Article Title: Mentorship

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Key Points:

Nursing, and particularly ophthalmic nursing practice, is primarily a competency orientated profession (RCN, 2005).

Placement Providers are healthcare institutions within the UK that have been specifically chosen by higher education institutions because they have been deemed suitable through quality review by the higher education institution for training students.

At least 40% of a student's placement time should be spent directly with a mentor.

Preparation programmes approved by the NMC for mentors and practice teachers must include learning in both academic and practice settings.
All mentors in the UK must maintain their knowledge, skills and competence through regular, annual updates (Glasper 2010; NMC, 2008).

Introduction

The purpose of this article is to explore the issues relating to mentoring students. Nursing, and particularly ophthalmic nursing practice, is primarily a competency orientated profession (RCN, 2005). Therefore the need for allocating students to clinical placements is based on the necessity to assess their level of competency. In the United Kingdom (UK), registered nurses/mentors are responsible for assessing students' competencies in clinical practice (NMC 2008). This applies in relation to pre-registration and post registration students.

The concept of mentoring was first used by nurse education in the UK by the former English National Board (ENB) in 1987. The ENB referred initially to mentors as 'wise reliable counselors' and 'trusted advisers' who would be selected by the student to assist, befriend, guide, advise and counsel students in their learning (ENB 1988, ENB 1989, ENB 1994).

The Nursing and Midwifery Council (NMC) inherited the educational functions of the ENB in 2002 and described the role and functions of a mentor in its '*Standards to Support Learning and Assessment in Practice'.* The NMC indicated that a mentor is a NMC registrant who, following successful completion of an NMC approved mentor preparation programme, or comparable preparation that has been accredited by an approved education institute meets the NMC mentor requirements. This means the mentor has achieved the knowledge, skills and competence required to meet the defined outcomes within a specific area of practice (NMC 2008). Refer to Table 1 *for the Standards to Support Learning and Assessment in Practice.* Areas of practice are delineated by 'Placement Providers'. These providers are healthcare institutions within the UK that have been specifically chosen by higher education institutions because they have been deemed suitable through quality review by the higher education institution for training students.

Table 1

Standards to Support Learning and Assessment in Practice

Placement providers will be responsible for maintaining a local register of mentors, sign off mentors and practice teachers
At least 40% of a student's placement time should be spent directly with a mentor
Ongoing records of achievement to be kept by students and to move with them from placement to placement
Mentors to have support networks to assist them, particularly for managing failing students
Sign off mentors will meet additional criteria and, when supervising students in their final placement, will have protected time for providing feedback to students
Preparation programmes approved by the NMC for mentors and practice teachers must include learning in both academic and practice settings

Historical Background

The word mentor derives from ancient languages: the Sanskrit language word '*mantar' which means* 'one who thinks', the Latin word '*monitor'* which means 'one who admonishes' and the Greek language where Mentor was a character in Homer's *Odyssey*. In this story Mentor is left to take care of the palace and to bring up Telemachus the son of Odysseus who has left for the Trojan War. In this story Mentor happens to be an ineffective guardian prompting the goddess Athena to take on Mentor's appearance in order to guide young Telemachus more effectively during those difficult times (Holmes et al 2010).

Differences in Being a Mentor as Compared to the 'Pure' Meaning of Mentorship

Over time the concept of mentorship in a nursing educational context has evolved and it now combines a variety of roles. Despite the 'pure' meaning of mentorship where the mentor shares their knowledge and experiences with their students to encourage them to develop their skills (Lawson 2011), the additional role of the mentor in the nursing profession is to supervise and assess students at levels determined by a higher education institution (HEI)

and the NMC enabling the students to progress through their course and allow them to be registered and entered onto the professional register. Price (2005) identifies the functions of a mentor using both approaches of personal development sharing the mentor's wisdom whilst also acting as an assessor and supervisor. Refer to Table 2 for the functions of a mentor as specified by Price (2005).

Table 2

Functions of a mentor (Price 2005)

	Example
Function	Choosing how best to approach an assessment.
Net Worker	Alerting the student to a knowledgeable colleague who can assist with questions.
Sponsor or Advocate	Highlighting the student's abilities, efforts and circumstances to others.
Resource Consultant	Alerting the student to useful articles, websites, policies or other sources of relevant information.
Role Model	Exemplifying good communication practice with patients and their relatives.
Facilitator of Critical Thought & Reflection	Using past experiences and helping the student anticipate the possible outcomes of a planned action.
Assessor or Monitor	Judging the student's progress on the placement and reporting on it.

