



Mentorship in the health disciplines

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Abstract

Learning outcomes:

On completion of this continuing professional development (CPD) activity, participants will be able to:

- identify strategies to support undergraduate students and new staff working in a supernumerary role;
- define the roles and responsibilities of the mentor and mentee;
- identify key attributes of successful mentors;
- discuss the stages of the mentor–mentee relationship and the key elements of each;
- describe a suitable strategy for engaging mentees and developing a mutually beneficial mentor–mentee partnership;
- enable staff to reflect on their current approaches to providing feedback to mentees and identify areas that may require change; and
- identify barriers to a successful mentor–mentee relationship;

Keywords

Mentoring, continuing professional development, education.



This continuing professional development paper is supplemented by a podcast on the NEN e-learning portal ONE. Go to <http://nen.moodle.com.au/login/index.php> and listen to Peter Sinclair speak with Laurie Bickhoff and Professor Tracy Levett-Jones about mentoring in the health disciplines

Introduction

Historically, mentoring evolved from Greek mythology during the Trojan War when Odysseus entrusted the care of his son to his comrade 'Mentor' to protect, guide and teach him (Ray, 2012). In health care, mentorship has evolved into a complex and multi-dimensional partnership between the mentor and mentee. Mentoring plays an integral role in the development of health care professionals, and has a positive impact on staff recruitment, satisfaction and retention (Bennett & McGowan, 2014; Kanaskie, 2006).

Mentorship is a broad concept and is generally related to personal and professional development in the long term. Alternatively the term preceptorship is used to describe a short-term relationship that focuses on the development of clinical skills and socialisation of students and new staff into the workforce (Huybrecht, Loeckx, Quaeysaegens, De Tobel, & Mistian, 2011; Mills, Francis & Bonner, 2005). Rightly or wrongly, the terms mentor and preceptor are sometimes used interchangeably and there is often regional variation in their use. For the purposes of this paper, we will use the term mentor to

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refer to any person who works with an undergraduate student or new staff member during their supernumerary period of employment. Therefore in this context, the relationship is short term, lasting for any period up to six weeks. During this time period there are four phases that the relationship generally moves through: preparing, negotiating, enabling and closure (Zachary, 2011). This continuing professional development (CPD) paper will identify key areas for mentors to consider during each of these phases and provide associated practice points. To this end, readers can reflect on their current abilities and approach to mentorship and to consider ways in which they can improve.

The role of a mentor is central to the professional development of the learner and facilitates the application of theory into practice, while increasing their clinical and professional competence (Myall, Levett-Jones & Lathlean, 2008). Depending on the context, this relationship can be formal or informal and is based on the principles of reciprocity, mutual trust and respect. The mentor relationship is primarily about identifying and supporting the potential in the mentee. Regardless of whether the relationship is short or long term, the mentee is responsible for identifying goal-related outcomes and the mentor for facilitating these. In long-term relationships these goals will evolve over time; however, in short-term relationships, for example with students or supernumerary periods for new staff, goals will be more focused around skill acquisition and often require a specific form of evaluation or assessment.

A positive clinical environment sets the foundation for a positive learning environment (Henderson, Briggs, Schoonbeek & Paterson, 2011). Providing mentees with learning opportunities as they arise increases satisfaction, reduces mentor dependence and provides a sense of belonging within the workplace (Myall, Levett-Jones and Lathlean, 2008). This satisfaction boosts learner confidence and their feelings of self-worth and acceptance as a valued team member (Levett-Jones *et al.*, 2009; Bradbury-Jones, Sambrook, & Irvine, 2011; Stapleton *et al.*, 2007). Students and new staff report this notion of belongingness as a crucial facilitator of feeling valued by the health care professionals they work with. This is achieved in part through active support, encouragement, commitment and enthusiasm to the personal and professional development of the mentee. For mentors, taking the time and consideration to connect and relate to the mentee is significant in facilitating their personal and professional growth (Warren, 2010).

Characteristics of good mentors

Ultimately, a good mentor must have the desire to mentor. All too often, undergraduate students are assigned to 'mentors' at the last minute and the literature demonstrates the damage

that can be done to the learning experience when a mentee is assigned to someone who is disinterested or poorly equipped for a mentorship role (Kanaskie, 2006). While not exhaustive, the literature has identified common characteristics shared by quality mentors, these include:

- Consistency, accessibility and continued support.
- Emotional intelligence: the ability to measure one's emotions and be sensitive to the emotions of their mentee.
- Good interpersonal communication skills and the ability to share their knowledge and experiences.
- Tolerance, and the ability to set aside personal bias and be non-judgemental.
- Good teachers who are able to provide timely and constructive feedback, foster critical thinking and provide a variety and appropriate level of challenging learning opportunities.
- Possess inherent personal qualities such as a positive attitude, passion, friendliness, enthusiasm and professional motivation.
- The ability to value and empower the mentee as a learner, team member and individual and consequently imbue mutual respect and trust.
- The ability to set realistic goals and source a variety of learning opportunities.

