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Skills to ensure success in mentoring and other workplace learning approaches

Workplace learning can be supported using various approaches but for this to be effective it is crucial that those supporting learners have the right skills to ensure success in mentoring and other workplace learning approaches.

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This article highlights approaches to facilitating and supporting learning in the workplace, whether for students or nurses, and considers the skills needed by the people responsible for offering that support. It outlines common roles – including mentor, coach and supervisor – and explores how they fit into different contexts from preregistration education, newly qualified nurse support to ongoing staff leadership and development. It also discusses how nurses can make use of different learning strategies in their everyday practice, whether they are students or have years of experience.

INTRODUCTION

Workplace learning is vital to nurses throughout their careers. Whether this is in the form of mentoring for the newly registered or those moving to a new specialty, or further training or formal supervision for those undertaking clinical child protection work, many of the approaches and skills needed are the same.

WORKPLACE LEARNING

Mentoring

At its best, mentoring offers "experienced professional nurturing and guiding" for novice practitioners (Butterworth and Faugier, 1997), who benefit from being taught by a more experienced practitioner and receive practice based teaching that is relevant to their specific needs. Mentoring also enables feedback to be contextual and as immediate as possible.

Preregistration mentoring

Although the term mentor is often used to mean trusted friend, guide and adviser (Gopee, 2008), its use within preregistration nurse education in the UK is very specific. A mentor is a registered nurse who has completed an approved mentor programme and meets the criteria set out by the Nursing and Midwifery Council in its standards for mentors (NMC, 2008a). Mentors are responsible and accountable for:

- Organising practice based learning activities;
- Supervising students and providing constructive feedback;
- Assessing total performance;
- Setting and monitoring realistic objectives;
- Providing evidence that a student has achieved or not achieved competence;
- Liaising with others to determine any concerns about student performance and setting action plans.

In this context, mentors are expected to support students and also to assess them – two potentially conflicting roles.

The NMC standards are mandatory and are audited to ensure compliance. All preregistration student nurses must be allocated an appropriately qualified, named mentor who should not support more than three students from any discipline at any one time. In the practice setting, 40% of student nurses’ time must be supervised, directly or indirectly, by a mentor.

In response to concerns regarding newly qualified nurses’ fitness for practice (Long, 2007; NMC, 2005; Duffy, 2003), a number of experienced mentors have been designated as “sign off” mentors for students in their final placement. These mentors are required to be on the same part, or sub-part, of the nursing register as the student and to make the final judgement on whether that student has achieved the expected standards of proficiency for safe and effective practice (NMC, 2009).

Preceptorship

A form of mentoring also used within other learning relationships is the preceptorship offered to newly registered nurses. In the UK, preceptors are experienced nurses on the same part of the register as the preceptee, with at least 12 months’ post registration experience (Gopee, 2008).

Their role is to help the newly qualified nurse, or a nurse new to their part of the register or one who has qualified overseas, to make the transition to qualified practice in the UK.

The NMC (2008b) strongly recommends that nurses and midwives are allocated a formal preceptor for at least four months following initial registration.

The role of the preceptor is to do the following (NMC, 2006):

- Enable the new registrant to develop confidence and become an effective team member;
- Provide feedback on all aspects of performance, whether it is at or above the expected standard or a cause for concern;
- Allow the preceptee to develop an action plan to address any concerns;
- Support the preceptee in achieving the competencies and objectives that have been set by the employer.

Staff development

Mentorship is appropriate for those undertaking further training and qualifications or moving to new clinical specialties such as palliative care or perioperative nursing. It may also be part of
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individual, leadership and team development programmes.

Unlike student mentorship and preceptorship for newly qualified nurses, where the mentor or preceptor is allocated, nurses decide what skill they would like to develop and choose a mentor who they respect or admire and who is more skilled or expert in that area. For example, a nurse undergoing a leadership development programme may choose a local nurse leader to offer mentorship on, for example, how to manage a team by motivating and inspiring.