Teaching and assessing are crucial aspects of the mentor's role making them 'gate keepers'. Functioning as a 'gate keeper' whilst a student is learning and developing their ophthalmic nursing skills protects the public from potential harm (NMC 2002). While all qualified mentors in the UK can assess students up to their final placement, final placements can only be assessed by those mentors who are recognised as a sign-off mentor (NMC, 2008). Sign-off mentors are senior members of clinical staff with extensive knowledge and skills in ophthalmic practice. All mentors in the UK must maintain their knowledge, skills and competence through regular, annual updates (Glasper 2010; NMC, 2008). Refer to Table 3 for the criteria established for a practitioner to be a sign-off mentor in the UK.

Table 3 **Criteria to be a sign-off mentor (NMC, 2008)**
The mentor should have clinical currency and capability in the field of practice in which the student is being assessed.
The mentor should have met the Nursing and Midwifery Council (NMC, 2008) requirements to remain on the local register.
The mentor should have received supervision on at least three occasions for signing off proficiency at the end of a final placement or supervised practice placement for specialist practice qualifications by an existing sign-off mentor or practice teacher.
The mentor should demonstrate a working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the student being assessed.
The mentor should display an understanding of the NMC registration requirements and the contribution he or she makes to meeting these requirements.
The mentor should demonstrate an in depth understanding of his or her accountability to the NMC for the decision he or she makes to pass or fail a student when assessing proficiency requirements at the end of a programme.

The Importance of Mentorship in the Practice Experience

Nursing programmes are designed in a way that students can spend a proportion of their training in a classroom and a proportion in clinical practice, which is the focal point of nurse education (NMC 2002a). Dobinson-Harrington (2006) identified that learning in practice is different than that received in the classroom because learning in practice takes place in an inductive environment before ‘an audience’ of a patient, relatives and other professionals who are bound by etiquette of enquiry and professional hierarchy to deliver holistic patient care. This is supported by Quinn (2000) who states that learning in practice involves a direct participation in the events of practice. Table 4 delineates these distinctions.

Table 4 **Learning in practice**	**Learning in classroom**
Strongly inductive – making sense of experience	Sometimes abstract (concepts) and often deductive (creating theories and applying them to the role of the nurse
Involves performance and learning and all before an audience of other stakeholders (patients, relatives, other professionals)	Emphasis upon pedagogy (teaching) and learning.
Collegiate – learning is often through consultation and discussion	Often private as when student concludes points from lectures and textbooks
Anxiety laden – safety and wellbeing of patients is paramount	Liberal, discursive, save for when facing assessment and examinations
Bound by etiquette of enquiry and professional hierarchy	Students encouraged to be inquisitive and rhetorical (a community of equals)

There is a consensus in the literature suggesting that working with a mentor whilst caring for patients and families enables the student to learn and develop technical, psychomotor, interpersonal and communication skills (Ali & Panther 2008, Banning *et al* 2006, Adams 2002, Chan 2002, Dunn *et al* 2000, Billings and Halstead 1998). These nursing skills can be acquired by observation where a student is observing experienced nurses performing ophthalmic procedures and by imitation where the student is demonstrating the observed skill under the supervision of a mentor. It should be noted that in relation to ophthalmic practice, the mentor will have an advanced qualification in ophthalmic practice [e.g., Diploma, BSc (Hons) or Masters Degree]. Table 5 reflects the primary nursing skills students should obtain through mentorship.

Table 5

Nursing skills
Technical skills refer to skills such as calculating drug dosages, medication administration, assessment of visual acuity, visual fields, EOM, administration of eye drops and history taking for example.
Psychomotor nursing skills are physical skills that fall into one of three categories of education that nurses must acquire and involve motor dexterity, coordination and movement e.g. taking a blood pressure, changing an eye patch, administering eye drops, showing a patient how to use an occluder with pin holes . Psychomotor skills also include skills such as assisting patients with eye care (e.g., how to properly scrub eye lids when blepharitis has been diagnosed) or teaching patients in matters of eye health, hygiene, and safety.