(Morrell & Ridgway, 2014; Jokelainen, Jamookeeah, Tossavainen & Turunen, 2013; Bradbury-Jones, *et al.*, 2011; Eller, Lev, & Feurer, 2014; Gray & Smith, 2000; Huybrecht *et al.*, 2010).

Handy tips

Tip 1: Set the ground rules for the mentor relationship from the very beginning.

Tip 2: Keep the channels of communication open; the mentor-mentee relationship should be based on mutual trust and respect. Allow the mentee to question practice without fear of discrimination.

Tip 3: Be willing to give constructive feedback that encompasses both the strengths and weaknesses of the mentee.

Tip 4: Be mindful of the adage "failure to fail" and if, during an assessment the circumstances warrant it, you should be prepared to fail a student. This reinforces the expectation of quality in care and reduces the risk of complacency with the assessment process.

Tip 5: Ask questions that promote critical thinking; don't give leading questions or just give answers.

The mentor–mentee relationship

Stage one: Preparation

Preparation is the most critical phase in the mentoring relationship (Zachary, 2011). As the saying goes, first impressions count, and within a few seconds of meeting both parties will have made a judgement about the other (Wood, 2012). You will go a long way in establishing a trusting relationship by the degree of enthusiasm and commitment you demonstrate during your first meeting. Not all mentors will have the absolute characteristic of 'enthusiasm', but mentees will be just as receptive to a calm and measured mentor who shows a genuine interest in the relationship. The preparation phase is largely reflective in nature; it is when both the mentor and mentee reflect on their readiness for the relationship. While this may sound 'academic' and far from practical, the answers to questions like: "Am I in the right frame of mind to commit to this relationship?" or "Do I have the energy to commit 100% to this relationship?" will influence the outcomes and learning experience of the mentee significantly. Therefore, if you are not genuinely committed to being a mentor, please do not enter into a relationship, as significant and long-term damage can be done to mentees by disengaged and/or disinterested mentors (Bradbury-Jones, Sambrook, & Irvine, 2011).

Having mutual respect and an understanding of one another from the outset creates the foundation of a successful mentor–mentee relationship (Masters, 2014). While key personal elements of learning include a motivation to learn and a willingness to accept responsibility for learning, the learning environment (that is, the ward/unit) and the degree to which it welcomes and accepts new staff and students are crucial to facilitating motivation. A mentee who is made to feel that they are not welcome, or a burden, will not be motivated to be an active participant in learning (Levett-Jones & Lathlean, 2007).

Optimal learning is maximised when a mentee is paired with the same mentor(s) for the duration of their placement. This facilitates consistency, particularly in the areas of feedback provision and the development of the mentor–mentee partnership and allows both parties to become familiar with one another and develop confidence around their clinical partnership. Although this sometimes may be challenging, this is a key factor for ensuring success in the mentor–mentee relationship. This illustrates the importance of the preparation stage, where forward planning and organisation are essential, particularly in the area of rostering.

Stage two: Negotiation

As the name suggests, the negotiation phase presents the opportunity for mentors and mentees to discuss how learning will occur and builds on the preparation phase.

Key points to remember during the negotiation phase are highlighted in Table 1.

Table 1: Practice points to consider during stage two of the mentor–mentee relationship

Introduce yourself and the members of the health care team in the ward/unit
Establish the background and experience of the mentee
Define role and expectations of both parties
Clarify and establish the scope of practice permitted by the mentee
Identify learning objectives or a goal framework and time frames for completion
Discuss and outline a clear learning pathway and how the period of relationship will be managed (e.g. will the mentee gradually take a patient load or 'be thrown in the deep end'?).
Discuss and establish clear boundaries
Give the mentee permission to question your practice (being mindful of expectations and boundaries)
Discuss and clarify how feedback will be given and set boundaries relating to patient safety
Establish a 'safe word or phrase' so that the mentee knows when you are concerned about patient safety and wish to take over temporarily without making it obvious to the patient at the time
Identify any other relevant information including training documents and expectations

