Anglia Ruskin University

The shifting perceptions of mentoring in mental health nursing

From student nurse to nurse and mentor, an inquiry into the transitional perceptions of mentoring in mental health nursing.

Julie Teatheredge SID: 9504451/6

A thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Doctor of Philosophy.

<u>Acknowledgements</u>

ANGLIA RUSKIN UNIVERSITY
ABSTRACT

FACULTY OF HEALTH, SOCIAL CARE AND EDUCATION

DOCTOR OF PHILOSOPHY

THE SHIFTING PERCEPTIONS OF MENTORING IN MENTAL HEALTH
NURSING

JULIE TEATHEREDGE

A mentor is a qualified mental health practitioner, namely in this instance a nurse who facilitates guides and supervises the learning experience and assesses the student's competences in practice.

This longitudinal study examines the perceptions of mentorship in clinical practice from nurses, as they move from students to recognised professionals with authority to advise and assess students' competence in practice.

This ethically approved study mainly uses qualitative methods. Initially it involved interviewing eight completing mental health nursing students, and 270 mainly qualitative questionnaires were sent to qualified mental health nurse mentors in clinical practice. The final data collection of the study involved interviewing six qualified nurses/mentors who were originally the students in this study. Existential phenomenology was a valuable means of interpreting the perceptions of both the students, qualified nurses and the mentors. This ontological perspective explores the consciousness of the self, operating within a collective consciousness of their world. The data analysis initially followed Van Manen's holistic approach; then extracting essences, identifying themes and then synthesizing essences. This was then followed by an existential processing of the data from the first and second interviews.

The results reveal that the students believe that mentoring is an absolute necessity for their practical training; but the mentoring experience is precarious due to the numerous barriers. The results also highlighted incidences where students who experience ineffective mentoring are inspired to become much more effective at mentoring, because they do not want their students to experience the poor mentoring they had received. The participants in this study said students who are not competent are still passing practice, and the craft of mental health caring is not taught to an appropriate standard. However, learning from the experience of the transitional process was also revealed, and how the development of the self affected the perception of mentoring.

Key words: Being, becoming, mental health nursing, mentoring, existential phenomenology.

<u>Contents</u>

Chapter three: Philosophical foundation of the research design

Chapter four: Methodology

Chapter six: Discussion

Chapter seven: Conclusions and recommendations

List of figures

List of tables

References

Bibliography

Appendices

Copyright

Attention is drawn to the fact that copyright of this thesis rests with:

(i)   Anglia Ruskin University for one year and thereafter with

(ii)   Julie Teatheredge

(iii)   This copy of the thesis has been supplied on condition that anyone who consults it is bound by copyright.

A note on the terminology used in the thesis

Phenomenology is the study of 'things as they appear', that is phenomena (Guignon. 2006), as opposed to 'things as they are in themselves', noumena. Heidegger's (1962) approach to phenomena is associated with Being-in-the-world so the phenomena this study explored were the stated experiences of mental health nurse training, presented to me by nursing students as they became qualified nurses, and by experienced mentors. These experiences are shaped by their interaction with others and things involved in-their-world and by the interpretation of what that interaction means to them and to me (see chapter 3, for detailed explanation).

This study was an exploration of the process of being and becoming a mental health nurse and how mentoring is perceived during each transitional stage, that is being a mental health student nurse, becoming a nurse, then being a nurse and becoming a nurse mentor, and then being a nurse mentor. It was important to understand more about the field-specific context (that is mental health) of mentoring, and the perceptions about being and becoming mental health nurse mentors, because mental health nursing is an art and craft of caring. It was about learning how to connect with human beings whose psyche is frail and vulnerable. Becoming and being a mental health nurse also takes extraordinary effort (Barker, 2009). Because mental health nursing is craftwork:

"The proper focus of nursing is the craft of caring. The value of care is defined by those who receive it. Yet, the nurse brings value, expressed through carefulness and expertise. Knowing when to talk, what to say and when to remain silent, whilst nursing a depressed, distressed or dying person takes great skill. This is not something that can be learned on a course, far less from books. It requires a life-long apprenticeship, where tools of the trade are sharpened with every encounter" (Barker, 2009, p.4).

1

This study aimed to unravel some of the complexities of being and becoming, to bring to the surface possible concealed meanings about the perceived understanding of mentoring through the transitional process.

For the purpose of this study transition means:

"*A transitional period terminates the existing life structure and creates the possibility for a new one. The primary tasks of every transitional period are to question and reappraise the existing structure, to explore various possibilities for change in self and world, and to move commitment to the crucial choices that form the basis for a new life structure in the ensuing stable period*" (Levinson,1978, p.49).

In keeping with the focus on being and becoming, a phenomenological approach grounded in the work of Martin Heidegger was appropriate as a methodological framework for the interviews. However, Heidegger's primary interest was in ontology, or the study of Being in temporal terms and in relation to the external world, and later in the hermeneutical nature of language and culture in this regard. His writings are acknowledged to be complex and difficult to interpret (Inwood, 1997), and in particular his terminology has been described as eccentric and obscure, even by other philosophers such as Bertrand Russell (1989).

For that reason it was necessary to explain at this early stage how I adapted some of the key phenomenological terms used in the chapters that follow. These include Dasein, care, concern, authenticity and inauthenticity.

Heidegger (1962) was intrigued with the concept of Being, not the beings that are in world or can be discovered, but Being itself. In his greatest work 'Being and Time', Heidegger used the German word Dasein to represent the meaning of being human, 'Da' meaning there, 'Sein' meaning Being or to be. Translated Dasein basically means existence. Heidegger, like many philosophers, turned an everyday German expression into a philosophical dilemma. He was intrigued to understand what the experience of being human means, which includes the individual's awareness of their personhood, which can only be understood in

relation to the self and to others within different social contexts, within differing times. To understand what existence means one has to understand the context of where the individual is in the world at any given time, and how that experience affects the person; how then that individual responds and reacts to others in the world with them.

Heidegger's ontology is complex and he believes that how we respond or react to others is driven though care (Sorge) and concern (Fursorge). Care and concern are moving sensations. When we care for things it evokes us to respond with a range of feelings and emotions depending on the context in which care is placed by the individual. When we care and have genuine concern for other people, it often induces us to act on those evocative feelings and do something to demonstrate to others how we feel. As human individuals we care and have concern for others (our friends and family), for things /objects (our home), also for ourselves (our needs, reputation, what others think of us). The care and concern we show to others has an effect on how they view us, but also on how we view ourselves (self-worth). How the individual balances the care for the self and the care for others can have an effect on the relationship one has with the world. We also have care and concern for how we are employed in our daily lives. The depth of this care is dependent on where we are in our lives; what is happening in our lives, how we are occupied, and how much that occupation means to us.

The nursing profession is often called the caring profession. However, it also does not necessarily mean every nurse has concern and cares for others. In other words, some nurses will fulfil their duties with a professional veneer, but the care and concern they have for their occupation may be somewhat superficial. For some, though, their world of nurse occupation is full of care and concern for others and the self (reputation and self needs) and their self-development is reliant on how the self and others give, receive and respond to that care and concern.

When a mental health nurse really cares she/he is being true to what they believe that care should be (Heidegger's concept of authentic). Through the transitions of life an understanding of the meaning of the craft of caring will have

developed. A nurse who cares for the craft understands that for craft to have meaning to their Being and to others, it has be understood as a process of continued development, which is also crafted through each relationship with another (the patient), but also the relationship with the team, the organization and so forth.

However, how we care and how we respond with or to others is affected by the circumstances in which we find ourselves, and due to the nature of the situation we may find ourselves compromised. This is part of the everydayness of living in the world. Everyday life is often a balance between being true to ourselves in the care and concern we have for the self and others, and conforming to the influence of others (other people's views, hierarchal directives, organizational demands and so forth) which may or may not compromise how we feel. Often when we automatically conform (which Heidegger termed 'falleness') to these influences we do feel compromised (Heidegger's concept of inauthentic). However, it is the understanding of how we are compromised and how it affects our Being which allows us to understand what the needs of the true self are, and how we can manage to rebalance and be true to ourselves (authentic). This is a central component of understanding Being itself.

For the purpose of this study 'Being' the B is in upper case, 'Dasien' uses a capital and Being connected to other entities will be hyphenated (e.g. 'Being-in-the-world') which is in keeping with how Heidegger (1962) wrote it in German.

Chapter One: Introduction

1.1. Introduction

I am a lecturer in nurse education, and I am part of the education team which teaches mental health nursing students in higher education. I also teach mentorship training to qualified nurses and I am a clinical link tutor. I was inspired to undertake this journey of discovery because my students had told me that many were unhappy with the mentoring they received, and many of the nurse mentors told me they were unhappy with the students' competence and behaviour. These debates were often passionate, fuelled by the sensationalization in the discussions, which often projected a wealth of anxiety, which in reality was related to the process of becoming a nurse, and the responsibility of being a mentor.

I believe that the educational needs of mental health student nurses in clinical practice is the central pivot of nurse training, because the craft of caring, as Barker (2009) suggests, cannot be learnt from a book. An effective mentor is the key in teaching, supporting, guiding and assessing the students' competence in clinical practice.

This existential phenomenological longitudinal study reviews the perceptions of mentoring experiences during the transitional phase of becoming a qualified mental health nurse.

1.2. Study aims

The aims of this study were to:

1. Explore how the role of the mentor affects the training of student mental health nurses in clinical practice.
2. Gather and interpret data about the essential meaning of being a student, becoming a nurse, being a nurse and becoming a mentor.

3. Understand the everydayness of Being for the individual through the different transitional stages and within different social contexts.
4. Explore how the process of Being-in-the-world of student nurse training reveals an understanding of self within the world of mental health nursing, and how this personal meaning of nursing is assimilated into their approach to nursing.

1.3. <u>Context</u>

The evidence as suggested by Gopee (2011) currently indicates that effective mentors help to produce effective nurses who themselves can become effective mentors, but the most important aspect in this process is effective nursing care for the mental health patients. However, evidence of the ongoing problems in the mentoring process will be highlighted in the literature review. As the literature and research state there are still numerous barriers preventing effective mentoring, it was important to discover what hinders or injures the mentoring experience, and causes it to become impotent or ineffective.

In the UK, a qualified nurse mentor is responsible and accountable for the learning, teaching and assessment of the student nurse in practice (Nursing and Midwifery Council, NMC, 2008a). A mentor in this study is a qualified mental health nurse, who has undertaken further training to become a registered mentor and whose role is to facilitate learning, teaching and assessment (NMC, 2008a) in clinical practice. The mentor's role is, of course, more complex than that. It involves support, supervision, guidance and role modeling. A capable mentor will facilitate a process of enabling the student to develop the confidence and competence to become a qualified mental health nurse, and the ability to find their own answers and solve problems, subsequently learning the craft of caring (Barker, 2009).

A mentor is also the person who struggles to motivate the student, who attempts to understand why the student has a poor attitude or why the student is not developing competence as they should do. The role of the mentor is multi-

faceted, yet at the same time the nurse is being a mentor, they are also being a nurse, thus their role is complex, demanding and pressured. Despite, at their very best they want to mentor effectively, at all times their allegiance has to be primarily to their patients' needs, then to the needs of the ward and the team, the needs of the organization, their employers, and the needs of the Department of Health and so forth.

The students, nurses and mentors are unique individuals (Gaarder, 1995). It was the action or the choice of the people in this study to train to become mental health nurses, to follow the dream that is an ambition or desire of their future possibilities (Levinson, 1978). It was the existential meaning of this process of becoming that I wished to discover during the life of the study. Deeper than that though, my aim was to discover the individual's understanding of the temporal nature of Being-in-the-world, and Being-with-others within that world of mental health nursing, which links Levinson's development theory with existential phenomenology (Heidegger, 1962):

"*An essential feature of human life is the interpenetration of the self and the world. Each is inside the other. Our thinking about one must take account of the other"* (Levinson, 1978, p.48).

The chosen qualitative methodology for this study was existential phenomenology which provides a valuable means of interpreting possible changes in nurse's world view, as the participants changed their status in society from student to nurse/mentor. The two strengths of this philosophical approach, which derives from the work of Martin Heidegger (1962), are that it acknowledges that an individual's sense of self is mediated by the experience of its social context in the world, and that it recognizes a duality in the self, an authentic or genuine self and an inauthentic self (not genuine), a construction or an expected identity which is a defence against the challenges of the society in which the individual lives.

This quote from Heidegger (1978) clearly highlights the depth of understanding this study aims to reveal (Munhall, 2012):

"*A cabinet maker's apprentice:*

His learning is not mere practice, to gain facility in the use of tools. Nor does he merely gather knowledge about the customary forms of the things he is to build. If he is to become a true cabinetmaker, he makes himself answer and respond to all the different kinds of wood and to shape slumbering within wood, to wood as it enters into man's dwelling with all the hidden riches of its essence. In fact this relatedness to wood is what maintains the whole craft. Without that relatedness, the craft will never be anything but empty busywork" (Heidegger, 1978 p.269).

1.4. <u>Overview of thesis</u>

This thesis commences with a literature review (chapter two), which will contextualize insights and understanding on various concepts related to mentoring. The review will explore theoretical concepts which highlight why the process is effective and what hinders the mentoring process rendering it ineffective at times. Many of the complexities discussed in the review focus mainly on the importance of the mentoring relationship being effective, and as Taylor (2008) suggests the chances of this relationship being successful fluctuates in accordance with the mentee's and mentor's commitment to the relationship. This professional mentoring relationship will also be affected by the motivation of each individual who is involved in the process, to instigate change in another. It is also influenced by the needs of the self and the needs of society. The review will draw a conclusion which justifies the reason why this research was needed, in order to search for evidence of what factors influence the mentoring process.

The third chapter presents a philosophical rationale for chosen methodology - that is, the ontological philosophy of existential phenomenology (Heidegger,

1962), rather than, for example, the epistemological philosophy of Husserl's (1931) phenomenology.

The fourth chapter presents the actual research process and how I adhered to the ethical principles and ensured the process was transparent. It was important that the process did not just allude to existential phenomenology, but ensured that the 'essential phenomena' were identified. Each section of this chapter presents a clear account of how the above was achieved and includes discussions on how certain quality indicators (Gray, 2009) were put in place to increase the trustworthiness of the process (Guba and Lincoln, 1989).

Chapter Five presents the analysis of the data. Firstly the '*conceptual elements of mentoring*' will be presented under the sub headings of the core essences identified in the analysis. These findings combine the findings from student interviews and the qualitative questionnaires sent to the mentors. The justification for this combination was that this data was collected at the same time and the students could have been on placement with these mentors. Furthermore, close analysis revealed that the core themes, which will be called essences in this study (Parse, 2006), were very similar and the only essence that the mentors did not really comment on was anxiety. Secondly '*the concept of transition*' will be presented under the sub headings of the core essences. These findings present the analysis of the second interviews, that of the qualified nurses and mentors who were the original students in the first interview.

Chapter Six discusses the findings, with the theory and literature highlighting what is already known and confirmed through the findings, and then presents the meaning of Being which this study reveals. The final chapter (Chapter 7) offers conclusions, summarising the most salient points. A discussion will also be presented in regards to how to take this research forward and finally some reflective points on what was learned through the whole process.

