

INSTITUTE OF EDUCATION, UNIVERSITY OF LONDON

Inside Mentoring Relationships

Influences and impacts on mentorship
learning for acute care nurses in the NHS

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Thesis submitted for the award of Doctor
in Education (EdD).

I hereby declare that, except where explicit attribution is
made, the work presented in this thesis is entirely my own.

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Abstract

Supervised practice as a mentor is an integral component of professionally-accredited nurse mentor education. However, the literature tends to focus on the mentor-student relationship rather than the relationships facilitating mentors' workplace learning. This thesis begins to redress this gap in the literature by asking the research question:

Which relationships are important in developing nurses as mentors in practice, and how is their mentorship impacted by professional, organisational and political agendas in NHS settings?

A qualitative case study of two NHS Trusts was undertaken with three modes of data collection utilised. Firstly, semi-structured interviews were undertaken with three recently qualified mentors, and those they identified as significant in their own learning to become a mentor. In total six mentors were interviewed. Interviews with nurses in senior NHS Trust-based educational roles, and senior policy-making and education figures augmented these initial interviews. Secondly professional mentorship standards were mapped across each of the mentors' interviews to gain an idea of their penetration into practice. Finally, each interview participant developed a developmental mentorship constellation which identified colleagues significant to their own development as a mentor or educator, and the attributes which enabled this.

The findings reveal complex learning relationships and situational factors affecting mentor development and ongoing practice. They suggest that dyadic forms of supervisory mentorship may not offer the range of skills and attributes that developing mentors require. Mentor network type, orientation to learning, learning strategies and organisational focus emerge as the foci of tensions in learning to be a mentor. The study recommends that nursing teams in acute areas further develop a shared culture of learning and development in providing multiple opportunities for supporting developing mentors.

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Contents

Abstract	2
Acknowledgements.....	3
Preface: Reflections on Professional learning	6
Chapter One: Introduction	12
The Research Questions.....	15
Chapter Two: Background	18
Chapter Three: Literature Review.....	29
Chapter Four: Methodology	50
Ethical Considerations.....	56
Data Collection	60
Sampling and Interview Piloting	61
Gaining a Snowball Sample	63
Interviews.....	63
Mapping of Standards.....	66
Relationship Constellations.....	66
Strengths and Limitations of the Research Design	67
Conclusions.....	68
Chapter Five: Analysis and Key Findings - Interviews	69
Emerging Themes	71
Being a Professional Nurse.....	71
Orientations to Learning	74
Mentorship as a Learning Trajectory	78
Chapter Six: Analysis and Findings - Mapping of SLAiP Standards.....	91
Chapter Seven: Analysis and Key Findings - Mentorship Constellations.....	97
Chapter Eight: Synthesis and Recommendations for Future Practice	111
References.....	132

List of Tables

Table 1: The SLAiP Framework	24
Table 2: Methods, Analysis and Data Yielded related to the Research Questions	52
Table 3: Participant Demographics	70
Table 4: A Typology of Developmental Networks.....	110

List of Figures

Figure 1: Relationships between EdD Components, Themes and Significant Events	9
Figure 2: A Map of Mentorship Programmes	31
Figure 3: Operationalisation of the Cases	53
Figure 4: Purity's Mentor Constellation	103
Figure 5: Kate's Mentor Constellation.....	104
Figure 6: Sade's Mentor Constellation	105
Figure 7: Seacole Trust Relationship Map	106
Figure 8: Nightingale Trust Relationship Map	107
Figure 9: Tensions in Workplace Mentorship Learning.....	113

List of Appendices

Appendix A: Glossary of Key Methodological Research Terms	143
Appendix B: Ethical Approval.....	145
Appendix C: Explanatory Statement	148
Appendix D: Consent Form.....	149
Appendix E: Interview Schedule	150
Appendix F: Hand-Drawn Constellation	153
Appendix G: Excerpt from NVivo Coding.....	154
Appendix H: Process of Categorising and Manipulating the Data	155
Appendix I: Mapping the Domains of SLAiP	156
Appendix J: Darling's Measuring Mentor Potential Inventory	159

Preface: Reflections on Professional learning

This thesis represents the culmination of five years work in undertaking the Doctor in Education (EdD) programme. Whilst the thesis itself is a stand-alone piece of academic research, this preface is a more personal commentary on my learning throughout my doctoral studies. The opportunity to reflect on one's own development is an important part of doctoral-level study. Whilst the thesis allows reflection on aspects of the research process and findings, it does not facilitate reflection on some of the more personal and esoteric learning outcomes achieved through this process. Therefore I welcome this opportunity to document some of the ways in which the EdD has helped to shape my professional identity as an academic and contributed to a valuable journey of self-discovery. I start by introducing my own professional practice as a Senior Lecturer and Registered Nurse, before exploring the influences from within the EdD programme on the direction of my doctoral studies.

Professional Practice

My current role is as Senior Lecturer in Educational Development at a large central London University (referred to hereafter by its pseudonym *Capital University*), where I act as programme lead for mentorship in Nursing and Midwifery. Taking up this post in 2008 I felt that mentorship lacked visibility in the University, and had become a relatively unpopular module with nurses and midwives in practice due to a high failure rate. Having acted as a mentor for student nurses in my early nursing career, I noticed a sea-change in opinions about mentoring. Delegation of mentoring roles to ever-more junior staff nurses had changed the perception of mentorship from a symbol of professional development and increasing role seniority, to a devalued yet fundamentally necessary element of pre-registration programmes.

Consequently the mentorship module had become unpopular with some practitioners, and Practice Educators. Similarly, student nurse and Midwife feedback regarding their mentors identified a lack of mentor engagement with their role in supporting student learning. As mentors had been the focus of much of my early doctoral work (undertaken whilst in post at another university) I embraced the opportunity and challenges of working in an area that demanded attention, to explore experiences of learning to be a mentor. Implementation of revised professional standards for mentorship (NMC 2008a) provided some impetus for change, but a real driving force behind this was the ethos of practitioner research ingrained within the EdD. I had a sense that my practise could inform my learning, and my learning

could inform my practise to make change happen and make a contribution to the knowledge of professional practice.

Thus my doctoral work influenced the redesign of mentorship modules in collaboration with the teaching team and practice education colleagues. This culminated in the development of an online version of the module as well as a shift toward more professionally relevant and blended learning activities. As registered nurses and midwives mentorship students needed an approach which valued them as adult learners, rather than forcing them into a more familiar and prescriptive student role and an expectation of didactic teaching. Integrating these elements improved module attendance, helped raise the pass rate of the module and improved the general perception of the module amongst staff in our partner NHS Trusts.

Becoming a Researching Professional

The EdD programme consists of a series of taught modules, and features an incremental immersion into research which prepares candidates for future careers as 'researching professionals'(Bourner et al. 2001: 71). The genesis of my learning journey was in the Foundations of Professionalism module. This, as its name suggests, laid strong foundations for the EdD in providing opportunities to explore my own professionalism, and that of nursing in general. As a registered nurse, I had long considered myself as a professional. I had based this on the precepts of the NMC Code (NMC 2008b) and would strongly argue my case to those who saw the nurses role as an adjunct to the doctor rather than a professional in their own right. I felt that mentorship was one of the keys to professionalism, as it introduced student nurses to the skills and attributes of nursing practice. The opportunity to explore this with my students and in my analysis of their group work interactions in their mentorship module ignited my interests in notions of professionalism, learning within communities of practice and reflection. These themes developed over the course of my EdD to inform my final thesis.

Looking back over my own professional development at key points within the EdD has highlighted how my thinking has changed over time. In a personal statement included with my year 2 portfolio I wrote

Having achieved seniority and relative expertise in clinical nursing practice, my earliest experiences of teaching were aimed at demonstrating clinical credibility above all else, with a naïve attitude that this would be all that was needed to 'teach' students about practice. This stance is reminiscent of Hargreaves (2000) discussion of the 'age of pre-professionalism': teaching characterised by didactic teaching methods, and influenced by my own experiences of studentship.

In this portfolio, I was writing retrospectively and went on to write about developing collegial and socio-political awareness in my teaching practice. However, I was surprised at how much this view resonated with the interview data in my thesis, where clinical credibility and maintaining a nursing identity took precedence over the ability to mentor or teach effectively. As my own professional identity has synthesised to accommodate my clinical and educational experiences, I have moved from a position of concern with absolute knowing, though to a more contextual knowing which intertwines relational and impersonal modes (Baxter Magolda 1999). This is reflective of the journey from novice to expert nurse described by Benner (1984), and provides some indication that may mentors will go on to accommodate this role in their professional practice.

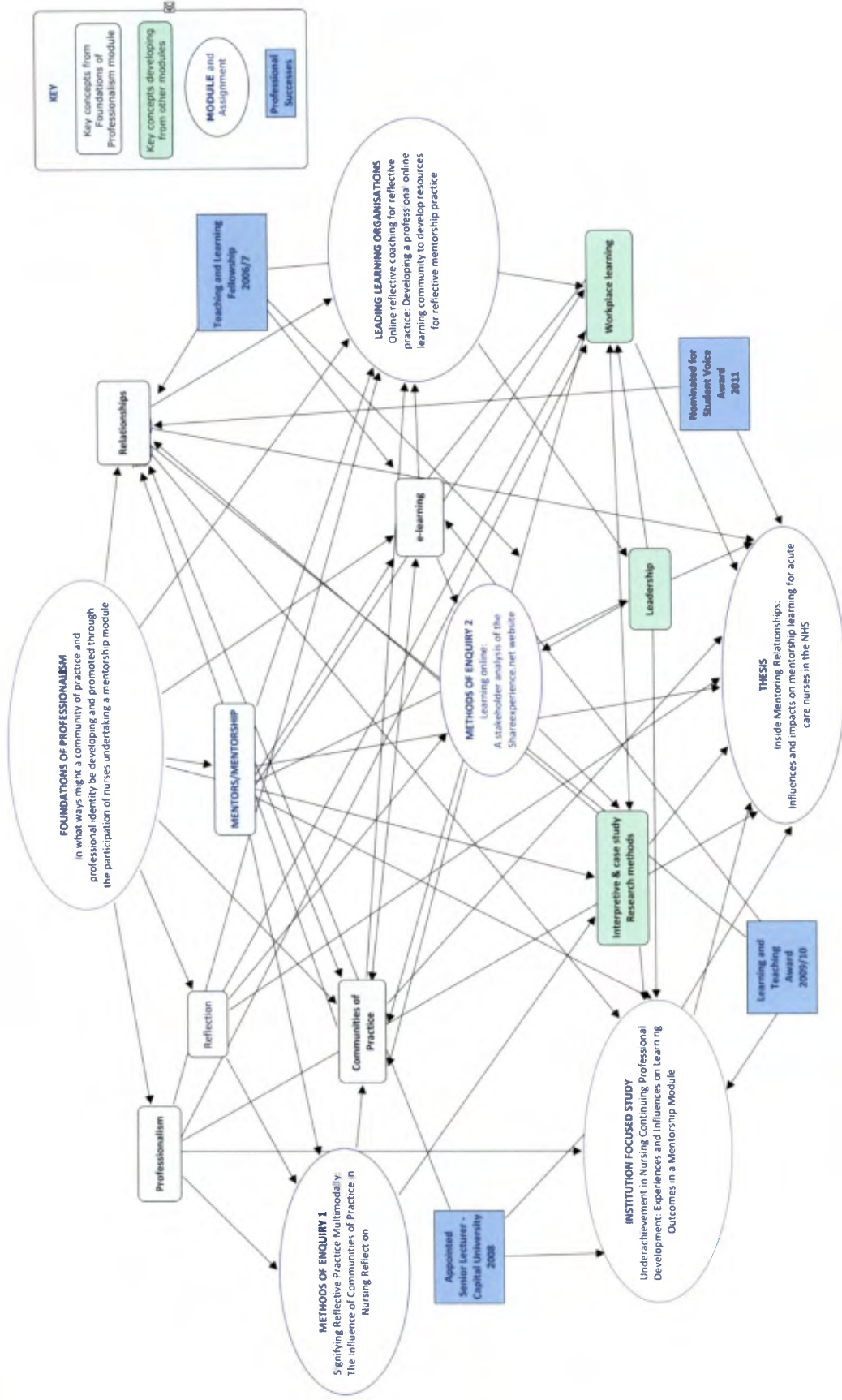
Thematic Links within the EdD Programme

I initially saw a linear relationship between my EdD modules. This was based on my focus on mentors and mentoring relationships. Further reflection indicated that this was less of a linear journey and more of a progressive construction of themes, concepts, research methods and philosophy. I have visualised this in figure 1 (overleaf) which gives a sense of the inter-relatedness of the EdD modules, module outputs, themes and significant events. The diagram also provides a pleasing visual motif of a crystal. I used this metaphor in my research methodology as a device to highlight the different perspectives that could possibly be gleaned from the findings of my case study. In this case my diagram reflects the many facets of professional education explored during my EdD studies. What it does not demonstrate is the social dimension of my learning. I learn best in collaboration with others. This was a key concern for me in choosing and embarking upon my doctoral programme, as I actively sought out taught elements and workshops that would provide social interaction, collaboration and friendship and found these fulfilled in the EdD programme at the Institute of Education. This influenced in no small way the focus on relationships that several of the EdD outputs took, and my own increasing identity as a social constructivist researching practitioner.

Professional Successes

Several professional successes can be attributed, at least in part to my participation and engagement with the EdD programme. My enrolment on the programme was a significant factor in gaining a teaching and learning fellowship from a Centre of Excellence in Teaching and Learning (CETL) in 2006/7. I was able to combine my studies in the Leading Learning

Figure 1: Relationships between EdD Components, Themes and Significant Events



This crystal-like structure illustrates the complex relationships between components of the EdD, developing themes in my work and significant professional events. Links are multiple and directional. Modelled using CMap Tools knowledge modelling kit 5.04.02.

Organisations module with a fellowship project exploring online support networks for practising mentors. Continued engagement with the work of the CETL gave me an opportunity to evaluate another online enterprise in the form of a community to connect university students who were away from the university on their sandwich year in industry. This formed the basis of my paper for the Methods of Enquiry 2 module.

More recently following a move to Capital University (involving promotion to Senior Lecturer) I was awarded a 'Learning and Teaching Award' for my work in transforming the mentorship modules at Capital University: improving student engagement and results. This was especially pleasing as I was nominated for this award by my peers and colleagues on the mentorship teaching team. The reputation of the mentorship modules amongst students has also improved. I was given an indication of this in my nomination, by several students, for the prestigious annual Student Voice Award within Capital University.

Challenges

The professional successes I have enjoyed are somewhat tempered by the personal and professional challenges I have encountered which have impacted variously on my studies. In my second year of study I was diagnosed with clinical depression for the second time, coinciding with the death of my much-loved grandmother. This was a painful time, necessitating clinical intervention and time away from work. However, I kept working on my EdD throughout as it gave me a sense of purpose and a focus on something external to my internal monologue of despair! What this episode taught me was that I am a very determined person who can succeed regardless of the odds. Knowing this helped me through some of the more difficult days of undertaking the thesis and kept any problems in my studies in perspective.

Other challenges were more prosaic, but no less important. My main challenge was in conforming to the word limit for the EdD thesis. As I collected and analysed more data it was increasingly evident that seemingly small-scale projects could produce vast amounts of data. I discovered I discovered that I had a second 'thesis' emerging in my data around the issue of the influence of policy on mentorship practice. A chapter which explored how policy is transmitted through significant relationships needed to be cut in order to conform to the 45,000 word limit. This work explored a seeming decay in understanding of the policy underpinnings of the professional Standards to Support Learning and Assessment in Practice (NMC 2008a) between Practice Education Facilitators and newly qualified mentors. The implication of this was that the policy underpinning the standards is considered less relevant by some practising mentors. Whilst it was disappointing not to be able to include

this work within the final thesis, this material is not lost. It will be written up as a stand-alone journal article and will impact on the mentorship curriculum by ensuring that the underpinning policy, as well as the standards for mentorship, is explored within the taught module.

Concluding Comments

I enrolled on the EdD programme in order to immerse myself in an exploration of my own professional practice. It offered an opportunity for doctoral study that could be more easily accommodated alongside my working life than undertaking a PhD programme. Its effects on my practice have been an evolution rather than a revolution. The EdD programme has not transformed me into an expert educator or researcher; rather it has deepened my understanding of practice issues within a wider political and social context. This has demanded a synthesis of my clinical and academic teaching practice with a deep understanding of the literature, and engagement with the research process. What has been transformed is my sense of confidence and self-belief in my own abilities. I will keep this with me as I negotiate the next challenges, in supervising doctoral students and publishing the fruits of my labour.

Chapter One: Introduction

Rationale and Overview

Mentorship forms an integral component of professional workplace learning for students and registered nurses (RNs) alike. The mentoring relationship between these parties is well established in the pre-registration curriculum, professional and organisational policy and clinical practice. Nurses have always played a role in the development of student nurses, although formalised programmes of mentorship were only introduced in the 1990s. These accompanied the transfer of nurse education programmes from hospital-based schools of nursing into higher education institutions (HEIs), and the adoption of more student-centred learning approaches in both classroom and practice. This approach acknowledged clinical practice areas as rich sites for learning, and RNs as uniquely qualified to teach and assess the clinical skills and knowledge required for everyday clinical practice. The Nursing and Midwifery Council (NMC 2008b) as the regulatory body for nursing highlights the obligation of learning relationships in two clauses within the professional code. These state that:

You must facilitate students and others to develop their competence (Clause 23)

You must be willing to share your skills and experience for the benefit of your colleagues (Clause 25)

Nursing mentorship is most commonly characterised as the relationship between an RN and a pre-registration nursing student. This learning relationship is considered instrumental in students' attainment of practical and professional competencies. It tends to consist of a series of short-term relationships in clinical placements, rather than an ongoing relationship. Further, it is prescribed in professional standards and institutional policy rather than developing organically.

The mentor-student relationship is not the only mentoring relationship enacted in clinical practice. RNs are required undertake a professionally validated mentor preparation module at a higher Education Institution (HEI), before they can practice as a mentor. This process requires RNs to undergo supervised and assessed practice as a mentor alongside taught components, leading to local registration with employers. Whilst a one-to-one relationship similar to that prescribed for student nurses is implied in national standards, there is little detail guiding these relationships. Indeed the vast majority of research relating to mentorship in nursing focuses on either pre-registration students' experiences of being mentored, or mentors' experience of mentoring student nurses. This reflects the necessity to deliver safe and effective patient care, but means that supervisor impact on both mentor and student learning has gone unexplored.

The *Standards to Support Learning and Assessment in Practice* (SLAiP: NMC 2008a) provide a national curriculum for mentor preparation, shaping the knowledge and competency bases of mentorship practise. The extent to which these are achieved in practice is reliant on an effective supervisor-mentor¹ relationship and supervisor competence in the domains dictated by the standards. However, the experiences of recently qualified mentors (RQM), and their supervisors do not feature in current nursing literature. Given the high turnover of staff and the mandatory allocation of mentors to all student nurses, mentor preparation programmes represent a large-scale concern for both HEIs and the NHS Trusts. A gap in the literature which might otherwise illuminate mentor development is evident and reinforced by my own experiences of research and as a nurse teacher.

Background to the Research

As an RN of twenty-years standing and nurse lecturer of ten, I am currently a Senior Lecturer and module leader for an NMC validated mentorship preparation module at Capital University. Capital has one of the largest healthcare faculties in London and works in partnership with local acute and primary care NHS Trusts, across a range of healthcare professions. *Mentorship* is a module which caters to Trust and professional requirements for qualified mentors to facilitate and assess student learning in clinical practice. This module accommodates up to 600 post-registration students yearly, mainly from the nursing and midwifery professions. Students undertake the academic component of their module either in face-to-face or online learning environments. All mentorship students are expected to undertake a period of supervised mentorship of a pre-registration student (or junior colleague) in order to satisfy the NMC of their fitness to practice as a mentor, via local registration.

Anecdotal and module evaluation feedback has highlighted that relationships with supervising mentors are sometimes problematic. In a case study of five students who had underachieved in their mentorship module (i.e. failed at first attempt or received a borderline pass), I discovered that some students felt coerced into mentorship as an institutional obligation (MacLaren 2010). Issues such as being unable to find a suitably qualified mentor (lack of personal promotion of status), personality clashes, lack of time for meaningful supervision, mentorship by perceived juniors, and work overload emerged

¹ Mentorship students, recently qualified mentors and supervising mentors are all referred to in the literature as 'mentors'. The terms recently qualified mentor (RQM) and Supervising Mentor/Supervisor are used to distinguish between the two roles in this work. Mentor is used generically to discuss issues relating to all mentors. Nurses undertaking their mentorship award are referred to as mentorship students.

from this study. These issues are reflective of inadequate mentorship in a wider range of professions and organisations (Eby and McManus 2004). Difficult supervisory relationships appeared to be related to individuals' orientations to learning in the workplace, based, in part, in a view of mentorship as a deviation from patient care as the 'real' work of nursing. This led to a perpetuation of negative stereotypes about the module and the mentorship role itself. Further, a perceived lack of institutional support for a near mandatory mentorship role was evident in the experiences of those I interviewed for my Institution Focused Study (IFS).

Despite difficult relationships students appear always able to get the workplace learning elements of their assessment signed off at the end of their module. However, the quality of feedback on these assessments is generally of a very poor quality and possibly indicates unreliable assessment of mentorship abilities. This has implications for the onward assessment of student nurses in practice as it may allow perpetuation of poor practise and place patient safety at risk. Debates over mentors 'failing to fail' weak or underperforming students and lacking confidence in the role (Duffy 2003, Gainsbury 2010) are ongoing concerns for nursing education. Meanwhile, pre-registration nursing and midwifery students commented negatively about their mentors' abilities in a recent National Student Survey (Capital University London Strategy and Planning Unit 2009). Negative features included the lack of commitment to the mentor role, unfamiliarity with learning outcomes and portfolios and a general unwillingness to mentor learners.

Both my case study and the NSS survey could be seen to be engaging with a marginalised and potentially aggrieved student group which may not be indicative of a wider sample of mentors and students. Some poor relationships have as much to do with the attitudes and dispositions of mentees as their mentors (Eby and McManus 2004). However, issues of problematic supervision surface fairly frequently in classroom discussions. A question arises that if mentors and supervisors are performing mentorship roles inadequately, or are abdicating their responsibilities, then who is there to support the learner in practice? Given that large numbers of student nurses (or mentorship students) are not failing the workplace learning components of their programmes, the potential influence of other supportive relationships needs to be considered.

The overall picture is one of complexity. Mentorship students occupy an interesting position within the clinical team as they are at once full members of the team, but also learners requiring supervision and assessment by their peers. Thus the interpretation of the mentorship role and the core messages transmitted within it are variable, complex and

dependent on individual dispositions, working relationships between learners and supervisory colleagues, and the institutional and policy context within which the mentor practises. A multi-faceted research question is therefore needed to unpick the relationships between mentors, their supervisors and those supporting workplace learning and how these are situated in both organisational and professional policy.

The Research Questions

In this case study I set out to explore what happens to facilitate workplace learning in mentor preparation, and the experiences of those supervising and being supervised. Because the mentor-supervisor relationship is under-explored in the literature, I draw upon interpretivist and ethnographic approaches in order to describe a culture and mentorship practises which are somewhat obscured from general view. This enables rich and detailed descriptions of mentorship activity to emerge from the data (Grbich 2007).

The study aims to develop an understanding of how learning occurs within these semi-obscured relationships, and recognise who is influential in promoting learning. The influence of the socio-political and organisational climate in which nurse-mentors are situated is also considered in the overarching research question

“Which relationships are important in developing acute care nurses as mentors in practice, and how is their mentorship impacted by professional, organisational and political agendas in NHS settings?”

This question can be best understood as a series of subsidiary questions which frame the outcomes of the study.

1. Which learning relationships in the practice settings are significant for nurses undertaking the mentorship module and those supervising them?
 - What happens to facilitate workplace learning in these relationships?
 - What is the understanding of these individuals of their role in the development of new mentors in practice?
2. What constitutes the current policy, professional and political agenda for nursing mentors and in which ways are these messages relating to mentorship transmitted and interpreted by those identified as significant in mentorship learning?
3. What role does the notion of professionalism play for practising mentors in their mentorship of learners?

The multi-dimensional nature of the research questions demands a multi-dimensional approach to the research. In-depth semi-structured interviews with mentors and Practice

Education Facilitators (PEFs) form the basis of data collection. These allow exploration of mentorship experiences. Within this approach I have used relationship constellations as a form of social network analysis to identify significant learning relationships and identify further participants for interview. Interviews with policy-makers and mapping of policy themes within interviews give an indication of the impact of SLAiP on mentoring practises.

Professional Learning Outcomes

This case study offers a unique perspective on an under-acknowledged area of mentorship practise. It provides opportunities to shape practice in three inter-related areas:

Professional, personal and technical. Professional outcomes are anticipated in the acknowledgement of supervisory mentorship as a bona fide learning relationship, rather than an adjunct to pre-registration student nurse learning. Supervisory and support relationships labour under certain professional assumptions. These are that they facilitate the required learning, are effective and are actually in place. By drawing focus toward the supervision of mentorship students, these assumptions may be challenged. An awareness of who is significant in supporting student-mentors and what happens to support learning in these relationships will be gained. From within the taught component of the module, it may be possible to develop learning activities which prepare students and enable them to get the best out of supervisory mentorship. However, changes to professional policies such as SLAiP might be required to more formally recognise the role and responsibilities of the supervising mentor, and provide formal direction for the preparation of supervisors.

My personal learning outcomes are two-fold. Firstly an insight into working practises that are otherwise obscured will be gained. This will lead to changes in my own practice as an educator and those of the wider teaching team in playing to the strengths of current practises whilst bolstering a rigorous evidence-based approach to mentorship practice. Secondly, completion of the research with the attention to rigour necessary for qualification at doctoral level will open up certain avenues of opportunity in relation to the dissemination and publication of this research. This means that the reach of this work will be greater than just ensuring that findings are fed back in to my own practise. In turn this may encourage others to research in this area, where I will be well placed to take on a supervisory role.

Technical learning outcomes relate to the methods by which mentoring relationships are analysed. Several unique features are included in the analytical frame of this research, such as the use of visual maps to identify significant learning relationships, application of a general typology of developmental relationships (Higgins and Kram 2001) , and analysis of

the attributes of mentorship networks, rather than individuals. As these have not been used before in a UK nursing context, they offer exciting opportunities for onward research with mentors.

This research has been shaped by insights gained from my previous research and experiences of practice. It attempts to bring together some of the complexities of professional mentorship practice for scrutiny. Chapter two sets the scene for this exploration, by presenting an overview of the development of mentorship policy and practice in nursing in the light of profession's current modernisation agenda. Chapter three provides a literature review which further contextualises nursing mentorship as a workplace learning concern, and draws together pertinent literature to further address my research questions. The research methodology of chapter four is followed by a discussion of the frames of analysis for each of the data collection methods used within this case study, along with key findings. The thesis concludes with a synthesis of these findings which explores some of the tensions surrounding mentorship supervision, in which I make recommendations for onward personal, professional and technical research practices.

Chapter Two: Background

The Changing Scene of Nurse Education in the UK: A Critical Examination

I start this chapter with a discussion of the milestones in the development of contemporary mentorship and how this has been influenced by wider professional and governmental policy. This outlines the context for mentorship practice and allows some of the key terms and concepts within the research questions to be operationalised. I include a discussion of how mentorship has contributed to the professionalisation agenda for nurses, setting the scene for the literature review in chapter three.

The Introduction of Nursing Mentorship

The mentorship role was formalised in the 1990s as nurse education was transformed by moving into the higher education arena under the auspices of Project 2000 (P2K). Until this point, qualification as a State Registered Nurse (the higher level of two nursing qualifications) was subject to national standards of educational achievement in the form of a universal curriculum and final examination (Roxburgh et al. 2010b). This form of nurse education was thus not without an academic basis, as it provided a certificate level qualification which could be utilised in a vast range of settings at home or abroad. However, training to become a nurse was beginning to be seen as synonymous with an apprenticeship-style nurse training, where an emphasis on training for service prevailed. Spouse (2003) argues that this engendered poor standards of care, alongside high levels of stress in student nurses which resulted in a pre-qualifying attrition rate of 30%, and high levels of nurses who once qualified never practised professionally.

This incarnation of state registration had also been an evolution from previous modes of nurse education where the practical experiences of students were at the exigencies of hospital need rather than gaining a broad experience to be utilised upon qualification in a variety of settings. However, by the late 1980s the nursing profession was struggling with fewer applicants to undertake nurse education. Spouse (2003) identifies that increasing career possibilities for girls was one factor leading to a national shortage of nurses, but that the apprenticeship style training. In raising the basic nursing qualification to diploma level, P2K potentially raised the status of the profession, offering a university education to those for whom it might otherwise not have been an option (Spencer 2006).

Changes in rhetoric are evident following the introduction of P2K, with an emphasis on 'education' replacing that of nurse 'training'. Further, student nurses became supernumerary to staffing requirements, rather than paid members of the workforce in

order to place the emphasis on education rather than in-service education. Many student nurse posts were replaced by health care assistants (HCAs). The initial aim was to boost numbers of qualified nurses and midwives to help support students, rather than maintaining assessment of practice by peripatetic clinical tutors. Nurses therefore became increasingly responsible as mentors and gatekeepers to the profession in ascertaining students' competency. The focus was explicitly educational: to learn the theory and practice of the nurse rather than nursing service as the primary objective (Dolan 1993, UKCC 1986).

P2K represented a wholesale change in pre-registration education of student nurses premised on the development of autonomous and 'knowledgeable doers' and 'reflective practitioners' with enhanced decision-making capabilities (Phillips et al. 2000: 3). It was influenced in part by predicted demographic shortfalls in the numbers of post-school teenagers available to join the profession (Burnard and Chapman 1990). The Judge report (Commission on Nursing Education 1985) had made recommendations including the institution of a single level of nursing registration at university diploma level to replace dual level registration². State Enrolled Nurses (SEN) who had a shorter period of training and practiced a reduced nursing skill set in relation to State Registered Nurses were phased out to accommodate a single level of registration (RN) whether at diploma or degree level. Other changes concerned the status of the student in practice. P2K students, unlike their predecessors, were not paid members of the workforce. Instead these students acted in a supernumerary capacity whilst receiving a bursary (or student grant for undergraduate nursing students).

The idea of mentorship in nursing had originated in business and management literature of the 1970s, and filtered through the academic nursing culture of North America in the early 1980s. Benefits of mentorship were considered from a perspective of 'everyone who makes it has a mentor' (Collins and Scott 1979, in Burnard and Chapman 1990: 103), rather than as a formalised system of learning and support. Initially definitions of mentorship in nursing demonstrated these influences, with reference to long-lasting mentorship relations and the natural selection of mentors rather than a formalised system. Burnard and Chapman (1990: 103) described a mentor as

Someone older than the student who has considerable experience of the job for which the student is being prepared.

² Nursing degrees were already available but existed outside of the mainstream mass education of nurses

This indicates a familiarity with classical definitions of mentoring, where sponsorship or patronage of a senior colleague is influential in career development.

Mentorship first appears in professional policy in 1987 (English National Board: ENB 1987) where it is recommended as a way in which to support students in practice. Despite ongoing concerns about the quality of Ward-based teaching throughout the 1980s, the ENB stopped short of recommending the full scale implementation of mentorship. A lack of consensus as to who should teach, and what their status would be within Ward teams was evident: Clinical tutor/educator roles had been in common usage, but tended to be peripatetic rather than embedded educational roles. These roles were also over-stretched and lacked continuity of teaching in practice (Robertson 1987). Whilst broadly supportive of the implementation of mentor roles, Burnard and Chapman (1990) highlight some of the typical worries of the time. They argue that rather than creating one level of RN, introduction of the nursing diploma would create an elite level of nurse. Further, the reliance on HCAs would devalue the caring nature of the nursing role, and that mentees could become dependent on the mentor in expert-led systems. This appeared to go against the prevailing move toward student-centred learning.

Mentor Registration and Assessment Practices

Mentorship rose to prominence in the 1990s with the development of a continuing professional development course aimed at preparing nurses to teach in practice. The *Teaching and Assessing in Clinical Practice* module (known as ENB 998 after its designation by the then professional body) initially had a dual focus of teaching students as well as patients, and allowed registration of mentorship status on the professional register. Prior to this, formal clinical assessment was often carried out by qualified clinical tutors, in four assessments during the three-year nursing programme. The assessment role within mentorship was recognised as integral to student learning (Phillips and Schostak 1993). However, it was only formalised into the mentor's role with the publication of joint Department of Health (DH)/ENB guidance papers on mentor preparation and placement preparation³. These were in turn influenced by Phillips et al's (2000:1) national study of assessment in mentorship. They identified wide variations in assessment practices and effectiveness, discussing a landscape where many practitioners were

'...so hard-pressed by the demands of day-to-day nursing and midwifery that they are regularly unable to undertake valid or reliable assessment'

³ Placements in Focus (DH/ENB 2000) and Preparation of Mentors and Teachers (ENB/DH 2001)

Unreliable assessment was characterised by Duffy (2003) as 'failure to fail'. Her grounded theory study of 24 nurse lecturers and 16 mentors categorised some reasons for mentors' failure to fail poor student practice. Technical issues such as the reliability and validity of clinical assessment tools were one consideration although personal factors such as leaving student assessment too late, fear of personal consequences, facing personal challenges and lack of experience and confidence were also cited (Duffy 2003). Finch (2009) and Bray and Nettleton (2007) both remark on the continuing difficulties and confusions in understanding and managing the professional mentor role, leading to failure to fail incompetent students. A lack of acknowledgement of the gate keeping role of the professions is evident in both studies.

Criticisms that newly qualified P2K nurses knew less and could do less than previous generations of nurses were clearly linked to issues of assessment. Meanwhile some authors argued that it was the course itself and not mentors' assessment of practice which was at fault. Concerns at what student nurses should be able to do without supervision at different stages of their programme were raised by Watkins (2000) among others. These concerns were exacerbated by a shift in student engagement from learning by 'doing', towards gaining a theoretical 'understanding' of practice. The Peach Report (UKCC 1999) provided a review of nurse education and in particular P2K. It instigated development of a new, *Fitness for Practice* curriculum. This would be premised upon continuous assessment of competency in practice, and influenced by the rhetoric of the reflective practitioner (Schön 1983) in its acknowledgement that

The learning that takes place at work through experience, critical incidents, audit and reflection, supported by mentorship, clinical supervision and peer review can be a rich source of learning (DH 1999: 20)

Despite the negativity toward mentorship roles exhibited in some of the criticisms of P2K, a renewed focus on reflective practice and the value of workplace learning were evident in national policy outputs, and had an effect on the modernisation of the profession.

Modernisation of the Nursing Profession

At the turn of century the New Labour Government's commitment to the NHS was reinforced through the NHS Plan (DH 2000b). This highlighted the need for 20,000 more nurses to be brought into service, necessitating a widening of nurse education provision. A general expansion in the University sector and a widening participation programme encouraged greater numbers of non-traditional applicants such as mature students, graduates, and students from access courses, to access the profession (National Committee of Inquiry into Higher Education 1997). Other influences included the increasingly

technological nature of some nursing roles, in part due to adoption of some junior doctors' roles (DH 2002). Nurse education continued to be influenced by educational discourses of reflective practice and lifelong learning as self-regulation of the profession (NMC 2008c, Gopee 2001).

Greater numbers of nursing students potentially placed a greater strain on workplace learning. Neary (2000) reported that supervision of students had already begun to be delegated to junior staff nurses, who were now the key target of mentorship courses. This represented a move away from more paternal forms of mentorship based upon expertise and patronage, towards more equal power relationships between mentor and student relationships. This relative inexperience of mentors, pace of technological advances in nursing and recognition of an NHS under pressure from a greater number of patients and fewer staff have all been offered as drivers in implementing roles to support mentors in practice (Clarke et al. 2003). Mentor self-regulation had led to issues of inadequate assessment (Duffy 2003, Phillips et al. 2000), and so a more strategic overview of placements was deemed necessary to provide support to mentors and the Wards they work in.

Making a Difference (DH 1999) and *Fitness for Practice* (UKCC 1999) reports spawned two key guidance frameworks which formalised both the role of the mentor and practice placements as learning environments. *Preparation of Mentors and Teachers* (ENB/DH 2001) incorporated advisory standards in clarifying the educational framework for mentor and teacher preparation. For the first time the divisive mentor/assessor dichotomy that had split opinion on the role of the mentor was discussed. This was framed within a repertoire of mentorship roles to shape practice. The academic basis for mentorship and practice education was explicit: mentorship was to become at least an HE2 level module, with practice educator courses set at post-graduate level.

The document *Preparation of Mentors and Teachers* (ENB/DH 2001) introduced the practice educator role which replaced the phased out clinical tutor roles. Various practice education roles were developed in the UK, although the term Practice Education Facilitator (PEF) is adopted here as it is in common usage at Capital University⁴. What these roles have in common is that they are peripatetic educational roles, funded by Strategic Health Authorities and embedded within hospital and community settings (Gopee 2011). PEFs operate on many different levels of service delivery and integrate clinical needs and

⁴ Variants in the literature include Practice development facilitator, Clinical placement facilitator and practice development facilitator.

concerns with a Trust-wide strategic educational focus (Larsen et al. 2006). One key role is to work in partnership with link lecturers to support staff and students academically and practically (Magnusson et al. 2007). Richardson and Turnock (2003) argue that a focus on educator roles for students neglects the professional development and educational needs of senior nursing staff. However, the main debate appears to be whether the PEF role is best placed to support students or mentors (or both). In both cases a benefit to students in creating a link between theory and practice is posited, albeit sometimes indirect (Clarke et al. 2003, Larsen et al. 2006).