Coaching
Clinical supervision and action learning can be described as group coaching. There is much debate about the definitions of coaching and mentoring and some consider the terms to be interchangeable. Passmore (2006) suggested coaching differs from mentoring because coaches are not necessarily experts in the same field of development. They may be peers or external to the work setting; their expertise is their coaching skills and the ability to facilitate growth and development.

Like mentoring, this is a one to one relationship but coaching skills can be developed in less formal settings. When discussing an incident with a friend and peer, it may be useful to test out these skills and experiment with each other to learn from the situation. Actions can be identified as something that could have been done differently.

Clinical supervision
Clinical supervision includes aspects of both mentoring and coaching. Supervision that is part of midwifery or child protection may be underpinned by mentoring principles. In these examples, the supervisor may be an expert, or more knowledgeable in the specialty than the supervisee, and there may be a more formal contract in place.

Clinical supervision may be carried out one to one or in groups.

The NMC (2008b) says that it “allows a registered nurse to receive professional supervision in the workplace by a skilled supervisor. It allows nurses and midwives to develop their skills and knowledge and helps them to improve care”.

Supervision also helps nurses to:

- Identify solutions to problems;
- Increase their understanding of professional issues;
- Improve standards of patient care;
- Further develop their skills and knowledge;
- Enhance their understanding of their own practice.

Action learning
Action learning is about reflection and experiential learning. In contrast with the other approaches, it overtly offers both support and challenges (Nash and Govier, 2009). “It is a way of learning from our actions, and from what happens to us, and around us, by taking the time to question, understand and reflect, to gain insights, and to consider how to act in the future” (Weinstein, 1999).

The action learning approach, developed by Reg Revans and used in many organisations over the past 70 years, focuses on asking questions. After his doctoral studies, Revans worked at a laboratory in Cambridge alongside five Nobel prize winners. He observed how they were willing to share, not only their knowledge or expertise but also their ignorance and the problems they encountered in their work. They listened to each other and asked open questions rather than claiming to know the answers or trying to instruct.

Action learning can be seen as a form of group coaching. The facilitator focuses on the processes of working within the group to foster fundamental skills for good communication and effective working relationships. Everyone in the group receives equal time and space from the facilitator, who offers active listening and a balance of support and challenge, and avoids making judgements or trivialising issues. Nash and Govier (2009) suggested that a workplace team can apply these principles and develop the discipline of working in this way.

PRINCIPLES OF FACILITATED LEARNING
The strategies available to support and facilitate learning in the workplace, while different in some respects, share similar approaches and skills.

All are based on facilitation rather than instruction, as is appropriate when working with adult learners and, in many cases, peers (Rogers and Freiberg, 1973). Fundamental to this is the exploration of the beliefs that underpin and guide personal practice as they become apparent in actions and attitudes. Action learning and coaching in particular are based on the view that individuals already have the resources and capability to solve their issues but may need help from the coach or the group in which they work to access and use these resources.

As Rogers (2004) argued: “It follows from the first belief that the role of the coach is not advice giving…. Advice giving also leads to dependency – the opposite of what you are trying to do.”

This is quite difficult to accomplish in the paternalistic – or maternalistic – culture of the NHS and in particular nursing, but this culture is believed to be on the decline. Christensen and Hewitt-Taylor (2006) pointed out the barriers it presents to the empowerment of patients, and there are parallels within nursing itself. It is often easier to tell someone what to do than to encourage them to think for themselves.

All the interventions require those in facilitator roles to have particular skills. With preregistration mentorship, knowledge of learning, teaching and assessment in the practice setting, integration of theory and practice, insight into curriculum design and communication and relationship skills are all deemed necessary (Department of Health and English National Board for Nursing, Midwifery and Health Visiting, 2001).