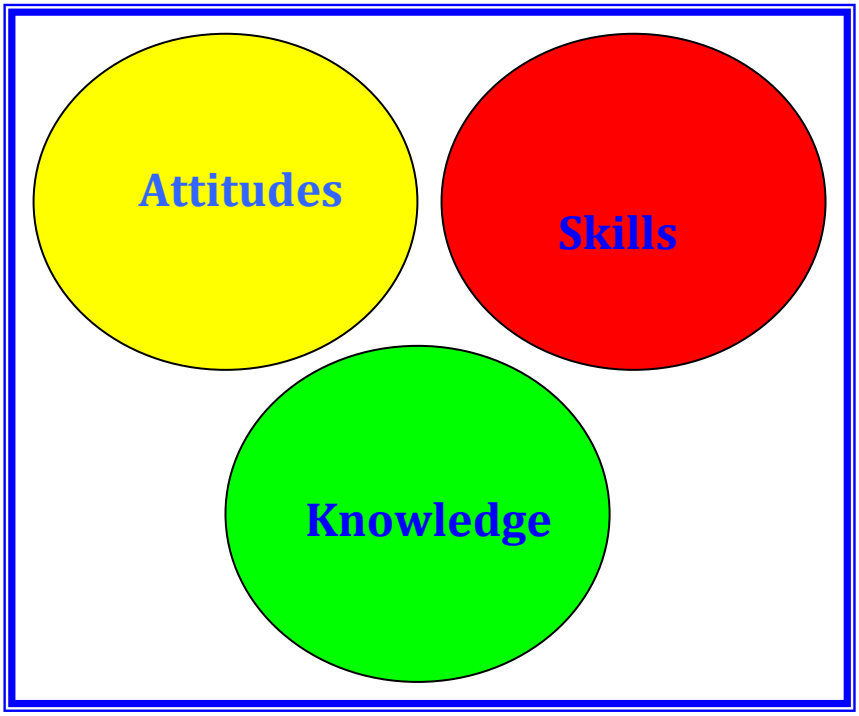
In order to enhance the student's clinical experience, it is important for a mentor to provide appropriate support, guidance and supervision in the clinical area [English National Board and Department of Health (ENB and DoH) 2001a, Andrews and Roberts 2003]. This also includes clarifying any misconceptions that students may have. Evidence suggests that various factors, such as the mentor-student relationship, reflection and feedback play an important role in students' learning (Pellatt 2006, Andrews and Roberts 2003, Andrews and Chilton 2000, Wright 1990, Campbell *et al* 1994, Baillie 1993).

Defining Learning

According to Bradshaw (1989) there is no adequate theory to account for all learning and therefore we have to take what we can from what is available. However, it is important to recognise that the real issue is whether or not we are aware of the theory guiding our actions (NMC 2004). Educational theory, therefore, may need to be adapted to suit particular individual and particular settings. Burns (1995, p99) defines learning as 'a relatively permanent change in behaviour with behaviour including both observable activity and internal

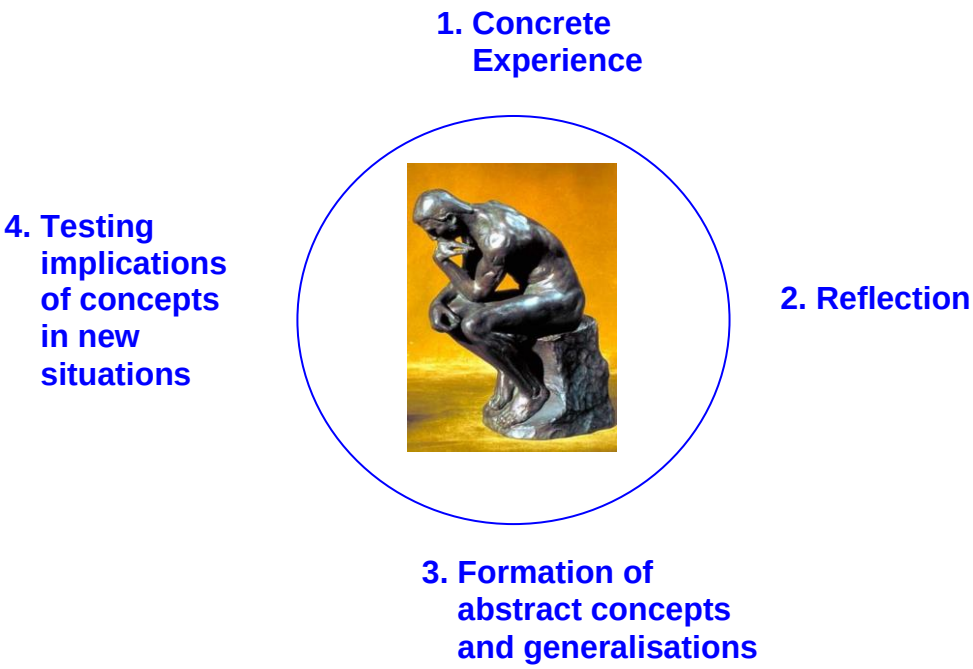
processes such as thinking, attitudes and emotions.' Similarly, Jarvis (1995) defines learning as the acquisition of knowledge, and importantly includes skills and attitude by study, experience or teaching. The relationship between the three domains of knowledge, attitude and skills (ASK) transpires in the definition of learning. Therefore ASK can be a useful anagram and reminder of the areas of behaviour mentors should address in relation to development in and/or assessment of their students (City University 1996) (Figure 1).

