies, which not everyone will be familiar with. These terms are included in the glossary, providing an explanation of any technical terms used.

ACTIVITY 11.1 GETTING STARTED

If you are relatively new to using the Internet there are some very good online resources which can provide an introduction. If you are a novice computer user go to the BBC learning web site at http://www.bbc.co.uk/learning/ where you will find WebWise and Computer Tutor. If you are a more experienced computer user, visit the Intute Virtual Training Suite at http://www.vts.intute.ac.uk/. Work your way through the tutorial and then build your 'basket' of useful resources for your particular profession or academic area of interest. ■

USE OF THE INTERNET AND OTHER NEW TECHNOLOGIES IN THE HIGHER EDUCATION AND HEALTH-CARE SECTORS

HIGHER EDUCATION

It is always perilous to talk about the Internet in print as there is the likelihood that even as a book is published the information is out of date. However, what can be provided is a history of its development and use at time of writing in higher education and the health-care sectors, and some predictions made as to the future.

There is a tendency to forget that technological tools have always been used in both education and medicine. Paper, pencils and the printing press are just some of the technologies that have transformed education. Looking back at the reaction of the church and universities to the invention of printing, and thus information being available beyond the elite, it can be seen that there are striking parallels to many of the negative reactions seen today regarding the Internet. It is only when the use of a tool becomes embedded and commonplace that it is not considered a form of technology. Until that point however, a new technology can appear to inhibit rather than aid a process, and its users need support to benefit from it. This is the current situation with the Internet.

The Internet is simply a global network of computers. It was developed in the United States as a tool for use amongst the military and the universities supporting it. In its earliest days it was used for the transfer of information and communication, and did not have a commercial use. Not surprisingly many groups in higher education have historically led the way in its use. The Internet really took off in the late 1980s and early 1990s with the creation of the **World Wide Web**. As more information began to be placed online, and as **e-mail** became a standard form of communication from the late 1990s, programmes of higher education would increasingly refer learners to online information.

At the time of writing, the use of the Internet as both an information and communication tool is now integral to most higher education programmes, with the majority of universities publishing their own information and resources online for their learners. Furthermore, many universities are beginning to use online communication tools, as these increase in sophistication and ease of use, to aid communication and reflection.

This increasing use of online tools has not however resulted in the demise of the traditional higher education programme. Instead a 'blended' approach of face-to-face contact, combined with the integrated use of online tools appears to be the preference amongst both learners and institutions in the United Kingdom.

Nevertheless, some learner groups are increasingly expecting to be able to study away from a traditional campus environment. They may be part time, studying at a distance

or on work placements for blocks of their course. Electronic or online resources enable this flexibility. Learners and their teachers no longer need to be in a university physically to access its resources.

This pervasive use of the Internet in higher education does not however mean that all learners are sophisticated users. As Bond (2004) found in a 2004 study, nearly half (48%), of new preregistration nursing students at an English university felt that they ended up with too much information when searching on the Internet.

HEALTH-CARE SECTOR

The availability and use of new digital technologies within the health-care sector has been a slow and variable journey. There has often been a lack of hardware and software, non-compatible systems, failed projects, resulting cultural negativity, and lack of time to engage in online learning.

The Royal College of Nursing (2005) report *The Information Needs of Nurses* showed that just under 20% of respondents 'never used the Internet in relation to their work', for those working in the independent sector it rose to 45%. The report illustrated how access to hardware continues to be an issue for the sector, even if the situation is clearly improving. Just under 50% of respondents 'could always get access to the Internet at work when they needed it'; however that still left just under 20% not having access, with this figure rising again in the independent sector to a depressing 44%. Furthermore, even for those with access, this is usually shared with many other staff.

In addition to the access issue, the health-care sector has historically had a negative attitude to staff using the Web. This culture is fast changing. The RCN report showed that 45% of all respondents said they were always encouraged to search for evidence to support their practice. However, 20% still stated they were never encouraged to search for evidence.

Not surprisingly, with this legacy of limited access and cultural negativity, respondents to the RCN survey felt they needed help both with the technical Information Technology (IT) skills (30% of sample) and the information skills of finding, selecting, critiquing and using what is found (44% of sample). This skills gap, combined with the increasing use of IT in the NHS, has led the NHS and the General Social Care Council to adopt the European Computer Driving Licence IT qualification as the standard for its staff.

These two pictures of the higher education and health-care sectors clearly illustrate the challenges that mentors face in using the Internet in their practice. Today, learners could arrive at their placement with greater experience of online learning and higher expectations in terms of access. The challenge faced by the mentor is to know what resources are 'out there', be able to use them critically in practice as an integral part of mentoring and encourage learners to do likewise. Mentors need to be as much a role

model in their use of today's learning tools as in their clinical practice, 'providing an observable image for imitation, demonstrating skills and qualities for the mentee to emulate' (Morton-Cooper and Palmer, 2000, p. 43).

ACTIVITY 11.2 ASSESS YOUR SKILLS

Go to your Trust library and IT departments. If you are not based within a Trust, contact the higher education institution that is placing learners with you. Ask either to recommend an IT and information skills audit that you can undertake with them. Use this to assess your skills and plan what development you may need. ■

SOME POTENTIAL BENEFITS AND CHALLENGES OF USING THE INTERNET TO SUPPORT LEARNING IN PRACTICE

The Internet offers huge benefits for learning and teaching, yet with these benefits come the challenges of a new ways of learning and working. Thinking specifically about health-care mentors and their learners, the following is an outline of some of these benefits and challenges.

BENEFITS

- The wealth of information available online can assist mentors and learners in ensuring their practice is **evidence-based**. The 2005 RCN report concludes that having good access to information – via the Internet and via a physical library and via information skills – appears to have a direct effect on putting evidence into practice (RCN, 2005).
- The ability to communicate online through e-mail, discussion boards, and **blogs** can enable mentors and learners to share practice and collaborate.
- Use of online and digital tools allows universities to provide additional support to learners on traditional face-to-face programmes of study, by providing administrative and learning resources online. For nursing and midwifery learners with long placement

periods in the workplace, use of online tools can also help maintain communications, and link theory and practice.

- Online tools can enable universities to deliver flexible work-based and/or distance courses.
- Online tools can also aid lifelong learning and can contribute efforts to widen participation, through greater access to education at a time and place convenient to each individual learner.

If both mentors and learners have the necessary access and skills to use online resources they can benefit from a wealth of information to support their practice, more easily link theory with practice and share their experiences with fellow mentors and learners.

CHALLENGES

- A robust infrastructure needs to be in place so that mentors and learners in the health-care sector can benefit from online tools. For this infrastructure to work:
  - Learners need permissions to access IT systems in the workplace.
  - There needs to be robust hardware in locations that are suitable and convenient for learning to take place.
  - Organizational computer **firewalls** need to be set to permit access to the Internet from PCs which are convenient for mentors and learners.
  - The connection to the Internet needs to be sufficiently fast to enable use of a variety of online media.
  - The appropriate software needs to be available on these PCs.
- There needs to be a culture where use of the Internet is viewed positively, and time is available for mentors and learners to access online resources.
- Mentors and learners need good information skills to be able to efficiently and effectively find, assess and use online information.
- The 'net-generation' (those born post 1982, who have grown up with the Internet) have new and distinct learning styles. To engage this generation of learners, mentors need a better understanding of the tools they prefer to learn with (blogs, **wikis**, web-spaces and so on).
- Many mentors and learners in the health-care sector are not confident users of digital technology. Training and support needs to be in place to help them develop their skills.

ACTIVITY 11.3 ANSWERING STUDENTS' QUESTIONS

Access to Internet-enabled PCs is increasingly essential for students in practice. Ensure that you know how your learners can gain access and include this information in the details you provide for them when they join you. Try to answer the following questions in your student welcome pack:

- How do learners gain the necessary permissions to use your PCs?
- Where can learners access an Internet PC – ward/library/office and so on?
- Does your organization have guidelines or regulations regarding the use of PCs and electronic systems, and where can learners familiarize themselves with these?
- Will full access to internal Web sites be allowed or restricted?
- Will the configuration of your organization's computer system mean that certain Web sites cannot be access?
- Can the learner connect to their university's Web site and access their university's online resources? ■

The Internet can therefore aid the role of mentors and the placement experience of learners in many ways. For this to happen, many pieces of the access and skills jigsaw need to be in place. Some issues will be outside of the mentor's control; however, having the confidence and understanding to help learners make use of online resources and tools can only help them, and benefit the mentor as a lifelong learner.

SOME PRACTICAL APPLICATIONS AND ILLUSTRATIONS OF THE INTERNET SUPPORTING PRACTICE-BASED LEARNING

THE INTERNET AS AN INFORMATION RESOURCE

There is a vast amount of information available online which can aid practice-based learning in the health-care sector. This can be divided into:

- information coming from the higher education sector, both course specific and more general resources;
- health-care resources including: online libraries, journals and databases; professional resources; and government, news and other general resources.

ACTIVITY 11.4 WHAT ONLINE RESOURCES DO YOU USE?

Before you read on, list the online resources you make use of to inform your practice and consider how you might share them with your students. You can then compare and hopefully add to this list once you have read this chapter. ■

INFORMATION COMING FROM THE HIGHER EDUCATION SECTOR

Most universities now use the Internet to provide information and enhance communication with their learners. Typically learners may be provided with administrative information such as timetables, contact information for their tutors, learning activities and notes and links to other online information. Many universities are beginning to publish video and audio files on the web, often in the form of **podcasts**. As indicated earlier, the key benefit here for learners on placements is that this can allow for the linkage of theory to practice, and enable learners to share their own experiences with others.

At present, the most common means by which the higher education sector is publishing programme or course-specific information and engaging in communication over the Internet is through the use of **Virtual Learning Environments** or VLEs. These tools look like standard web pages and enable staff to post information and engage in communication without having advanced technical skills. Like many newer web sites they are usually personalized, so that when the learner or member of staff enters the system they only see the course(s) that they are studying or developing.

Many universities are now also giving their mentors access to their VLE. In this way mentors can access the materials their learners are using, and better tailor the placement experience provided with the theoretical learning at each point in the course. Taking this a step further, universities can also create an area on their VLE for mentors. This enables both mentors and staff in the university to share information and documentation, and discuss issues.

ACTIVITY 11.5 WHAT RESOURCES DO YOUR STUDENTS HAVE?

