1

Mentorship

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Introduction

This chapter introduces *Mentoring in Nursing and Healthcare: A practical approach* and looks at what we mean by the term 'mentorship'. The history of mentorship is discussed and terms used within healthcare to describe an experienced practitioner supporting a novice student are examined. A comparison of mentoring and coaching will facilitate healthcare practitioners' critical analysis of their own role within practice. Case studies are used to illustrate the characteristics that an effective mentor should demonstrate. The activities provided will give you an opportunity to reflect on your own mentoring skills.

Web Resource 1.1: Pre-Test Questions

Before starting this chapter, it is recommended that you visit the accompanying website and complete the pre-test questions. This will help you to identify any gaps in your knowledge and reinforce the elements that you already know.

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Learning outcomes

On completion of this chapter, the reader will be able to:

- Demonstrate an understanding of the concept of mentoring
- Recognise the differences in terminology used within healthcare
- Appraise the characteristics required by an effective mentor
- Appreciate the difficulties in distinguishing between the terms 'mentoring' and 'coaching'

Mentoring and mentorship

A mentor has commonly been regarded as someone who encourages and offers direction and advice to a protégé or novice. Over the centuries, artists and musicians have had mentors. The concept has also been used in the business world, especially in the USA. According to Palmer (1987, cited in Ellis 1996), a classic mentoring relationship develops and grows between two individuals over a long period of time. Such relationships have lasted for 2–15 years and have provided professional and emotional support for both individuals. Classic mentoring provides an informal link between two people who are willing to work with each other and provide wise advice with no financial gain on either side. Mentorship within healthcare and social care is not classic mentoring. One obvious difference is that students are allocated to practice areas for a relatively short period of time so that the mentoring relationship does not develop and grow over a long period of time. Another point is that students have a different mentor for each practice area and a student does not have the opportunity to choose his or her own mentor. Students are allocated mentors, usually by the practice area manager, who has to consider issues such as workloads, staff holidays and sickness. Morton-Cooper and Palmer (2000) do consider mentoring within healthcare and social care to be true mentoring because it contains elements of mentor function with the onus on helper functions, from which a relationship often develops.

Activity 1.1

Thinking back over your health or social care career, recall significant people who have influenced your career and learning. What did they do that inspired you? What did you get out of the relationship?

When I think of significant people in my own career, I think of a manager who was my professional 'sounding board'. I was a newly appointed night sister and I would use her to talk through solutions to problems that I had. She would listen to me and then ask me why I had made that particular decision. What else could I have done? I would go to her when I had made a decision that I was concerned about. Again, she would listen to me and then she would make me reflect on my actions. If she thought that I had made the wrong decision, she would talk me through what I had learnt from the situation and what I would, or could, do differently the next time. She did have expectations of me and she would tell me truthfully when I had let her down. I had an enormous amount of respect for her as a healthcare professional and an individual.

Mentorship is intended to be a one-to-one relationship where the mentor invests time, knowledge and efforts to help the mentee reach his or her potential as a person and as a professional in terms of behaviours, knowledge and skills.

Mentoring is an old formula of human development with its origins in the Stone Age, when the artists who painted on cave walls or the medicine men who used medicinal herbs to heal sickness instructed the youth in their clan in order to pass on their knowledge.

Mentorship, as we know it, owes its name to Greek mythology. The original 'Mentor' was a friend and adviser of Telemachus, Odysseus' son in Homer's poem,

The Odyssey. In this poem Odysseus went off to war and left his son under the care and direction of Mentor. Mentor's role encompassed elements of guardianship, tutoring and support. This original idea of the word mentoring is based on experiential learning with support and challenge. The Indo-European root *men* means to 'think' whereas in Ancient Greece the word *mentor* means adviser. So a mentor is an adviser of thought (Garvey et al 2009).

During the Middle Ages the concept of mentor developed. Fénélon (1651–1715), who was the tutor to Louis XIV's heir, viewed mentoring as providing support and helping to remove the fear of failure by building confidence. Fénélon considered life events to be learning opportunities. He stated that pr-arranged or chance happenings, if explored with the support and guidance of a pre-mentor, provided opportunities for the learner to acquire a good understanding of the ways of the world (Garvey et al 2009). Fénélon's attributes of a mentor included being assertive and calm in the face of adversity, demonstrating charismatic leadership abilities, and being inspirational and trustworthy (Garvey et al 2009).

In 1759, Caracciolli wrote about the importance of the mentor expressing wisdom so there was a need for the mentor to have self-knowledge in order to enhance the knowledge of the mentee. The mentor should be able to build rapport and establish trust, be inspirational and empathetic. Caracciolli mentions the benefits of reflection for enriching the mind and the need to understand the cultural climate of the mentee (Garvey et al 2009). He proposed a staged mentoring process model with developing awareness as the main outcome of mentoring. He stated:

> Observation leading to . . .
> Toleration leading to . . .
> Reprimands leading to . . .
> Correction leading to . . .
> Friendship leading to . . .
> Awareness.
>
> (Garvey et al 2009, p 15)

Garvey et al (2009) state how two versions of mentoring can be depicted in this model. One version is the stern mentor who reprimands and corrects and the second is the friendly mentor who tolerates and offers friendship. They argue that this model is just as relevant today within mentoring and coaching. Observation can be interpreted as an aspect of performance coaching, and toleration can be linked to listening and acceptance, reprimand with challenge and correction with skills coaching.

In 1762 Rousseau developed the idea even further and founded experiential learning which is still promoted today. He saw mentoring as a vehicle for learning, growth and social development of the student, which in turn leads to confidence. He saw dialogue between the mentor and the mentee as an important element of learning and considered the most effective learning to take place on a one-to-one basis.

