Mentoring in times of change

Ciarán Hurley and Sally Snowden

ABSTRACT

Objective: The aim of this study was to establish the barriers to nurses performing the mentor role in three critical care wards.

Background: Imminent changes affecting mentors to preregistration students in our wards and our awareness of their ill-preparedness prompted us to design interventions to prepare colleagues for the changes. Literature shows a range of perceived barriers to mentoring, we wanted to compare these to our colleagues’ perceptions.

Design: Prospective, self-administered service evaluation questionnaire of a saturation sample of nurses in intensive care and high dependency wards.

Results: Of the 118 questionnaire pro formas issued, 43 were returned (36%). Key results include: lack of time to perform the mentor role because of patient care workload, lack of opportunity to update knowledge and skills of mentoring and lack of familiarity with the programme of study and the documents used to record assessment of a student’s proficiency.

Conclusions: Mentor update opportunities must be delivered alongside the competing demands of safe and effective patient care and the need to ensure the development of individuals as well as the profession as a whole through fostering its students.

Relevance to practice: To ensure future generations of patients enjoy quality critical care, we must invest time and resources in mentoring the nurses who will deliver critical care in the future.

Key words: Barriers • Change management • Mentors • NMC standards • Service evaluation • Work-based education

RATIONALE

Although the role of mentoring in nursing has been well explored in the literature, there is relatively little discussion specific to the challenges of mentoring in critical care. As link lecturer (C. H.) and clinical educator (S. S.), we have a responsibility to support education and development in three critical care wards and we were faced with a period of predictable challenge derived from the services demanded of us by three distinct but related organizations. In this paper we aim to explore the ways in which these demands manifested and discuss the actions we took to address them.

This paper is arranged to give a background of the organizations to which we are committed. We go on to specify the demands that we perceived to be placed on our mentors and describe the findings of the service evaluation we performed to establish barriers to mentoring as perceived by the mentors we work with. We conclude the article with a discussion of the actions that we have implemented to address the challenges and barriers.

BACKGROUND

We met when, in February 2007, C. H. took the role of link lecturer (UKCC, 1999) for the three critical care wards on one site of a multisite, acute-care provider in a city in northern England. The role is primarily aimed at supporting the team of nurses based on the wards in the teaching and assessment of student nurses. The Nursing and Midwifery Council (NMC) had recently published its standards to support learning and assessment in practice (Nursing & Midwifery Council, 2006), reiterating (among other things) the requirement for an annual update of knowledge and skills related to mentoring in practice; the strategic health authority was in the process of transferring the contract for preregistration education of student nurses and midwives in the region from the local Russell Group institution to the post-1992 university and plans were underway for a significant reconfiguration in the hospital’s provision of acute critical care. This reconfiguration included the introduction of a new role of assistant practitioner to the nursing team, the building of a new wing on one of the sites to house an increase in the number of patients who could be offered critical care and the development and implementation of a computerized care planning and records system for the whole multiprofessional team.

Authors: C Hurley, RN, MA, BMedSci, PGDip, Lecturer, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK; S Snowden, RN, BMedSci, Clinical Educator, Directorate of Critical Care, Sheffield Teaching Hospitals, Sheffield, UK

Address for correspondence: C Hurley, Lecturer, Faculty of Health and Wellbeing, Sheffield Hallam University, Mercury House, 38 Collegiate Crescent, Sheffield S10 2BP, UK

E-mail: c.hurley@shu.ac.uk

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The most apparent challenge was in the combination of two factors. On the one hand, the NMC’s more robust stance on updating and recording mentor’s knowledge and skills. On the other, the fact that preregistration education of nurses was to be delivered by an institution with different practices from the usual provider of preregistration undergraduate nurse training, bringing a new structure, documentation and philosophy after 15 years. To date, students in critical care were placed for 2 weeks during which time there was no expectation that the students’ proficiency should or could be assessed after such a short period. In the future, critical care wards will be used for the emergency care placement element of its programme; a 4-week period during which the student is expected to acquire and demonstrate a range of proficiencies. This presented a twofold problem attributable, in part, to the historical lack of demand for assessment of students’ proficiency; the nurses of the wards were unfamiliar with the process and documentation, and those with mentor qualifications had not been keeping records of their update activities, if they had completed any at all. These problems are of course compounded by what human resources experts call natural attrition in which the personnel become unavailable because of illness, retirement and resignation to take up new posts.