Ask your students about the online resources their university is providing, and how they are expected to use them. Find out if you can access these resources too, and how they could aid your role as a mentor. ■

In addition to providing course- or programme-specific information and activities online, most universities will also have a wide range of other resources, which are effectively an e-extension of their library.

All university libraries will have an electronic catalogue, and the majority will be web based, allowing off-site access for students and staff. The catalogue will contain a record for every physical item in the library, and will be searchable in a variety of ways. The catalogue is one of the most time-saving technologies a library has, and should always be the first port of call for a learner beginning an assignment.

Online resources can vary in format but the majority are **bibliographic databases**, electronic books (**e-books**) or online journals. Content and subject may vary, but the following features are common in each format:

- Bibliographic databases:
  - provide references, not full articles
  - are searchable by keyword, author or title
  - index the contents of the major journals in a particular subject area.
- E-books:
  - are available via a publisher's web site
  - provide access to a whole text online
  - can either be an electronic version of a print book, or a text which is only available electronically.
- Online journals:
  - are available via a publisher's web site
  - provide full articles in **PDF** or web page format
  - are searchable by keyword, author or title.

Students are encouraged to use all three types of resource during their course of study, as well as texts they can borrow. University libraries usually provide some form of

information skills training to help students access these resources. It is particularly important for health-care students to be proficient in literature searching and information retrieval as they need to be aware of new research in their area of practice in order to provide the best care possible.

As subscribing to these resources can be costly, students will usually have to 'log in' using a username and password in order to access them. As most university web sites can be viewed by anyone with Internet access, security measures are essential to ensure only students enrolled at that particular university can use them. Some universities issue students with Athens accounts; others may provide another form of login.

These types of resource are essential for any student, and the information skills needed to use them should be developed during their course of study. But the use of these resources should not stop when the student qualifies – these are the sorts of resources all health-care professionals should be utilizing to ensure that their practice is evidence based. As part of the mentoring process, revisiting databases, journals and e-books with learners could prove rewarding and help mentors discover new material.

KEY HEALTH-CARE ONLINE RESOURCES

NATIONAL LIBRARY FOR HEALTHCARE (NLH)

There are a multitude of online resources available to staff employed in health care, and the NHS in particular has fully embraced the possibilities that electronic resources afford. The National Library for Health is a concept that encompasses all physical health libraries, as well as electronic resources. It aims to:

- deliver a mode.rn, equitable library service to all NHS staff;
- extend NHS library services to patients and the public for the first time;
- be built around user need;
- integrate library services with the National Project for Information Technology (**NPfIT**) and other services;
- simplify access arrangements for learners and staff working partly in the higher education/further education sector;
- reach NHS staff who do not regularly use NHS library services;
- offer demonstrable value for money (NLH Team, 2005).

Part of the NLH is a set of resources available at national level, commonly referred to as 'National Core Content', which is available via the National Library for Health web site: www.library.nhs.uk. The National Core Content comprises a set of databases

and online journals that is centrally funded, and that any member of NHS staff can have access to. For those mentors not employed by the NHS, there is still the possibility of access to these resources. Staff employed by hospices and not-for-profit care-providing charities are entitled to access, as are many other health-care workers. For more information, mentors should contact their local NHS library who will be able to clarify their entitlement.

ACTIVITY 11.6 GET A USERNAME AND PASSWORD

To find out more about accessing these resources, and to gain a username and password if you don't already have one, contact your local NHS library. They should be able to give you a username and password so you can access the National Core Content, and provide you with information skills training if you need it. ■

The National Core Content is similar to the general resources higher education institutions subscribe to, and so the benefits in using them are similar to those discussed above. There are, however, several other sources of information that are health-care and social-care specific that are worth mentioning.

There are many organizations within health care that have been set up to support evidence-based practice, a concept that has been championed since the mid 1990s. These organizations provide guidance, evidence based reviews, protocols, care pathways, clinical knowledge summaries, economic evaluations and a whole host of other material in a variety of formats to help practitioners provide the best level of care. Knowing where to look for this sort of information can be difficult, and can be time consuming. With the extent of information available online, it is easy to feel that something important has been missed. The National Library for Health web site goes some way to solve these problems. It brings together a large number of resources from these organizations, and allows users to search them *en masse*. For example searching for 'rheumatoid arthritis', would return the following type of results:

- guidance on the use of a particular drug from the National Institute for Clinical Effectiveness (NICE);
- a position statement from the British Society for Rheumatology;
- an article from Bandolier, an evidence-based-practice electronic journal;
- a systematic review from the Cochrane Database of Systematic Reviews.

These resources can be used to demonstrate to a learner the link between policy and practice. By putting material like this into context, learners can better understand the benefits of evidence-based practice.

PROFESSIONAL ONLINE RESOURCES

All professional bodies and organizations in nursing and midwifery have a web presence in some form or another, and a large number provide material to support their members. Some resources are freely available, but some organizations do require membership to access their online material. Many professional organizations divide their web pages up into sections – there may be areas for registered professionals, learners and members of the public. This helps ensure that the person accessing the web site is directed towards the right level of information.

There are obvious benefits to both learner and mentor in checking profession-specific web sites on a regular basis. It's an easy way of keeping up to date with news, new initiatives, position statements and guidance. A lot of policy and guidance documents are available to download for free, and some organizations provide free online access to profession-specific journals as part of any membership, helping mentors and learners to keep up to date with profession-specific research.

ACTIVITY 11.7 TRY SEARCHING A WEBSITE

Have a look at the appropriate web site for your area of practice from the following list. Think of an issue that you and your learner are currently experiencing. Conduct a search of your professional web site to find information relating to the issue. Then build a learning activity based around this for your learners.

www.nmc-uk.org – Nursing and Midwifery Council
www.hpc-uk.org – Healthcare Professions Council
www.rcm.org.uk – Royal College of Midwives
www.gscc.org.uk – General Social Care Council
www.cot.org.uk – British Association/College of Occupational Therapists
www.basw.co.uk – British Association of Social Workers
www.sor.org – The Society of Radiographers
www.csp.org.uk – The Chartered Society of Physiotherapy
www.rcslt.org – The Royal College of Speech and Language Therapists ■

INFORMATION GATEWAYS

Information gateways work in a similar way to library catalogues, in that they allow users to search for information on a specific topic and then direct them to relevant resources on the web. They help find quality information quickly on a specific subject. They do not easily fit into the categories that have been considered previously, as they are usually freely available (no subscription fees or usernames and passwords needed), and the majority are maintained by universities, with the help of practitioners and librarians.

There are two major advantages to information gateways over using a search engine such as Google. All of the web sites within an information gateway would be freely available, and in theory could be found using Google, but due to the volume of web sites Google searches, this is not always the case. So an information gateway can save huge amounts of time when looking for material.

There are a suite of subject-specific information gateways available from intute: www.intute.ac.uk. Each one is searchable by subject, and contains links to web sites. If, for example, the term 'wound care' was entered into an information gateway, some of the results returned might be:

- a patient information web site on venous leg ulcers;
- a technology appraisal from NICE on debriding agents;
- guidelines on wound management dressings from the National Prescribing Centre;
- the homepage of a wound care journal.

The other advantage is quality – when searching the web using a search engine, there is no control over the standard of results. There will be all sorts of web sites in the results, and trying to decipher which are reliable can be difficult. Every resource in an information gateway will have been chosen because it meets a certain set of criteria, so there is assurance that the web sites found are trustworthy. Information gateways are a great way of increasing confidence in learners who are a little apprehensive about using information from the Internet, and are a quick and easy way of discovering new resources. In research carried out into the usage of a nursing information gateway, 87% of users said they could find the information they wanted easily, and '84% of respondents rating the relevance of the resources they found as being good or excellent' (Ward, Scrivener and Smart, 2004).

OTHER ONLINE RESOURCES

In addition to all the resources already listed, there are many other online sources which can aid learning in practice. Government web sites are useful for obtaining latest policy information, whilst news sites are valuable for gaining a wider appreciation or context about an issue learners are confronting in their practice. In addition to these are patient sites, and an increasing number of personal web-logs or Blogs.

ACTIVITY 11.8 GET SOME BACKGROUND INFORMATION FROM A WEBSITE

Go to the Department of Health news site and the BBC health-care pages. Find some information on these sites that could provide some background or context for an issue you are engaged in with a learner.

http://www.dh.gov.uk/NewsHome/fs/en

http://www.bbc.co.uk/healthcare/ ■

THE INTERNET SUPPORTING COMMUNICATION, INTERACTION AND REFLECTION

The Internet is not just an information repository; it is increasingly becoming a means to communicate. E-mail is the main method by which most universities will communicate with learners, enabling them to quickly and easily stay in touch whilst they are away from campus. Many courses now also make use of online discussion boards and other social software. These tools are not open access chat rooms, but online areas where only a predefined group of people, for example a seminar group or a group of practitioners from different geographic locations, can discuss issues. In addition to enabling more social approaches to learning, these tools help facilitate peer support and sharing of practice, which can be especially helpful to learners in practice.

Burrill *et al.* (no date) writes:

> *In most cases, the learning that learners will engage in during practice education can be described as experiential learning – learning from experience . . . Vital to this is the notion of reflection.*
>
> (*Burrill* et al., *no date, p. 8*)

The demands of the modern working world mean that learners and mentors need to be able to reflect as and when required, hence tools to aid the recording of reflection

are increasingly becoming available online. The most common of these are Blogs. Many organizations are beginning to provide their learners and staff with **e-portfolios** including Blogging tools.

HOW TO MANAGE ALL THIS INFORMATION

If the amount of information available on the Internet is a good thing, it presents new challenges: to find the information required, to use it appropriately and ethically and to manage it in a way that makes it easy to retrieve and use. There are an increasing number of online tools to help manage information from basic favourite or bookmark tools in web-browsers, to online bookmark managers and information feed managers. Finish this chapter by undertaking our final activity, to ensure you are managing your online information in the way best suited to your skill level.

ACTIVITY 11.9 TRY OUT YOUR SKILLS

Undertake one of the tasks listed below, depending on your confidence and skill level in using electronic information.

