Current mentorship schemes might be doing our students a disservice

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Summary This paper reports on a multi-professional research study, which aimed to explore mentee and mentor perceptions of the mentorship role within nursing, midwifery and medicine. The specific focus of the study was on the conceptualisation of mentoring within the health setting, the factors that influence the mentor–mentee relationship in a positive/negative way, what the professional and personal needs of the mentees are and what are the training and development needs of mentors. This paper will focus on the nursing responses from both questionnaire and interview data highlighted by the responses from the other healthcare professions. The changing nature of the role may be preventing mentors from providing adequate support to students, this is especially relevant in view of the recent concentration on failing students and ensuring trainees are fit for practice at the point of registration. Additionally data suggests that nurse mentors are struggling to fulfil the role with minimal formal support from their work environment, in contrast to other professions.

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Introduction

There can be little doubt that effective mentoring systems benefit individuals. Professional mentor-
mentors own professional development (Watson, 2004). Although considerable attention has been given to the benefits of mentorship, equally poor mentorship can bring long lasting consequences for those being mentored. The impact of poor mentorship has been cited in a range of studies/student testimonials (Neary, 1997; Gray and Smith, 2000; Spouse, 1996; Duffy, 2004).

Background

The classical definitions and formulations of mentoring involve two adults being drawn together naturally with an underlying premise of trust (Morton-Cooper and Palmer, 2000). Traditionally mentees chose their mentor, to ensure matching of personality and ability to work in a close relationship. This original portrayal of mentorship has now altered and adopted varying guises. Currently health and social care professionals have differing professional requirements of the mentor relationship. Formal mentorship was introduced within nursing in the United Kingdom (UK) with the inception of Project 2000, a new form of education introduced in 1986, which aimed to change nurse education from an ‘apprenticeship’ model whereby students learnt their skills on the ‘job’ as employees of the National Health Service, to create self-directed autonomous practitioners, based on supernumery status (UKCC, 1986) and placed all directed autonomous practitioners, based on requirements of the National Health Service, to create self-directed autonomous practitioners, based on supernumery status (UKCC, 1986). Mentors were required to nurture and teach nursing students, it was not binding on practitioners or institutions until the inception of the UKCC Project 2000. The effect of this change resulted in an imposed role/requirement on practitioners who have a specific professional qualification and associated responsibilities for the support, supervision and assessment of the student in practice learning.

More recently a new model of nurse education ‘Making a Difference’ has been introduced to address the professional deficits identified in Fitness for Practice (UKCC, 1999) that newly qualified nurses do not possess the practice skills expected of them by employers. The mentor role until recently has not currently demanded protected time, any remuneration or any additional status. Other professionals have varying roles, with mentoring carrying a number of titles including, practice teacher, practice educator, clinical educator, educational supervisor and facilitator. Currently allied health professional bodies are considering accreditation for qualified professionals who undertake assessment of practice (Foster-Turner, 2006). There are differences between professions and the conceptualization of the mentor role, these raise a number of challenges for all professional bodies currently engaged in debates around standards for mentorship. Currently health and social care professional bodies are seeking to understand the mentorship role to meet the needs of a multi-skilled workforce (Marshall et al., 2004).

The Nursing and Midwifery Council’s (NMC) own quality assurance activities have identified issues relating to practice learning and demands on mentors for supervising and assessing students in practice (NMC, 2005). To better ensure fitness for practice at the point of registration the NMC (2006) have agreed mandatory standards to support learning and assessment in practice, expressed through the developmental framework for personal and professional development underpinned by mandatory requirements for each part of the register (NMC, 2006). The standard reflects significant support for protected time for mentors to function adequately in their role, not least to strengthen their judgment in assessment to ensure fitness for practice. Whilst public protection is every professional’s responsibility, the enforcement of the role of assessor in the mentorship role poses further challenges for the mentor and student in the learning and assessment relationship (Bray and Nettleton, in press).

Coupled with the emerging inter-professional practice learning agenda and the rigorous standards required of the regulatory bodies and Commissioners as well as educational partners and service and workforce needs it seems prudent at this juncture of policy development that mentor roles, require serious consideration for separate models for mentoring and assessing functions. The differing skill mix and learning needs of a diverse workforce and the impact of other students who are gaining clinical experience undergoing different service driven mentorship schemes in an already overburdened clinical environment may well serve to exacerbate the conflicts that prevail in current mentorship schemes. The dual role of mentor and assessor (which is contrary to the values and principles of the traditional models of mentorship) may well require separation as a means of reducing the conflicts within the supportive role of the mentor (Baley et al., 2004).

The distortion of the actual meaning of mentoring can in part, be attributed to the lack of clarity over the past few decades, various directives lacked a conscientious definition of the role and function of the mentor. The workload of mentors, the perceptions that mentors are reluctant to fail
students in practice and increasing numbers of students in practice areas, could result in students not having their learning needs met, coupled with lower satisfaction for mentors.

