

How to use coaching and action learning to support mentors in the workplace

Mentoring student nurses can be challenging. Clear strategies and a supportive environment can help to ensure student-mentor relationships are effective

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Using the example of mentoring preregistration student nurses, this article explores facilitation of learning in the workplace and examines the use of coaching and action learning to support mentors and the wider clinical team. A case study, where a mentor has difficulties with an underperforming student, is considered.

Action learning and coaching are then explored, with the aim of maximising personal and team learning. These strategies can be easily transferred to other work based learning situations.

MENTORSHIP IN PREREGISTRATION NURSING EDUCATION

A main aspect of the Nursing and Midwifery Council's role is to set and maintain standards of education. The standards to support learning and assessment in practice were published in 2006 and updated two years later (NMC, 2008) to take into account wider policy developments.

In particular, the updated standards aim to ensure adherence to the NMC (2009) equality and diversity scheme.

In response to concerns over nurses' competency at the point of registration and having raised some issues about mentors' role with failing students, they offer clearer guidance about the "sign-off" mentor role. They outline the requirement for local mentor registers and the necessity for ongoing records of achievement to follow students as they move from one placement to another.

The standards state that student nurses on NMC approved preregistration programmes must be supported and assessed by mentors who have completed an NMC approved mentorship programme. Since September 2007, sign-off mentors – who have met additional criteria – have been responsible for confirming that students in final placements have met the required competencies for entry to the register.

The standards outline a framework to support learning and assessment in practice, comprising eight domains with developmental stages, reflecting mentor, practice teacher and teacher levels:

- Establishing effective working relationships;
- Facilitating learning;
- Assessment and accountability;
- Evaluating learning;
- Creating an environment for learning;
- Context of practice;
- Evidence based practice;
- Leadership (NMC, 2008).

Placement providers keep a local register of mentors and practice teachers, including those designated as "sign-off" mentors. To remain on this register, mentors and practice teachers must demonstrate updated knowledge, skills and competence (the triennial review); for mentors, this includes having mentored at least two students over the past three years and having attended annual mentor updates.

Nurses and midwives making judgements about students' proficiency must adhere to five principles (NMC, 2008). They must:

- Be on the same part of the register as the student they are assessing;
- Have developed their personal skills and competence beyond initial registration level;
- Hold professional qualifications at an equivalent or higher level than the students they are supporting and assessing;
- Have been prepared for their role as mentor, practice teacher or teacher;
- Hold an approved teacher qualification that may be recorded on the NMC register.

PRACTICE POINTS

- Work based learning is fundamental to improving individual and team effectiveness and patient care.
- Effective mentorship is crucial to enable preregistration student nurses to develop their professional and clinical skills.
- Barriers to effective work based learning will adversely affect the development of competent practitioners.
- Coaching and action learning can help clinical teams to learn from experience and improve future practice.

ENABLING GOOD MENTORSHIP

Much of the literature focuses on the mentor-student relationship, including mentors' qualities and characteristics. The relationship is seen as close and by some as quite intense (Morton-Cooper and Palmer, 2000), with the best characterised as a learning partnership based on mutual respect (McCarthy and Murphy, 2008).

The literature agrees that while effective mentorship is crucial to developing student nurses' professional abilities, it is a challenging role, not least because there is no protected time, except in students' final placements (NMC, 2008).

Nonetheless, the standards require all preregistration student nurses to be allocated an appropriately qualified, named mentor who must commit to directly or indirectly supervising 40% of students' time in clinical practice. While 40% may seem a rather minimal standard, students must be supervised at all times while in practice, but this responsibility may be shared among the wider clinical team. However, unlike the resourcing of supervision for other healthcare professions, this is incorporated into registered nurses' role, which suggests little value is attributed to the role or that there is minimal acknowledgement of the time required for

effective supervision (Mulholland et al, 2005).

The impact of the 40% rule is that time to support students in work based learning is likely to be at a premium as their needs will inevitably take second place to clinical demands. Similarly, any educational role is difficult to accommodate given the high acuity of care in many clinical placements. Both student learning and support for facilitators may suffer.

