Chapter 1

Mentoring and supervision and other facilitative relationships

Ian Scott and Jenny Spouse

Introduction

In this chapter, we will be providing an overview to the text. We will discuss the origins of mentoring as a tool for personal development and its position within professional education from a macro- and micro-perspective. We will describe the increasingly important factors that are influencing the role, such as professional and national concerns, local and national policies. We will emphasise the critical importance of the person providing mentorship and who, in fulfilling their professional duty to protect the public, is both a gatekeeper to their profession and instrumental to the professional development of colleagues and visiting learners.

Throughout the chapter, we shall be exploring some of the vocabulary used across different professions to describe mentoring activities, and introducing and exploring some of the core concepts that are discussed in greater depth in later chapters.

This chapter includes the following:

- mentoring, coaching/supervision, the personal and professional implications of the role;
- what the different terminology means, for example, facilitator, mentor, supervisor, coach, sponsorship;
- introduction to the concepts of apprenticeship, communities of practice, sponsorship;
- the qualities of effective mentors to promote personal and professional development;
- the learner's perspective;
- learning and teaching.

Exploring the role of the practitioner teacher

Since ancient times, vocations have been learnt through practice by the aspirational learner working alongside an established practitioner. This way of learning has stood the test of time; it has been developed and expanded, and exists in many forms; and it is known by many names, but at its heart is one individual facilitating the learning of another through an individualised relationship. In the health professions, several terms are used to

identify such relations; it is common, for example, to find the terms mentor, supervisor and coach being used. In this book, will we commonly use the term 'mentor' or 'supervisor' to describe the person supervising and facilitating learning. We shall use the term 'learner' to describe a pre-qualification student as well as a qualified member of staff who is also a learner.

The term 'mentor' refers to the person who is helping the other person in the relationship learn, although quite often, the mentor will also be learning. If you have been asked or volunteered to help someone to learn in this way, then the world has honoured you, for helping someone to learn is a great gift to give, brings pleasure, will no doubt lead to your own personal and professional growth, and is in recognition of your own professional value and expertise. At some time during your journey in this role, you will want to develop and hone your skills as a mentor. Many people in this role not only have the responsibility of helping someone learn but also may have to make the decisions that will determine whether or not their learner can enter their profession. Working in this way means you have become a gatekeeper of the professional standards for your area of practice. This book is intended to help you to become that kind of gatekeeper to your profession. Through this text, we will explore the different aspects and skills of being a work-place facilitator in a health care setting, and as we do so we will introduce different ways of developing these skills. In writing this book, and through our own experiences, we are keenly aware that the process of facilitating is felt both ways by both learners and facilitators, and thus throughout the text, we have introduced the 'learner's perspective' often using real case studies from our experience and research.

Before we start getting down to the detail, it is worth spending some time exploring how the terms 'mentor', 'supervisor', 'facilitator' and 'coach' are used and in particular how they are used differently by different health professions. This is important because if we do not understand different professional terminology, discussions between professionals can become difficult. It will also help you to place your own workplace into the situations described in this book. Before we start this discussion, we want to emphasise that all of the terms used are equally correct. We just need to accept that the meaning placed on these terms varies a great deal across different professional groups.

Mentor

The first term we will look at is that of 'mentor'. The term 'mentor' is very widely recognised across organisations in the English-speaking world. It emerged largely in connection with large business organisations, where a 'mentor', normally someone successful at their business, would help another individual develop and succeed; the mentor's role was to offer advice and guidance to help the mentee form networks, and would also often act as a role model. The 'learning' aspect of the relationship was informal, as was often the formation of the relationship itself. Notice that the informal nature of this form of mentorship meant that the relationship developed between individuals that had 'attraction for each other'. For this reason, mentoring, although regarded as a route to success, was also considered to be a potential source of discrimination and potentially one of the reasons why certain groups within society (for example, women) are under-represented in the higher levels of top business.

Nevertheless, the role of the mentor as a significant person in an individual's development within a company or organisation was recognised, and this led to many organisations developing formal systems of mentoring. Probably the most common types of mentoring to be seen in organisations are those connected with the induction of individuals into the organisation. Here, a newly appointed member of staff is 'given' a mentor that will help the mentee 'find their feet' during the first few months of their new employment. Normally, after the induction period, the formal mentor/mentee relationship discontinues; it may, depending on the individuals, continue informally. In some organisations, there have been attempts to develop formal more prolonged periods of mentorship that attempt to mimic the initial form of mentorship that we described. In general, all the mentors described in the relationships above will have very little or no training for their role.