Contemporary definitions of mentorship encompass a number of concepts including coaching, sponsorship and counselling. Clutterbuck and Megginson (2005) give a variety of definitions including the following:

- Mentors are influential people who help individuals achieve major life goals.
- Mentoring is a process in which one person (the mentor) is responsible for overseeing the career and development of another (the protégé or mentee).
- Mentoring is a protected relationship in which learning and experimentation can occur, skills can develop and results can be measured.

Why do students need a mentor?

Is it important that students have a mentor during their clinical placements? Do mentors actually support the student? Think about Scenario 1.1.

Scenario 1.1

This was Lizzie's second clinical placement – a respiratory medical ward which, it seemed to Lizzie, was always manic. Lizzie felt totally out of her depth although the rest of the staff, including the other student who was a third year, seemed to know what they were doing. This intimidated Lizzie; she felt scared to ask for help in case she was thought to be stupid and slow – after all this was her second placement so she should know what she was doing by now – she was 6 months into her course.

But, then again, she wasn't sure whom to ask for help because she seemed to work with different members of staff on every shift.

Lizzie had started to dread coming on to the ward for her shifts and panicked when she was asked to do anything by the staff or even by a patient. She couldn't think clearly and she couldn't remember how to do even the simplest of tasks.

On one shift after receiving the handover from the night staff, Lizzie was allocated to work with the 'red team' for the morning. The team leader who was a staff nurse, asked Lizzie to go and shave Mr A straightaway. Lizzie felt the familiar wave of panic inside and struggled to control it. 'I can do this' Lizzie told herself as she shaved Mr A's face, chest and pubic regions.

Activity 1.2

This scenario is based on an actual incident.

- **Why do you think this incident occurred?**
- **Think of it from the team leader's point of view.**
- **Think of it from the student's point of view.**
- **What kind of help do you think Lizzie needed?**
- **How do you think this incident could have been prevented?**

There are several reasons why a student needs a mentor.

The obvious reasons are for guidance and support. But the mentor can also structure the working environment for the student so that the student becomes familiar with the ways of working of those in the clinical area. The mentor is also a role model. This prevents students such as Lizzie being left to their own devices and trying to decide what they should be doing and how it should be done. Mentors can also provide an appropriate knowledge base for the student; they can answer students' questions, and give encouragement and support, thus building up a student's confidence. Also important is the mentor giving constructive and honest feedback and debriefing the student after a good or bad experience (Neary 2000; Gopee 2008). In Lizzie's case, her mentor needs to ensure that Lizzie feels confident and safe in the clinical area and does not feel 'out of her depth'. Lizzie needs to know whom she can go to gain practical experience and support.

The benefits of mentoring for the student

Several benefits have been identified for the student who has a mentor:

- Improved performance and productivity
- Enhanced career opportunities and career advancement
- Improved knowledge and skills development
- Greater confidence, wellbeing, commitment and motivation.

Morton-Cooper and Palmer (2000) support the above arguing that students need a mentor for the following reasons:

- As a defence against feelings of disorientation, disillusionment and burn-out
- As a sounding board to clarify values
- For skill rehearsing and for role modelling in practice
- To help the student develop an ability to deal with emotions in a beneficial way
- To demonstrate best practice
- To develop relationships within practice with other team members.

Benefits for the practitioner acting as the mentor have also been recognised.

The benefits of mentoring for the mentor

These include the following (Alred et al 2006):

- Improved performance
- Greater job satisfaction, loyalty, commitment and self-awareness
- New knowledge and skills acquired; the mentor learns from the student as well as the student learning from the mentor
- Leadership development
- Improved relationships with colleagues, students and patients/clients as communication across boundaries between disciplines and teams is improved as the mentor identifies learning opportunities for the student in practice.

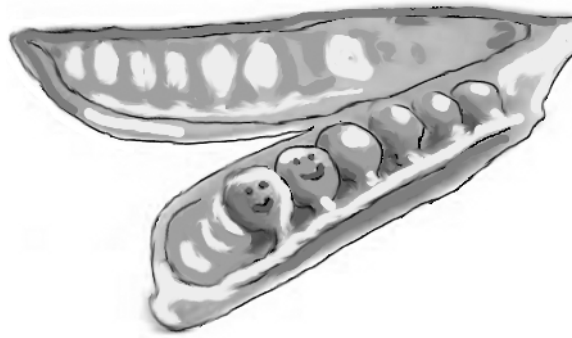
Morton (2003) mentions *mutuality* (p 7) which is the idea that both parties gain from the experience.

Characteristics of a mentor

Darling (1984) identified three requirements for a significant mentoring relationship. She stated that these were absolute requirements:

Attraction, affect, action

The student must be **attracted** to the potential mentor by their admiration for them and desire to emulate that person in some way – 'I want to walk like you, talk like you'. In return, the mentor must recognise qualities in the student that are a potential for further development.



I WANT TO BE LIKE YOU

Although it would be ideal to be able to choose a potential mentor whom the student admires and respects (Morle [1990] argues that mentors are selected by mentees for their professional ability and personal characteristics), within health and social care this is rarely achievable because students are allocated blindly to mentors in clinical areas. Before the students' placements, mentors and students have not previously met each other. If students could choose a mentor it may be the case that there would be an imbalance of mentor allocation (students soon learn which mentors are better than others!).

The mentor must have positive feelings, **affect**, towards the student as an individual, and be able to give respect, encouragement and support.

This can be difficult to achieve in healthcare because students are allocated to clinical areas for short periods of time. This means that a rapport has to be developed rapidly and assumptions have to be made by the mentor and the student that may or may not be correct, and conflict may ensue.