Chapter Two: Literature review

2.1. Search Strategy

The aim of the search process was to identify current and established literature pertaining to a shared understanding of mentoring in nursing. This would 'confirm the research question' (Moule and Goodman, 2009). The objective was to explore and develop theories related to mentoring, and find the evidence to underpin the discussions (Bryman, 2008), and to support where relevant with the policy drivers and the evidence base. This was to ensure that a sound background of the topic was presented and also to justify the gap in knowledge which highlighted the relevance of this research (Holland and Rees, 2011). The literature included articles, research studies, books, policy, guidelines, Acts of parliament, and so forth. It was important to investigate national and international concepts of mentoring adopted in many countries.

The search terms used were mentorship, mentoring in health care, mentoring in mental health nursing and transition from student to qualified nurse.

The search commenced with a general internet search using Google Scholar with the key term 'mentor', which produced 883,000 hits, 'mentoring in health care', gave 37,400 hits. The public British library produced 7694 hits using the same key words, and the Cochrane libraries using the key terms 'mentor', 'mentoring' and 'mentoring in health care' produced 27 hits mainly on peer monitoring and healthcare. 'Transition from student to qualified nurse' was then searched in all three domains. The Cochrane library had no hits, British library 27 and Google scholar 37,400. All searches used truncation and Boolean operators. These findings were then narrowed (Polit and Beck, 2014) by limiting the search to last 10 years, then sorted by relevance to abstracts only, and found from the overall search several relevant articles, research studies and some books which were recorded for use in the university library (Burns and Grove, 2011).

The university's reading lists for mentorship courses were examined for recommended reading lists. Hand searches (Ely and Scott, 2007) at the local library and the university library identified relevant articles, books and studies.

Key terms rather than sentences, and Boolean operators and wild cards were used to refine terms (Burns and Grove, 2011). An advanced search as advised by Holland and Reeves (2010) through the university library, included databases such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cambridge Journal Digital Archive, Careknowledge, MEDLINE (medical literature online), Brutish Medical Index (BMI), PudMed, PsychoINFO (psychological information). The key term 'mentoring' revealed 2,043 hits, 'mentoring in health and social care' produced 24,950 hits, the term 'mentor' produced 52,411 hits, 'mentorship' reduced this to 21,115 hits. 'Transition from student to qualified nurse' produced 3,906 hits, the hits were reduced (LoBindo-Wood and Haber, 2010) by selecting years of publication, full text and English language (Holland and Reeves, 2010) and then cross referenced with the lists made earlier.

'Citation pearl searching' (De B'run, et al., 2011) was also used, searching through reference lists of all literature, however, De B'run suggests caution with this as not all reference lists are accurate. The literature which met the criteria was saved in a file. The final number of hits from these search methods produced approximately 2000 hits, with 71 physical items. The search was then refined by scrutinizing the titles and reading abstracts, and as Bryman (2008) suggests this method of searching was undertaken many times during the compilation of this thesis, thus the number of final hits changed over time.

The evidence found was mainly qualitative in design, thus the studies referred to in this literature review are also mainly qualitative, or were systematic reviews using mixed method studies, though still mainly qualitative. The reason for this was because the focus was on mentoring, which is an interpersonal experience (Gopee, 2011) and lends itself to a naturalistic inquiry.

2.2. <u>Historical perspective</u>

The primary aim of this literature review was to explore and analyse issues related to mentorship in the clinical area of nurse training, and the focus in this study was on mental health nurse training. A mentor in regards to nurse training is a registered nurse who is additionally qualified to supervise, teach and assess students in the clinical placement areas (NMC, 2008a), Standards to Support Learning and Assessment in Practice (SLAiP). However, the term mentor is also generic and has contrasting aspects, and is phrased differently depending on the meaning of the professional area. This will also be reviewed, but the origins of mentoring will be presented first, followed by the role of the mentor in the stage theory of adulthood (Levinson, 1978).

The origin of the word *mentor* is Greek, originating 3000 years ago. In Homer's *Odyssey* Ulysses appoints a trusted individual named 'Mentor' to advise and teach his son to look after the family estate whilst he is away fighting in the Trojan wars (Wallace and Gravells, 2007). In Homer's account, the goddess Athena disguises herself as 'Mentor' and hence subterfuge takes place. In fact, Homer was sending out a cautious message to a prospective mentee about first impressions, that not all is what it appears to be, and having more knowledge and (sometimes being more mature) does not necessarily make a person a good mentor (Downie and Basford, 2003). However, Playdon (1998) believes that over the years, Homer's work had been misconstrued and misunderstood.

It was common practice for young males in ancient Greece to be assigned a consociate, to whom the younger person could aspire to and from whom he learnt (Downie & Basford, 2003). Later, Roman officers often had an advisor or mentor with them during war. The term 'mentor' during these periods signified a person who was a wise teacher and would be faithful during the companionship (Kinnell and Hughes, 2010). The mentor relationship is also found between master and apprentice, common in craft guilds and religious orders (Hatton-Yeo and Telfer, 2008) and also between the Hindu guru, a spiritual guide to his residential pupil, who served the guru with devotion and obedience. Throughout

the centuries that followed mentoring could be found in many activities, including agriculture, industry, banking, and in the role of teacher, advisor and companion. In both formal and informal modes, it would have been essential for a process of maturity to occur. Without an experienced guide, one generation could not have learned from another the skills and artistry of living. This concise history highlights that mentoring is not a new phenomenon. Mentorship became synonymous with a '*wise and trusted one*' (Kinnell and Hughes, 2010).

"*Mentors are guides, they lead us along a journey of our lives. We trust them because they have been there before. They embody our hopes, cast light on the way ahead, interpret arcane signs, warn us of lurking dangers, and point out unexpected delights along the way*" (Daloz, 1986, p.17).

This literature review aims to explore various concepts and theories specific to mentoring, however the focus will be on nursing. The following framework on the next page (Figure 1) reflects the initial developing concepts in regards to mentoring.

Figure 1: The process of becoming a nurse

An Individual's ambition (dream) of becoming a MH nurse becomes:

A student

The student being mentored in practice by the nurse mentor becomes:

A nurse

The nurse being mentored in practice by the nurse mentor becomes:

A nurse mentor to students

2.3. **Facilitation of adult development**

One of the aims (aim, 1 see, 1.1.) of this study was to explore the mentor's role in nurse education and how that role can affect the development of a mental health nurse. This review incorporated the concept of how adults develop focusing on the importance of mentoring within this process. The most widely cited theory (in mentoring literature) which explores this notion (consequently perhaps the most influential received interpretation of mentorship) is Daniel Levinson's et al. (1978) classic stage theory of adulthood, titled the 'Seasons of a man's life'.

The changing relationship between mentor and mentee is integral to the seminal theory on adult development (Levinson et al., 1978), but has been considered limited and biased because of its focus on male occupation and socialisation processes (Gross, 2005). Nevertheless, Levinson reflects upon the relevance in

society of the concept of mentoring and refers to a mentor as someone who facilitates adult development. The theory identifies the 'seasons of a man's life', proposing a life cycle consisting of four 25-year stages, namely 'childhood and adolescence, early adulthood, middle adulthood and late adulthood'. These life stages Levinson (1978) described as transitional periods of development, that initiate change through a series of tasks that are undertaken in order to develop one's self and create a position in society.

For the purpose of this study the term transition or 'transitional period' means:

"*A transitional period terminates the existing life structure and creates the possibility for a new one. The primary tasks of every transitional period are to question and reappraise the existing structure, to explore various possibilities for change in self and world, and to move commitment to the crucial choices that form the basis for a new life structure in the ensuing stable period*" (Levinson,1978, p.49).

These transitions are related mainly to the concept of occupation (Gross, 2010), and this theory has significant relevance to mentoring in mental health nursing.

"*The term mentor…generally means teacher, advisor or sponsor….The mentor has another function, and this is developmentally the most crucial one: to support and facilitate the realization of the Dream*" (Levinson, 1978, pp.97-98).

The motivating factor that initiates the change for the individual is a 'dream' (vision) that is the ambition of what the person hopes or wants to achieve in adult occupation. It is these visions at each transitional stage in life that inspire and motivate the person to undertake the necessary processes towards fulfilling their ambition. Levinson (1978) believes that a mentor's function is to facilitate and help the learner 'novice' to fulfil their ambition. Mentors are distinguished as both formal and informal. As informal supportive advisors they are dealing mainly with the emotional aspects of learning and developing, and in the more formal roles

they are teachers or guides to the novice apprentice in life and on their chosen path, e.g. mental health nursing (Levinson, 1978).

Levinson (1978) identifies the 'boom' period that is, when the mentee or novice apprentice reaches their goal (fulfils their ambition) and consequently no longer requires the mentor. It is then that the mentee is ready to become a mentor to someone else. However, Levinson (1978) does not consider that striving towards the ambition or 'dream' is easy. The mentor supports the mentee through the disappointments that must be overcome, so that the mentee through self-development and training can become more experienced and knowledgeable. On reaching the 'boom' the individual still strives to become more successful in their acquired occupation that subscribes to society, but at the same time has developed an understanding of their self, and can be more self-sufficient. This understanding of the self in and within the world is the centre of Levinson's theory. In relation to the person's 'life-structure' and the relationship that the individual has in or with the world at any given time, it allows the person to make sense of their self in that world: "…*the interrelationships of the self and world, to see how the self is in the world, and world is in the self"* (Levinson, 1978, p.42).

The metaphysical notion is not dissimilar to that of May's (1953) philosophical view of existentialism, where it is the pivot of the individual's existence. The process of this is the emergence of a person's unique potential through the process of becoming. Through this process he believes the person becomes what he terms 'realised' and the 'realised' individual is able to declare their being in the world. The realised self also has existential 'authentic' courage and is able to be them-selves in the world (genuine), with the ability to make decisions, but also to accept the world's reality and limitations. This courage also gives the individual the ability to create (May, 1975).

Levinson believes that creativity develops for the individual/mentee during 'transitions' and boom stages in life, through knowledge and experience, and through the mentoring process. The relationships between the self and the world throughout the life journey changes. This process of change is termed

individuation: "*this term refers to the changes in a person's relationship to himself and to the external world*" (Levinson, 1978, p.195).

"*Individuation is a process of personal development whereby a person becomes more conscious of who they are. The term is normally employed to denote a process that encompasses the whole person and spans the whole course of his or her development*" (McGlashan, 2003, p.19).

During the process of individuation one has to learn to attach to significant others (e.g. the mentor) but also to understand the need to separate (Bowlby's, 1969, classic theory on attachment). The individual needs to attach to connecting persons in the world, and to attach to elements of the world itself in order to belong and become (May, 1953), but also to learn from others. If one is secure enough in their attachments (Bowlby, 1997), they will also feel free enough to explore the world. Separating from the world allows the individual space to understand one's existential inner world (May, 1953), and allows the individual to understand this divisible distinct self (Jung, 1939).

This separateness from the world allows the individual to find and form a balance between the needs of the world and their own needs, the outcome of which according to Levinson (1978), is 'greater individuation' which allows one to be more independent from the world. This independence develops self-confidence and thus allows the individual to have more 'intense attachments' with the world. Thus the individual is able to bring to the world aspects of the self that had previously been protected or unknown (unconscious). The consequence is an improved equilibrium between the needs of the self and that of the external world (Redfearn, 1977).

Levinson's (1978) dream or ambition could be the motivating factor for individuals to undertake mental health nurse training. Once qualified (reaches the 'boom'), the nurse then undertakes extra training to become a mentor to student nurses in the practice areas. Barker's (2009) belief is that mental health nursing is about 'extraordinary human support' concerned with the 'healing of the soul'. Barker

(2009) is convinced that it is a specialist craft, which includes both 'knowledge (science)' and art (aesthetics)', to care for someone with mental health problems. Barker (2009, p.4) refers to mental health nursing as:

"*A specialty craft that operates primarily by working alongside people with mental health problems; helping individuals and their families find ways of coping with the here and now (and past); helping people discover and ascribe individual meaning to their experiences; and exploring opportunities for recovery, reclamation and personal growth all through the medium of the therapeutic relationship.*"

Barker (2009) believes that the student nurse cannot learn the craft from books alone, because it is in the clinical practice area where the real understanding of the craft and its meaning takes place. According to Peplau (1988) mental health nursing is a 'therapeutic interpersonal process' in which the nurse works alongside people with mental health problems. This helps them and their carers find adaptive coping strategies to deal with the problems, in order to begin the process of recovery (Barker, 2009). Thus a student mental health nurse needs an experienced understanding professional nurse in the learning environment (practice area), who will facilitate the student developing their own 'craft of caring' in mental health nursing, and an understanding of the meaning of the craft. This person is called a mentor. Students whose experience of mentoring is positive find it helps to inspire and motivate them through each transitional process (Elcock and Sharples, 2011): from individual to student and from student to qualified nurse, then nurse to nurse mentor. During the training process, the student attaches to the 'mentor' who (in Levinson's, 1978 theory) acts as the informal supporter of the emotional needs of the student. At all other times, the mentor takes the more formal role of teacher and guide, helping the student to develop the skills and knowledge they require to facilitate change in themselves and ultimately qualify as nurse (Ely and Scott, 2007). If the student nurse has been mentored satisfactorily, consciousness will have been developed and

integrated with the unconscious, so that the nurse's own personal needs and the needs of society have been securely balanced (Redfearn, 1977). The nurse may well be motivated through a vision (ambition) that generates excitement (Levinson, 1978) to become the 'ideal' mentor.

Levinson (1978) relates the mentor to a role of teacher and emotional supporter to the novice, but the role and process of mentoring is much more complex than that. For most mentors, the process of individuation would not consciously be apparent, however each transitional stage (Levinson, 1978) that forms part of the person's ambition (dream), can either serve to motivate them into becoming good mentors, or the actual process could get in the way of them reaching their goal. The needs of the self can overpower the needs of the external world (mentoring), due to a selfishness that is driven by the unconscious forces of the self to satisfy personal emotional needs (Redfearn, 1977). In other words a mentor whose motivation in the world is a continual need to achieve, and whose need is permanently attached to the world and the occupation therein (Levinson, 1978), but who does not feel secure (Bowlby, 1969), will be unable to separate and understand their inner world, and therefore may fail to understand or meet the needs of the mentee.

Furthermore, the anxiety that drives the need to feel secure and safe during transitional stages may often lead the person/mentee to attach themselves to an unresponsive, disorganised or inconsistent others/mentors (Bowlby 1969). Although the mentee may feel rejected by the unresponsive mentor, the need to be attached and feel secure is too great. It is concluded from this that the mentee is dependent on the mentor, (Bowlby, 1997), but this mature mentoring relationship may not always be reciprocal (Kilgallon and Thompson, 2012).

However, according to Foster-Turner (2006) the effectiveness of the mentoring process is dependent upon this reciprocal relationship and the commitment of the mentor and mentee. This relationship will be further explored in the mentoring process and experience (see, 2.5 and 2.7). The concept of mentoring will be presented next.