1. Develop a list of favourites or bookmarks of the sites you find most useful.
2. Look at your favourites on a regular basis and every 6 months review your list and consider if each resource is still as useful for you. At this time you should also review other resources not on your list to see if they should be added.
3. Look into **RSS** feed aggregators. Take a look at the BBC news web site (http://www.bbc.co.uk/news) you will notice that next to most sections there is a button saying RSS. If you use an RSS aggregator you can sign up to receive 'feeds' from the BBC web site about that topic so instead of you having to go to the BBC and all your other regular sites to check for new information, it would come to you and be listed on just one page – your aggregator page. Some popular aggregators are listed below – all are free to sign up to.
   - Google Reader
   - Newsgator
   - Bloglines ■

CHAPTER SUMMARY

We hope this chapter has provided some ideas as to why mentors need to make use of the Internet, and shown how to do so practically. Use of online or digital resources will probably be relatively new to many mentors and, if this is the case, it is essential to seek out further help from library and IT staff, as the Internet is here to stay and effective mentors and learners will be those who are happy negotiating the virtual world.

REFERENCES

BBC (no date) *News feeds from the BBC*, http://news.bbc.co.uk/1/hi/help/rss/default.stm (5 March 2007).

Bond, C. (2004) Surfing or drowning: learner nurses' Internet skills. *Nurse Education Today*, **24** (3), 169–73.

Burrill, J., Hussain, Z., Prescott, D. and Waywell, L. (no date) *An Introduction to Practice Education*, University of Liverpool, Liverpool, http://www.practicebasedlearning.org/resources/materials/docs/introductiontopracticeeducation.pdf (5 March 2007).

Higher Education Funding Council for England (2005) *HEFCE Strategy for e-Learning*, Higher Education Funding Council for England, London, http://www.hefce.ac.uk/pubs/hefce/2005/05_12/05_12.pdf (5 March 2007).

Morton-Cooper, A. and Palmer, A. (2000) *Mentoring, Preceptorship and Clinical Supervision*, 2nd edn, Blackwell, Oxford.

NLH Team (2005) *National Knowledge Service, National Library for Healthcare: Strategy 2005–2008*, National Library for Healthcare, London, http://www.library.nhs.uk/nlhdocs/nlh_strategy_2005_2008v2.doc (5 March 2007).

Royal College of Nursing (2005) *The Information Needs of Nurses: Summary Report of an RCN Survey*, Royal College of Nursing, London, http://www.rcn.org.uk/publications/pdf/TheInformationNeedsOfNurses.pdf (5 March 2007).

Ward, R., Scrivener, R. and Smart, N. (2004) NMAP: UK's nursing Internet gateway. *CIN: Computers, Informatics, Nursing*, **22** (4), 227–31.

CHAPTER 12
CHALLENGES IN THE INTERPROFESSIONAL AGENDA

Judith Parsons
Canterbury Christ Church University

LEARNING OUTCOMES

This chapter will:

- **Define interprofessional learning and assessing in practice**
- **Examine the commonalities in interprofessional learning and assessing in practice**
- **Explore the opportunities for interprofessional collaboration in student learning and assessment**
- **Consider the challenges in collaborating with other health and social care professionals**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

INTRODUCTION

So far this book has explored the skills required to become a successful mentor with nursing and midwifery students. Increasingly there is an emphasis on interprofessional education, which requires the development of new skills in working interprofessionally. This chapter provides an interprofessional perspective to learning and assessing in health and social care practice. It offers the reader the opportunity to explore their own practice as a mentor and to consider how they might develop their collaborative skills as both a practitioner and a mentor.

WHY AN INTERPROFESSIONAL APPROACH?

This is a question that has not always been considered in relation to teaching and learning and many mentors have had limited exposure to this in practice. The extent of interprofessional experience will most probably depend on the type of role or the type of service that practitioners offer. Some areas of practice appear to offer more scope than others for interprofessional working and seem to be centred more around specialist teams. However, this is not the only type of team that can collaborate in providing excellence in practice. Those working in very generalist places, for example an acute medical or surgical ward, do not work in isolation; the multiprofessional team are available to support care delivery. As long ago as 1988 the World Health Organization (WHO) were highlighting that interprofessional team working could have a positive effect on health outcomes (WHO, 1988). In spite of this, the health and social care professions have tended to function separately. This might be because all these professions have been striving to achieve not only a professional identity but an academic one, as they have moved to educational provision in higher education. In pursuance of an academic professional identity the health and social care professions have not all necessarily aimed at a collaborative approach in education. This is largely changing as the result of two major tragedies which occurred in practice.

The Royal Bristol Inquiry (Kennedy, 2001) examined the poor outcomes in paediatric cardiac surgery, which resulted in higher than average mortality rates in Bristol compared with other similar units. Amongst the many issues highlighted, the report drew attention to the poor collaboration between the affected families and health professionals. Similarly, the inquiry into the death of Victoria Climbie (Laming, 2003) identified a gross failure in interagency communication, resulting in this child's death. Thus, in both cases lack of interprofessional working emerged as key themes. It is against this background that an interprofessional focus has been adopted in the educational preparation of health and social care professionals. The content of these programmes varies enormously, from just

a day spent in some shared learning activity to a few weeks. Some universities only provide interprofessional preregistration programmes, which can include one-third of the programme being offered as interprofessional education. There have been fewer universities offering assessed interprofessional practice, but this is likely to change. Increasingly there are opportunities for students to experience interprofessional practice in either formal or informal placements. It is in this context that many health and social care professional bodies/regulators have revised their standards for the preparation of practitioners who have responsibility for facilitating the learning and assessment of students in practice.

They have adopted explicit requirements which include an interprofessional approach to the mentor's/facilitator's role. This includes the College of Occupational Therapists (COT, 2006), the Nursing and Midwifery Council (NMC, 2006), the General Social Care Council (GSCC, 2005) and the Chartered Society of Physiotherapists (CSP, 2004). The implications are that mentors and others are required to provide interprofessional learning opportunities for their students in collaboration with higher education institutions (HEIs).

In this chapter the term **interprofessional practice** describes two or more professionals collaborating to improve the quality of service provision for individuals, families or communities and is based on the Centre for the Advancement in Interprofessional Education (CAIPE) definition (CAIPE, 2002). On this basis this chapter defines interprofessional education in practice as the opportunities used by health and social care mentors/facilitators to work collaboratively to improve the quality of the student learning experience and provide them with an interprofessional perspective to health and social care practice.

A SHARED VISION

The qualities of an effective mentor have been described in Chapters 5 and 7. Any health or social care practitioner who is able to fulfil this role with students from their own professional background potentially has the skills to facilitate a student from another profession. This may seem to be a very sweeping statement, but it is best viewed in the context of the common skills required to facilitate and assess practice learning (see Chapter 10). These skills are shared across professional groups and can be found in programmes of study preparing health and social care professionals for teaching and assessing in practice. In some instances they may be prepared together on interprofessional programmes which provide an ideal opportunity to explore opportunities for interprofessional education in practice. This is not to suggest that any professional can facilitate another profession's student in the specialist activities of their role, this is clearly

unacceptable both to professional bodies/regulators and health and social care practitioners and is very unlikely to be achievable! Yet if health and social care professionals analyse the knowledge and skills they use in their daily practice they will find many overlaps. In a study of a preregistration shared learning programme Colyer and Parsons (2005) found that students approaching the end of their final year were able to identify areas of common competencies in a pilot assessment tool devised to assess a collaborative practice module. These areas of practice were centred on assessment of the needs of service users, referrals, communication with and between professionals and service users and record keeping. The students seemed to have a clarity of vision of what was interprofessional practice and, in contrast, what belonged to them as professionals in their own right. This would suggest that to be an effective collaborative practitioner each professional needs to have a very clear understanding of their own professional role. One of the ways in which this can be clarified and supported is through practice grounded in critical reflection.

ACTIVITY 12.1 OWN PROFESSIONAL ROLE

Spend some time reflecting on your own professional role:

- How confident am I in this role?
- What do I enjoy about being a . . .?
- Do I have a good knowledge base?
- Is there anything I find difficult or do not like about my role? ■

This activity may not have been as easy as it first seemed, it may have taken some time to come up with some of the answers and they may have been surprising. It will be helpful to continue to think about your own role as the chapter goes on to explore the skills required for interprofessional mentoring.

SKILLS IN INTERPROFESSIONAL FACILITATION OF LEARNING

Because preregistration interprofessional education in practice remains a relatively new concept there is limited literature demonstrating an interprofessional approach to facilitat-

ing and assessing students in practice (Muholland *et al.*, 2005). Yet some published papers indicate that this approach is growing (Stew, 2005; Marshall and Gordon, 2005; Walsh *et al.*, 2005). As stated earlier in this chapter, anyone with mentoring experience has the potential to facilitate a student interprofessionally. The reason for this is that whilst there are very clear differences in supporting a student from another profession there are common mentoring skills that each profession draws on to facilitate practice education.

ACTIVITY 12.2 MENTORING SKILLS

Take a few minutes to consider the skills that you may already have as a mentor, or you are beginning to develop during your mentoring preparation. You might find it useful to revisit Activity 3.2 in Chapter 3.

Now stop and reflect on whether any of these skills can help you mentor a student from another profession. ■

Some of the ideas you have thought of might include:

- I enjoy mentoring students.
- They *are* a student and I am an experienced professional.
- I have confidence in my professional knowledge.
- I can assess core skills such as communication with service users.

All the examples used are positive ones but it is just possible that some may have thought of a few negative attributes. These will be explored a little later in the chapter; for now the focus is on the positive. By this stage readers may be asking the question: but how can I do this, what do I know about social work, occupational therapy, physiotherapy and so on? It is important to remember the evidence cited earlier, it suggested that practitioners who are secure in their own roles have the confidence to work interprofessionally and collaborate with their colleagues. This is reinforced by the shared values of an interprofessional team who will frequently cite trust, respect and mutual support as values which underpin their interprofessional practice (Meads and Ashcroft, 2003).

So, the starting point is the individual practitioner and how they work. If the previous activity was undertaken it should have provided you with a reminder of your own

role and how you approach practice, for example your values and beliefs about nursing or midwifery. This can be the basis from which to move forward and start thinking about interprofessional mentoring.

For those who answered the questions from a more negative perspective, it might be useful at this point to go back and re-reflect on why the questions were answered in such a negative way. It may be due to a lack of interest in interprofessional learning, or feeling rather diffident or deskilled by the thought of it. On the other hand it may have challenged you to consider just what your own practice is about. This is can be equally useful when mentoring nursing or midwifery students.