The third requirement, **action**, requires the mentor to invest time and energy on behalf of the student – teaching, guiding and counselling.

These attributes are additional to the mentor's main role and are sometimes undertaken in the mentor's own time. Therefore, some mentors are able to facilitate students' needs more effectively than others.

This is similar to Palmer's (1987) work (cited in Ellis 1996) which breaks down the mentor role into three subsections:

1. The first subsection describes a personal element wherein the mentor encourages confidence, creativity, risk taking and the fulfilment of potential within the student.
2. The second functional element deals with practical issues of teaching, instruction, support and advice giving.
3. The third element supports the development of an enabling relationship between the mentor and the student, which encompasses interpersonal skill development, networking and sponsorship.

Activity 1.3

What were the important factors that characterised the relationship that you had with the people who influenced your career and learning?
Consider: Attraction, Affect and Action

Gopee (2008) mentions characteristics such as being patient, open-minded and approachable. The mentor should have a good knowledge base and be up to date in their knowledge and practical skills. Other factors include the ability to communicate verbally and the ability to listen. A mentor should encourage their students and demonstrate concern, compassion and empathy.

What should a mentor do?

Activity 1.4

Thinking about your own experience as a student or mentee, what did you want from your mentor at that time?

A common theme with students is the need for the mentor to possess personal and professional qualities such as approachability, good interpersonal skills and self-confidence. The mentor also needs to respect the student and to show interest in them while demonstrating their skills as a competent and enthusiastic practitioner. Morton-Cooper and Palmer (2000) state that mentors should enable students to

discover and use their own talents while encouraging and nurturing the contribution that the student can make to their profession. The mentor should help the student to become successful. Neary (2000) considers that mentors should be prepared to give both time and energy to their role, be up to date in their knowledge and skills as well as being competent in the basic skills of coaching, counselling, facilitating, giving feedback and networking.

Benner (1984) stated that the role of the experienced practitioner in the clinical environment was to facilitate the transition from novice to competent practitioner.

Burnard and Chapman (1990) see a mentor as an experienced practitioner whose role is to guide and look after the student. In general a mentor is usually someone who is experienced and more senior than the student. It used to be the case that they were also older than the student, although this now often tends not to be the case (see Chapter 2). It has been found that students' stress levels are significantly decreased if the mentor and the practice environment are friendly (Spouse 2001). Mentors should therefore be friendly, enthusiastic and demonstrate a genuine interest in the student (Quinn and Hughes 2007).

Characteristics of a good mentor (Quinn and Hughes 2007)

- Approachable
- Knowledgeable and motivated to teach
- Supporting
- Good listener and trustworthy
- Patient and friendly
- Experienced and enthusiastic
- Demonstrates interest in the student
- Committed to the mentoring process

Characteristics of a poor mentor (Quinn and Hughes 2007)

- Intimidating to students
- Unapproachable
- Poor communicator
- Promise breaker
- Lacking in knowledge and expertise
- Unwilling to spend time with students

Darling (1984) undertook a study that looked at the characteristics that student nurses wanted in a mentor. This study resulted in a number of roles being identified; these roles are equally valid for students of all healthcare professions (Box 1.1).

Box 1.1 Characteristics that student nurses wanted in a mentor (Darling 1984)

- **Role model**: an individual whom the student can look up to, respect and admire, an observable image for students to imitate
- **Energiser**: an individual who is enthusiastic and dynamic and fires the student's interest
- **Envisioner**: an individual who gives a picture of what could be done, is enthusiastic about opportunities and possibilities, and sparks interest
- **Investor**: an individual who makes time for the student, imparting their own knowledge and skills and spots potential, and who is able to let go of the student and delegate responsibility
- **Supporter**: an individual who listens, is warm, caring and encouraging, and is available in times of need
- **Standard prodder**: an individual who is very clear about the level of achievement that is required and who pushes and prods the student *to achieve higher standards*
- **Teacher/Coach**: an individual who guides on setting priorities and problem-solving, helps in the development of new skills, and inspires personal and professional development
- **Feedback/Feedforward giver**: an individual who can give both positive and constructive feedback and help the student to explore issues when things go wrong, so that, in the same situation, the next time the student can make a more effective decision (feedforward)
- **Eye opener**: an individual who motivates interest in new developments and research, facilitates reasoning and understanding and directs the student into seeing the bigger picture
- **Door opener**: an individual who provides opportunities for trying out new ideas, and suggests and identifies resources for learning
- **Idea bouncer**: a sounding board – an individual who encourages the student to generate and verbalise new ideas, listens to them and helps the student reflect on them
- **Problem solver/Solution focused**: an individual who helps the student to think systematically about problems using the student's strengths and weaknesses to enable further development to take place
- **Career counsellor**: an individual who offers guidance in career planning
- **Challenger**: an individual who questions and challenges the student's opinions and beliefs, enabling the student to critically think about decisions taken

Activity 1.5

Thinking about this list, how would you assess your skills as a mentor against it?

Mentors have their own educational experiences, knowledge base, level of competence and past experiences of caring and practice. These variations, which are unique to the individual, will influence the way that individual mentors practise their roles and how they view the clinical work environment. Phillips et al (2000) found that many mentors were enthusiastic about having students in the clinical areas and wanted to share their knowledge and skills with them. These attitudes will obviously have a positive affect on the student in the clinical area. Some mentors, however, were distracted by the busyness of the workplace and students were viewed as an additional burden. Mentors sometimes feel that they have no time to teach the student. Stuart (2007) argues that the mentor's beliefs about how learning takes place will influence the climate of the clinical environment. Students can acquire knowledge, skills and attitudes independently of any formal teaching. One way that students learn in the clinical environment is by observing their mentor as they work alongside each other. No formal teaching is done here. Students learn from observing the actions and understanding the reasoning processes of their mentor who acts as the student's role model (Stuart 2007).