The reconfiguration of services brought with it a number of potential and actual problems that would have been challenging enough alone, other changes notwithstanding. In the 2 years leading up to the reconfiguration, the wards took part in the national assistant practitioner programme; a number of non-registered care workers were being trained to fill a new role. This required the support of registered nurses in the development and assessment of the learners’ knowledge and proficiency using the National Vocational Qualification programme. The design and development of the fabric of the new building was a time-consuming and important aspect of the project that was given high priority by the wards’ senior personnel; input from all levels of personnel was canvassed and this took time from other aspects of the critical care services. The design and implementation of computerized records was a similarly time-consuming project; well in advance of the expected implementation date, the design team drew on all types of personnel in the critical care workforce and met frequently and regularly. Further to the design and implementation team, the whole workforce would require education and ongoing support in the use of the access terminals to log the work they did in relation to delivering care to the wards’ patients.

It is important to note that these challenges were presented in addition to the daily challenges that face critical care nurses; working as they do in an emotionally charged, fast-paced, highly technological environment to deliver care across the whole spectrum of activities of living to some of the hospital’s most dependent patients.

In short, we were working with a team of nurses in which the practical skills of assessing proficiency had been unused for some time; there was little or no evidence of updates that met the NMC standard, that was being asked to supervise and assess the work-based learning for a large number of learners on the assistant practitioner programme and was faced with the imminent introduction of preregistration students who would require assessment.

LITERATURE REVIEW

Our main priority was to ensure that the wards met the rigorous expectations of the NMC and the universities without too great a cost to the well-being and good-will of the registrants; while the NMC standards are unequivocal in their expectation that all registrants have some part to play in mentoring students, acceptance of the formal mentor in assessing proficiency role is ultimately voluntary. For this, we began with a thorough review of the NMC’s 2006 standards to identify the elements that would be easy to achieve and which would prove more difficult. We went on to search the CINHAL, Medline and Google Scholar databases to identify relevant literature with disappointing results. Our search terms were: organizational OR organizational OR institutional, barriers OR obstacles, mentoring OR mentors OR mentor (critical OR intensive) AND (care OR therapy) AND (unit OR units OR department OR ward). Boolean operators were ‘on’. Lastly, we undertook manual searches of the university’s health sciences library shelves for books and back issues of journals likely to carry articles of relevance published in the previous 10 years and applied incremental methods using the citation lists from other works. Although we applied a general exclusion of pieces older than 10 years, some seminal texts are cited on grounds of their contribution to the ontology of practice-based learning or their continued influence and relevance. We took a thematic analysis approach to extracting and synthesizing data from the literature and used this as the theoretical framework for our service evaluation.

Theme 1: motivation to acquire the mentor qualification

Nurses have been found in mentor roles or attending mentor preparation programmes for a variety of reasons, some positive and some negative; they
include requirements of the nurse’s job description (Andrews and Chilton, 2000, Watson, 2004), promotion to senior roles being dependent on the acquisition of the qualification (Watson, 2004) and response to positive feedback from students or peers (Andrews and Chilton, 2000).

Theme 2: the mentor’s self confidence in the role
Mentors’ confidence and students’ confidence in mentors increased when the relationship and the two roles were clearly defined and understood by all parties, but surprisingly there was no relationship between the students’ rating of the quality of their mentor and the mentor’s possession of a suitable qualification, suggesting that at least some of the skills required are inherent rather than acquired or taught (Chow and Suen, 2001). Duffy et al. (2000) infers that mentors’ confidence may be bolstered by regular contact with and on-site provision of support from lecturers.