Evaluations of the PEF role have positively highlighted their contribution to increasing the capacity for student placements within Trusts (Hutchings et al. 2005, Magnusson et al. 2007), proactivity in helping mentors deal with mentorship problems (Hutchings et al. 2005) and providing a bridge between HEI and practice areas (Clarke et al. 2003, Magnusson et al. 2007, Jowett and McMullan 2007, Carlisle et al. 2009). Jowett and McMullan (2007) report on the positive attributes of the PEF as being communication skills, professional credibility and flexibility in their roles. However, Clarke et al (2003) note that PEFs sometimes felt marginalised in their roles whilst Larsen et al reported colleagues' scepticism (Larsen et al. 2006).

Placements in Focus (DH/ENB 2001) provided a quality assurance framework within which mentors and practice teachers could practice. This incorporated the notion of educational auditing of practice placements to assess their suitability to meet learning outcomes, as well as their ability to support and maintain the safety of students and patients. Critics of these two policy directives argue that, whilst named as standards, no parameters for achievement were given (Bradshaw and Merriman 2008). However, taken together, these two reports influenced the landscape of mentorship over the first ten years of the twenty-first century, through firmly demonstrating a commitment to practice education.

The Standards to Support learning and Assessment in Practice (SLAiP)
SLAiP (NMC 2008a) was developed by the NMC following a lengthy period of consultation (2003-4) across the nursing and midwifery professions. Implemented initially in draft form (NMC 2004), SLAiP forms a broad curriculum of eight domains of practice for mentorship (table 1). These domains clarify contentious areas such as the assessment function of mentorship, but also foreground mentors' roles as leaders, and as competent and evidence-informed practitioners. Mentorship qualification is now recorded locally within Trusts rather than against the professional register and is subject to periodic audit of its currency and effectiveness, as part of a rigid quality assurance framework (NMC 2010).

SLAiP (NMC 2006, 2008a) further clarifies the scope of other practice education roles providing a developmental and career-wide framework which stipulates conditions for entry to mentor, practice educator and teacher roles.

Table 1: The SLAiP Framework

The framework presents eight domains of mentorship practice, in which standards of competence must be achieved. These continue to be of importance through development into specialist practice and university education roles (NMC 2008a).

- Establishing effective working relationships
- Facilitation of learning
- Assessment and accountability
- Evaluation of learning
- Creating an environment for learning
- Context of practice
- Evidence-based practice
- Leadership

Standards of student engagement are introduced in SLAiP in terms of the amount of time mentors spend supervising students in practice (40% of student placement time). The requirement for annual updating of mentorship skills is also formalised. Consequently competency documentation for ongoing development has been introduced by local Trusts. This enables mentors to document their experiences, prepares them for triennial review of their practice as a mentor, and permits them to remain on the local register of mentors. Mentors must demonstrate that they have mentored at least two students (or learners) within a three year period, participated in annual updating activities and mapped their ongoing development against the SLAiP domains.

Triennial review is in its infancy within the two Trusts studied in this thesis. Therefore penetration of the standards into day-to-day nursing and mentoring practice has remained a relatively unknown factor. Assessment of awareness and implementation of the standards form part of the profession's quality assurance framework (NMC 2010). However some coaching of mentors occurs pre-visit to prepare them for inspection, so audit findings may not be representative of actual diffusion of SLAiP. Additionally, at Capital University the mentorship module assessment has until recently relied on global evaluation of the mentorship student. This was focused developmentally on reinforcing positive mentorship behaviours, and providing remedial supportive feedback to develop mentoring traits. A tacit understanding that shortfalls in the standards could be remedied after module completion, rather than the student reflecting the 'complete' mentor underpinned the philosophy for this assessment. However, a recent monitoring visit by NMC auditors

recommended the introduction of a workplace competency document for mentorship students based on SLAiP, which was subsequently implemented. This document mirrors the assessment mechanisms of pre-registration nursing portfolios, in that it has an expectation of proficiency in each of the domains: necessitating a substantive change in philosophy.

A new level of mentor was introduced by SLAiP, namely that of sign-off mentor. This role adds an additional layer of professional accountability for the quality and competence of newly qualified nurses through signing-off overall competency at the end of the final placement. Preparation of sign-off mentors is a joint endeavour between HEI and Practice Education Facilitator, with elements contributing to this role incorporated within the mentorship module itself, and bolstered by supervised and assessed assessment of student competency on three occasions in practice.

Nursing Mentorship within a Wider Professional and Policy Context

Contemporary nursing mentorship sits within a unique context, on the cusp of major changes to professional preparation and workforce deployment. A modernisation agenda which commenced with a wholesale review of grading, pay and competency structures across the healthcare professions (DH 2004a, 2004b), is reaching a climax in plans for graduate-entry to the nursing profession. Several reports acknowledge that the nursing workforce needs transformation to cope with developments in the delivery and structure of health care (RCN Policy Unit 2007, The Prime Minister's Commission 2010, DH 2000a, 2006b, 2008). The profession is challenged by high public demand and expectations of healthcare as well as the implications of an aging population. Two key drivers for the reform of nursing and nurse education have been the gradual implementation of the European Working Time Directive (EWTd) in relation to reducing junior doctors' working hours (European Community 1993) and the roll-out of graduate level nurse education for all new recruits to the profession.

Reduction of Junior Doctors' Working Hours

The European Working Time Directive aimed to protect European citizens from long working hours without breaks and to reduce accidents and incidents caused by fatigue. This was particularly pertinent for the medical profession where in 2004 most junior training grade doctors worked an average of 156 hours per week including on-call time (Craig and Smith 2007). The new legislation provided the political will to reduce junior doctor working hours in stages to a maximum 48-hour working week in 2009. With the reduction in availability of junior doctors, nurses were called upon to up-skill to fill gaps in service delivery. There had long been recognition of the overlap between medical and nursing

activities, and as far back as 1972, governmental reports had advocated that some roles could be safely fulfilled by either profession (Briggs 1972). Criticisms that training nurses would be too costly, that delegation of roles to nurses would cause confusion over the ownership of activities and de-skill junior doctors were evident in the literature (Scottish Office Department of Health 1995). However, change was promoted as vital in increasing both health care productivity and empowerment of the nursing profession (Doherty 2009). This would have implications for workforce planning in terms of nursing skill mix and future developmental opportunities.

Nurses had formally been able to undertake extended roles including some of those undertaken by junior doctors since the early 1990s (United Kingdom Central Council 1992). The process usually required training and supervision by medical practitioners, although formalised competencies for these roles were not always evident and adoption was by no means widespread. Castledine (2007) notes that in the first instance, the scope of extended roles was generally restricted to routine tasks such as phlebotomy and administration of intravenous drugs. The delegation of these activities alone could have an impact on junior doctors' working hours, although now often form a key part of nurses' daily activities. Senior nurses were encouraged to take on these new skills as well as providing a buffer between ward-based nurses and on-call doctors in a 'night coordinator' role. Pilot projects across England observed a reduction in wards' dependency on junior doctors and no detrimental effects in implementing this advanced role (Mahon et al. 2005). Indeed, many respondents in the Mahon et al study reported benefits for staff and patient care.

A wider delegation of roles was envisaged in a statement on the future scope of nursing practice within the NHS Plan (DH 2000b), which led to the development of nurse practitioner roles in both acute and community settings (Linsley et al. 2008). These roles have developed to meet patient need through nurses managing their own patient case loads, undertaking the prescription of medicines and triage of patients using information technology (c.f. NHS Direct). The knowledge and skills framework (DH 2004b) has provided some role and competency guidelines. Despite this implementation of advanced practice roles has not been uniform, with many differences in job description, roles and competencies evident across the profession (Bryant-Lukosius et al. 2004).

What is clear is that the delegation of junior doctor roles has provided nurses with new options for developing practice. Role development requires significant post-registration education and practice opportunities, as well as mentorship by appropriately qualified nursing colleagues. Sadler-Moore (2009) argues that this has led to a degree of 'crowding'

in the RN role as nurses become responsible for an ever increasing repertoire of activities. However, the proliferation of top-up undergraduate degree programmes for those qualified to certificate and diploma levels, and wishing to develop skills and knowledge is testament to the CPD currently undertaken by nurses. Similarly, opportunities to undertake clinically-focused Masters Degrees and doctoral programmes continue to develop advanced practice nurses.

Graduate Level Nursing Registration

Introduction of degree-level nurse education is the biggest change to nursing registration since the implementation of P2K. Fergy (2011), in a snapshot of the preparedness of London NHS Trusts for the new graduate nursing programmes, notes that most senior nurses and many staff nurses are positive about this development. Fergy cites equal status with other graduate professions, and improvement of patient safety outcomes as positive outcomes of graduate status. The professionalisation project of nursing has been long-fought. Nursing was considered a 'semi-profession' at the end of the 1960s by dint of its close and often subordinate relationship with the medical profession and a perceived lack of unique knowledge base for practice (Etzioni 1969). The development of expertise, a developing language and evidence to support it may be seen as the developing 'epistementality' of a profession (Knorr Cetina 2006: 37). In nursing this has been achieved through a move away from certified apprenticeship towards higher education at diploma, degree and post-graduate level, and an ever proliferating body of practice and scholarly work (Gerrish et al. 2003). Other indicators such as lengthy socialisation, a code of ethics regulating practice, community sanction and public service appeared undisputed (Freidson 1983, Schön 1987).

In the foreword to the recent *Prime Minister's Commission on the Future of Nursing and Midwifery in England* (2010) Anne Keen MP (Chair) argued that nursing diplomas and degrees have been important contributors to the increasing education, career choices and social mobility of women from working class, black and minority ethnic groups. However Fergy's (2011) interviews with Senior Nurses surfaces worries that raising the entrance criteria for pre-registration programmes might lead to a possible reduction in the diversity of the profession. Governmental support for graduate status has been variable. The Prime Minister's Commission (2010) outlined clear support for graduate nurse status. This rhetoric is not matched by an incoming Prime Minister who has espoused a view that nurse education programmes are 'too academic' (Santry 2010). However, a recent review of research on the effects of graduate level nursing failed to identify significant differences

between diplomate and graduate nurses (Robinson and Griffiths 2008). A lack of adequate comparators in this work was noted; the new nursing degrees are three-year courses whilst most degree courses until recently were four-year programmes. In an echo of the implementation of P2K, concerns that an all graduate profession will narrow the entry gate to nursing and create 'elite' groups of nurses are evident in the literature (Burnard and Chapman 1990, Grindle and Dallat 2000, Fergy 2011).

The need to provide support and learning opportunities to colleagues is, like mentorship, a feature of *The Code* (NMC 2008b). Support and supervision of those undertaking mentor preparation programmes has been mandated since the publication of *Preparation of Mentors and Teachers* (ENB/DH 2001). Mentorship students must be supervised by a mentor who has met the SLAiP standards (NMC 2008a). A parallel with supervisory mentorship is found in the introduction of preceptorship programmes for newly qualified staff nurses, which is identified as a key component of *Modernising Nursing Careers* (DH 2006b). This has been formalised in national Preceptorship programmes such as Flying Start in Scotland (Roxburgh et al. 2010a). This has now been rolled out across other areas of the UK, including the London NHS Trusts taking part in this research.

In the last thirty years nurse education has moved from an apprentice-style certification programme, to one where theory and practice combine in the nursing curriculum and SLAiP. The parallel track of modernising nursing careers and professionalisation means that the scope of nursing practice is wider than ever, meaning that sharing of experience and knowledge is vital to maintain standards. Nurse education has always needed a flexible outlook as change in capacity and role expectations have been a constant feature in the past 30 years. Mentorship has proved an adaptable platform for developing student nurses' clinical practice, but its role in developing mentors is less clear. In the following chapter I expand on this theme, contextualising supervisory mentorship as workplace learning concern. In this I explore the literature surrounding mentorship and theories of workplace learning to gain an insight into the field of study and identify gaps which may be addressed by this research.

Chapter Three: Literature Review

The Culture and Contexts of Nurse Mentorship Learning

This literature review focuses exclusively on the workplace learning components of the Mentorship module introduced in chapter one. As chapter two has shown, nurse education has evolved from apprenticeship to standard-driven professionalism. This evolution has traced a route from almost exclusively behaviouralist educational beginnings to the embrace of modes of learning that value an explicit and holistic⁵ nursing evidence base. Further, an increasing working repertoire, advances in technology and a focus on developing accountability for practice have signified a distinction between professional nursing and lay concepts of 'care' (Liaschenko and Peter 2004, Warne and McAndrew 2004). Changes in educational ethos over time have led to a general acceptance that qualification is only the beginning of a journey into professional practice. Opportunities for CPD are necessary to refine (or learn) the rules of registered practice, and develop flexible styles of behaviour required to develop expert practice (Benner 1984, Eraut 1994, O'Connor 2006). Engagement with CPD is mandatory for post-registration socialisation into practice, practice improvement and maintenance of professional registration (NMC 2008c). For many nurses mentorship forms their first experience of post-registration CPD.

Developing as a mentor requires mentorship itself. This creates a unique ecology of mentorship within practice areas which is poorly explained within current literature. Student nurses require mentoring by mentors (often mentorship students) who themselves require mentorship by a supervising mentor. Supervising mentors need the skills to facilitate learning in their mentorship students, who as full colleagues hold a different status and place within the work environment. This is somewhat akin to the grandfather-father-son systems found in computing, where each generation informs the next. However, the literature tends to focus on the archetypal mentoring relationship of student nurse and mentor; although some inroads in discussing the preparation of the sign-off mentor are noted (Andrews et al. 2010, Fisher and Webb 2008). Literature that reflects supervisory mentorship in British acute care settings is scarce. Therefore I present international literature based in similar nurse education (although not always similar healthcare) systems. Likewise, research literature from other domains, and in particular mainstream education, business studies and the wider health context are used to offer different and

⁵ Considering the patient as a whole individual rather than as a series of systems or symptoms

alternative perspectives. Together these serve to illuminate issues in nurse education and the development of mentors.

I start with an exploration and positioning of the concept of mentorship in nursing. An understanding of the archetypal mentor-student relationship in terms of how students are socialised into practice and learn from work is provided. Further, this chapter aims to address how this relationship is changed when the mentee is a registered nurse rather than student. Exploring theories of workplace learning alongside organisational and professional drivers of mentorship provision, allows acknowledgement of the complexities involved in learning to be a mentor. I finish this chapter with a discussion of the limitations of the current literature and how this thesis will contribute uniquely to an understanding of workplace learning and mentorship for nurses working in acute care settings.

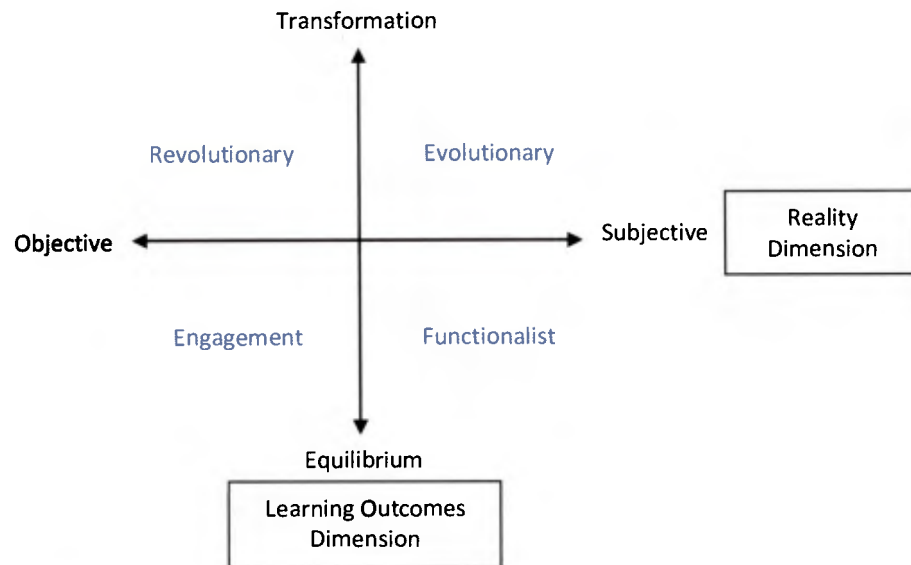
Contextualising Contemporary Nursing Mentorship

This section aims to contextualise UK-based nursing mentorship within the wider mentorship literature, in order to explore its scope, boundaries and working practices. Mentoring as a form of helping relationship is contested in the literature, with many variants evident. Brockbank and McGill (2006) identify that most mentorship programmes can be explored in relationship to their position along two axes. These are the learning outcomes dimension and the reality dimension (Figure 2). The vertical poles of the learning outcome dimension are transformation and equilibrium. Mentorship of student nurses tends toward the latter as it is concerned with maintaining the status quo and standards of both organisation and profession. However, discourses of lifelong learning for RNs seem to suggest an alternative model underpinned by self-direction and adult learning theories.

Equilibrium is linked with discourses of socialisation, grooming for career success, improved performance and job efficiency. In extremis it ensures that power structures remain intact and power recycled among similar individuals, creating organisational cliques and power vacuums. Newer nursing curricula advocate transformative approaches through the use of problem and enquiry-based learning approaches (Darbyshire and Fleming 2008).

Exploration of power relationships, and discussions of how individuals and groups can influence mentorship conditions and outcomes, is common in classroom discussions. Students, whether pre-registration or RNs rarely indicate to me that they have power to make change happen in the workplace. Therefore the evolutionary and revolutionary approaches of the transformation axis seem less applicable to nursing mentorship than those favouring equilibrium.

Figure 2: A Map of Mentorship Programmes



Adapted from Brockbank, A. & McGill, I. (2006) *Facilitating Reflective Learning Through Mentoring & Coaching*, Kogan Page, London: 11

Brockbank and McGill offer a broad typology of mentoring programmes based on the axes of reality (horizontal) and Learning outcomes (vertical). Mentorship programmes in Nursing tend toward the equilibrium pole, underpinned by the need to maintain standards and conform to professional and organisational requirements. Mentorship of student nurses can thus be seen as functionalist in its role of socialisation into the profession. Engagement mentoring is suggested where theories of adult learning are prevalent, or where practice or learning deviates from the norm.

The horizontal axis of Brockbank and McGill's (2006) taxonomy of mentorship highlights the reality dimension, with its poles of objectivity and subjectivity. Nursing is an innately humanist endeavour which recognises the subjective world of others. Extending this metaphoric quality into mentorship alongside the culture of equilibrium would appear to place nursing mentorship within an engagement mode of mentorship (Brockbank and McGill 2006). This is set against a focus on the personal learning outcomes and self-direction suggested in adult learning theory (Knowles 1973), and the encouragement of lifelong learning in RNs (Bahn 2007). However, this does not fit all nursing mentoring relationships. Colley's (2003) description of engagement mentoring as positive action with disadvantaged individuals could be considered representative of an unequal power differential between student nurse and experienced (and thus advantaged) mentor. It does not necessarily reflect the relationship between mentorship student and supervising mentor. As a reforming approach, engagement mentoring may be more evident where there is deviation from expected norms of student learning such as underachievement (Brockbank and McGill 2006).

Professional obligations and organisational needs play a more important role in approaches to nursing mentorship. This fits functionalist approaches (Brockbank and McGill 2006), and finds agreement with Roberts' (2000) notion of structured, formalised mentorship. The Nursing Order (DH 2001) lays out the core function of nursing to be ensuring public safety. This is reflected in curricular and professional documentation surrounding the practice education of student nurses, leading to specific learning outcomes being privileged over others (UKCC 1999, Moore 2005, DH 2006a). SLAiP (NMC 2008a) further informs the prevailing discourse of accountability and fitness for practice of mentors, and nurses in general. Through the socialisation of individuals into working practices existing organisational and professional values and norms are reproduced throughout the workforce. In this model, workers whose own learning needs conform to organisational ones can be groomed for advancement and career success. Above all it represents a conformity model which minimises challenge to an organisation and ensures power structures remain intact. This discourse has contributed to an understanding that mentorship is a near mandatory aspect of professional practice. Both Bahn (2007) and Moseley and Davies (2008) identified that nurses tended to see mentorship as an institutional obligation aimed at risk and litigation reduction rather than personal or professional benefit.

Although there is now a growing body of literature addressing healthcare mentorship, the vast majority of mentorship literature falls outside of the profession (including Roberts 2000). Typically it assumes a dyadic relationship between a senior and junior employee (Beech and Brockbank 1999), which is long-lasting and naturally terminating once the junior colleague reaches certain organisational or maturational goals. The concept of mentorship as paternalistic and male-dominated is also prevalent (Colley 2003, Gopee 2011). In recent years concepts such as team or group mentorship have appeared in the literature surrounding mentorship (Chandler and Kram 2005, Higgins and Kram 2001, Kram 1983, Dobrow and Higgins 2005, Salami 2007, van Beek et al. 2011), but have made little impact on the British nursing mentorship scene due to its entrenched position of dyadic mentorship.

In comparison, mentorship of nursing students tends to be serial rather than long-lasting. It occurs within a fixed timeframe such as the length of a practice placement or module. It involves a third person, namely the patient, in an explicit learning, rather than purely developmental process. As a public process, it differs from the private relationships evident in the mentorship literature from other professions and work groups (teaching,

business, health service management, youth mentoring) where mentorship activity occurs away from the direct workspace. Other differences include the gender-mix of mentors and mentees. Whilst nursing is female-dominant, mixed-sex pairings are common in some areas. Further, the goals for achievement are professionally set within the context of the nursing curriculum, whilst mentorship itself is subject to professional standards including guidance on who may act as a mentor (NMC 2008a). Outside of this structure, students receive pastoral support from personal tutors.

Post-registration mentorship, such as for mentorship preparation also requires supervising mentors to be locally registered. This supervision is not necessarily organised hierarchically, and is as likely to be enacted by colleagues at similar career points. Occasionally a supervising mentor may be at a lower level in the Ward hierarchy, as it is the possession of a mentorship award which is deemed requisite rather than longevity in post, or clinical experience. The supervised mentorship period also exists for the finite period of the module itself. In practice, relationships are often ongoing as nurses continue to work with each other on a daily basis. Ongoing supportive relationships for RNs are conceived within a framework of clinical supervision (Jones 1998, Morton Cooper and Palmer 2000). As relationships aimed at personal and practice development, clinical supervision has an orientation towards coaching, and mentee ownership of the process. This would appear a better fit with Brockbank and McGill's (2006) evolutionary approach to mentorship. Although this appears limited in both availability and take-up within the acute sector, it is well utilised in mental health nursing and midwifery contexts.

In both types of nurse mentor relationship, an assessment function further separates nursing mentorship from other forms. Its introduction has not been trouble-free. Bray and Nettleton (2007) studied mentors and mentees in nursing, midwifery and medicine. They aimed to explore perceptions of the mentorship role and the context within which it was practiced. Questionnaires were distributed to healthcare professionals across five UK NHS Trusts, and semi-structured interviews were undertaken with self-selected questionnaire respondents. This was a large scale study with a total of 1696 questionnaires distributed, but a low overall response rate. The response rate from qualified staff, and in particular nursing mentors was low (13%), affecting the validity of their findings in generalising to a wider mentorship audience.

What is clear is that all of the mentors interviewed in Bray and Nettleton's study had a strong idea of mentorship as being in some way related to specific learning rather than broad developmental support. The dual focus of mentorship of students and mentorship as

a form of continuing professional development is an additional dimension which further separates it from other forms of mentorship, placing it firmly within the realm of workplace learning. These interlinked aspects necessarily involve workplace learning, one from the perspective of developing skills of workplace learning, the other from applying them in practice. Discussion of the latter is less prevalent in the literature. Therefore I have drawn upon wider discourses of workplace learning to explore learning relationships in practice, and the understanding of mentors of their role in supporting student nurses. I start with a discussion of mentorship as workplace learning for qualified nurses, before exploring a wider perspective on workplace learning as applied to nursing. The chapter concludes with a discussion of the relationships affecting workplace learning for nurses and the role that personal orientation to learning might play within these.

Mentorship Learning as CPD Activity

Few studies explore the experiences of qualified nurses who are being mentored, or providing such mentorship for colleagues undertaking formal CPD programmes. Indeed, although learning outcomes such as integration of knowledge and skills learnt in the university, application of theories to practice and collaborative working within professional and interprofessional boundaries are identified in the literature (Allan and Smith 2010, Guskey 2000), they are not always assessed components or indeed evident. Allan and Smith note that as mentorship programmes introduce practitioners to similar ways of learning (in particular reflective learning), there may be more synergy between mentor and learner, but that reflective learning is not a reality in practice. Informal CPD is similarly under-researched. Co-mentorship represents a pragmatic work-based response to insufficient numbers of qualified and locally registered mentors in the workplace. It also serves to introduce practitioners to the mentor's role as a form of informal CPD prior to undertaking a mentorship course. Despite its implication in both *The Code* and mentorship standards, little research explores or evaluates the co-mentor role.

Muir (2007) reports on the evaluation of a year-long mentorship course for specialist primary care nurses, but her focus is on programme evaluation rather than exploring what is happening in the mentorship relationship. In her small case study of semi-structured interviews with five mentees and two mentors, Muir notes a consensus in the understanding of the mentor-mentee relationship which is mirrored in Watson's (Watson 1999) study of mentors and student nurses. The mentorship role was valued by both parties in Muir's research; for offering opportunities for collaborative practice. Despite this, concerns about a lack of protected time for mentor-mentee meetings, and problematic

allocations of mentor and mentee were raised by those being mentored, echoing Cahill's (1996) findings with mentors and student nurses, and findings from Robinson and Griffiths (2009) review of preceptorship research. Muir's study was based in primary care, where practitioners are often lone workers, and are thus not a good match for the acute sector participants in this study.

An indication of the value of co-mentorship as informal CPD is highlighted in my previous doctoral research (MacLaren 2010). In this case study of underachieving mentorship students, participants described co-mentorship as doing all of the 'work' of mentorship but someone else taking credit for it. As co-mentors they had found themselves as de facto mentors with little structured support or learning available from mentors. This work was small-scale (five participants) and thus of limited generalisability to a wider audience, but relevant here in that some of the participants came from the Trusts studied in this research. Participants identified few opportunities to develop mentoring skills as a co-mentor, often just being 'left to it' by qualified mentors. Whilst studying for the mentorship module formalised the relationship between co-mentor and mentor (now supervising mentor), reports of the mentor/co-mentor relationship were variable, and study time for attending the mentorship module was not always forthcoming. Participants in this study were those who had underachieved, and thus may have good reason to exaggerate their poor experiences (MacLaren 2010). However it provides an insight and benchmark from which to assess the experiences of more successful mentorship students and their colleagues in workplace learning.

Mentorship as Workplace Learning

Mentorship takes place within a wider workplace learning debate. Due to size constraints, my discussion will focus on socio-cultural theories of workplace learning. These represent the emerging paradigm of learning in nursing education, and are seen as a participatory, collaboratively constructed and socio-culturally situated activity (Lave and Wenger 1991, Hager 2004a, Fenwick 2008). Learner-centred facilitation of learning rather than teacher-led transmission of knowledge and skills form the focus of educational provision, with strategies such as problem-based learning, and clinical simulation common within taught nursing curricula (Andrews and Reece Jones 1996, Haigh 2007). Fifty percent of the pre-registration nursing curriculum takes place in practice placements, where learning in practice occurs through the provision of opportunities to engage in patient care and reflection on this practice.

Benner (1984) provided a phenomenological exploration of the development of nursing expertise and the knowledge embedded within practice. She conducted initial interviews with 21 expert and novice (newly qualified) nurse pairs, using shared experiences of a clinical situation as the basis of the interviews. Further interviews and observation with nurses at all career stages bolstered the data. Application of the Dreyfus skills acquisition model (Dreyfus and Dreyfus 1979: cited by Benner 1984) with its five stages of skill acquisition (Novice, proficient, competent, proficient and expert) allowed Benner to identify clear differences in the ways that experts and newly qualified staff practice. Novices appeared rule-bound and task driven, whilst experts appeared not to rely on the same analytical principles as their junior colleagues to guide their course of action. This was reported in terms of changes in learners' perceptions of task demands from a series of equally relevant components as novices, to a more holistic overview where only some aspects are relevant. Furthermore it is attributed to practitioners' moves from detached observer to involved performer, reflecting an apprenticeship or Communities of Practice (CoP) model such as that outlined by Lave and Wenger (1991).

CoP theory advances learning in the workplace as a gradual enculturation into working practices of a group (Lave and Wenger 1991). Wenger (1998) identifies that mutuality, joint endeavour and a shared repertoire are key assisting factors in socialisation into a community of practice. Thus, nurses working in an acute Ward environment might be considered as working within a community of practice, with nurses sharing a sense of public service, professional belonging, working practices and goals in patient care (Levett-Jones and Lathlean 2008, Jensen and Lahn 2005). As identified in Benner's (1984) study, newcomers to practice experience a period of socialisation which draws them more centrally into the nursing work of the practice area. This occurs not only with students, but when a nurse enters a new area of practice.

The focus of learning in this context is individual skill acquisition (psychomotor and decision-making/judgemental skill) through mastery, and experience of a wide range of patient-centred episodes. Benner foregrounds the use of reflection for making sense of practice experiences, identifying patterns and testing formal and informal theories (Benner 1984, Innes 2004). This offers nurses a powerful tool for personal learning and professional development which has almost become a competency in its own right. It is organisationally attractive as it does not require further resources to manage, but crucially it does not demand that knowledge and experience are formally shared with colleagues. Reflection is

instead considered a personal professional capacity and responsibility (NMC 2008c, Newman 2011).

With outcomes regarded in terms of personal capacity rather than 'learning' and enshrouded in a body of codified and propositional knowledge, more complex aspects of workplace learning can become difficult to elucidate (Billett 2008, Eraut 2004, Brown 1991). For example, the Dreyfus model does not necessarily provide a mechanism for explaining *how* learning towards specific outcomes happens in practice or the relationships that foster learning. The influence of others is recognised in that learning is constructed over many patient episodes or experiences, but the role of the team or mentor in practice-based learning or developing expertise is not fully explored in this schema.

From a participatory socio-cultural learning perspective, studies of student nurse learning in practice provide some insight, but offer an imperfect proxy for the learning of registered nurses. These tend to focus on the notions of participation and belongingness as prerequisites for learning. Jensen and Lahn (2005) frame this as the development of a 'binding' professional identity as a nurse. Further, full team membership, a common perspective on reality, conforming to norms of practice and collaborating to uphold working practices have been suggested as both key predictors of a social identity (Haslam and Platow 2001), and prerequisites for a community of practice (Wenger 1998). Meanwhile Levett-Jones and Lathlean (2008) foreground the interpersonal relationships required in socialising into practice, where students' orientation, intellectual capacity and willingness to learn appear the most influential indicators of learning. Likewise, Thrysoe et al (2010) recognised that student proactivity played an important role in final year students' assimilation into the Ward as a community of practice. Similar findings were discussed by Newton et al (2009) in their longitudinal interview study of eight Australian student nurses, whilst O'Driscoll et al (2010) indicated that assertive students are better placed to negotiate learning opportunities, than their less assertive colleagues.

Whilst these studies have focused on students developing a sense of belonging and sameness, nurses are not a homogenous group. Different expectations of students emerged from Newton et al's (2009) study of several generations of nurses⁶. Valuing of practitioners own (apprenticeship) modes of initial training and education and differing work expectations and experiences led to negative stereotyping of nursing students. These factors mediated against invitational aspects of clinical practice experiences, leaving

⁶ Nurses who have been educated according to different versions of the nursing curricula, or who have trained abroad.

student nurses feeling that they were used as 'glorified auxiliaries' rather than team members. Student conformity and dissembling in the face of incorrect nursing practices of mentors and qualified RNs, is noted by Levett-Jones and Lathlean (2009) and mediates against belongingness: maintaining student reputation is paramount for registration.

Each of these studies identifies the process of socialisation by which newcomers are introduced to, and become more significant individuals within practice settings. It can be argued that student nurses in these studies represent professional learning communities where the shared endeavour is to gain entry to the nursing profession. This appears a stable concept across the different countries and cultures identified in the studies presented. However the CoP framework is criticised as offering a view of workplace learning as merely socialisation and situational determinism (Bierema 2001, Hodkinson and Hodkinson 2004). Several factors are influential here. Firstly, the forced heterogeneity of team members within a Ward means that team membership necessarily includes colleagues from other professions and occupations. It is shaped by contractual working obligations rather than a community developing out of explicitly shared practice values. The aim of apprenticeship in Lave and Wenger's (1991) conception of situated learning is full engagement with practice, however lack of invitation to participate and the generational differences identified by Newton et al (2009) would mediate against learning and community engagement.

Secondly, the motivation to participate within a CoP is broadly unchallenged by Lave and Wenger (Lave and Wenger 1991, Wenger 1998), with an understanding that peripheral participation can lead to more central engagement with the work of the community. Just as sitting in a classroom does not guarantee learning, peripheral engagement in the practicum requires cognitive stewardship through the invitational practices of others (Newton et al. 2009, Spouse 2001). Similarly Kupferberg (2004 - cited by Andrew et al. 2008) argues that the CoP model does not explain why some individuals are fast-tracked into a more central position, whilst others never fully participate.

Finally Andrew et al (2008) identify that although influential in other professions, communities of practice have not been widely acknowledged within British acute nursing settings. Instead work premising CoPs has focused on experienced nurses involved in small-scale strategic project working (Lathlean and Le May 2002) or wider-scale practice development (Tolson et al. 2005). The CoP concept appears most successfully applied where group learning is based on an area of uncontested agreement. The professionalisation agenda within nursing has somewhat distanced itself from

apprenticeship models. This may account for the relative unpopularity of this theory in the nursing literature.

A fundamental critique of both Benner (1984) and CoP models of workplace learning is that they suggest a relatively unproblematic enculturation of group norms and ideals based on a power differential between old-timers and newcomers. They do not account for how existing members of a group are influenced to engage in learning and mentorship of others. Additionally, the professions studied by Lave and Wenger (1991) do not fit with contemporary understandings of professionalism. The increasingly technological, managerial and regulatory world of contemporary nursing practice is not reflected in either research. The role of relationships and the individual dispositions that orient individuals to act in certain ways is not explored in these approaches.

Mentorship Learning and the Role of Relationships in Practice

Whilst Lave and Wenger's work is considered influential in workplace learning (Lave and Wenger 1991, Wenger 1998), Bourdieu's (1977) theory of practice is increasingly looked to as a lens through which to view the effects organisation, institution and profession (field) on personal practice (habitus) (Rhynas 2005). Several constructs are keys to Bourdieu's theory of practice. The notion of 'field' is conceptualised by Bourdieu and Waquant (1992: 105) as being a,

"...critical mediation between the practices of those who partake of it and the social and economic conditions",

and could be seen, in part, as a proxy for community of practice. Habitus is acknowledged as the combination of previous biography, identity, lifestyle, class and culture affecting individuals' beliefs attitudes and values by other authors (Colley 2003, Billett 2008).

The ability of individuals to impact on field and practice is influenced by their perceived and actual agency⁷ and capital⁸. Through a Bourdieuan lens, meaningful understanding of workplace learning can only be gained through examination of relationships at all levels within an organisation. This places a community or practice within the broader contexts of organisational, strategic and professional influence similar to that outlined in Stoll and Seashore-Louis' treatment of a 'professional learning community' (Stoll and Seashore Louis 2007), rather than the undefined parameters of a community of practice. Warne and McAndrew (2004: 15) describe nursing habitus as the means through which the nursing profession perpetuates itself, through the actions of its membership in concert. This gives

⁷ Capacity to act

⁸ Resources – both physical and social

an appearance of 'rationality and intentionality' to seemingly unconscious group behaviours, and shapes and constrains interpretation of events within a limited frame of reference. In the following sections I explore key relationships and their effects or impact on learning. The chapter culminates with a discussion of the impact of learning orientation on mentorship as an indicator of personal disposition.

Strategic and Operational Relationships: Transmission of Mentorship Policy

Organisational learning in the health services has been influenced by a drive toward Universalist standards of service delivery. The boundaries and competencies of a profession are set by the controlling professional or governmental body in reaction to current political and societal imperatives (Stronach et al. 2002). Chan (2003) traces these back the imperatives of organisational learning to the early 1900s which called for specialisation, repetition, observation and feedback in order to promote worker efficiency. Such managerialism created a literal hierarchy of skills and practices within workplaces, where each stratum of a profession or occupational group privileged certain practices and knowledge above others (Solomon 2001). Task-oriented nursing was a feature of this form of organisational learning, and was characterised by organisation of work by task, rather than a consideration of the patient as a whole. This has been replaced, by and large by a professionalising agenda which values broadening the repertoire of nurses to respond to healthcare need according to the best evidence available and the preferences of the patient (Benner 1984, Sackett et al. 2000). However one focus on universalism in service provision (Cooke and Philpin 2008) has continued in the regulatory framework of nursing, the UK clinical governance agenda and the development of benchmarked standards of care (Matykiewicz and Ashton 2005, NHS/DH 2010).

Thus the nature of learning in health care practice is shaped by relationships between HEI, NHS commissioners, practitioners and educators. A key example is the discussion of organisational mentorship capacity which appears to dominate the agenda on mentor preparation (Hutchings et al. 2005, Magnusson et al. 2007, Murray and Williamson 2009, Fergy 2011). This relates to concerns of ensuring adequate mentors are available to service the mentoring needs of pre-registration students. It is further influenced by the needs of professional bodies and working practices of other professions (such as medicine) in extended nursing roles and collaborative patient care. Two studies exploring the organisational relationships dimension are presented here.