Web Resource 1.2: Characteristics of an Ineffective Mentor

Visit the accompanying web page for further information about the characteristics of an ineffective mentor.

Activity 1.6

- **What is a role model?**
- **Can you think why students need a role model?**

Students are allocated to practice placements so that they can observe the behaviours and interactions between qualified practitioners and the patients/clients to whom they are delivering aspects of care. The mentor is key in helping students learn acceptable healthcare behaviours that the student can further develop. Although the idea of role modelling is to expose the student to observing practitioners, experience in the practice placement helps the student not only to acquire clinical/practice skills,

but also to gain an awareness of professional attitudes and effective interactions between patients/clients and the members of the multidisciplinary team.

Role modelling is a process that allows students to learn new behaviours without the trial and error of doing things for themselves (Bandura 1977). It is a form of learning from experience that uses humanist and social learning theories (see Chapter 5). A key feature is the experience that students themselves bring to a situation.

Bandura (1977) suggests that when people are born who they have no behaviour patterns and have to learn these by watching people. He describes social learning as an interaction between a person (in this case the student) and the environment. It occurs when a student learns by observing another (the mentor) and is influenced by:

- the relationship between the role model and the student
- the usefulness of what is modelled
- the student's ability to undertake the role
- the student's motivation.

Social learning theory focuses on the social aspects of learning and the complexity of the interaction between the environment and the student. The nature of healthcare means that social learning and role modelling are fundamental to professional socialisation (Murray and Main 2005).

According to Schön (1992) working with and observing a mentor helps students, through reflection, to internalise their mentors' behaviour and build on previous knowledge and experience. Bandura (1977) supports this view, and states that role modelling allows the mentor to effectively transfer values, beliefs, attitudes and aspirations to the student. However, if the student simply just imitates the mentor, then student learning will not occur (Bandura 1977). Students have to be actively involved in the modelling process to acquire the knowledge that the expert practitioner takes for granted (Nelms et al 1993, cited in Murray and Main 2005).

Quinn and Hughes (2007) discuss four dimensions involved in the observational learning situation such as role modelling:

- Attention
- Retention
- Motor reproduction
- Motivation.

Attentional processes: when the student learns from a role model he or she needs some feedback. Positive reinforcement is needed when the desired behaviour demonstrated by the mentor is imitated by the student. This will ensure that students are aware of the healthcare behaviour and it is acknowledged by them. The effectiveness of the feedback, however, depends on students' psychological functional processes, such as students' ability to process learned information, their perceptual abilities and their previous learning experiences. Mentors need to be aware that students have different capabilities to learn and to develop their knowledge, skills and professional attitudes. These are dependent on the students' interest and will-

ingness to learn. The interpersonal attraction between the student and the mentor is also important. This is Darling's (1984) **attract** stage. The mentor has to know the student and his or her ability to learn. Some students will need to observe the role model undertaking a particular skill on more than one occasion in order to internalise, retain and be able to reproduce the behaviour demonstrated.

Retention processes: the student has to remember the behaviour role modelled by the mentor if he or she is going to learn from it. Strategies such as rehearsing are therefore crucial to the student retaining information. Other strategies include the use of acronyms, a word made from a series of initial letters or parts of words. An example of an acronym is **APIE:**

A – assessment
P – plan
I – implement
E – evaluate

This approach can be useful in assisting learning in the practice placement and can be further developed depending on the feedback that the student receives from the mentor.

Motor reproduction processes: the student has to be capable of actually carrying out the observed behaviour and of evaluating it in terms of accuracy. This is an important aspect of the practice of health and social care because these professions are composed of practical activities. Kinnell and Hughes (2010) do state that it may not be until the student has qualified that they can reproduce the practical skills that they have acquired perfectly.

Motivational processes: behaviour is more likely to be learned if the student sees some value in it. The likelihood of the modelled behaviour being learned is increased when the student sees the mentor being positively reinforced for performing the behaviour – this could be recognition by a manager or senior management, financial reward or recognition by peers. This is called vicarious reinforcement.

Spouse (2001) considers that the benefits of role modelling are in the opportunities for students to work with experienced and knowledgeable practitioners. This facilitates students developing an enthusiasm for professional development that, Spouse claims, is not achieved by any other learning experience.

Students develop their professional identity through a process of socialisation. Role modelling is seen as an accepted method of teaching these processes (Murray and Main 2005). In the clinical practice area professional values can be repeatedly demonstrated by the mentor so that theory and practice can be integrated and professional roles and values acquired by the student (Murray and Main 2005).

Professional socialisation is not, however, just something that happens automatically or by magic in the clinical area; it is not just a reactive response by the student to the practice placement. Professional socialisation does depend on the student's

past experiences and the ability to reflect on the processes and values promoted by the higher education institution (the university). These are not necessarily positive. To be accepted into a practice placement, students will internalise poor practice if it is the norm.

Case study 1.1

Amelia was allocated to a busy medical ward where she was asked to help a patient with breathing exercises. The patient, a woman in her 30s, was a regular on the ward. The patient had a long-term condition and complained bitterly about pain when attempting the breathing exercises. Amelia asked the nurse in charge about analgesia for the patient before starting the exercises. The nurse exclaimed that the patient was just trying to avoid doing the exercises and was a 'baby' – she always complained – and anyway the pain couldn't be that bad as the patient was still able to speak and laugh with Amelia. Reluctantly Amelia agreed and went back to the patient. She didn't want to upset the staff because she was going to have to work on this ward for the next 2 months.