Having explored the role of mentor and the stage theory of development, the concepts are presented in a developed framework (Figure II):

Figure II. Being and becoming a qualified nurse and mentor

The process of becoming

The dream---an ambition

The individual becomes a student mental health nurse

The student is mentored in clinical practice (effective and ineffective)

The student becomes a qualified nurse and has developed a sense of self through the experience

The qualified nurse is ready to become a nurse mentor

Being a nurse and being a mentor

2.4. <u>Understanding the mentoring phenomenon in professional practice</u>

The role of formal mentoring became more established in health and social care during the 1970s and 1980s in the UK (Downie and Basford, 2003). Continuous assessment was also introduced during this period and passing or assessing students in practice became the responsibility of the mentor in 2001 (Duffy, 2003). Prior to this the Department of Health (DH) defined the mentor as a registrant who facilitated learning and the assessor was another registrant (Gopee, 2008).

However, the regulated process of mentoring did not become exclusive to nurse training. Students in all areas of health and social care training have a nominated qualified person, who will facilitate practice learning and is accountable to their professional body for the assessment of the student. In all areas of industry and business it has been established (Clutterbuck, 2004) that mentoring 'fosters talent' in the organisation, increases productivity, improves communication, and mentoring improves retention. In Canada mentors support trainees (protégés) in the practice of law through career advancement and increasing commitment, better earnings have been some of the results for this model (Kay, 2010).

In health and social care training different professions refer to the instructors (mentors) of their students by different names in the clinical practice, according to the regulations of each governing authority. The British Association of Occupational Therapists (2008) uses the term 'practice placement educator', as do physiotherapists (Health Professions Council, 2009). In nursing (Nursing & Midwifery Council, 2008a) the term used is a 'mentor'. In social work they are referred to as 'practice teachers' (General Social Care Council, 2002), while the nominated person who supervises student doctors is called a 'clinical supervisor' (NHS London Deanery, 2009). For each student this differing phraseology is not confusing because to them the denotation means the same; it is the name of the person who supervises, teaches and assesses them in the clinical area. However, the terminology is confusing for those in other health and social care training areas: A clinical supervisor (NHS Deanery, 2009) in nursing and social

work means something very different to trainee nurses and social workers. A clinical supervisor in these professions is someone who, like a mentor, has extensive knowledge and skills in their own field of practice but supervises qualified staff not students (NMC, 2008a). According to Jones (2006), clinical supervision in nursing is a reciprocal relationship, but with a similarity to mentoring. It is a relationship between practising professionals, and, is '*a formal process of professional support and learning'* (Jones, 2006, p.578), that helps the qualified person to improve patient care through development of their knowledge and expertise. In social work, clinical supervision is described as a working collaboration between two equivalent professionals (Jones, 2006). Clinical supervision is also the term used in psychotherapy training, and for qualified psychotherapists (Mc Glashan, 2003).

The term 'supervision' is common throughout these occupations, and many more professions, whether the adult is in training or is already qualified. Supervision generally means facilitation of development and learning through a supportive, reflective reciprocal relationship (Stuart, 2007). Yet what is different is the model or the method of supervision, which is determined by the individual's professional culture, the individuals therein and their training needs and the process of mentoring therein.

2.5. <u>The mentoring process</u>

The term 'mentor' in this literature review relates to qualified mental health nurses, who facilitate, guide and supervise the learning experience and assesses the student competences in the practice area (Stuart, 2007). A good mentor also facilitates a process of enabling the student through empowerment to find their own answers and solve problems (Wallace and Gravells, 2007).

Downie and Basford (2003) suggest that the learning theories of Rogers (1983), Knowles (1984) and Kolb (1984) have had the greatest influence on the developmental strategies for formal mentoring roles which are person-centred, facilitating learning in practice which is stimulating and helps the mentee to

achieve their full potential or their ambition (Levinson, 1978). Hatton-Yeo and Telfer (2008) also believe that the person centred model of mentoring focuses on the fact that we are capable of much more than we think we are, and that this approach to mentoring has the 'potential to achieve the goals we have in life, and to develop the creative process of becoming a mental health nurse, understanding the meaning and skills of the craft of caring (Barker, 2009).

In a person-centred approach/model the student/mentee is encouraged to take responsibility for their own learning needs, taking a self-directed approach (Stuart, 2007). As adult developers they are encouraged to take charge of their own learning, including problem solving and developing their self-awareness (Downie and Basford, 2003). Mentoring is not a formal process of creating clones but a process of the student nurse developing their own identity in the world of nursing, 'a process of becoming', or individuation (Levinson, 1978). Rogers (1983), a person centred theorist, like Levinson, believes that adults have an internal need that motivates them to learn and discover; that this need is part of the transitional process in life which helps develop self awareness, confidence and esteem.

The person-centred approach/model to mentoring and learning begins for the student nurse or mentee in a state of anxiety, which fosters dependence and in turn activates the attachment processes (Downie and Basford, 2003). The skilled mentor facilitates movement in the mentee from dependence towards a more independent stance towards learning, which involves being more self-directed and taking charge of their learning needs in the practice area (Kinnell and Hughes, 2010). This process can be built on a trusting relationship (Rogers, 1983) in which the student feels confident or more self-sufficient in exploring the world of nursing. A good mentor does this according to Walsh (2010) through creating a sense of belonging, ensuring the student feels valued, making sure they are involved in the craft of caring and know what they need to do, giving them time, and asking the student's opinion.

As the student gains experience and has accumulated skills, and assimilated some theory into those practice experiences, the student mental health nurse

according to Downie and Basford (2003), will feel more confident in seeking out other new experiences and processing them in the same manner, demonstrating a keenness to learn whilst at the same time feeling confident in asking for help. The person centred goal is for the mentee to move from being 'subject-centred to performance-centred' Downie and Basford (2003). Miller (2002) terms this type of mentoring as 'holistic' mentoring, which involves tutoring, counseling and coaching and it is likely that:

"*Holistic mentors will be very experienced and well-trained individuals who are able to operate at a high level of skill*" (Miller, 2002, p.31).

For this person-centred/holistic experience of mentoring to be achieved, it is expected that all mentoring experiences are good, and that all mentors are experienced (Walsh 2010). It is also assumed that the outcomes for the mentee will be achieved. However, there is much international evidence (which will be presented under the sub-heading 'the mentoring experience' (see, 2.7), which suggests that the mentoring process is highly variable, generally inconsistent and inadequate (Gopee, 2011). Many mentees will be able to learn the craft of caring (Barker, 2009) but not the meaning of the craft, nor will all student nurses reach their full confident potential (Wallace and Gravells, 2007).

The training of mentors is the central component of effective mentoring (kilgallon, 2012). What complicates the training is that some qualified nurses would choose not to train to be mentors, but it is an expected requirement for nurses and is part of their continuing professional development, prescribed by the NMC (2008a), (Kinnell and Hughes, 2010). The NMC (2008b, p.5) states "*you must facilitate students and others to develop their confidence".* Taylor's (2008) suggests that because mentoring is linked to the nurse's professional development many undertake the role of mentor just to gain promotion.

Further discussions will explore more deeply the practice of mentoring in nursing education and fundamental issues that lead to either effective or ineffective mentoring, or indeed a combination of the two (see, 2.7). However, before

reviewing these aspects of mentoring, the next discussion will first present how the formal mentoring process in nursing is actually governed and monitored in different countries.

2.6.   <u>Regulation</u>

Since 2002 nursing has been regulated in the UK by the Nursing & Midwifery Council (NMC). Once the students have successfully completed their training they are then placed on the NMC register, and are bound to the NMC's Standards for Conduct, Performance and Ethics for Nurses and Midwives (NMC, 2008b). The NMC's primary concern is the safeguarding and well-being of patients/public. The latest standards, which present a clear model of mentoring students in practice, were published in 2008a (*Standards to Support Learning and Assessment in Practice*.

In these standards NMC (2008a, p.45), defines a mentor as:

"A registrant who has met the outcomes of stage 2, and who facilitates learning, and supervises and assesses students in the practice area."

Other countries around the world use different terms (like different professions in this country), and use slightly different models in teaching, learning and assessment in practice for their nursing students.

The Nursing Council of New Zealand (NCNZ, 2008) 'Standards for Competence Assessment Programmes', are slightly different to the United Kingdom's NMC (2008) standards. The NCNZ standards (2008) require each practice placement area to name a registered nurse as the 'clinical placement coordinator', who manages and oversees the student nurse's clinical experience. The NCNZ term for the mentor is a 'preceptor'. It is the clinical placement coordinator's responsibility to allocate a preceptor to the student before they arrive at the clinical placement. The preceptor has to have three years' registered experience (NCNZ, 2008) while the NMC (2008a, SLAiP) requires the mentor to have only

25

one year's experience. In New Zealand though, like the UK, the preceptor has to undergo extra training (a preceptor assessors programme) before they are able to assess students. The preceptor is supported by the clinical placement coordinator and the programme coordinator from the training establishment, and the student is assessed by the preceptor and the programme coordinator (NCNZ, 2008).

The Australian Nursing & Midwifery Council (ANMC, 2002) 'principles for assessment', call the mentor/preceptor an 'assessor'. The assessor is accountable to the ANMC for assessing the competency of nurse candidates, similar to the UK NMC's standard. However, the ANMC document focuses more on what is required for assessing rather than the qualifications of the assessor. The assessors have to build 'collaborative participating relationships' with the candidate and then gather a range of evidence to assess the candidate, (for example, observation, interviews with other staff members and the candidate) which is also similar to the NMC's (2008a) standards.

The American Association of Colleges of Nursing (AACN, 2007) refers to student nurses being supervised in practice by experienced and willing preceptors (like New Zealand) and role models. However, they are assessed in practice by specially trained nurse educators, and the emphasis on student nurse training is on collaborative partnerships with the educational providers and the practice setting, like New Zealand and the UK.

However, what the NMC, NCNZ, ANMC and the AACN have in common, is that clinical practice mentors, preceptors, assessors and educators all have to continually develop their own professional practice knowledge, and ensure all clinical practice is evidenced based. Those who train student nurses have to continually update their knowledge and skills, and this edict is worldwide.

In UK the NMC standards (2008a, SLAiP) clearly stipulate the mentor requirements in clinical practice, which state that mentoring pre-registration students is a 'mandatory requirement' and that only a qualified mentor can mentor students, that is, assess students. To become a qualified mentor a nurse has to have been registered for a year, then has to undertake an approved

training at a higher education institution (HEI), like in America and New Zealand, and has to meet the NMC outcomes outlined in the standards domains. If the nurse successfully passes the required mentorship training, they are then annotated on the mentor register (NMC, 2008a).

Chambers (2007) stated that in the UK many qualified nurses are not given study leave due to pressure of work, and have to attend this required training in their own time, which can cause resentment (Chambers, 2007). Once the mentor has achieved the competencies they are then placed on a live register, which is held by the placement provider and the mentor's employers (NMC, 2008a). Live mentors have a mandatory yearly update which is provided by the HEI, and undertake a triennial review of their competence as mentors every three years, which is regulated by the nurse's employer. The NMC (2008a) standards also stipulate that the student and mentor should spend the minimum of 40% of working time together each week, and three students can be mentored by the same mentor at any given time. The NMC (2008a, SLAiP) and the Royal College of Nursing (2007) also emphasize the need for protected time for mentoring; however the protected time is managed by each employer. The mentor has to try to balance the demands and pressures of the daily workload with the needs of the student, and in many cases the many demands of the clinical activity takes priority, due to staff shortages and high sickness levels (Foster-Turner, 2006). Thus the required 40% of time that the mentor and mentee should spend together is often compromised (Gopee, 2011), e.g. they are just on the same shift. Whilst the student understands that patient needs come first, it is hard if they are unable to have any time with their mentors (Walsh, 2010).

Mentors have to be creative in finding time to teach their students:

"*Carving out the time to stop and help the student to reflect upon a learning experience, facilitate a discussion or give an explanation to a student is often difficult due to the pressures of work*" (Walsh, 2010, p.50).

Chambers (2007) states that working conditions for qualified nurses are much better and less pressured in Australia and New Zealand than the UK, and many qualified nurses leave the UK for the southern hemisphere, where continual professional development, like preceptor (mentor) training is supported through protected time, and study leave is not a problem. Staff shortage in nursing is problematic in the UK. Migration due to superior working conditions only increases the pressure the UK nurses are under and makes time to mentor a greater problem (Chambers, 2007).

The standards (NMC 2008a, SLAiP) also highlight the criteria for mentoring in practice, and clearly state the responsibilities of the mentor which includes accountability. The NMC (2008a, SLAiP) requires that a qualified mentor has a responsibility towards the mentee/student nurse, which includes facilitating student learning activities, to enable the student to meet their learning outcomes in practice. In order to work towards achievement of these outcomes, the mentor should set realistic achievable goals for the students and take responsibility for supervising these activities in the practice area (NMC, 2008a, SLAiP). The mentor is also required to assess the student's competencies in accordance with the learning outcomes, and provide evidence of this competence for the HEI provider. This is similar to the regulations of the Australian Nursing and Midwifery Council (ANMC, 2002). It is also essential that the mentor liaises with all interested parties over the performance of the student in practice (NMC, 2008a, SLAiP).

These regulations give the mentors clear instructions about their responsibilities as a mentor. While adhering to these requirements and responsibilities does not make nurse an effective mentor in practice. Gopee (2011) suggests that the NMC's (2008a, SLAiP) underlying principles of the domains and standards set a clear blueprint for effective mentoring. However, these requirements do not take into consideration the limitations of time and other resources in practice which also affect student assessments (Chambers, 2007). A qualitative study (Duffy, 2003) on 'failing students', revealed that mentors were passing students in clinical practice even when deemed not competent, the NMC standards (2008a)

were produced to ensure this practice of not failing incompetent students did not continue. Duffy's study was ethically transparent (Bryman, 2008), however, the data was collected from three universities in one region and this can affect credibility (Guba and Lincoln, 1989), and limit the transferability. Gopee, (2011, p.227) suggests there could be many different reasons why a mentor still passes a student, who is not competent none of which are 'likely to be a justifiable reason'. Mentors can be charged with misconduct if they pass students who are not competent (Duffin, 2005). However, in 2010 the *Nursing Times* surveyed 2,000 qualified mentors and 37% said they had passed incompetent students (only the results were published, not the method), while 69% stated that they struggled to manage the relevant paperwork; lack of time and confidence were two of the main reasons for this (Gainsbury, 2010). These persistent issues have an adverse effect on the mentoring experience. The NMC have a responsibility as the governing body to regulate these serious practice issues, but the Council for Healthcare Regulatory Excellence (CHRE, 2012), found the NMC lacking in its regulatory performance, and poor operational management. This continued practice of failing to fail incompetent students can have potential consequences on patient care, thus the governing body of nursing could be more thoroughly questioned on their ability to protect the public (CHRE, 2012).

2.7. The mentoring experience

It is clear from the earlier discussions that the primary purpose of the mentor is facilitating change through the individual's learning experience, to promote independence and enable the person to make transitions in their professional development (Wallace and Gravells, 2007). However, the mentoring experience has to be effectual to facilitate transitional periods of development.
.
"*Effective mentoring encompasses effective working relationships, relevant mentor-mentee communication, and includes generic and specialist*

communication skills. The characteristics…..include the mentor as a role model
for learners and ascertaining own mentorship potential "(Gopee, 2008, p.35).

Effective mentoring is more than this; Walsh (2010) suggests the goal of mentoring has to be that the quality of care given to the patient is clinically effective and meets the patient's needs, and that plans of care have been adhered to, aiming always to improve standards of care.