Simpson's (2009) PhD thesis used mixed methods to explore the impact of strategies and mechanisms to implement and support the workplace learning (including mentorship) of nurses in UK practice settings. Representative views from all strata of influence in practice through interview, focus group and questionnaire were sought within three NHS Trusts in Scotland. Simpson found gaps between strategic and operational understandings of workplace learning, and implementation of mentorship. These gaps were significant in how organisational values and commitment were demonstrated by those practising within the system. The mentor supervisor relationship was not one of those explored, but might have given some insight into the operational-strategic divide found. A regular practice education forum with a wide membership of stakeholders was recommended to address this gap.

Chan (2003) undertook a large questionnaire-based survey of 800 staff members in an Australian hospital, where 90% fell into the category of nursing and administrative staff (no distinction between employment types is offered). Like Simpson, Chan identified a gap between individual learning and organisational learning. He notes that this was not statistically significantly related to any of the recognised facets of organisational learning. His study found that individual learning was significantly related to team learning, and that team learning significantly related to the organisational learning attributes of:

- Clarity of purpose and mission
- Leadership commitment and empowerment
- Transfer of knowledge
- Experimentation and rewards
- Teamwork and problem solving

These attributes have some linkage with the domains of mentorship identified in SLAiP (NMC 2008a), such as facilitating learning (knowledge transfer), leadership, and teamwork. Chan's findings suggest that hospital staff are more likely to learn through team-working than through individual learning. It is this team-built knowledge that is likely to transpire to the organisational level. It also suggests that single practitioners have less impact on organisational mechanisms than do groups. The broad sample of hospital workers in this study does not give any suggestion of whether nurses as a discrete group of professionals might have had further influence on organisational learning. Local and national differences in the regulation and organisation of hospital services in Australia may also influence staff engagement. However, as a corollary to Simpson's (2009) study it appears to denote some disconnection between policy and practice.

Operational Relationships: The Ward as a Learning Environment

What happens within Ward teams to promote learning is as important to consider as a mezzo-level analysis. Although much of the research indicates the Ward as a learning environment for student nurses, it is also the learning environment in which staff nurses develop their clinical and mentorship roles. Pulsford et al (2002) note the central role of colleagues in supporting workplace mentoring. Their survey of mentors linked their HEI aimed to gain an overview of the practitioners supporting pre-registration students. Information was gained on the levels of support experienced in undertaking the mentoring role and experiences of annual update sessions of 198 mentors (50% return on their initial distribution to 400 mentors). This indicated that 67% (n=132) of respondents felt that they were suitably supported by colleagues to undertake the role of mentor. However a significant minority felt that they would like more support (14%), or had experienced no support from colleagues at all (5%). Similar numbers of mentors agreed that they had received sufficient support (38%) from a manager, as would have liked more (36%). This suggests that colleagues were more influential in supporting each other in mentorship roles. What the study does not explore is the ways in which these colleagues were influential, or the differences in support received from manager and colleague.

Berings et al (2010) explore the antecedents of nurses' actual learning activities using Karasek and Theorell's (1990) demand-control-support model. A survey of 912 qualified nurses working in 13 Dutch district hospitals, explored the interplay between learning behaviours, intrinsic motivation and psychological work conditions. Seven learning behaviours were identified which appear to take in a variety of different learning theories. The most significant of these for the nurses surveyed was learning through reflection and learning through talking to others. This suggested to the authors a relational, if not participatory, mode of nurses' learning. Learning activities appeared to be influenced by the level of nurse education received.

Those with higher nursing qualifications were more able to learn through the experience of work, modifying their own work tasks and reflecting on their actions. Workload and social support were found to have significant impact on intrinsic work motivation, with the social support of a supervisor (in this case, managerial) having a direct influence on five of the seven learning behaviour indicators; and job autonomy influencing four. No direct effects from job demands (workload) on learning behaviours was found. Berings et al (2010) suggest that supervisory management style is important in providing sufficient job control and that transformational leadership and coaching will yield results in learning outcomes.

Intrinsic work motivation had a consistent effect across all seven learning behaviour indicators and mediated key parts of the impact that the psychosocial work environment had on the workplace learning of the nurses taking part.

Lewin (2007) used clinical learning indices such as clinical grade of mentor, demonstration of practical procedures and time taken over these, time supervised and testing of theoretical knowledge to compare the experiences of two cohorts of UK student nurses twenty five years apart. Despite organisational changes, Wards as learning environments for student nurses were considered relatively stable. Acknowledging significant differences in data collection methods in his two studies, Lewin reports that the learning experiences of these groups remained positive and broadly similar, although other historical studies identify lack of support, leadership and Ward management as negatively affecting student nurse learning outcomes (Muncer et al. 2001, Menzies Lyth 1988, Fretwell 1982).

Fretwell (1982) implicated hierarchical and rigid leadership as counter-productive to effective Ward-based learning and responsible in part for a high attrition rate in pre-registration nursing courses and rapid turnover of qualified staff. This suggests that the steady state identified by Lewin (2007) perpetuates poor as well as positive practices in student learning. Indeed, Last and Fulbrook (2003) recognised that occupational stress and polarised working and learning conditions were still problematic for nursing students 21 years on from Fretwell's study. The practice areas described above can be considered in terms of offering restricted and restrictive opportunities for workplace learning along a continuum described by Rainbird and colleagues (Rainbird 2004, Evans et al. 2006). Within this expansive-restrictive framework practice areas are considered expansive where learning forms an integral part of work. Increased responsibility and discretion alongside access to qualifications offer practitioners the opportunity to raise aspirations and develop their roles, within a meaningful clinical appraisal system are also important components (Rainbird 2004, Berridge et al. 2007, Felstead 2008). Within expansive learning environments an ethos of learning as repertoire expansion rather than authoritative or authoritarian hierarchy is often described (Solomon 2001).

Whilst mentors have not traditionally been seen as leaders, leadership is a function of mentorship which is evident in the current standards (NMC 2008a). Mentorship is closely aligned with distributed leadership because of the devolved nature of the role. O'Driscoll et al 's (2010) multi-stage case study across four NHS Trusts, aimed to explore responsibilities for the leadership for student nurse learning. Engaging a wide range of participants across hospital and HEI settings, they explored different academic and clinical roles in relation to

supporting students in practice. Their main finding was that day-to-day leadership for student learning has been increasingly devolved to junior staff nurses acting as mentors, and in some instances, health care assistants.

Changes to the roles of the Ward Manager, Modern Matrons and Nursing Leads which take them further away from this key interface are seen as causes for devolving responsibility, although the ward sister appears to retain an overview responsibility (Warne and McAndrew 2001). Devolution of educational leadership roles was associated with several barriers. Issues such as inadequate training, the increasing demands of a heavy clinical workload and feeling pressurised to mentor for career development are identified.

O'Driscoll et al found that mentors experience difficulties in modelling care work when their nursing role is increasingly technology and liaison-focused. This is similar to the erosion in the status of 'relational care' noted elsewhere in the literature (Scott 2008, Stronach et al. 2002, Warne and McAndrew 2004), and suggests that caring has become less valued by a profession striving toward advanced technological and specialist practice. O'Driscoll et al suggest that leadership for learning needs strengthening in order to re-couple clinical practice with education.

Where transformational or motivational leadership styles are employed by nursing leaders, learning is promoted. The successful leader in this context is able to act as an 'entrepreneur of identity' (turning me and you into us) (Haslam and Platow 2001) and is able to capitalise on their similarities with members of their group, whilst managing in-group and out-group (potentially marginalised or dissenting) relationships. Russell (2003), in case studies on leadership in community-based organisations argues that groups with strong and clear-cut self-definition appeared more cohesive, whilst weaker group cohesion stopped groups working in concert. This seems to further endorse the development of an expansive learning environment, and the development of an often elusive sense of team spirit (Wilson-Barnett et al. 1995).

However, it is the role of individuals within a team which appear to be the fundamental building block of behaviour reproduction and what gets learnt by an organisation. What follows is a discussion of one aspect of this, namely individuals' orientations to learning. Manley (2004) identifies that effective (transformative) working cultures have several key features in common in their focus on practice development, person-centred and evidence-based care and staff empowerment. Other features which may be present include shared values and practices, adaptability (reflected in a learning culture), a match with service

needs, valuing of stakeholders and leadership, with potential developed at all levels of an organisation.

Personal Disposition and Relationships in Practice

Shared practices result from a constant process of contestation of knowledge and practices between members of a team or community (Warne and McAndrew 2004). Launer comments on the tendencies for knowledge learnt as a student nurse to be considered sacrosanct, claiming that it '*...sticks tenaciously*' and is hard to unlearn (Launer 2003: 57). A caveat here is that the student or newly qualified nurse as a relative novice has little experience as a qualified practitioner to reflect upon. As peripherally situated learners, new staff nurses may not be privy to the heuristics or decision making processes which enable community members to negotiate culture and practices of a workplace (Greeno et al. 1999, Taylor and Care 1999, Field 2004, Haslam and Platow 2001, Warne and McAndrew 2004). These are crucial in developing a sense of professional habitus and personal agency (O'Connor 2006).

The contested nature of knowledge and nursing practices means that these may not always be truly shared or valued by nurses. Poor practices are as likely to be perpetuated in workplace learning as 'good' ones, with Fenwick (2001: 7) positing that

Problematic knowledge may become authoritative through continuous reinforcement in social learning processes and resistant to change

Even purported 'good' practice can belie poor practices as Nichols and Badger (2008) demonstrate in their observation and interview-based study of the hand-hygiene practices of UK nurses. They found that whilst nurses claimed to be acting on the basis of best evidence, their actions did not match the beliefs espoused. Conversely when hospital consultants were shown to adhere to a strict hand-hygiene policy, junior doctors followed suit and applied the same process as standard. Nichols and Badger claim this as evidence of nursing workplace pedagogies based on behaviourist learning and practice, and social desirability. This serves to perpetuate rather than challenge ritual and local custom and practice, rather than safeguard patient care. Other authors argue that learners fall into or explicitly unlearn certain practices rather than choosing them explicitly (O'Connor 2006, Bourdieu 1990). This may be related to an individual's' desires to fit into a new social group or workplace system, and relates back to issues of belongingness and social norms.

Gainsbury (2010) reported on a recent online survey of 1945 registered users of nursingtimes.net⁹ with regards to their experiences of failing student nurses. The statistics presented demonstrate that mentors still have significant concerns about assessment practices. Echoing earlier studies (Duffy 2003, Phillips et al. 2000, Gainsbury 2010), 40% of respondents reported that they couldn't prove their assessment concerns were valid, to fail the student. 31% thought that their assessment would be over-ruled by the university. Concerns about lack of training (18%) and confidence to deal with the situation (15%) were also raised. Significantly when asked about general student attributes mentors' reported on poor attitude (69%), poor clinical skills (43%).

Gainsborough's results need to be viewed with some caution as the accompanying report does not contextualise the methodology leading to these results. Respondents are not guaranteed to be RNs, or indeed mentors, as neither is a requirement of registration on this website. However, the survey does raise questions about the competence of mentors to assess students and how attributes such as professional attitude and best practice of skills is shared between nurses. Mentorship students are supervised and assessed by the same mentors, who will go on to assess the competence of future generations of nurses. Taken in conjunction with Duffy's (2003) work on failing to fail students it would appear that poor mentoring and assessment practices are perpetuated in clinical practice. This has implications for workplace learning, but more importantly, patient safety.

From their review of the literature Eby and McManus (2004) identify that difficulties and dysfunctions in the mentoring relationship occur where there are conflicts and disagreements between mentor and mentee, such as those resulting from differences of judgement (as in assessment). This often manifests in blaming learners for their own failure to achieve learning outcomes. Warne and McAndrew (2004) discuss this in relation to reducing patients to 'bodies' rather than whole people, but the same can be said of mentors' reactions to underperforming students where the gaze is suddenly on what the student cannot do rather than them as whole individuals and learners. This blame is reminiscent of psychological reactance. In this professional habitus is challenged in such a way that the professional responds by discounting the deviant (non-privileged) view in order to reassert their professional dominance over a situation.

Brown and Duguid (1991) offer an explanation for the propagation of non-standard practices in their analysis of the workplace learning of photocopier repairmen. They

⁹ Website of the nursing magazine *Nursing Times*

identify that the accounts of work embedded within organisational policy or course materials may have little practical relationship with the complex decision-making that real-life practice entails. This requires experienced practitioners to problem-solve and develop 'work-arounds' to get the job done rather than relying on explicit guidelines or protocol. This could be viewed as the type of organisational learning espoused by Argyris and Schön (1978) which allows recognition, questioning and eventual replacement of implicit theories-in-use. However, organisations often place little value on these 'shop-floor' innovations despite their value to practitioners, giving them a counter-cultural feel (Cox 2005). For the nurses in the case described by Nichols and Badger (2008), the learning that followed was not always best practice. For Thrysoe et al (2010), an acquisition model of learning related to student nurses' being able to answer the 'right' questions, sat alongside a participative learning structure in their study. However there was some suggestion that the basic knowledge that nurses required of students was different from the theories introduced to students in the classroom. This suggested to the students that formal theory was less important to nursing than practice experience itself.

The Role of Personal Orientation in Mentorship Learning

Lifelong learning is well understood concept within nursing due to the requirements to demonstrate this with every re-registration. However, the concept of the 'learning professional' (Hager 2004a) is problematic. Workplace learning is often accepted at face value in the literature as developing certain types of workers and certain types of learner (Solomon 2001) but this fails to recognise that to adopt a 'learner' stance may be to invite vulnerabilities in practice. As mentorship tends to occur at an early stage in nurses' careers, they may yet to have fully gained mastery of organisational and clinical processes (Boud and Middleton 2003, Berings 2006). Because mentorship is often seen as informal learning, it can be seen as a low priority for other staff (Eraut 1994, Eraut et al. 2007). This creates a cycle of performance anxiety and unmet needs. Informal networks may be useful in meeting some mentorship needs, but unless there is some overall responsibility for mentors, learning may be compromised (Higgins and Kram 2001), and blocks to onward performance may develop into more concrete dispositions or orientations toward learning (Evison 2006, Dweck 2000).

Hodkinson and Hodkinson (2004) take a Bourdieuan approach in identifying key differences in the learning dispositions of two mid-career secondary school teachers. Whilst both were considered successful teachers, they employed different strategies and dispositions to either 'survive' imposed CPD, or to expand their teaching role and horizons. Malcolm is

portrayed in terms of his isolated yet co-operative practice within the school's history department. He is described as taking an experiential approach to his work, and learns through a variety of means. He chooses to use the cultural capital he has accumulated (knowledge of working practices and micro-politics) to either cooperate with or resist strategically imposed changes to his practice. Conversely, Steve uses his cultural capital and position as head of the music department to gain influence at departmental, school and university levels. He mobilises a wide network of working relationships and his preferences for collaborative learning. The detailed descriptions offered are a useful parallel to the aims of this thesis, offering a resonance and situated generalisation that has an impact beyond the profession for which it was intended to influence (Simons et al. 2003). However, whilst they provide an understanding of individual motivations, the case studies do not explore in depth how dispositions affect those working relationships.

Orientations to workplace learning may account for individual adoption or rejection of learning. In my IFS research (MacLaren 2010) I identified that some nurses who failed or underachieved in their mentorship module displayed different orientations to learning which affected their onward learning. These orientations appeared to be indicative of how both mentorship and underachievement was framed for the individual. Students demonstrated entity or mastery-oriented responses to the challenge of the module and its outcomes. Their responses were similar to the entity-theorist and incremental –theorist orientations identified by Dweck and colleagues (Dweck and Sorich 1999, Dweck 2000, Nussbaum and Dweck 2008). Entity-theorist orientations to learning, regard learning potential as fixed and unresponsive to effort, with the locus of control situated outside the individual, making them to susceptible to learned helplessness (Seligman 1975), as they doubt their intelligence, ability and personal capacity to reach learning outcomes.

In comparison, those with incremental-theorist orientations appear to thrive in the face of learning challenges. The concepts of commitment, perceived personal control and challenge are significant components in promoting positive outcomes and coping with stressful situations (Maddi 2004). Incremental-theorists demonstrate high self-efficacy and problem solving approaches to new challenges in learning (Nussbaum and Dweck 2008). Kristjansson (2008) criticises Dweck's categorisation of incremental and entity-theorist orientations as creating a crude polar division between the two categories. However, Dweck's later works suggest that there is more likely to be a continuum and relative movement between states (Dweck 2000).

Conclusions

The literature reviewed provides some insights into the complex relationships between students, mentors and supervising mentors. It reiterates the centrality of mentorship within the context of nurse education, and its role in socialising practitioners into their nursing careers. Whilst communities of practice might form one way of looking at how this occurs, it provides a limited frame of reference for the complexities evident in contemporary mentorship practice. Bourdieuan theory adds an additional dimension in allowing both macro- and micro-perspectives on workplace learning to emerge. The literature identifies some clear evidence about what makes for successful mentoring in terms of its features, aspects and activities. It also provides insights into why this might be so. However, there is little or nothing about *how* this happens in practice in terms of the quality and appropriateness of interactions or the dispositions of key individuals to take part in mentorship itself.

Whilst Mentorship awards are often criticised for not preparing competent and confident mentors, little literature explores mentor/supervisor learning relationships in nursing practice. No previous studies have sought to explore the policy, professional and relational influences surrounding mentorship in nursing and their expression in day-to-day nursing practice from a practitioner up perspective, whilst the majority of literature on workplace learning in nursing comes from an Australian or wider European sources, rather than offering a perspective culturally situated within the UK. This study seeks to redress this gap in understanding by bringing in to focus what is actually happening in mentorship relationships in a range of acute care settings and through accessing a range of stakeholder perspectives.

This research would make a timely contribution to the available literature exploring broader workplace learning strategies, policy and wider issues of professionalism in nursing. A broad appeal to the wider academic community concerned with developing workplace learning and continuing professional development is anticipated.

Chapter Four: Methodology

Introduction

Within an interpretivist methodology a case study approach is utilised within the research, which considers mentorship learning relationships and policy dissemination in two acute NHS Trusts (Seacole and Nightingale). In the widest sense, this approach is influenced by my view of workplace learning as socially and culturally situated, and mediated through relationships with peer and colleagues, professional and organisational influences. This reality is complex, holistic, and context dependent. Simons (2009) identifies the case study approach as offering an intrinsically qualitative form of validity, because it values subjectivity, emotionality and feeling in both researcher and researched. This approach gives a voice to marginalised voices such as those of mentorship students and supervisors, but relies heavily on the critical subjectivity and reflexivity of the researcher. I have thus endeavoured to write myself into the story of the research, noting ways that my values have influenced the selection, interpretation and analysis of the data collected. This practice is supported by critical theorists and post-structuralists alike (Simons 2009, Hall 1996).

The data collection methods I have chosen are broadly interpretivist, and influenced by a range of methodological approaches (see glossary; Appendix A). The relationship between the research questions and the methods is identified in table 2. Further, the data collection methods represent the range of qualitative data that was pragmatically available without accessing additional research funding, and in the time available. Each data source used brings different methodological issues to bear in collecting and analysing data, but allows an assessment of the consistency and coherence of multiple perspectives to be made.

In this chapter I outline the justification for the case study design used, providing an operationalisation of the case as the basis of my sample selection. The methodological and ethical rigour underpinning the choice of methods and mode of analysis are also considered here, with a discussion of my motivations and justifications for their use. Whilst criticisms of subjectivism and sloppy research are often levelled against case study research, I explore these and argue for case study as an effective means to explore complex real-life situations.

The Case for Case Study Research

Simons (2009: 21) provides both a definition and rationale in explaining case study, which has influenced my understanding of the approach:

“...an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a ‘real life’ context. It is research-based, inclusive of different methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic, ...programme, policy, institution, or system to generate knowledge and/or or inform policy development, professional practice and civil or community action”

Thus case study research is considered ‘strong in reality’ but difficult to organise and summarise (Cohen et al. 2000: 184, Flyvbjerg 2006). More generalisable research designs were not considered for this study. Whilst these might provide breadth of data and a more straightforward mode of statistical analysis, they lack the opportunity to explore the richness and complexity of the context in which these experiences are situated. For example quantitative surveys of mentorship students might identify trends and patterns in mentorship supervision. This may have served to provide an overview of the field, but would not engage with the experiences of participants in real-life situations. It is the complexity of real-life which adds to the richness of the data.

Qualitative case study is an apposite method for exploring workplace learning as it allows a focus on both the context of a case and integration of the personnel within it. The focus on the particular rather than the universal, the practical rather than exclusively theoretical, and the affective and social domains rather than the cognitive are central to both case study and workplace learning (Street 2004, Beckett and Hager 2000, Simons 2009). Indeed the notion of ‘situated’ generalisation (Simons et al. 2003) recognises that information is not free-standing but contextualises data rather than generalising it to wider populations.

Table 2: Methods, Analysis and Data Yielded related to the Research Questions

Method	Participants	Data yielded	Rationale for use in qualitative research (after Silverman 2006)	Mode of Analysis	Link to Research Questions
Semi-structured interviews with recently qualified mentors	3 recently qualified mentors 3 significant others	Experiences of learning to mentor, being a mentor, and being supervised in the workplace.	Allows open-ended questions to a small sample group of participants. Allows construction of narrative from the bottom up		<ul style="list-style-type: none"> What happens to facilitate workplace learning in relationships with significant others What is the understanding of these individuals of their role in the development of new mentors in practice What role does the notion of professionalism play in the mentorship of learners?
Semi-structured interviews with Practice Education Facilitators (PEF) and Nurse Education Leads (NEL)	2 PEFs (one of the PEFs was also highlighted as a significant other) 2 NEL	An organisational and strategic view of mentorship in Seacole and Nightingale Trusts. Routes of relational influence through the Trusts.	Provides evidence of the organisational context of mentorship	Interpretive, inductive thematic analysis	<ul style="list-style-type: none"> What happens to facilitate workplace learning in relationships with significant others (PEFs) What role does the notion of professionalism play in the mentorship of learners? What constitutes the current policy, professional and political agenda for nursing mentors and in which ways are these messages transmitted and interpreted by mentors?
Semi-Structured interviews with policy-level nurses from the local Strategic Health Authority and Education department of the NMC.	2	Insight into the development dissemination and governance of mentorship. Policy views of the role of the mentor	Frames the policy structures surrounding mentorship		
Mapping of Standards to Support Learning and Assessment in Practice Policy, and related requirements across interview content	All mentors / PEFs and NELs	An indication of policy awareness/impact and diffusion of SLAIP within the Trusts	Use of the standards is assumed. Mapping policy content in interviews gives an idea of the extent to which this has been internalised by mentors	Interpretive, based on own knowledge and understanding of SLAIP	<ul style="list-style-type: none"> What constitutes the current policy, professional and political agenda for nursing mentors and in which ways are these messages transmitted and interpreted by mentors?
Development of relationship constellations	All	Visual representation of the strength of relationship tie, density and diversity of relationship network	Identify who is significant to learning and development in mentor and practice education roles	Interpretive analysis using Higgins and Kram's (2001) typology of developmental networks, and Darling's (1984) Measuring Mentor Potential Inventory	<ul style="list-style-type: none"> Which learning relationships in practice settings are significant for nurses? What happens to facilitate workplace learning in these relationships

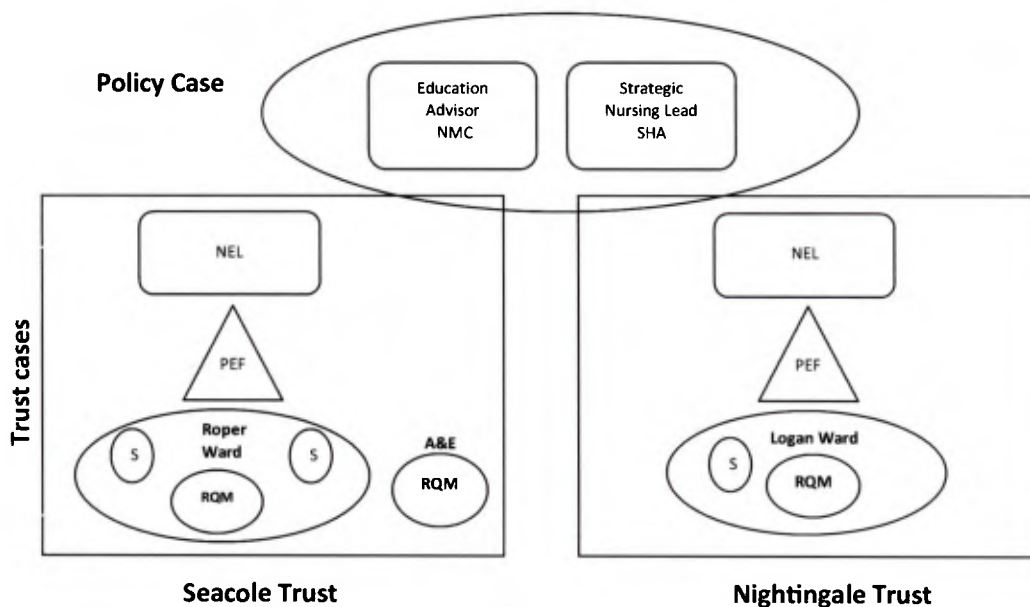
Fenwick (2001: 8) identifies the importance of context in relation to workplace learning ,
...whose values shape the naming of valid knowledge and whose activities and interactions conjure and shape cognition.

I provide this not to cause confusion between teaching cases and research cases, but to note the general symmetry between case study, workplace learning and my own social constructivist leanings. The context is thus important in operationalising the cases.

Operationalising the Cases

The type of case study chosen has implications for the wider rigour and generalisation of findings. For this research I have chosen an approach which relies on multiple participants taking part from within a series of different contexts and organisations. This approach is described by Yin (2009) as a multiple (embedded) case study design. It has advantages in synthesising a collective account of phenomena, as well as taking individual perspectives into account. In the main, my research concentrates on individual nurses working at various levels within two NHS Trusts linked with Capital University. These nurses represent individual units of analysis within the cases, and are illustrated in figure 3.

Figure 3: Operationalisation of the Cases



This diagram locates participants (as broad units of analysis) within the multiple (embedded) case study design. Each of the Trust Cases contains at least one recently qualified mentor (RQM), two of their significant learning relationships (S), a Practice Education Facilitator, responsible for the day-to-day leadership of mentorship across the Trust (PEF), and a Nurse Education Lead (NEL). In Nightingale Trust, the PEF was one of the named significant influences. The policy level case consists of one senior education advisor from the NMC, and a strategic policymaker from the local NHS Strategic Health Authority (SHA), representing the sources of organisational and professional policy for many practising nurses.

A third case is composed of two nurses working in policy-level organisations outside of the Trusts. The three cases provide opportunities for comparison between organisations, but also between strata of personnel (Yin 2009). Issues of triangulation between methods and participants will be discussed in the following section.

My approach to case study can be characterised as instrumental (Yin 2009, Simons 2009), with individual participants and cases building a bigger picture of the overall case. The issues identified in the research questions are therefore the dominant focus rather than the cases per se, or the individuals within them. Individuals have been chosen strategically for their unique roles and perspectives on mentorship and workplace learning in nursing. This was to ensure that the two hospital cases were similar, and thus comparable. Each Trust case is composed of at least one RQM (ex-mentorship student), and two colleagues identified by them as significant to their workplace learning. The case also contains colleagues with a specific practice education role (Practice Education Facilitators, PEF) and nurse education leads (NEL) from within each of the Trusts. This allows a picture of mentorship and workplace learning within each Ward, and more widely, Trust to develop. The two Trust cases are augmented by a further instrumental case, composed of a strategic policy-maker from the local Strategic Health Authority (SHA) and an education advisor from the professional regulating body (NMC), whose role and outputs affect the hospital-based cases, but whose roles are not under scrutiny in this research.

These cases build into a complex narrative or thick description (Geertz 1973) of mentorship culture within these organisations. Mindful of claims of case study as less rigorous than other forms of qualitative or quantitative research, Yin (2009) reports that multiple case designs are generally considered more robust. To yield more compelling evidence, this may be related to replicability of data collection methods across multiple sites. This claim is further explored in the upcoming section on research rigour.

Rigour of Approach

Case study research has been subject to a wide range of criticisms from both quantitative and qualitative researchers. These tend to focus on the issues of validity, reliability and generalisability, and characterise the approach as 'flawed', 'sloppy', anecdotal and selective (Simons 2009). Criticisms are often based on views of research rooted in epistemologies of objectivity, logical positivism and technical rationality, but also within purist qualitative traditions within the social sciences (Brown and Dowling 1998, Cohen et al. 2000). Nevertheless, they provide a framework from which to determine the rigour of my own research approach, which will inform this section of the chapter.

Whilst different markers of reliability and validity tend to be at play within quantitative studies, these are no less significant within the qualitative research paradigm in which they are situated. Indeed, Tight (2003) prefers not to separately label case study within his list of eight key qualitative methodologies, stating that in essence *all* research is case study research. This view is shared by Flyvbjerg (2006) who gives an example of Galileo's rejection of Aristotle's law of gravity as a critical case, which has proved as influential and as generalisable as any more traditionally framed research projects.

Precautions aimed at minimising bias have been implemented in this research. Whilst positivist research calls upon measures of validity and reliability to achieve this, such measures are not considered entirely relevant to qualitative case study designs. A degree of internal validity is needed to establish the credibility of the research. Simons (2009) explains internal validity in terms of establishing the warrant for research. Validity claims are considered in terms of whether research is sound, coherent, defensible and well-grounded and whether any claims made can be clearly seen as having a basis in the data. General methodological issues contributing to internal validity include immersion in the research situation, triangulating data sources, conducting member-checks, collecting referential materials and engaging in peer consultation (Merriam 1985). I used most of these in establishing credibility of my own research.

In terms of my relationship with participants, I employed member-checking to authenticate and clarify the typed transcripts. I carefully attended to any comments and clarifications needed in the text and confirmed these with participants. Peer consultation in the form of doctoral supervision was used to explore and comment on the plausibility of the emerging data, whilst the opportunity of a four-month sabbatical allowed time for immersion into the research process. Conducting the literature review, along with my existing knowledge and experience of mentorship helped to focus my research. Several forms of triangulation were also employed, and will now be explored in further detail.

Triangulation

Methodological triangulation between the interviews, relationship constellations and policy mapping was employed. Whilst their primary function is to answer different components of the research questions, the different methods employed offer different perspectives on the overall field of mentorship and supervision. These could be analysed together to add richness to the data. Further triangulation across different levels of participants enabled organisational and strategic perspectives to be compared with the individual. Situating the research in two acute NHS Trusts provided further opportunities to compare responses

between organisations. Purposeful selection of the initial case, and strategic-level Trust-based participants offered some of the replication logic of positivist research (Yin 2009), although strict replication measures were limited by the lack of control over the selection of significant learning relationships. However, thus some generalisations (albeit limited) could be inferred.

Multi-level and cross-case triangulation offer opportunities for multi-perspectival analysis. This is considered analogous with construct validity and respondent validation, in its use of multiple sources of evidence and establishing chains of evidence (Simons 2009, Yin 2009). Further, it counters some of the drawbacks of triangulation based in realist research agendas where the convergence and confirmation achieved are considered closer to the 'truth' of reality, but can privilege one reality over others. Commensurate with my view of learning as socially constructed, I believe that realities are multiple, constructed and interpreted rather than singular, fixed or stable. Thus what I have looked for in my own data is a sense of authenticity arising from multiple perspectives and how they do, or do not intersect within the context of mentorship. This provides data which is complex and at times conflicting. My own perspective is integral to my understanding and interpretation of this data but is not privileged over the voices of others in this research.

Generalisation is not the aim of either case study, or qualitative research in general. Notions of the contextual 'situatedness' of findings tend to replace those of generalisation in case study (Flyvbjerg 2006, Janesick 1994, Richardson 1994). Although in this design some generalisations may be gained through cross-case analysis, it is the in-depth and holistic nature of case study research which generates both unique and universal understandings for the researcher and reader (Simons 1996). The metaphor of a crystal though which to view the findings of case study work is used by some (Yin 2009, Stake 1995, Simons 2009) to give a sense of the complexity of research exploring social experiences. The crystal is described as offering symmetry, substance, multiple lenses and multiple angles of approach. As with a polished gem the case study research can only ever claim to be partial, reflecting that there will always be other facets that are not seen or not considered relevant by the reader. Effectively the research and its findings become what the reader makes of them (Thorne 2011).

Ethical Considerations

This research was subject to the British Educational Research Association revised guidelines for educational research (BERA 2004) which insists upon an ethic of respect for the person, knowledge, democratic values, the quality of academic research and academic freedom.

My own professional registration as a nurse and nurse teacher imposed further complementary regulation and ethical guidance in the form of adherence to the NMC Code (NMC 2008b) and local partnership agreements between university and NHS Trust. In this section I discuss how ethical concerns were addressed within this research, in terms of the key issues of negotiating access to the field, gaining informed consent, the use of incentives, confidentiality and privacy, and a discussion of my role as an insider researcher.

Approval to undertake this case study research was obtained from both the Institute of Education research ethics committee, and the local NHS research ethics committee (LREC) covering all local NHS Trusts. Because the participants were all (except one) NHS employees, NHS ethics approval was sought as this provides a check that patient care will not be compromised through participation in research studies. As this research is linked to a course commissioned by the NHS Trusts involving significant assessed workplace learning, LREC did not require full ethical approval but granted access and approval as a service evaluation (Appendix B), with an implication that findings from the study will be shared with Trust-based education colleagues.

Nurses meeting the inclusion criteria for the study were invited to take part in this research initially via targeted emails to their university registered account which included a copy of one of the explanatory statements (Appendix C). Practice Education Facilitators (PEFs), nurse education leads (NELs) and strategic policy and education advisors were also recruited via email, although a modified version of the explanatory statement was used, indicating a different interview focus from other participants. In both of the policy level interviews, an interview with the intended candidate was not possible (Chief Nurse for London, Director of Education, NMC) although their interviews were delegated to knowledgeable colleagues. It would not have been possible to anonymise such high profile figures by role, whereas the deputised participants could retain anonymity with portmanteau titles such as 'strategic nursing lead', thus simplifying matters of anonymity. The explanatory statement formed the basis of further discussion at the point of interview, where formal consent was gained (Appendix D). Participants were made aware that their contributions were voluntary and that they could withdraw at any point of the study with no repercussions. Whilst no detriment was considered to arise from participation, positive sequelae of participation was that nurses could use their interview transcripts as documentary evidence of engagement in mentorship activities, using this to meet and maintain CPD and specific competencies in their ongoing mentorship portfolio.

All participants are given a pseudonym in this thesis and were assured of their anonymity in the final report. Anonymity of participants was balanced against the need to demonstrate the authenticity of the work, with participants able to 'see themselves' in the completed work as a key measure of this. Member-checking of interview transcripts gave an option for participants to review these for accuracy and representation of their views. This was not only to increase validity and reliability (Merriam 1985), but to create a sense of trustworthiness and build upon the spirit of co-construction of data (Lietz et al. 2006).

Snowballing of participants (see page 61) held potential problems for anonymity. It was necessary to identify the initial participants to these individuals, to contextualise their own participation. This potentially reduced the anonymity of the initial interviewees. However all gave explicit permission for me to use their name, or contacted their colleagues on my behalf. In return participants were generally very pleased to be nominated in this way. I had had initial concerns that this approach might lead to nurses verifying their own and their colleagues' learning and working practices. This proved mostly unfounded, as there was not a trend between the first two waves of interviewees to nominate each other, whereas this was noticeable in those working in more operational and strategic Trust-wide roles where the sampling strategy did not rely on snowballing. This has implications for the perceived reciprocity of relationships between PEFs and mentorship students at Seacole Trust, as discussed in chapter seven.

Location of interview was an important ethical consideration. To emphasise the importance of participants experience as practitioners, interviews were held either in university accommodation within each of the hospital campuses, or quiet rooms within Wards, yet away from the practice area so as not to disrupt patient care. Interviews were digitally recorded and transcribed by a professional transcription service compliant with the Data Protection Act (1998). Audio files were shared by means of an encrypted file sharing programme. Completed transcripts were emailed to a password protected email account of which I am the sole user, and saved alongside the original audio recordings in a password protected computer folder. Whilst video recording might have captured the constellation-making process with more clarity, I considered this would be intrusive and make participants less likely to volunteer. It would also create large and unwieldy files and add expense to transcription costs.

Use of Incentives

BERA guidelines (2004) state that researchers' use of incentives must be commensurate with good sense and recognise the effect of such incentives on the research design and reporting of the research. Incentives were offered following difficulties in attracting initial participants. I was unable to interview mentors during their clinical working time and this appeared to discourage participation for some nurses. This was a safeguard I had introduced into the study to ensure that patient care would not be affected through staff participation in the study. A £10 store voucher was therefore offered to mentors in recognition of the personal time given up for these long interviews. Managers were able to schedule time within their normal working hours for interviews and did not receive any financial incentive.

Positioning Myself in the Research

Practitioner research generally supposes that the researcher has a pre-existing role within the 'in-group' under study, which allows detailed and privileged access to the organisation. My own position was more nuanced than this supposition implies. Given that I was interviewing participants from different strata within the two Trusts as well as external policy-makers, I had different relationships with different people. It was inevitable that some of my participants would be known to me or me to them, for example through teaching, or committee work. The former may have caused some ex-students not to take part whilst the latter had benefits in attracting strategic-level Trust staff as participants in the study. Immersion into the world of mentorship rendered the possibility of a blank slate impossible, except, perhaps with the strategic level interviewees. Even with this group there was some common ground in a shared profession and educational focus.