This view is supported by a longitudinal, multimethod research study that investigated factors that influence professional development during practice experiences; it concluded that the most significant influence was the quality of mentorship (Spouse, 2001). From the perspective of students, the mentor role was particularly important in helping them to become accepted as part of the clinical team. It enabled them to experience whole scenarios rather than just tasks, and allowed them to observe and participate by using through mentors’ coaching skills.

Similarly, research into preceptorship (Ross and Clifford, 2002) suggested that knowledge of preceptees’ needs, excellent communication skills and supporting strategies are significant to the success of the relationship. Whatever the area and context of workplace learning, a prerequisite is enthusiasm for the role and an understanding of its remit.

Mentors need specific skills if students are to get the most benefit from workplace learning. These include:

- A questioning approach;
- Active listening;
- Holding to account and the ability to give constructive feedback;
- Good communication skills;
- Good interpersonal skills;
- Knowledge and expertise;
- A clear idea of roles and ways of working.
Approaches to facilitated learning

Questioning
A questioning approach is the basis for action learning, mentoring, coaching and clinical supervision. Rather than being the expert in the subject and offering solutions, the mentor needs the skills and expertise to ask open questions. These often begin with “what?” “why?” “when?” “how?” “where?” or “who?” and encourage further discussion of an issue. They help individuals to seek their own solution.

It should be noted, however, that although open questions may be used in the mentoring process, as the mentor often is the expert in the field and the mentee is interested in developing their learning, the mentor may give advice and direction. As such, closed questions, which can usually be answered with a one word answer (generally “yes” or “no”) may be appropriate.

Active listening
Active listening is described by the NHS Institute for Innovation and Improvement (2005) as “listening to others in order to understand their ideas, opinions and feelings and to demonstrate actively to the person that you have understood their ideas, opinions and feelings”. This will include skills such as being able to build rapport and acknowledge feelings, as well as summarising and clarifying. Box 1 outlines an active listening exercise.

Holding to account
Holding to account involves following up any actions mentees have agreed to in previous sessions to ensure they have done them.

According to the NHS leadership qualities framework feedback tool, the ability to hold to account is vital to ensure quality and consistency of care, and so that people inside and outside the organisation do what they have contracted to do (NHS, 2004). This is also the case in action learning and clinical supervision where the facilitator and/or participants hold the person bringing the issue to account by feeding back any action taken and then identifying the learning.

Mentors, particularly when mentoring students, supervising midwives and during child protection clinical supervision, must be able to make professional judgements about another’s competence and provide constructive and honest feedback. While teaching, coaching and assessing, a good mentor should promote students’ self-confidence and awareness, creativity and potential, and be able to move them from dependence to self direction (Morton-Cooper and Palmer, 2000).

The assessment should not focus solely on skills; it should also concern student conduct and overall performance.

Mentors, in effect, guard the gateway to the profession. Their role is vital. Once through the gateway, mentorship, preceptorship and coaching are all vehicles that can be used to maintain standards.

Interpersonal and communication skills
Good interpersonal skills are central to workplace learning and, in respect of mentoring and preceptorship, this has been highlighted in several studies (McCarthy and Murphy, 2008; Ross and Clifford, 2002). Duffy (2003) highlighted the importance of constructive feedback to students, particularly to identify areas for improvement and to pick out areas of strength.

While words are important, body language, voice tone and facial expression can also be used to enhance meaning. For example, Gray and Smith (2000) found that effective mentors were perceived as enthusiastic, approachable, understanding and having a good sense of humour. They were professional, confident, appeared to feel genuine concern for students as individuals and chose to be a mentor. On the other hand, poor mentors were perceived to lack knowledge about the preregistration course and clinical expertise, have poor teaching skills and either overprotect students or throw them in at the deep end.

Knowledge and expertise
In coaching, clinical supervision and action learning, the knowledge and expertise will be primarily in helping nurses to address the issue, not the specific subject with which they need help. This relates well to Revans’ identification of the powerful role of the non-expert in problem solving. It is underpinned by the belief that individuals are resourceful and the coach’s role is to enable them to realise their potential.