Figure 1 ASK Anagram (City University 1996)



David Kolb's Learning Cycle often referred to as experiential learning and reasoning model provides a useful framework for mentors when working with students. The cycle refers to the process by which mentors and students can attend to and understand their experiences and consequently modify their behaviours.

The Learning Cycle



David Kolb (1984) created his famous model out of four elements: concrete experience, observation and reflection, the formation of abstract concepts and testing in new situations. He argues that the learning cycle can begin at any one of the four points and that it should really be approached as a continuous spiral. However, it is suggested that the learning process often begins with a person carrying out a particular action and then seeing the effect of the action in a given situation. Following this, the second step is to understand these effects in this instance so that if the same actions were taken in the same circumstances it would be possible to anticipate what would follow from these actions. Using this ‘cycle’ the third step should enable the learner to understand the principles under which the situation is underpinned (Kolb 1984).

The Importance of Feedback

Feedback has long been considered central to learning and therefore it has considerable importance in nursing education to promote learning and ensure

that standards are met (Quinn 2000, Nickling and Kenworthy 2000).

Rosen et al (2006 p. 211) defines feedback as ‘a subset of the available information in the work environment that indicates how well an individual is meeting his or her goals’. Rosen et al (2006) demonstrate~~s~~ an important relationship between feedback/reflection, learning environment, attitudes, and behaviours. According to their study, environments high in feedback tend to reduce uncertainty and ambiguity by reflecting, guiding and motivating thus reinforcing effective behaviours and reducing ineffective behaviours.

There is evidence in the literature suggesting that feedback is a two way process, which is beneficial to both students and mentors e.g., in receiving feedback by students and giving feedback by mentors. When mentoring students in practice mentors provide information on students' practice and offer practical advice on how to improve their performance. The aspect of receiving constructive feedback for students is essential for their growth and development of their self-confidence and motivation. On the other hand, the benefit of giving feedback by mentors promotes their personal and professional growth as well as enhancing their communication and interpersonal skills. This can also give mentors a sense of personal satisfaction, in particular, when sharing their knowledge and experience with students so enhancing the students learning (Clynes 2008 and Raftery 2001). London (2003) and Steelman et al (2004) argue that feedback provides data on which an individual can reflect and provide the means to correct or modify one’s experience in order to improve it.

According to the RCN document ‘Guidance for mentors of nursing students and midwives’ (2007) theoretical knowledge does not always translate into practice and therefore having a mentor helps students adapt ~~in~~to a ward or clinical routine, deal with challenges of the practical aspects of patient care and the dynamics of the workplace. Apart from bridging the gap between theory and nursing practice it also positively affects professional development, develops critical thinking, enhances professional growth and above all improves quality of patient care (Jarjoura, Jennifer 2003).

Teaching, learning and assessing is a crucial aspect of the mentor's role as it monitors a student's progress. In the worst case scenario, when the student is not sufficiently competent, it acts as the 'gate keeping mechanism' and thus protects the public. However, learning and assessing is a psychological process and requires assessment of these psychological processes. Therefore, it is important that the mentor's have an understanding of these psychological processes and how to go about measuring them. Bloom's Taxonomy, also known as the taxonomy of learning objectives, matches the cognitive, affective and psychomotor domains identified in the definitions of competency and learning and provides a useful structure when assessing students' competencies in practice (Blooms 1956 cited by Blais et al 2002).

Bloom's Taxonomy of Learning	
Affective domain	Attitudes
Psychomotor domain	Skills
Cognitive domain	Knowledge

To illustrate the understanding of the domains in clinical practice a visual acuity test with a patient can be used as an example. Thus the psychomotor domain will concentrate on how to adjust the patient's position to see the Snellen Chart. The cognitive domain will include knowledge of the individual patient's condition, policies for visual acuity assessment (e.g., assessing one eye at a time). The affective domain will include an understanding of how it feels to have a visual acuity test and thus the compassionate and empathetic attitude shown to the patient that is experiencing vision loss or impairment.