One overarching commonality I shared with all of the participants was registration as a nurse. This gave us a shared language and experiences that might not be as obvious to outside researchers. My previously roles in clinical practice (including as a mentor), practice education (as a lecturer-practitioner) and my current role as Senior Lecturer and mentorship module leader served to give me some credibility with Trust-based participants. Conversely it also meant that I could be potentially blind to certain perspectives, having made assumptions about what I was hearing and reading. Morse (1998) argues that the roles of practitioner and researcher are incompatible, causing potential biases and conflicts of interest. However I do not subscribe to this view as it loses sight of the wealth of authentic experience and knowledge the practitioner brings to enrich the research process. It also fails to recognise the contribution of practitioner research to practice change. Outsider researchers may have just as strong a desire to justify their own

role and status as a researcher (Loxley and Seery 2008). Thus there is no reason why practitioner researchers should be any less biased than those from outside the field.

Issues of reflexivity, critical thinking and technical research skills were therefore important components of this research process. As I no longer practice clinically, I was aware that my own perspective on practice was a partial one. Therefore in reading and listening to interviews I was careful to question my own perceptions of what was being said in order that my own views are not given privilege over participants' experiences. Instead they were used to challenge the dominant world view in which the study is set, and to reflexively test emergent themes and theory (Corbin and Strauss 2008, Hall 1996). I used memos and annotations during the coding and analysis phases to question my own assumptions about what was said. Likewise I used the iterative nature of the interview process to test out assumptions across the sample group.

Data Collection

Three key inter-related modes of data collection were employed within this research, and form the basis of this section of the chapter. Interviewing participants and analysing policy documents are relatively commonplace within qualitative case studies. These were augmented by the development of relationship constellations with each participant. This is a new feature in mentorship and nurse education research, offering a simple and highly visual means of documenting relationships and their attributes. This approach was inspired by social networking systems and professional learning communities. I had explored the concept of professional learning communities earlier in my doctoral study, where I had made some (relatively unsuccessful) attempts at engineering such a group for mentors. In my current research I did not wish to make assumptions about group membership. Instead I wanted participants to be able to identify for themselves who they felt was significant in their learning and mentorship development, and why. This approach was influenced by appreciative enquiry (AE), in that the focus of the research is a positive aspect of practice to be developed through change-management techniques, rather than notions of deficiency in practice (Cooperrider and Whitney 2005). This strategy encouraged the initial participants to identify other potential participants, and their recommendation served to encourage the participation of those contacts. The rationale and justification for these approaches is presented here, starting with a discussion of my sampling strategy and interview piloting.

Sampling and Interview Piloting

A combination sampling strategy was used to recruit participants in order to meet the multiple interests and needs within this case study research. An initial information-oriented selection of participants was employed (Cresswell 2007). Flyvbjerg (2006) identifies this as a useful strategy to maximise the utility of data in research with small sample sizes.

Potential participants were identified on the basis of the types of information that they might yield. This corresponds to a stratified purposeful sampling approach (Robson 1993), which along with a further snowball sampling of significant others identified the first two strata of the cases. Potential participants were identified from the May 2010 cohort of the mentorship module run at Capital University using the grade book correlated with student registration information. This gave details of their employing organisation. Students were approached to take part in the study if they were currently working within one of the acute NHS Trusts affiliated to Capital University. Therefore they were more likely to be working in a Ward or acute care setting.

Acute care areas were chosen as the study site as this is where the majority of nurses in the UK currently practice. There is a universality of acute care experience amongst adult branch nurses who will have had exposure to this in their pre-registration nursing education.

Community-based nurses such as district nurses and health visitors, those working for non-NHS organisations, were not included in the sampling frame due to the disparity of the organisation of their day-to-day work with Wards (lone workers rather than Ward-based teams). Midwives also undertake the mentorship module, and are subject to a shared professional body (NMC). However, they were not included in this study due to differences in the organisation of their workplace supervision.

Potential participants were chosen from those who had been successful in completing the mentorship module in September 2010 and who had achieved a final module mark of 60% or greater. As the research has a flavour of appreciative enquiry, I was keen to avoid polarised opinions within this study. I therefore purposefully chose to focus upon students who had done well in their module to focus on what works in workplace learning, rather than what does not. I avoided interviews with disillusioned or disenfranchised ex-students. Ex-students interviewed within my study of underachieving students on the same module had tended to hold views of mentorship that were more critical of the support they had received in practice and their experience of undertaking the module itself (MacLaren 2010). The cases used here are no less critical for being examples of success. Indeed I felt that if similar themes were raised by successful mentorship students, then there may be an

argument that some of the negative experiences attributed to becoming a mentor are more universal.

The September 2010 mentorship module attracted 132 students (across four modules, each facilitated by either myself or one of three other lecturers). The majority of students undertaking the module gained a mark between 40-60% (pass mark 40%). Twenty nurses were identified who had achieved a mark of above 60% and who were potentially practising in an acute area of nursing (ward or A&E department) within one of Capital University's partner acute NHS trusts. It was not possible to identify actual practice area from the grade book, therefore an email was sent to each of these students. This included a copy of the information for participants' identifying that the study required nurses working in acute practice areas only (appendix C). The low number of actual respondents to this call for participants may be reflective of further self-selection by area of practice. The email was sent out only once the module marks had been released, and contained a financial incentive to take part in the study, in the shape of a £10 store voucher. Of the three potential participants, one did not take part as the interview could not take place in her work time. The two other volunteers were interviewed, but belonged to the same Trust, albeit different acute nursing department settings.

Whilst these two participants offered different perspectives from within Seacole Trust, I was not able to make contact with the significant others highlighted in Kate's interview. This left me with potentially only one organisational case with which to collect data, thus limiting one of the proposed elements of rigour within the research. I therefore made the pragmatic decision to include data from my pilot interview within this study, in order to build a second organisational case. The inherent bias of this participant (Sade) being known to me as a student, needs to be acknowledged here. However, access to other perspectives through her significant relationships allowed for some triangulation of data which reduce the overall impact of this bias. I was meticulous in role-modelling the ethical practices involved in qualitative research, ensuring that Sade's account was not privileged above others in the research.

Organisational and Strategic Interviews

Practitioner interviews were augmented with a politically informed sample selection of key individuals involved in Trust-based strategic support, planning and operationalisation of mentorship. Practice Education Facilitators (PEFs) were chosen because of their proximity and influence at both mentor and strategic levels, whilst Nurse Education Leads (NELs) had a broad overview of educational issues in their Trusts. Two further interviews were held

with key policy-makers, contributing to both cases due to their influence at either professional body or Strategic Health Authority level. Policy level interviewees were identified through initial emails to key leadership figures within the NMC educational department and the Strategic Health Authority (SHA). Both the Chief Nurse for London (SHA) and the Director of Education (NMC) declined interviewed but arranged for a senior colleague to be interviewed in their place.

Gaining a Snowball Sample

Faugier and Sargeant (1997) and Noy (2008) identify snowballing as an under-explored sampling method, which relies on participant referral to others who fulfil the demands of the sampling frame. Snowball sampling emerged from studies of deviant behaviour in the 1960s, when regular sampling frames failed to identify suitable research participants due to the sensitivity of the topic under investigation. Colleagues who had played a significant role in mentor development were identified through development of relationship constellations with initial participants. Interviews were sought with two colleagues who represented the most significant of influences, as graded by the RQMs on a scale of one to four. This identified mentors who were not necessarily known to me. Participants kindly agreed to facilitate introductions to their significant colleagues, which acted as a recommendation to those interviewed. However, not all significant colleagues were available for interview. Neither of Kate's colleagues returned calls or emails, whilst Sade's most significant colleague declined to be interviewed.

Snowball sampling reduced the impact of insider-status on the research process, and provided some triangulation of the experiences suggested by interviews with junior mentors. The snowballing of interviews was limited to those generated from the initial interviews in order to stay within the prescribed word limit for this thesis. Further snowballing from this group would provide an opportunity for further research at a later date. Information about who had provided supervisory mentorship might have been gleaned from other sources such as the end of module supervisor evaluation statement. However, I was not necessarily interested in this prescribed mentor relationship. Rather, the research focus was on the relationships with people highlighted as significant, which sometimes, but not always, coincided with actual mentorship relationships.

Interviews

As the sample was limited in size, semi-structured interviews, allowing for depth of understanding rather than breadth of coverage, were employed. A responsive data collection method was important for this study. This would allow opportunities for

question rephrasing and clarification of answers to understand the underreported phenomena of mentorship supervision (Fielding 1994). The interviews were thus framed as informal 'conversations with a purpose' (Rubin and Rubin 2005, Robson 1993). The tone of these interviews was friendly and accessible in order to minimise potential power vacuums between researcher and participants. They reflect a joint interest in the subject matter and shared professional experiences. The semi-structured rather than unstructured interview format ensured uniform coverage of key questions in each interview. Also, as discussions of mentorship easily veered into discussions of pre-registration mentorship practice, a pre-designed interview schedule permitted a sustained focus on the research questions.

Whilst quantitative methods such as questionnaires might identify broad generalisable trends in the relationships between participants within this study, my interest is in a more subjective and socially situated understanding of learning and working relationships. My use of interviews reflects my understanding of qualitative research as essentially a humanist, holistic and social activity, with interviewees as participants and collaborators rather than informants.

Hammersley (1993) argues that no one position can guarantee valid knowledge with different perspectives offering potentially different dimensions of a research field. Within this research there are multiple participants and groups to be considered and therefore multiple perspectives that inform research design, data collection and analysis. The interview guide needed to be flexible enough to be adapted across each of the participants within the study (Appendix E). The initial guide was informed by recent research in practice education, workplace learning and mentorship in nursing. It was further developed through discussions with colleagues, students and supervisor. The initial interview guide was piloted with an ex-student who had qualified as a mentor in the previous 12 months, and who had also served as a pilot case for my IFS research. She otherwise conformed to the inclusion criteria for sample selection, making her a good choice for anticipating how the interviews would progress.

An in-depth discussion with the pilot participant as part of the interview was recorded and subsequently transcribed with her interview (Brown and Dowling 1998). The pilot interview identified the degree to which the interview questions addressed the research questions (face validity). It permitted the optimum flow of questioning to be considered and allowed calculation of interview timings. This pilot interview was eventually used as primary data within the study, with similar minor changes occurring between other iterations of its use. The flexible iterative design afforded it a degree of credibility in its ability to explore

emerging themes with each iteration, and between levels of participants. This increased the consistency and coherence between accounts (Rubin and Rubin 2005).

Interview schedules were modified for each level of participant. Thus initial interviewees were asked more about the period of supervised mentorship during their mentorship programme and their experiences of co-mentorship, whilst their identified colleagues were generally asked about their role in supporting colleagues as well as their experiences of mentorship preparation. More strategic Trust-based participants (Practice Education Facilitators and Nurse Education Leads) were asked about the links between organisational and professional policy and the operationalisation of mentorship in their Trusts. Interviews with strategic policy-makers focused on the wider policy agenda underpinning mentorship in practice. The linking themes of relationships and the impact of policy on practice are a unifying element across all of the interviews.

Rigour in Interviewing

Validity is reported as a persistent problem in interviewing (Cohen et al. 2000). Biases may be widespread and emanate from the participant through misconceptions of what is being asked, or a desire to please the interviewer. Social desirability in providing answers that the researcher wants to hear were my initial concerns, although Simons (1981) drew my attention to the possibility of institutionalised responses as a form of bias. This is akin to Merton's (1972) argument that insider research serves to reify the practices of a cultural group. To an extent, this was unavoidable given the positions of those being interviewed at senior management and policy development levels, as they sought to explain the corporate or strategic views of their own organisation. It was possible that this was also present at other levels as participants sought to conform or reject the status quo of the organisation.

Institutional responses are an area of rigour which will not easily be influenced by implementing member-checking, as this will provide participants further opportunity to ensure that their interview transcript conforms to organisational norms. Arguably, institutional responses reflect the culture, in which these people work on an everyday basis. As such they represent part of the complexity of researching in the social context of an NHS Trust and should thus be embraced as such. Opportunities for member-checking, through return of interview transcripts, were still implemented as a tool to create a sense of trustworthiness of myself as a researcher in how I would represent opinions and perspectives, and encourage co-construction of data. The interviews were considered for analysis both as stand-alone data and in conjunction with the constellation relationship maps generated within them.

Mapping of Standards

Policy provides a backdrop for current nursing practice in terms of organisational and professional aims and objectives. The core policy relating to mentorship is SLAiP (NMC 2008a) which provides a context for analysing interview data. The key learning domains of this document were indexed within a table and the interviews interrogated for corresponding content that would enable the category to be checked according to its representation within the data.

Relationship Constellations

This approach is ostensibly a formalised approach to the 'tentative mapping' of informants discussed by Faugier and Sargeant (1997) in their discussion of sampling hard to reach populations. However, it goes beyond being just a sampling method. This is because, whilst significant parties are identified within the map, the map must be used in conjunction with the interview in order to identify the characteristics, nature and strength of individual relationships, networks and teams that are supportive of mentor development, potential routes for policy dissemination and involvement in policy development around mentorship and workplace learning. In their study of mentorship in the law profession, Higgins and Thomas (2001: 224) defined a constellation as

"...the set of relationships an individual has with people who take an active interest in and action to advance the individual's career by assisting with his or her professional development"

Using Higgins and Thomas' definition, significant others are those identified by the participant as having been, or currently important in their development as a mentor (or for those in peripatetic, leadership or policy roles practice educator or current role). As such these were not necessarily those in mentorship or other formalised roles to participants.

Studies of professional and developmental constellations reported in the literature tend to be on a grander scale. They tend to be quantitative in nature and focus on the statistical interpretation of the quality and diversity of the constellation (Higgins and Thomas 2001, Higgins and Kram 2001). My research takes a different and qualitative turn in inviting participants to name and explore their relationships with those identified in their constellation. This offers a way to explore both social capital and policy dissemination and generation, and is more akin to the approach used by Kram (1983) who used in-depth interviews to identify and explore significant developmental influences in junior corporate managers. During each interview participants were asked to identify individuals (although networks and other groupings were increasingly identified by those in hierarchically senior roles) who had been influential or significant in developing their mentorship or practice

education role, and note these on a diagram. I was keen that the constellations were drawn during the interview process as it allowed the diagrams to be explained and their purpose clarified.

Several participants were initially concerned about 'drawing' the maps as they felt that they were not 'artists'. In these cases I gave the example of my own constellation (Appendix F) to demonstrate the format. This appeared to quell anxieties, but also indicated that had I asked for these constellations to be completed and returned to me, I may not have managed to achieve full return of data. I wanted these to represent participants' gut reactions, rather than allow editing which might encourage participants to provide a socially desirable diagram.

Relationship significance was further clarified, where necessary as a relationship which helped you learn to become, or develop as a mentor or educator. A discussion around each of the relationships proceeded from the constellation mapping. This explored the characteristics of those identified, strength of relationship, reciprocity of support, and elements of the relationship that promoted learning. The strength of significance or importance of each relationship was graded by the participant between 1 and 4 (with 4 holding the most significance and 1 the least) and the justification for each grade probed.

Whilst interviews with significant others was limited to those highlighted in the three initial interviews, this yielded a total of six interviews and constellations with mentors in practice (including initial participants). Further interviews and constellation mapping were undertaken with practice education facilitators (PEF), Nurse Education Leads (NEL) at both Trusts, and with NMC and Strategic Health Authority (SHA) participants. Constellations were reviewed for reciprocal links between participants and combined to create a meta-map for each Trust. These allowed demonstration of intra-organisational connections and relationship gaps. Meanwhile cross case review enabled identification of similarities between Trusts and their structures as constructed by participants.

Strengths and Limitations of the Research Design

The strength of this research lies in its combination of methods in pursuit of the research questions. The sampling strategy for interviews has allowed access to a group of practitioners whose views in the context of mentorship and developing as a mentor are rarely sought and little understood, despite the ubiquity of the mentor role. In retrospect, a larger number of initial cases might provide a better basis for snowballing out to significant others. The sampling frame might be widened to include nurses or midwives working in other settings, to enable a representative sample.

Accessing data about the nature and quality of relationships in practice using constellation mapping is a unique feature within research in nursing education, especially when combined with a focus of tracing policy dissemination. Arguably a richer understanding of the complex constellations at play within the workplace might have been afforded by continuing with this snowballing interview and mapping process rather than choosing other strata purposively, such as following up interviews with individuals from outside of the organisations under study such as university colleagues, or representatives from networks and groups. I have needed to be pragmatic in the amount of data accumulated for analysis considering the scale of this doctoral research. This gives me scope to extend and develop this methodology in the future.

Conclusions

This chapter has outlined the choices made in designing and operationalising this case study, in relation to both research question and my own personal views of learning and research. Case study is an appropriate research approach for exploring mentoring relationships as it allows me as a researcher to engage with the complexity involved in researching a real-life situation. Different sampling techniques are required to engage different participants, but in turn these participants provide multiple perspectives that add up to a rich understanding of workplace learning for mentors. Meanwhile as the researcher I play a crucial role in interpreting these perspectives. The following chapters describe the choices I made in analysing the data and begin to give a voice to participants' experiences.

Chapter Five: Analysis and Key Findings - Interviews

Data Analysis

A total of twelve interviews took place. Interviews were recorded using a digital voice recorder and transcribed by a third-party transcription service. Demographic details of all participants can be found in Table 3. Interview length ranged from 58 to 100 minutes. Interviews were listened to several times, during which I augmented the notes made at the time of interview. The initial reading of the transcripts identified many transcription errors which I corrected before sending out to participants for review and approval. Not all participants chose to review their interviews (and had made it clear at interview that this was the case), but those that did offered further clarification of meaning and interpretation. Only Imogen (Strategic Nursing Lead) wished to remove data from the transcript, but this was because a passage was muddled, rather than containing sensitive information. The Strategic level participants gave useful comments about when they were talking with their own voice, and when they were acting as representatives of their respective organisations. Allison (NMC Education Advisor) was happy with her interview but felt that the transcript possibly made her sound judgemental (I had not picked up on this) and so careful use of her interview was made in analysis in order to maintain her trust in the research process.

Further readings of the transcripts allowed a line-by-line coding of the data using NVivo 8 software (Appendix G). Despite attempts to make code data as discretely as possible, much initial duplication across the interviews was noted as initially I had a tendency to over-code and duplicate these between participants. This was, in part, due to a post-coding approach, rather than using pre-set analytical criteria. Subsequent analysis allowed these nodes to be clustered or incorporated into more coherent and meaningful parent nodes, and ultimately the final themes. This process is highlighted in Appendix H. Certain sets were represented by a greater frequency of references in the text than others across the cases. Therefore I focused on these in the final analysis, interrogating them for quotations that would illuminate key points and enable an interpretive and thematic analysis.

Table 3: Participant Demographics

The following table outlines some key demographic details about the participants in this study, focusing on their employing trust, current role, qualifications as a nurse, and length of service as a mentor.

Name	Qualified as mentor/Teacher (year)	Current role	Educational and Nursing Qualifications	Comments
Seacole Trust				
Kate	Yes (2011)	Band 5 Staff Nurse (Accident and Emergency)	RN, Diploma in Nursing, A&E Course (level 3).	Has been in post 5 years. Qualified in 2005
Purity	Yes (2011)	Band 5 Staff Nurse (Surgical Ward)	RN Diploma in Nursing	One year post-registration. Was an HCA previously
Anna-Maria	Yes (2007)	Band 6 Staff Nurse (Surgical Ward)	RN BSc (Hons) Nursing	Was a qualified midwife in the Philippines prior to nursing career
Dora	Yes (2004)	Ward Sister, Band 7 (Surgical Ward)	RN Bsc (Hons), MBA, Diploma in Nursing	Previous career in pharmaceutical sales
Joan	Yes Qualified Nurse Teacher (2010)	Practice Education Manager (Practice Education Facilitator)	RN, HV, BSc (Hons), PG Cert Ed.	Has acted as a mentor before and after standards introduced
Sharon	No, but has worked in supportive roles as nurse	Deputy Director of Nursing / Nurse Education Lead	RN, BSc (Hons), MSc.	Acted as a mentor before standards were introduced
Nightingale Trust				
Sade	Yes Dec (2009)	Band 6 Staff Nurse (Coronary Care Ward)	RN, BSc (Hons), PG Diploma in Nursing Currently studying MSc Nursing	First degree in pharmacology
Lulu	Yes (2002)	Band 7 Ward Sister (Surgical Ward)	RN, Diploma in Nursing,	Qualified midwife in the Philippines, Currently studying BSc in Nursing
Marion	Yes, ENB998, (1990s) / Practice Teacher (2006)	Practice Education Facilitator	RN, BSc (Hons), MSc Nursing, PG Cert Ed.	
April	Yes ENB 998, (1990)	Nurse Education Lead	RN, BSc Nursing	About to start Masters level study
Strategic and Professional Participants				
Imogen	Yes Lecturer/Practice Educator (1991)	Strategic Nurse Lead Strategic Health Authority	RN, EdD	
Allison	Yes Lecturer/ Practice Educator (1986)	Educational Advisor Nursing and Midwifery Council	RN, RMN	Presumed Masters level qualifications – has worked as Senior Lecturer in nursing

Emerging Themes

Several themes arose from the interview analysis, although not all are able to be displayed here due to the constraints of size of EdD thesis. In analysing the interviews I have focused on discussing the four key themes which best contribute to a consideration of the research questions. These are:

- *What happens to facilitate workplace learning in supervisory mentorship relations?*
- *What is the understanding of key individuals of their role in the development of new mentors in practice?*
- *What does the role of professionalism play for practising mentors in their mentorship of learners?*

The findings of the interviews are presented here in terms of four major themes:

- Being a professional nurse - What mentorship means professionally and organisationally
- Orientations to learning
- Mentorship as a learning trajectory, and
- The role of role-modelling

In 'being a professional nurse', I explore how participants conceptualised their professional nursing practice. Here, issues such as the practical and hands-on nature of nursing and the significance of 'caring' are highlighted by the nurses interviewed. 'Orientations to Learning' draws upon the work of Dweck et al (Dweck 2000, Dweck and Sorich 1999, Nussbaum and Dweck 2008), Evison (2007) and Johnson et al (2011) to explain participants' orientations to mentorship and workplace learning. In including findings from all levels of the nurses interviewed, a degree of organisational attitudes to mentorship is illuminated. The following section ('Mentorship as a learning trajectory') explores the processes involved in initiating staff nurses into the mentorship role. Here I explore experiences of formal learning opportunities such as mentor preparation and updating, alongside the more informal processes involved in co- and supervisory mentorship. The chapter ends with 'The role of role modelling'. Role modelling is seen by participants as a key learning activity in developing as a mentor. This section explores how role modelling both promoted and inhibited learning for the staff nurses interviewed. In each section, quotations from the interviews are used to illustrate the emerging themes.

Being a Professional Nurse

Participants were *passionate* about their nursing careers. They discussed their enjoyment of nursing in relation to the rewards that come from patient care. Affective, psychomotor and cognitive attributes of nursing are evident in their accounts. The affective domain is highlighted in Sade's description of nursing as helping those unable to help themselves. Dora talked about enabling improvement in patients' health status through sharing their

journey as a patient, whilst the idea of nursing as a humanitarian endeavour was highlighted by Lulu. Overall there is a great sense of nursing as an empathetic profession. This chimes with contemporary views of nursing care in the literature (Liaschenko and Peter 2004). Anna-Maria's description of nursing balances a sense of public service with recognition of an emotional workload that goes hand-in-hand with the profession's affective orientation:

It's very rewarding as well ... Sometimes you get emotional because our patients, their life is only short. But rewarding: you can give a proper care for them for the short times of their admissions and they are very happy. And you receive sometimes the card, the message that they're really thankful for the service that they get from you. It's really rewarding.

The affective orientation of the nurses interviewed underpins the psychomotor domain of nursing which is discussed in terms of it being a 'practical' rather than academic profession. Both Kate and Marion assert themselves as *practical* nurses. The concept of bedside nursing appeared key to this understanding, which was also explained by others as being *hands-on* with the patient. I saw no evidence of the erosion of relational caring identified by Scott (2008) as a trend in nursing professionalism. Instead hands-on care was promoted in most of the interviews as a way for students to learn core skills.

Care and Patient Safety

Hands-on care appeared to be a valued and uniting theme across all levels of nurses. With the exception of Allison, all participants spoke of having at least some designated time in their schedule where they worked in clinical practice. Clinical practice of senior staff served to enhance their credibility amongst other nurses, especially where this was not necessarily perceived as part of their role. Dora garnered praise from her junior colleague Purity:

Honestly, if you go on Roper, you'll know she's the manager [Dora], she's wearing a blue thing, you wouldn't know. Behind the curtain, what she's doing, probably wiping a patient's bum and she's had her paperwork to do. How she's able to juggle both worlds I really don't know. I think she's a very good role model.

Bedside hands-on nursing care and an empathetic approach were not considered enough for professional nursing practice. Patient safety was a concern at all levels from Allison's discussion of the role of the regulator having this express concern, through to the RQMs. This was linked with competency in the interviews. Both Sharon and April (Nurse Education Leads: NEL) are clear that competencies must be met to balance compassion with patient safety and dignity, echoing the Chief Nurse for England, in her vision for future nurses (Beasley 2009). Competence incorporates a cognitive element, concerned with developing knowledge for practice, or documenting care delivery. CPD is highlighted as a core

dimension of professional practice, linked to both personal development and developing others through mentorship. At senior management level this was especially evident:

... part of your responsibility as a registered nurse, that you are a mentor and that you support and develop, you know, you do that with students and you do that with your colleagues, you do it with junior members of staff so it's integral to your role so it's expected (April, NEL, Nightingale)

Continuing Professional Development

Mentors discussed the importance of keeping up to date with the latest developments in practice in order to better teach students through going on courses or undertaking professional reading. Lulu was typical of the established mentors in her consideration that

...you shouldn't be stagnant in one place you need to read ahead so that you will be able to know more but the modern things now because you can't compare the training you had and the training as is current now, so you need to be current with what is going on.

Lulu and Anna-Maria were keen to point out that they do not know, or need to know everything. They were happy to discuss this lack of knowledge with their students to facilitate co-learning activities such as literature searching. Keeping abreast takes time and energies both within the workplace, and in personal time. Dora spoke about how time for developing knowledge and competence is being eroded in the current climate of cutbacks and efficiency savings

*Bedside [nursing] is important but in order for bedside to work you have to create a time outside of bedside nursing because a lot feeds into that... I think what is missing now is that that time is being taken away and for some reason we think it's **all right** and I don't know how we can get it back because I think it's being taken away, because if you don't have that time outside then you will not have the quality of bedside nursing that we want.*

For Sharon (NEL, Seacole) the additional personal time required for self-development activities is one of the things that mark out nursing as a profession rather than just a job (*Like working for Sainsbury's*). This is clearly linked to her understanding of The Code (NMC 2008b)

...we all have to take some personal responsibility for studying things and know that actually it is our responsibility to actually...and our Code of Conduct clearly states it, keeping ourselves abreast of changes and what's happening...

Other signifiers of professionalism are provided by Kate, who feels empowered to nurse through wearing her uniform, and Dora who remarks on the professional standing of nurses in her Ward. Dora discourages her team from falling into some of the older stereotypes as nurses as this affects the way they are seen as professionals in the workplace

*I try to encourage them and say, look you are a professional: you are only a hand-
maiden when you make yourself one.*

April (NEL, Nightingale) sees the professional image of nursing as being modelled from top-down through the clinical activities of senior nurses. However, there was recognition amongst the participants that not every nurse subscribed to notions of a wider nursing professionalism. Imogen comments

*It's quite interesting isn't it, because I think frontline staff sometimes go to work,
deliver their frontline care and come home again...*

Similarly, Dora identifies colleagues for whom nursing is a *means to an end*: namely a salary.

The introduction of a graduate nursing curriculum was felt to be changing perceptions of what professional nursing is. Worries that *some* nurses will feel left behind if they have not achieved graduate status were clearly directed at others¹⁰. For example, Dora discusses a colleague on Roper Ward who has not engaged with mentorship:

*...the one that is resistant, they are quite scared because they trained in the very old
school. I think they trained in the late 70s, early 80s and for that reason they've
never really been through a formalised way that the teaching of nursing has gone
and they're a bit concerned that they don't have the academic prowess to do that.*

Imogen was clear to point out that from a strategic perspective; changes are not about creating *better* nurses. Instead she talks about adding a critical dimension to existing practice-based skills and improving the accountability of nurses in practice. In terms of the changes to the curriculum

*...it's around having a nurse who's going to be able to hit the ground running in a
way that maybe nurses haven't been able to do in the past... We've tried to focus it
away from the degree side of it, more to this nurse will be more comfortable in any
setting as opposed to being traditionally trained in a hospital.*

Thus, provisions for previous generations of nurses and mentors to develop these skills are necessary, rather than wholesale re-education of staff nurses.

Orientations to Learning

The interviews demonstrate some differences between participants' orientation to learning, which may also contribute to differences in engagement with mentorship activities. Drawing upon descriptions of mastery and entity-orientations of learning identified by Dweck (2000, Dweck and Sorich 1999). I was keen to consider whether these same orientations were present in students who had been successful in the mentorship

¹⁰ All participants had studied to at least degree level. I am unsure whether Kate has graduated, but she has completed several HE level 3 modules

module, in relation to their workplace learning, and looked for indicators within the interviews with the three RQMs.

Confidence to Practice

Key to my understanding of learning orientation was the concept of confidence to practice as a nurse. Development of confidence was articulated by all of the RQMs as a prerequisite for effective mentorship. Confidence in their own capabilities was drawn into doubt when co-mentorship was introduced to their roles. This caused initial performance anxiety blocks; described by Evison (2006) as anxiety about performing in social situations. The following quotes from Kate illustrate her performance anxiety blocks

I found it really hard when I think I'd been in A&E about six months and they went, "Okay co-mentor this student" and I thought I don't know enough. But you realise that actually you do know quite a bit because you've been qualified for 18 months by that time and you learn a vast amount in that 18 months.

Kate also notes that the physical proximity of students could exacerbate these performance anxieties.

...when I first co-mentored my student would follow me and then I'd turn round and they were there and you would clash. And I'd forget because I was so busy concentrating on right I've got this, this, this and this to do, but now I'm a bit more relaxed.

Kate's experiences mirror that described by Eraut et al (2007), who identify the initial months of practice as containing critical challenges for nurses. These include learning new clinical and time management skills, managing new interprofessional relationships and developing confidence in a staff nursing role. Despite being a key learning period for nurses, support and formal professional development opportunities were not always available for the 40 newly qualified nurses in their longitudinal study.

This lack of support affected confidence to practice, commitment to the organisation and profession and thus contributed to staff nurse attrition. The implication is that Staff nurses require more time and support to develop confidence in their nursing knowledge and skills before taking on mentorship roles. However, this may not fully represent the complexities of individuals' orientations to learning. These develop as the result of learning histories. Evison's (2006) description of performance anxieties caused by put-downs and thinking and powerlessness blocks developed from defensive and oppressive teaching and learning regimes are apposite here. In such cases outcome is privileged over student effort.

Organisational Effects on Learning

Perceived organisational valuing of the mentorship role may also be an influence here.

Although recognition of the value that students place in mentorship is widespread amongst participants, the organisational value of their role at Seacole Trust is not always evident to mentors as the following quotes show.

*Oh I don't think they care. (laughs) No that's **completely** seriously... I think the Trust are more concerned with targets, budgets. I don't think patients come into the equation either ...I don't think they're that bothered about people being mentored. I think that's down to the individual Wards and Units and what have you. (Kate)*

I don't think they value us because I haven't heard anything from them to say: oh thank you for mentoring the students, thank you for your support; even how busy are you, are you able to pass on your skills to this student, are you able to guide this student until they finish? (Anna-Maria)

I think sometimes mentors see it as another job that isn't necessarily well recognised by the workforce itself. So that's a challenge I've experienced. The work requirements don't always match up with mentor requirements. (Joan)

Both Evison (2006) and Johnson et al (2011) discuss powerlessness as a block to learning which occurs when people believe they cannot do certain things, or that they are beyond their reach. Both discuss this in terms of being triggered by events in the school learning career of individuals. It is possible that these are perpetuated in the RQMs workplace learning as perceived limitations in role-breadth self-efficacy. For example, powerlessness is evident in Kate's discussion of the delay in her accessing a mentorship course,

I had been trying to become a mentor since I joined the Trust... ..it's one of the most frustrating things trying to get on the course never mind anything else... ..Seven applications and I got there! I think that deserves a medal in perseverance if nothing else.

This appears to mark her out as having little social capital within A&E, and may be linked with her failure to progress from a band 5 staff nurse position in her six years as an RN. In comparison, Anna-Maria has been qualified as a nurse for a similar length of time within the same Trust, and also found initial difficulties in accessing the module as it was not valued within the Ward where she then worked. However, she completed mentorship in 2007 (albeit in her own time), and gained promotion to band 6 in Roper Ward. Kate has undertaken a specialist A&E nursing course and considers herself to be a senior staff nurse. This is in terms of her experience and not matched in her clinical grading where band five is considered relatively junior (c.f. DH 2004a). Whilst issues such as the valuing of the mentorship qualification within A&E have not been explored here, they might influence Kate's view of mentorship as a *natural* or fixed entity.

Entity and Incremental Theorist Orientations to Learning

Kate considers her junior colleague Lottie as a 'natural mentor', and describes herself as *lucky* to have had fantastic mentors as a student nurse, rather than it having anything to do with her own efforts to learn. It is clear that she does not see herself as a natural mentor. Instead she focuses on her clinical rather than mentorship credentials. This could be seen as an indication of Kate's entity orientation to learning, similar to the doctor described by Nussbaum et al (2008) who wears a stethoscope to reaffirm her status after she makes a mistake in practice. For Kate the reasons for not undertaking the mentorship module are considered out of her control and thus not her 'fault'. Assertions of her senior clinical position and as a practical nurse act as reinforcements of her status and achievements. Indeed Kate is clear to describe herself as a practical nurse,

I'm quite a kind of practical person and yes I could go back and go, "Right okay so that's pedagogy and that's andragogy and what have you" but I don't think about it day to day.

She perceives that deficiencies in the mentorship programme are due to poor structure of the course (too long) and a lack of clinical focus. Likewise it is a lack of time which inhibits Kate's mentorship most, as she seems less able than Sade or Purity to access support or senior sponsorship to help her juggle clinical and mentorship roles in practice.

In comparison both Sade and Purity can be seen as more strongly allied to an incremental-theorist orientation to learning. Like Kate, Sade wonders whether the good mentorship she received as a student was down to fate,

I saw my mentors as my role model and I must say at this point whether it was sheer luck or faith I had fantastic mentors who were ready to teach me, perhaps it's down to the fact that I'm eager to learn as well so they carry me along. I never sit down, I'm always there, what can, I do, I want to learn this because I come with my list of stuff. So it's like I was always being put through to learn a lot.

But her description of her own actions show a proactivity and hardiness that is less evident in Kate's account. Sade seems able to activate her own social capital (through eagerness) in order to receive support and learning opportunities. Purity appears to share this hardiness and proactivity in her personal learning, describing a similar approach to being mentored during her mentorship module. Unlike Sade, Purity looks within herself for support, effectively self-mentoring. She recognises the limits of this in helping her learn:

Imagine if I'd trained, no students coming through. I will mentor myself. Well, these things need experience and you can't learn the same thing over and over. So I think the key thing is having students coming through is one area and, I love to do it so I don't mind.

...no patient is structured as boxed, no patient is like boxed and you yourself, you're not boxed, there are things you don't know about yourself that show up when you're under pressure. So all of that is still a learning curve I think for everybody.

The latter suggests that Purity is engaged in a personal, critical and reflective learning process in her development as a mentor. Johnson et al (2011) recognise such traits in terms of a flexible role orientation, relating this to self-awareness, perceptions of responsibility and ownership for work beyond immediate operational tasks. However, this critical reflective capacity is not discussed in relation to mentoring students.

Although she has been successful in her mentorship module, Purity feels that she could have done better and problematises the issues leading to a less successful mark than she would have liked. However her overall approach to course-based learning is one of optimism in the face of adversity.

...be positive, you'll make it. Never defer... my friends said, 'oh I think it's just too much I'm going to defer my exams because I'm not sure I'll cope'. I said, if I defer and I fail - I've wasted time, I've attempted, fail, see why I failed, then repeat. So for me that was the thing.

This juxtaposes her orientation as an incremental-theorist against the perceived entity-theorist orientations of others in her student cohort.

These pen-portraits of the RQMs as a learner do not detract from their commitment to the mentor role and understanding of its importance in student development. Rather it attempts to explain why experiences of mentor development have been markedly different between cases. Kate's persistence to take part in the mentorship module despite several rebuffs suggests some incremental-theorist tendencies rather than a purely entity-theorist orientation to learning.

Mentorship as a Learning Trajectory

In the interviews I identified stages in Ward-based mentorship leading to sign-off, key mentor and supervising mentor roles. Whilst SLAiP (NMC 2008a) goes on to outline standards for practice-based educators and lecturers, my focus is on developing nurses into the mentor role, and the supportive structures facilitating this transition. Therefore this section will focus on four key stages: co-mentorship, selection for mentorship, workplace learning in the supervisory relationship and developing in the mentor role.