The last form of mentoring that occurs is that which has formal structures and rigid controls over who can mentor and how they are trained for the role. The mentoring role is closely tied to formal education programmes, and the mentor may well have a significant involvement in the summative assessment of their mentees. Many professions would call this form of relationship 'supervision' This form of mentorship can be seen in its most extreme form in relation to pre-registration education programmes for nurses midwives and social work within the within the United Kingdom, although in social work, the term 'mentor' is not used.

The term mentor itself, comes from ancient Greek mythology. Odysseus placed his son, Telemarchus, in the care of Mentor and Eumaeus; their relationship with Mentor was akin to that of teacher but also carer. An interesting twist in this tale is that Athena, a goddess of wisdom and war in Greek mythology, masqueraded as Mentor when she was trying to persuade him to follow her ideas and suggestions. You may want to consider which version of the mentor described above best fits with your experiences of being helped to develop your clinical practices.

Supervisor

The term 'supervisor' in the context of developmental relationships is harder to describe and find consensus for. The word supervision implies to oversee, and thus one thing we can say about these types of relationship is that they should be asymmetric; that is, the supervisor is normally in a more senior position to the supervisee. Such a term is used, for example, in universities in relation to learners being 'supervised' while they undertake projects. In many health care professions, however, the term 'supervisor' is used to describe a relationship whereby clinicians meet to discuss their practice with the purpose of improving it. Normally, however, one of the clinicians is more senior to the others. In nursing and midwifery practice, this form of supervision is often referred to as 'clinical supervision', but their activities are clearly much more focused on facilitating learning than on oversight. In some professions such as social work, the 'supervisor' is responsible for both providing opportunities for learning in practice settings and assessing whether the supervisee is fit to practise. Use of the term 'supervisor' in this way is synonymous with the term 'mentor' as used in the Nursing and Midwifery profession.

Interestingly, for the medical profession in the United Kingdom, 'supervised practice' is also the term used to describe the period of training and development that newly

graduated medics undertake before becoming fully registered. Subjecting a qualified practitioner to supervision can also be applied by the General Medical Council as a sanction to a practitioner who has been found not to be fully competent.

Coach

The term 'coach' can be applied to a facilitative role or to describe a process and has become popular to describe a 'personal coach' who is used to assist their 'client' to make a lasting change in their behaviour. They do this by helping their client to establish their goals and the ways they will go about achieving these goals. A coach is intently focussed on helping their client 'find' their own way, rather than showing them the way. In general this kind of coach relationship with a client is less close than that of a 'mentor' and they are unlikely to be present and work alongside their client. In addition, unlike many mentor/supervisor relationships, the coach's career success does not tend to be linked to the success of their clients.

The exception to this would be the 'sports' coach. Use of the term 'coach' to describe a facilitative relationship is not commonly used within health care settings, but it is a term growing in popularity in the 'personal development' industry and so is likely to permeate the health care professions.

Obviously the terms 'mentor', 'coach' and 'supervisor' are used in different ways in differing context and have overlapping features. Unless your profession or your work place has adopted one of these terms and provided a clear definition, it is important that you qualify what you perceive your role to be, both for yourself and for the person you are working with. In this textbook, we will focus the discussion largely on the roles that relate to the descriptions of mentor and supervisor that we have given above. We will use the term 'coach' as a verb to describe some of the facilitative techniques used in 'coaching'.

Professional statutory regulatory organisations (PSROs)

Some PSROs regulate who can and cannot act as mentors/supervisors. For example, in the United Kingdom, the Nursing and Midwifery Council and the General Social Care Council have clear requirements of those wishing to act as a mentor or practice educator. These include successful completion of a prescribed training programme, the curriculum of which is largely dictated by the PSRO. Professional organisations normally require mentors/supervisors who are involved in the formal assessment of learners preparing for professional qualification (sometimes called neophyte – literally new growth) to be formally registered. The PSRO may also require further education and additional qualifications if a professional is taking on an extended role such as advanced prescribing. It is the case, however, in most countries that when ever a qualified professional is supervising another individual that could be deemed to be a 'learner', the qualified professional has the legal and ethical responsibility for the patients or clients in their care. Before taking on the role of a supervisor or mentor, it is a good idea to ensure that you are aware of the nature of this relationship and your own legal and professional responsibilities.