The focus of the mentor's role is on the facilitation of learning. This has already been discussed in Chapters 3 and 5. This approach to learning is based on an active approach, which enables both mentor and student to recognize that students are not merely an empty vessels to be filled through the wisdom and experience of the mentor or, as Freire (1996) puts it, the banking principle, banking up the knowledge that might come in useful at some time, rather than focusing on relevant learning. As a mentor facilitating interprofessional learning in practice every practitioner has wisdom and experience which is drawn from their own practice and can be used in a positive way. In nursing, the work of Benner (1984) has highlighted the importance of experience in relation to expertise. Nussbaum (1997) writes specifically about practical wisdom as a way of understanding and interpreting a situation, which can allow individuals to approach more concrete situations in a creative and sensitive manner and she considers reflection central to this approach. It is likely that as an experienced nurse or midwife mentors act in this way automatically; this way of practising has been referred to as professional artistry (Schon, 1995). Now it is time to apply professional artistry to interprofessional student learning.

ACTIVITY 12.3 INTERPROFESSIONAL MENTORING

Spend some time thinking about what you would do if a colleague from another profession asked you to give their student some experience and to provide feedback on the student's performance.

Now make a list of the questions you would need to ask your colleague and yourself before you agreed to take this student. ■

The list of points from Activity 12.3 might include some of the following; it is not exhaustive and there may be other relevant questions:

- The name of programme/module the student is undertaking.
- What stage are they in the programme?
- What is the purpose of the time spent with you?
- What are the student's learning outcomes?
- Is there any assessment to be undertaken and is it formal or informal, formative or summative?
- Do I feel competent to undertake formal assessment, have I been prepared effectively for this?
- Is there anything else of significance that I should know which does not breach confidentiality or assessment regulations?

The above list is relatively straightforward and not dissimilar to the information any mentor needs prior to supporting a student. Some readers might have produced a complicated or comprehensive list, but working interprofessionally as a mentor is essentially concerned with using transferable skills (Prosser and Trigwell, 1999). These are the same skills that you are already using or developing to facilitate learning with students from nursing or midwifery. In some situations practitioners may be asked in a more formal way to work with students from other professions and this request may come from a university as interprofessional learning in practice becomes more common. However, every practitioner would expect to have had some formal preparation for this role, which will also be dependent on the regulations of the various regulatory/professional bodies, particularly in regard to student assessment. Much has been said about roles in interprofessional mentoring/facilitation, but mentors who provide experience for other colleagues' students it is likely that they will offer reciprocal arrangements for your students. In this way it may be helpful to collaborate not merely as different professionals but as mentors or practice teachers and so on. This could lead to supporting each other in teaching roles and could be developed into undertaking joint teaching sessions on relevant topics in practice. The most obvious are areas of common interest or policy imperatives that require collaborative working. Some examples might include joint assessments, falls prevention, rehabilitation and child or adult protection.

However, some readers of this chapter will probably be thinking that they do not work in such a team or that they do not have any opportunities to work interprofessionally. For them it might be useful to reflect on the times they have come across students from another profession in their day to day work, however fleetingly. This could suggest that there are opportunities for interprofessional learning and it would be beneficial to seek out colleagues and explore with them when they have students and if there

are opportunities for your students to spend some time with them. Once this has happened in one direction and relationships have been established it is more likely that reciprocal arrangements can be put into place.

ACTIVITY 12.4 INTERPROFESSIONAL COLLEAGUES

Make a list of all the different professionals you encounter in any working day, your list may include those you communicate with on the telephone. ■

How long was the list? Can you name the different individuals or do you just know them by their professional title, for example physiotherapist, social worker and so on? Did you have any difficulties compiling the list? If so reflect on your practice and consider whether you always work in isolation. In reality this is very uncommon; sometimes it is easy to forget the impact of other professionals on day to day practice.

MOVING FORWARD

It has been suggested that it is important to establish opportunities for interprofessional education and collaboration with colleagues. Any student will need to be prepared for an interprofessional learning experience. At this point it is useful to revisit the answers to the questions found in Activity 12.3. As indicated previously, they may not seem any different to the information required for any nursing or midwifery student. In many ways this is true; the significant change is the ability to facilitate both similarities and differences. In the first instance it may be important to establish what practitioners share in common. One very obvious starting point for a number of professions may be shared records used. This is commonplace in hospital settings, but will vary outside of the institution. Some other examples of shared records are the Care Programme Approach of the Department of Health (DH, 2006), the Single Assessment Process (DH, 2004) and the Common Assessment Framework (Department of Education and Skills, 2006); when working with these tools, approaches may be different between different professional groups. This may mean a student from another profession is going to approach a practice situation from a very different perspective to a student from your own profession. This can be challenging for both yourself and the student. You may not have

thought about approaching assessment from this perspective and it may seem alien, intrusive or confusing. Remember that the student is likely to be responding in exactly the same way to the method of assessment used by your profession. Each profession has both similarities and differences and sometimes will be practising in a different paradigm to nursing or midwifery. This is when a mentor can facilitate learning by explaining their own professional, philosophical approach to practice and perhaps learn from the student about theirs. It is important to remember that mentors can only facilitate what is known and familiar – that is individual professional practice. In another study undertaken by Parsons (cited in Colyer and Parsons, 2005) it was found that experienced mentors/facilitators mirrored their own interprofessional practice when they worked with students from another profession. This can be explained as having internalized the way they worked with other professionals interprofessionally into their own professional repertoire and being used on a regular basis in their professional artistry. Thus they mirrored this style of interprofessional working to their students.

This next activity draws on all the teaching and learning skills gleaned from other chapters in this book.

ACTIVITY 12.5 INTERPROFESSIONAL LEARNING OPPORTUNITIES

Spend some time identifying learning opportunities in your practice area and plan a teaching and learning programme for a third year student from another profession. (Ask colleagues from other professions what they would expect you to provide for their students).

Consider how you would assess this student either formally (summatively) or informally (formatively) and what evaluation strategy you would use. ■

It has probably taken some time to put the programme together. It may require some modification, especially if the student is spending a little time with you and you have the opportunity to identify their learning needs. Remember that students have different learning styles and subsequent preferences for teaching methods.

Now that you have formulated your approach to interprofessional learning and assessment in practice, all that is left is for you to try it out!

CHAPTER SUMMARY

This chapter has tried to demystify interprofessional learning in practice and provide readers with an understanding of the skills that are required by mentors to facilitate students from another profession.

It has defined interprofessional learning in practice (CAIPE, 2002) and examined the key skills that mentors develop to facilitate learning in their own profession. It provided opportunities for mentors to reflect on their own practice and to recognize their own professional artistry (Schon, 1995) and how they use this to facilitate learning. The use of transferable skills (Prosser and Trigwell, 1999) has been used to help practitioners to identify their existing skills and how these might be used to facilitate interprofessional learning in practice. The importance of developing effective collaboration with other professional colleagues has been highlighted as a key factor in developing interprofessional learning in practice. The only way individual mentors will know if they can undertake interprofessional learning in practice is to try out some of these things for themselves!

REFERENCES

Benner, P. (1984) *From Novice to Expert Excellence and Clinical Power in Nursing*, Addison-Wesley, Menlo Park CA.

CAIPE (2002) www.caipe.org.uk.

Chartered Society of Physiotherapists (2004) *Accredited Clinical Educator (ACE)*, Chartered Society of Physiotherapists, London.

College of Occupational Therapists (2006) *Framework for the Accreditation of Practice Placement Educators Scheme (APPLE)*, College of Occupational Therapists, London.

Colyer, H. and Parsons, J. (2005) *Modernising Pre-registration Education for the Allied Health Professions. First, Wave Development Funded Project 2002–2005*. Report to the Department of Health.

Department of Education and Skills (2006) *Common Assessment Framework*, The Stationery Office, London.

Department of Health (2004) *Single Assessment Process*, The Stationery Office, London.

Department of Health (2006) *Reviewing the Care Programme Approach: A consultation document*, The Stationery Office, London.

Freire, P. (1996) *Pedagogy of the Oppressed*, Penguin, London.

General Social Care Council (2005) *Specialist Standards and Requirements for Post Qualifying Social Work Education and Training: Practice Education*, General Social Care Council, London.

Kennedy, I. (2001) *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: learning from Bristol (Cm 5207(I))*, The Stationery Office, London.

Laming, L. (2003) *The Victoria Climbie Inquiry (Cm 5730)*, The Stationery Office, London.
Marshall, M. and Gordon, F. (2005) Interprofessional mentorship: taking on the challenge. *Journal of Integrated Care*, **13** (2), 38–43.
Mead, G. (2003) New primary care policies: from professions to professionalism, in *Interprofessional Collaboration: From Policy to Practice in Health and Social Care* (ed. A. Leathard), Brunner-Routledge, Hove, pp. 133–45.
Muholland, J., Mallick, M., Moran, P. *et al.* (2005) *Making Practice Based Learning Work*, Occasional Paper No. 6. The Higher Education Academy, Health Sciences and Practice Network, London.
NMC (2006) *Standards to Support Learning and Assessment in Pratice*, NMC, London.
Nussbaum, M.C. (1997) *Cultivating Humanity: A Classical Defense of Reform in Liberal Education*, Harvard University Press, Cambridge MA.
Prosser, M. and Trigwell, K. (1999) *Understanding Learning and Teaching; The Experience of Higher Education*, Society for Research into Higher Education and Open University Press, Buckingham.
Schon, D.A. (1995) *The Reflective Practitioner: how professionals think in action*. Aldershot: Arena.
Stew, G. (2005) Learning together in practice: a survey of interprofessional education in clinical settings in South-East England. *Journal of Interprofessional Care*, **19** (3), 223–35.
Walsh, C.L., Gordon, F., Marshall, M. *et al.* (2005) Interprofessional capability: a developing framework for interprofessional education. *Nurse Education in Practice*, **5**, 230–7.
WHO Africa Regional Committee (1988) Document AFR/RC37/Rl. Bamako Initiative, Mali.

CHAPTER 13
WORKING AS A PROFESSIONAL: STANDARDS FOR PROFESSIONAL PRACTICE

Melanie Jasper

Swansea University

LEARNING OUTCOMES

By the end of this chapter you will have:

- **Explored your own practice in relation to the Nursing and Midwifery Council's (2004a) *Code of Professional Conduct***
- **Identified your needs for continuing professional development as a practitioner**
- **Considered how you can meet the standards for practice as a mentor**

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

INTRODUCTION

In order to call yourself a practitioner with a title regulated by the Nursing and Midwifery Council, such as nurse, midwife or specialist community public health nurse, you have to agree, upon registration, to abide by your professional body's rules and regulations and practise within their code of conduct and published standards of practice. This chapter considers the obligations imposed on all practitioners through codes of conduct, what practitioners need to do in order to stay on their register and the standards for supporting learning and assessment in practice by mentors.