Co-Mentorship

All registered nurses are expected to play a role in the development of students and colleagues, and this appears uncontested by all participants. Co-mentorship¹¹ is well-established for supporting pre-registration students. This pairs a qualified mentor with another RN (usually pre-mentorship) in the mentorship of a named student. It is usually the first exposure to mentorship of a newly qualified nurse. Lulu explains that, on Logan Ward (Nightingale),

...the associate is like; shadowing what the mentor is doing and preparing them for the course and the training.

The co-mentor period lasts until the nurse has successfully completed the mentorship module and is registered on a local register of mentors.

The RQMs linked co-mentorship with performance anxiety around the level of knowledge and skills they had developed to date. However most of the mentors (recently qualified and experienced alike) felt that recent qualification as a nurse was useful for empathising with students, and usually meant a better understanding of curriculum needs. Marion is a strong advocate of co-mentorship at Nightingale and considers that

...students will feel more comfortable if the person is newly qualified. Which is why I feel quite strongly that you need that associate mentorship at the beginning.

Purity is the only participant to identify any structure to her co-mentorship period, but this is very much linked to her acting as a co-mentor whilst on the mentorship course. She found great value in shadowing her qualified co-mentor, and appears to have been set certain activities such as completion of student notes under supervision. Some of her learning was vicarious and observational, in seeing

...the way they're handling issues, see the way they're really supporting the students, so that way you are learning without your knowing.

Purity's experience is suggestive of apprentice-style learning; however despite her more structured co-mentorship experience she felt frustration at not being able to sign-off the student's portfolio, feeling it:

...a waste of time for the students... ...you can do some of the work, you know. I'm not qualified; just wait for the mentor to come. So it's like slowing the student down.

Similar sentiments arose in my work with underachieving mentorship students, who felt that they did all of the work of mentorship, for someone else to come and take the credit by signing the portfolio (MacLaren 2010).

¹¹ Associate mentorship at Nightingale Trust

Sade's story of co-mentorship is also one of 'picking things up' from the mentors on the Ward, and it is this rather than intentional learning which appears more commonplace amongst the RQMs interviewed. However, what is not picked up can be seen as just as important in the co-mentorship period. Kate only found out that she should not be signing-off the student's competencies (without mentor countersignature) once she had completed her mentorship course. Similarly, Dora states that in her experience as an unqualified co-mentor:

...I wasn't aware, well it didn't matter to me whether they had any meetings or assessments and all that, the main thing was just okay you're working with me today and just teaching them things hands on.

Kate feels that better preparation of co-mentors is necessary and links this with increased exposure to the practice setting:

...don't have anybody as a co-mentor until they've been, you know, six months post qualification, because I think it's unfair doing it less than that.

Joan feels that within Seacole Trust there is recognition that new nurses require some consolidation before commencing co-mentorship, but concedes that she does not:

...have direct input with how managers manage their staff in relation to whether the co-mentoring or mentoring... If the manager or shift coordinator designates a co-mentor and that co-mentor is a newly qualified nurse I wouldn't necessarily know that. So that may be challenging for newly qualified staff if they are a co-mentor.

However, she is clear that early exposure to mentorship has some benefits for nurses in having

... maybe a higher awareness of the portfolio requirements, and you could possibly aid them in how they manage themselves, not necessarily in the assessment process, but the management of yourselves in your time management. In recognising patient care is always first, and how they can integrate learning and also different ways of learning.

The SLAiP standards that student nurses be allocated both a mentor and co-mentor, and be qualified for a year before commencing a mentorship programme appear to be adhered to. However no definitive local policy regarding a timeframe, or structure for co-mentorship is evident in either of the Trusts. What is evident is that all of those currently acting as a mentor had some kind of co-mentorship experience prior to selection for a mentor preparation module. This had not always prepared them for working with students.

Selection for Mentorship

All of the participants held positive views on the value of mentorship in supporting students and in helping them to develop as practitioners. Whilst undertaking the mentorship module is a personal milestone for many practitioners in career progression,

Imogen is clear from a strategic perspective that capacity is driven by organisational need rather than personal need, despite being seen by nurses as *'doing my mentorship course'*. April highlights the constraints on sending nurses for their mentorship module at Nightingale Trust

...if it's essential that we need to have three mentors trained for this clinical area this year, then they should get all the study leave but if it isn't essential, if it's part of a PDP¹², you know, at this point in time against all those sort of competing requirements of that clinical area then there are occasions possibly where they won't get their full study leave time but I would say that 90% of the time they do.

Mentor capacity appears to be the main driving factor in commissioning places on the mentorship module. Growing student numbers mean that Trusts struggle to provide enough mentors to comply with the SLAiP standards (NMC 2008a). These state that student nurses must spend 40% of their clinical placement time under the supervision of their mentor. Mentor capacity is an important dimension of Joan's role as PEF in compiling and maintaining the local register of available mentors within Seacole Trust. She finds herself constantly advising Wards:

"From my database it indicates your mentor numbers are dropping. Would you be considering that your Band 5 or 6 needs to go onto mentorship", just to enable to keep my mentor numbers at a workable level,

Meanwhile Imogen (Strategic Nurse Lead) likens the maintenance of mentorship capacity to *water going down a plughole*. The constant turnover of mentors can lead to a burden of mentorship on supervising mentors.

Sade, in her new capacity as a key mentor, is responsible for allocating mentors to students. She recognises that some mentors need a break from having students *all of the time*,

...I try and shuffle people round from being co-mentors so you can have the sister on the Ward being a co-mentor to the students because then it gives them a better reflection, you know, and then they can also role model the mentor who probably has just been qualified.

Undertaking the mentorship module was considered near mandatory by both Practice Education Facilitators and Nurse Education Leads. Selection to undertake the mentorship course typically occurred within the first couple of years as a qualified staff nurse. Thus at Seacole, Purity undertook her mentorship module after one year of qualification, reflecting the SLAiP minimum recommendation. Both Joan, (PEF), and Sharon (NEL) advocated this time frame for starting the mentorship module. Like Kate, Anna-Maria (experienced

¹² Professional Development Plan

mentor, Seacole) had to fight and sacrifice her own time to get onto her mentorship course because the Ward where she worked at the time was

...not really kind of very supportive because they were short of staff. So, they prefer the nurses to be working than to go to school. So, I did my mentorship on my day off.

However she achieved this within a couple of years of registration. The prescription of mentorship is seen by Joan and Marion (PEFs) as being problematic as there is no consideration of suitability for the role:

...where it is a Trust requirement that you progress to a mentor the option of those staff that actually thoroughly enjoyed supporting the assessment and learning with students has now gone to a compulsory aspect and ...When you make something sort of mandatory, the aspect of well, I actually enjoy doing it anyway is actually gone. (Joan)

Mandatory mentorship can potentially denigrate the contributions of other team members, who are not keen to mentor,

You see people... and you need it in teams. I'm not saying they don't mentor. It's just not their favourite thing. They don't put themselves out to do it too often. But they're probably very good at the audits that nobody else wants to do. You need those kind of people in teams. (Marion)

Amongst the RQMs interviewed a sense of mentorship as a rite of passage was evident, and represented a means to progress in the profession. There appears little resistance to undertaking the mentorship programme in either Trust, with nurses keen to participate. Dora takes a persuasive approach with her staff, encouraging them to take up the mentorship course but identifies that

There are a few that are not very keen and if they are good on the job and going for the mandatory updates I don't really fuss over that.

Dora and Anna-Maria's (Seacole) discussions of colleagues, who have been qualified for many years but have not undertaken his mentorship award, are seen as exceptional cases rather than the norm. A sense that these individuals are not best suited to mentorship is evident. In this light, Kate's inability to access a mentorship course appears extraordinary.

Selection for the mentorship course appears to be at the discretion of Ward Managers such as Dora bat Seacole, and ward sisters such as Lulu (working with senior nurses) at Nightingale. Selection is dependent on issues such as professional development needs as well as available budget and current mentor capacity. However, allocation of mentors to students and supervising mentors to those undertaking the module appears to be undertaken in the main by link or key mentors. This is described as *allocations*, and appears to be an administrative role rather than a matching of skills and attributes.

Workplace Learning in Supervisory Relationships

A broadly humanist approach to student learning is demonstrated by participants, reflecting their views of patient care. Compassion and empathy for the student experience is most evident where students are seen to be keen, willing and able to learn. However, frustrations occur where students fail to share the passions for practice of nurses. Kate is frustrated when an otherwise able student does not share her passion for A&E nursing, whilst Imogen remarks that nurses are

Very good at eating our own

This suggests an element of intolerance toward learners similar to the psychological reactance discussed by Warne and McAndrew (2004). This is matched by the slight disdain for *spoon-feeding* students who are not proactive in their own learning exhibited by active learners Dora, Purity and Sade.

Supervisory mentors discussed different approaches to mentoring student nurses and their learner-mentor colleagues. Supervisory mentor relationships were discussed as more laissez-faire and hands-off by both experienced mentors (Dora, Lulu, Anna-Maria), and the newly qualified recipients of their supervisory mentorship. The laissez faire approach was, however, not always what these developing mentors felt they needed. Dora's input is limited to supervising the formative, midpoint and summative student meetings provide the structure of the mentoring relationship and correspond with what is to be completed in student portfolios. She is otherwise confident that her staff already meet the SLAiP standards:

If I'm supervising the staff who's doing a mentorship course I leave them, apart from our meetings and then meeting up with their own students that they are basing their workbook on, I leave them to their own devices (laughs), yeah, literally. If they have issues they will come to me but other than that I ...I just ask them how they are getting on but I don't really other than that.

In comparison, Sade found her own supervisory mentor's lack of engagement and eventual withdrawal frustrating. This meant that she had to seek further support from another mentor. She describes her original mentor as *nonchalant* towards her,

It was, it was perhaps the notion ... that, oh, you can get on with it, you know what you're doing, you know, I don't have to be there, you know

Kate also experienced mentor withdrawal, although this was due to long-term sickness of her supervising mentor, meaning that she also had to seek alternative support arrangements during her mentorship course. As Logan's ward sister, Lulu took Sade's supervision and appears to have implemented the necessary structure to enable Sade's learning.

...in terms of ...documenting, assessing patients ...all the kind of clinical skills, she was one for that. Which helped me during my time of mentoring to see, to know how important that is to actually developing a student. Yeah. And being thorough, and... being an expert... in that field of learning

A structured approach is noted in Anna-Maria's supervision of Purity. This forced her to participate in student mentoring, rather than just observing it.

...she said you're going to write it. I said, well Anna-Maria... No, no, no. Sit down, okay, she gave me a clue, this one here, what do you think she did with the patient? How did she do it? What did she do? So sit down and write, you're going to do it on her portfolio, I'm only going to sign... ...that was a very big challenge, and I wrote it... ...breaking it down for me helped me to do the writing.

The structure of the learning experiences appears to have been varied across the three RQMs. However, all research participants discussed role-modelling as a key dimension in their learning to become a mentor.

Developing in the Mentor Role

Once qualified as a mentor, nurses settle in to refining their mentorship role through onward mentorship of students and junior colleagues. Several influences on mentorship practice, such as available time, workload and throughput of students were identified in the interviews. However the biggest influence appears to be that of the ward environment, and in particular ward sister/Manager roles. This section will explore how the role of the Ward manager in Roper Ward enables an expansive learning environment to support mentorship and learning (Evans et al. 2006). The influence of the organisation is paramount in setting the agenda for mentorship, but its operationalisation varies across the Wards and Trusts studied here. Roper Ward provides a clear example of the influence of the Ward Manager (Dora) on mentorship aside from that experienced through role-modelling. Lulu and her colleague Karen appear to serve the same function as ward sisters in Logan Ward. At its core, the ethos of Roper Ward is stated by Purity as

...centred around the patient. The way I see it ... because patient care is paramount so mentoring should be, and that's my view, that's what I think I get from the Ward. So that's why you must find time to make sure your study days you go, get your mentorship out of the way so that you're ready to ensure the continuity of quality nurses in future.

This identifies the multiple foci of patient-centred care, personal responsibility for learning, and mentorship quality, which are evident in the interviews of all three Roper Ward nurses. Organisational support for mentorship is provided by Dora as Ward manager, who places value on the mentorship course and acting as a mentor. She is discussed as highly significant in the developmental mentorship constellations of both Purity and Anna-Maria. This leadership steer towards mentorship is supported by Dora's provision of regular semi-

formal and interprofessional learning opportunities which take nurses off-site and encourage team-building and shared learning. Dora has to justify these to her superiors as 'awaydays' are costly in terms of workforce backfill, but feels she has the backing of the senior nursing team. These are opportunities are appreciated by Anna-Maria and serve to update clinical knowledge and skills

We have lectures. We are updated with some cases in our Ward, like sepsis, like what operations we do have, and then the consultant will come in and teach us what is the liver section, ... upper GI, like gastrectomy or oesophagectomy, how they do perform the surgery...

Clinical excellence is valued as the basis of mentorship by Dora who sees the link between mentorship and clinical practice as a positive one

... because if you are a mentor and you've got a student you're bound to show them what is the right thing so you're thinking about doing what is right, having a good grasp, explaining why things are and what I like is... coming back, you get people coming back to you and saying, I was asked this and I didn't know what is it and then you explain to them and you say, oh thank you for that. .. I think it's a good experience and if...it helps the mentor keep up to date because they want to be saying what the right thing is so I think it's a positive thing and the students surprisingly like it.

Skills are seen by Purity as perishable over time, needing to be immediately and then regularly enacted in order to gain confidence in practice. Her discussion of her own mentorship of students privileges and invites opportunities for supervised hand-on clinical learning. This is similar to the invitational approach suggested by both Dora and Anna-Maria, further underlying the cultural importance of mentorship in the Ward, and ensuring that good practice is reproduced.

Encouraging Hands-on Care

Kate and Sade also extol the importance of enabling students' hands-on care. However, because her role models are less hierarchically significant, Kate may lack the senior sponsorship or leadership required to ensure that her own actions are reproduced and valued within the Ward. Allowing students to participate in more meaningful care delivery activities is not only valued by the RQMs, but appears to be something that does not always occur. However, Anna-Maria gives an insight into the relationship of her confidence in her knowledge and skills and the degree to which she now enables others to participate in care. The following quotes from Anna-Maria identify a widened knowledge and skills base, an increasing tendency to engage learners in hands on care, and improved abilities to troubleshoot as her knowledge and skills have developed.

I think I add so many things because I have a lot of skills now, especially with my like surgical skills. Now I can... I think I do... my knowledge is wider than before.

Before I used to be always only showing to the students; I kind of tend to be reluctant to let them be hands-on. But now I always do hands-on with them and I always let them be hands-on. Everything I show them once or twice, they need to hands-on the next time, but with my supervision.

This is reminiscent of the 'old-timers' described by Lave and Wenger (1991) who act as gatekeepers to skills and knowledge situated in the workplace. It also harks back to the discussion of performance anxiety blocks earlier in this chapter (Evison 2006). Anna-Maria has only recently developed a more participatory approach, despite having been qualified as a mentor for four years. Her own movement from legitimate peripheral participation to engaged mentor has been mediated through development of her own confidence in her nursing skills, and thus overcoming her performance anxiety. This is credited to Dora's leadership of Roper Ward, as this development was not considered possible in her previous job due to a restrictive Ward culture and lack of value attached to the mentor role. It is only through her own full participation that she is able to encourage others into hands-on participation in care-giving. Further fit with theories of situated learning and socialisation of new practitioners is provided by Sade, who comments that

...students come on to the Ward for placement and they pick up on the skills and they pick up on the knowledge and they pick up on the habits actually, you know, of what they see the staff doing on the Ward.

The use of the word 'habits' suggests the role of informal learning through immersion in practice and echoes Bourdieu's use of 'habitus', signifying personal practice influenced by the objective structures of the organisation (Bourdieu and Wacquant 1992). This is in contrast to Kate's more formalised ideal of mentorship as a bridging of theory and practice, which appears premised on skill and knowledge transfer:

...you're trying to impart the right way of doing something and there are so many different tasks in, in nursing that can be learned and things like doing a dressing, so you've got aseptic technique, you've got your choice of dressing, looking at wounds and things like that, there's so much involved in that that I think all these tasks kind of help you to mentor because you, you can see whether a person's taking it in or not and linking it into things that they've learned in the classroom.

Anna-Maria's experience indicates that mentorship skills are refined and developed over time and under strong directive leadership. Whilst Wards with weaker leadership structures would appear to be at a disadvantage, several options for development in the mentor role are described in the interviews.

Mentor Updates

Mentor updates serve to standardise mentorship approaches across Trusts and provide potential routes for mentor development. Roles such as sign-off mentor (as outlined in SLAiP) and key mentor are also used in each Trust. These are identified by PEFS as

important in drawing together mentorship experiences organisationally. Updates are a significant organisational commitment for PEFs, who have been seeking alternative methods of achieving these. Joan talks about acknowledging more informal encounters as mentor update activities. She recognises that keeping mentors up to date is more than *bums on seats*, yet still needs regulation:

I developed opportunistic mentor updates and developed core aspects that the team would have to achieve on a shortened version of a mentor update if they were in the clinical area. And then I also developed our mentor newsletter that would also supplement that shortened mentor update contact.

Marion's *bespoke* mentor updates seem to fulfil the same niche for Wards and departments unable to free colleagues for timetabled update sessions. Here she will bring the update session to the workplace. Joan highlights a new key mentor group she has started in Seacole Trust, which will bring together mentors with an interest in developing their role from across the Trust. Although this is a recent development, it is an established group at Nightingale Trust, where Sade is a keen participant. The Ward-based role of these mentors is described in terms of dissemination of information by Joan and Marion

..our practice advisory board very much embraced the concept and said yes, that would be a positive way forward to look at a named responsible person within a clinical area being the key contact to enable further dissemination of... [Information] (Joan)

The key mentors will tend to allocate the students to mentors. So they will know who their sign-off mentors are, they will know who final placement are. (Marion)

Ward-based nurses were aware of the key mentors' administrative role in managing the allocation of students to registered mentors. However, none of the Ward-based nurses discussed the key mentor as a significant influence of their mentorship learning. This is suggestive that whilst the role may be effective at disseminating information about student allocations, it is not currently perceived as, or associated with disseminating best mentoring practice.

Similarly, the RQMs do not make overt reference to sign-off mentors as supportive in their development as mentors. This is despite the additional training which these mentors undergo. Lulu is the only mentor who identified herself as undertaking the sign-off training, which she did following persuasion of Marion. Marion identifies that mentors are unsure of their own accountability in the assessment and evaluation of final year students, suggesting that this might reflect a more widespread worry about *comeback* and accountability across all mentors.

The Role of Role-Modelling

Role-modelling is far and away the most common approach to mentorship learning discussed by participants. Experienced and RQMs alike aspired to becoming good role models for their students, often linking this with their own professional identity (via The Code), and notions of expertise as a nurse. It appeared to offer both positive and negative examples from which to model practice. Anna-Maria's explanation of what this means to her as an experienced mentor appears typical across the mentors:

Being a role model... you need to show them: show them that you are a good nurse, and you are able to provide a good, proper care to the patients, so that when they finish they are able to follow that step as well

To facilitate role-modelling, Anna-Maria adopts an invitational approach; inviting students to witness, observe and take part in patient care. To this end she says,

I'm always calling the student: 'come, I have something to do and I want to show you, so next time you'll be the one to do it'.

Purity's interview concurs with this as Anna-Maria uses this approach in her supervisory mentorship of her, which adds to her sense of vicarious learning through role-modelling. She states that

...it's a very vital role because before you become a proper mentor if you have somebody was shadowing, see the way they're handling issues, see the way they're really supporting the students, so that way you are learning without your knowing.

Senior figures were more often referred to as role models in relation to mentorship. They were also more likely to be named in individuals' developmental constellations as significant to their learning in this capacity. This was associated with their visibility in practice and willingness to deliver, or facilitate others to deliver hands-on care. Kate discusses a key role model in her student career as

...somebody that just had a vast amount of knowledge and was prepared to share it and, and was also prepared to let me loose and do things which, which was great.

However, in terms of her current practice, enthusiasm and ability to communicate with others are considered more important in role models:

...we need nurses who are enthusiastic about their jobs and are enthusiastic about being a people person even if you've not got all the knowledge and all the skills being able to communicate with people is so much more important.

In comparison, Marion (PEF, Nightingale) and Purity give examples of negative role-modelling that influenced their practice positively. Marion had found her initial nursing education as

...very draconian, very... 'learn by humiliation' really and it didn't suit me at all. I did pass but I didn't look back at it fondly. So when I started to get students of my own I thought I would hate to be treated like that and that there's different ways of

learning. So I think probably my student days probably did affect me quite a lot because I didn't think that the style led you to be enquiring, it was very much this is what you do, you don't question you do it.

In her mentorship preparation, Purity found herself observing others to see how they mentored students. She recounts an incident in which a mentor had refused to sign the portfolio of a student nurse:

Well, I wasn't happy with the way she treated the student... [she said]... "Oh no! ...I'm not signing this now because you've not done it". I just thought, okay she's not done it. ...[but], if you had called her and tell her, perhaps give her a clue of what to look for, because sometimes they might want to get it but they're not getting it, probably because they need extra help. Not spoon-feeding but just saying, okay you know what, have you tried Google or have you tried bringing this up or just give a hint, they might get these things.

This incident provides evidence for mentorship learning from negative role-modelling, but also gives some indication as to the relative status of knowledge and skills in the mentorship relationship.

Knowledge and skills are seen as crucial for mentorship, although generally it is nursing knowledge and skills rather than learning theory from the mentorship course that appears to be prized. However, theoretical elements of the mentorship curriculum are represented some of the interviews. Dora displays a learner-centred view of learning which appears influenced by notions of andragogy, whilst Purity focuses on educational theory as justifying her own mentorship practice

I didn't know this is a theory, or that was a theory and I'm able [now] to pin a theory but I know that's what I'm doing or that was what I saw or that was what I experienced. Okay, somebody said this already before, okay, being able to relate to it, that's okay. I think it really helped.

April also draws upon educational theory as something that gives her confidence in her abilities. However, as the Nurse education Lead for Nightingale Trust, it could be argued that learning theory is more closely related to more of her educationally oriented role.

A common perception of mentorship amongst those interviewed is one of expert-led and modelled practice. However, skill development is about more than observing the registered practitioner perform. A tension was evident in participants' discussions of how students do and do not learn. In discussing their past experiences as students a common theme arising was being treated *like an HCA*¹³. This involves students being allocated tasks to complete which, whilst useful for the functioning of the Ward do not extend their skill set or expand their nursing knowledge. This lack of exposure to practice was linked by Lulu to notions of

¹³ Unqualified Health Care Assistant

mentor power over students. Other participants linked this to students being offered opportunities to observe rather than participate in care.

The findings presented in this chapter illustrate the complexity in managing mentorship relationships and roles. Practising mentors (and all nurses to some extent) must juggle the multiple demands of patient care, personal and professional obligations to continue developing skills and knowledge, as well as a commitment to pre- and post-registration student learning. It is unsurprising then, that these competing demands are not always met effectively, with *laissez faire* attitudes to learning only challenged where students hold conflicting views of learning.

In acute areas, key learning activities appear focused around opportunities for role modelling from senior colleagues. In this context ward sisters and managers provide credible patient-centred examples, and expertise. However, expansive learning opportunities for mentor development are only afforded when coupled with effective leadership; with nurses sometimes needing to change their work environment in order to find this. The stories of restrictive learning environments offered by participants might account for some of the learning blocks and orientations to learning identified in this chapter. Having focused on perceptions of developing as mentors in this chapter, chapter six explores how participants accounts fit with professional policy: identifying how the rhetoric of the *Standards to Support Learning and Assessment in Practice* (SLAiP: NMC 2008a) is demonstrated in their interviews.

Chapter Six: Analysis and Findings - Mapping of SLAiP Standards

Several policies affect the practice and workplace learning of mentors. These range from the policies of individual Trusts through to Governmental level initiatives. In my opening chapter I posed the research question

What constitutes the current policy, professional and political agenda for nursing mentors and in what ways are messages relating to mentorship transmitted and interpreted by those significant to learning?

It is impossible to present all of the findings of interest from this aspect of my research. Given the limited scope of this thesis I have chosen to concentrate on my mapping of the SLAiP learning domains (NMC 2008a) as they best answer this question. SLAiP represents the single greatest policy influence on mentorship practice in the UK. I introduced this document in chapter two as the latest set of standards and guidelines for practice education. In this chapter I focus explicitly on mentorship standards rather than the other stages of practice education it covers. Participants' interviews have been interrogated for evidence of the domains of mentorship (Appendix I). Mapping the domains of the standards enables me to gauge the potential penetration of policy into mentorship practice, identifying areas of both consensus and divergence. The applicability of the standards in supervising mentorship students and promoting supervising-mentor development will be considered. The mapping process employed is interpretive, and influenced by my own experiences as a nurse, mentor and lecturer in mentorship, and my own adherence to the SLAiP standards as a nurse teacher recorded on the professional register.

The RQMs interviewed undertook their mentorship module before recent changes to the assessment protocol to include assessment of competency were introduced. This might influence policy coverage within their interviews, although all would have had an introduction to these influential standards in classroom teaching sessions. The experienced mentors all qualified as a mentor prior to the publication of the first edition of SLAiP (NMC 2006), but have had exposure to them through annual mentor updates, which are part of the SLAiP framework. The mapping considered here concerns mentors only, rather than senior Trust or strategic level participants.

Mapping the Standards across Mentor Interviews

A broad consensus regarding the domains of mentorship is evident in mapping the interviews with SLAiP (Appendix I). Most items within the standard domains are discussed in relation to the expectations of the role. Marion is keen to stress that RQMs have a better

understanding of the mentorship standards, than previous cohorts, however Sharon feels that nurses at Seacole tend to work with the broad principles of the standards rather than knowing them word for word. Kate is in agreement. Talking about her pragmatic relationship with the standards she says,

I don't think they're actively in there (taps head), you know in my day to day "I'm being a mentor, quick check the NMC website" I don't think day to day that comes into my head, but I know that if I want to look anything up I can.

Notable disagreements between participants occurred in each of the following the following domain statements:

- **Facilitation of Learning:** Support students in critically reflecting upon their learning experiences in order to enhance future learning
- **Assessment and Accountability:** Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team
- **Assessment and Accountability:** Be accountable for confirming that students have met, or not met the NMC competencies in practice.

These key areas of dissonance will be discussed in terms of their significance for developing mentorship provision, exploring possible explanations for findings.

Facilitation of Learning - Reflection

Reflection is an integral part of the nursing curriculum at pre-registration level. It also forms a key part of the rhetoric of professionalism. It is only used in discussion of mentoring student nurses and not discussed as a learning strategy with mentorship students. Instead the focus of learning and teaching activities appears to be the transmission of knowledge and skills, and the modelling of professional practice. The ability to reflect on practice appears in the mentorship curricular learning objectives; the summative assessment requiring mentorship students to reflect on their supervision of a student, so I had an expectation that this might form a more substantive part of the findings. All of the nurses interviewed were able to reflect on their own practice with clarity and insight, yet reflection was not discussed by three of the six mentors. Two others referred to reflection in the abstract in discussions about getting students to 'think' about their practice. Only RQM Kate is explicit in her use of reflection as a learning tool for the student she has co-mentored. This is based around the student reflecting on their practice rather than her own reflection used to benefit the student, or her own learning.

In support of a more developmental attainment of reflective capacity, Spouse (2001) draws upon the Vygotskian theory of scaffolding. Spouse argues that nurses hold knowledge in waiting until they have developed the maturational ability to deal with it. Lee (2005) posits a relationship between the pace at which reflective practice develops and exposure to the

field of practice. However, experience alone does not seem to account for the distribution of awareness of reflection as a tool for facilitating learning in these interviews. It is the novice mentor Kate who leads the field here, rather than her more experienced or expert colleagues. Lack of evidence of reflection may be indicative of the group effects noted by Platzer et al (2000) who state that group commitment to learning from experience can lead to either group engagement or the prevention of using this learning strategy. As no colleagues of Kate took part in this research it is impossible to gauge whether her responses indicate that she works in a more reflection-friendly working culture, or whether her own ability to reflect on practice reduces her need for a wider mentorship network.

What is evident is a similarity in experience within the two teams forming whole cases. No evidence of reflection is evident in Sade or Lulu's accounts at Nightingale Trust. Similarly on Roper Ward, Dora and Purity show only weak evidence to support mentorship, whilst it is absent in Anna-Maria's discussions. The culture of mentorship within Roper and Logan Wards warrants further exploration to ascertain whether this promotes or inhibits reflective practices. Further, a more nuanced understanding of what it means to reflect in practice and deliberate coaching and modelling of reflection in practice needs to develop to encourage its use as a learning tool (Schön 1987).

Two possible explanations for this arise in the literature, namely the discrepancy between teaching and using reflective practices, and the development of reflective activities through coaching and mentoring. Teaching reflective practices is advocated to assist nurses in developing the necessary cognitive processes, yet it is no guarantee of its adoption in practice (O'Connor and Hyde 2005, Nairn et al. 2006). Barriers to its implementation have been identified by Platzer et al (2000) as issues of previous education and socialisation into nursing, organisational culture and the affect of group membership. A key issue highlighted is that of performance anxiety, which is prevalent across the RQMs' interviews and discussed in the previous chapter. This could possibly make a mentor less willing to share their reflections on practice, or elicit it in others. I noticed a similar phenomenon in a my small case study of specialist nurses piloting reflective diaries prior to their implementation with students on a specialist post-registration course (MacLaren et al. 2002).

Assessment and Accountability

Within the domain of assessment and accountability the statements regarding understanding of a broad range of assessment strategies, and the confirmation of student achievement show variation in mentor awareness. Significantly they correspond with areas of mentorship practice which have been identified as problematic in recent literature (Duffy 2003, Webb and Shakespeare 2008). Assessment and accountability were more likely to be commented on by the PEFs. Joan identifies that mentors are often not confident or empowered to write their own assessment of the student's performance in the student portfolio, often calling her for assistance with this.

Andrews et al argue that mentors may be encouraged to avoid difficult decisions knowing that additional scrutiny will take place at the end of a student's programme (Andrews et al. 2010). Currently a relatively small number of nurses go on to become sign-off mentors, highlighted by the fact that only Lulu (Nightingale) is currently a sign-off mentor. Purity backs this up. She is more likely to allow a student another attempt at assessment than fail her student. Meanwhile Kate has only mentored unproblematic students to date, but ponders her probable reaction should issues arise:

I've never had somebody that I've thought no they're completely unsafe so I've been quite lucky. Because I think that would... it would affect me as well as the person that I was mentoring, you know, have I failed them? Have I done something you know I'm not bringing them on enough? But yeah it is a big responsibility and (laughingly) you think, "Am I doing everything I should for you?"

Her comments identify the emotional workload associated with assessing problematic or failing students. Although as nurses they have experience of breaking bad news to patients, breaking bad news to students about their performance appears to cause stress. This is linked by both Marion and Lulu to a real fear of professional *comeback*. Lulu explains:

...in the future, if anything happens, the sign-off mentor is going to face the problem. So you really need to know what you are doing before you sign-off.

The reliance on role-modelling as the predominant learning activity within mentorship may have some resonance with the range of assessment strategies employed. I have already reported on the lack of reflective activity in mentor-student relationships. This reduces the possibility that it might be used to assess learning in the affective and cognitive domains. Constructive alignment of learning outcomes and assessment criteria is required to enable students to see how their achievement fits with the assessment criteria (Hargreaves 2004). Where portfolio items lack performance indicators, this may be problematic both for student and mentor. Where assessment criteria is even less explicit (such as in the

workplace learning component of the mentorship module), this issue is further compounded.

Whilst in broad agreement that mentors need support to make difficult assessment decisions, Joan also highlights a related issue of student complaints of a lack of feedback in practice. This, she feels may be related to a misunderstanding of what constitutes feedback on practice

...from our student evaluation forms, the students are reporting that they don't feel they're getting feedback. Now again, without being able to interpret the student as to what they determine is feedback I think that's a hard one to say as to feedback is not necessarily a sit down session, that could have been every day I'm giving you feedback as we go along, unless you use the words, 'and that's feedback' the students may not necessarily understand it's that. (Joan)

Where SLAiP suggests that PEFs and sign-off mentors should be available to give mentors support in decision-making, it is clear that the PEFs are fulfilling this role rather than sign-off mentors.

Additionally, Dora appears to act in a similar role on Roper Ward. Although she is not a sign-off mentor, Dora's experience as a mentor is significant and would prepare her well for this role. However, Dora has resisted taking on further educational roles, preferring to focus on her clinical role instead.

Validity of the Standards

The validity of the standards for developing mentors must be considered. At Ward level SLAiP encodes a route from RN to sign-off mentor, yet it does not provide guidelines for supervisors of mentorship students. This may account for variations in the experiences of RQMs interviewed, and the range of attitudes and responses to supervising mentorship discussed elsewhere in this thesis. The only structured mentorship development is preparation to become either a mentor or a sign-off mentor. This role has been criticised as potentially weakening the assessment process across the three year nursing diploma/degree (Andrews et al. 2010).

The success of SLAiP is affected by the focus on mentorship capacity rather than fit of mentor and supervisor. With a predominant focus on the learning of pre-registration nursing students, attention is drawn away from the development of mentorship knowledge, skills and attitudes and the relationship between mentorship student and supervising mentor. The domains of learning contained within the standards do provide a curriculum of sorts for initial mentor preparation, but do not provide benchmark standards from which to assess performance at either mentor or sign-off mentor level of registration.

Competency portfolios to support mentor development in both the mentorship course and in ongoing practice have been developed by the mentorship team and practice educators (including those from Nightingale and Seacole) to enable nurses to demonstrate that they meet, and continue to meet the standards. This contributes towards a triennial review of their mentorship performance. However within the ongoing developmental portfolio the SLAiP domains and descriptors do not contain outcome measures. Therefore mentors may be invited to repeat experiences year on year rather than further develop their competence and expertise (Andrews et al. 2010).

Chapter Seven: Analysis and Key Findings - Mentorship Constellations

The analysis of developmental networks has been used in a diverse range of research including Nursing administrators (USA: Hirsch and David 1983); Nurses in elderly care (Netherlands: van Beek et al. 2011); breastfeeding mothers (Brazil: Souza et al. 2009); law firms (USA: Higgins and Thomas 2001) and manufacturing companies (USA: Kram and Isabella 1985), and Student teachers (Netherlands: Zanting and Verloop 2001). A range of approaches is evident in these studies, but they tend toward large scale surveys utilising statistical analysis. Souza et al, and Kram and Isabella offer rare qualitative insights, although not case study form. To my knowledge there has been no British use of such networks with a nursing, let alone with a post-registration mentorship focus. This aspect of my study represents a unique insight into an under-explored group of nurses. The constellations presented here focus almost exclusively on the constellations drawn by mentors, in order to consider the research question

Which learning relationships in the practice settings are significant for nurses undertaking the mentorship module, and those supervising them?

However, this chapter will also consider the similarity and differences between the constellations at different levels of the Trusts and Strategic appointments.

Developing the Constellations

The constellations presented here are based on what was drawn during the interview, augmented with what was said. An example of the original format of the constellations is demonstrated in my own constellation in Appendix F. Constellations were converted into a digital format using concept mapping software (CMAP Tools knowledge modelling kit, version 5.04.02). Concept maps are generally represented hierarchically with the most general concepts at the top and specific concepts arranged hierarchically below (Novak and Canas 2008). I use the concept mapping software differently by making the starting point an individual, and using the relational labels to denote the perceived attributes of significant others. This better corresponds to Moreno's notion of a sociogram (1934, cited by Scott 2007), or ego-centric personal network (McCarty 2002).

The strength of relationships between the initial interviewee and those identified as significant in their learning was gauged through applying a four point grading system to each of the relationships, where one equalled least significant, and four equalled the most significant relationship. Thus different options for line thickness and colour were employed to correspond with the strength and currency of relationships with directional arrowheads used to show relationship reciprocity. The scoring system was an arbitrary choice made

following the pilot interview where the participant had awarded four lines of connection between herself and her most significant relationship. It offered a way of gauging how significant each person was in relation to development within either their mentorship role, or current post. Higgins and Kram (2001) define relationship strength in terms of the level of emotional affect, reciprocity and frequency of communication. This research was not known to me at the point of data collection, and might have altered my approach to assessing the strength of relationship ties. What is evident from the interviews and constellations generated in this study are that these psychological aspects as well as the ability to act instrumentally to enable development *are* present in the selected relationships, but may have benefitted from a more formal analysis.

Network Analysis

Scott (2007) identifies that the key units of network analysis are *Attribute* (properties and characteristics of relationships), *Relational* (relationships), and *ideational* data (meanings, motives, definitions and typifications themselves). Whilst Scott argues that not all network analysis research will use each type of data, elements of each type are present in this research. Attributes are presented as labels on each of the constellations and descriptively analysed to show what is perceived of significant others. Most social network research relies on a statistical analysis of attribute but with such a small scale case study this would not provide reliable results. Relational data is concerned with the contacts, ties and attachments that individuals hold, and formed the basis of the constellations. Meanwhile ideational data is used to describe the nature of such relationships and the meanings and motives attributed to significant others by individual participants. Ideational data was gleaned from the supporting interview data, and forms a key tranche of the discussions in Chapter five of this work.

The mentorship constellations represent simultaneous rather than sequentially held developmental relationships, and form an ego-centric network around each participant. There is a difference in focus of the constellations at each level. RQMs were asked to document people significant to their learning whilst undertaking their mentorship course. At the other hospital-based levels participants were asked who supports them in their mentorship or practice education roles. At the strategic and policy-making level, participants were asked who supports them in the practice education component of their current role. The constellations developed therefore represent a retrospective point in time within a fixed context of their work. McCarty (2002) warns that accuracy of respondents' reports of their relationships may be questionable. Individuals have been

shown to downplay the importance of mentors after the event. This is based on notions of mentorship by individuals outside the immediate work arena, where mentor relationships may lack longevity and proximity. The constellations generated here might be considered reasonably stable representations of the support and learning development roles of those depicted within them. This is because all except one of the mentors interviewed still works in the Ward or Department where they had undertaken their mentorship preparation. Even this person (Sade) had remained within the same organisation and retained links with her previous ward-based colleagues.