Apprenticeship and its relationship to mentorship and supervision

The term 'apprentice' seems to have emerged in the middle ages and is used in relation to the right of craftsmen to employ (at very low cost) boys that would provide labour in exchange for being trained into a particular craft or skill. Apprenticeships were highly prized, since, in the Middle Ages, becoming a craftsman or a professional was a route to a more secure future (just as it is today). Recognition as a craftsmen or 'professional' was through membership of a Guild. As the Guilds became successful and powerful, they sought to protect their reputation by imposing strict rules and regulations on their apprentices and guild members such as protecting the use of certain titles such as 'Stone Mason'. The Guilds regulated the terms of apprenticeships and controlled access to a wide range of professions. It is considered by some that the 'Guild' system led to the formation of Universities in the 12th century. Guilds covered a wide range of important economic activities, for example baking, brewing, weaving and carpentry. The authority of the Guilds was given to them by the monarch or the government of their respective nations. You can probably see in these Guilds similarities with modern professional regulatory organisations.

Interestingly, the Guilds system was largely abandoned by the 20th century. This is because they were seen as being highly protective, stifled innovation and were restrictive of free trade (Ogilvie 2004). Nevertheless many Guilds still have presence in modern times and are very influential in supporting charitable activities and promoting education.

An apprentice is thus someone who is learning a craft or profession through the process of watching and working alongside someone who is already fully capable with respect to that activity. The mode of learning would be best described as 'reproduction' learning or modelling. The apprentice would seek to mimic the actions of the master and thus acquire their skills. Modern forms of apprenticeship often include some form of formal study. Apprenticeships are often typified by apprentices having to practise and rehearse certain task over and over again, often irrespective of their actual level of competence (Singleton 1989).

Working and learning as apprenticeship

The nursing literature contains numerous accounts of nursing as an apprenticeship or sitting-by-nellie (Quinn 1981). There seems to be an implicit assumption that nursing learners were taught by an experienced artist or craftsperson at the bed side. The historical perspective of this is very different and more akin to that described by anthropologists of traditional craftsmen in apprenticeship (Maggs 1983). A number of studies from around the world demonstrate that apprentices are normally assigned to one master and work within a stable environment over a period of years. Throughout such arrangements, the master appears as a somewhat shadowy figure remote and impersonal, with apprentices relying on support from peers and experienced craftsmen (who may be masters to other learners) working within the workshop rather than with their own master (Coy 1989; Goody 1989; Singleton 1989). The organisation of such apprenticeship schemes was designed to enable learners to observe and later to participate in assigned and carefully structured tasks. Such tasks may be menial for a long time until the master believes the

apprentice to be ready to undertake the next stage. Apprenticeship activities were carefully structured around repetitive activities that became increasingly sophisticated as apprentices demonstrated their worth. Theoretical information was obtained from talking to peers or another master. This model of learning relates very closely to the task-dominated wards of British general hospitals up until the end of the 20th century, and probably continues to exist in many health care settings. In these task-orientated settings, nursing learners were locked into the same type of progression as apprentices, by working through a scale of tasks. They had to practise these repetitively until they reached a more senior status within the organisation and could then be allowed to undertake a further series of more sophisticated tasks. Characteristic of this system is the most junior nurse being assigned the bed-pan rounds, cleaning the sluice and tidying the ward. After moving to the next ward or when another more junior learner arrived and s/he became more senior in the hierarchy, the learner is permitted to undertake more specialised procedures such as surgical dressings, management of intravenous infusions and drug administration. In the final year, learners are permitted to accompany doctors, to chaperone patients and to practise managing the ward. With few opportunities to observe another practitioner who is often hidden behind the screens, or engaged in more technical tasks, learners relied on gaining help from approachable peers. The role of the ward sister might have included some formal teaching, but this was only by chance and was often such an unfamiliar experience that the learner perhaps feared for the worse when s/he was summoned to the office for a tutorial.

In his discussion of common themes in adult industrial and professional apprenticeships, Graves argued that rites of passage created by obstructive and unhelpful behaviour of the 'masters,' were deliberately constructed to test learners' suitability for admission to the professionals' craft knowledge. These relationships were deliberately impersonal, competitive even combatory (Graves 1989: 51–64). Although his examples are concerned with men interacting using friendly but aggressive techniques that women may find threatening and destructive, there is evidence that nurses substituted such activities for their own with the same intent (Maggs 1983: 104). In order to survive, learners left the profession, adopted unacceptable behaviours such as erratic attendance or adopted the air of one who knew and thus became accepted by their seniors (Haas 1989: 102).