Method

Previous publication relating to this research study describe the methods used (Bray and Nettleton, in press), but focus on different aspects and findings relating to the mentorship role.

The research was designed from the outset to involve two complementary phases of data collection which focussed on; the conceptualisation of mentoring within the health setting, the factors that influence the mentor–mentee relationship in a positive/negative way, what the professional and personal needs of the mentees are and what are the training and development needs of mentors.

Questionnaires

Consultation with practitioners and the existing literature informed the design of a two-page questionnaire, which was pre-tested with five healthcare professionals and five pre-registration students prior to distribution. The postal questionnaire was distributed to mentors, in five acute trusts within the North West of England. A separate questionnaire was distributed to mentees, (in their third year of training at Edge Hill University and at house officer level within the medical training programme) during taught sessions in their training course. The distribution and response rates for the three professions are provided in Table 1.

The questionnaire involved both closed and open questions and was returned anonymously by post to the research team. Closed, quantitative questions were analysed descriptively using SPSS 11.5 and open-ended responses from the questionnaires were analysed by content analysis.

Semi-structured interviews

Respondents were asked at the end of the questionnaire to self-select to take part in a further semi-structured interview. Respondents were provided with the choice of telephone, face-to-face or email interview, the majority of respondents chose a telephone interview as this was seen as the most convenient method. It was hoped this qualitative approach would enable the topic to be further investigated and findings from the questionnaires to be explored. The interview schedule used, allowed for flexibility during the process and all interviews were conducted by the same researcher. The telephone interviews lasted between 20 and 60 min. Mentors and mentees were interviewed from all three professions but the focus of this paper will be on the twenty nursing mentor and mentees interviewed. The 37 telephone interviews from within the nursing profession, were recorded, transcribed and analysed using the principles of framework analysis (Ritchie & Lewis, 2003), the three responses via the internet were subjected to the same analytical procedures. The codes and categories resulting from analysis were independently created and verified by two members of the research team.

The Local Research Ethics Committee granted ethical approval and full research governance guidelines were adhered to. The process of gaining the necessary approvals for all sites involved took approximately seven months.

Findings

Due to limitations in wordage, descriptive statistics will be presented from all three health care professions but qualitative interview data are drawn exclusively from the interviews with nurse mentors and mentees. The study highlighted many themes relating to mentoring, some of these findings will be published separately; the results in this paper

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will focus on data relating to the recognition of the mentor role, improving the mentoring system and the allocation of mentors. Different themes which arose from the research study have been described separately (Bray and Nettleton, in press). It is important to note that both the mentors and mentees discuss similar themes and although certain topics were defined by the interview and questionnaire format, participants were encouraged to discuss the topics of most importance to them.

Mentor findings

Value of being a mentor

Mentors were prompted on the questionnaire to answer how their mentor role was recognised within their workplace. Most nursing respondents gained minimal recognition or reward, with the mentor role being seen as part of their job description (41%, n = 45) or existing role (15%, n = 17) (Graph 1). Only a few respondents felt that the responsibility awarded any status (12%, n = 13) or recognition (8%, n = 9).

Within the other professions a similar picture is represented, 50% (n = 11) of medical mentors report that the role is not recognised and 33% (n = 7) state that it is an expected part of their job. Midwives reported that being a mentor was an expected part of their job (45%, n = 14) and that it was not recognised in their workplace (39%, n = 12).

In the interviews nursing mentors were questioned as to how rewarding the role of the mentor was and how valued they thought it was within the nursing profession. The nurses reported little formal appreciation of the role, although 'Agenda for Change' was discussed in relation to possible recognition by several staff members.

"You don’t really get any reward professionally, well you might do on the agenda for change now, because it is in your knowledge and skills framework and it is what you are doing on the job". (Respondent = 1)

"I think you are valued more by students than by the college because then the students get to learn more in practise if they are actually put with somebody on the ward instead of just saying "go with anybody on the ward". They are actually with one person and they learn more from that one person than getting loads of mixed conflicts from others". (Respondent = 28)

"I think the idea (of mentoring) is highly valued, but you make it up to what you can. I think some people don’t make enough of it and some people use it very effectively to maximum benefit for everyone, but the word mentorship and the concept of mentorship is valuable but it is not always put into practice properly I think". (Respondent = 9)

The mentors recognised the inconsistencies, which can exist within the mentoring system and how local practices can vary within the profession.

Choosing to be a mentor

Nursing mentors were asked to discuss why they became a mentor in their clinical role. Respondents identified aspects including it being expected of them and a role that they had little choice in selecting, even though most reported that they were happy to undertake this responsibility.