Constellation Attributes

The attributes of individuals identified on each constellation were collated and compared with Darling's Measuring Mentor Potential Scale (MMP) (Darling 1984). This is an inventory consisting of fourteen characteristics identified by American hospital staff (including nurses) as significant in mentors who are guiding their guidance and growth. The MMP is not a perfect fit, as it refers to a mentorship role within a different cultural context, and has not been validated for its use in exploring the attributes of a group of mentors. Darling's MMP was widely adopted into the rhetoric of some UK mentorship courses in the 1990s and the mentorship texts supporting them (Andrews and Chilton 2000, Gopee 2011). I have several reasons for choosing the MMP for this research. Firstly it offers a list of characteristics thought useful in mentorship and similar to those reported elsewhere (Best 2005), but more significantly it rates the strength of these attributes, allowing a suggestion of the presence and gaps in individual attributes within a constellation (Appendix J). The MMP estimates 'mentorship potential' through the spread and scoring in three groups of items. These are described as Inspirer, Support and Action roles, but more properly represent domains of mentorship. Such lists of roles and functions have been criticised as inexhaustible and thus unachievable (Colley 2003). I chose to use the MMP to compare what naturally emerged from interviews with the inventory, rather than providing a list which might force them to shape their responses to the perceived needs of the instrument. The MMP tended to describe characteristics in similar ways to the participants in this study. However I did observe that the attribute of 'leadership' proved hard to categorise, and might be added to the inventory for future use.

In this research the MMP scale has been modified to reflect the four point scale used during the interviews and constellation-drawing process, rather than using the original 5 point scale. Whilst this may be seen as a threat to the validity of the inventory, there are few published accounts of its use and validity in nursing literature. Darling's (1984) original

article referring to the inventory lacks methodological discussion, although she does explain that it was used with 150 hospital employees (mainly nurses). Despite what would be a statistically significant sample group there is no discussion of results and findings aside from an assertion that all groups within the research wanted similar things from mentorship. Andrews and Chilton (2000) adapted the inventory for use with UK mentors and nurses, using this with a small sample group of 22 mentors and 11 mentees. For this part of my analysis I analyse the attributes of significant relationships for the practising mentors only, giving a small sample. I thus echo Andrews and Chilton's warning that their findings are therefore not generalisable in the traditional sense (Andrews and Chilton 2000).

In using Darling's MMP, I took the descriptions of characteristics attributed to significant relationships and the strength of relationship tie as the basis for scoring. I rated the highest score in each category enabling a maximum 'score' of 56 from the fourteen items. Darling's own estimation of high mentor potential equals a score in one of the inspirer roles (model, envisioner, energiser) of +4 or +5, along with the same scores in a support role (Investor, Supporter), which should be buttressed by high ratings in several of the nine other roles making up the MMP. High scores were estimated here by a relationship strength of +3 or +4 (strong or very strong).

A range of attributes are highlighted by the mentors, which demonstrate that for all of the mentors had representation within at least one of the core inspirer categories. Whilst for most this was a very strong association, for Kate this was only moderate. Kate is the only mentor who has no supporter roles (supporter, investor) in her constellation. Both Inspirer and Supporter roles are considered by Darling (1984) to demonstrate high mentoring potential in combination with high ratings across several of the action roles, which are also lacking in Kate's network.

None of the constellations fulfil all aspects of Darling's MMP. Like the findings of Andrews and Chilton (2000), the only attribute which is not evident in any of the constellations is Career-Counsellor. RQMs were more likely to refer to their decision to undertake mentorship as their own decision (Kate), or a decision made for them by someone else (e.g. Ward Manager). There is no sense of counselling around mentorship as a career development option. When Lulu discusses Marion's role in helping her to develop as a sign-off mentor, she is described in a teacher-coach mode rather than career-counsellor. There was coverage across all other attributes albeit with variance in strength.

The Feedback-Giver category scores poorly across the participants' constellations. The exception to this is Purity who has a strong Feedback-Giving link with one member of her constellation. Dora, Lulu and Anna-Maria do not have a feedback-giving link in their constellations, whilst this is a moderate (+2) link in the constellations of Kate and Purity. The standard-prodder category is also unchecked by three mentors, although those who had a standard-prodder in their constellation tended to have a very strong link with that person. This corresponds with the issues of assessment and accountability discussed in the previous chapter, and with Marion's suggestion that mentors find this aspect of the role difficult. It is implicated in issues of 'failing to fail' underachieving students, and accounts of poor feedback by students. This may be one reason why there are very strong links with problem-solvers across all of the practising mentors interviewed. These are discussed in terms of helping to deal with problematic student outcomes, but may be symptomatic of an assessment culture where the end-on assessment by sign-off mentors encourages mentors to defer assessment to others perceived as more 'expert'.

The cluster of MMP scores from 28-38 demonstrate similarities in availability of certain mentor attributes across the majority of mentor constellations, suggesting stable mentor networks of support at all levels of mentorship. The lack of higher scores may indicate that the terms used by Darling do not quite fit a British context. Thus additional research would be required to validate this. The highest and lowest scores are found in RQMs. Purity's constellation has very strong links ties with colleagues who act in inspirer and supporter roles. Four other 'action' categories have strong or very strong links, with two others offering moderate links. Her overall score of 38/56 compares starkly with Kate's constellation (scoring 9/56). Although this contains a model, energiser, feedback giver and problem solver, her ties are weak. Her constellation could be described as having low mentorship potential. The only attribute in her constellation that is underpinned by a strong tie is that of problem solver.

The Constellations

My focus in this section is the constellations of the recently-qualified mentors (Kate, Purity and Sade). The size constraint of the EdD thesis does not permit presentation of all of the constellations. However, I draw upon the constellations of individuals identified as significant in the learning of the RQMs. This enables me to explore the perceptions of reciprocity in relationships supporting mentorship learning and the mentorship role.

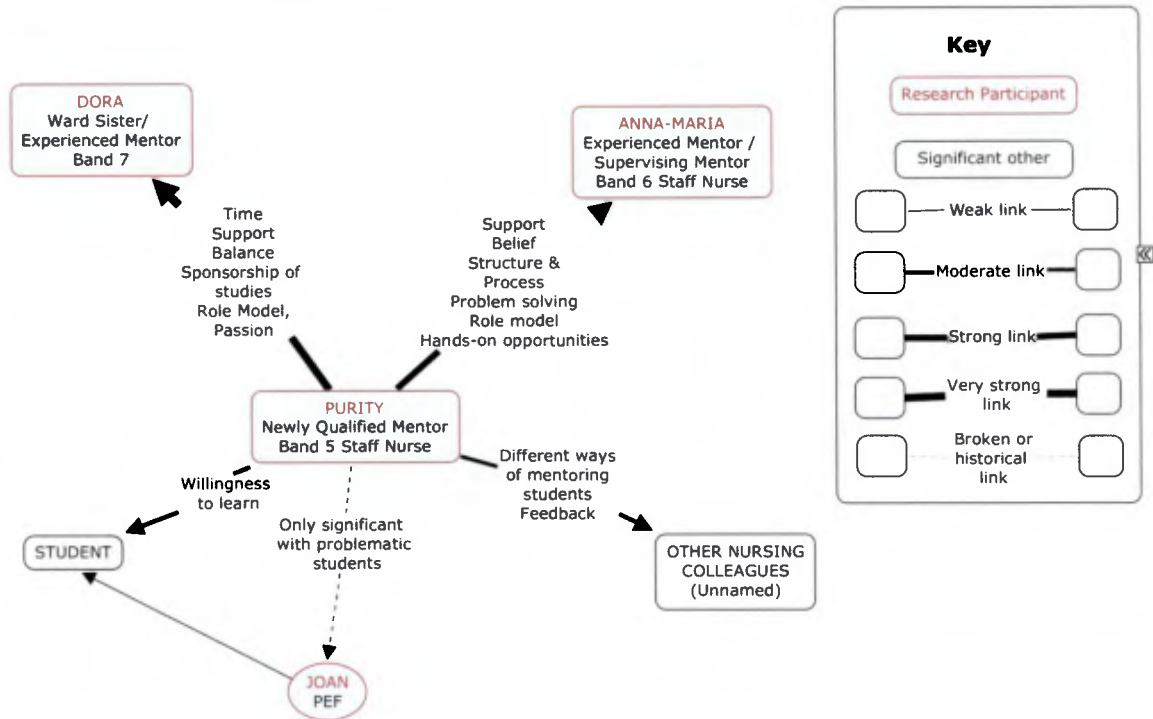
Purity

Purity is a band five staff nurse who has been working in Roper Ward (Seacole Trust) since qualification as a nurse one year ago. Purity's network (Figure 4) consists solely of colleagues in her Ward. Like Sade she has a significant link who acts as a problem solver, but support seems to be the most significant attribute for Purity. In particular Purity's most significant relationships offer her sponsorship and belief in herself in the role of mentor. The pre-registration student appears on Purity's constellation, but is not mentioned by the other RQMs. The relationship is predicated on the students' willingness to learn, rather than on Purity's responsibility or duty to mentor. Like Kate, she doesn't see the PEF role as immediately relevant to her own role as mentor. Instead they are only important when experiencing problems with students. Therefore Purity has a broken weak link with Joan (PEF). Like Sade, Purity has sponsorship and support from a managerial figure as well as her supervising mentor (Anna-Maria). Unlike the other two RQMs, Purity has an unbroken link with her supervising mentor which may be related to the management of the Ward, and attitude toward learning of Dora who is perceived by both Purity and Anna-Maria (experienced mentor) as a very strong relationship link (+4).

Purity's constellation contains two key relationships; with her own supervising mentor and her line manager. All of Purity's significant relationships are with colleagues in her own Ward. This limits the scope of her network. From her interview it is clear that she does hold relationships with other colleagues in terms of clinical practice, but Dora and Anna-Maria are the only significant relationships relating to her development as a mentor. The student is considered a member of the Ward team for the duration of the placement, but in some places is seen as 'other', not part of the team, and having limited agency to get the learning they need, being seen as 'glorified health care assistants' and not core team members. A moderate link with other colleagues (generic) appears to serve the function of role-modelling with both positive and negative instances recalled in her interview.

Figure 4: Purity's Mentor Constellation

Purity's constellation shows strong relationships with Ward-based colleagues rather than interdepartmental links. There is no regular relationship with Joan as PEF. This is theoretically useful when dealing with problematic student issues, but this situation has yet to arise.



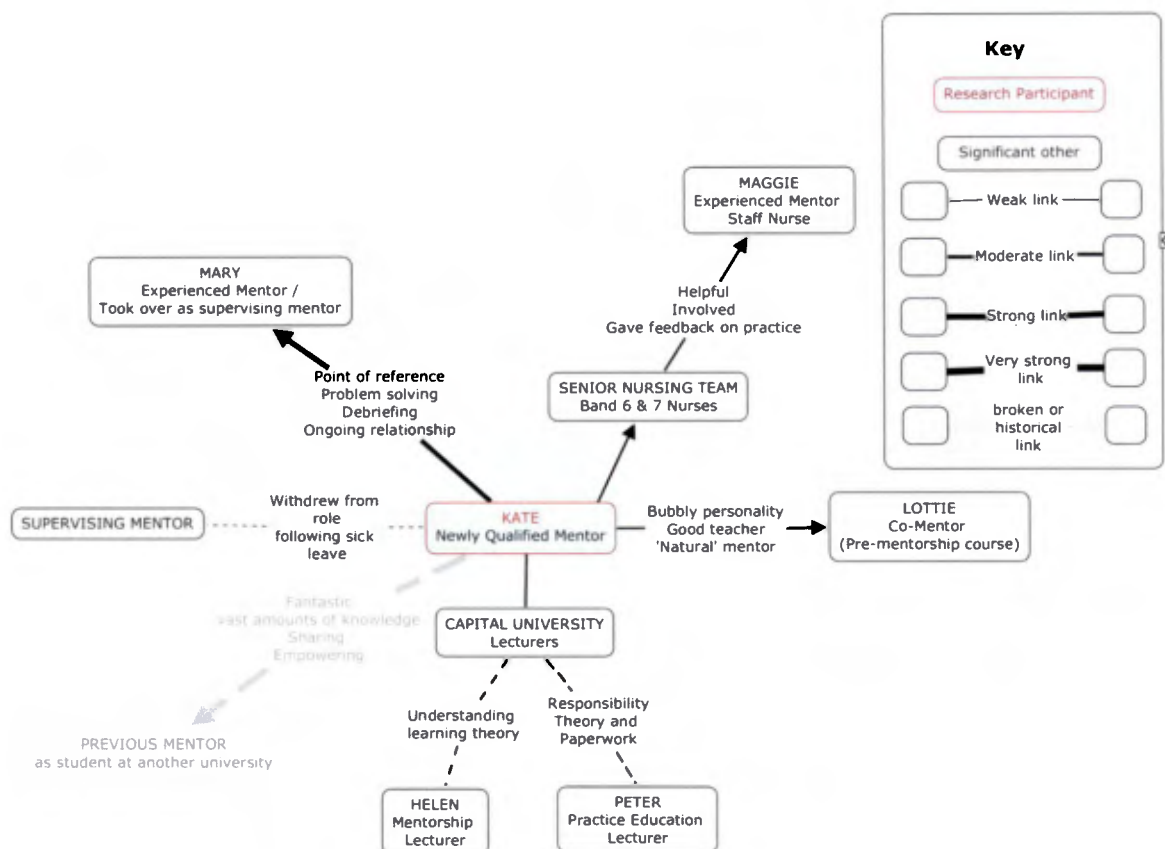
Kate

Kate's constellation (Figure 5) shows one strong (+3) relationship. Mary takes over as Kate's mentor when her original mentor is unable to continue due to poor health. although her team is also identified as available if needed, but appear much less significant in her development as a mentor, than they appear to be in her clinical practice. Her muted response to identifying significant others is a stark comparison to her description of one of her pre-registration mentors (+4). Maggie is only identified through probing questions and prompting for a name, and it is clear that she is held in less esteem than Mary. The weaker ties in Kate's constellation may be linked with lack of social agency, and lack of redundancy in her support network.

Kate is the only RQM to include her course tutors in her constellation. Whilst this might suggest a wider network, in practice it serves to underline Kate's mental divorce of theory from practice. Thus the lecturers are instrumental only in helping her pass the written component rather than helping Kate to develop her actual mentorship in practice. Although Helen is credited with helping Kate to understand learning theory, her interview identifies that she has some difficulties in making sense of this in a practice setting.

Figure 5: Kate's Mentor Constellation

Kate's constellation has the weakest links. Her supervisor withdrew from the role, and her only strong relationship is with the person who took over her mentorship. Kate describes Mary as having experience, but is not necessarily at a higher grade than Kate herself. The only person identified as being of a higher grade is Maggie. She has since left the A&E department and is not a significant source of support or development. This flattened, rather than hierarchical mentorship structure, may represent the flatter hierarchy of A&E itself, where all staff (including medical staff) wear the same uniform of 'scrubs', and are known to each other on a first name basis.



Sade

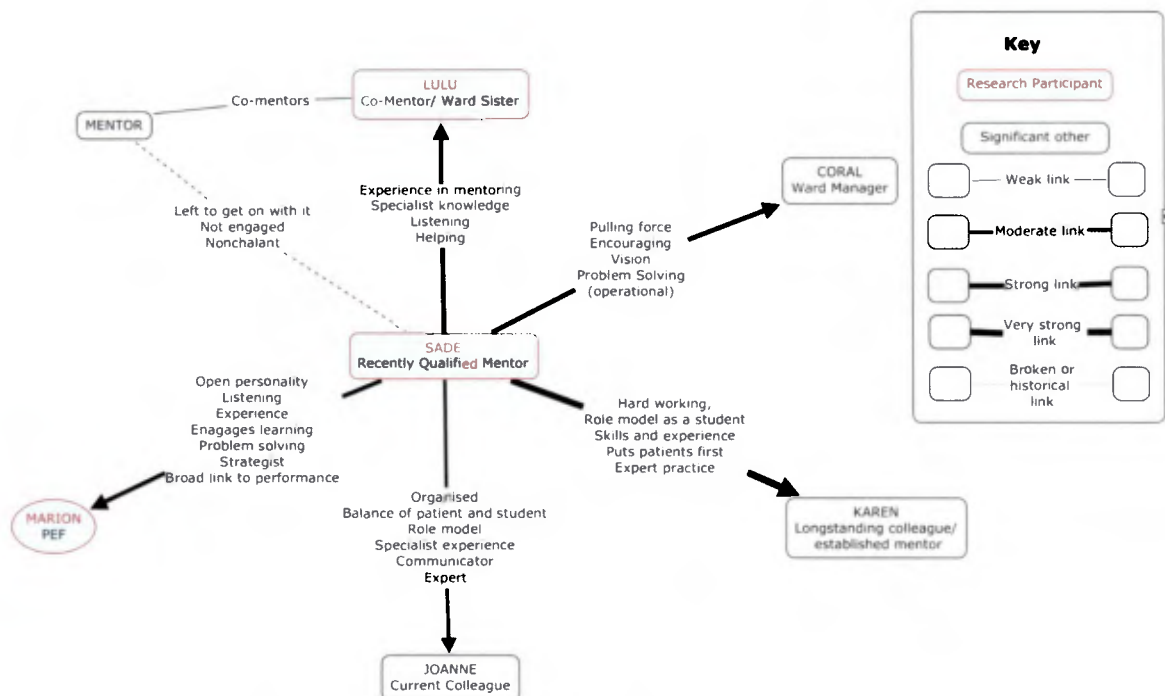
Sade's constellation (figure 6) is predicated around specialist knowledge and experience/expertise. Several members of her constellation carry similar attributes, perhaps indicating that her needs can be met through a range of relationships. Aside from the broken link with her original supervisor, none of Sade's relationships can be considered weak as all are +2 or above. Her original supervising mentor is seen as unsupportive, but she is able to tap into Lulu's experience and specialist knowledge. Sade is the only RQM participant to have changed roles since her mentorship course, and cites Joanne, her current colleague as a significant influence in her development as a mentor in a new Ward setting. Sade is the only RQM to have a direct, and fairly strong (+3) link outside of the Ward to a PEF. Of the three RQMs, Sade has the most experience of working as a mentor with students. This may be why she has more of a link with Marion as the PEF. Conversely

both Purity and Kate identify that the PEF is there to support students, rather than mentors. Strong tie relationships are more common amongst more senior nursing staff, with the range of relationship type developing with seniority rather than experience. This has benefits to mentees in helping them to navigate around organisational structures (Beech and Brockbank 1999). Indeed, a lack of senior support is shown in Kate's constellation, where she has no identifiable senior figure, and talks about difficulties in accessing her mentorship course.

Higher status networks increase the likelihood of promotion and organisational commitment (Higgins 2007). This appears true in Sade's case as she was seconded soon after her mentorship course into an educational role. She has now returned to a clinical practice role.

Figure 6: Sade's Mentor Constellation

Sade's constellation shows a range of attributes to support her development as a mentor. It is characterised by strong relationships both within the Ward, and outside of this with Marion, the PEF. Sade is unusual in having moved on from her original job on Logan Ward. She maintains links with her colleagues on Logan, especially Karen. This is made easier by the proximity of her new post to Logan Ward. Her constellation also includes a current colleague.

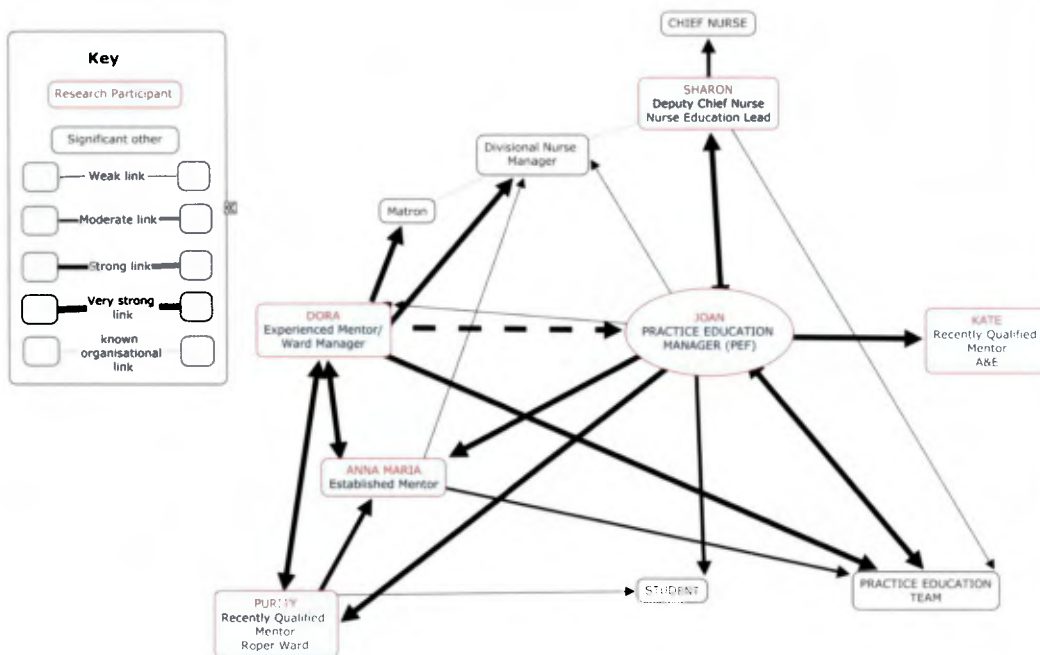


Reciprocity and Direction of Significance

In order to test the relationships between the RQMs and those identified as significant, it was necessary to explore other constellations. There appeared to be consensus in reciprocity in all constellations except Joan's¹⁴. By combining the constellations from Seacole Trust, (with Joan's constellation at the centre) differences in the perceived significance of relationships can be seen (Figure 7). It is clear that she considers her role relationally. Joan identifies post-registration students and mentors across the Trust as *indispensable* in supporting her role as PEF. She denotes these relationships as very strong (+4). However, these relationships are not reciprocated by the Seacole RQMs. Neither Kate nor Purity identifies Joan as a significant influence.

Figure 7: Seacole Trust Relationship Map

Within this diagram it is the direction of arrows which is of interest. Joan considers the relationships she has with students and mentorship students. However, these are not reciprocated. The link between Dora as a Ward Manager is considered weak by Joan, and a strong but currently broken relationship by Dora.

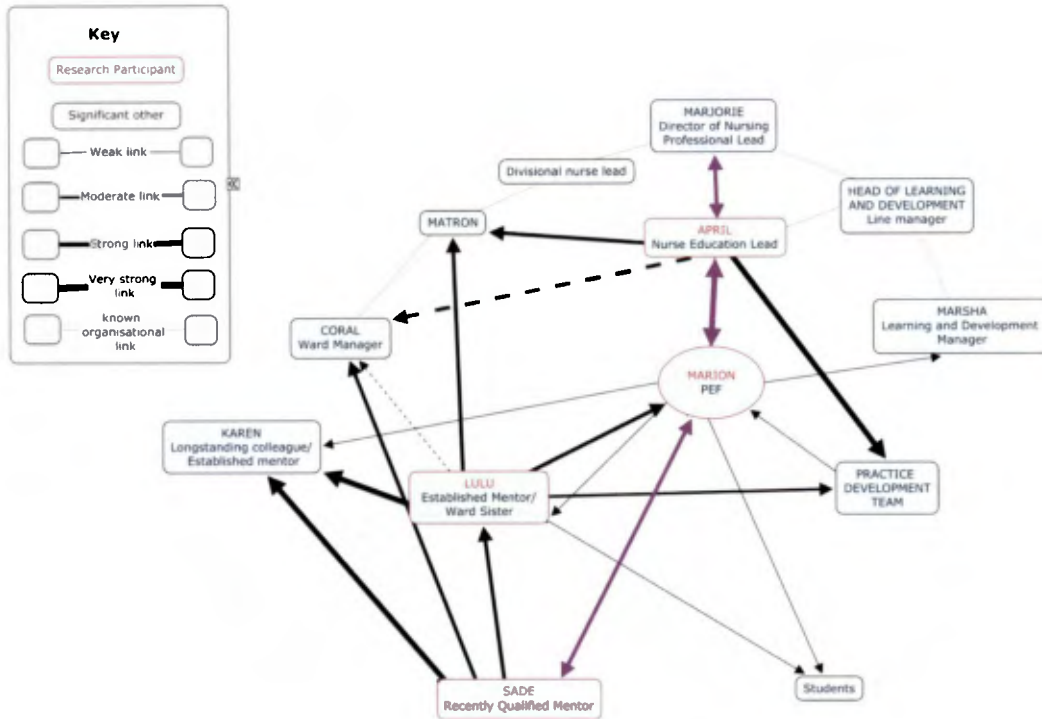


In comparison at Nightingale Trust (Figure 8), Marion is a strong link (+3) in Sade's constellation, with Marion explicitly stating a reciprocal relationship with Sade, and with mentors in general. Similarly Joan identifies a fairly weak link with Ward Managers, which is not reciprocated by Dora who identifies this relationship as strong but broken. This indicates her strong relationship with Joan's predecessor.

¹⁴ Kate's significant relationships were not explored

Figure 8: Nightingale Trust Relationship Map

In contrast to Seacole's relationship map, there are fewer links between 'ward' and 'board', with three reciprocal links to the director of nursing shown in purple. Marion is at the hub of the organisation in regards to mentorship and workplace learning.



Both diagrams signify another important relationship which may be related to individuals' agency to perform within their roles as mentors and nurses. I have identified this as the number of reciprocal links between ward (in particular the RQMs) and board level nursing representation. This may be indicative of the scope of influence of participants, but requires further work to substantiate further. At first sight, there appears to be a 3-link pathway to the chief nurse from the RQMs at Seacole trust, the direction of influence is top down, rather than bottom-up because of the lack of reciprocity in relationships. Neither of the Seacole RQMs cites their Trust PEF as a significant relationship, whereas at Nightingale a true three-link path is evident and highlighted in purple.

Identifying Mentorship Constellation Type

Attribute and Relational data are analysed using a framework which focuses on two main elements of analysis: namely the make-up of individual networks, and the strength of individual developmental relationships within them. This framework developed organically from observations within the data collection phase, but has since been refined using Higgins and Kram's typology of network relationships which formalises these concepts as

network diversity, and network strength. The concept of network diversity concerns the flow of information, with Higgins and Kram (2001: 269) noting that

The less redundant the information provided by one's network, the greater the focal individual's access to valuable resources and information

In this context a network has greater redundancy if information and resources are available from more than one source. Redundancy is important at individual level, but also at organisational level as is shown in Chapter six with the policy dissemination and sharing aspects of this research. Network diversity is defined in two ways: though the range or number of different social systems the relationships stem from; and the density, or depth to which people in a network are known and connected to each other. In this instance network diversity is not conceived as diversity of race, ethnicity or gender, but instead I have taken this to mean the organisational clusters and working groups that participants are in allegiance with such as Ward Team, Practice Development Team and hierarchical management structures.

Dunn et al (2011) characterise healthcare-related networks as smaller than those in other organisations, which can spread to hundreds of connections. This corresponds with the relatively low density of relationships across the mentors in this research and may be related to the fact that hospital and nursing communities are quite small. As Dora outlines, Roper Ward consists of 35 staff members (nursing and ancillary) working a range of shifts across a 24-hour period. In this context, nurses will know some colleagues better than others because they work a similar shift pattern, whilst others will be less familiar. In smaller hospitals such as Nightingale more people tend to know each other across Wards and Departments because they are located on one site thus increasing network diversity. Larger groups of hospitals might be expected to show a less diverse range of contacts.

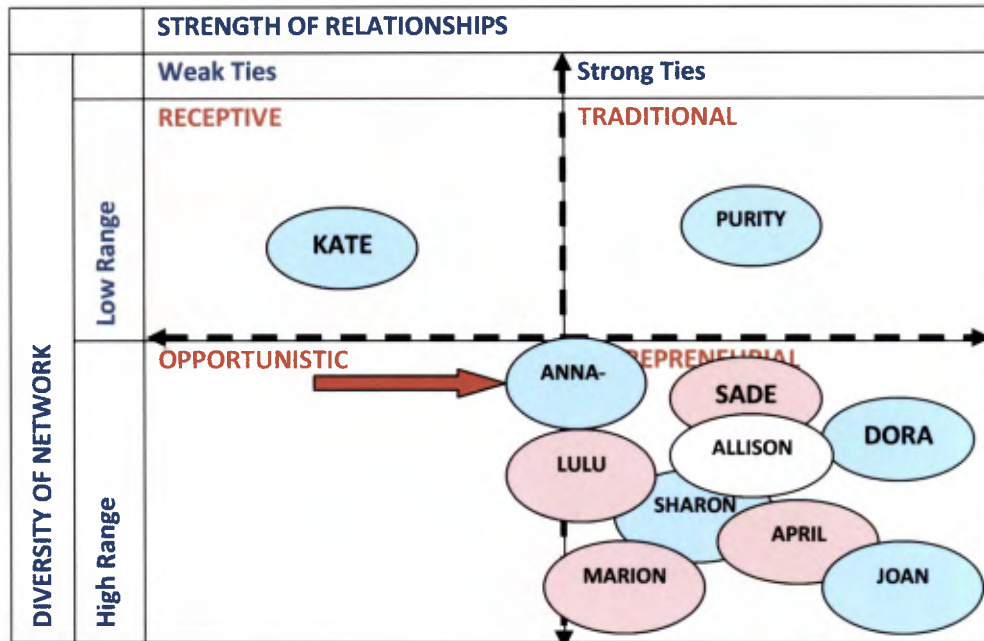
The self-reported grading of significant others works because it allows participants to explore and justify their choice and rationale for selection. However, in retrospect, the scope of the 1-4 scale does not always provide adequate descriptions to be generated. A standardised 1-5 scale akin to a Likert scale might have offered better labelling of the strength of relationships. Reciprocity was not always mentioned by participants, it was charted wherever inferred by participants, with the amount of overlapping between constellations demonstrating that even when this was not clear from the original diagram, reciprocity and mutuality were present.

Using the continua of network diversity and network strength as the axes on a graph, Higgins and Kram (2001) identify four network types which may be applied to gain insight

into individual constellations. These are presented as four distinct types by Higgins and Kram, namely receptive, traditional, opportunistic and entrepreneurial. Receptive networks are categorised as containing weak or passive relationships. In this type of network, there is little overt help-seeking, and generally the relationships formed will be those within the immediate working environment. Higgins and Kram (2001) link receptive networks with low job satisfaction of mentees. Similarly traditional networks have a limited number of networked relationships, but these tend to be strong links with engaged mentors. Traditional networks most represent mentorship as prescribed by SLAiP, in that it suggests a formalised and dyadic approach, rather than group involvement in the mentorship process. Opportunistic networks are signified by wide-range but weak strength relationships. Granovetter (1973) identifies this type of relationship network as indispensable to individuals opportunities and their integration into communities. The mentor in an opportunistic network will thus have a range of potential supports, without experiencing the fragmentation that Granovetter feels is inevitable when individuals are promoted or leave the organisation.

Each of the constellations with the exception of Imogen's (Strategic Nurse Lead, SHA) have been classified using this typology (Table 3 overleaf) in order to make estimations of the social capital of participants and the implications for onward personal and professional development (Higgins and Thomas 2001, Higgins 2007). There was insufficient time to complete a full map with Imogen in her interview. Higgins and Kram (2001) include a caveat that there may be changes along both continua which enable movement between network types. In recognition of this, the axes are depicted as semi-permeable, dashed lines.

Table 4: A Typology of Developmental Networks



The placement of individuals is based on an interpretation of their constellation and interview in relation to the strength and diversity of network relationships. Higgins and Kram demonstrate a negative relationship between Receptive networks and job satisfaction. Traditional relationships may be seen as favourable for organisations as they encourage organisational commitment, as well as personal learning (weak link). Opportunistic networks promote personal learning and are weakly associated with job satisfaction. Finally, Entrepreneurial networks are strongly linked with career change (normally promotion). A pattern emerged which emphasised the similarity of many of the participants’ constellations as belonging to entrepreneurial networks. The most common characteristic is the presence of strong-ties. All participants except Kate described strong-tie relationships with members of their constellations. Anna-Maria’s interview demonstrated that her network type had changed as a direct result of changing job and Ward within Seacole Trust, confirming the semi-permeable nature of the axes. Whilst statistical packages are available which might test the positioning of individuals along these axes, the small sample group mediates against this.

Table adapted from Higgins, M.C. & Kram, K.E. (2001) Reconceptualizing mentoring at work: a developmental network perspective. *The Academy of Management Review*, 26, 264-288

Chapter Eight: Synthesis and Recommendations for Future Practice

In my scene setting and literature review chapters, I outlined how mentorship has developed over recent years to become a standardised element of the clinical and educational governance of the Ward. As I noted in my literature review, mentorship has been linked to benefits for both individuals and organisations. However this is not the focus of my research. I take as my starting point a belief that good mentoring brings benefits to all parties. This has provided a benchmark from which to explore acute nurses' experiences of developing as a mentor, but has not been the focus for my research. Instead I wished to explore the relationships which enabled mentorship learning in practice and the influence of SLAiP (NMC 2008a). My concerns about this aspect of mentorship had surfaced as an issue over several years of working with mentorship students. Anecdotal student accounts indicate experiences of ineffective or absent workplace supervision alongside stories of good mentorship and support. Based on these experiences I posed the main research question:

Which relationships are important in developing Ward-based nurses as mentors in practice and how is their mentorship impacted by professional, organisational and political agendas in NHS settings?

Three secondary research questions helped to further shape the research, namely:

1. Which learning relationships in the practice settings are significant for nurses undertaking the mentorship module and those supervising them?
 - a. What happens to facilitate workplace learning in these relationships?
 - b. What is the understanding of these individuals of their role in the development of new mentors in practice?
2. What constitutes the current policy, professional and political agenda for nursing mentors and in which ways are these messages relating to mentorship transmitted and interpreted by those identified as significant in mentorship learning?
3. What role does the notion of professionalism play for practising mentors in their mentorship of learners?

In addressing these questions, my literature review revealed that current mentorship literature has gaps in its understanding of the complex nature of mentorship for RNs. Firstly it fails to account for the role of the supervising mentor, or the development of registered nurses into the mentorship role. A dyadic mentoring relationship is assumed in the majority of the nursing literature reviewed, despite recommendations within SLAiP (NMC 2008a) that nurses should develop a network of supports. The communities of practice model of

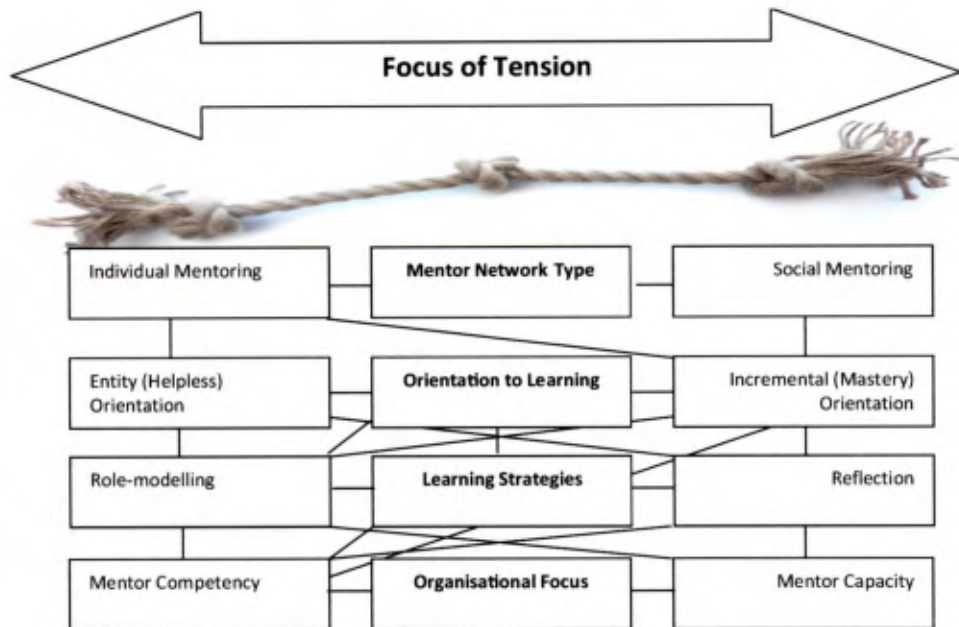
workplace learning offered some insights into the mentorship experiences of student nurses, and workplace socialisation per se. However, it failed to account for learners who were not new to the organisation or workplace, and considered teams as homogenous. What happens in post-registration mentorship learning contexts is underrepresented in the nursing literature. Both Bourdieu's theory of practice and Stoll and Seashore-Louis' notion of a professional learning community offered extensions of the communities of practice framework, by allowing a focus on relationships, personal dispositions and the effects of organisation and profession (Bourdieu 1977, Stoll and Seashore Louis 2007). Again, little of this literature was nursing-based, indicating that an exploration of what happens in, and who is involved in supporting mentors learning makes a timely addition to a mentorship knowledge base. This chapter draws upon the literature highlighted in my literature review, but also on new literature which has come to light in the course of undertaking the research.