The ward sister as teacher in health care practice

Instrumental in fashioning the attitudes of nurses and teachers was a view that the 'art of nursing' could only be imparted through learners 'doing' and that their initiation into the art and science of their profession should take place at the bedside. It was also believed that this could be best achieved by delegating responsibility for learner teaching to one member of ward nursing staff (Lamond 1974: ix, 78). However, terms such as 'imparting values' and 'socialisation' are attached to these teaching activities. This suggests there was little perception that the actual nursing activities described as 'basic nursing care' required any teaching or guidance by clinical staff when a learner had arrived on the ward. Gott's observations indicated that ward teaching was associated with transmission of theoretical knowledge or techniques on which medical diagnosis and treatment, and thus the safety of the patient, may depend (Gott 1984: 68). Her observations were confirmed

by several later studies, which demonstrated that supervision of learners was haphazard and that learners worked unsupervised for more than 75% of their clinical placement (Reid 1985; Melia 1987; Jacka and Lewin 1989). Earlier reports of the paucity of contact between learner and ward sister attributed the difficulty to the task-orientated management of nursing care as well as with high numbers of learners or other unqualified people staffing the wards (Nuffield Provincial Hospitals' Trust 1953). Two later studies investigating the nature of the clinical learning environment in general hospitals confirmed these findings and concluded that the nature of nursing management and staffing levels influenced opportunities for learning or teaching. This was hardly surprising if only one registered nurse (a ward sister or staff nurse) was on duty and responsible for supervising the care of 20 or more patients as well as the learners (Dodd 1973; Pearson 1978). There existed an assumption that learners' technical nursing knowledge would be acquired in the practical room of nursing schools and that they would arrive in practice as an essential part of the workforce, capable of fully undertaking the workload. Indeed, studies from this period implied that schools of nursing were failing to ensure learners were prepared for any incident that they may encounter in practice. The prime training task of ward staff was to teach learners the unusual and specialist technical skills. Such attitudes deny the complexity of everyday clinical practice and the uniqueness of delivering patient-centred nursing care. Such an interpretation explains Reid's findings that learners were more likely to receive supervision when undertaking a (high status) technical activity (Reid 1985: 73).

These research studies reflect nursing in the 1970s and perhaps earlier. It would be reasonable to believe that with better education and preparation of nurses, this research would be widely known, and changes will have taken place to improve the ward environment. Sadly, studies in the 1980s and 1990s demonstrated that learners continued to feel alienated by their clinical experiences and identified aspects of learning to nurse that would deter all but the committed (Hempstead 1988). Attrition (or 'wastage') from nursing, especially in the first year of training, has always been identified as problematic and expensive. MacGuire's extensive research of over 60 reports concerned with recruitment to, and withdrawal from, training from the period of 1940–1967 demonstrated that little had changed over the period reviewed and that learners left because of dissatisfaction with their working and living conditions (MacGuire 1970). Her conclusions were substantiated by later studies that specified reasons for learners feeling alienated from nursing. In particular, she found that they were stressed when left to encounter patients alone, particularly in the early part of their training when they lacked confidence in their interpersonal and practical abilities and knowledge of patients' needs (Birch 1975; Bradby 1990: 104; Seed 1995; Spouse 2003a, b). This unsatisfactory situation perhaps stems from the pervading assumption that providing care, more commonly described as 'basic nursing care', was routine and part of a common repertoire of human skills. Possibly this was true when the demography of society was different, sickness was more common, and most people were nursed at home. Nursing during these times recruited mature women who either were widowed or came from large families. Maggs cites Florence Nightingale as saying that the art of nursing was more than 'nursing one's own family as a loving daughter, wife or sister'. Perhaps she was implying that recruits were familiar with nurturing children or caring for the sick and for elderly relatives. Nurse training was concerned

with transforming such elementary knowledge into artistry and a science through instruction and information on how to undertake specialised variations of techniques (Maggs 1983: 119). Magg's analysis of nursing and nurse education before the inception of the NHS contains much that is relevant to current experiences of learners learning, with a predominance of learning by trial and error (House 1977; Powell 1982; Mackay 1989; Bradby 1990: 136; Spouse 2003a, b). Inherent in the majority of research reports appears an assumption that with more and 'better' (formal) teaching, learners will learn. Nightingale's assertion that she cannot teach nurses but only point them in the direction of what to learn has perhaps been taken too much to heart. A consistent theme underlying all these reports is learners' dissatisfaction with their status as workers and the difficulties they experienced in receiving adequate support and supervision in their clinical placements. Contributing to this problem has been the conflicting interests of clinical practitioners charged with providing patient care and learner education. The over-dependence on learner labour as a prime source of care delivery with consequent insufficient qualified staff to provide supervision created significant tensions between idealised concepts of nursing and the bureaucratic needs of the hospitals (Gott 1984). Nurse teachers have been found wanting in meeting learners' learning needs in clinical practice, perhaps inevitably when considering the magnitude of their task.