"(I became a mentor) (a) because it is expected of me, is the first one, but that is not the most important one (b) is because I feel that I have an awful lot of experience I feel that I can pass on to others and help them avoid pitfalls and help them to reflect on things that they have done or things that have happened and try and get something positive out of that experience". (Respondent = 6)

"To be honest, it is expected anyway as part of the job, you are nominated when you are a staff nurse, and if it is something that you don’t mind doing that’s great, which I didn’t mind doing it but people are nominated routinely anyway because of the volume of students that are coming through and for the majority of time the staff nurses are happy to do that". (Respondent = 9)

"I had no choice I don’t think. I think it was just a case that as my experience grew on the ward, it was put to me that I would be involved in assessing
students and then just took on the role of mentor as expected I think, more than anything’. (Respondent = 13)

These comments support data from mentees discussed later in this paper, emphasising the perceived benefit gained from being able to choose the role of a mentor.

**Improving the system-mentor perceptions**

Mentors were asked on the questionnaire in an open-answer format, from their experience what would improve the mentoring process for both students and mentors. Within nursing, time was identified as the factor most needing to be addressed (39%, \( n = 43 \)), followed by increased Higher Education Institution (HEI) input (15%, \( n = 17 \)) and training and updates for mentors (17%, \( n = 19 \)) Graph 2.

In other health care professions, findings reflected those from nursing. Within midwifery 64% (\( n = 20 \)) of those answering the question reported that more time was needed to fulfil the role, followed by 12% (\( n = 4 \)) reporting a need for increased training. Within medicine dedicated time was most frequently recognised as being of importance (46%, \( n = 10 \)) followed by the need for improved paperwork (19%, \( n = 4 \)).

During the interviews the nursing mentors were asked to comment on what would improve the mentoring process from their perspective. Reflective of the questionnaire data, time was discussed as a barrier to carrying out the role of mentor.

"I think probably more staff always helps, more time, less demands on your time”. (Respondent = 27)

"I think it comes down to staff time. I’d like to have a bit more time with them on the first days, having a set up time to do it, but with the way the ward staff is at the moment, there is no chance because we are 3 or 4 staff nurses down, so it is all hands to the pump, so unfortunately it is a terrible things to say, but it is not as good as when I was a student, I can see that definitely”. (Respondent = 5)

"Time (is the main challenge). The thing is I’m not on the ward as often as I was and so I find that with students now maybe they are not getting as much of me as they used to. Maybe they think that is a good thing, I don’t know”. (Respondent = 6)

Mentors also discussed how due to increasing workloads and challenges to their time – mentoring was often denigrated due to other commitments.

"It (mentoring) has to come way down now (compared to my clinical workload). I wish it didn’t but it does because of the problems and things I’ve got, especially now at this moment in time”. (Respondent = 4)

"Just time really, it is always the time factor and I’d love to do more proper teaching with them but your priority is always your patient and sometimes with the best will in the world you will plan a supernumerary day but then someone will ring in sick, so it is just the time factor but if you invest time in them first, they are learning on the job more effectively anyway”. (Respondent = 9)

**Mentee findings**

**Improving the system**

Mentees were asked on the questionnaire in an open-answer format, from their experience, what would improve the mentoring process. As previously with the nursing mentors, time (26%, \( n = 45 \)) was identified as an important factor, which needed addressing, followed by increased awareness of the students training (22%, \( n = 38 \)) and the need for mentors to choose their role voluntarily (15%, \( n = 26 \)) Graph 3.

These findings reflect those from other professions, with 36% (\( n = 25 \)) of medical mentees commenting that increased time and contact with their mentors would improve the process, followed by a clearer role definition (20%, \( n = 14 \)), mentor education (15%, \( n = 10 \)) and mentoring being a voluntary role (10%, \( n = 7 \)). Within midwifery the
The most prevalent improvement related to mentors having an increased awareness of training (39%, n = 11), increased communication between Higher Education Institution (HEI) and placements (17%, n = 5) and mentors role being voluntary (13%, n = 4).

The nursing mentees were asked to discuss during the semi-structured interviews, what changes could be made to the current mentoring system to improve the current situation. Many respondents discussed that being a mentor should be adopted as a voluntary role, with them expressing that they felt that many had been forced into the role.

