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.
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

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.
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


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