MENTORS AS PROFESSIONAL PRACTITIONERS

Preregistration educational programmes for nurses, midwives and specialist community public health nurses act as gateways to the professional register which enable practitioners to use certain regulated titles. Other practitioners, who have not completed these approved programmes of study are not entitled to use these titles and, indeed, may be prosecuted in a court of law if they do so. Hence, being admitted to a professional register is a great privilege, and says something about you, your knowledge, skills and capabilities to the general public. It also imposes certain expectations of you in relation to the way you practise and conduct yourself as a practitioner.

The Nursing and Midwifery Council, as the professional regulatory body, has as its remit the establishment and improvement of standards of care in order to serve and protect the public. Its key tasks are to:

- Maintain a register of qualified nurses, midwives and specialist public health nurses
- Set standards for education, practice and conduct
- Provide advice on professional standards
- Consider allegations of misconduct or unfitness to practise due to ill health

(NMC, 2004a)

One of your primary roles as a mentor is to act as a role model of good practice. This involves ensuring that your own practice is within the standards expected by the Nursing and Midwifery Council in the *Code of Professional Conduct: Standards for Conduct, Performance and Ethics* NMC (2004a). The clauses of the *Code* are shown in Box 13.1.

BOX 13.1 THE NURSING AND MIDWIFERY CODE OF PROFESSIONAL CONDUCT: STANDARDS FOR CONDUCT, PERFORMANCE AND ETHICS (NMC, 2004A)

As a professional nurse of midwife, you are personally accountable for your practice. In caring for patients and clients, you must:

- Respect the patient and client as an individual
- Obtain consent before you give any treatment or care
- Protect confidential information
- Cooperate with others in the team
- Maintain your professional knowledge and competence
- Be trustworthy
- Act to identify and minimize risk to patients and clients ■

In addition to the *Code*, the NMC also provides guidance on aspects of practice that contribute to these standards, such as *Guidelines for Records and Record-keeping* (NMC, 2005) and advice sheets on a range of topics such as medicines management and complementary therapies. A full list can be found at the Council's web site at www.nmc-uk.org. These guidelines provide the practitioner with advice about how safe and competent practice would be perceived by other practitioners in the same field of practice, and provide the yardstick by which the 'average' practitioner would be judged if their practice ever came under scrutiny. It is assumed by your employer and by your patients or clients, that when you are practising as a result of the nature of your registration, you will conform to these 'everyday' expectations of standards of practice. If you fail to do so, you may be called to account for any misconduct or unfitness to practise to the Fitness for Practice committee of the NMC. This committee has the power to suspend a practitioner from the register or, in extreme cases, to remove a person's name from the register. This means that they can no longer practise using their registration. The Fitness for Practice Committee publishes an annual report of its work, which is available on the Council's web site.

ACTIVITY 13.1 PRACTISING WITHIN THE CODE

How would you demonstrate to others that you are practising within the *Code of Professional Conduct*?

Give an example from your recent practice, for each clause, that you would be prepared to discuss with a student as an illustration of working within the *Code*.

As a mentor, how would you ascertain for yourself that a student is 'fit for practice' within the *Code*, and is sufficiently trustworthy to be accountable for their practice as a registered practitioner?

List some examples of student behaviour that would cause you to have concerns about a person's conduct within the *Code*. ■

STANDARDS FOR MENTORING

The *Standards to Support Learning and Assessment in Practice* were published by the Council in 2006 (NMC, 2006) to provide outcomes for mentors, practice teachers and teachers for nursing, midwifery and specialist community public health nursing. The *Standards* identify mandatory requirements for students studying for each part of the register:

- Nursing and midwifery students on preregistration, specialist practice programmes leading to a recordable qualification, and advanced practice programmes, must be supported and assessed by mentors when in practice.
- From September 2007, a sign-off mentor must make a final assessment of practice and confirm to the NMC that the required competencies for the programme have been achieved.
- From September 2008, the signing-off for specialist (SPQ) and advanced nursing or midwifery practice (ANP) programmes must be by a practice teacher.
- Midwifery mentors will all have met the additional criteria to be sign-off mentors.
- Specialist community public health students must be supported and assessed by a practice teacher, who will also have achieved the competencies of the sign-off mentor.

These standards confirm the significance and importance placed by the NMC on learning for practice in practice, and places the responsibility for ensuring a student's practice competence squarely in the hands of the practitioner. The aim of the NMC in publishing these standards was to ensure that there is 'clear accountability for making decisions that lead to entry to the register' (NMC, 2006, p. 6).

THE FRAMEWORK TO SUPPORT LEARNING AND ASSESSMENT IN PRACTICE

The NMC's single developmental framework consists of eight domains, each with four stages. The domains are:

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

The stages relate to development within the professional role that can lead to a registrant becoming a teacher for a particular part of the register, or for specialist or advanced practice. These four stages build on one another and can be represented diagrammatically (Figure 13.1).

At stage two, the mentor stage, there will be an additional responsibility placed on mentors who are sufficiently experienced to become sign-off mentors. These mentors will have the responsibility, delegated from their employer, for judging the student in their final placement and declaring them 'fit for practice'.

The eight domains of the framework have standards identified for each of the four stages (NMC, 2006, Annexe 1).

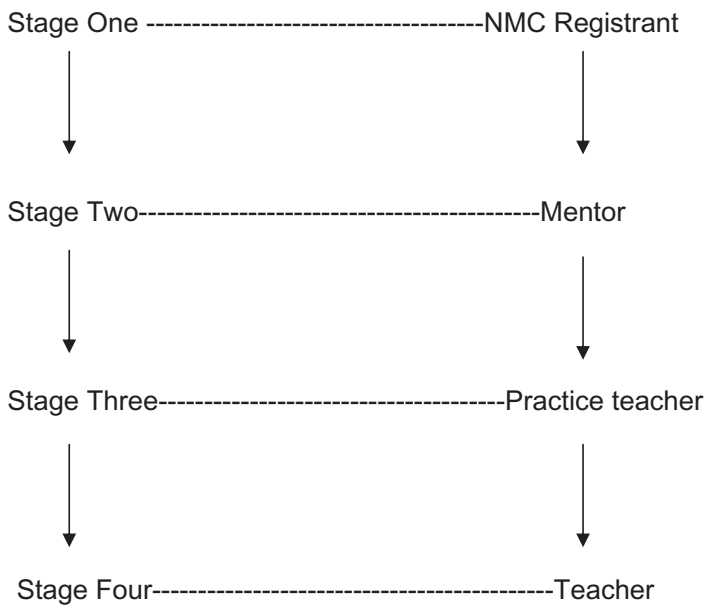


FIGURE 13.1

The Four Stages of the Developmental Framework for Standards to Support Learning and Assessment in Practice.

ACTIVITY 13.2 UNDERSTAND THE STANDARDS

As a mentor you will need to have a thorough understanding of the standards expected of you. You will be introduced to these during your mentor training, and I consider them later in this chapter. However, I can only provide a modified version here. I suggest you download your own copy of the standards from the Council's web site (www.nmc-uk.org) and familiarize yourself with the expectations outlined for the role. ■

The framework is underpinned by five principles relating to those NMC registrants who support learning and assessment in practice:

A. Those who make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice, must be on the same part or subpart of the register as that which the student is intending to enter.

B. They must have developed their own knowledge, skills and competency beyond that of registration through Continuing Professional Development (CPD) – either formal or experiential learning – as appropriate for their support role.

C. They must hold professional qualifications at an appropriate level to support and assess the student they mentor/teach, that is professional qualifications equal to, or at a higher level than, the students they are supporting and assessing.

D. They must have been prepared for their role to support and assess learning and meet NMC defined outcomes. Also, that such outcomes have been achieved in practice and, where relevant, in academic settings, including abilities to support interprofessional learning.

E. If intending to record their teaching qualification they must have completed an NMC approved teacher preparation programme or have been assessed by the NMC, through its accreditation of prior learning route, as having met the equivalent of this.

BECOMING A MENTOR

The NMC has provided specific criteria for registrants who want to become mentors which must be fulfilled before the role is undertaken. You must:

- be registered on the same part or subpart of the register as the student you are to assess; nurses must be in the same field of practice, for example adult, mental health, learning disability or child;
- have developed your own knowledge, skills and competence beyond registration (i.e. been registered for at least one year);
- have successfully completed an NMC-approved mentor preparation programme or equivalent;
- have the ability to select, support and assess a range of learning opportunities in your area of practice;
- be able to support learning in an interprofessional environment – selecting and supporting a range of learning opportunities for students from other professions;
- have the ability to contribute to the assessment of other professionals under the supervision of an experienced assessor from that profession;
- be able to make judgements about competence/proficiency 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 registrants in meeting CPD needs in accordance with the NMC *Code of Professional Conduct: Standards for Conduct, Ethics and Performance*.

(NMC, 2006, p. 18)

Clearly, the NMC wishes to protect both the student and the mentor in ensuring that mentors have appropriate qualifications, experience and preparation for the mentoring role. These criteria also suggest that a practitioner taking on a mentoring role will do so in the knowledge of the professional responsibility invested in them and the commitment that they are making towards ensuring standards of practice. Practitioners embracing a mentoring role need to have self-confidence in their ability not only to enable others to learn, but also to assess those learners and be able to make decisions about their competence to practise.

ACTIVITY 13.3 MEETING THE CRITERIA TO BE A MENTOR

Before going any further, consider your own background and experience against these criteria – do you fulfil the criteria for becoming a mentor? Using the eight bullet points above, write a list of how you meet these criteria. This will be a useful addition to your professional portfolio. ■

MENTOR PREPARATION

To become a mentor or practice teacher of nursing, midwifery or specialist community public health nursing the practitioner must undergo a programme of preparation that is approved by the Council and includes some elements of work-based learning. The requirements for these programmes are outlined in Table 13.1.

Mentors or practice teachers who have already completed a Council-approved programme will not need to repeat preparation at that level. However, the Council advises mentors to map their current qualifications against the new standards and meet any outstanding competencies through continuing professional development (NMC, 2006, p. 7). Practitioners with qualifications approved by other bodies, such as NVQ assessors, must use AP(E)L[1] procedures and undertake further preparation as specified by the programme providers to ensure they meet the standard.