The preceding chapters have outlined findings from the three distinct qualitative approaches used in this study. The findings attest to the complexities involved in exploring experiences of mentorship relationships and workplace learning provision. Whilst the research questions have provided a highly productive framework in which to locate my research, simply answering the questions does not provide an adequate framework to present the complexities of relationships between people, ideas and concepts emerging from the study. The structure of this chapter thus provides a synthesis of all strands of the research. It offers some triangulation of the findings from each method used, adding to that achieved in cross-case analysis of themes.

I have conceptualised my conclusions as a series of tensions which must be managed if effective mentorship relationships are to occur (Figure 8). These tensions emerged in the main from my findings, but are also influenced by the literature surrounding both mentorship and workplace learning. Whilst not polar opposites, these tensions represent competing forces which jostle for primacy in a mentorship 'tug-of-war'. The metaphor of tensions is apt. Some tensions hold things in place, creating stability and standardisation where their lack might cause anarchy and unregulated, dangerous practices. Meanwhile other tensions challenge the status quo to create innovative practice and progress. Each section identifies one of these tensions and concludes with recommendations for practice and education at all levels, including a consideration of these issues for a wider nursing workforce, where appropriate. As will become evident, these tensions are inter-related and interlinked. The thesis comes to a close with an outline of the unique contribution of

this work to the body of literature surrounding nursing mentorship, and workplace learning in particular. Avenues for further research to extend these findings will be offered alongside a discussion of the personal impact that this research will have on my own educational practice.

Figure 9: Tensions in Workplace Mentorship Learning



The metaphor of a rope is used to give a sense (rather than an exhaustive matrix) of the tensions that shape workplace mentorship learning and development. The central column presents the focus of tensions, whilst either end of the continuum gives a flavour of some of the competing forces. This is not to suggest that they are poles representing extremes of good and bad practice, instead they are considered competing foci. Some links between these tensions are evident in the data and provide a tentative model that is akin to the metaphor of skeins within a rope. In a 'tug of war' between different parts of the system, different tensions and dimensions of these will be tense or loose at any given time. However, the rope (mentoring system) must keep its tension to maintain stability and avoid unravelling altogether. The connections require further exploration in ongoing work.

Picture: <http://www.thepaws.co.uk/Rope+Bones+PWtoTXdBRE14b0RkalZIWnZKSGM>

Individual and Social Mentoring

Two major findings are explored here. Firstly, the make-up of individual constellations is explored in terms of Higgins and Krams' notion of attribute redundancy¹⁵. Mentor withdrawal or lack of support was a significant factor for students who failed or underachieved in their mentorship award in my IFS research (MacLaren 2010). It is also described by the RQMs in this research, where replacement support was not always

¹⁵ Used to signify the general availability of attributes amongst a constellation or network rather than the absence of an attribute

forthcoming. Having identified the scope of mentorship attributes I will then explore the potential tensions between traditional and entrepreneurial¹⁶ mentorship network types, arguing that changes are required to fully support post-registration learners' development as mentors. Finally I will discuss how movement between Higgins and Kram's (2001) mentorship network types might be possible through educational and workplace developments.

A range of attributes appear significant in supporting mentorship students, and developing in the mentor role. Support, expertise and specialist knowledge are foregrounded by RQMs, whilst collegial working is a feature of more senior nurse educators. These attributes appeared to equate with the roles within Darling's Measuring Mentor Potential inventory (Darling 1984). Large constellations like those of Sade and Anna-Maria appears to have a greater redundancy in the number of people with similar skills or attributes. This means that if one person withdraws from Sade's constellation (as her mentor has already done) there are plenty of others able to step in and support her with a full range of appropriate attributes.

In small constellations such as those of Kate and Purity there is a risk that if one of the existing links was removed, the quality of mentorship would suffer from loss of a link who fulfils all or many of the key attributes. There must therefore be enough redundancy in a mentorship network in terms of the type of support that learners receive from their network. Currently the greatest lack of redundancy is in the area of assessment and feedback, linking with recent concerns about the validity and reliability of mentors' assessment of students (Allen 2002, Duffy 2003, Gainsbury 2010). The complete lack of career counsellor roles identified corresponds with similar findings by Andrews and Chilton in their work with nursing mentors and students using the Darling MMP inventory. This might suggest an organisational desire to perpetuate traditional mentorship forms. It might also reflect a relatively clear developmental and promotion structure within the NHS for nurses (DH 2004a).

The strong tie relationships with supervising mentor fulfil the supporter and inspirer role needs considered to be the basis of the mentoring relationship (Darling 1984). Meanwhile developmental opportunities must be made available to encourage the network diversity required to create redundancy in mentorship networks and Wards. In particular, the link between Practice Education Facilitator and mentorship student needs strengthening.

¹⁶ Diverse range, strong tie developmental constellations/networks

Although experienced mentors already counted a relationship with their PEF in their constellations, there was a sense in Seacole Trust that the PEF role was pre-registration student-oriented rather than directed toward supporting mentorship development.

Contrary to the perceptions of Joan (PEF), the RQMs from Seacole felt they would only contact her if they experienced problems with a student. If this is the case for other RQMs, then their first encounter with their PEF is likely to occur at their first mentor update, 12-months after qualifying as a mentor, thus reducing the possibility of a fairly strong support in their development as a mentor. Joan's recent appointment as Seacole's PEF could account for her current lack of visibility. This is indicated by Dora acknowledging the strength of the PEF role, just not a relationship with Joan yet. The consequence of this is a reduction in mentor influence within the organisation (measured in terms of number of relationship links from Ward to Board level representation). In comparison, both RQM Sade and experienced mentor Lulu have Marion the PEF as a strongly significant constellation link. This gives the impression of a flatter hierarchy within Nightingale Trust. Conversely, Joan at Seacole appears more strategically aligned with links outside the Trust to SHA and NMC links.

Traditional and Entrepreneurial Mentor Networks

A key finding is the clustering of most participants within an entrepreneurial type of mentorship network (Higgins and Kram 2001). My literature review identified many versions of mentorship, concluding that pre-registration nursing conformed most closely with Roberts' (2000) discussion of structured, formalised mentorship underpinned by professional standards. Traditional mentorship appears to be the current default within nursing. Higgins et al characterise this as a reliance on one or two key relationships between a protégé and her senior colleagues (Higgins and Kram 2001, Higgins and Thomas 2001). In nursing this reflects the responsibility and accountability for mentoring individual students of named mentors and co-mentors rather than their team or Ward Manager (O'Driscoll et al. 2010). Benefits of traditional mentorship are reported as organisational commitment and personal learning (Higgins and Kram 2001). These benefits are especially useful to organisations such as the NHS Trusts in this research wishing to retain staff in an otherwise fast turnover of nursing workforce.

Traditional mentorship might be encouraged by organisations perceived to have a more restrictive outlook (Evans et al. 2006, Rainbird 2004) and who use workforce development to tailor individual capability to organisational need, rather than as a vehicle for aligning staff development and organisational capability. Traditional mentorship networks reflect

the professional accountability structure associated with student nurse learning (NMC 2008a, UKCC 1999). Thus most nurses are familiar with this form of mentorship which appears reproduced in their mentorship of colleagues undertaking their mentorship award. However its main role appears one of socialisation, rather than the continuing support and development of colleagues. Mentorship relationships amongst colleagues can impact on team-working and colleague relationships. Supervision relationships for those undertaking the mentorship course appear to be an extension of normal working relationships with colleagues, rather than planned learning opportunities. Unlike mentoring student nurses, there is no termination phase in the supervisor-mentor student relationship. This dyad may continue to work together as colleagues, after the award is achieved. A greater range of power relations between supervising mentor and protégé are seen than in mentor-student relationships, such as the horizontal support relationships in Kate's constellation, and the boundary-crossing links of Sade.

Entrepreneurial networks may be appealing for individuals and for the profession as they are thought to promote personal learning, professional autonomy and career mobility. For example, as an entrepreneur, Sade has changed jobs (with promotion) since qualifying as a mentor, whilst Kate as a receptive mentor has stayed at the same grade for six years. Entrepreneurial networks among junior staff may not be seen as attractive for the same reasons: staff retention is a particular problem within inner London Trusts. Strong ties in wider networks seem to be the norm amongst those who have progressed beyond the stage of RQM, and these individuals find themselves more likely to be nominated as significant influences in their colleagues' constellations.

A structure likely to promote entrepreneurial mentorship networks is emerging in the Trusts with regards to mentorship in the new undergraduate curriculum. Marion's discussion of the long-term and long-arm mentorship methods under consideration within Nightingale NHS Trust, suggest that entrepreneurial mentorship networks might become more of a feature of the pre-registration student experience. In long-arm mentorship, students are mentored by senior colleagues who provide support across all of a student's placement areas, sewing together the patchwork of their clinical experiences. This appears to be based on the model of personal tutoring currently in place within Capital University, although Marion's discussion demonstrates that these mentors would play a greater role in directing practical placements and negotiating access to learning experiences.

The long-arm mentor role will thus require greater social capital and links with other practitioners than is currently necessary. Long-arm mentors could be drawn from a wider

pool of qualified and registered mentors within the Trusts. For example, Marion indicates that a natural group for this type of mentorship would be mentors who are working as Clinical Nurse Specialists. This group generally has both experience and network to support them as mentors, as they work in peripatetic roles across the hospital. Indeed, O'Driscoll et al (2010: 215) identify that the CNS is not currently recognised by students as having an educational remit but are generally considered to be

Excellent staff nurses who became mentors, then CNS's eventually ceasing to spend much time on the Ward, which was seen as a loss to the leadership of students' learning

Incorporation of Clinical Nurse Specialists into mentor roles would necessitate strengthening their relationships with Ward-based mentors who will continue to work alongside those mentors teaching and assessing students in everyday practice (placements). Imogen also suggests long-arm mentorship where senior nursing staff could mentor non-graduate RNs facing the challenge of mentoring undergraduates for the first time as a way of developing a critical thinking nursing workforce.

Whilst my research has focused on nurses working in acute NHS trusts, the attributes and strengths of supportive relationships are equally important for nurses working in other settings. For example, in community settings such as primary care trusts, nurses tend to work more autonomously with less reference to a wider nursing team. There is a risk that small and weaker networks might proliferate. Opportunities to work together across teams, networks and professions must be afforded these nurses, to help develop their individual constellations. Community-based PEFs might play an active role in facilitating joint working, supervisory mentorship and clinical supervision¹⁷.

Development of high range, strong tie entrepreneurial mentorship is not a current feature of mentorship policy as prescribed in the SLAiP (NMC 2008a) standards. Whilst stating that mentors should,

Have effective professional and interprofessional working relationships to support learning for entry to the register (NMC 2008a: 20)

there is no description of what 'effective' means in this context, or the qualities that would need to be demonstrated beyond a basic 'nodding relationship' with others. In this respect the standards are statements of intent rather than measurable outcomes or competencies, and the attributes or strength of such relationships is left unstated. *Traditional* mentoring

¹⁷ Clinical supervision is aimed at personal and practice development rather than mentorship, with an orientation towards coaching, and individual ownership of the process.

relationships such as that described by Purity could be considered a minimum standard for participation in the professional learning community of the Ward as they offer students mentorship within the accountability framework of SLAiP. However a lack of redundancy in the network might indicate that mentorship students will be left without appropriate support, if mentorship is ineffective or absent. Future mentor development activities might then focus on activities and network connections necessary for gaining promotional opportunities *within*, rather than outside the organisation.

Development of opportunistic networks might be more useful to the organisation in this respect as they represent weak but wide networks, and may represent an interim stage between traditional and entrepreneurial mentorship types (Dobrow and Higgins 2005) . Whilst Higgins and Kram (2001) identify that opportunistic networks are negatively associated with personal learning, and work satisfaction they do offer potential benefits in that these networks bridge departmental barriers without necessarily jeopardising commitment to the organisation (Granovetter 1973, Dobrow and Higgins 2005). Anna-Maria's position as an entrepreneur by way of an opportunistic network, lends some support to this view, but would require further investigation to validate. Eraut et al (2007) identified that the quality and quantity of learning can be enhanced through providing increased opportunities for consultation and team working within organisations. This could provide the initial weak links, which might strengthen over time. Roles such as key mentor roles which pull together mentors across a Trust into a cogent group might serve to diversify individuals' networks. However, these roles are discussed by mentors in this research as broadly administrative in allocating mentors to students in the Ward, rather than in terms of their contribution to the wider Ward learning.

An educational development issue will be that of explicit recognition of the range of colleagues engaged in supporting mentorship students in practice. Whilst this is a complex issue with no easy-fix solutions, I make several practical recommendations to encourage a shift in attention towards multiple mentoring relationships. Developing the diverse, strong-tie network required to develop entrepreneurial mentorship requires commitment by both HEI and NHS Trusts. This must occur alongside further development of effective accountability structures which can be modelled by all nurses to promote patient safety and student nurse learning. Within the University, it is recommended that the mentorship team formulates learning activities which develop personal capacity to network with colleagues and actively seek out mentorship support during their course and beyond. One

way of exploring the networks and available mentorship for mentorship students would be for them to complete the constellation exercise as a learning activity.

Introducing the role of the PEF through engaging them in the teaching of the module might offer one avenue for raising their visibility and potential usefulness as a key supporter within a personal network. Meanwhile, Hospital Trusts need to continue developing their Ward teams through the leadership of Ward Managers who are well placed to take an overview of the range of mentoring skills and attributes within teams and have the organisational authority to encourage *mentorful* Wards with the potential for multiple mentoring relationships rather than exclusive dyadic ones. In particular, attention should be made to the pairing of supervising mentor and mentorship student. This needs consideration in terms of ensuring that the key inspirer and supporter roles are fulfilled alongside accountability needs, limiting the possibility of mentor withdrawal, but creating redundancy across the whole mentoring team. Creating opportunities for intra-departmental working, strengthening the key mentor role beyond an administrative role, and opportunities to network with the PEF team at an early stage in mentor development are all potential ways in which the diversity of mentorship networks can be promoted. The strong links between PEFs and Capital University staff (including myself), is a good starting point for discussions around implementing such recommendations.

Entity and Incremental Orientations to Learning

Dweck's (2006) notion of a continuum of orientations to learning identifies that different individuals have a different locus of control relating to their own perceptions of learning capacity and capability. Where learning is viewed as a fixed entity, learners perceive that their learning or development is somehow beyond their control, and is suggestive of an external locus of control. This is regardless of whether they are successful or not.

Conversely those with an incremental (mastery) orientation appear to thrive in the face of learning challenges. Similarly to the health-related concept of hardiness, the concepts of commitment, perceived personal control and challenge are significant components in promoting positive outcomes and coping with stressful situations (Maddi 2004).

Some linkage between an entity-orientation and weak social ties is suggested in the findings of the constellation mapping and interviews. Kate appears to have the strongest entity-orientation in relation to mentorship and workplace learning. The experiences of performance anxiety in her initial co-mentoring and her lack of senior staff sponsorship placed her in a powerless situation where she was unable to access the CPD which is considered mandatory within the Trust where she works. Evison (2006) argues learning

facilitators and blocks are often associated with the social emotions of pride and shame. Thus increased emotional resilience and self-efficacy can be achieved through effective coaching and mentorship. These promote 'Respecting People' behaviours (showing respect, affirming learning capability and appreciating achievements) and minimise those characteristics of learning which negate the learner (such as using threat reminders, using fouls, or giving approval) (Evison 2006). This appears to be the case with Anna-Maria, who started her mentorship career in a Ward environment which showed poor leadership and support for developing her role. She was forced to seek support from her network of Filipino colleagues to help her cope with her day-to-day work. However, by moving to Roper Ward she gained a wider supportive network and importantly transformational leadership from Dora.

Performance anxiety can also be seen in terms of developing self-efficacy. Bandura (1977) defines this as an individual's judgement or beliefs about their own capabilities to perform a particular task. This is expanded in relation to the workplace by both Parker (2007) and Johnson et al (2011) to consider flexible role orientations (the degree to which individuals' consider tasks as part of their role) and role-breadth self-efficacy (the number of roles they consider themselves proficient in). Engagement in learning groups and increased control over tasks is linked with increased role breadth self-efficacy (Johnson et al. 2011), and may be due to improved social bonding and reduced alienation in groups (Scheff 1997). In particular, role-modelling has been suggested as a way to improve self-efficacy (Armstrong 2008) linking with another of the themes emerging from the data.

It is significant that both Purity and Sade talk about cross-departmental groups that they belong to: Purity functions as Roper Ward's infection control link nurse, whilst Sade currently has a key mentor role. These represent the further echelons of a mentorship trajectory which starts at the preceptorship stage. Although Kate acknowledges the importance of mentorship, it does not appear as a privileged component of her nursing practice. In this case, orientation to mentorship learning offers an insight into Kate's experiences. Kate had difficulties accessing the mentorship course but these circumstances were considered out of her control. She foregrounds her role as an autonomous but 'practical nurse'. She also suggests that her mentorship preparation did not teach her much that she did not already know. These attributes suggest she holds an entity-theorist orientation to mentorship learning (Dweck and Sorich 1999, Dweck 2000, Nussbaum and Dweck 2008).

Students holding an entity-theorist (helplessness) orientation to learning, see learning potential as fixed and unresponsive to effort, with the locus of control situated outside the individual, making them susceptible to learned helplessness (Seligman 1975), as they doubt their intelligence, ability and personal capacity to reach learning outcomes. The entity-theorist orientation would appear to mitigate against movement between mentorship types, as all of the other participants (and in particular Sade and Purity) appear to exhibit the converse orientation (incremental-theorists). In varying degrees Sade and Purity demonstrate high self efficacy and problem solving approaches (including seeking out problem solvers) to new challenges in learning (Nussbaum and Dweck 2008).

Role-Modelling and Reflection

Bandura (1977) identifies four interrelated concepts in his social learning theory relating to role-modelling, which provide a framework for understanding of participants' use of role-modelling. The concepts are: the importance of exemplary performance, retention of observed practice, mastery of the observed action and the effects of motivation on learning. Firstly learners tend to model their own practice on exemplary clinical performances. Dora's strong leadership of Roper Ward makes her a role model for both Purity and Anna-Maria. This appears for Purity to be based on her clinical activities and willingness to engage herself in essential nursing care. This creates a strong social group with its basis in the privileging of patient care and professionalism (not being a hand-maiden).

Clinical practice appears to provide a powerful social identity for nurses that even organisational leaders wish to capitalise on. Non Ward-based Trust participants (PEFs and Nurse Education Leads) and Imogen as a Strategic Nurse Lead all retain a clinical component to their role. Whilst this serves in one respect to allow them visibility in their Trusts, ostensibly what is performed is a role-modelling of core institutional values and (in Foucauldian terms) a regulatory gaze over nursing staff. Mentors were equally as likely to discuss their (positive) learning from negative mentoring experiences, suggesting that role models showing extremes of practice can engender vicarious learning outcomes (Donaldson and Carter 2005).

Retention of observed practice occurs through rehearsal or practice of the skill. A key mentorship learning activity that Sade recounts as influential from her mentorship class relates to role-modelling. Students were shown a video of poor communication skills within a mentoring relationship, which paints an overt picture of poor mentorship and acts as a warning to mentors not to act in this fashion. Discussions of why the videoed performance

is poor take place in the classroom, but it is the performance rather than the reflective discussion (and thus evidence) which are retained, and that influence Sade's practice.

Reflection as a workplace learning strategy does not feature strongly in the interviews. Despite a professional preoccupation with reflection as a means through which to develop practice, this does not seem to be a feature of either the mentor-student relationship (the exception here is Kate) or the supervisory mentoring relationships experienced. Role-modelling is normative process, but as Nichols and Badger (2008) show, the norm may not relate to best practice, but can often be accepted uncritically despite a recognised evidence base. However, the issue may not lie with a lack of an evidence base for the mentor participants; rather it may be the case of a competing evidence base which takes precedence over that used for mentorship (Allan and Smith 2010). This is discussed in further detail in the following section in relation to the tensions between competence and capacity.

Bandura's (1977) third concept relates to mastery of practice. Stengelhofen (1992) argues that the type of role-modelling where learners are left as passive observers to care does little to encourage the active learning or mastery which is essential for developing expertise (Benner 1984). Role-modelling is thus not just about observing behaviours, but requires context, explanation and discussion to facilitate hands-on student learning (Armstrong 2008). This is recognised by the mentors interviewed, who discuss that they are increasingly confident in letting student nurses take part in care delivery. In supervisory mentorship, the reverse seems to happen. Some new mentors appear to be the passive observers of mentorship practice, but this is from a distance rather than first hand.

Laissez-faire attitudes toward mentor development such as that identified by Dora mean that nurses such as Sade, whose mentor withdraws from her role find little benefit in the mentorship relationship are forced to make their own informal arrangements to support their learning. This may be compounded in areas such as community nursing practice where fewer team members may be available to meet individual learning needs, and less opportunity for role modelling present. This reduces the opportunity for meaningful reflection on mentorship practice in the supervisory relationship. An exception in this study is in the pairing of Purity and her supervising mentor Anna-Maria. Anna-Maria exposes Purity to some of the key tasks of mentorship and allows her to experience these under supervision, and in relative safety.

Bandura's fourth concept is that of motivation. He postulates that what or how much is learnt is related to the motivation and incentive of an individual to succeed (Bandura 1977). The status of mentorship has changed over the past twenty years. Strategic participants noted that it was the band five staff nurses who were more likely to be called upon to undertake mentorship duties (c.f. O'Driscoll et al. 2010, Warne and McAndrew 2004). This erosion of status appeared to compound with practising mentors' perceptions of the lack of value that their Trusts placed on mentorship. What is clear is that some motivation came either from students' overt valuing of them as mentors or from an intrinsic desire to teach students. However, in situations such as Sade's, where her mentor was disinterested and withdrew from her role, this creates additional workload on the more enthusiastic mentor which could possibly lead to stress and burnout.

Whilst role-modelling has benefits in facilitating learners' self-efficacy, it may thus be affected by strong personalities and the power politics of the workplace. The lack of hands-on mentorship supervision and associated reflective activity in relation to mentorship at once reinforces the professional identity of nurses as care-givers, but also the view that mentorship is a natural rather than learned attribute or skill within nursing. Adopting this view allows the agenda of mentorship, especially for the supervision of mentorship learners and those supervising them to become subsumed into the more pressing needs of clinical practice.

A closer link with reflection is needed within the mentorship module. Here much of the reflective activity is focused around written reflection rather than its practical uses in facilitating and assessing learners. Development of activities which bolster a range of learning strategies might serve to broaden the learning repertoire of mentors. It might also offer opportunities to demonstrate how reflection augments other forms of mentorship practice such as the role-modelling, which appears crucial to developing mentorship practice. However, a more focused exploration of what nurses consider to be reflection in practice is necessary. That reflection has not arisen as a factor in student or mentor learning may suggest that different measurement techniques are necessary to elicit this information in a meaningful way for nurse mentors. Participant observation of supervisory mentor and mentor-student relationships might serve to fill in some of this detail, although was not possible to fit into the scope of this EdD thesis.

Competency and Capacity

Participants were unanimous in their understanding of the role of mentorship as developing the knowledge and skills of learners. However two concerns emerged which were strongly linked to the level of strategic influence of participants. Ward-based mentors were more likely to discuss issues of clinical competency and knowledge development as relevant to their mentorship development, whilst Ward Managers and strategic level participants tended to also discuss the impact of managing mentor capacity. These appeared to act as parallel and not always complementary indicators for developing mentorship and mentors. The focus on competency related almost exclusively to developing student nurses competency, whilst capacity related to servicing the pre-registration student need for mentorship. These dual foci served to obscure the view of mentor and supervisory mentor competence for this role.

Competency and Knowledge

Being knowledgeable and skilled is a major preoccupation of mentors. This reflects current organisational and professional obligations to maintain and develop knowledge and competence (NMC 2008a, 2008c). An expectation to keep up to date with developments in clinical practice necessitates not only study in work time, but a significant sacrifice of personal time (Munro 2008). Participants linked this with their perceptions of self-efficacy as nurses and mentors. A view learning as knowledge and skill acquisition emerged from the data. This appears at odds with the view of learning as socially constructed and collaborative in nature which has come to dominate the workplace learning literature, and which might be suggested by a focus on learning through role-modelling. It initially appears to jar with the extensive use of role-modelling described by mentors. However, the distinction for the nurses interviewed occurs in the type of knowledge that that is required.

The descriptions given appear to match some of the assumptions underpinning a propositional and 'learning as product' view of workplace learning (Hager 2004b). Reflecting the centrality of clinical knowledge in their nursing practice, mentors understood their role as the imparting of clinical skills and knowledge to students. This was seen as important for creating the next generation of nurses and carried moral as well as professional obligations. Mentors were keen to explain their practice credentials. All of the practising mentors told exemplar stories which affirmed the centrality of competent patient care in their roles. These stories often moved the conversation away from an explicit mentorship focus and onto 'safer' patient-centred ground for them. Student learning was focused on related clinical competencies within their portfolios such as learning to suction a patient (Sade) or aseptic dressing technique (Kate). Transmission of

skills and knowledge was seen as relatively unproblematic, once mentors had embraced the notion of allowing students hands-on experience with patients. Exceptions occurred where either the student experience or their experience of the student did not fit the recognised norm. This hints at expectations of learning replicability which are underpinned in the use of competency statements considered stable across populations and time (Hager 2004b).

Mentors' own opportunities to develop clinical knowledge and skills were also considered valuable. These ranged from the personal and informal (journal reading), through to staff awaydays (organisational), and formalised courses (HEI). Attempts to formalise personal learning such as through sharing relevant journal articles with colleagues may indicate that unless learning is visible or officially sanctioned, it is considered inferior. Overall, the foregrounding of clinical skills and knowledge alongside role-modelling of practice ideals points to a continuation of an apprenticeship mode of nurse education, which has benefits in the reproduction of group norms and in-house standards, but does not necessarily promote innovative practice.

In comparison, mentors' descriptions of learning to be a mentor appeared to consist almost exclusively of role-modelling. A wide repertoire of explicit learning strategies to encourage mentorship development was lacking in this research. Instead, problem-solving was an important attribute for significant others to possess, but was not always talked of as a personal quality by mentors. PEFs were more likely to discuss their role with mentors as providing this type of peripatetic support, which may have implications for the onward development of mentors. When considered alongside mentors' lack of awareness in the assessment and accountability domain of SLAiP it could provide evidence of a distancing of mentors from their assessment role, similar to that suggested by Andrew et al (2010).

A tacit understanding that the skills required for mentorship are already within the skill-set of an RN is not just present in those with an entity-orientation to learning. The assumption that mentorship students do not need as much supervision on the basis that a manager is familiar with their (clinical) work (shown by Dora and Lulu) may be flawed. The relational links between clinical skill and mentorship are often dovetailed in activities such as patient teaching and health promotion. The problem with this is that *clinical* knowledge (content) and competence are fore-grounded rather than the theory required for the facilitation of learning in practice.

The relative lack of value of mentorship skills and knowledge is suggested in the difficulties in recalling and applying learning theories taught on the mentorship course (e.g. Sade, Kate). This might indicate that they do not influence how mentors facilitate workplace learning. Similarly the drop-off in awareness of the professional standards between PEFs, experienced and RQMs might suggest that these are not reinforced in the workplace, despite their centrality in annual mentor update training. The privileging of clinical skills and knowledge thus almost obscures the development of mentorship competency, and suggests a dual track of learning between practice and academia similar to that described by Allan and Smith (2010). This is further compounded by the lack of reflective activity with mentorship students and focus on role-modelling. Together this could lead to imitative rather than evidence-informed supervisory mentorship practice.

What is therefore required is for mentorship competencies to become more visible within practice. The recent implementation of a mentorship competency portfolio has begun this process. Whereas supervising mentors were previously only asked to provide a global statement of a student's abilities to practice as a mentor. They are now asked to assess practice with a grading system similar to that used in the pre-registration curriculum. This forces a gaze on practice according to SLAiP, but its success will be dependent on its interpretation by existing mentors, organisational sanction and leadership endorsement.

Mentorship capacity

Related to the issue of mentor competency is the issue of Trust mentor capacity.

Organisationally, this provides another obscured lens to the development of competent mentors. Senior interviewees within the Trusts and SHA saw mentorship capacity as ensuring sufficient mentors were available to service the growing student nurse population. Mentor capacity appeared a major preoccupation for PEFs alongside their troubleshooting role in student assessment. Imogen (SNL) talks about mentorship as predominantly existing to service the pre-registration student nurse commission. She questions the personal ownership that this learning appears to instil, arguing mentorship courses are only provided because of organisational need. This view does not consider the wider professional role of mentorship in career development, and the significant time in both work and personal life that is contributed to both study and mentorship of students (Munro 2008).

Both of the nurse education leads interviewed (April and Sharon), and the Strategic Education Lead (Imogen) talked about the future workforce developing from their current

students, as a method of promoting Trust loyalty. Imogen and April referring to this as 'growing your own'. Imogen also comments:

I'm a great believer in that you'll grow your own workforce for the future, therefore if you buddy students with your organisation for their three years undergraduate education they're more likely to work for you at the end of their three years and understand your values and their contribution to your values.

This contrasts with her perceptions of nurses achieving mentorship and then moving on. Mentor turnover is a significant administrative issue for both Trusts and necessitates ever more numbers of staff nurses each year to undertake their mentorship qualification. Imogen likens this to watching *water going down a plughole*. Imogen suggests that the Trust loyalty built over the three-year diploma or degree programme, somehow erodes on qualification as a mentor, and may be related to perception of limited career development prospects. This potentially links to a lack of obvious career development roles within each of the participants' constellations. Attention to better advertisement of career development opportunities within the Trust might be one way of addressing this, alongside the preceptorship programmes which have been implemented to support transition between student and RN (Roxburgh et al. 2010a).

Mentorship and Organisational Commitment

Whilst mentorship no longer offers a guarantee to in-house promotion as a rite of passage, the mentorship award could be seen as a litmus test of organisational commitment. This fits with the notion that mentorship is still a gateway qualification, but also seems to suggest that a newly qualified staff nurse does not fully join a Trust's nursing community until they have achieved this. For Kate, the A&E course appears to have more currency in her workplace, and serves the same purpose of demonstrating commitment. This suggests that the community she privileges is the A&E clinical practice team, where the knowledge and competency privileged is clinical. Once organisational commitment is demonstrated opportunities could then be facilitated to further develop the diversity of network that might be required to function at higher levels of the organisation.

Key mentor and sign-off mentor roles are well-placed to offer mentors links between departments and across Trusts. Mentor capacity issues have contributed to the development of these roles, although issues of assessment and accountability have also influenced the sign-off role nationally. Described by PEFs as useful networks for disseminating good practice and information across Trusts' mentor population, in reality, mentors saw the key mentor as an administrative role. This was instrumental only in managing a Ward's student allocations, and consequent mentor selection. This finding

reflected that of Robinson and Griffiths (2009) in their review of the preceptorship literature.

Similarly for the mentors in my study, allocation of a supervising mentor did not always equate with receipt of (effective) mentorship (e.g. Kate, Sade) (Cahill 1996) or managerial support (Anna-Maria) (Pulsford et al. 2002). Some choice in supervising mentor selection was evident for mentorship students. For example, Lulu chose someone who was a good role model, but even where choice was possible adequate mentorship was not guaranteed. Similarly, whilst most nurses under Dora's management appear to be keen to advance themselves through mentorship, this was not a universal desire. Dora alluded to the fact that not all of her staff nurses are suited to the role. Again this is at odds with her indication that the mentorship role falls into the natural skill-set of a nurse, and thus under her clinical rather than educational gaze. Whilst these individuals might contribute to the learning of the Ward in different ways, the clamour for more mentors means that those who do not mentor become stigmatised as the equivalent of nursing dinosaurs.

Ward managers can play a significant role in supporting and valuing the key mentor role through careful consideration of the skill-set of individual nurses. Choosing mentors at both course selection and student allocation stages that have a strong desire to develop their mentoring skills may allow stronger ties between mentor and learner to develop. In turn this may further encourage others rather than adhering to as a one-size-fits-all strategy for workplace learning where capacity outweighs desire, competency and individual development needs. The tensions between mentor competence and mentor capacity provide an avenue for future research, to explore best practice in mentor selection and allocation. In the meantime PEFs and their teams may be well placed to effect change through collaboration with and promotion of extended mentor roles.

Contributions to Technical, Professional and Personal Practice

In this final section I outline what I believe to be the unique contributions of this work to the mentorship canon. These contributions fall within three domains: the technical, the professional and the personal. In the technical domain, I discuss how the use of relationship constellations and mapping of the standards offer new and exciting ways of exploring relationships in mentoring. Secondly, in the professional domain I discuss how an understanding of the relationships supporting mentorship learning might go some way towards rethinking support structures for mentors in Ward environments. Finally, in the personal domain I outline how undertaking this research has changed my own personal professional understandings and practice as an academic nurse. I also refer back to my

discussion of mentorship tensions, as providing some indicators of where further organisational intervention or research is required. I am keen not to be overly prescriptive in promoting my findings. Although these may strike a chord with other academics, policy makers or practitioners, this study represents a small-scale case study across two Trusts, and as such does not have the generalisability of a large scale research project. Instead what it offers to the literature is a flavour of the richness and complexity involved in workplace mentorship learning.

Technical Domain

Arguably, the greatest contribution of this work to the mentorship canon is in its methodological approach. Whilst multiple and mixed-methods case studies are commonplace in mentorship literature, The use of hand-drawn mentorship constellations to identify significant relationships is a simple but effective way of identifying the relationships available to individual mentors. Furthermore when augmented by interview data and transformed into CMap diagrams, the constellations visualise these relationships in a meaningful fashion, which account for not only personnel, but strength of individual relationships. Furthermore the application of Higgins and Kram's (2001) developmental network typology which enables comparison of networks on the basis of network density, diversity and strength represents a new approach within UK mentorship research.

Similarly, previous mentorship research has failed to consider the penetration of the SLAiP standards into mentorship practice. Although the mapping of interview data with the standards represents only my own interpretation, in future research reliability and validity might be improved where multiple researchers undertake the same mapping, so that a consensus may be achieved. Despite its limitations this mapping does give an indication of the current status and impact of the Standards in day-to-day mentorship which have yet to be explored in other research studies. Further refinement of the interview schedule may help to identify whether reflection as a learning strategy really is absent from nurses' accounts of mentorship.

Professional Domain

Although mentorship of student nurses is well explored in the literature and premised in professional standards, the same cannot be said of the relationships that support nurses in their development as mentors. The focus on student nurse competence has shifted the mentorship gaze away from mentorship learning. This thesis begins to redress this balance, providing an insight into what actually happens in the supervisory mentorship of those undertaking their mentorship qualification. However action at both organisational and

strategic (professional) levels is necessary to maintain and develop this focus. Firstly, organisations need to consider how they can strengthen relationships between strategic and operational levels of mentorship, whilst raising the profile and perceived value of mentorship within their Trusts.

Mapping personal developmental and mentorship constellations may translate well to classroom activities. Proactive exploration of personal support could contribute to workplace learning through identifying potential support systems and introducing the role of the PEF within this context. Activities which bolster network redundancy and increasing student social capital (e.g. developing negotiation and assertiveness skills) might enable them to ask for what they need from supervisory mentorship support, seek useful alternatives where necessary, and limit development of an entity orientation to learning.

Similarly, the NMC in their forthcoming review of SLAiP might consider how supervisory mentorship can be strengthened across the profession. My recommendation that this be undertaken only by those with an advanced understanding of the mentor's role represents a medium to long-term goal. Many acute and primary care trusts are struggling to achieve the levels of sign-off mentorship required to support all final year nursing students and are not well placed to implement this recommendation in the near future. However, regulatory guidance would signal the importance of the supervising mentor role in the dissemination and reproduction of good practice. As an interim measure, the introduction of mentorship competency documents to be achieved by mentorship students offers some standardisation of workplace learning experience.

Personal Domain

I end, however by outlining how this research has contributed to my own development and professional practice. As a module leader, my view of mentorship was limited by my own outdated experiences of mentorship, a course inherited from the previous incumbent of my role, and feedback from mentors and PEFs alike. Although I was already familiar with the literature surrounding the mentorship of student nurses, undertaking this research has allowed me to become more familiar with what happens in the workplace whilst students undertake the mentorship module, and the relationships that shape this experience. As a social constructivist by nature, I feel privileged to have had the opportunity to collaborate with participants and assist in the construction of their own understandings of mentorship as professional practice. It has provided me with a unique opportunity to fill in some of the gaps in the mentorship literature and foreground the unique position of the mentorship learner and supervising mentor, which were hitherto underrepresented in the literature. I

feel this enables me to take a more empathetic and informed stance when discussing the issues surrounding learning in the workplace, in organisations where I have never worked clinically myself.

The findings of this work will doubtless impact on module provision in many different ways, including those I have highlighted in this conclusion. The tensions that are highlighted could be said to be true for many public and large-scale organisations and reflect the day-to-day realities of balancing patient safety, personal and professional development, organisational mentorship needs and clinical governance that are present within acute NHS Trust areas. This may widen the potential readership of publications in the dissemination of this work.

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Appendix A: Glossary of Key Methodological Research Terms

This glossary highlights the main methodological influences on this research. These influences are qualitative and linked by their focus on the individual in the context of their practice or experience. A key theme of co-construction of knowledge underpins most of these methodological approaches.