There have been comprehensive national and international studies undertaken over the years that explore the concept of mentoring in nursing. Darling's (1984) qualitative study of health care staff's experience with mentors revealed that the mentee believes that for mentoring to be effective it is essential that a mentor facilitates building mutual trust. Darling (1984) termed this 'bonding' (Levinson 1978 termed it connecting), and the mentors have to make a commitment to investing time and energy into the relationship. Darling's seminal study (1984) led to her development of a theory/model titled 'the mentoring mosaic'. Although the original study stated that 150 interviews took place and the methodology used was grounded theory, there was no discussion of the validity of the research process, and there was no evidence that the study was ethically regulated (Burns and Grove, 2011). Bryman (2008) believes that often published studies often identify the research method, but do not state how it was actually used; ethical dilemmas are then not transparent. However, Darling's (1984) study identified the main roles of a mentor, to which Gopee (2011) and Stuart (2007) refer in their texts a quarter of a century later. These characteristics or roles range from 'role modelling', 'energizer', 'teacher' and 'counsellor' (Darling, 1984).

An earlier study by Spouse (1996) also highlighted that the mentor needs to be a good planner and teach in a collaborative way with the student. Ethical issues were not transparent in this study (Gray, 2009) and it was not clear if the informal interview process followed ethical regulation (DH, 2005). The students in Spouse's (1996) naturalistic longitudinal study felt it was the quality of the relationship that made mentoring effective. Ashton and Hallam (2011) also suggest that the quality of the whole learning experience is reliant on the

30

effectiveness of the relationship between the mentor and mentee; (Levinson, 1978 termed this 'satisfactory mentoring').

In 2000 a longitudinal qualitative study by Gray and Smith, explored student nurses' perspectives on what the 'qualities of an effective mentor are'. There are some methodological issues: the published research did not explore the limitations of the study and omitted to explain whether the 10 participants remained in the study over the four-year period and whether they participated in each of the four data collections (Burns and Grove, 2009). However, the results of Gray and Smith's (2000) study highlighted that students felt that effective mentors will spend quality time with the students, are good teachers and take time to teach the student but at the students' own pace. Furthermore, a good mentor is a good role model. The students also stated that a good mentor is not only confident, caring and enthusiastic and involves the students with ward activities, but is also approachable, patient and has excellent communication skills (Gray and Smith, 2000). Many of these attributes are the same characteristics that Darling's study (1984) revealed.

A peer reviewed study by Hubbard and Foley (2010) in North America produced similar findings. A survey completed by a convenience sample of nurse educators, showed that having a professional commitment and a positive past experience of mentoring improved its effectiveness, and that planning is essential, as is good communication and a supportive environment. However the participants were asked to complete the survey at a nurse educator's conference, the responses received could have been coercive or not a true account due to the presence of the researcher (Polit and Beck, 2008). Furthermore evidence of ethical permission was not clear (Burns and Grove, 2011), these issues can affect the validity of the study.

Whilst these discussions present an outline of an effective mentoring experience, many students are unhappy with the mentoring they receive and mentors often complain about the pressure and stress they are under to fulfil the mentoring role (Taylor, 2008).

Hubbard and Foley (2010) believe that the barriers to mentoring have to be acknowledged in order to improve effectiveness. Barriers highlighted in this study were lack of time, an unsupportive environment, lack of support, negative criticism, anxiety and insecurity.

Taylor (2008) believes that the student's experience of the clinical placement can be either 'inspiring or demoralizing' and the outcome of the experience is dependent on the mentor, that is, the mentor is the 'key' to successes. Even with the governance of the NMC (2008a) standards, the quality of the mentoring experience for nursing students is 'highly variable' (Taylor, 2008). Gray and Smith's (2000) study also made the same point, the participants declared that having a good mentor in practice was down to luck. Hubbard and Foley's (2010) study made similar points including that mentors sometimes do not have a commitment to the role and do not appear to be interested in ensuring its effectiveness. The mentor has responsibility as a professional to ensure they deliver the best evidenced-based care to the patient (Gopee, 2011, NMC, 2008a); this professional competency should act as a role model and be part of the student's learning experience (Foster-Turner, 2006). The mentor should demonstrate to the student how 'to practise one's craft to the highest standard' (Gopee, 2011, p.142), and highlight sound safe practice which encompasses evidenced-based risk management, emphasizing the importance of continual professional development.

However, mentoring might sometimes be ineffective because not every nurse is suited to mentoring. With the NMC's requirements many nurses now have no choice but to become mentors (Taylor, 2008) but many people do have the necessary skills for mentoring, and while others have the capacity to learn these skills some people will never master the process of mentoring (Hatton-Yeo and Telfer, 2008). Hubbard and Foleys (2010) study suggested that some mentors are just not interested in mentoring, and they often have a different agenda from the student, which in most cases is not relevant to the student's needs. More concerning is that these types of mentor often lack the insight to understand they are behaving in this unhelpful manner (Clutterbuck, 2004).

However, some nurses for many reasons including lack of interest, do not want to be mentors even though they were mentored themselves, and are aware that the practice area is a teaching environment (Kinnell and Hughes, 2010). There are also some mentors who have undertaken the required training but find it difficult for many reasons, including lack of time, to be competent at mentoring (Hatton-Yeo and Telfer, 2008). This sometimes results in these mentors developing a negative attitude towards students' (Gopee, 2011) in order to compensate for their inadequacy. Levinson (1978) acknowledges that there can be problems and these can affect the mentoring relationship. He believes that the mentors, due to their own developmental needs, may manipulate the mentee into an impotent position, thus preventing development (Scherer, 2010).

Chambers (2007) suggests that student's experience can also be affected by the philosophical change in nursing. Chambers (2007) argued that nursing used to be 'patient-centred' and is now 'business orientated', and has moved from a public to a commercial service that is efficiency driven. However, budget cuts during the last few years have reduced staff numbers considerably (Klage, 2013), leaving less time to nurse let alone mentor due to the increased workload. The Francis (2013) report aims to rectify these problems, recommending that senior management needs to collaborate with all staff, to become more patient-centered adhering to the Compassion Strategy (DH, 2012), but Klage (2013) foresees problems with the overall implementation of the Francis report (2012) recommendations, stating it will take years to change the culture of the NHS.

Some students' also receive inadequate mentoring in the practice area due to a lack of consistent access to the mentor and poor communication (Taylor, 2008). Students often do not understand the jargon language of a qualified nurse. Darling (1984) refers to poor mentors as 'toxic mentors'.

In Gray and Smith's (2000, p.1546) study the students all reported they had experienced some form of 'toxic mentoring'. The authors stated:

"*Poor mentors often dislike their job, and might in fact be disliked by other members of the ward team. Poor mentors are often distant, less friendly,*

unapproachable and intimidate the student. They lack knowledge about the training and have unrealistic expectations".

Some mentors who are not competent will resort to bullying the student to mask their own inadequacies. Hubbard and Foley's (2010) study identified this behavior, which they termed 'horizontal violence'. These types of inadequate mentoring can increase the anxiety in the student, and block learning (Mullins, 2007). However, some students learn how to cope and become resilient (Kilgallon, 2012). They learn to become more independent and seek guidance from other members of the team, and in extreme cases report the mentor to the team manager (Gray and Smith, 2000).

Anxiety is a cause for concern for the student nurse and too much anxiety can block learning (Kilgallon, 2012). Each new placement creates anxiety caused by lack of experience, fear of the unknown and the unpredictability and risk involved in mental health nursing (Walsh 2010, Barker, 2009). The student is much more open to learning if they feel secure and wanted by the team and their mentor (Hubbard and Foley, 2010). Gray and Smith's (2000) study suggested that students are also more anxious and less likely to develop resilience (Newman, 2004) in the early part of their training, when they need more reassurance and guidance, and often need the mentor all the time. However, competent students begin to develop knowledge and skills in the latter training years and their view of mentoring becomes more realistic and less needy (Smith and Gray, 2000). They then value the quality of time with a knowledgeable, interested mentor. Foster-Turner (2006) refers to this quality in a mentor as 'being there' for the mentee; this is built on trust, respect and good communication.

2.8. The mentor-mentee relationship

One of the most important aspects of mentoring is the professional relationship between the mentor and mentee (Ashton and Hallam, 2011). Creating an effective working relationship in the clinical environment is one of the domains in the NMC's (2008a) standards. The mentee enters into the journey of nurse

training with the ambition of becoming a qualified mental health nurse (Levinson, 1978); it is through a capable mentoring relationship that the student can make the transition from student to registered nurse (Boore and Deeny, 2012). However, according to West et al. (2007), the mentoring relationship can be inconsistent, ineffective and even toxic (Darling 1984).

Daloz (1986) believes that developing an effective mentoring relationship begins with the mentor listening to the needs of the mentee. Thompson (2012) suggests that not listening to the student creates another barrier in the relationship. Kilgallon (2012) suggests that one of the most influential factors in building an effective relationship is interpersonal skills which include receptive, congruent communication. Effective communication and the interconnectedness in the mentoring relationship is the responsibility of both the mentor and mentee, and if effective it can help reduce some of the barriers in mentoring (Hubbard and Foley, 2010). Gopee (2008) suggests that the mentor as a qualified professional in health care would likely be more skilled in communication than the mentee, although this is not necessarily true. Communication is a dynamic process, and the goal of effective communication is to arrive at a mutual understanding by the sender and receiver of what was actually said (Sullivan and Decker, 2005). Both the mentor and mentee need to be honest in their communication in order to build a trusting relationship. If the relationship is trusting the students will feel safe enough to articulate their real views of the world and be open with their fear and anxieties (Kilgallon, 2012), also it is important that the mentor is open and honest with the student (Riddell, 2012), giving constructive honest feedback.

What further complicates the forming of a relationship is that each mentoring relationship for the student does not last very long, because the NMC (2008a) insists that the students move placement area regularly during their three years of training, in order to experience as much as possible the many different skills and specialties of nursing (NMC, 2008a), and at each new placement the forming of a new relationship begins. Ford (2010) stated that a report seen by the Nursing Times (2010) asserted that students are very concerned about the frequent change of placement, and many students stated that they had just got

settled (after four weeks) and had understood ward routine, when it was time to change placement. The students believed that longer placements would give them more time with their mentors and enable them to develop a relationship and enhance their practice skills (Ford, 2010).

An effective relationship should also demonstrate mutuality in the learning process. A systematic review undertaken by Jokelainen et al. (2011) found the effectiveness of the professional relationship requires the mentor to respect and trust the student (Jokelainen et al., 2011). By treating the student as an equal colleague, as a human being showing the student care and understanding, and taking an interest in their needs, can help the student feel secure and believe that the mentor thinks they are capable. Jokelainen et al., (2011, p.12) states this is the mentor and mentee "*interacting as professional partners in a co-operative relationship".* The study was according the University of York (2008) extremely thorough, the inclusion and exclusion criteria were transparent and 23 studies were reviewed which adds to the robustness of the study (Petticrew, 2006). However, whilst the review was international, there was a lack of evidence from North America which could restrict its validity (Petticrew, 2006).

A qualitative study by Po-Kwan and Sivan (2010) also found that mutual respect is essential in the mentoring relationship. This published article though gave a brief and rather unclear discussion on the research process, making an assessment of its methodological quality difficult to ascertain (Holloway, 2008).

The mentor and mentee are aware of the power in the relationship at the start of their journey (Gray and Smith, 2000). It is the mentor's responsibility not to use that power coercively (Best, 2005) and to act in an ethically professional manner (NMC, 2008b, Code). Gray and Smith's (2000) study reveals that mentors often do not meet their students' needs. They have the power to refuse to support the students and could 'withhold' information relevant to the student practice experience preventing the mentee from developing (Ashton and Hallam, 2011). Communication can also be affected because the mentor has more power in the relationship (West et al., 2007), the mentee will attempt to initiate communication more often than the mentor, in order to ensure that the relationship is

'maintained' and restored. However if the mentor is professional about the issue of power, the communication will be reciprocal in regards to maintaining the relationship with equality in initiating communication (Kalbleisch, 2006). These issues all affect the consistency and effectiveness of mentoring as does the organization.

Issues connected with the complexities of the organization that the mentor is employed by, and the intricacies of dynamic relationships within the practice team the mentor is working with, further exacerbate these issues of interpersonal relations within the mentoring relationship (Kinnell and Hughes, 2010):

The organization's role in the success of the mentoring scheme is paramount, for it is the attitude of the organization towards the environment as a culture for learning that most affects the mentoring process and the relationship (Megginson, 2006). If the organization accepts and nurtures the function of mentoring, and the philosophy of the organization is to undertake learning as an ongoing need for staff development (Wallace and Gravells, 2007), then mentoring will be integrated into the organizations culture. For this to become effective, the organization needs to make a commitment to and have a positive attitude towards mentoring (Jarvis et al., 2006).

This positive culture towards mentoring is then needed to be promoted from top down. When managers encourage the mentoring process through mentoring the staff they lead the staff to feel more confident in mentoring students (Wallace and Gravells, 2007). By investing in staff and giving protected time for students learning needs (Gopee, 2011), the driving force of these initiatives should be an enhancement of the quality of care the patient receives (Gopee, 2011).

This type of positive culture is a 'learning organization' and defined it as a setting:

"…*where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together"* (Mullins, 2007, p.351).

However, if organizations do not adopt the cultural characteristics of a positive learning environment, this can have a negative effect on the mentoring process, and the nature of the mentoring relationship (Foster-Turner, 2006). Furthermore, Jokelainen et al. (2011) suggests the development of the student is not necessarily just influenced by the organization, but also by the environment in which development is facilitated. Gopee (2011) suggests it may be that the mental health organization where the student practice placement is does promote a 'learning organization', but the dynamics and cultural inferences of the team, and the individuals who work in that team, also affect and influence the mentoring experience, and ultimately the mentoring relationship. Individuals work within the same organizational world, but they do not have the same views and beliefs and have different expectations of themselves and others (Stuart, 2007). As Parse (2004) suggests no situation or idea is ever understood in the same way by two individuals. These complex issues will influence the effectiveness of the mentoring experience and the development of the student, and it is therefore not surprising that the mentoring experience is highly variable in different clinical environments (Taylor, 2008). The NMC (2008a) standards emphasise the responsibilities of the learning health organization in the facilitation of mentoring:

"*Service providers are responsible for ensuring that learning opportunities and support for learning and assessment is available in the practice learning environment"* (NMC, 2008a, p.46).

This includes continual professional development of staff, mentoring of student nurses and providing protected time for this supervision to be facilitated. However protected time is only recommended by the NMC it is not mandatory. The RCN (2007, p.15) also advocates protected time for mentoring:

"*Placement providers have a responsibility to: allow time for mentors to meet with their students to undertake and record assessment activities and outcomes.*"

Gopee (2011) suggests that managers should ensure wherever possible to allocate protected time for mentoring, but whilst the NMC also approves protected time, it does not have the power to enforce this with the mental health trusts. Mentoring can only be effective if there is time to mentor, to build an effective relationship, to accurately assess the student's competence and support the student to develop (Stuart 2007, Kinnell, 2010).