Murray and Main (2005) claim that the fact students will accept and internalise poor practice reinforces the importance of positive role modelling.

Case study 1.2

Sister Weightman was known to be a scatty individual who didn't have particularly strong organisational skills. The orderliness of her unit and its smooth running were primarily due to the staff nurses who worked in the team. But the one skill Sister Weightman excelled in was her approach and care of relatives of the patients on the unit, especially those who were distressed or bereaved. The unit could be in total chaos but Sister Weightman would spend time with and be there for the relatives. She was a tactile individual and always managed to give comfort to the families.

I remember watching her one Sunday evening. A patient in his 40s had died quite suddenly and his wife was bereft. Sister Weightman was there immediately; she was present. She gave physical and emotional support to the patient's wife, speaking gently and quietly to her. She sat with the woman at her husband's bedside and, when the woman was ready, took her to a quiet room and drank tea with her. As a first year student nurse I was impressed by Sister Weightman's approach; there was no hurry or drama, the patient's wife was made to feel that she mattered and was cared for. I stored the scene that night inside of me until I could put those skills into practise for myself. I wanted to care like her.

As previously stated, Bandura (1977) states that learning occurs when a student learns by observing another and the learning is influenced by factors such as the usefulness of the behaviour that is being modelled. Having grown up with a parent who had a long-term condition and who was frequently hospitalised, the way that families were or were not cared for was something that I personally could easily identify with. Sister Weightman was a positive role model for me because the skills that she demonstrated were very relevant to me as an individual and as part of a family who had a member of it in ill-health. She treated families and relatives the way I wanted my family to be treated. This perhaps identifies the importance of the mentor 'knowing' their student so that the mentors can role model behaviours that are relevant to the student and help the student to learn.

What are considered to be the qualities of a positive role model are consistently mentioned throughout the literature.

Qualities of positive role models

These health professionals

- Enjoy their profession
- Are professionally competent and provide excellent patient care
- Interact with students and structure the clinical environment to ensure learning occurs (Wiseman 1994)
- Lead by example, and enjoy teaching and demonstrating clinical skills
- Have a caring attitude to patients/clients and students, displaying warmth and genuineness
- Demonstrate an interest in the student using eye contact, keen questioning skills, and a willingness to listen and respond to students.

Qualities of poor role models

These health professionals (Murray and Main 2005)

- Deliver task-oriented care with minimal patient/client interaction
- Allow no time for questions by students or patients/clients
- Create an atmosphere of possible fear, hesitancy, and lack of trust and respect
- This places the emphasis on work practices at the expense of effective communication with the student and patient/client.

According to Gopee (2008) there can be good role models and bad role models or rather *How not to be a healthcare professional!*

Gopee does argue that bad role models should not be seen as a model at all. If a role model is defined as an exemplary person, a perfect exemplar of excellence, then such a person should therefore be someone whose practice, attitudes and beliefs can be emulated by the student. It is therefore imperative that mentors realise, and be aware of the fact, that their actions make all the difference. Donaldson and Carter's (2005) evaluation of students' perceptions of role modelling in clinical practice found

that students wanted good role models whose competence they could observe and practise. The role models needed to give constructive feedback on students' practice so that the students could develop their competence and build their confidence. This would then allow them to convert observed behaviour into their own behaviour.

Mentorship and coaching

The term 'coaching' is often seen in mentoring literature and. although it is not yet widely used in health or social care, it is frequently used interchangeably with the word mentoring.

Garvey et al (2009, p 9) pose the question: Are mentoring and coaching distinctive and separate activities or are they essentially similar in nature?

Alred et al (2006) state that the terms 'mentoring' and 'coaching' have a lot in common, claiming that the differences between mentoring and coaching are becoming blurred whereas the similarities are becoming more apparent. They see coaching as having a specific and tightly focused goal whereas mentoring goes further by offering support or advice. They state that the mentor may offer coaching (Box 1.2).

Coaching and mentoring share similar historical features (Figure 1.1). Both concepts can be linked to education and learning and both are described as one-to-one processes.

Mentoring has gained popularity in private sector businesses, the public sector, and in education and social welfare; coaching has also increased in popularity. According to Garvey (2010) this increased popularity in both processes has led to confusion about definitions. It has been suggested that trying to define mentoring is difficult because it can be as informal a process as pairing or as complicated as the organisation in which it is carried out (Garvey 2010).

Garvey mentions four main elements in mentoring.

Box 1.2 The differences between mentoring and coaching

Mentoring	Coaching
Implications beyond the task	Task oriented
Agenda set with the student	Agenda set by or with coach
Capability and potential	Skill and performance
Reflection by the student	Reflections to the student
Can be longer term	Shorter time
Implicit, intuitive feedback	Explicit feedback
An emotional bond between mentor and student	No emotional bond

Based on Alred et al (2006) and Garvey (2010)

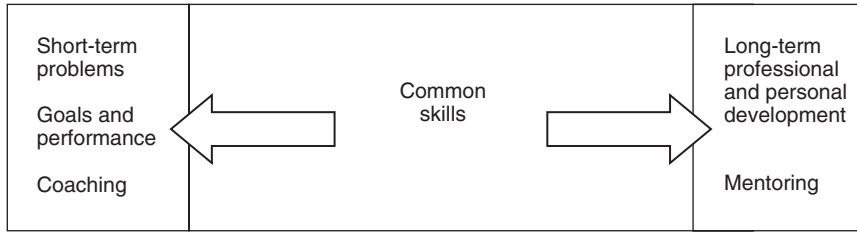


Figure 1.1 Common skills of coaching and mentoring. (Based on Hawkins and Smith 2006.)