"I think that mentors should be allowed to choose if they want to do it. I think most of them were railroaded into doing it, it was a case of they were told that was what was going to happen and they had to do it". (Respondent = 16)

"If you are going to do the training to be a mentor you’ve got to want to be a mentor. It is no good doing the mentorship and then really not wanting to do it. It didn’t happen in my case, but I know a couple of cases where students have gone on to the ward and they’ve said "you are my mentor" and they go "oh am I, I didn’t know". That didn’t happen to me but some want a be a mentor and some don’t and it is not nice if you get someone and they are having a bad time and they’ve got no time for you and things like that". (Respondent = 17)

"Somebody who is willing to do mentoring. I think that stands out and somebody who knows what they ought to be doing with the students. They are aware of the learning outcomes, they are aware of the competencies that you are trying to reach". (Respondent = 24)

"The impression I get is that some mentors are forced into mentoring because they are a certain grade and the ward feels as that is the next step and they have to be a mentor because it is part of their job description and they probably don’t actually want to be one. So I think if somebody is forced into doing it they are never going to give 100% because it is not something they want to do". (Respondent = 26)

**Discussion**

The role of the mentor covers a range of activities, it is argued that with the increasing emphasis on assessment, there is now a real risk that the essential meaning of mentorship has been diluted and a valuable concept devalued with a lost opportunity to tailor mentorship schemes as they were originally intended.

The integration of important support mechanisms for both students and qualified staff including clinical supervision, preceptorship and mentorship have been adopted to varying extents across the wider healthcare setting and confusion still prevails regarding their appropriate implementation. The literature and findings from this research highlight the lack of support often received by mentors to enable them to carry out their role effectively within clinical practice. They identify lack of time as a major constraint and also feel that the important responsibility of the role is not currently recognised either in remuneration or status. This supports previous research which has highlighted that identifying time for undertaking mentoring activities as being a significant factor in the undertaking of the role (Phillips et al., 2000). Regulatory changes to provide protected time for mentoring will enable enhanced relationships between mentor and student, and will increase the sense of worth of mentors undertaking this vital role (NMC, 2006). It is recognised that this allocation of time will have practical staffing issues for trusts. It is noted that other professions such as education provide financial reward and social care roles can include a time commitment to professionals adopting the role of mentor (Morton-Cooper and Palmer, 2000). This inconsistency in the implementation of the role will have an impact on professionals with the growing enthusiasm for inter-professional education (DOH, 2000).
It is recognised by some that many trusts have failed to recognise mentorship as a priority for investment making it difficult for mentors to undertake mentorship training and updates (Jones, 2005). This coupled with the overstretched clinical areas, students without mentors, and demands for placement capacity in already oversubscribed clinical areas, poses a real challenge to find sufficient and appropriate trained mentors who can meet the NMC standards to support learning and assessment to practice. The need to provide numerical data to support organisational initiatives and performance targets focussing on the percentage of staff receiving mentorship qualifications and all mentees allocated a mentor, exacerbates the often limited thought given to the nature and type of mentorship schemes adopted (Clutterbuck, 2003). The need to achieve such goals can result in mentorship programmes being implemented with unsuspecting and sometimes unsuitable individuals without recognition of ability or deficiency. As highlighted by this research, some mentors have not chosen to undertake the role and some students have experienced nurses who do not perform the role adequately to support their learning. It has been identified by those involved in this study that pressures of workload and increased responsibility can mean that time is not available to undergo updates on new student training, creating mentors who are not meeting the new NMC mentor standards. As students spend at least fifty percent of their programme in practice, it is vital that there are appropriate criteria for mentorship selection and systems in place to support their learning and well-being.

It is felt that a supportive mechanism has been lost by the integration and conception of the dual role of assessor and mentor. This is most evident in the support received by students who may be struggling through their placements. If the mentor role was conducted as originally intended and students could choose their mentors and the role of assessor was assigned to them, this would allow for improved relationships and increased opportunities for the pastoral aspects of mentorship. With the recent increased awareness of the need to identify ‘failing students’ throughout training to prevent nurses qualifying with minimal or poor clinical skills the support mechanisms in clinical practice need to be improved and clearly defined. It is described that there is insufficient evidence to demonstrate whether freedom to choose or forced matching of mentor provides the best method for assigning mentees (Morton-Cooper and Palmer, 2000). Despite this many respondents in this research, both mentors and mentees, identified that mentoring being a voluntary role would improve the process. This sentiment is mirrored in research, which demonstrated that many mentors felt the role had been imposed upon them and there was a lack of choice (Andrews and Chilton, 2000). The traditional notion of a mentor supplying pastoral and long-term support is now in contrast to the short placement assessment role, which now dominates health care.

Conclusion

It is recognised that this study has limitations regarding response rates and geographical coverage, which may influence the wider applicability of findings. The aim of the article is to add to the current body of knowledge regarding mentorship in the changing context of healthcare. The findings from this study highlight concerns felt within health care practice that current provision and support for the mentoring relationship is insufficient. There is a lack of recognition of the importance of the mentor role, resulting in a poor commitment for time and resources with this creating a relationship which in some cases is not supportive or beneficial for either the mentor or mentee.

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References

United Kingdom Central Council 1999. Fitness for Practice: the UKCC Commission for Nursing and midwifery Education: UKCC.