More recent studies (Wisdom 2012) suggest that little has changed for the learner. This seems to be because of a reliance on care assistants, and later assistant practitioners, who have replaced the learner workforce with the introduction of the supernumerary status of learners with Project 2000 in 1989 and further in 1999 (UKCC Fitness for Practice). Yet evidence suggests that supervision by a knowledgeable practitioner, while undertaking practical care, is both valued and effective in developing learners' understanding and care (Alexander 1982; Spouse 1990; 1998; 2001; Wilson-Barnett et al. 1995).

Thus, the term apprenticeship has become synonymous with the notion of 'time served', that is, that the time served being an apprentice had significance and needed to be achieved. Thus, irrespective of the actual level of competence of an apprentice, learners would still need to complete their time. Apprentices often considered themselves cheap labour. Beyond the obvious (cheap labour) criticism of the apprenticeship approach, it is also attacked on learning and teaching grounds in that it supports the acquisition of the 'knowledge of action' and the uncritical reproduction of the model (master) which is a form of learning analogous to 'copying'. You may well question whether this is what is wanted in a caring profession. Probably not, and as a result, this form of apprenticeship model has been abandoned by the health care professions in favour of models that are more likely to lead to knowledge-driven, critically aware, innovative professionals.

The different forms of supervision that we have described are based on viewing learning in the workplace as learning that can be successful only when it is engaged with and is made possible through the support of a named learning facilitator.

You are not alone

As a mentor/supervisor, it is important that you recognise that it is unlikely that you are the only person acting in such a role within your organisation. You will have your own 'community of practice' where you can share your experiences with others in a similar

role. Having supportive relationships with colleagues who understand the role is important to your own well-being. You need opportunities to discuss issues of interest and to learn from each other. It is likely that your organisation has its own network for meeting regularly. In addition, there are online networks and special-interest groups specially for health care professionals working as supervisors and mentors, for example, the coaching and mentoring network (http://www.coachingnetwork.org.uk/resourcecentre/whatarecoachingandmentoring.htm) and the network for mentors working in health settings in Scotland (http://www.flyingstart.scot.nhs.uk/mentor-area/mentor-networks.aspx), among many others. This process of forming a network like these is a first step to developing, or joining, a community of practice.

As discussed earlier in this chapter, the Guilds had many criticisms, but something that they certainly provided was the opportunity to create a common understanding, a place for shared learning, and a force to promote members and their actions (Ogilvie 2004). These aspects of Guilds can also be recognised as features of a community of practice. Lave and Wenger (1991) described a community of practice as made up of those 'participating in an activity system about which participants share understandings concerning what they are doing and what that means for their lives and for their communities'. As with any organisation, its success depends on each member using the same vocabulary and subscribing to the same values. This is socialisation, and if you are a new mentor, you may find it helpful to be sensitive to how your own language and attitudes are influenced by the group, as you will find that you are using similar techniques to socialise your mentee into your own workplace community of practice. Lave and Wenger's is not the only account and definition of a community of practice, and a good description and comparison of a range of ideas and thoughts on this subject have been provided by Cox (2005).

Why learning facilitators are important

The main way in which people learn is not through formal education in the classroom but informally through everyday activities within settings that are not designed for the purpose of learning. This type of 'everyday' learning is not structured and does not occur in discrete subjects; it is sometimes called experiential learning. Experiential learning, when it initially occurs, can seem rather chaotic, unordered and inefficient. The inefficiency is not hard to see; after all, this learning tends to be random, and we are not sure what learning opportunities may arise, and when. This form of learning, however, is extremely important because it is the principle way in which we develop our 'know-how' or tacit knowledge and develop skills. If we learn this way in our day-to-day lives naturally, you may ask 'Why do we need others to help us?' The role of those that facilitate learning, be they called mentors or supervisors, is to make this 'experiential learning' more ordered and more efficient. A good mentor, for instance, will remember that they need to help their mentee by finding suitable opportunities to learn. Where it is possible, they will create learning opportunities for them. They will also help their mentee to discover the learning that they have experienced through discussion and reflective practice. Another important action by mentors is to encourage their mentee to relate their new experiences to their existing knowledge.

Much learning that occurs is not obvious and stated; it is hidden. Indeed, the literature refers to it as the 'hidden curriculum'. A good example of this 'hidden curriculum' is the socialisation process, that is how professionals of one group 'learn' to talk and relate to those in another group or indeed how they learn the way a 'professional within their social group' dresses and behaves. In terms of this hidden curriculum, novices often learn by 'modelling' themselves on their mentors. Knowing that this form of learning is occurring is critical for a mentor to be aware of, because bad practice can be modelled as well as good if both the mentee and mentor are not critically aware of their practice.