It is important that clinical leaders acknowledge and support time for essential development activities such as coaching and action learning. By taking time for reflective practice and individual development, quality of care can be enhanced.

MENTORSHIP AND INTERPERSONAL SKILLS

Personal communication skills are important, but only part of the picture in effective mentorship.

Cope and Cuthbertson (2000) identified that a significant part of a mentor's role was to orientate students to the social and professional norms of the practice community. For example, mentors can help students adjust to employers' expectations, such as arriving on time and being appropriately dressed.

Furthermore, literature on attrition indicates that first year students in particular may leave if they do not feel part of the clinical team (Department of Health, 2006). Mentors can be vital in introducing and including students in the wider nursing and healthcare team.

Wilson-Barnett et al (1995) identified that students wanted "good team spirit" to help orient them to new placements. Interestingly, Gray and Smith (2000) found a perception that poor mentors were people who "did not fit in" and were disliked by other members of the team.

Some research highlights personal factors in forming relationships, although it is obvious that some mentors will not like some students and vice versa. The assumption is that, as professionals and aspiring professionals, they will rise above such considerations. However, Gray and Smith (2000) found that students perceived that poor mentors disliked their jobs and/or students and were distant, less friendly and unapproachable.

OBSTACLES TO GOOD MENTORSHIP

Organisational constraints

Organisational constraints can be an obstacle to effective mentoring. Work

pressures can result in conflicting roles and responsibilities regarding patient care versus student support. Ideally, the two should be combined but time out to reflect, even briefly, on activities is essential. However, teaching care skills can take longer than completing care oneself.

Nonetheless, if students and mentors are not rostered to work together regularly, it can be difficult for mentors to judge students' developing competence and confidence over the placement. Continuity of supervision is the reasoning behind the 40% rule but this must be facilitated and supported in daily practice.

Part-time workers can find this problematic but this can be overcome by linking them with another mentor to offer team mentorship, which also offers students the benefit of expertise from two practitioners.

Finding time, particularly to provide reflection and feedback, can be challenging but must not be viewed as optional; a lack of feedback is a significant barrier to learning and leads to considerable frustration for students.

An evaluation by Scammell et al (2007) indicated that students did not want to simply hear they were "doing fine" but wanted to know:

- In what way were they "doing fine"?
- How could they improve?
- What were they not doing well?

This is the same for any practitioner at any level – providing constructive feedback is essential for their continuous professional development.

Effective working relationships

Poor working relationships in the form of personality clashes can be a barrier to effective mentoring. Ideally, these should be worked through, since nurses cannot choose who they work with or care for.

The learning environment should be such that students or mentors can discuss these issues with a clinical leader or practice based teacher to find a resolution.

Unfortunately, many clinical areas have difficulty in recruiting enough mentors to support the students on placement. This means that some registered nurses who do not want to take on the role may be required to do so by their organisation. However, as indicated earlier, students soon pick up a lack of interest from mentors and may feel not only unsupported but also unable to maximise learning through questioning and shadowing activities.

Accountable practice demands that all practitioners are open about their strengths and areas of concern. In a supportive clinical team, mentorship in this situation may be shared, while reluctant mentors should be encouraged to share their difficulties with a clinical supervisor and be coached to address these. Education of junior staff – students or otherwise – is, after all, part of registered nurses' role.

Personality clashes can affect other supervisory relationships. For example, some participants in clinical supervision want to choose their supervisor or the colleagues they work with in action learning. This may not always be possible but this situation can provide the ideal arena to practise giving constructive feedback and to develop relationships with the supervisor or facilitator who was not their choice. However, this opportunity is often missed because of intransigence or unwillingness to participate in a group where they have been unable to choose their supervisor/facilitator.

As stated earlier, this mirrors the workplace where nurses cannot choose colleagues, leaders, managers and patients to work with, but nonetheless need to be able to develop skills and the ability to form good and effective working relationships. Where better to do this than in a supervision group, where this can be explored safely with the challenge and support of facilitator and peers?

Equality and diversity

One further issue that may inhibit effective mentoring relationships is discomfort surrounding equality and diversity issues between mentor and student.