Methodology	Key Authors	Underpinning Principles
Appreciative Enquiry/Inquiry	Cooperrider and Srivastva (1987) Cooperrider and Whitney (2005)	<ul style="list-style-type: none"> • A form of action research where enquiry based on <i>what works</i> in organisations, and aimed at organisational change • Building and sustaining momentum for change requires positive affect and social cohesion • Individuals are engaged in constant cycles of knowing / inquiring / reading and continuously build upon their knowledge, skills and experience • Enquiry and change are simultaneous and based on individuals' need to know • Organisations are co-constructed and their pasts and futures offer learning opportunities • Humans have an endless capacity for generating organisational change based on our collective imagination and discourse about the future
(Qualitative) Case Study	Stake (1995) Yin (2009) Simons (2009)	<ul style="list-style-type: none"> • Allows the study of bounded systems – i.e. individuals, groups or organisations within geographical and temporal boundaries • focuses on the particular rather than the universal, the practical rather than exclusively theoretical, and the affective and social domains rather than the cognitive • May use multiple data collection strategies • The case study may be shaped by organisational arrangements, or by the roles of individuals • Aims to provide a 'situated generalisation' rather than generalising to a wider population (see below)
Interpretivism	Geertz (1973) Denzin and Lincoln (2005) Kuhn (1996): Anti-positivism	<ul style="list-style-type: none"> • Sees the social world as consisting of and constructed through making meaning of subjective experiences • Posits that to understand social and individual action, the meanings and reasons people attribute to their actions can be explored and interpreted • 'Facts' about behaviour are always context-bound rather than generalisable, although some polarised arguments between practitioners are evident. These discuss whether it is inevitable, or at the other pole, even possible. • Situated in an anti-positivist stance in the qualitative paradigm which rejects the notions that sociology should use the methods of the natural sciences to explore a rational, observable world

<p>Practitioner (Action) Research</p>	<p>Carr and Kemmis (1986) (1986) McNiff and Whitehead (2002) Somekh (2005) Sikes and Potts (2008)</p>	<ul style="list-style-type: none"> • Research situated inside the researched organisation and in the practice of individuals and groups – sometimes referred to as ‘insider research’ (Sikes and Potts 2008) • Problematises practice issues and seeks to effect change • Research designed to improve practice and the community • Often constitutes a strong social justice element in challenging the status quo • Research includes the researched in the process (i.e. participants rather than subjects) to collectively co-create knowledge • May involve a combination of methods to achieve research ends • Research, learning and knowledge generation are considered part of the same process
<p>Social Constructivism</p>	<p>Vygotsky (1986) Wenger (1998)</p>	<ul style="list-style-type: none"> • Build upon notions of constructivism where learners build upon their own mental structures when interacting with their environment. • In social constructivism, this knowledge building is co-constructed by groups • Emphasises the importance of culture and context in understanding the social world and constructing knowledge based on this understanding • Is seen as both a theory of learning as well as underpinning certain types of action research

Appendix B: Ethical Approval

Please note: details of both NHS Trusts and University have been removed or anonymised with capital letters.

RE: Potential educational research at LONDON TRUSTS

Burke Sandra [Sandra.Burke@thpct.nhs.uk]

You replied on 03-Nov-10 2:04 PM.

Sent: Wednesday, November 03, 2010 10:46 AM

To: [MacLaren, Julie](#)

Hi Julie

The Chair has read the contents of your email and advised that the project as described is service development therefore review by an NHS Research Ethics Committee is not required.

I hope the above is helpful.

Miss Sandra Burke
Research Ethics Committee (REC) Co-ordinator
East London Research Ethics Committee 1
(Formerly known as East London and The City REC 1)
National Research Ethics Service (NRES)
National Patient Safety Agency

Tel: 020 8223 8602

Room 24, 2nd Floor Burdett House
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If your email is regarding a formal request for information under the Freedom of Information Act, please resend to foi@npsa.nhs.uk to ensure it is dealt with promptly.

-----Original Message-----

From: MacLaren, Julie [Email address removed]

Sent: 29 October 2010 12:41

To: Burke Sandra

Subject: FW: Potential educational research at [LONDON TRUSTS]

Importance: High

Dear Sandra

Angela Hawkins at [name of Trust] R&D suggested I contact you with regards to the level of ethical and R&D approval that would be required for an educational project that I hope to carry out as part of my Doctor

in Education award at The Institute of Education, University of London. This project is likely to involve other Trusts, but I am making a start with [TRUST] as I know it slightly better than the other Trusts that CAPITAL University links with. I am seeking ethical approval from the Institute of Education, but need to know what additional permissions I might require in working within the NHS.

My project aims to explore the work-based learning relationships of registered nurses who are acting as mentors to pre-registration student nurses in the hospitals associated with CAPITAL University London. My aim is to map learning relationships between ex-students of the mentorship module run at CAPITAL [Mentorship], and those other practitioners they considered significant to their learning, in developing as a mentor, as well as identifying how mentorship policy is transmitted within organisations. Mentors are now responsible for the teaching and assessing of 50% of the pre-registration nursing curriculum, yet little is known about how these relationships operate and the influences upon practice as a mentor, despite them working as agents of both the University and of the Nursing and Midwifery Council in this respect. My role within CAPITAL University is as programme and module leader for mentorship, and we offer a range of online and traditional classroom formats for this, working in liaison with Practice Education Facilitators from all of the Trusts and Independent Sector organisations which offer placements for pre-registration nursing students, to develop appropriate mentorship content.

This will be a qualitative case-study with two phases of interviews that may require your permissions:

1) Stage one initially involves contacting ex-students of the module from our databases at the university and interviewing them about the work-based component of the module and those relationships that enabled their learning in the practice setting. These interviews will be held either in the CAPITAL University Office at [TRUST NAME], or at my office at the University and will take place out of their regular working hours. I anticipate that no more than 5 staff members will be involved at this point - all ex-students from the mentorship module (some of whom will be involved only to pilot data collection tools). At this point participants will be asked to identify those colleagues who were influential and significant in developing mentorship skills during the work-based component of the module. These individuals are likely to consist of fellow staff nurses, their mentor for the duration of the module, ward sister, Matron or Practice Education Facilitator, but there may be others identified by participants. The focus is on development of mentorship skills and knowledge and not on patient care, but some discussion of wider mentorship issues within the trust are anticipated.

2) Interviews of those identified as significant to work-based learning will again take place outside of regular working hours and in the locations identified above. It is anticipated that interviews will be sought with as many of the identified individuals as possible, given that some may chose not to participate.

Participation in the research is voluntary, and no payment or inducements will be offered. All participants and organisations/Trusts will be anonymised at the point of transcription, with audio recordings destroyed following analysis.

A final strand of the research takes place outside the NHS and involves on-the-record interviews with senior public policy makers with regards

to mentorship policy. This intends to show how policy at the top level filters into and is shared in mentorship practice.

The research will provide a useful insight into an aspect of nurse education which is under-researched. As programme leader for mentorship, I hope that this will lead to improvements in the understanding and structure of the workplace component of the modules we offer, and the general provision of mentorship across the acute NHS healthcare sector.

I would be grateful if you could advise me of the level of permissions required to conduct this study within the NHS settings as outlined above.

Kind regards

Julie

Julie MacLaren
[Contact details removed]

Appendix C: Explanatory Statement

This statement has been anonymised

LOGO REMOVED

Title: Inside Mentorship Relationships: The impact of institutional and professional policy on workplace learning for qualified nurses working within NHS settings

Researcher: Julie-Ann MacLaren, Senior Lecturer, CAPITAL University London

Explanatory Statement

Thank you for considering participating in this research study which is undertaken as part of a five year Doctor in Education programme (EdD) at the Institute of Education, University of London, where the researcher is currently a final-year student.

The aim of this research is to explore the experiences of mentors in clinical practice and map significant learning relationships between colleagues. You have been asked to participate in this study because you either recently passed the [MENTORSHIP] module at CAPITAL University, or have been highlighted as having played a significant role in workplace learning for another participant in this study. You have a unique experience and perspective of workplace learning within nursing, which can help the module team to develop the module for the future; improving student experience and outcomes within mentorship and pre-registration nursing programmes. The interviews will give you a chance to reflect on your own practice as a mentor and may be helpful in completing your ongoing mentorship portfolio.

Interviews with key senior policy figures within organisations such as the Nursing and Midwifery Council, Royal College of Nursing involved in setting the agenda for mentorship are also planned and will be based on the outcomes of interviews with nursing staff, so your interviews are an opportunity for you to influence and to be involved in a project that goes to the heart of mentorship and indeed the profession!

The planned interviews are expected to last approximately one hour in length, and will involve identifying those colleagues who have been significant and influential in your own learning in practice to create a map of relationships. Interviews will be recorded using a digital voice recorder, and transcribed by a third party outside of the university before analysis. This research adheres to both the Nursing and Midwifery Code (2008) and the British Educational Research Association Code of Professional ethics. It has approval from the local NHS Research ethics committee as well as the Institute of Education (University of London). As such you are under no obligation to participate in this research, and may withdraw your consent to participate at any point of the study.

All contributions to this study will be considered confidential, with your interview data anonymised in the final research report. You will be offered an opportunity to review your interview data following its transcription, if you wish to do so.

Further information about this research study may be obtained from:

Julie-Ann MacLaren

Senior Lecturer

CONTACT DETAILS REMOVED

Appendix D: Consent Form

This statement has been anonymised. Two copies were signed and dated, and one retained by the participant.

LOGO REMOVED

Researcher: Julie-Ann MacLaren, MA, BSc (Hons), PCE, RN, DipHE (Cancer Nursing), FHEA

Project Title: Inside Mentorship Relationships: The impact of institutional and professional policy on workplace learning for qualified nurses working within NHS settings.

I agree to take part in the above research project. I have had the project explained to me, and I have read the Explanatory Statement, which I may keep for my records. I understand that agreeing to take part means that I am willing to:

- be interviewed by the researcher
- allow the interview to be recorded with a digital voice recorder
- allow transcription of interview for data analysis

Data Protection

This information will be held and processed for the following purpose(s):

- Completion of the thesis, as part of the author's Doctorate in Education (EdD) at the Institute of Education, University of London
- Further development of the 'Supporting and Assessing Learning in Practice Settings' modules at CAPITAL University
- Publication of findings in relevant peer reviewed journals in the fields of health sciences and education

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.

I agree to CAPITAL University recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.

Withdrawal from study

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Name of Participant :.....(
please print)

Signature: Date:

Name of Researcher :.....(
please print)

Signature: Date:

Appendix E: Interview Schedule

<p>Introduction and Scene Setting</p> <p><i>Thank you for agreeing to be interviewed for my doctoral research project. As you know I'm looking at relationships in practice and in particular how these help nurses to develop as mentors to students and junior staff. I'm going to start off with some general questions about you becoming a nurse and a mentor before moving on to some specific questions about preparing to mentor, mentorship in your Ward and organisation and exploring some of the important relationships in your development as a mentor.</i></p>	
<p>Start recording after introduction</p>	
<ul style="list-style-type: none"> • Tell me how you came to be in your current role as a nurse? <ul style="list-style-type: none"> ○ How long qualified? ○ Trained in UK/overseas? Where? • What sorts of nursing practices do you find most engaging or satisfying and why? (<i>establish what they are most enthused with – can gauge enthusiasm for other things</i>) <p><i>Link with mentorship....</i> <i>e.g. It looks as though you are quite passionate about this/these how important to you is it that these skills are passed on to others..... & why?</i></p> <ul style="list-style-type: none"> • How did you come to start in a mentorship role? (If >5 years before starting mentorship why so long?) <ul style="list-style-type: none"> ○ Prompt: Tell me about being a co-mentor and how you got to be one • How do you feel the role of the mentor works in practice now that you have had experience of being one? • How much do your experiences as a pre-registration student affect how you now act as a mentor? • How much do your experiences being supervised in practice as a mentorship student affect how you now act as a mentor? 	<p>Notes:</p>
<p>Preparing to mentor</p> <p><i>This section is concerned with being on the mentorship course and learning to mentor in practice</i></p>	
<ul style="list-style-type: none"> • Tell me about when you were starting the module; how was a supervisor selected? <ul style="list-style-type: none"> ○ Who chose who? ○ What were you looking for in the relationship? ○ What was your relationship with your supervisor like? (How did you get on?) • What were the priorities for your learning? • What sorts of activities did you undertake together / apart that helped your mentorship learning? • What sort of activities in the workplace helped you to learn how to be a mentor in practice? <ul style="list-style-type: none"> ○ Prompt: In the workplace? ○ How did this related to the classroom part of the module? 	<p>Notes:</p>

<p><i>So, it's some time since you completed your mentorship qualification.</i></p> <ul style="list-style-type: none"> • How do you feel you have settled in to the mentorship role and what has changed (if anything) for you? • How do you now view this role in relation to your primary role in patient care? 	
<p>The organisation <i>In this section I'm interested in the messages you get about mentorship from your employing institution, your professional body and your colleagues and managers</i></p>	
<ul style="list-style-type: none"> • Tell me a little about the Ward where you work? <i>It will help set the scene for me understanding what being a mentor in this practice area is like?</i> <ul style="list-style-type: none"> ○ What sorts of students and how long do they generally spend in your practice area? • In what ways does your workplace assist or encourage you to participate in mentorship? <ul style="list-style-type: none"> ○ What inhibits your mentorship of others? ○ How are you helped to further develop your mentorship skills? • How do you feel mentorship is perceived or valued in your practice area? <ul style="list-style-type: none"> ○ In your organisation as a whole • What sort of priority does mentoring students have on your Ward/in your department? • How do you feel valued as a mentor? How is your contribution recognised? • What sorts of conversations might you have with your colleagues about mentorship on a day to day basis? <ul style="list-style-type: none"> ○ Prompt: If no discussion of conversations, why do you think that is? ○ How do these differ from the types of conversations you might have about patients? • How is the agenda for mentorship set in your practice area? <ul style="list-style-type: none"> ○ Who makes the key decisions and how is this shared/communicated with the team? ○ Who is dominant in your team when it comes to mentorship? Why do you think this is? • What role do the following play in helping you develop and maintain your skills as a mentor? <ul style="list-style-type: none"> ○ Professional body NMC ? ○ The University? ○ Your workplace? • How are changes in nursing policy regarding mentorship or learning communicated with you? <ul style="list-style-type: none"> ○ Prompt: can you give an example? • What is your role as a nurse in the development of mentorship policies and practices <ul style="list-style-type: none"> ○ What opportunities exist to engage you with this? ○ What would stop you from being involved? 	<p>Notes:</p>

Relationship Mapping

I'm interested in who people learn from in practice when it comes to developing your skills as a mentor. I'm hoping to identify a pattern of relationships that will enable us to target learning in the university to better suit the needs to nurses in practice. So the next questions are about your relationships with your own colleagues in practice. I am only really interested in those colleagues/actions that were helpful in your learning, rather than those who played lesser or negative roles in shaping your practice as a mentor. I'm hoping that you will help me convince them to be interviewed too, so we can map who they feel is significant in their learning too.

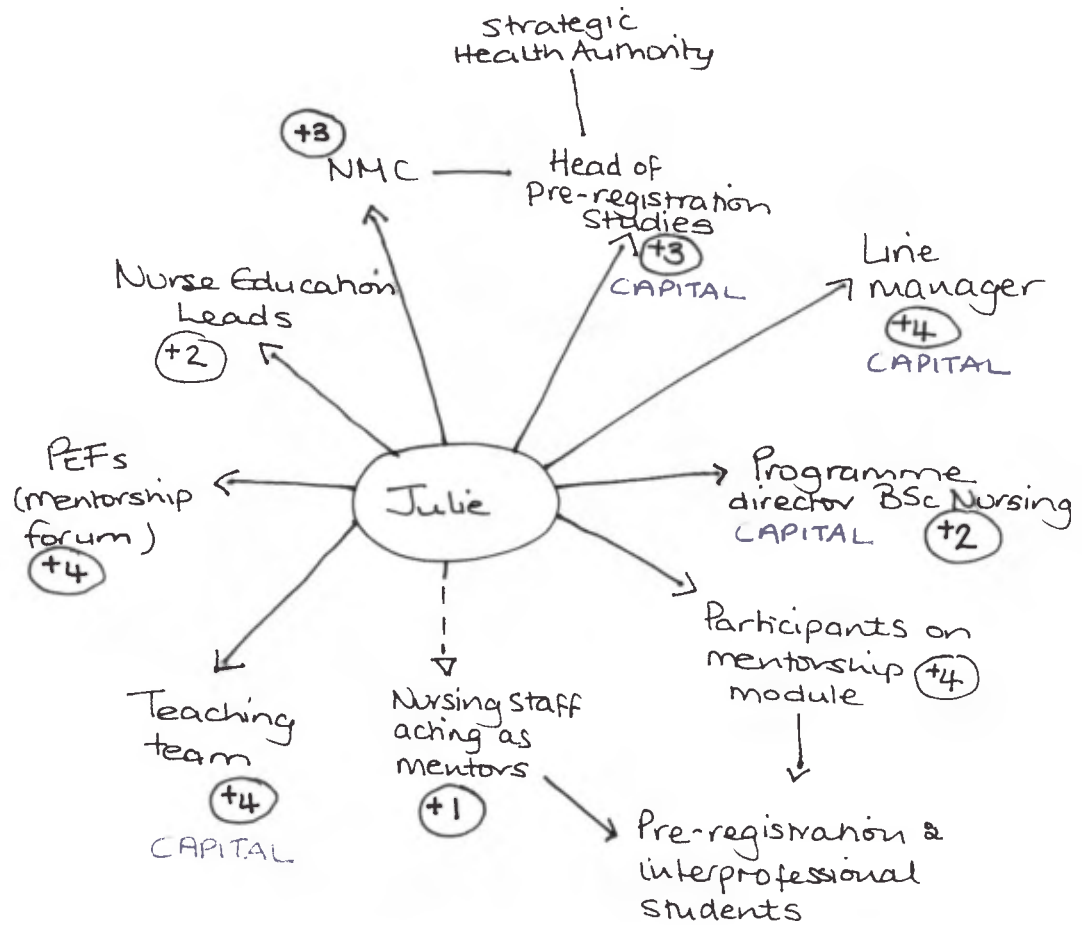
- Who was influential in your learning to be a mentor in your own workplace? Can you explain to me how they helped you to learn to be a mentor? (Map using Muckety spreadsheet which can be input into or draw spider diagram noting what the relationships are)
 - **Prompts:** Who aside from your supervisor would you say was influential or helped you to develop as a mentor?
 - Who else is significant in your mentorship now?
 - In what ways were they helpful or influential? What was it about them that made you want to learn from them?
 - What is their relationship to you within the Ward?
 - **Prompt:** Do they have any managerial responsibility for you?
- What was it about this relationship that encouraged your learning?
- What were the key messages or ideas about mentorship that they encouraged?
 - So are there any sorts of activities that have you replicated with your own learners based on your colleagues ideas or messages about learning?
- Can you compare for me your experiences of being mentored as a student nurse, being supervised as a trainee mentor and your role now as a mentor to others?
- Now that you are practising as a mentor, what relationships are significant to you in gaining support for your mentorship of learners?
 - Who do you share your learning with?
 - How do you share your own learning with them?
- What relationships do you feel are important for you in passing on your own skills and knowledge in nursing? Why?

Notes:

Any other questions?

- Are there any questions you thought I might ask but didn't?
- Is there anything you think I might have missed in these questions, or anything you would like to add?

Appendix F: Hand-Drawn Constellation



Constellations were hand-drawn during the interview. I offered elements of my own constellation as an example if participants were unsure what to draw. I analysed these drawings in conjunction with what was said about individual relationships. CMap concept maps were used to present the resulting constellations. These allow the attributes of each relationship to be displayed. Thickness of line replaced the numeric scoring shown here (+1 - +4).

Appendix G: Excerpt from NVivo Coding

This excerpt is taken from my interview with Sade.

SADE

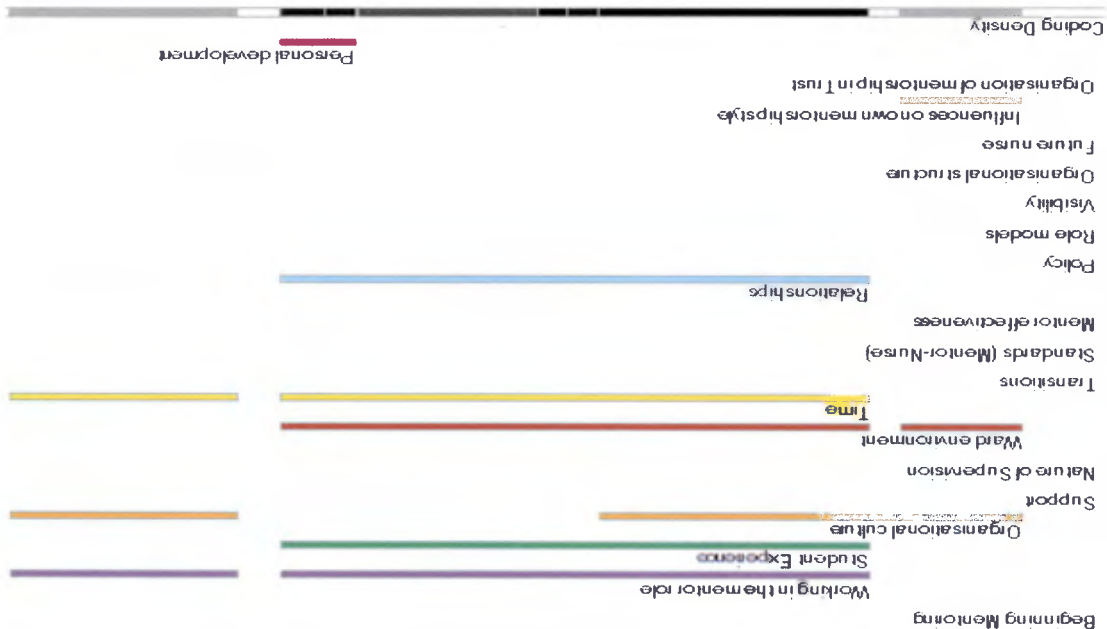
Yeah, and they're the ones in training and it was like, I said wow, you know, and she said, you know, and she still has time for me, you know, so in that wise I think the... the spectrum is quite broad, Julie. On one end you have very keen, I have noticed you have very keen, you know, nurses and on the other end of the spectrum some wouldn't even want to venture into that at all. Whether that is lack of motivation or confidence or whatever, I mean I overheard one, because on my last shift apparently, if I can just quickly set an example, we had a paramedic who was in training and I think they'd done all their A&E, you know, bits and they had to come into the clinical area to go into the critical care area to do like some three day placements in every area. So you know, we came on shift and, you know, and the other, my other colleague was like, "Oh I can't take him on because I will be too busy, and I won't be able to teach or show him anything." And I'm thinking well that's the whole purpose of, of him being here, to see things being done and to learn how we do things as nurses. And you know, I took him on, ((laughs)) And, you know, and he was able to gain because he was able to see, I mean he even assisted me with washing which he was quite happy to do and he said he had done his cannulation training on dummies but he was, he was hoping on the placement to be able to cannulate a real person and I had an admission that day and the manager said, that's the opportunity to go for it. And I assessed him and he was able to cannulate, I mean you come and see the look on his face, he was so happy for the fact that he could do that and if he didn't get anything that day I'm sure that for him, he left the ward coming back to say thank you very much, I said, "My pleasure." ((laughs)) That's why I'm here. So that gives me, so any opportunity for me to take somebody to learn, I'm happy.

JM

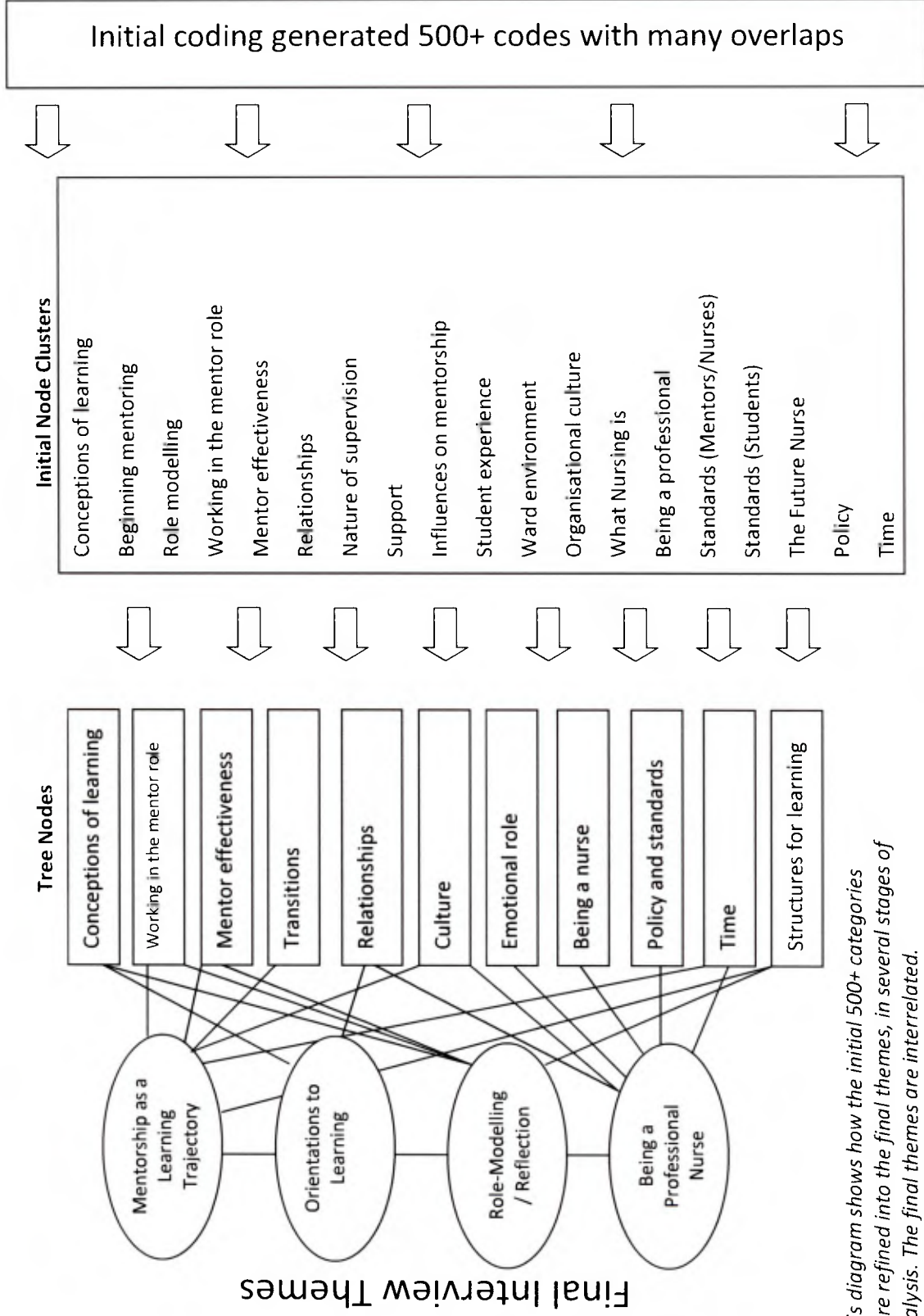
But others?

SADE

No, so I just think that, you know, so it's like on one end of the spectrum they just can't be bothered, they've been there, there've been nothing for years, they've been in the uniform ages, it doesn't bother them that they don't get allocated students, even as co-mentors, because they feel it's a burden, you know. Whereas you have this other end of the spectrum who are very keen and eager and they take on the students, you know, time on, time off, you know. And I think it's the way we view mentoring.



Appendix H: Process of Categorising and Manipulating the Data



This diagram shows how the initial 500+ categories were refined into the final themes, in several stages of analysis. The final themes are interrelated.

KEY TO MAPPING DOCUMENT	Explicit reference		Abstract awareness		No reference	
Appendix I: Mapping the Domains of SLAiP						
Domains of Learning (SLAiP: NMC 2008)						
Establishing effective working relationships	Demonstrate an understanding of factors that influence how students integrate onto practice settings					
	Provide ongoing and constructive support to facilitate transition from one learning environment to another					
	Have effective professional and interprofessional working relationships to support learning for entry to the register					
Facilitation of learning	Use Knowledge of the student's stage of learning to select appropriate learning opportunities to meet individual needs					
	Facilitate the selection of a appropriate learning strategies to integrate learning from practice and academic experiences					
	Support students in critically reflecting upon their learning experiences in order to enhance future learning					
Assessment and Accountability	Foster professional growth, personal development and accountability through support of students in practice					
	Demonstrate a breadth of understanding of assessment strategies and the ability to contribute to the total assessment process as part of the teaching team.					
	Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future.					
Be accountable for confirming that students have met, or not met, the NMC competencies in practice. As a sign-off mentor confirm that students have met, or not met the NMC standards of proficiency in practice and are capable of safe and effective practice.						
Illustrative Comments and Quotes						
All mentors described integrating students into the team. Kate discusses the importance of a welcome pack, whilst Lulu talks about creating a welcoming atmosphere.						
Lulu: <i>if you create too much fear in a student, the student will not gain a lot, because there are certain things she will like to discuss with you Dora , Anna-Maria and Lulu discussed transition to staff nurse roles, and transition to mentorship roles. All discuss the relationships necessary in the workplace – see also constellation maps</i>						
Despite heavy emphasis on reflective learning within the pre-registration nursing curriculum, and literature on professionalism, use of reflection as a learning strategy was only clearly highlighted by Kate. Purity talks about how she learnt from observing a colleague's practice with a range of students, necessitating reflective activity, not explicitly framing it as such. Instead the main focus in facilitation of learning is role modelling and knowledge and skills transmission.						
The newer mentors seem to cope with best with unproblematic students (i.e. Ones who are easily meeting learning objectives) but struggle with borderline or failing students. Evidence is given for activity-centred rather than global assessment of the person, but tended to be seen as one activity rather than a range of strategies. Feedback mechanisms were discussed by all mentors, but PEFs consider this the most problematic area. Marion highlights problems in delivering timely feedback at Nightingale. This is related to the issue of 'comeback' which is discussed by April & Marion. Lulu discusses her sign-off mentor perspective <i>...in the future, if anything happens, the sign-off mentor is going to face the problem. So you really need to know what you are doing before you sign-off.</i>						
Joan highlights a lack of mentor confidence in making judgements about student performance, when mentors are actually capable without her intervention. A general reticence to complete student documentation is discussed, although good practice is shown by Anna-Maria who ensures that Purity writes her comments in the student portfolio.						
Nightingale Mentors		Lulu				
Seacole Mentors		Kate				
		Purity				
		Anna-Maria				
		Dora				

	Domains of Learning (SLAIP: NMC 2008)	Nightingale Mentors		Seacole Mentors				Illustrative Comments and Quotes
		Sade	Lulu	Kate	Purity	Anna-Maria	Dora	
Evaluation of learning	Contribute to evaluation of student learning and assessment experiences – proposing aspects for change resulting from such evaluation.							As Ward Manager Dora has more of a focus on the CPD needs of her staff, than student learning. The weaker aspect of this domain is in the proposition of changes. Kate lobbies for a recognition award for 'fabulous' students. Purity recognises and learns from poor mentorship practice of others, but does not address this with her colleagues. Marion (PEF) feels that evaluation is a weakness as mentors do not always see the full picture.
	Participate in self and peer evaluation to facilitate personal development, and contribute to the development of others.							
Create an environment for learning	Support students to identify both learning needs and experiences that are appropriate to their level of learning.							Negotiation appears the weakest aspect here. Although Purity is able to negotiate for more time with her student, Kate struggles with getting enough time with hers. The status of mentors is alluded to by Lulu ... they don't give mentors enough power because of student rights . This could be linked with perception that the organisation does not value mentors (Kate, Joan, Lulu), despite it being considered important by mentors and students. Joan argues that, When you make something sort of mandatory the aspect of well, I actually enjoy doing it anyway is actually gone . Sade alludes to mentors becoming burnt-out and thus needing to rotate mentor roles in the Ward. Kate, Dora, Anna-Maria and Lulu discuss supporting co-mentors or supervising mentorship students.
	Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs.							
	Identify aspects of the learning environment which could be enhanced – negotiating with others to make appropriate changes.							
	Act as a resource to facilitate personal and professional development of others.							
	Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated.							
Context of practice	Set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care.							A range of evidence to support this outcome was evident. Kate and Sade discuss supporting a colleague from the ambulance service. Kate, Anna-Maria and Dora discuss their relationships with Doctors. Dora demonstrates a strong commitment to CPD and arranges staff awaydays which focus on clinical updating. However, the main discussions were professional rather than interprofessional. Link roles are important: Sade is Key Mentor, Purity is an Infection Control Link Nurse, and Anna-Maria is a Tissue Viability Link Nurse. Lulu and Dora are involved in selecting colleagues for the mentorship module – Lulu has acted as a key mentor in the past.
	Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained.							

	Domains of Learning (SLAIP: NMC 2008)	Nightingale Mentors		Seacole Mentors				Illustrative Comments and Quotes
		Sade	Lulu	Kate	Purty	Anna-Maria	Dora	
Evidence-based practice	Identify and apply research and evidence-based practice to their area of practice.							Reading professional and research literature is key for most participants in keeping themselves up-to-date. Kate shows how theory is related to practice in supporting a student: We had one student who...had done aseptic technique brilliantly when we were doing a dressing; got her to set up a catheter trolley and she kept putting her hands on the trolley. I was like 'throw that away, you've just contaminated your field'.
	Contribute to strategies to increase or review the evidence-base used to support practice.							
	Support students in applying an evidence base to their own practice.							
	Plan a series of learning experiences that will meet students defined learning needs.							
Leadership	Be an advocate for students to support them accessing learning opportunities that meet their individual needs – involving a range of other professionals, patients, clients and carers.							For Dora this is more about planning learning experiences for her staff. For the other mentors this appears to be about creating opportunities for students to participate in hands-on care. Marion considers that many mentors at Nightingale have ...difficulties in seeing themselves as a leader when they are quite junior Anna-Maria discusses some of the limitations of mentorship, but not how she might have fed back about this. Kate feels she has limited influence on mentorship strategy but is only mentoring her second student since qualifying as a mentor. Issues tend to be escalated via the PEF team, although there is variance between the two Trusts as to the relationship between mentors (especially newly qualified) and PEFs, and thus the chain of direct influence between practitioners and Trust executive board
	Prioritise work to accommodate support of students within their practice roles.							
	Provide feedback about the effectiveness of learning and assessment in practice.							

Appendix J: Darling's Measuring Mentor Potential Inventory

The Darling MMP (1984) was designed to assess the mentorship potential of individuals. In this research I have used it differently as a checklist of attributes and characteristics displayed by colleagues significant to learning within their mentorship or educational role. Each of the interviews was interrogated alongside the original contellation for evidence of the following characteristics. Darling's MMP is ascribed limited validity in its original format as it fails to disclose its methodological underpinning. In my use of this tool, the scoring system has been modified to fit the four point system used to signify relationship strength. This allows the MMP to code for the relative strength of each characteristic. Where more than one person demonstrates an attribute, the strongest link is documented on this proforma.

The following characteristics have been identified by nurses as significant in their guidance and growth. Use this questionnaire to assess your mentoring potential or to assess the mentoring potential of other nursing leaders.						
	Low				High	
1. Model	1	2	3	4	5	"I'm impressed with her ability to..."; "really respected her..."; "admired her..."
2. Envisioner	1	2	3	4	5	"Gave me a picture of what nursing can be"; "enthusiastic about opportunities in..."; "sparked my interest in..."; "showed you possibilities"
3. Energizer	1	2	3	4	5	"enthusiastic and exciting"; "very dynamic"; "made it fascinating"
4. Investor	1	2	3	4	5	"spotted me and worked with me more than other nurses"; "invested a lot in me"; "saw my capabilities and pushed me"; "trusted me and put me in charge of a unit"; "saw something in me"
5. Supporter	1	2	3	4	5	"willing to listen and help"; "warm and caring"; "extremely encouraging"; "available to me if I got discouraged and wondered if I was doing the right thing"
6. Standard-Prodder	1	2	3	4	5	"very clear what she wanted from me"; "pushed me to achieve high standards"; "kept prodding me if I allowed myself to slack off"
7. Teacher-Coach	1	2	3	4	5	"taught me how to set priorities"; "to develop interpersonal skills"; "guided me on patient problems"; "said 'let's see how you could have done it better'"
8. Feedback-Giver	1	2	3	4	5	"gave me a lot of positive and negative feedback"; "let me know if I wasn't doing right and helped me examine it"
9. Eye-Opener	1	2	3	4	5	"opened my eyes; got me interested in research"; "helped me understand the politics of the hospital"; "...why you had to look at the total impact something has on the hospital"
10. Door-Opener	1	2	3	4	5	"made inservices available"; "Included me in discussions"; "said I want you to represent me on this committee; this is the information, this is our view"; "would delegate to you"
11. Idea-Bouncer	1	2	3	4	5	"bouncing things off her brings things into focus"; "eloquently speaks for professional issues; I like to discuss them with her"; "we would discuss issues, problems, and goals"
12. Problem-Solver	1	2	3	4	5	"let us try new things and helped us figure it out; always had a pencil and calculator"; "we looked at my strengths and created a way to use them to benefit nursing"
13. Career Counselor	1	2	3	4	5	"got me started on a 5-year career plan"; "I went to her when I was trying to sort out where I wanted to go in my career"; "I could trust her"
14. Challenger	1	2	3	4	5	"made me really look at my decisions and grow up a little bit"; "she'd challenge me and I'd be forced to prove my point; I found out if I believed what I recommended"

Figure 1. The Darling MMP: Measuring Mentoring Potential.

Adapted from Darling, L.A.W. (1984) What do nurses want in a mentor? *The Journal of Nursing Administration*, 14(10), 42-44.