Other roles and qualities of the mentor/supervisor

The roles described to the mentor in the literature are varied, and the qualities required often resemble a mixture that might be recognisable in saints or at least someone related to a saint. The roles have been placed into useful categories by several authors, although these categories are not necessarily the same. Box 1.1 illustrates Pawson's typology of roles or activities based on previous work by Kram (1985) and Eby (1997) that Pawson developed. He refers to these as mentoring mechanisms, and they are based on a wide range of mentoring situations. Box 1.1 lists descriptions of the ways that mentors can exert their influence, although not necessarily the way they should act.

In clinical settings, we would also want to add teaching, but Pawson's model certainly captures a significant number of the 'non-teaching'-related activities that a mentor/ supervisor would be expected to undertake. Looking at these in turn:

Advocacy refers to the ways in which a mentor might work by:

- introducing their learner to colleagues and wider networks;
- finding opportunities for the mentee, and where necessary helping them to secure these opportunities;
- supporting (where appropriate) their mentee's decisions and generally using their influence within the organisation to enhance the development of their mentee.

Coaching activity, for Pawson (2004), is about 'encouraging, pushing and coaxing their protégés into practical gains, skills and qualifications' (Pawson 2004: 7). We would add that as 'coach', the mentor works by helping the mentee to see what their strengths are and to orientate their goals; for the coach mentor, attainment of measurable goals is very important.

When a mentor is '*Direction setting*', they are offering advice, particularly where difficult decisions are being taken.

As an *emotional resource*, the mentor is acting as confidant and friend.

Box 1.1   Pawson's mentoring mechanisms (Source: Pawson 2004).

Advocacy (positional resources)
Coaching (aptitudinal resources)
Direction setting (cognitive resources)
Affective contacts (emotional resources)

Pawson (2004)

In clinical situations where the mentor/supervisor may also be an assessor and guardian of patients' and clients' safety, some of the 'mechanisms of mentoring' will not work, or certainly can create tensions. It is difficult to see, for example, how a supervisor can be both a formal assessor and a confidant and maintain objectivity in relation to the assessment.

Point to ponder:
Which of Pawson's categories do you think coincides with your own experiences of mentoring to date?

Expressed in more pragmatic terms, McKimm et al. (2007) produced the following list (Table 1.1) of activities that mentors were likely to undertake in the clinical setting; we have removed references to those activities that relate directly to the role of teacher.

Fortunately, the list compiled by McKimm et al. (2007) and that of categories provided by Pawson (2004) have considerable degree of overlap. McKimm et al.'s list also has considerable overlap with the activities of mentors described by Hay (1995) and Darling (1984). Their list of qualities also based around the ideas of Hay and Darling, required of mentors is a bit scarier (Table 1.2).

You have probably concluded that this list is not exhaustive, and some qualities are more important than others. To possess all these qualities and to be able to use them all the time would be a great achievement, and probably few of us would be able to succeed. It is, however, worthwhile being aware of these qualities and activities described in Tables 1.1 and 1.2, because to be a successful mentor or supervisor, you will need to use many of them.

Table 1.1   Activities of mentors adapted from those described by McKimm et al. (2007).

Translator and decoder, for example, of organisational culture and values	Critic
Confidante counsellor	Energiser
Interpreter	Guide
Motivator	Sounding board
Time manager	Taskmaster
Facilitator	Devil's advocate
Planner	Sponsor
Coach	Protector
Problem-solver	Process consultant
Friend	Role model
Adviser	Target setter
Diagnostician	

Points to ponder:
Look at this table, and think about the extent to which you have used these activities in the mentoring or supervision that you have done thus far. Give yourself a score from 1 to 5 (5 being the most).
Are there any additional activities you could add to the list?

McKimm (2007).

Table 1.2 Qualities of mentors adapted from those described by McKimm et al. (2007).

Good interpersonal skills	Good interpersonal skills · objectivity
Objectivity	Role model
Role model	Flexibility
Flexibility	Command peer respect
Peer respect	Demonstrable competence
Demonstrable competence	Reflective practitioner
Reflective	Empathy
Non-threatening attitude	Advocacy
Facilitator of learning	Sincerity
Allowing the development of independence	Sincerity
Open-mindedness	Warmth
Approachability	Commitment
Self-confidence and self-awareness	Understanding
·	Aptitude for the role

Points to ponder:
Look at the table, and think about the extent to which you have used these qualities in any mentoring or supervision you have done so far. Give yourself a score between 1 and 5 (5 being the most).
Can you think of any other qualities to add to this list?
Now ask a friend to rate you on the same scale of 1–5.
How closely does your own score match those given to you by your friend?