However Walsh (2010) believes if the mentor and student are supported in practice by the link tutor from the university, the mentoring process can be more effective. Walsh (2010) suggests the link tutor can advise the mentor of curricular changes which can affect the practice learning outcomes. The tutor can help the mentor plan learning needs according to the learning outcomes, and be a support to the students and the mentors (Gopee, 2011). Boore and Deeny (2012) suggest that the link tutor should visit every two weeks, because the expertise of the tutor can be supportive, and it adds an independent opinion. However, how the link role is facilitated is highly variable depending on the university. The RCN (2007) have called for the NMC to make the standards mandatory, because each trust and university puts their own interpretation on the context and meaning of the standards (Gopee, 2011). The NMC could insist that the standards are implemented in a very directive approach, rather than this passive process (CHRE, 2012).

A mixed method survey by Price et al. (2011) explored students' views on the support provided by the link lecturer in practice. This mainly qualitative survey was conducted in one university limiting the generalisability of the findings (Gray, 2009) and the response rate was low which suggests that they may not have achieved a representative sample (Denscombe, 2003). Nevertheless the findings made some valid points. In the university where this survey took place it is normal practice for the students to be visited once on each clinical placement, but this is not common practice in other universities (Price et al., 2011). The results of this study emphasize that the students' value these visits from the link tutor. The visits help to enhance the mentor-student relationship and to clarify learning needs with the mentor and student. Furthermore, the results of the

survey were very favourable of this support in 'monitoring the mentoring relationship'. It forged good, collaborative tripartite relationships, and encouraged the mentors to give constructive feedback to the students (Price et al., 2011, p. 783).

A mixed method study by Gidman et al. (2011, p.466) recommends that there is a "*need for a collaborative approach between the HEIs and placement providers to develop effective support systems".* This study was also conducted in only one university limiting the transferability of the findings; however it used a mixed method which can increase reliability (Holloway and Wheeler, 2010). Support systems in clinical practice for mentors and students should be reviewed in regards to how the link lecturer role can be utilized to its full effectiveness.

Managers should wherever possible allocate protected time for mentoring, but, whilst the NMC recommends protected time, Gopee (2011) said that protected time has been recommended by the governing bodies of nursing for many years, but has not been made policy. Mentoring can only be effective if there is time to mentor, to build an effective relationship, to accurately assess the student's competence and support the student to develop (Stuart, 2007, Kinnell, 2010). The previous discussions question whether students reach their full potential due to ineffective mentoring (Levinson, 1978). What is evident is that students who are competent do become qualified nurses, but also many who are not competent may also achieve qualified status. Furthermore the anxiety does not dissipate (Elcock and Sharples, 2011), but can manifest into more stress during and after the transitional process.

2.9.   The transition into becoming a qualified mental health nurse

Elcock and Sharples (2011) suggested that starting nursing as a newly qualified nurse can be challenging, and the real world of being a qualified nurse can be quite different than what is expected. Sprinks' (2012) survey presented brief results in the published article, which was part of a discussion about the care campaign and the methodological issues were not cited. This survey (Spinks,

2012) which was implemented for the Nursing Standard revealed that nurse training does not prepare students for the transition, or the role of qualified nurse. However the Willis commission (2012) found no shortcoming in nurse education, but stated that the learning experience in the clinical areas needs improving urgently. Thus the emphasis is on the experience in clinical practice. Roberts (2009) suggests that students learn clinical skills at university, but these are not always practised in the clinical areas to a capable level, thus newly qualified nurses are not always competent, and this can add to their anxiety. A qualitative study by Mooney (2007) revealed that students are poorly prepared for the transition to qualified nurse, and students need to be much more involved in clinical practice. Mooney (2007) argues that it is the supernumerary status which hinders them developing confidence, competence and the true meaning of nursing. However, Mooney's (2007) study was limited due to only one university being involved (Burns and Grove, 2009), and was conducted within a limited time frame (Holland and Rees, 2010). However, the methods and ethical issues were visible and transparent (Polit and Beck, 2014).

A qualitative Canadian study by Ferguson (2010) suggested that the transition from student to qualified nurse is anxiety provoking and full of uncertainty. Ferguson's (2010) study used a grounded theory design, though the method of data analysis and ethical considerations were unclear (Bryman, 2008). However the data collection was robust (Gerrish, and Lacey 2010), and the 'member checking' was transparent (Polit and Beck, 2014). Ferguson's study also stated that the newly qualified nurses valued the support of experienced nurses who assisted them to develop their skills and understand the complexities of being a newly qualified nurse. Often though their assigned nurse (preceptor) was not effective in supporting the nurse through this transition, and other role models (nurse's) who were more receptive were approached (Ferguson, 2010). In Canada this assigned nurse is named a mentor, in England the term is preceptor. In England there is a formalized period of preceptorship (DH, 2010a), which is usually for a period of six months; the newly-qualified nurse has a range of learning outcomes to achieve during this period. The employer is guided by the

41

'Preceptorship framework' (DH, 2010a). The preceptor is a registered practitioner (not necessarily a qualified mentor), who will formally support the student through this transitional process. The preceptor's role is to promote autonomy through the development of clinical competence, building confidence and self awareness as a qualified nurse (Sharples and Elcock, 2011), fostering a belief in life-long learning as prescribed by the DH (2010a). Effective preceptorship can help the newly qualified nurse develop confidence in the decision making process, however, if mentoring is not effective then it is possible that preceptorship is not always effective (Higgins et al., 2009).

Elcock and Sharples (2011) suggest that it is also the accountability and responsibility that the newly qualified nurse's are not prepared for, compounded by a lack of confidence in their abilities (Roberts, 2009). A qualitative English study by Clark and Holmes (2007) found that newly qualified nurses are not always competent or confident, and that an effective preceptorship can help develop confidence and competence. However, the data collection used focus groups and these can be unreliable depending on the skills of the facilitator in dealing with group dynamics (Holland and Rees, 2010), and coping with this issue was not transparent in the article. However, the study had an extensive sample group which aids the rigour (Holloway and Wheeler, 2010). A transparent systematic review by Higgins et al. (2009) found that the transition into being a qualified nurse is stressful and full of ambiguity and recommends that a longitudinal study needs to be undertaken to explore this process more. However, the search done in this review appeared in the publication as limited (Petticrew, 2006), and this can affect the robustness of the results. The study highlighted the limited competence nurses had at transition to qualified nurse especially in clinical skills (Higgins et al., 2009). Sharples and Elcock (2011) suggest that organizations expect competence from the newly qualified nurses they employ, but the above evidence suggests this is not always the case. However, Clark and Holmes (2007) found it was the newly qualified nurse expectations to be competent which caused more stress than the expectations of the organization.

Higgins et al. (2009) also suggests that what also hinders the progression is that the transitional process is ill-defined and confusing, which suggests the Department of Health's (2010a) framework for newly qualified nurses is not adequate enough, or the implementation of the framework is not robust at a local level.

Furthermore a qualitative study by Rungapadiachy et al. (2006) found newly qualified nurses were also not prepared for the transition, and dealing with the accountability and responsibility was the main issue. Rungapadiachy et al.'s study was transparent and acknowledged that researcher bias could have affected the findings (Holloway, 2008). Higgins et al. (2009) study also suggested that dealing with the accountability as a newly qualified nurse is stressful, and student nurses do not always understand the complexities of decision making during their training (Clark and Holmes, 2007) so that once qualified the responsibility in making those decision is difficult. Thus it is evident that mentoring can be ineffective, that many nurses are not prepared for the transition into becoming a qualified nurse and that developing competence and confidence can be affected by the quality of the preceptorship.

2.10. <u>Summary of literature review</u>

It has become clear in this literature review that the intricacies of the mentoring process are complex.

This literature review has established that the mentor has roles and responsibilities in regards to the formal structure of the mentoring relationship, including teaching, supervising and assessing the student's competencies, and passing and failing the student in the learning proficiencies which reflect the curriculum governed by the NMC. This formal role of mentoring relies more heavily on the professionalism of the mentor, in fulfilling their duties and requirements of the establishment (Gopee, 2011). The mentor should ethically use expert power (Gray and Smith, 2000) in facilitating of the student's progress. This component of the mentor's role is objective and accountable to the

development of the mental health student. Barker (2009) refers to mental health nursing as the craft of caring, a process of blending both 'knowledge (science) and aesthetics (art) to form as a craft'. The process of the student becoming competent in the craft of caring is reliant on the quality of the mentoring experience.

"Craft workers use their skills and knowledge to satisfy the demand and expectations of patrons or customers while satisfying their own aesthetic and technical ambition" (Barker, 2009, p.7).

This forms part of the reciprocal process of mentoring: the qualified craft worker also ethically uses their skills and knowledge to satisfy the needs of the mentee, facilitating development (Levinson, 1978) for the student and developing both the student's and the mentor's ambitions. It is accepted that the qualified mental health nurse has crafted the art of caring (Barker, 2009), and has already developed their interpersonal skills to a very high standard.

As the mental health mentors guide the student through each transitional phase, the student, if successful, will eventually reach their goal (the 'boom' stage (Levinson, 1978), taking their place on the NMC register, and a position in society as a mental health nurse. If the journey has been effective a deeper understanding of one's self will have been achieved through the process of individuation (Levinson, 1978).

It is an existential journey that the student mental health nurse undertakes. The process involves forming an effective relationship with their mentors, which moves them from the objective to the subjective, which facilitates learning from experience and develops growth as a whole unique person. Once reaching their 'boom' the student is then ready to make another transition into becoming a mentor themselves (Levinson, 1978).

2.11. <u>Conclusion</u>

The complexities discussed in this review focus mainly on the importance of the mentoring relationship being effective. The chances of this relationship being successful, fluctuates in accordance with the mentee's and mentor's commitment to the relationship and the many barriers discussed, including lack of time, poor facilitation, inadequate preparation for transition and failing to fail. This professional mentoring relationship will also be affected by the motivation of each individual who is involved in the process to instigate the process of change in another. It is also influenced by the needs of the self and the needs of society. The mentor has the power to inspire or demoralise the student during their journey of discovery (Parse, 2004). The journey will not only be affected by attitude, competence and commitment of those involved, but also the agenda that bound the mentor to the task, and that some qualified nurses do not have the necessary skills to become mentor (Hatton-Yeo and Telfer, 2008).

The ability for all involved to understand why the professional mentoring relationship is ineffectual at times can help reduce tension (Hubbard and Foley, 2010), and foster a more person-centred approach to the learning relationship. The health organizations have to make a commitment to fostering a mentoring culture in their learning environment, and to giving staff protected time to mentor. Employers also have a responsibility to ensure their employees (the mentors) adhere to the NMC (2008a) regulations about the clinical experience for students and the NMC needs to be more mandatory about the implementation of the standards. Furthermore from the discussions it is evident that the nurses once qualified feel unprepared for the transition (Higgins et al., 2009), and were not fully prepared for the experience and lacked understanding about what it really means to be a qualified nurse (Mooney, 2007), which included lack of knowledge about accountability and lack of confidence about competence (Clark and Holmes, 2007).

The aim of the process of mentoring is that the organization, the team, the mentors, are preparing the students for not only the transition into registrant, but also reciprocally preparing them to become mentors themselves.

2.12. <u>Rationale for the study as was revealed in the literature</u>

This literature review has highlighted there are many barriers to effective mentoring and preparation for professional practice. It is clear that failing to fail, poor facilitation, 'toxic' mentors, lack of time, and inadequate preparation for transition are some of the issues which create ineffective mentoring and prevent students and qualified nurses reaching their full potential. Furthermore ineffective mentoring does not help the student to develop competence or confidence, or help them to understand the meaning of the craft of caring or what being a nurse really means in the world of mental health nursing.

What is lacking in the literature is knowledge about the perceived reality of mentorship in each social context, and how the meaning of this reality affects the individual in each new transitional phase. Furthermore there is a lack of information about how Being-in-the-world of student nurse training affects the development and understanding of the self and the individual's approach to mental health nursing. That is, what it means to be a mental health student nurse in an unpredictable mental health clinical environment, and what that student believes they need in order to reach their full potential and learn the craft of caring competently and safely. It is also important to establish if their training in clinical practice enables them to understand the meaning of the craft of caring. This literature review established that the mentor has a pivotal role in the potential development of the student nurse. Further information is required about how the complex mentorship relationship affects the student's development in becoming a qualified mental health nurse, and how the mentoring they received as student's impacts on the transition to becoming a qualified nurse. Furthermore, it is important to establish if the mentoring the qualified nurses received as student's influences how they interact with students on the units, and

if it has any effect on how they perceive their role as mentors. In order to establish how mentoring in clinical practice can be strengthened, to ensure the students learn how to care for mental health patients competently, we also need knowledge about how mentorship influences the development of the sense of self through each transitional stage as the individual progresses towards their future potentiality.

Thus this study aims to gather data about the perceptions of mentorship through the transitional stages: being a student, becoming and being a qualified mental health nurse, and being and becoming a nurse mentor (Teatheredge, 2010).

Chapter Three: Philosophical foundation of the research design

3.1. Introduction

Phenomenology is the study of 'things as they appear', that is phenomena (Guignon, 2006), as opposed to 'things as they are in themselves', noumena. Heidegger's (1962) approach to phenomena is associated with Being-in-the-world so the phenomena this study explored were the stated experiences of mental health nurse training, presented to me by nursing students as they became qualified nurses, and by experienced mentors. These experiences are shaped by their interaction with others and things involved in-their-world and by the interpretation of what that interaction means to them, and to me.

Thus this study set out to explore being a student, becoming a nurse, being a nurse and becoming a mentor in mental health nursing (the craft of caring). This was to develop a deep understanding of the phenomena known as the craft of caring and what this means in different social contexts over time. This qualitative component involved interviewing student nurses in their final year of training and interviewing them again once they had qualified and become nurses and nurse mentors. It was a study of how mentoring is perceived during each transitional stage. Heideggerian (1962) existential phenomenology was deemed by the researcher to be the most appropriate design. The following sections will justify why that decision was made, including a rationale for choosing Heidegger's ontological approach as opposed to Husserl's.

This study was an exploration of the understanding of Heideggerian concept of the individual's Dasien (Being-there, there-Being). It was a study of the process of being and becoming, and how mentoring is perceived during each transitional stage. The study embraced the Heideggerian ontological approach, to explore the concept of Being (that is, what it means to be in the world, Being-in-the-world), with the participants, and the perceptions of mentoring whist Being in the world of mental health nursing, over time and within different social modes of Being, (student, nurse to mentor). Therefore it was important to explain why this

philosophy was chosen as an adapted method. This study explored the meaning of mentorship within the changing contexts in order to understand a perceived existential view of how the transition itself affects their view of mentorship, and what is perceived to affect the fidelity of the mentoring process. Furthermore, this study explored the mentorship experience and how this challenged the individual's sense of self of being true to themselves, freely choosing their way of Being (Heidegger's concept of authenticity), and conforming to the needs of others without considering their own needs (Heidegger's concept of inauthenticity), and how or if this affected their Being-in-the-world.

The study used mainly qualitative evidence to construct a shared understanding of the meaning of mentoring within the context of mental health nursing. The evidence gathered was mainly verbal and written statements from students, nurses and nurse mentors, because ontological consideration requires searching for the existential meaning of the 'lived reality' (Sartre, 1958) of those involved in mentoring in the process of being and becoming a mental health nurse.