1. Mentoring is dependent on trust, commitment and emotional engagement. In a successful mentoring partnership, the pair often respect and like each other, which may result in friendship.
2. Mentoring includes skills such as listening, questioning, challenging and supporting.
3. The mentee's dream is central to mentoring. Mentoring is first for the mentee and so it is associated with a desire to progress, learn, understand and achieve.
4. Mentoring is a relationship between two individuals with learning and development as its core purpose. It is a dynamic relationship.

Coaching

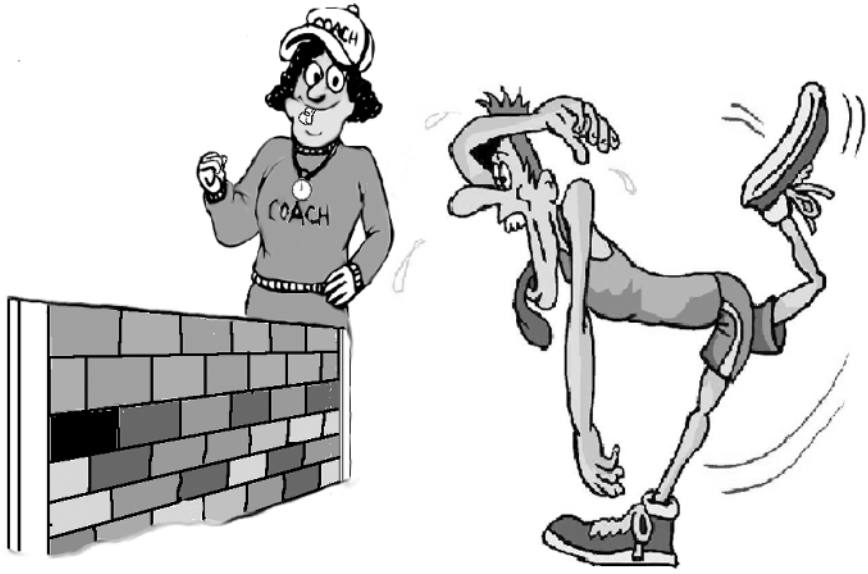
Web Resource 1.3: Coaching Powerpoint Presentation

Please see the web page for the PowerPoint on coaching.

The term 'coaching' was originally used to describe travelling in a horse drawn carriage from A to B (B being Oxford University) to expand the mind. In the early 1800s it was a slang word used at Oxford University to describe a tutor who supported or carried a student through an exam. Later it was used to describe performance enhancement in sport and life skill development. In the twentieth century coaching was used in the workplace where it was used with a specific process of education for recruits (trainees or apprentices). The coach was usually a more experienced employee who often had managerial responsibility for the trainees. Typically the coach would demonstrate a task, instruct the trainees to attempt to do the same task, observe the trainees' performance and then give feedback. This feedback was based on either the coach's own performance or a standardised perception of performance. The coach and trainee would then discuss the feedback and plan how the trainee could approach the task differently the next time (Bachkirova et al 2010). Bachkirova et al claim that this form of coaching was similar to instructing.

The idea of coaching has since developed. Although the coach of the trainees required expert knowledge of the task to be done, today the coach requires expertise and knowledge of the coaching process. The trainees' coach observed the trainees' performance – how they did the task. Today the coach encourages the student's self-actualisation – the student becoming an expert him or herself. Bachkirova et al (2010) do state that the line manager as coach is the most difficult and controversial coaching role. They express doubt as to whether line managers can give the coachee's agenda priority and spend enough time and effort to coach at anything more than a basic level. The arguments within healthcare are similar when a student, especially a junior student, is mentored by a senior member of staff or a clinical manager. The priorities for the manager rarely include the student's competencies.

The coaching literature is more concerned with psychology than mentoring literature. Garvey (2010, p 350) mentions 'the psychological mindness as an important element of the coach's practice'. This is the ability to reflect on themselves, others and the relationship in between. Where mentoring does use psychological concepts it is generally to inform and challenge rather than to create practice (Garvey 2010).



Coaching is defined as some kind of helping strategy, designed to help people reach their full potential. But, as Bachkirova et al (2010) state, this type of definition does not distinguish it from mentoring, counselling and training because these processes make similar claims. Coaching is often described as aiming at individual development or enhancing wellbeing and performance (Bachkirova et al 2010, p 3). Although these definitions may be true, they do not differentiate coaching from mentoring, counsel-

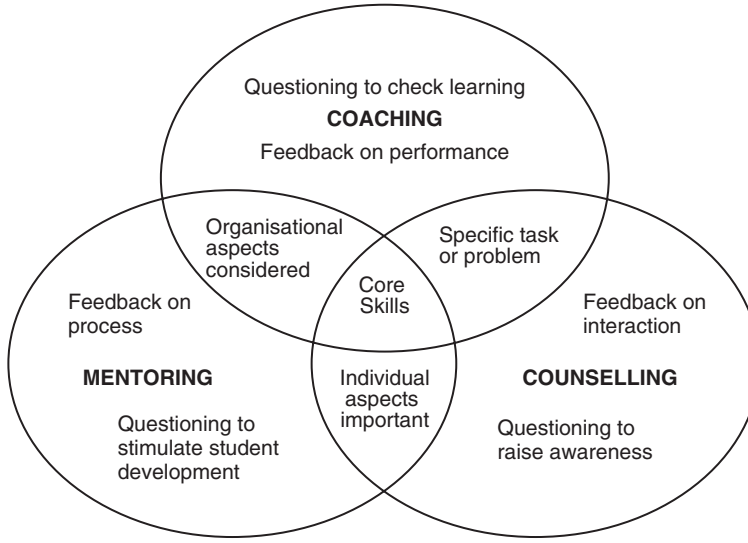


Figure 1.2 Differentiating coaching, mentoring and counselling. (Based on Hay 1995.)

ling or training because their purposes are the same. Figure 1.2 illustrates the difficulty in differentiating between the three concepts.