Stage three: Enabling

The enabling stage builds on your initial assessment in the preparation and negotiation stages, and allows the mentee to gradually apply their theory-based learning into practice. This has been demonstrated to promote self-esteem, confidence and allows the mentee to develop and refine their clinical skills further (Gray & Smith, 2000). As a mentor, you have a great impact on your mentee's progression and should have realistic expectations, facilitate their transition from observer to doer and involve and motivate them to be active participants in care (Gray & Smith, 2000). Furthermore, your role contributes to preparing the mentee for workforce readiness, ensuring they develop competency and confidence in their area of practice (Myall, Levett-Jones & Lathlean, 2007). This is largely accomplished in the enabling stage and with the correct approach, you will develop confidence in your mentee's clinical abilities to the point where supervision is gradually withdrawn. This is known as 'gradual distancing', whereby you gradually

distance yourself from the mentee, enabling them to become more independent as they gain confidence in their practice. This approach enables you to pace your teaching method to match the mentee's needs from observation to participation and promotes a sense of accomplishment in the mentee (Krause-Parello, Sarcone, Samms & Boyd, 2013).

One strategy to consider during the enabling stage includes encouraging your mentee to use a learning journal for the duration of your relationship. You can then use it as a platform to discuss and reflect on progress, achievement of learning objectives and areas that may require further work. Keep a notebook yourself and write down practice points throughout the day to ensure you do not forget areas that you wish to provide feedback on or challenge further learning. The learning journal can be an effective tool to assist in increasing self-esteem and confidence and is a powerful conduit for reflection, knowledge generation and feedback (Epp, 2008). When used correctly, they can assist the mentee to reflect on a particular episode of care and on how well/poorly it was handled. The strengths and limitations in their practice can be identified and learning objectives developed to overcome these and enable them to respond more effectively should a similar situation arise.

Feedback

While good feedback is usually the easiest to deliver, issues can be harder to discuss. This can only occur if the recipient is open and receptive to the feedback given and that it is delivered in a non-threatening and constructive manner. Feedback is a fundamental aspect of mentoring and is used as a tool to raise the mentee's awareness of their behaviour and to remediate concerns and issues (Clynes & Raftery, 2008; Ivers *et al.*, 2012). This is provided that the mentees are willing to modify or improve aspects of their practice when given feedback. The impact and effectiveness of the feedback depends greatly on how it is delivered by the mentor. There are many ways of providing feedback, but most importantly effective feedback must be timely, specific, honest, constructive, supportive, and considerate and direct (Ivers *et al.*, 2012).

Conflict in the relationship can develop where the parties hold different opinions or when there is disagreement over values, ideas, motivations and/or perceptions. Although this may appear trivial, it can trigger strong feelings and a deep personal need is generally at the core of any conflict (Kourkouta & Papathanasiou, 2014). It is important to remember that conflict is a normal component in relationships; however, when

conflict is poorly managed in the workplace it can harm staff relationships and the team environment (Iglesias & Vallejo, 2012). Conflict management is how an individual identifies and handles conflicts efficiently, equally and sensibly, and it is vital that mentors are confident in managing and resolving conflict and are proficient in negotiation, communication and problem-solving skills (Duffy, 2013).

Conflict can be managed by establishing early in the relationship how it will be approached. Ideally, the mentor and mentee should discuss their position on this during the negotiation stage and agree on how to manage conflict if it arises. If any issues do arise, then that original conversation can be used as a benchmark to remember the shared agreement made. The most effective approaches towards resolving conflict include negotiation, collaboration and compromise. An emphasis should be placed on avoiding blame, maintaining a level of respect for all involved, and actively listening to allow alternative solutions to be voiced (Stone, 2012). It is important to remember to keep things in perspective and to avoid escalating an episode or making a bigger problem out of a minor issue (Iglesias & Vallejo, 2012).

For more information about ways to approach conflict see the web link below.

Providing feedback is not limited to the role of a mentor and all staff should be empowered to provide ongoing constructive feedback to support the practice of mentees in the workplace. While many models exist in terms of feedback delivery methods, the acronym CORBS (Table 2) is a good framework with which to guide how you provide feedback (Hawkins & Shohet, 1989).



The Royal College of Physicians and Surgeons of Canada has a good online resource on conflict resolution which debunks some common myths, discusses the importance of communication, emotion and moral distress in conflict resolution. More importantly, it provides some practical management strategies to ensure patient safety is not compromised through the course of conflict. You can access it here via this google short link: <http://goo.gl/XPc7RJ>

Barriers to feedback from either party can prevent its effectiveness and Tables 3 and 4 lists some of the more common characteristics. Review the tables and take a mental note of these barriers. Next time you are providing feedback, consider how you are delivering or your mentee is receiving the feedback. If either of you is displaying any of the characteristics of ineffective feedback it may be worth revisiting the feedback process at a later time or even with a third party.