Theme 3: the mentor’s knowledge of the programme of assessment
There is a range of information with which a mentor must be familiar in order to be effective in the role. Significantly these include familiarity with the programme of study, without which mentors can feel like they are ‘shooting in the dark’, and familiarity with the documentation and the terms used in it (Andrews and Chilton, 2000). It has been noted that familiarity with documentation can be difficult to achieve, especially when changes are made without the involvement of clinical mentors (Duffy, 2000), suggesting that this might be a suitable point of focus for the clinical educator and link lecturer team. There is also a responsibility to maintain the relationship by which changes to this information can be communicated, in this case the link lecturer (Landers, 2000), and there is evidence suggesting that mentors perform their role more effectively and with greater confidence when they have regular access to support from academic colleagues in the university (Duffy, 2000).

AIMS AND QUESTIONS
Our aim was to establish if the registered nurses in critical care perceived barriers to taking on three educational roles: mentor (responsible for assessing proficiency), supervisor (nominated to support learning in practice) and facilitator (no responsibility in relation to students but might be asked on an occasional basis to teach knowledge or skills to a student). We devised a questionnaire derived from the themes in the literature and a detailed 11-point list of potential barriers (a copy of the questionnaire is appended). The questionnaire was self-administered on a voluntary basis after a copy was delivered by internal post to every registered nurse working in the wards.

SAMPLE
Before we began the data collection, we completed the hospital’s governance process for audits and service evaluations in which the methods and purpose of the data collection and analysis are reviewed. Only after approval from the Clinical Effectiveness Unit were the questionnaires delivered. In an attempt to improve the response rate the questionnaires were anonymized, while this may have weakened the data collected because of the inability to stratify the data by role/grade, we wanted to ensure that nurses felt they could comment with impunity. Every registered nurse (n = 118) was issued with a questionnaire and asked to return it to the clinical educator team within 2 weeks of the delivery date. The response rate was disappointing at 34%, but S. S. estimates the actual response to be nearer 50% if long- and short-term illness, maternity leave and secondment to external departments/services are taken into account. Among the respondents, there is a greater representation of nurses with a mentor qualification than those without, suggesting a level of apathy towards the investigation if the nurse did not already hold a mentoring qualification.

ANALYSIS
The Likert-type and tick-list data were analysed using simple descriptive statistics. The free text entries were analysed using a thematic analysis framework (Ritchie et al., 2003). Both investigators agreed the framework, each entry was discussed and agreement was required before the entry was placed into the framework and the themes finally agreed.

FINDINGS
Findings are presented according to the conceptual themes that emerged from the responses.

Learners in clinical practice
The questionnaire asked ‘What types of staff do you consider to be a “learner”?’ Answers to this question varied, from the very reassuring position that all staff are learners (n = 29, 74%), all nursing and related staff are learners (n = 13, 32%) to anyone who is studying for an award (n = 3, 7%). Two respondents (5%) recognized the demand for learning among other
professions working in critical care environments, but only one (2.5%) cited the NMC demand for nurses to update their knowledge and skills.

We also asked ‘How many learners have you supervised or assessed in the last six months?’ In retrospect, this question would have been more useful if separated into the divisions of supervision and assessment as it would have been interesting to see how many nurses appreciated the distinction between the assessment of proficiency of preregistration students and the assessment of competence required by the employer. Nonetheless, the number entered in this box ranged from 0 to 20 with one senior nurse commenting that they had contributed to and supported the learning of all members of the team as it was a significant part of their role.

**Mentors’ workload and willingness to accept the mentor role**

We asked the nurses to indicate their willingness to supervise learners at work using a Likert-type scale, where 0 meant absolutely unwilling and 10 meant very willing. The mean willingness of the respondents was 8.7, the range was between 5 and 10. Twenty nurses rated their willingness at 10 and only two rated as low as 5, one of whom commented in the margin that they expected their willingness to increase with experience, intimating that they were relatively new to the team.

The fourth and final question gave a list containing some of the potential barriers to effective supervision identified from literature and from our own reflections on practice. Respondents were invited to tick as many as they felt applied to their experience and were given free text to add others that were not on the list.

Table 1 outlines the responses to the pick –list, while the self-reported barriers are outlined below.