Benner's (1984) model of acquisition also underpins the criteria for assessment of a student's competency. The model is based on the work of Dreyfus and Dreyfus (1980) and describes five stages of development in nursing: novice, advanced beginner, competent, proficient and expert. The model provides a logical framework for nurse education, with students entering as Novices, and reaching the level of Advanced Beginner by the end

of the first year or first part of their programme. The level, Competent, is achieved by the end of the chosen programme. Proficient, and ultimately Expert status is reached only after many years of experience in ophthalmic practice and may not be achieved by all registered nurses. The application of Benner's model in 'local practice' is the students practice assessment document, which consists of a list of the clinical, communication skills and activities, which are to be achieved prior to nursing registration (You may wish to refer to the RCN (2012) Competencies in Ophthalmic Practice: http://www.rcn.org.uk/__data/assets/pdf_file/0006/485898/004350.pdf.pdf which have been developed using Benner's 1984 model).

Assessment levels related to the framework proposed by Benner (1984)

Level	Standard	Quality of performance	Supervision and assistance
Expert	Safe } Accurate} all of Effective} the time Affective }	• Intuitive grasp of each situation • Problems focused rapidly and problem solving well developed • Draws upon professional experience • Proactive in relation to change • Proposes professional development	Collaborative discussions with colleagues
Proficient	Safe } Accurate} all of Effective} the time Affective }	• Skilful, co-ordinated and confident • Perceives caring situations in their entirety • Draws upon professional experience • Responds to change • Uses problems solving approach and knowledge which has been analysed and critically evaluated • Reflects upon professional rôle	Collaborative discussions with colleagues
Competent	Safe } Accurate} all of Effective} the time Affective }	• Skilful and co-ordinated • Confident • Focuses on individual and responds to subtle cues • Identifies long range goals • Seeks occasional supervision and direction appropriately	Occasional supervision and directive cues
Advanced beginner	Safe and accurate all of the time Effective} some of Affective} the time	• Skilful and co-ordinated • Confident • Focuses on individual, but distracted if activity is complex	Frequent supervision and some directive cues

Novice	Some at risk performances Accurate} some Effective} of the Affective} time	• Considerable time required to complete activity • Some degree of confidence • Beginning to focus upon the individual and their needs	Frequent supervision and directive cues

Safe = Activity does not cause harm by action or omission
Accurate = Demonstrates knowledge base and application, verbal, non verbal and written communication
Effective = Intended purpose of activity achieved
Affective = Attends to the feelings/emotions of individuals involved in the situation

Benner (1984) describes how nurses develop competence and grow in optimal clinical environments. Her work describes how experienced nurses can create an environment to foster professional development and good morale in other nurses and students.

According to the NMC (2002) accountability and duty of care to patients is paramount to the role of the nurse. In addition, the role of preparing the next generation of nurses is equally important. Although being a mentor can be challenging because it requires understanding of nursing curricula, the NMC standards and RCN Ophthalmic Competencies, the processes of learning and teaching as well as having excellent communication skills is rewarding because there is a certain satisfaction that comes from teaching students and sharing knowledge with them resulting in helping them learn ophthalmic skills (Holmes et al 2011; Bradshaw 1998). In other words the role of mentor brings benefits to the nursing profession because it is a core element of ongoing competence development leading to potential for promotion (NMC 2004) and also leads to evaluating what mentors do, which invariably leads to improving their teaching skills.

Conclusion

The aim of this article was to provide a critical overview of the issues relating to mentoring students. The key concepts attempted to encapsulate the balance between professional responsibility and accountability manifested in adhering to the code of professional conduct and professional privilege expressed through the educational role of the nurse. It is evident that the responsibilities that professional status implies and carries are extremely

complex. However, it is absolutely crucial to demonstrate fitness to practice of students in order to protect the public as well as maintain high standards of care and practice. This can be underpinned by promoting excellence in clinical and professional practice by ensuring that registered nurses are supported in their role as clinical educators. It is important to recognise that students will only be 'fit to practice' when the nurses/mentors themselves are 'fit to practice'. This includes both the delivery of care to patients as well as teaching and assessing students in the ophthalmic practice environment.

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