Reflecting policy developments in this area, the updated standards (NMC, 2008) require mentors, practice teachers and teachers to promote equality of opportunity regardless of race, gender or disability and to prevent intentional or unintentional discrimination. However, this is challenging if any individuals have difficulty in responding constructively to those they perceive as different.

Thomas (2001) referred to "protective hesitation" in describing the problems in cross-race mentoring relationships of raising potentially difficult issues, where they are often not tackled to avoid accusations of prejudice. This issue is evident in the case study, adding another challenging dimension to concerns about an underperforming student.

BOX 1. A MENTORING CASE STUDY

Sonya* is an adult branch student who has recently started her third year. She is about to start the fourth week of a six week hospital based placement.

Her mentor, Gino*, met with her on her first day to discuss her experience, set personal learning objectives and develop an action plan to help Sonya meet the practice assessment requirements for the placement. Gino felt Sonya seemed a little uninterested but put this down to first day nerves. Gino and Sonya were scheduled to work the same shifts.

Gino, who trained overseas, has been a qualified mentor for one year. Sonya's mid-placement interview is overdue. Gino has some concerns and is unsure how to tackle them. He has approached a colleague who tells him he is worrying too much as Sonya still has time to improve. Gino's concerns are:

- Out of 15 shifts over three weeks, Sonya has been off sick on four separate occasions and, on the first two, she failed to notify the ward team;
- She has been late arriving on duty for most shifts;
- Sonya has changed her shifts without Gino's knowledge, resulting in them not working together for the last two weeks;
- She has been asking other mentors to sign her assessment documents instead of Gino and colleagues have done so;
- Gino has noticed that Sonya seems to be off hand with people who have difficulty communicating, notably those with hearing problems and limited English language abilities, and is tending to shout and look annoyed.

*Names have been changed.

UNDERPERFORMING LEARNERS

Duffy (2003) identified that weak students tend to have poor interpersonal skills, are uninterested in practice learning and are frequently late, and lack personal insight and awareness of professional boundaries.

Duffy said that early intervention is essential; if mentors or members of the clinical team notice an issue or concern about students, time must be made to discuss it. There may be other pressures affecting performance and these mitigating circumstances may need to be taken into account. Regardless of these, performance must meet the required standard.

It is important to encourage students to express their feelings about the placement and to highlight any concerns. Realistic expectations in line with their set learning outcomes have to be made clear so they know what to aim for and how to achieve them. Ideally, by working together, appropriate action plans and realistic goals can be developed to improve performance. However, situations are frequently confounded by other factors, as the case study illustrates (Box 1).

ISSUES AND ACTIONS

Clearly, Sonya is underperforming in a number of ways. There may well be reasons for this and some important first steps have been taken.

Gino met with Sonya at the start of the placement and developed an action plan. This gives him a baseline from which to judge future performance. Unfortunately,

because of heavy workload pressures, this meeting was not documented so is subject to memory distortion, although the learning objectives were recorded.

Gino feels out of his depth and has sought support from a colleague. However, the advice is inappropriate, as Sonya has less than half the placement left and also seems to be undermining Gino's judgement.

Sonya has been aware from the start of the placement that a midway review was planned; this provides a useful opportunity for both student and mentor to discuss any concerns and flag up areas of strength and those needing development. Unfortunately, this is late so, although timely intervention is needed, Sonya is not being confronted with her mentor's concerns – nor does Gino feel able to do this.

The outcome

While feeling unsupported, nonetheless Gino does not seek the advice of a clinical leader but feels he should cope and "get on with it".

He arranges the mid-placement interview and, although Sonya changes her shift, Gino spots this and comes in so he can see her. He uses Sonya's set learning objectives as a measurable framework to discern progress since the initial placement interview, then starts to highlight his concerns. Preparation for such interviews is essential but, unfortunately, Gino has not written a list of concerns as well as strengths so, when Sonya becomes defensive and states they have a personality clash, he becomes

flustered and ends the interview more quickly than planned.

Sonya goes on to complete the placement and asks different staff members to sign her objectives. On the day Gino arranges her final interview, Sonya is off sick. She has, however, passed the objectives for that placement and so progresses. Gino feels frustrated as well as a failure.