[1] AP(E)L stands for the Accreditation of Prior Experiential Learning, and relates to learning achieved through practice that has not been awarded formal academic credits already.

TABLE 13.1

Requirements for Programmes Leading to Approval as a Mentor or Practice Teacher

Mentor preparation programmes	Practice teacher preparation programmes
• At a minimum academic level of HE intermediate level (previously known as level 2) or SCQF level 8 • A minimum of 10 days, of which at least 5 days are protected learning time • Include learning in both academic and practice settings • Include relevant work-based learning and have the opportunity to critically reflect on such experience • Normally, be completed within 3 months • Should provide a foundation for undertaking an NMC approved practice teacher programme • Allow AP(E)L to be applied to 100% of the programme and recognize previous preparation of an equivalent nature and standard For sign-off mentors: • It is for placement providers to determine if an individual meets the additional NMC criteria	• At a minimum academic level of HE honours (previously known as level 3) or SCQF level 9 • Include at least 30 days protected learning time, to include learning in both academic and practice settings • Include relevant work-based learning with the opportunity to critically reflect on such an experience • Meet the additional criteria for a sign-off mentor • Be completed within 6 months • Provide a foundation for undertaking an NMC approved teacher preparation programme • Allow AP(E)L to be applied • Accredit the content of a previous mentor programme

Adapted from (NMC, 2006, pp. 28–29 and 34–35).
HE, Higher Education; SCQF, Scottish Credit and Qualification Framework .

The NMC specifies mentor competencies as outcomes that need to be achieved by the end of a programme. These are shown in Table 13.2.

This list of outcomes suggests that the role of the mentor is seen by the NMC as going beyond supporting and assessing the student in practice at an individual level. The last three categories of outcomes clearly identify a developmental role for the mentor within the environment of practice. The mentor is perceived as key in enforcing practice standards and their development, ensuring that care is evidence based and in leading development of the clinical area as a learning environment.

TABLE 13.2

Competencies for Mentors (Adapted from NMC, 2006, pp. 18–19)

Establishing effective working relationships
- Develop effective working relationships based on mutual trust and respect
- 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

Facilitation of learning
- Use knowledge of the student's stage of learning to select appropriate learning opportunities to meet their individual needs
- Facilitate selection of appropriate learning strategies to integrate learning from practice and academic experiences
- Support students in critically reflecting upon their learning experiences in order to enhance future learning

Assessment and accountability
- Foster personal growth, personal development and accountability through support of students in practice
- Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team
- Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance ad capabilities for safe practice or be able to understand their failure and the implications of this for their future
- Be accountable for confirming that students have met, or not met, the NMC competencies in practice. As a sign-off mentor, confirm that students have met, or not met, the NMC standards of proficiency in practice and are capable of safe and effective practice.

Evaluation of learning
- Contribute to evaluation of student learning and assessment experiences– proposing aspects for change as a result of such evaluation
- Participate in self and peer evaluation to facilitate personal development, and contribute to the development of others

TABLE 13.2

continued

Creating an environment for learning
- Support students to identify both learning needs and experiences that are appropriate to their level of learning
- Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs
- Identify aspects of the learning environment which could be enhanced–negotiating with others to make appropriate changes
- Act as a resource to facilitate personal and professional development of others

Context of practice
- Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated
- Set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care
- Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained

Evidence-based practice
- Identify and apply research and evidence-based practice to their area of practice
- Contribute to strategies to increase or review the evidence-base used to support practice
- Support students in applying an evidence base to their own practice

Leadership
- Plan a series of learning experiences that will meet students' defined learning needs
- Be an advocate for students to support them in accessing learning opportunities that meet their individual needs–involving a range of other professional, patients, clients and carers
- Prioritize work to accommodate support of students within their practice roles
- Provide feedback about the effectiveness of learning and assessment in practice.

CONTINUING PROFESSIONAL DEVELOPMENT FOR MENTORS

As with any other skills for practice, a mentor needs to ensure that they maintain and regularly update their knowledge and competence. Placement providers, that is your employer, are required to keep a record of mentors and to ensure they are updated regularly (in partnership with the local education provider). At a minimum, this annual updating needs to ensure that mentors: have current knowledge of NMC-approved programmes; can discuss the implications of changes to NMC requirements; and have the opportunity to discuss issues related to mentoring, assessment of competence and fitness for safe and effective practice with their colleagues (NMC, 2006, p. 29). Evidence that demonstrates these standards are met will be assessed during NMC quality monitoring events. At an individual level, attendance at these kinds of events will provide useful material for inclusion in your own professional portfolio, particularly if you take the time to reflect on the event, its content and how you intend to implement or use the knowledge that you gained. Your employer is required to review your competence as a mentor every three years and therefore you will need to provide evidence that you are achieving the mentor standards within this role in order to be able to continue as a mentor.

These updating sessions will be particularly important in enabling you to develop further understanding of the mentoring role, and will, ideally, include useful tips and strategies for supporting and assessing learners in practice. After all, the NMC stipulates that at least 40% of a student's time is spent being supervised (directly or indirectly) by a mentor (NMC, 2006, p. 29), which means that you will need to plan activities and sessions for the student to ensure that they are making the most of opportunities for learning in the practice setting. This has been discussed in more detail in Chapter 7. Do remember that as a mentor you are expected to use your professional judgement and work within local and national policies to ensure that activities are delegated safely to students, and to assess the level of supervision that they require. You are accountable for these decisions and for ensuring public protection in making them.

These activities are considered to be part of the role of the mentor, and therefore part of your overall working activity if you are designated as a mentor. Time therefore needs to be put aside, within this role, for you to be able to explain, question, assess performance and provide feedback to a student in a meaningful way. You should not be expected to be mentoring more than three students at any one time, and may be able to make creative use of your time by organizing activities to involve all your students, and perhaps even to share activities with another mentor or ask students to prepare sessions. An effective way of maximizing learning opportunities is to set up action learning sets for students, who can then be facilitated through activities that ensure they meet the objectives required for your clinical area.

Action learning sets are also effective for groups of mentors too, who can offer peer support and development for themselves on an on-going basis.

ACTIVITY 13.4 ACTION LEARNING SETS

What is your understanding of the way an action learning set works?

Do you need to do some independent research to expand your knowledge about them?

Can you see ways in which you could utilize action learning sets for:

(a) students in your clinical area?

(b) you and your colleagues? ■

THE SIGN-OFF MENTOR

The NMC has responded to criticisms regarding the standard of assessment of students as competent to practise at the end of their programme by creating a mentoring role with additional responsibilities (NMC, 2006). These mentors are called sign-off mentors, and need to be experienced mentors who are capable of making the judgement that a student is ready to be entered on the professional register as a competent practitioner. The NMC statutory midwifery committee has decided that all midwife mentors must have met the additional criteria to be sign-off mentors (NMC, 2006, p. 32). Sign-off mentors need to fulfil the same criteria as mentors, and also to have:

- clinical currency and capability in the field of practice in which the student is being assessed;
- met the NMC requirements to remain on the local register;
- been supervised on at least three occasions for signing-off proficiency and the end of a final placement (or supervised practice for Specialist Practice Qualifications) by an existing sign-off mentor or practice teacher;
- a working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the students they are assessing;
- an understanding of the NMC registration requirements and the contribution they make to meeting these requirements;

- an in-depth understanding of their accountability to the NMC for the decision they make to pass or fail a student when assessing proficiency requirements at the end of a programme.

NMC, 2006, p. 20

It is the employer's responsibility to maintain the register of sign-off mentors and to confirm the mentor's eligibility for designation as a sign-off mentor.

ACTIVITY 13.5 ARE YOU A SIGN-OFF MENTOR?

- How does your employer differentiate between a mentor and a sign-off mentor?
- What are the criteria within your organization for becoming a sign-off mentor?
- What would you need to do to become a sign-off mentor if you are not already one? ■

YOUR ROLE AS A MENTOR

The NMC sees mentors as being responsible and accountable for:

- organizing and coordinating student learning activities in practice;
- supervising students in learning situations and providing them with constructive feedback on their achievements;
- setting and monitoring achievement of realistic objectives;
- assessing total performance – including skills, attitudes and behaviours;
- providing evidence as required by programme providers of student achievement or lack of achievement;
- liaising with others (for example sign-off mentors, practice facilitators, practice teachers, personal tutors, programme leaders) to provide feedback, identify any concerns about the student's performance and agree action as appropriate;

- providing evidence for, or acting as, sign-off mentors with regard to making decisions about achievement of proficiency at the end of a programme.

NMC, 2006, p. 17

These functions can be divided into two main categories – supporting learning in practice, and assessing learning in practice.

SUPPORTING LEARNING IN PRACTICE

The NMC tasks the mentor with four main activities:

1. providing support and guidance to the student when learning new skills or applying new knowledge;
2. acting as a resource to the student to facilitate learning and professional growth;
3. directly managing the student's learning in practice to ensure public protection;
4. directly observing the student's practice, or using indirect observation where appropriate, in order to ensure that the NMC defined outcomes and competencies are met.

(NMC, 2006, p. 30)

The NMC sets the following requirements for achieving these:

1. Every student must have a named mentor for each period of practice learning.
2. Mentors should not normally support more than three students, from any discipline, at any point in time.
3. Whilst giving direct care in the practice setting at least 40% of a student's time must be spent being supervised (directly or indirectly) by a mentor. When in a final placement this 40% of the student's time is in addition to the protected time (one hour per week) to be spent with a sign-off mentor.
4. An on-going achievement record (student passport), including comments from mentors, must be passed from one placement to the next to enable judgements to be made on the student's progress.
5. The mentor should have access to a network of support and supervision to enable them to fulfil their mentoring responsibilities, assist them in making complex judgements such as failing a student and to support their professional development.

6. Placement providers are responsible for ensuring that an up-to-date local register of mentors is maintained, with annotations of those who have met the NMC additional criteria for assessing proficiency (sign-off mentor).
7. Placement providers are responsible for triennial review of mentors to ensure that only those who continue to meet the NMC's mentor requirements remain on the local register.

NMC, 2006, pp. 30–1

Clearly, mentoring is perceived by the NMC as going beyond the individual relationship between a mentor and their student. It is now within a framework of accountability and responsibility for professional standards that is implicit within both the individuals' practice and that of the employer. This should enable mentors to feel secure in their role by a support system and framework that is implemented at a local level.