Hawkins and Smith (2006) state that there is no single agreed definition for coaching and include definitions such as:

- a process that enables learning and development to occur and performance to improve
- a short-term intervention aimed at improving performance or developing a competence
- unlocking a person's potential to maximise performance.

Coaching appears to be the facilitation of performance improvement, which is goal focused, results oriented and practical, adult learning, and personal development, support and unlocking of potential (Hawkins and Smith 2006). To achieve this, the coach needs skills such as:

- relationship and rapport building
- understanding of organisational systems and their dynamics
- designing interventions.

Bachkirova et al (2010) state that coaching has been described in at least four dimensions (Figure 1.3): **I**, **It**, **We** and **Its**.

I	It
Coach and coachees as individuals *subjective*	Behaviours, processes, models, techniques *objective*
We	**Its**
Coaching, relationships, culture and language *intersubjective*	Systems: organisations, families, societies *interobjective*

Figure 1.3 Four dimensions of coaching. (Reproduced from Bachkirova et al 2010 with permission.)

The **I** quadrant focuses on how individuals – the coach and coachee – experience the coaching encounter. The individual's feedback on interventions is important because it increases the understanding of what is important to people in coaching. The **It** quadrant looks at effective techniques and tools that can be reliably used in coaching. The **We** quadrant emphasises the relationship between the coach and the coachee. The influence of language and culture in the coaching interaction is important in the interpretation of the experience. The **Its** quadrant highlights the importance of having an awareness of the factors that influence the coaching process. The individuals belong to families, cultures and professional groups. These factors will affect how coaching takes place.

Bachkirova et al (2010) state that the individuals involved in the coaching should learn from the encounter. A coaching encounter should extend and clarify the meaning of the experience. The concept of change is inherent in learning, so any change in behaviour or cognitive development implies that learning has taken place (Bachkirova et al 2010).

Considering how students are currently supported within health and social care either term, 'coaching' or 'mentoring', could be applied effectively to the practice areas. Figure 1.4 could be describing either coaching or mentoring.

Garvey (2010) states that mentoring has a longer tradition than coaching but both approaches share many of the same practices and values, as seen in this section. Garvey suggests that, in the end, the choice of term is determined by the meaning associated with that term. Meanings are dependent on the social context, so it is obvious that mentoring and coaching will mean different things to different people in different contexts, especially as coaching was originally derived from mentoring. For example, the NHS Education for Scotland (NES 2011) report on two support roles – a named mentor and a clinical coach, for nurses and midwives undertaking early clinical careers fellowships. The fellowships are designed to identify talented, newly

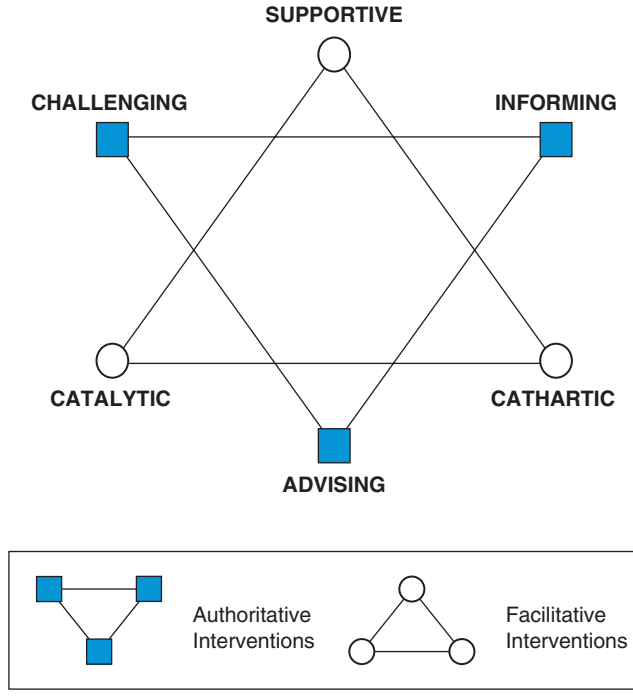


Figure 1.4 Helping interventions in mentoring and coaching. (Based on Heron 1975.)

qualified nurses and midwives so that their skills can be developed and hence their careers. The role of the mentor in each clinical area is to support the nurse or midwife as she or he progresses through the programme. NES also state that, once the programme is completed, the mentor will continue to support the practitioner to develop confidence in her or his day-to-day clinical practice. The clinical coach is an expert/advanced nurse or midwife who is clinically based and located outwith the practitioner's clinical area. The role of the coach is to:

- support and challenge the practitioner in the development of their clinical leadership skills to facilitate evidence-based practice and improved patient outcomes
- expose the practitioner to wider issues and contexts that relate to the organisation of clinical care at local, NHS board and national levels
- provide career advice as the practitioner progresses through the programme.

This initiative demonstrates very clearly the overlap between the mentor and coach in practice. But, whichever term is used to describe the practitioners who support students in the practice area, it is worth remembering that:

> To be competent students have to be in practice. Students have a right to be in practice. Students have a right to appropriate supervision and support. The public has a right to expect students to be supervised and supported.