McKimm (2007).

What about the learner perspective?

It is worth asking the question, where did the information in Tables 1.1 and 1. 2 come from? Was it just the authors' thoughts? Are they the thoughts of those facilitating learning or learners? The answer is probably a mix of all three, although within the literature, there is some concern that the learner's voice is often missed. In addition, the research cited above does not capture any real idea of what are learners' top priorities in relation to the capabilities and qualities of their facilitator. Gray and Smith (2000) interviewed nursing learners and asked how they would 'be' if they were mentors. These learners reported that if they were mentors, they would:

- form a relaxed relationship with their learner;
- support the learner, rather than breathe down their neck;
- encourage and allow involvement and participation in patient care, rather than just observation;
- show confidence in the learner's abilities and trust them to do things unsupervised;
- take time every day to let the learner do or observe something and not assume that because they were in a certain term, they would have already seen or performed it;
- regardless of the learner's stage, have an initial discussion preferably on the first day, to determine what the learner's present abilities were and their intended learning outcomes (a term used to describe what will be learnt at the end of a period of learning) for the placement;
- ascertain what the learner required as an individual to meet the desired learning outcomes;

- clarify ground on both sides and discuss the opportunities available to meet desired learning outcomes;
- remember the learner if there was anything interesting happening in the clinical area;
- allow the learner some independence by giving more guidance at the beginning of the placement; then, they would stand back and let the learner show initiative and self-motivation;
- make arrangements with other members of staff to 'look out for them' if they were going to be off duty when the learner was on duty, rather than have the learner feel abandoned;
- think carefully about the duty rota in terms of arranging shifts to allow learner and mentor to work together at some point each week.

While these views from nurse learners, mostly on placement with hospital wards, seem to be informed by negative experiences, they do accord with the general literature on mentoring and supervision, and with others who have researched the experience of this group of learners (e.g., Spouse 1996). Gray and Smith's study is also particularly interesting, because it highlights the value mentees place on their mentors' being realistic, enthusiastic and positively disposed towards their profession. Their work suggests that it is important to learners that mentors hold their own profession in high regard and believe it to be worthwhile. It also suggests that 'putting a profession or a role down' should be something to avoid.

Attributes and knowledge for the learning and teaching role

So far, we have argued that the main role of the mentor is to facilitate learning and therefore to make the process of experiential learning more efficient. To do this in addition to those attributes described in Tables 1.1 and 1.2, it is important for you to have a good understanding of how to facilitate learning and to appreciate the personal attributes that are more likely to ensure a supportive, mutually beneficial relationship.

The terms 'learning' and 'teaching' is worth exploring. They are used widely by educationalists to encapsulate purposeful activities and actions (teaching) that lead to learning. It stands to reason that someone who is facilitating another's learning will need to know about 'learning' and the processes that are effective in helping others to achieve this learning.

The term 'learning' is harder to define than teaching, and indeed the definitions vary depending on the source that you are using. In addition, it has also been recognised for some time that there are different types of learning and knowledge. Simple definitions of learning include:

1 *Learning concerns the acquisition or modification of knowledge, skills and behaviours*. Like most simple definitions of complex things, it hides more than it actually reveals! What, for example, is meant by knowledge, and does it include knowing how to do things with 'knowledge'? Ormrod (1999) gives two definitions
2 *Learning is a permanent change in behaviour*

3 *Learning is a relatively permanent change in mental associations due to experience.* You may note that in this definition, sitting in a class room listening to someone also counts as experience.

Definition 1 describes a number of situations in which learning can take place, covering practice as well as academic study, but this does not necessarily cover all forms of learning experiences. Ormond's two definitions of learning require evidence that something has changed. Thus, in definition (2), reading a book on history may result in you acquiring new facts and understanding, but under this definition, it is not learning. Definition (3) has the most application, as it does not muddle us by talking about different types of things that may be learnt. It describes learning as making 'new' mental associations.

It could be argued that many of the processes that support learning are probably known intuitively; after all, we imagine that most parents seem instinctively to know how to help their offspring learn skills of survival in modern society. Other types of learning, however, the types that we would equate with the knowledge and skills required to be a health care professional, require more than this instinctive ability, and indeed if we look around, we will know that some people are better at helping others acquire practical or technical knowledge than others.