The initial focus of the research is on shifting perceptions of self and others involved in nurse mentoring. This involves gathering statements regarding the existential experience of mentoring (as student, nurse or mentor): both the internal and external experience. It also means understanding the subjective 'hermeneutic' meaning attributed to this experience. It is important that this research integrates existentialism and phenomenology into decisions regarding the research process, and that hermeneutics is taken into consideration during the data analysis. This will allow exploration of this 'interpretive paradigm' (Denzin and Lincoln, 2008) in regards to a philosophical movement rather than a subjective systematic meaning (Stewart and Mickunas, 1990).

Thus a Heideggerian existentialist phenomenological philosophy underlies the interpretive stance of the interviews in this study. This chapter gives some explanation as to why this ontological perspective was helpful to this study, and it was important not to adopt a superficial approach to phenomenology, as some nurse researchers have done previously, which will be discussed first, followed by a philosophical discussion on why the Heideggerian ontology was chosen.

3.2. <u>Phenomenological approaches in nursing research</u>

Qualitative research into various aspects of nursing has regularly used a phenomenological research method. More than 15 years ago an article by Rose et al. (1995) positioned the phenomenological research method as an alternative to the positivistic approach to nursing research, because this method aims to identify the essence of the phenomena being studied. However, they cautioned nurse researchers to make sure much attention was focused on the rigour of this methodology in order to avoid 'method slurring' (Rose et al., 1995). The application of rigour in nursing research has resulted in many authors expressing concern about how this compromises the underlying philosophy of the phenomenological methodological design in nursing research.

Mackey (2005) is of the opinion that many nursing research studies which adopt a phenomenological method do so without adhering to the philosophical rigour which Rose et al. (1995) refers to. Thus nursing knowledge is being acquired through an approach which is not coherent with a phenomenological methodology, and consequently nursing knowledge could then be criticized for method slurring (Moule and Goodman, 2009). Crotty (1996) also critiques phenomenological nursing research, arguing that the methods used are inferior and were not being used as true phenomenology. Crotty's (1996) criticism focuses not on the findings of the nursing studies but on the methodological process itself. Crotty (1996) believes that the phenomenological approach used in nursing research was descriptive and utilized the third person, and it was also a mere symbolic interaction rather than

"*a critical methodology that invites us to revisit our conscious experience and open ourselves to the emergence of new meaning or at least the authentication and renewal of our present meanings: it is essentially a first person experience*" (Crotty in Barkway, 2001, p.192).

Crotty's work is challenged by many, including Benner (in Barkway, 2001) who referred to Crotty's work as 'unobjective and pejorative'. Darbyshire et al. (1999) believe that Crotty's view is misguided and narrow and focused more on the existential understanding of Heidegger (1962). However, Barkway (2001) concludes that Crotty's (1996) critical analysis proposes a challenge to nurse researchers who use a phenomenology as a method, that is, to ensure that the 'essential phenomenon' is identified. Crotty (1996, p.174) believes that to do this the researcher needs to revisit the data repeatedly, leaving subjective preconception behind in order to ensure the 'description is free from extraneous considerations', thus bringing new meaning to life.

The following philosophical discussion will present an analysis of the ontological approach in the study, an understanding of its relevance in this study.

"*Heidegger sees Dasein analysis as ontology, that is, a study of Being, for Dasein is the place where Being reveals itself. The way Dasein reveals itself is in the light of its openness toward Being, and the way Being primarily manifests itself through what Heidegger calls the existentialia, or the basic mode of Being-in-the-world.*" (Stewart and Mickunas, 1990, p.70)

3.3. <u>Phenomenological philosophies</u>

The premise of this thesis is based on the phenomenological idea that the individual self is shaped by its experiences in the world, specifically to changes in the student nurse's evaluation of mentorship within their profession. While a discussion of the nature of the self is in essence a metaphysical one (Alter and Walter, 2007), it remains useful for identifying the type of data to collect, and the intuitive interpretation of such data, because it suggests changes in the nature of an individual's perception of themselves, as mentors or mentees. Data is directly sourced through the senses: sight, taste, touch, sound and smell (McKenna, 2009). This data is generally regarded as measurable. Such information provides

the grounding of empirical thought and scientific deduction. Empiricism provides a counter philosophical position to classical bases for philosophy based on pure reason.

Descartes (1968), an early modern rationalist who provided a foundation to modern concepts of the self, believes that evidence can be derived from a priori reasoning or from spontaneous thoughts. These suppositions were a focus on 'Cartesian doubt' a distrust of pure sensation (McKenna, 2009). Descartes began to question the validity of the knowledge derived from the senses:

"…by means of reason alone, knowledge and certain universal self evident truths could be discovered, from which evidence could then be derived" (McKenna, 2009, p.31).

Descartes believed that all knowledge could be derived from theorems self-evident to reason and therefore were independent from experience. Charles Darwin (1808-1892, Boghossian and Peacocke, 2000) also believed that 'reason' was one of the most important features of the human mind, and that the emphasis on reason was in the 'discovery of truth' through a priori reasoning (McKenna, 2009, p.32).

"*Empiricism only recognizes knowledge derived from experience, that which is observed, sensed and where possible measurer*" (McKenna, 2009, p.32).

Auguste Comte (1798-1857), a founder of the social science of sociology, rejects Cartesian metaphysical philosophy, believing it had no credibility in regards to knowledge (McKenna, 2009), as empirical evidence can determine knowledge (Hughes, 1990). Comte's focus is on what he termed 'positive knowledge' (Hughes, 1990). Only 'robust rigorous scientific methods', including empirical observation, could research human knowledge (natural science methodology), and be free from bias and therefore provide more reliable evidence (Haralambos and Holborn, 2004). Comte believed that through this scientific method that

problems related to humans could be solved and thus 'social conditions would be improved' (McKenna, 2009).

Phenomenology, which provides a syncretic philosophy, is a merger of several original philosophies which allow for an inclusive approach between these opposing stances, which was first proposed by Immanuel Kant.

Empiricists such as Locke (1632-1704) believed that the consciousness is hollow and inert whilst Kant (1724-1804) believed the mind is more potent and active (Crotty, 1996). Although Kant (1724-1804) agreed that knowledge about the world comes from the senses, he also believed that reason was influenced by factors or conditions of the mind that contribute to our perception of the world (Gaarder, 1995).

Russell (1961) puts this quite succinctly:

"*Kant holds that the immediate objects of perception are due partly to external things and partly to our own perceptive apparatus.....Kant does not at most times question that our sensations have causes, which he calls 'things-in-themselves' or 'noumena'. What appears to us in perception, which he calls a 'phenomenon', consists of two parts: that due to the object, which he calls the 'sensation', and that due to our subjective apparatus, which, he says, causes the manifold to be ordered in certain relations. This latter part he calls the form of the phenomenon. This is not itself part of the sensation and therefore not dependent on the accident of the environment; it is always the same ....and it is a priori*" (Russell 1961, p.685).

For Kant, using pure reason without applying it to experience only leads to illusions, but subjective experience also requires reason to transform it into knowledge (Crotty, 1995). Transformational effects of this reasoning between the individual perception of the self and external experiences are central to our intuitive understanding of the influences of mentorship.

Although the most prominent philosopher to address phenomenology was Hegel (1806), much of his complex work is largely irrelevant to a justification of the

ontological position of this thesis. While critical of Kant, he reinterprets many of his concepts (including dialectic or triadic models of reasoning). Hegel believes there was a problem with epistemology, because he deduced that all the known ways of understanding truth are imperfect, and this he felt had to be 'overcome', and there has to be a 'separation of knowing and truth' (Denker and Vater, 2003). Thus for Hegel phenomenology (Brooks, 2005) is about the unfolding of one view of knowledge to another, a progression through a 'pathway of doubt', where subjectivity transforms the objective world. This process develops knowledge creating a speculative logic that generates new ways of viewing the world or thinking about the world.

Bertrand Russell (1961) considers Hegel the culmination of the idealist movement started by Kant, but he considers Hegel's doctrines to be entirely false (Russell, 1961). Others consider Hegel's views were very rigid:

"*Hegel's philosophical system left no room for the individual as a unique, willing, choosing, conscious being. The individual is merely one stage in the unfolding of the absolute and is even unaware that he is a tool of the absolutes coming-to-self-awareness*" (Stewart & Mickunas, 1990, p.16).

Hegel was however, a significant influence on Husserl and Heidegger, the most prominent twentieth century phenomenologist's. "*Hegel seems to have anticipated some of Heidegger's central doctrines & strategies. a rejection of traditional epistemology in favour of ontology, that is a explanation of the knower and the known, and of the relationship between them*" (Inwood, 1997, p.35).

Despite the work of Kant and Hegel, Edmund Husserl is regarded as the 'father' of modern phenomenology (Sawicki, 2005).

3.3.1. <u>Husserl</u>

Husserl's (1859-1938) philosophical inquiry was not about the sense perception of objects in the world but '*rather the a priori contents of our consciousness*'

(Cuddon, 1991, p.705), embracing Descartes' theory of consciousness. He believed that the centre of original meaning is the human's individual mind. Husserl's approach to phenomenology is subjective. It focuses on the perceiver being the pivot in determining meaning (Cuddon, 1999) and knowledge about the self, which is known as transcendental phenomenology. Husserl's philosophy takes a reductionist approach to understanding the self and is a protracted endeavour to narrate experience (including 'things themselves') which does not include conjecture about theory or metaphysics. Husserl designates the concept of 'bracketing' (phenomenological reduction), in regards to suspending the 'natural attitude' (current understanding), in order to study consciousness (Sawicki, 2005), to allow the phenomena or essence to articulate themselves, untainted by assumption or attribution (Gray, 2009): in other words, to derive the essential self from the data of everyday experience. Husserl's method intended to expose *Verstehen* (understanding), the very nature of consciousness in a manner that is atemporal and ahistorical, in order to establish "a trans-subjective theory of understanding" (Cuddon, 1991, p.705). This concept is termed intentionality.

Gaarder (1995) suggests that the development of philosophy in understanding how individuals make sense of the world was influenced by many different thinkers. Intersubjectivity is important to Husserl's approach: the world is shared by individuals, where many subjectivities exist, so because most people are generally empathic, they are able to access the intersubjective worlds of others (Holloway & Wheeler, 2010), allowing others to make sense of subjective experience (Schwandt, 2007). This occurs in a *Lebenswelt* (lived-in-world). The Lebenswelt relates to the ordinariness of the lived experience, prominent in the foundations of phenomenology today (Holloway & Wheeler, 2010).

"*In his analysis of the lived-world, Husserl pointed out that the distinctions commonly used are not arbitrary but inhere in the very nature of the particular entities experienced within the lived-world. Not all objects are the same, and it is*

the task of the philosophy to make proper distinctions" (Stewart and Mickunas, 1990, p.46).

3.3.2. <u>Heidegger</u>

Unlike Husserl, Heidegger (1962) believed that the fundamental component of phenomenology is ontology, opposed indeed to Descartes epistemic certainty (Crotty, 1996). As a young man Heidegger was inspired by Aristotle and much later by Plato (Stewart and Mickunas, 1990): "*The object of knowledge is what exists and its function to know about reality*" (Plato Republic, 2003). Heidegger (1962) was also intrigued by Plato's ideas on 'Being' as an 'unseen permanence of behind all becoming' (Gorner, 2010).

Martin Heidegger (1889-1996), Husserl's protégé, provides a different and more practical use of phenomenology in terms of research. His phenomenology was used as a means of understanding Being, rather than detached consciousness (Mills, 2003). He criticized Husserl's approach in regards to the central primacy theory and that Husserl did not take into account the lived experience of the ego in the world (Mills, 2003). Heidegger (1962) was not a Cartesian like Husserl (Inwood, 1997). His work provides a basis for modern forms of phenomenology: hermeneutics and existentialist philosophies, including the interpretation of post-modernism and political theory through the work of Marcuse, Habermas and his own early protégé, Hannah Arendt.

Heidegger's primary interest is ontology, or the study of Being in temporal terms and in relation to the external world, and later on the hermeneutical nature of language and culture in this regard. His writings are complex and difficult to interpret (Inwood, 1997) which has led to dismissive criticism from other philosophers, such as Bertrand Russell:

"*Highly eccentric in its terminology, his philosophy is extremely obscure. One cannot help suspecting that language is here running riot. An interesting point in his speculations is the insistence that nothingness is something positive. As with*

much else in existentialism, this is a psychological observation made to pass for logic" (Russell, 1989, p.303).

Heideggerian phenomenology is based on his early (1962) work 'Sein and Zeit', (Being and Time), an ontological analysis of Sein (Being) within a Lebenswelt (lived-in-world). Existence for Heidegger should not be confused with the subject: the consciousness of the self. Dasein (literally meaning 'there-Being, Being-there') involves different relations: '*Being-in-the-world*' is the primal state of the self in relation to other entities or 'objects of concern', or 'Being-with-others", which can be either as part of the mass I-am-with-Others or with they-self (meaning we make sense of ourselves from society's view rather than our own unique interpretation) (Heidegger, 1962). Dasein is also temporal and involves being presently reflecting of the past and considering future possibilities (Stewart and Mickanus, 1990).

Being is therefore only expressed in a series of triadic relationships that are temporal or related to care (Inwood, 1997). A fundamental basis of our Being-in-the-world is for Heidegger not matter or spirit, but care:

"*Care (Sorge), as Heidegger uses the word, is a structure of our being and it gets expressed in all the different ways we relate to the entities in our world. When we are dealing with people, and not things, the word he uses is not care or concern but solicitude (Fursorge). Solicitude, Heidegger says, 'corresponds to our use of "concern" as a term for an existentiale'. Solicitude is grounded not merely in our Being-in-the-world but in our Being-with, which too is an existentiale*" (Crotty, 1996, p.84).

Heidegger's ontology is complex and obscure and changed from his initial work to later post-war interpretations (Cuddon, 1999). It is beyond the scope of this thesis to make a comprehensive interpretation of his overall canon of work, which may defy any interpretation, according to Russell and others. However, his general perspective provides particularly useful insights into the research design

and the analysis of data, and these have been co-opted to provide a theoretical support for the approach taken in the research.

1. Dasein (a located definition of Being) is a useful concept to understand how the participant's self is expressed in the data. Heidegger's approach to hermeneutics, the interpretation of meaning within the data is very relevant to the analysis.

2. Heidegger's concepts of care Sorge (concern for ready-to-hand entities) and Fürsorge (solicitude/concern for others/reputation in our relationship with others in the world), are useful in interpreting the influence of practice environments and mentorship.

3. The temporal nature of Dasein, a subjective sense of time, is also conducive to a longitudinal study of perceptions.

4. Existentialist states of authentic (independent decisions) and inauthentic self, doing what one has to do because it is considered right, comfortable, or helps one to belong and conform (Guignon, 2004), is of great relevance to the way individual student nurses may show evidence that experience is used to construct their own identity as a mentor, or to socialize them into standardized or expected views of mentors.

The practical uses of existentialism and hermeneutics have been considered by later writers, influenced by the Heideggerian phenomenological position.