**Self-reported barriers to supervision**

Themes emerged from the nurses’ own perception of barriers that were not explored in the literature review. These were: that administrative responsibilities compete with the mentor role; changes that occur between updates; several of the respondents cited the phenomenon of having to supervise and assess learners on almost every shift, we termed this ‘mentor-overload’; lack of motivation in the student was vehemently stated; the brevity of the placement and an apparent underestimation of the ability of junior staff to supervise or at least support students.

**DISCUSSION**

Based on the background and findings described above, we identified a need to increase the number of mentors available to support the learning and assessment of preregistration students in practice and to ensure that these mentors had frequent and regular access to support in updating their knowledge and skills of mentoring. We perceived three distinct requirements to achieve our goals. We require funding for 36 places on mentor training programmes over 3 years followed by re-evaluation of the number of nurses with mentor qualifications in late 2010. Mentoring should be included on the agenda of the regular meeting of senior critical nurses with nurses in charge expected to support the update programme by releasing nurses with mentor qualifications to attend the lunchtime seminars. Implementing a rolling programme of mentor update seminars using the wards’ existing lunchtime education programme, the content of the seminars to change on a quarterly basis:

- new NMC standards and an overview of the documentation and process used by the incoming provider of preregistration training;
- how to record mentor updates, including what constitutes evidence of update, how to demonstrate and record learning and how to reflect the influence of learning on future work;
- the content, process and documentation of auditing a placement area;
- developments and changes in the previous year.

At present, an indicative content for the fourth stage might include dissemination and discussion of the outcome of the Department of Health and NMC consultations regarding nursing education and careers (Department of Health, 2007, Longley et al., 2007).

<table>
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<tr>
<th>Table 1 Barriers to the mentor role</th>
<th>Frequency n (%)</th>
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<tr>
<td>Lack of time because of clinical workload</td>
<td>31 (23.7)</td>
</tr>
<tr>
<td>Lack of familiarity with programmes of study</td>
<td>23 (17.6)</td>
</tr>
<tr>
<td>Lack of familiarity with documentation</td>
<td>21 (16.0)</td>
</tr>
<tr>
<td>Lack of opportunity to update your knowledge of supervision and assessment</td>
<td>19 (14.5)</td>
</tr>
<tr>
<td>Lack of training in supervision and assessment</td>
<td>13 (9.9)</td>
</tr>
<tr>
<td>Lack of familiarity with systems for training and assessment in your workplace</td>
<td>9 (6.9)</td>
</tr>
<tr>
<td>Lack of confidence in your ability to assess a learner’s proficiency</td>
<td>6 (4.6)</td>
</tr>
<tr>
<td>Lack of confidence in your ability to supervise a learner</td>
<td>4 (3.1)</td>
</tr>
<tr>
<td>Lack of confidence in your interpersonal skills</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td>Lack of motivation to be involved in supervision and assessment</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td>Lack of confidence in your written English</td>
<td>1 (0.8)</td>
</tr>
</tbody>
</table>
The final requirement is actually a caveat to the second; in recognition of the demands that will be placed on the nurses during and shortly after the relocation, we plan to suspend the rolling programme of update seminars to prevent placing too many demands on their attention and risking disillusionment. These discrete activities are to be coupled with a developing and ongoing relationship between the wards’ nursing teams and the link lecturer. By building familiarity and being a regular visible presence in the wards, the lecturer can be available to answer ad hoc questions and problems raised in relation to students and their assessment.

On resuming the programme, however, we aim to apply some of the principles of change management (Keyzer and Wright, 1998). In the main, there is a high level of commitment to education and development in these wards, and developing the knowledge and skills of mentoring in the workforce requires little more than direction and support. Responsibility for expediting the desired changes will lie with the team already nominated for the delivery and support of workforce education and development. These individuals will foster the support required by other senior members of the nursing team in ‘behind the scenes’ work during ward and directorate business meetings. We will employ the rational–empirical approach to facilitate change by using the lunchtime seminars as an opportunity to explain and explore the benefits of.