Table 2: The CORBS acronym for guiding feedback (adapted from Hawkins & Shoheit, 1989)

Clear	Clarity is essential. Ensure you know what feedback you want to deliver before you provide it. Being vague will increase the recipient's anxiety and potentially give mixed messages and damage the mentor relationship.
Owned	'Own' the feedback you give: never give 'second-hand' feedback (i.e. Another RN told me ...). Start your feedback with 'I' statements as this will assist in providing specific feedback rather than leaving the recipient guessing what you actually mean.
Regular	Feedback that is provided regularly is more likely to be beneficial to the learner. Two potential issues may occur if regular feedback is not provided. Firstly, if concerns about practice are delivered late in the relationship, there is a risk that there will be insufficient time to remediate. This does not take into account the patient safety issues, or your duty of care, if you are aware the learner is unsafe and do not act appropriately to rectify this. Secondly, if feedback related to poor practice is left too late, it may have lasting effects on learner confidence, especially if large amounts of feedback are delivered simultaneously. Always aim to provide feedback as close to the event as possible. This will enable the learner to establish goals for improving practice in a timely manner where required. If the feedback you want to deliver is positive in nature, do not just say "Well done today". Be specific about what they did well and always aim to provide some sort of positive feedback at the end of each day; this will do wonders for their confidence and self-esteem.
Balanced	It is good to balance negative and positive feedback and if you find that the feedback you give to any individual is always either positive or negative, this probably means your view is distorted in some way. This does not mean that each piece of critical feedback must always be accompanied by something positive, but rather a balance should be created over time.
Specific	It is difficult to learn from feedback that is generalised. This applies to positive and negative feedback. Comments like "You don't stop to think before charging into a task" are ambiguous, lack specificity and potentially damage the mentor relationship and make the mentee less responsive to any feedback delivered. The mentee will understand the feedback better if you are specific and provide rationale for the feedback including the impact the practice or event had. Before providing feedback it is always good practice to ask the mentee to recall the event and ask them "Tell me about the dressing you did on Mrs Smith's venous leg ulcer". This will give the mentee the opportunity to reflect on what happened and through the use of open-ended questioning you may be able to assist them to unpack some of the issues which may prevent you from having to deliver feedback in the first place. This is good way to further demonstrate your commitment to the mentees development. If the situation requires it, for example you are very time poor, and you do need to be more directed with feedback, ensure you identify the situation, what happened and what the impact was. To illustrate "When you were doing Mrs Smith's central line dressing, you had to leave the room three times to get additional equipment to complete the dressing, this added about 5 minutes to the time it took to complete the dressing and also meant that the sterile field was left exposed for longer than was necessary. This is an element of your time management that you will need to address. What would you do differently next time you need to do a dressing?"

Table 3: Effective and ineffective feedback: mentor as deliverer

Effective and ineffective feedback	
Effective feedback (mentor)	Ineffective feedback (mentor)
Supportive	Attacking
Clear	Judgemental
Sensitive	Lack of respect
Considerate	Patronising
Owned & Specific	Superficial
Regular & healthy timing	Demearing
Thoughtful	Poor timing &/or location
Acceptance	Attacking
Active engagement	Closed
Authentic & Balanced	Defensive

Table 4: Effective and ineffective feedback: mentee as receiver

Effective and ineffective feedback	
Effective feedback (mentee)	Ineffective feedback (mentee)
Acceptance	Attacking
Active engagement with process	Closed
Authentic	Defensiveness
Open	Denial
Reflective	Lack of respect
Respectful	Passivity
Responsive	Rationalisation

Stage four: Closure

The end of the mentoring process is sometimes met with mixed feelings. While the closure of the relationship is inevitable, it is important to ensure that long-term dependence or co-dependent relationships do not form. As discussed previously, mentoring is a goal-orientated process, consequently, stage four is characterised by reviewing learning outcomes and goals as identified in stage two and delivering honest feedback about the mentee's performance and strategies for continued development. Mentors should ensure that they allow sufficient time for this process and an opportunity for mentees to ask any follow up questions or to seek clarification of feedback. Remember that there is no benefit in providing feedback about poor performance at the end of the mentor–mentee relationship. Feedback at the closure stage should be more focused on overall progression and speaking with the mentee about longer term goals and areas that they can continue to work on in the future.

Conclusion

Mentors play a vital role in the education of future health care professionals and the way in which they approach this role significantly impacts the quality of the mentee's learning experience. A good mentor–mentee relationship has a positive impact on satisfaction and performance and should be a crucial component of any organisation's staff retention strategy (Bennett & McGowan, 2014). Mentors have the privilege and responsibility of supporting students and new staff in their professional development. Your commitment should in turn be valued and respected by the mentees and organisations for which you work. Ultimately, today's mentees are tomorrow's colleagues and it is important for everyone that we get the mentor–mentee process right.

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