3.4. <u>Existentialism</u>

Heidegger's (1962) existential phenomenology is also influenced by the work of the existential philosophy of Kierkegaard (1813-1855) and Sartre (1958). However, as Gaarder (1995) claims, 20th century existentialism has its roots in the Renaissance period and the belief that evolved during that time of the human uniqueness, a rebirth of ancient humanism that followed the so called Dark Ages.

"*But Renaissance humanism was to an even greater extent characterized by individualism. We are not only human beings, we are unique individuals*" (Gaarder, 1995, p.155).

Kierkegaard's (1996) influential views on existentialism were not appreciated until after his death. He disagreed with Hegel's views on objective truth, declaring them irrelevant to the personal life of humans. Instead he believed in the importance of meaningful truths, the understanding of one's own existence, and argued that it is through action and choice that humans can relate to their own existence (Gaarder, 1995). Sartre (1958) argues that it is imperative that life has meaning, and that man creates his own existence (Gaarder, 1995). Some of Sartre's (1958) theories correspond with Heidegger's phenomenology: existentialism is humanism. The meaning of what it is to be human, rather than the meaning of being human in the world is linked to Heidegger's concept of Dasein the question of Being.

Heideggerian phenomenological concepts of '*Being and Time'* have an existential meaning, in regards to the meaning of Being*,* and Being-in-the-world, and the existence of human beings in Time (Crotty, 1996). Furthermore, for Heidegger Dasein is an ontological analysis (Stewart and Mickunas, 1990:70), an investigation of Being, because Being is revealed in Dasein, as it becomes transparent through the existential experience 'or the basic modes of Being-in-the-world':

"*Phenomenology is our way of access to what is to be the theme of ontology, and it's our way of giving it demonstrative precision. Ontology is possible only as phenomenology*" (Heidegger, 1962, p.60).

Care (Sorge) is the basic mode of Dasein (Stewart and Mickunas, 1990), care for other people, care regarding Being and care about the existence of life: care can be authentic or inauthentic. Dasein for Heidegger (Hornsby, 2004), vacillates between authentic or inauthentic modes, concepts that are central to

existentialism. Authenticity (meaning being true to the self, being one's own person, freely choosing one's way of Being-in-the-world), it is a component of the temporality and is part of the unique process of 'unfolding' (Mills, 2003, p.117):

"*It is a state of being that is active, teleological, contemplative, and congruent, an agency with quiescent potentiality. As such, authenticity is a process of becoming one's possibilities and by nature it is idiosyncratic and uniquely subjective.*"

Being inauthentic (Inwood, 1997) is when humans conform to others' needs without considering the options and needs of the self. For Heidegger (1962) inauthenticity or 'fallenness' is not about Being–no-longer-in-the-world, but is a positive component of existence of Dasein, that is Dasein-with and Dasein Being-in-the-world (Mills, 2003). In order for the self to return to the authentic Dasein there has to be a sense of the inauthentic (Hornsby, 2004). Being-in-the-world is part of Dasein, which takes on an essential quality of a priori, and exists within the vacillation of the authentic and inauthentic self.

"*Dasein exists. Furthermore, Dasein is an entity which in each case I myself am. Mineness belongs to any existent Dasein, and belongs to it as the conditions which make authenticity and inauthenticity possible. …Dasein exists in one or the other of these two modes*" (Heidegger, 1962, p.78).

Mills (2003) questions if authenticity is more than uniqueness but part of the ontological process of Being.

"*The urge toward authenticity arises from the other modality of human existence, which is being-toward-death. Man is finite, and time in which he can choose his existence is limited; thus, a person postpone his choices indefinitely. Since man is finite, he is temporal and thus historical* " (Stewart and Mickunas, 1990, p.71).

Therefore, in 'Being and Time' Heidegger (1962) proposed an ontological approach in the study of the meaning of Being, or the truth of the real existence of humans in time and space (Guignon, 2004). This research study aimed to explore the meanings of Being in relation to becoming a mental health nurse. Heidegger's phenomenological view was the very essence of this process in discovering some truth, but the focus of this study was the Dasein of mental health nurse training and how the relationship between student and mentor affects the process of becoming. Therefore the analysis of the study's data relies on phenomenology and the focus is on existentialism, taking into consideration hermeneutics.

3.5. Hermeneutics

Hermeneutics dates back to Aristotle's, (384-322 BC) 'treatise *On Interpretation'* (Stewart and Mickunas, 1990). The meaning for Aristotle of hermeneutics was the rules and theory of interpreting texts, bringing meaning to the unintelligible. Hermeneutics remained the method of 17th century theologians whereby they interpreted the Bible in accordance with their views (Cuddon, 1991). During the romantic era theologian Schleiermacher (1768-1834) took the concept of hermeneutics to a much deeper level by introducing the 'hermeneutic circle':

"*The circle is that movement from a guess at the whole meaning of a work to an analysis of its parts in relation to the whole, followed by a return to a modified understanding of the whole of the work. It embodies that belief that part and whole are independent and have some necessary organic relationship. In this version of interpretation, the historical gap which separates literary work from critic or reader is a negative feature to be overcome by an oscillating movement between historical reconstruction on the one hand and divinatory acts of empathy on the part of the critic or reader on the other*" (Schleiermacher, 1768-1834 cited in Cuddon, 1991, p.405).

The German philosopher Dilthey (1833-1911, cited in Cuddon, 1991) brought the concept of hermeneutics into the philosophical world. He was concerned with 'essential meaning' the essence of being human and understanding Verstehen (meaning). He believed that hermeneutic interpretation could help to understand essence. Dilthey argued that these meanings of essence could not be understood through the natural sciences (*Naturwissenschaften*), but through the *Geisteswissenschaften,* the 'science of the human spirit' (Cuddon, 1991). Critical and intellectual thinking and theory have been developed through Dilthey's ideas of hermeneutic interpretation (Cuddon, 1991).

Hermeneutics has its roots in theology and philosophy, but it is also closely linked to psychoanalysis, namely Freud and phenomenology (Gray, 2009). Hermeneutics in the 21st century means, 'the art and science of interpretation concerned with human experience' (Rycroft, 1995, p.69). Hermeneutics is about interpreting social construction and understanding human behaviour within social reality (Bryman, 2008). Whilst the positivist scientist is looking for an explanation or description of human behaviour rooted in objective facts (Gray, 2009), hermeneutics aims to empathically understand the meanings of behaviour (Weber, 1947) in order to deepen knowledge of the understanding of social action. Gray (2009) also argues that this process also enhances self-understanding. For Heidegger (1962) hermeneutics typifies the actual phenomenological project (Crotty, 1996):

"…*the meaning of phenomenological description as a method lies in interpretation….Philosophy is universal phenomenology ontology, and takes its departure from the hermeneutic of Dasein, which, as an analytic of existence has made fast the guiding-line for all philosophical inquiry at the point where it arises and to which it returns*" (Heidegger,1962, pp.61-62).

Crotty (1996) suggests that what Heidegger has done is to bring phenomenology and ontology together, but also to unfold the meaning of Being through making explicit ('manifest itself') what is implicit using hermeneutic connotation (of

language). Heidegger starts with Dasein (Being-there, there-Being), because that is where Being is encountered and manifests itself (Crotty, 1996). He believed the process to be circular (connected to Schleiermacher's, (1768-1843) hermeneutic circle) because for Heidegger once Being begins to manifest and starts to thematize, it then returns to the Dasein to 'enrich our existence'. Heidegger believes that '*we make fast the guiding line for all philosophical inquiry at the point where it arises and to which it returns*' (Crotty, 1996, p.82). For Heidegger though, the hermeneutic circle '*is the expression of the existential fore-structure of Dasein itself*' (Heidegger, 1962, p.195).

3.6. <u>Phenomenology as methodology</u>

Conceptual schema of mentoring (figure III)

The process of becoming

Authentic   Care and concern   Authentic

The student   The individual in clinical practice 'BEING'   The nurse

Inauthentic   Inauthentic

The nurse mentor

Authentic
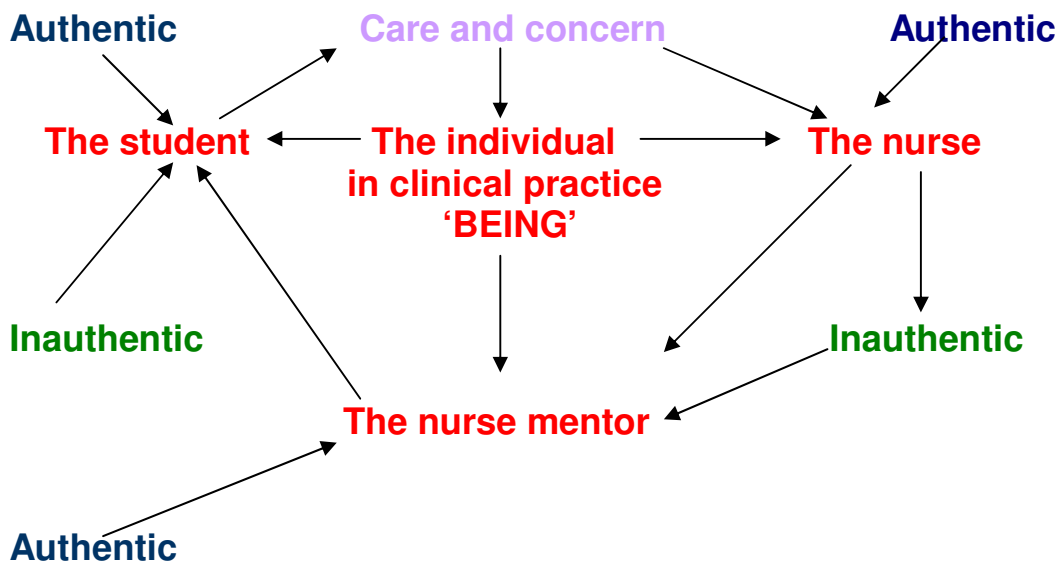
This study is concerned with the nature of Being itself, a philosophical approach to understanding the meaning of Dasein. It is important to acknowledge that Heidegger's ontology is not a precise methodology, but an adaptation which

seeks to understand the participants essential meaning of their world in different social contexts and over time, as it is presented, not shaped by what I have been taught through my own world view. It is not the nature of knowledge and meaning (epistemology) that is being searched for. Its purpose is to be attentive to Being itself and where it reveals or conceals itself. The aim is to follow a phenomenological process, to understand the individuals' life-world experience between situations. The individual 'both constitutes and is constituted by the situation' (Munhall, 2012, p.129).

Thus, the chosen qualitative stance for this study is existential phenomenology. The two strengths of this philosophical approach are derived from the work of Heidegger (1962) which acknowledges that an individual's sense of self is mediated by the experience of its social context (Dasein); and that it recognizes a duality in the self, an authentic or genuine self, and an inauthentic self, a construction or a received identity which is a defence against the challenges of the society in which the individual lives. The research was designed to explore students', nurses' and nurse mentors' perceptions as trainers and trainees operating in relation to the social world of nursing and nurse education in clinical practice.

However, it was important that the research connected existentialism and phenomenology as integral to the data collection and analysis, in order to explore with the interviewee changes between these two roles, their essential view of themselves as a student and a nurse and the socially imposed standards within each world. Otherwise the results may have just reflected an existential view that only gave a view of systematic meaning which would have been subjective (Stewart and Mickunas, 1990).

Existential phenomenology essentially explores consciousness of the self, operating within a collective consciousness of their world: that is, the correlation of these phenomena of experience where one is in the world, but also the conscious ways of the world. This is a view similar to the theories of Carl Jung (1939). As Heidegger (1978) proposes, existential phenomenology is an exploration of the pre-reflective, pre-ontological, lived understanding of the world

(Guignon, 2004), the maintenance of the individual self within the social world of nursing mentorship. This methodology had its advantages for credibility and trustworthiness, Heidegger's (1978) concept of the authentic and inauthentic self and care and concern, were central components of the research analysis.

Whilst the interpretivistic approach includes different research procedures (Gray, 2009), including realism and symbolic interactionism, this study also took into consideration a hermeneutic interpretation of Dasein. However, primarily the focus was the ontological philosophy of existential phenomenology (Heidegger, 1962) rather than the epistemological philosophy (Husserl, 1983) of phenomenology. Holloway and Wheeler 2010 believe that Heideggerian phenomenology is a very acceptable approach in nursing research because it examines presuppositions of 'Being a person in the world'.

The research used a combination of methods. Third year mental health nursing students were interviewed in the first data collection, then mainly qualitative questionnaires were sent to the qualified mentors in mental health practice areas. The rationale and design for this data collection will be discussed in the next chapter (4.1.). The third data collection involved re-interviewing the participants in the first data collection after they had become registered nurses and qualified mentors in mental health practice. Chapter Four will explore and detail the actual research process, and include the robustness of the study.

Chapter Four: Methodology

4.1. Introduction

This longitudinal study (Holland et al., 2006) primarily considered qualitative data sources, because it aimed to understand the changing perceptions and ascribed meaning of individuals operating within a distinct professional sub-culture. It therefore examined the individual's perception within a context of their lived reality (Munhall, 2012). In stage one third-year mental health nursing students were interviewed in the first data collection (eight participants); the same participants were re-interviewed (six participants which will be explained in 4.2.3.) after they had become registered nurses and qualified mentors in mental health practice. In stage two, mainly qualitative questionnaires were sent out to the qualified mentors in mental health practice areas. This chapter will firstly present the stage one, interviews, including sampling and data collection. Then stage two, the survey, will be presented, giving a rationale for its use in this study, and also covering the sampling, data collection and analysis of the closed question responses. Consideration of data analysis and ethics will be combined for the two stages since the analysis of the qualitative data from the survey followed the same method as for the interviews.

Table 1: The research stages

Stage 1	Stage 2
Interviews	Survey
1st. Eight mental health student nurses were interviewed at the end of their three year training.	A questionnaire was sent to 270 qualified mentors in one mental health trust. There were five closed questions and seven open, qualitative questions.
2nd. Six of the same participants were interviewed when they had become registered nurses and qualified mentors.	

4.2. <u>Stage one: interviews</u>

Stage one involved a longitudinal design in order to explore the lived reality within the social contexts over time, to establish if perceptions change within each reality. Longitudinal studies can highlight changing perspectives that may be experienced by individuals, and qualitative longitudinal studies "*can offer fresh perspectives into established arenas of social enquiry, drawing attention to the psychological and biological processes ('lived through experiences) through which social outcomes are generated and mediated"* (Holland et al., 2006, p.2).

The rationale for using qualitative longitudinal research (QLR) was to map perceptional changes by monitoring over a period of time (Gerrish and Lacey, 2010), in this case two and a half years. Longitudinal studies allow researchers to explore and explain how social and policy issues affect staff attitudes over time (Gray, 2009). Gerrish and Lacey (2010, p.220) particularly recommend QLR for nursing research "*as certain phenomena from this field lend themselves to being studied over a long period of time",* in this case the shifting perceptions of mentoring. Heidegger's (1962) concept of the temporal nature of Being is also conducive to a QLR study. Research in the arena of health is 'suited' to QLR, and this method is conducive in understanding "*temporal and geographical movement between individual/collective agency and structural dominants*" to "*study transitions*" (Holland et al., 2006, p.19). This is exactly one of the purposes of this study. Holland et al., (2006, p.2) also suggests that QLR research can present new perspectives on the lived experience which have 'social outcomes'. However, it could be argued that this is more a before and after study rather than a longitudinal one, because usually in a longitudinal study many data collections are facilitated over time, in some studies with the same participants (Gray, 2009). However, there is evidence to suggest that a longitudinal study can involve only two data collections (Mould and Goodman, 2009). This study made two data collections with the same sample (see section, 4.2.1. for sample sizes) over a period of time, in order to study the perceptions of mentorship during the

transitional processes over time; this process is recommended by Holland et al. (2006).