Of course, when mentoring preregistration students, knowledge and expertise will be needed in their particular field or specialty. However, it is also necessary to know about learning, teaching and assessing.

Clarity on roles and ways of working
Each of these work based learning interventions relies on establishing a contract, which will include process as well as values and behaviours. Nash and Govier (2009) suggested using the “How? Why?” approach to establishing ground rules such as respect and confidentiality. The contractual process needs to include an agreement around the practicalities such as:

- How long to meet for – one to one coaching, mentoring and supervision can last for an hour or 90 minutes per session;
- How regularly to meet – some find that a monthly meeting comes around too soon and does not give enough time for the person to take action between sessions, although meeting every other month runs the risk of motivation being lost;
- Where to meet – this is up to those taking part and may be dependent on any facilities that are needed being available;
- Expectations, clarification and responsibilities of the roles – for example, are you a mentor, mentee, coach, coachee, participants in supervision or action learning facilitator? Ways of working, as alluded to above, may include understanding each other’s approach to confidentiality and respect. Being explicit about these and clear about perceptions of what the roles and responsibilities reduces the likelihood of any misunderstandings;
- Use of records – most records made in workplace learning are the responsibility and property of the individual under supervision or observation. The facilitator, supervisor or mentor may keep their own notes of who brought issues and what actions were agreed.

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**Box 1. Test your listening skills**

With two colleagues, take turns at being the presenter/speaker, the listener and the observer:

- The presenter talks for three minutes on any subject of their choosing without being interrupted;
- The listener actively listens, not interrupting and gives full attention to the presenter as well as building rapport through non-verbal cues;
- The observer watches the interaction and constructively gives feedback to the listener.

Then ask yourselves: how was it to speak for three minutes uninterrupted, how was it to listen for the same period without interrupting and what non-verbal cues did the observer note? Use the results to reflect on your listening ability at work, be it with a patient, student or colleague.

To vary the exercise, ask the listener to switch off after two minutes and discuss the effect that not hearing what is said has on the outcome.
to hold participants to account at a subsequent session. The mentors of student nurses, midwives and those doing child protection supervision may need a more formal approach because of regulatory issues. In terms of child protection supervision records, Scott (2002) stated: “Supervision, which promotes good standards of practice and supports staff members, requires a supervision record for child protection practice. This includes the names of the cases discussed and the themes discussed in the course of the supervision. Key decisions taken during the casework discussions should then be recorded in the child/family record. A record should be kept by everyone present during the supervision. The end of year supervision opportunities record is completed by the child protection supervisor, providing a history of the provision of child protection supervision in the previous year”;

- Commitment – this may form one of the ground rules and could include issues such as being well prepared for the session as well as turning up, being punctual, and participating. Preparing for the session, whether it is mentoring, coaching, action learning or clinical supervision, is the key to a successful outcome. Some thought needs to be put into exactly what it is the person wants out of the session and what the issues are.

**MODELS**

When it comes to team leadership, Nash and Govier (2009) suggested the Gibbs model (1988) of reflection be used to “explore critical issues, near misses and incidents, working towards an avoidance culture instead of a blame culture”. This model could be used in all the workplace learning interventions outlined so far. An alternative model frequently used in coaching is the GROW model described in Box 2 (Passmore, 2006).

**CONCLUSION**

A number of strategies are available to support learning in the workplace. Although their focus may differ, they share similar guiding principles. Individual and team effectiveness and, ultimately, patient care may be significantly improved by well organised workplace learning.

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**BOX 2. THE GROW MODEL**

This can form the basis for supervision, coaching, mentoring and learning. 

- **Goal** – What do you want to get from today’s coaching? Defining what needs to be achieved; 
- **Reality** – What is happening? Understanding the situation; 
- **Options** – How can we get there? Discussing the options available; 
- **Wrap up** – Do what? When? Agreement of the course of action.


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**REFERENCES**

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