ACTIVITY 13.6 SUPPORTING LEARNING IN PRACTICE

Take some time now to consider the four main activities identified by the NMC. List how you will be able to fulfil these within your own area of practice. It is useful to add concrete examples rather than general statements.

Then, consider the seven requirements in terms of how you will achieve these when supporting a student within your normal working week. In particular, think about how you will communicate and link with other mentors for an individual student, and where support in your role will come from in terms of your peer group. ■

ASSESSING LEARNING IN PRACTICE

The judgement about a student's competence clearly rests with the mentor for a placement, and, in the final placement, with the sign-off mentor who has the ultimate responsibility of enabling the student to be registered with the NMC as a qualified nurse, midwife or specialist community public health nurse. Failing a student is often a difficult task, especially as all decisions need to be supported by evidence and examples that can be made clear to the student, other people who will be involved in the consequences

of the decision and through an appeals process. The NMC set the following requirements for assessing learning in practice:

1. Most assessment of competence should be undertaken through direct observation in practice.
2. Mentors should be involved, wherever possible, when competence is assessed through simulation.
3. Mentors should consider how evidence from various sources might contribute to making a judgement on performance and competence.
4. Mentors should seek advice and guidance from a sign-off mentor or a practice teacher when dealing with failing students.

NMC, 2006, pp. 31–2

Assessment is a different component of the role completely to that of enabling a student to learn. While assessment can be seen as a formative process, where students receive continual feedback about their strengths and areas for improvement, it is often perceived only in its summative aspect – that is, at the end point when a judgement is made about the student's performance and their progress within their programme is dependent on their success.

Many mentors find this the most difficult aspect of their role. Indeed, there is often a conflict when guiding a student through a clinical placement and helping them to achieve objectives in a supportive and developmental way, to the need to make judgements about the student. Often, you can see that there has been progress, and that a student is trying very hard. Also, you form personal relationships with students, and become part of their lives. However, ultimately, you need to remember that you are acting as a gatekeeper for entry to your profession. And, that your role as a mentor is a professional one, not a personal one. From my own experience, I can remember the agonizing decisions from several mentors who did not want to fail a student. Indeed, often the mentor would avoid taking that decision, and despite raising concerns with the academic staff, still completed an assessment of practice which passed the student. The responsibility now lies directly with the mentor, and sign-off mentor, for verifying a student's competence and fitness to practise. This is quite rightly so, for the people in the best position to judge practice are those in practice themselves. The challenge is for practitioners, as mentors, to differentiate between the responsibilities of supporting learning in practice, and assessing that learning. These issues are discussed in more detail in Chapter 10.

ACTIVITY 13.7 RESPONSIBILITIES OF ASSESSMENT AS A MENTOR

- Have you ever thought, in-depth, about your attitudes and feelings towards your responsibility for assessing students as competent and fit for practice?
- Take some time now to consider the issues I raised in the last paragraph.
- Work through the four NMC requirements for assessing students in practice and write yourself some ways of addressing these. This is often easier to do without having a particular student in mind, as you can focus on your expectations and standards rather than the individual.
- It is also important to identify your own support mechanisms and be clear about who you can consult if you are finding a particular student challenging. ■

SIGNING OFF PRACTICE PROFICIENCY

The sign-off mentor verifying the student's final practice placement proficiency is also confirming that a student has successfully completed all practice requirements. This confirmation contributes to the portfolio of evidence that is considered at a final assessment board for recommendation of an award from the educational institution and to the NMC for application for registration on the professional register. The NMC apply the following requirements:

1. The NMC has identified progression points within each approved programme where confirmation is required that students have met specified outcomes and competencies.
2. All mentors may assess specific competencies throughout the programme.
3. Mentors must keep sufficient records to support and justify their decisions on whether a student is, or is not, competent/proficient.

4. In the final placement of a preregistration, SPQ or ANP programme, mentors are required to be either a sign-off mentor, or to be supported by a sign-off mentor or a practice teacher, in order to make final decisions on proficiency.

5. Sign-off mentors must have time allocated to reflect, give feedback and keep records of student achievement in their final period of practice learning. This will be the equivalent of an hour per student per week. This time is in addition to the 40% of the student's time to be supervised by a mentor.

6. Only sign-off mentors, who have met the additional criteria, must sign-off achievement proficiency at the end of the programme, unless the mentor is being supervised by a sign-off mentor or practice teacher who should countersign that the proficiency has been achieved by the student.

7. The programme leader/lead midwife for education must confirm to the Approved Educational Institution's Examination/Assessment Board that all NMC requirements have been met (to the best of their knowledge) for individual students, presenting evidence of sign-off of practice from a sign-off mentor or practice teacher.

8. The student must self-declare their good health and good character for entry to the register.

9. The programme leader/lead midwife for education must provide a supporting declaration of good health and good character of the student for registration.

NMC, 2006, pp. 32–4

This is a daunting responsibility, and one that is now enshrined within the NMC requirements. In the past, the overall responsibility for competence in practice rested with the educational institution, informed by the practice assessments completed by practice assessors. That responsibility has now been transferred to the sign-off mentor. However, it must be remembered that each placement a student undertakes will be adding incrementally to their skills and knowledge base – it is not only at the final placement that a student will be assessed. Indeed, it is likely that a struggling student will be identified early on in their programme, and it really should not be left until their final placement for problems to be identified. A student failed at this stage may well have cause for appeal or complaint if problems had been noted earlier in their programme and not acted upon.

ACTIVITY 13.8 RESPONSIBITIES AS A SIGN-OFF MENTOR

- How do you feel about taking on the responsibility of the role of a sign-off mentor?
- In what way would it be different to the way you act as a mentor now?
- What development would you need to be confident in becoming a sign-off mentor? ■

MAINTAINING YOUR PROFESSIONAL COMPETENCE

Once a practitioner is registered they have a responsibility for their own continuing professional development and maintaining their competence against the standards. The NMC requires a practitioner to reregister every three years. At that time the practitioner has to sign a declaration confirming that they have met the professional development and practice standards outlined by the Council (NMC, 2004b) in *The PREP Handbook*. These are:

- The PREP (practice) standard – you must have worked in some capacity by virtue of your nursing or midwifery qualification during the previous five years for a minimum of 100 days (750 hours), or have successfully undertaken an approved return to practice course.
- The PREP (continuing professional development) standard – you must have undertaken and recorded your continuing professional development over the three years prior to the renewal of your registration. This comprises at least five days (or 35 hours) of learning activity, and requires a personal professional profile to be maintained.

This declaration is a 'notification to practice' by the practitioner to the Council, and commits the practitioner to complying with an audit of their evidence of compliance with the standards if the Council requires it.

Any work that you do as a mentor will come within your usual working role and therefore is part of the PREP practice standard. Mentors are required to undergo prepa-

ration for their role before mentoring a student, and this will count towards the PREP CPD requirement. It is worth keeping a 'mentoring log' of your activities as a mentor, including any reading you do about the role, study days or updating you attend so that when you need to produce your PREP evidence you already have it compiled. The NMC expects registrants to include CPD for their teaching roles in their personal development plans (NMC, 2006, p. 13). This will also be useful in demonstrating the mentoring standards expected by the Council.

ACTIVITY 13.9 REVIEW YOUR OWN QUALIFICATIONS

- When is your registration next due for renewal?
- What evidence to do have that demonstrates that you meet both PREP standards?
- What does your professional profile contain? ■

CHAPTER SUMMARY

This chapter has presented the reality of the responsibility and accountability of being a mentor. It emphasizes the significance of being a registered practitioner, with the duties and standards of practice imposed as a result. To some extent however, the action of the NMC in clarifying a statutory responsibility for mentors, and practice teachers, puts an end to the uncertainty that has dogged the role to date. The responsibility for verifying capacity to practice quite rightly lies with the practitioners who are practising their craft everyday. This recognizes the skill and expertise of the practitioner, and enables them to act as gatekeepers for the standards of those who apply to join the profession. It is for those who mentor to come to terms with the added responsibilities that this entails.

REFERENCES

Nursing and Midwifery Council (2004a) *Code of Professional Conduct: Standards for Conduct, Performance and Ethics*, NMC, London.

Nursing and Midwifery Council (2004b) *The PREP Handbook*, NMC, London.
Nursing and Midwifery Council (2005) *Guidelines for Records and Record-Keeping*, NMC, London.
Nursing and Midwifery Council (2006) *Standards to Support Learning and Assessment in Practice*, NMC, London.

FURTHER READING

Caulfield, H. (2005) *Accountability*, Blackwell Publishing, Oxford.
Jasper, M. (2006) *Professional Development, Reflection and Decision-Making*, Blackwell Publishing, Oxford.

Glossary of Terms

Activist A person who prefers to be actively involved in new experiences and enjoys constant stimulation. Activists tend to learn best when working with others in team tasks.

Adobe Acrobat A computer program used for displaying PDF files.

Auditory learner A style of learning that relies predominantly on auditory cues, normally preferring things when heard.

Behaviourism A theory that was based on research with animals and considers that learning has occurred when a change in behaviour is observed; no evidence of mental or cognitive ability is required. Key terms within this theory are classical conditioning, stimuli and reinforcement.

Bibliographic database A searchable index of journal articles, usually providing citations and abstracts.

Blog Blog is short for Weblog. It is an online journal or diary which can be closed or open for public viewing.

Classical conditioning A form of associative learning where a neutral stimulus is paired with a stimulus of some significnce. For example Pavlov took a dog's normal response to food (salivation) and linkeed this to an introduced stimulus (bell sounding). If repeatedly paired, eventually the two stimuli become associated, and the dog begins to produce a behavioural response to the conditioned stimulus.

Cognitive style or **learning style** is a preferred method or approach to learning that seems to be fairly consistent in most people.

Cognitive theory A theory that is concerned with the development of central concepts such as growth of intelligence and that identifies stages of development and construction of congnitive abilities through self-motivated action.

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper

Competence is characterized by the presence of the components of appropriate knowledge skills and attitudes to enable safe care to be given within a defined practice situation. These broad components interrelate within a profile of: skills (practical, technical, interpersonal, organizational, ability to transfer into other settings); knowledge (up to date, critical thinking, reflection); attitude (values and beliefs, professional attitudes, confidence); practice situation (adequate resources, ethos of support, reasonable workload).