Mentoring is a dynamic activity and the form that it takes within a health and social care setting influences its potential for success or failure as a way of developing students. According to Garvey (2010) mentoring has the potential to be either wholly supportive and helpful to students or abusive and manipulative.

Mentoring relationships can be about the exercise of power and control over students. The form that student support used to take – such as 'sitting by Nellie' – had the potential to allow some mentors to abuse the power that they had. Garvey states that this is partly due to the fact that such an ordinary and natural human activity as mentoring and difficulties in human relationships are a normal part of life. Also, genuine practical and structural difficulties contribute to the success or failure of mentoring within health and social care.

The 'sitting by Nellie' model of development characterised the apprenticeship model of learning where students were part of the clinical team and were not seen as having individual learning needs. This approach is described as mentorship by Garvey (2010) but it took the form of the students learning whatever 'Nellie' thought was appropriate or relevant, possibly based on what the mentor knew or thought they knew. Mentors did not feel any obligation or need to increase their knowledge of a practice because they were not challenged by students nor were they in a teaching situation; they merely instructed the student on how to complete a task. The problem with this model is that the student can only ever be as good as 'Nellie'. The student was seen as an empty vessel waiting to be filled by the knowledge that the mentor gave him or her. Every student who was placed in a particular clinical area was expected to be able to complete certain tasks (see Chapter 3).

Education support roles and functions

This chapter concludes with a section that distinguishes some other terms used to describe supporting students' practice learning.

Terms frequently used to describe student support in practice

Preceptor: the Nursing and Midwifery Council (NMC 2008) identified preceptors as registered practitioners with at least 12 months' experience who supported newly qualified practitioners, those returning to practice after a break of 5 years or more, practitioners changing their area of practice and practitioners from other countries. The preceptor, working within the same area as the student, offers support in the form of preceptorship for approximately 4 months. This role emerged from the realisation that going from student to registered practitioner was a major transition that needed support. A famous study by Kramer in 1974 found that there was a

high attrition rate among nurses in the first few months after qualifying. Kramer's study, which was titled 'Reality shock: Why nurses leave nursing', identified conflicting value systems between the aims of pre-registration nurse education and the reality of day-to-day nursing as the main reason for nurses leaving the profession. The NMC (2008) recommend that the preceptor should:

- facilitate the transition or the new practitioner from student to a practitioner who is confident in their practice and sensitive to the needs of the patients and clients and an effective team member
- provide feedback to the new practitioner on aspects of their practice being well performed
- provide feedback on those aspects of the practitioner's practice that are a cause for concern and help the practitioner to develop an action plan to address these
- facilitate the new practitioner to gain knowledge and skills
- be aware of the standards, competencies and objectives set by the employer that the new practitioner is required to achieve and support them in achieving these.

Assessor: used to describe a role that is similar to the mentor but which has a definite assessment component as well.

Clinical educator or practice educator: a role similar to mentor generally used by healthcare professions such as physiotherapy for student learning during practice placements. The Society of Radiographers (see www.sor.org) define the practice educator as the identified practitioner in practice who facilitates students' learning face to face on a daily basis, and generally has responsibility for formative and summative assessments. Within physiotherapy the clinical educator role includes the following:

- Communicating effectively with the student, providing pre-placement information and other recommended information
- Providing the student with an appropriate and practical learning environment
- Demonstrating clinical competence and continuing professional development
- Facilitating the students' learning needs
- Supporting the students' learning needs
- Monitoring student progress, providing regular and constructive feedback
- Assisting the student's set objectives for the placement
- Completing the final assessment report.

Clinical supervisor: this role signifies the provider of peer support to the clinical supervisee within clinical supervision. Clinical supervision is a peer-support role based on a clinically focused professional relationship between a healthcare practitioner and a clinical supervisor. The aim is to improve care and standards, and to develop the practitioner's personal and professional skills and satisfaction. Clinical supervision is an exchange between practising practitioners to enable the

development of professional skills (Bond and Holland 1998). This is usually achieved by the practitioner reflecting on clinical critical incidents, using the clinical supervisor as a professional 'sounding board'.

Practice teacher: this term often refers to a specialist area of practice where the practice teacher supports students undertaking a specialist qualification. A practice teacher is also used within social work for mentoring student social workers during placements.

Facilitator: in this situation the practitioner helps the student to achieve learning objectives. The practitioner uses networking skills to help the student achieve outcomes. Klasen and Clutterbuck (2002) claim that, in this situation, the practitioner tends to instruct the student, meaning that support is directive until the student becomes more knowledgeable.

Counsellor: the objectives in this situation include changing the student's thoughts, beliefs and behaviours. Although the objectives are agreed by both the student and the counsellor, they are strongly influenced by the counsellor.

Summary

This chapter has focused on mentoring as a concept and as a professional role. It has explored the history of mentoring and its influence on how mentorship is currently implemented in health- and social care. The role of the mentor has been examined as well as the characteristics of effective mentors. Effective mentoring, which encompasses effective working relationships, appropriate mentor–student communication and role modelling, has been discussed. The point has been made that students copy the professional behaviour that they see in practice, in some cases whether or not this behaviour is good. This tends to be the case when students are trying to be accepted as part of the clinical team. A mentor's actions are therefore important. The use of case studies has illustrated the importance of students being supported in practice placements.

Post-test questions

Web Resources 1.4: Post-Test Questions

Now that you have completed this chapter it is recommended that you visit the accompanying website and complete the post-test questions. This will assist you in identifying any gaps in your knowledge and reinforcing the elements that you already know.

Please visit the supporting companion website for this book: www.wiley.com/go/mentoring

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