In this case study, issues of discrimination appear to be evident, as well as the reluctance to fail students nurses identified by Duffy (2003). Duffy's report has been extremely important in influencing the review of competence of newly qualified nurses (Moore, 2005) and the revision of the NMC (2008) standards.

A recent survey of experiences of practice assessment (Scammell et al, in press) indicates that some mentors still have concerns about failing student nurses. When asked how confident they felt to fail students, 60% (n=67) of mentors in the sample expressed confidence to fail those whose competence was in question. However, 18% (n=20) were not confident, while a further 20% (n=22) responded with a neutral grade to this question. Clearly, this area of mentorship continues to be challenging and indicates the need to review practice on preparing and supporting mentors in failing students.

COACHING AND ACTION LEARNING

The references and examples given above explore the barriers to good mentoring relationships with student nurses. However, the learning from this can be applied to the processes of coaching, clinical supervision and action learning.

In the case study, the opportunity was missed when Gino tried to explore the issue with a colleague. He was given advice that was inappropriate for the context. Had an action learning or coaching process been used – even in this informal one to one exchange between peers – Gino may have felt more supported and empowered to tackle the issues with Sonya.

In the first in this two part series (Nash and Scammell, 2010) we referred to the impact of disempowerment in nursing culture. Although this problem is beginning to be challenged, it may act as a barrier to enabling nurses to confront issues of concern constructively. This may be interpreted as a culture of telling, an attitude that can be challenged through coaching and action learning. Gino, his colleague or any other team member could have used a coaching

BOX 2. THE GROW MODEL

- **GOAL:** what do you (mentor and student) want to get from today's coaching/mentoring? Defining what needs to be achieved.
- **REALITY:** what is happening? Understanding the situation – strengths noted and celebrated, areas for development identified.
- **OPTIONS:** how can we get there? Discussion of the options available.
- **WRAP UP:** Do what? When? Agreeing the course of action with SMART objectives.

Source: Passmore (2006), originally developed by Alexander in 1984 (Alexander and Renshaw, 2005)

model instead of giving advice.

The GROW model can be used as a framework for coaching; an example is shown in Box 2.

Notes should be made and kept in students' personal files. Follow-up should be identified and a date set when the action plan will be discussed and progress identified: this is called "holding to account" (Nash and Scammell, 2010).

This framework of structured yet open questions could have been used between Gino and his colleague. It does not need to take long to work through, and the time invested then would be outweighed by the resources required to limit poor performance or quality of care in the future.

Reluctance to fail students and the general difficulty some nurses have in giving constructive feedback may be due to personality type. The Myers-Briggs type indicator (MBTI) of personality was developed from Carl Jung's theory of psychological type (Briggs-Myers et al, 1998).

In decision making and the general way of evaluating perceptions and communications, there are difference between thinking (T) and feeling (F) types (Briggs-Myers et al, 1998). Feeling "types" emphasise involvement with people in their lives and practices. They like harmony and, if they have not developed their T capacity, they often allow their own or others' likes and dislikes to influence decisions. F types dislike and may avoid telling people unpleasant things. Developing the T capacity involves considering something analytically, logically, looking at the advantages, disadvantages, cause and effect, and being objective.

Without development, T types may upset people if they have not considered the impact they may have when expressing

their concerns. However, F types may disguise feedback so much with the aim of being gentle that they fail to get the message across.

Anecdotal evidence suggests that nursing has a higher prevalence of F types. Briggs-Myers et al (1998) described the importance of type functions in occupation choice and that those with an F preference are more likely to want to help people in practical ways, such as in healthcare and education.

Constructive feedback therefore needs to be objective, logically looking at the issue while sensitively considering the impact. It needs to be about being "hard on the issue and soft on the person".

CONCLUSION

Since workplace learning is important to improving individual and team effectiveness and, ultimately, patient care, awareness of the barriers is essential, as well as an understanding of the underpinning skills and attributes required.

An effective learning environment is one where all staff are learners, working to develop personal and team insights to enhance practice. Mentoring, coaching and action learning can be useful strategies in meeting this aim.

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