Competence (lay definitions) include:

1. having sufficient skill, knowledge;
2. suitable or sufficient for the purpose;
3. the Latin '*competens*' means to be fit, proper or qualified.

Competencies Essential skills which contribute to being competent and achieving the proficiencies for registration.

Competent Relates to the need for the student to demonstrate their 'capability' in certain skill areas to a required standard at a point in time. Competencies contribute to being competent.

Concept is an abstract idea conceived in the mind.

Concept maps are a method of providing a Gestalt or overview of certain speciality topics.

Constructivism Constructivism views shared or social construction of knowledge, as collaborative *development*, where the learner is in an interactive role, being guided by others. Knowledge is constructed by being exposed to the language and culture, and by exploring the individual's beliefs and experiences within that culture. Constructivism therefore values developmentally appropriate facilitater-supported learning that is initiated and directed by the learner.

Criterion-referenced A specific set of criteria developed for assessment in practice against which all learners are measured.

E-book A book available electronically, usually via the Internet.

E-mail Electronic mail carried over the Internet.

Eu-stress Eu-stress is defined as a positive form of stress that keeps us energized within our professional lives.

Evidence-based A basis for best practices, to open up and guide discussion, and used to aid decision-making.

Facilitation encouraging another to participate fully in their own learning through the development of an effective relationship, mutual understanding and shared responsibility.

Firewalls A means of security or barrier which protects a computer or network of computers from access by other computers.

Formative assessment A developmental process of assessment that helps identify strengths and areas for development.

Gestalt theory is concerned with the effect of perception on the process of learning and assumes that learning takes place by visualizing the world as a *whole*, in patterns or *Gestalten*, and not in fragments or pieces.

Internet 'The worldwide, publicly accessible network of interconnected computer networks … It is a "network of networks" that consists of millions of smaller domestic, academic, business, and government networks, which together carry various information and services, such as electronic mail, online chat, file transfer, and the interlinked Web pages and other documents of the World Wide Web' (Wikipedia).

Interpersonal skills A range of communication skills and attitudes that are thought to be necessary for a practitioner to have in order to carry out her work effectively in partnership with clients or patients.

Interprofessional Different health professionals working together for the benefit of the client or patient. For example, midwife, obstetrician and General Practitioner.

Interprofessional practice describes two or more professionals collaborating to improve the quality of service provision for individuals, families or communities.

Intervention (catalytic) Catalytic interventions are useful in encouraging a learner to problem solve and to seek out their own solutions.

Intervention (cathartic) Cathartic interventions encourage learners to explore how they feel about something.

Intervention (challenging) A challenging intervention imparts an uncomfortable truth within a psychologically safe environment.

Intervention (informative) Informative interventions will be used when the mentor wants to tell the learner something, to impart new knowledge that is relevant to the learner's needs.

Intervention (prescriptive) Prescriptive interventions are used to direct behaviours, so the mentor would be instructing the learner in what he/she should do.

Intervention (supportive) Supportive interventions are positive strokes that make the learner feel good about themselves, affirming his/her worth and value.

Kinaesthetic learner A style of learning that relies predominantly on movement cues, normally preferring things when action is present.

Knowledge (conditional) Knowing when or why to use declarative and procedural knowledge.

Knowledge (declarative) Factual knowledge, for example 'knowing that' there are four chambers in the heart.

Knowledge (procedural) Knowing how to do something, for example 'knowing how' to take a pulse.

Lancaster Inventory An inventory used to explore the differences between deep and surface approaches to learning.

Learning (deep) An approach to studying in which the learner is internally driven to achieve and actively organizes content into coherent wholes, relating new ideas with what is already known and applies concepts to their everyday experiences.

Learning (strategic) An approach to studying in which the learner is motivated to get good marks and acquires the skills and understanding required to meet the demands of assessment. The more comprehensive the assessment the better the learner's performance.

Learning (surface) An approach to studying in which the learner is externally driven, most likely by the demands of assessment and tends to focus on the task in isolation from other learning or their practice.

Learning Contract A written agreement between two individuals regarding agreed learning outcomes. The contract provides a statement of outcome, the resources or structure needed, the processes required and how the learning and outcome can be evidenced.

Learning style or cognitive style is a preferred method or approach to learning that seems to be fairly consistent in most people.

Mentee one who is undergoing a learning relationship with a named mentor.

Mentor is a named, suitably skilled practitioner who is in an educational relationship with a named student to provide guidance in health or social care placements.

New registrant Newly qualified nurse or midwife.

Norm-referenced assessment Norm-referenced assessment involves comparisons being made between what one learner has achieved and the expected norms for their stage of education.

NPfIT stands for 'National Project for IT', and is the NHS initiative with four goals: electronic appointment booking, an electronic care records service, electronic transmission of prescriptions and fast, reliable underlying IT infrastructure.

Parts of the register The NMC Register, which opened on 1 August 2004, has three parts: nurses, midwives and specialist community public health nurses. A mark on the register identifies the field of practice, that is, adult, children, mental health and learning disability nurses.

Patient pathway A model for placement allocation that enables the student to experience a full and relevant range of learning opportunities.

PDF Portable Document Format. An electronic file that can only be read through Adobe Acrobat software. The file can be secured so that others cannot edit it. Many official Government documents are often published on the Web in this format.

Placement profile An outline of the placement that provides information for the student regarding staff, routine and the learning experiences available. This can be viewed by students prior to placement and inform the development of their learning contract.

Podcasts Podcasting is the feeding of audio and video to portable media players (mp3 players). Users need to subscribe or sign up to a podcast in the same way as they would a magazine.

Point of registration Prior to initial registration with the NMC, the student must have successfully completed an NMC approved programme of education.

Practice teacher A registrant who has received further preparation (beyond that of mentor) to achieve the knowledge, skills and competence required to meet the NMC defined outcomes for a practice teacher.

Practice/Clinical Placement Facilitator An experience practitioner employed by the Trust or University to work collaboratively to enhance the capacity and quality of preregistration placements.

Practicum A supervised opportunity to apply the practical components of an education programme.

Pragmatists People who learn best when there is an obvious link between the topic and their job. They value the chance to try out techniques with feedback where they are shown techniques with obvious advantages such as saving time.

Preceptee is a new or inexperienced practitioner who is being supported by a named preceptor as part of staff development.

Preceptor is an experienced and qualified practitioner who acts as facilitator to new or less experienced colleagues and provides feedback support and challenge to aid their professional development.

Proficiencies These are contained within the Standards of proficiency for each of the three parts of the register. Fitness for practice is demonstrated by meeting all NMC proficiencies and other requirements by the end of the programme.

Reading and writing learner A style of learning that relies predominantly on written cues, normally preferring things when in word form.

Reflection An in-depth consideration of events or situations outside of oneself; solitary or with critical support.

Reflective learning involves deliberative, cognitive processes which actively set out to explore and experience for what can be learnt from it.

Reflectors People who learn best when observing individuals or groups at work. They need the opportunity to review what has happened and think about what they have learned so prefer doing tasks without tight deadlines.

RSS 'News feeds allow you to see when web sites have added new content. You can get the latest headlines and video in one place, as soon as it's published, without having to visit the web sites you have taken the feed from. Feeds are also known

as RSS. There is some discussion as to what RSS stands for, but most people plump for "Really Simple Syndication". In essence, the feeds themselves are just web pages, designed to be read by computers rather than people' (BBC).

Sandwich method A method for giving feedback that involves negative points being placed between positives.

Scaffolding is a technique that can be used to support the development of skills. The mentor constructs a 'scaffold' around the area so that learners have direct access to the chosen focus, with nothing allowed to get in the way and when the learner is able to handle the task the 'scaffold' is gradually removed. Scaffolding enables learners to reach beyond their current competencies and explore new understandings and skills.

Schemata A model that shows relationships between objects.

Self-referenced assessment A method of assessment in which a student measures their own ability against their previous performance and self-defined criteria.

Serialist approach A person who organizes information by adopting a step-by-step approach which develops a detailed and logical analysis, so that the parts are understood before the full picture.

Sign-off mentors are appropriately experienced and qualified mentors who have a special role to ensure students' fitness to practise at the end of each significant progression point including the point of qualification.

Situated learning Situated learning is 'enculturalation' or adopting the norms, behaviours, skills, beliefs and language of a particular area.

Situated practice Learning that takes place in authentic, real world settings.

Social learning theory A form of learning that recognizes people learn from social interaction or 'role-modelling'. Learning takes place by observing many different models, and is useful when applied in any health-care setting, to develop professional skills and attitudes. Four conditions must be present for learning through observation to be successful: (1) attention, (2) retention, (3) motor reproduction and (4) motivation.

Summative assessment is usually undertaken at the end of a period of learning. This may involve either a pass/ fail or grade of practice that influences students progression to subsequent placements or the professional register.

Tacit knowledge is that knowledge that exists in a profession that underpins everyday automatic actions in practice. It is so normal that established practitioners take it for granted and therefore rarely make it explicit to new or inexperienced colleagues.

Theorist People who best when they are put in complex situations where they have to use their skills and knowledge. They do best in a structured situation with clear purpose and where they are offered interesting ideas or concepts even though they are not immediately relevant. They value the chance to question and probe ideas behind things.

VARK system is a method that assesses how much people rely on different senses such as **V**isual (sight), **A**uditory (hearing), **R**eading/Writing and **K**inaesthetic (movement, which also includes touch and temperature).

Virtual Learning Environment (VLE) A system which allows an organization to create a personalized web site to support learning. The tools within it allow for the posting of documents, images, videos, assessments and discussions.

Visual learner A style of learning that relies predominantly on visual cues, normally preferring things when seen.

Wiki 'A Wiki is a type of Web site that allows the visitors themselves to easily add, remove, and otherwise edit and change some available content, sometimes without the need for registration. This ease of interaction and operation makes a Wiki an effective tool for collaborative authoring' (Wikipedia). The best known Wiki is Wikipedia.

World Wide Web 'The World Wide Web ("WWW" or simply the "Web") is a system of interlinked … documents that runs over the Internet. With a Web browser, a user views Web pages that may contain text, images, and other multimedia and navigates between them using hyperlinks' (Wikipedia).

Index

An asterisk (*) after a page number indicates a reference to an item in the Glossary of Terms

Enabling Learning in Nursing and Midwifery Practice A Guide for Mentors, Edited by S. West, T. Clark and M. Jasper