Point to ponder:
Think about someone whom you admire as a good teacher.

- What attributes do they have that makes them memorable?
- Do you think you might have adopted any of their attributes when facilitating learning in others?
- Which of your attributes might others adopt in their own work?

The workplace and learning

The exact nature of learning opportunities depends upon each individual learner and how they learn. The learning itself takes place in what is called a placement, which may or may not have an environment that promotes learning (the learning environment). The concept of a learning environment describes not only the setting where learning takes place but the quality of the professional activities, the abilities of the resident and visiting practitioners, and their ability to provide learning opportunities. Building a series of opportunities, for a particular learner, in a particular environment, is sometimes referred to as a learning strategy. It is sometimes easy to lose sight of how learning in the workplace happens. You may find a model created by Beard and Wilson (2002; 2006) useful. They have identified six core aspects of learning. The six core aspects they identify are:

- belonging;
- doing;
- sensing;
- feeling;
- thinking;
- being.

Belonging is the notion that learning depends on the learning feeling that they are part of a community and the setting. It includes notions of place, culture and local socio-political context, and can be summed up in the term used earlier: the 'learning environment'.

Doing is the representation of the 'Learning Activities'; these are the things that the learner does that give rise to learning.

Sensing concerns how information is received internally for processing, by the learner; this area is particularly complex, since people vary in their preferred way to receive information.

Feeling embodies the emotions that are involved in learning, which can be very profound when learning in clinical settings and greatly influence what, how and the quality of our learning; in some books, this may be referred to as the affective domain of learning. It includes those things that influence attitudes, motivation and the valuing placed on what is being learnt.

Thinking or cognition refers to those mental activities that help us to internalise knowledge and to gain understanding; it includes processes such as comprehending, applying knowledge to new problems, analysing, synthesising, evaluating and reflecting.

Being is the act of change in a person being caused and the learning occurring. The act of learning influences the other core aspects. Beard and Wilson (2002; 2006) view these aspects as existing in a dynamic change, each interlinked but able to have different levels of prominence depending on the learner and their situation.

For learning to be successful, it is important for the learner and supervisor/mentor to determine and agree the professional needs, or goals, of the learner. This process is always based on some form of assessment. It is often taking place continuously although as a sub-conscious activity. When you are facilitating formal 'accredited' learning, this identification of needs is often based on a series of learning outcomes. Indeed, very often learners come from their Adult Education Institution armed with a set of predetermined learning outcomes.

Learning outcomes are statements of what should be achieved following engagement with a range of learning opportunities. Writing learning outcomes that are comprehensible and usable is always a challenging activity; in fact they are a complex concept masquerading as a simple one (Scott 2011).

Learning opportunities are the activities that learners need to engage in, and will include things such as: developing an understanding of different health care pathways in the community and a range of institutions; understanding the work of a wide range of associated health care professionals; participating in managing and delivering a wide range of health care activities; dialogue with clients, carers and colleagues; joining and functioning effectively within a health care team; developing their evidence-based knowledge; and personal development.

At the end of the period of learning, it is always important to evaluate whether or not your facilitation strategy was successful. In other words, to what extent the desired learning outcomes have been achieved, or whether different learning outcomes from those intended have also been achieved. This process of evaluation, by necessity, involves some form of assessment; in many circumstances, the evaluation and assessment will and should be ongoing. Documenting your findings from your assessment is a vital part of the

mentor role, as it provides your learner with evidence of what they have achieved and what is outstanding. In the rare situation where your learner's standard of performance is unsatisfactory, your documented records of your assessments, the actions and the outcomes provide evidence that is vital for making fair and proper decisions that could save someone's life.

Summary

From what you have read in this chapter, you can appreciate that mentorship or supervision of novices has a long and important history. Throughout this book, we will consider factors that contribute to learning in practice settings, take you through the learning process from the perspective of both the learner and the mentor, examine ways in which facilitation skills can be developed, and provide information, ideas and activities to inform your own practice as a supervisor and as a professional.

Because we believe that learning is more effective when the reader is actively engaged, in the text we have included some vignettes and snapshots that illustrate how our main points could be applied to everyday professional practice. We have also included some questions (Points to Ponder and Socratic Questions) that we think will help you to learn, and we hope you will answer them before progressing to the next section of the book.

We have written this text so that each of the main chapters can be read in isolation from the others, although of course we would prefer you to read the whole text. At the end of reading the book, we are certain you will have a better understanding of how to facilitate the learning of other individuals in your workplace and be more effective in your role as a facilitator. Enjoy!