<table>
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<tr>
<th>Stage of mentoring</th>
<th>Knowledge</th>
<th>Behaviour</th>
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<tbody>
<tr>
<td>Novice</td>
<td>Understands student proficiency in terms of ‘objective attributes’</td>
<td>Relies on ‘context-free rules’ and focuses on ‘what is known and what must be done’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Applies a limited range of teaching and assessment strategies rigidly and comprehensively</td>
</tr>
<tr>
<td>Advanced beginner</td>
<td>Recognizes ‘recurrent meaningful components’ of proficiency and of learning environments</td>
<td>Identifies and exploits signs of readiness to learn in students</td>
</tr>
<tr>
<td>Competent</td>
<td>Perceives long-term goals in student allocations</td>
<td>Remains focused on what must be learned</td>
</tr>
<tr>
<td></td>
<td>Perceives barriers to learning</td>
<td>After a period of observation can help learners to identify aspects of their proficiency and knowledge that require development</td>
</tr>
<tr>
<td>Proficient</td>
<td>Assesses a student’s needs quickly and accurately based on their intimate knowledge of the learning environment and their cumulative experience of teaching and assessing</td>
<td>Employs a growing repertoire of teaching and assessment strategies</td>
</tr>
<tr>
<td></td>
<td>Sets differential priorities for learning based on an early assessment of the student as an individual</td>
<td>Selects teaching strategies that develop the student’s needs and assessment strategies that exploit the student’s abilities</td>
</tr>
<tr>
<td>Expert</td>
<td>Recognizes a student’s needs accurately and intuitively</td>
<td>Unconsciously makes teaching and assessing a natural extension of their everyday work and therefore does not need to ‘manufacture’ assessment opportunities</td>
</tr>
<tr>
<td></td>
<td>Identifies and offers the student experiences and discussions that develop their needs</td>
<td></td>
</tr>
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Table 2 Stages of skill acquisition (Benner, 2001)
students in practice. The normative re-educative approach will be used through allowing mentors to contribute to the materials used and encouraging them to share their reflections on teaching and assessment strategies, thus challenging and developing their repertoire of skills in relation to mentoring and by facilitating and supporting their collective input to the learning materials used in practice. The power-coercive approach will only be used as a last resort and will take the form of using the introduction of a robust personal development review (PDR) process. The new system of pay and career progression by which National Health Service (NHS) staff are remunerated requires that the individual demonstrates their ongoing commitment to developing the knowledge and skills required by their role and professional status; we plan to ensure that all registered nurses who claim the status of mentor have met the NMC requirements and to include this as an element of the PDR.

CONCLUSIONS
We found that themes within the literature relating to barriers to effective mentoring were still relevant to our colleagues. We also found that they perceived barriers that were not found in the literature; some because they are unique to these wards, others are speculatively attributed to a combination of novel methods of investigation and elements of the organization and culture in which our investigation took place. As educators, investigators and authors of this article, it seems redundant to state that we place great value on the support and assessment of students but it is important to recognize that there are many competing duties placed on nurses in acute and critical care sectors. These competing duties must sometimes be rationalized and there is a real risk that by stressing the demands of the educative aspect of a nurse’s role when significant organizational changes are taking place, we might risk alienating colleagues and adding yet another barrier against effective mentoring to the already long list.

CONTRIBUTIONS
Design, administration and analysis were performed by C. H. and S. S. on a joint and equal basis. Data collection was made by S. S. and preparation of manuscript was by C. H.

WHAT IS KNOWN ABOUT THIS TOPIC
The barriers to effective mentoring in nursing have been researched and include:
• Incongruence between the motivation to acquire the mentor qualification and the motivation to act as a mentor
• Disconnection of preregistration from hospitals and its provision by universities creating a potential for infrequent and ineffective communication between educators in the university and mentors in practice
• Front-line nurses are neither involved in nor informed of the development process for nurse education programmes, this leads to low familiarity with the philosophies, processes and requirements of programmes and subsequent lack of confidence in their practical application.

WHAT THIS PAPER ADDS
While the themes from literature were borne out by our findings we also found that:
• From the literature, there are important requirements for mentors to ensure their skills are updated and recorded
• From the survey, we found that workload pressures were perceived by a significant number of respondents as a barrier to effective mentoring
• To promote motivation to mentorship, nurse leaders and nurse educators may find success in supporting and promoting familiarity with the programmes of study that require assessment of proficiency and the documentation that supports them.

REFERENCES