4.2.1. Interview sampling

"*Sampling is a complex process which is informed by the research question and theoretical considerations, and it is guided by the phenomenon of interest to the researcher*" (Holloway and Wheeler, 2010, p.137).

Understanding sampling theory is an important part of the research process (Burns and Grove, 2009). Davies (2007) argues that the theory of sampling dictates that there should be honestly and rigour involved in presenting the evidence.

Ethical issues and principles guide the researcher's methods when choosing the target population and the sampling frame (Holloway and Wheeler, 2010). Procter, Allan and Lacey (2010), suggest that in qualitative research small samples of potential participants are identified, because they will be in a position within a social context to give meaningful information about a particular phenomenon. Morse (2000) believes qualitative studies which aim to deeply understand people's perceptions on a phenomenon, should aim for a sample of no more than 10 participants, however as Gray (2009) suggests this is highly debatable.

For this study, the chosen sampling strategy was non-probability and the sample framework used was purposive. The strength of this sampling method in meeting the methodological criteria (Moule and Goodman, 2009) is that the potential participants are judged by the researcher to have valuable knowledge and experience about the phenomena being studied, that is, mental health nurse training, specifically being and becoming mental health nurses and mentors.

This stage was comprised of two separate qualitative data collections (see, Table 1). Because the study was a longitudinal methodological approach, the same sample group participated in both sets of interviews (Holland et al., 2006).

The sample chosen for the interviews were in the first instance, mental health student nurses, who volunteered to share their perceptions of their experience of being mentored, and who had also consented (see consent form, appendix III) to be interviewed again when they became qualified nurses and mentors to ascertain if their perceptions had changed (NRES, 2008).

The inclusion criteria (Moule and Goodman, 2009) limited the sample to one cohort of mental heath student nurses who were about to complete their three-year mental health nurse training programme at 'the' university. These students had three years' experience of being mentored and it was anticipated that these students would have their own views on the experience (LoBiondo-Wood and Haber, 2010).

This sample was also chosen to be included because once qualified, they would be eligible to train to become mental health nurse mentors after a year as a qualified nurse (NMC, 2008a), and this fitted into the time frame of this study (Denscombe, 2003). The sample size could have been increased (Procter et al., 2010) if every current mental health nursing student at 'the' university had been included (approximately 300 students). However this would have resulted in a much longer complicated study (Todres and Holloway, 2010). For some students it would be four years before they undertook their nurse mentor training, and a much larger sample may have made elicitation of deep data impossible (Gray, 2009). Therefore the rest of mental health nursing students were excluded from this study (Holloway and Wheeler, 2009).

All the students that were included had a mentor in each clinical practice area during the three years of their training, and were deemed to have relevant knowledge and experience of being mentored (Denscombe, 2003).

Forty student nurses, two months away from completing their three years of nurse training, were sent to their home addresses through a authorized administrator (as stipulated by the ethics committee, NRES, 2008): an invitation letter (see appendix IV) two consent forms (see appendix, III): and a participant information sheet (see appendix, II) and a pre-paid return envelope addressed to the researcher's work address (NRES, 2008). Eight of the forty students agreed

to participate in the interviews. This sample size met the criteria of Procter et al. (2010) in regards to being a sufficient homogeneous group. A follow-up reminder to all 40 students, so as not to disclose who had responded (Bryman, 2008) yielded no more participants. This sample was also agreed to participate in the second set of interviews as Holland et al. (2006) suggests. This was central to the whole research process, because it explored the perceptions of mentoring through the transitional change between the role of student to becoming a registered mental health nurse and then nurse mentor within each social context. Eighteen months after the first interview the participants were contacted by letter and asked if they wished to continue to participate in the second interview (Holland et al., 2006), the returned information identified that none of those who responded had qualified as mentors, thus it was agreed that the participants would be contacted again in six months' time (see 'Data collection' below for further details).

4.2.2. <u>Data collection (interviews)</u>

Data collection, like sampling, is a complex process, and is the most interesting part of the research process according to Burns and Grove (2009), but it also needs careful planning:

One requisite of data collection in existential phenomenology is to ensure that the method of collection is deep and detailed enough to ensure the authentic experiences are understood (Denscombe, 2003). Also, as Todres and Holloway (2010, p.180) suggest, instead of using the word 'data' the term lifeworld or lived experience is used in phenomenological studies, because '*they are not gathering separate pieces of information but rather interrelated themes or stories'.* The experience of the individual is where the inquiry starts, then moves towards the general (Holloway and Wheeler, 2010).

It is important to take into account that phenomenology is not a precise inquiry methodology, but a philosophical approach, thus when gathering phenomenological qualitative data, the researcher's focus should be on the

emergence of the 'philosophical implications inherent to the question' (Holloway and Wheeler, 2010). Crotty (1996, p.20) suggests that a phenomenological approach to data gathering avoids, wherever possible, using data collections that are biased and tainted by methods that merely guarantee them data the inquiry wants. Instead the approach tries to ensure that the essential individual quality of the data is 'left intact and untainted'.

The planned (Burns and Grove, 2009) aim and focus of these interviews with eight third year mental health student nurses was to ask meaningful questions about the students' lived experience of being mentored, in the context of clinical practice (Heidegger, 1962). The second set of six interviews (see section, 4.2.3. for explanation of reduced number of participants) took place when the students in the first set of interviews had qualified as registered mental health nurses, and some had trained or were in the process of training to become nurse mentors (the second interviews took place 2.5 years after the first interview).

The aim and focus of these interviews was to explore the essence of becoming nurses and nurse/mentors, the meaning of these transitions and their perceptions of their conscious sense of self (Dasein. Heidegger, 1962) in the context of their changed lived in world.

Semi-structured interviews were the chosen method because of their humanistic and interactive qualities (Creswell, 2003), and they gave an opportunity to probe and elicit deep meaningful information from a small sample about their perceptions of mentoring (Todres and Holloway, 2010). Structured interviews are too fixed and standardized (Bryman, 2008) and far too rigid for a phenomenological approach (Crotty, 1996). Furthermore, the semi-structured interview accommodates the phenomenological approach because it '*is concerned with meanings that people ascribe to phenomena*' (Gray, 2009, p.370). The semi-structured interview also allows both the interviewer and interviewee space for clarification, thus avoiding misinterpretation of the question or the response (Burns and Grove, 2011).

"Interviewing is a powerful way of helping people to make explicit, things that have hitherto been implicit, to articulate their tacit perceptions, feelings and understandings" (Arksey and Knight, 1999, p.32).

Using a phenomenological approach to interviewing meant not only was the planning of the interview important, but also the way in which the interview was conducted (Munhall, 2012). The success of the interview is also largely reliant on the skills of the interviewer.

4.2.3. <u>The interview process</u>

The first set of interviews took place during March 2009, and the second set of interviews in September/October 2011.

The eight consenting (see appendix, III) student nurses in the first interviews were contacted by phone to arrange a convenient date, time and place for the interview, that met the needs of the participating students not the interviewer (Holloway and Todres, 2010). If the interviewee has to fit into the researchers' schedule, it could cause harmful anxiety about personal and work commitments of the interviewees (Gray, 2009). During the initial phone call, the participants were also informed that the interview would take no longer than an hour, so they could plan their day (Holloway and Wheeler, 2009).

The second interviews took place at approximately two years and six months after the first interview this was because during this time the NMC (2008a) had changed the rules on mentorship training. The training now has to take place one year post qualification whereas previously it had been six months (NMC, 2008a). I had contacted the participants after a year by letter, asking them to indicate if they were qualified mentors yet. Holland et al. (2006) recommends this continued communication with the participants for longitudinal studies. The responses indicated that it was too soon for the second interview, because none of the participants had undertaken the mentorship training. Participants were then contacted again by phone, some six months later, at which stage one declined to

participate in the second interview due to time constraints, although she did not wish to withdraw completely from the study.

These second interviews were much more difficult to organize, because once the students had qualified they had migrated geographically and worked for different organizations, and all had professional and personal time constraints (Holland et al., 2006). However, six interviews eventually took place in the participants' own time, because ethical permission (NRES, 2008) had not been sought to conduct the interviews in work time (Johnson and Long, 2010). The seventh interview did not take place. Contact was made with this participant several times and she agreed to participate, but eventually due to communication difficulties and subsequent delays this was not possible. This resulted in data being lost from two participants which Holland et al. (2006) suggest, is quite common in longitudinal studies.

The first interviews took place in a quiet private pre-booked room at the university. This provided a conducive, undisturbed environment (Burns and Grove, 2011). The second interviews took place either in quiet rooms at the participant's place of work, or in the quiet rooms used before at the university. Tod (2010) believes the interviewee will be more relaxed and will be able to concentrate if the interview room is comfortable. The privacy of the interview adhered to the ethical issues of confidentiality (Moule and Goodman, 2009), and allowed the interview to take place without interruption (Holloway and Wheeler, 2010). Gray (2009) stipulates the importance of preparation, and the interviewer made sure that an independent person was available during and after each interview to support the interviewee if for some reason the participant became distressed, and the interview had to be stopped, thus fulfilling the ethical criteria (DH, 2005, Research Governance Framework). This consistency of the research process was transparent to the participants (Polit and Beck, 2014) to enhance the trustworthiness of the study (Guba and Lincoln, 1989, see 4.5 for details). It is important to note here, that all the interviews concluded without incident. There were no disturbances or interruptions, and there was no identified need to stop

any of the interviews or ask for the support of the independent person (NRES, 2008).

All interviews were digitally recorded to capture the verbatim dialogue, enhancing the accuracy of what was said (Bryman, 2008). The expensive equipment was checked and prepared before each interview, to prevent errors (Gray, 2009). The room being quiet helped to record the interview clearly, and lapel microphones were used, to give a better quality of sound (Holloway and Wheeler, 2010). The interviewees were identified primarily (e.g. participant 1) to maintain confidentiality (Tod, 2010). In the interview room were the participant information sheet the interviewee's consent form, and a note pad that was used to take notes (to capture non verbal communication). For the second interviews the researcher had brought the participants' first transcript (Morse, 2000).

After welcoming the interviewee into the room, the participant information sheet and consent form were reviewed with the participant as deemed appropriate by DH (2005).

At this stage it was also explained that some notes were going to be taken, to capture perhaps non-verbal nuances that would not be accessible from the recordings, as Tod (2010) recommends. Bryman (2008) argues that taking notes can supplement the recorded dialogue, and increase the accuracy of the study. Tod (2010) also suggests that interviewers need to be aware of how the participant responds to the note taking, as this activity can distract cohesion in the interview, in regards to the development of the interpersonal relationship, because the interviewer's concern with writing notes could denote to the interviewee a lack of interest in the dialogue. Very few notes were taken at any interview, because I became attentively absorbed in the interview itself and the ascribed meanings being discussed. Also, losing eye contact to make notes seemed rude, and when eye contact was lost the participant appeared to hesitate, and lose their thread (Holloway and Todres, 2010).

I initiated the process of setting up and turning on the digital recorder, and did a sound check, as Gray (2009) suggests, it was surprising how at first this process created an almost anxious embarrassment for the interviewees and I was

concerned if the presence of the recorder would affect the process, as Gray (2009) warned. However, these first few awkward moments soon passed, and the interview proceeded. These first discussions with the interviewees as discussed above are part of the process of establishing a rapport (Tod, 2010). Building a rapport can be an ambiguous process and it is a prerequisite of the skilled interviewer. Too much rapport and the interviewer can become a therapist, too little may result in a minimal or superficial response (Tod, 2010). Conducting and managing the actual interviews also needed to be planned (Burns and Grove, 2009). This included, making sure that actual questions were generated from the aims and focus of the study. Crotty (1996, p.20) believes that a phenomenological semi-structured interview has very 'few predetermined questions', and that to elicit data only one question is needed. However to allow for spontaneity, flexibility and clarification, the interview schedule for the first interview referred to four open-ended questions; and for the second interview there were five questions (see appendix, VIII), plus reference was made to the original transcripts. The interview schedules and the use of the transcripts had been approved by the research supervisors.

Crotty (1996, p.21) also suggests that in true phenomenological research the dialogue should be circular, or even Socratic:

"*The dialogue tends to be circular rather than linear; the descriptive questions employed flow from the course of the dialogue and not from a predetermined path. The interview is intended to yield a conversation, not a question/answer session.*"

The interviewer not only has to conduct the interview, but conduct themselves. The interview itself is an 'existential interaction' (Munhall, 2012), and I was searching for the meaning of the human experience (the phenomenon). My previous training and experience as a mental health nurse and therapist enabled me to attempt to put aside supposition and preconceived ideas, and allow myself to come into interaction from a position of not knowing (Munhall, 2012). I have

75

had no formal interview training, although all the PhD training was completed, including interviewing**.** Although I have little research interview experience, I have much experience of interviewing patients with mental health problems and my training as a nurse and therapist ensured that I learned how to let the patient tell their own story, from their viewpoint (Barker, 2009), without me contaminating it, by making judgements based on preconceived ideas. However, Holloway and Wheeler (2010) suggest these professional skills do have commonalities: they caution the researcher in regards to being aware of the difference between the aims; the researcher's aim is to gather meanings, and the therapist's to heal.

I tried to ensure that the questions were more like open statements and to not impose my own understanding onto the interviewee (Crotty, 1996). I attempted to reflect during the process, to consider what I was saying before expressing the words. I was aware that the language itself could constrain the interaction (Munhall, 2012). Reflection was helpful (Johns, 2009) because at times I offered leading questions rather than open questions. I shared these mistakes and re-formed the question (Crotty, 1996). These skills are about respect and sensitivity and the success of the interview was very much dependent on the skill and deportment of the interviewer, making sure the questions were open, unbiased and not linear:

For example, extracts from the interviews:

Interviewer: '*Can you tell me your opinions about mentoring in practice*?'

The interviewer checked out rather than imposed e.g.:

Interviewer: '*So I guess what you're saying is, it is better if you have an idea of how they work.*'

As Munhall (2012) suggests there was an emphasis on the feelings and perceptions of the individual:

Interviewer: '*What was it like, the transition from being a student to being qualified? I wonder if you could say a little more about that*'.

It was important that I listened and clarified what was being said, this approach is central to phenomenological data collection (Crotty, 1996), also attentiveness, active listening, reflective silences and frequent non-verbal or minimal cues

(Holloway and Wheeler, 2010; and Tod, 2010). Prompts encourage a balance in the questioning process, and the researcher should in fact say as little as possible (Tod, 2010). The focus is on the interviewee and encouraging them to share their perceptions, meanings and feelings about mentoring, for example:

Interviewer: 'W*hat do you think is good about mentorship?*'

The relationship between the interviewer and interviewee is an intersubjective process of co-constructing meanings about the essence of being and becoming (Munhall, 2012). It is a participation of subjective experience of the phenomenon, and these very important issues will be explored in the results, discussion and conclusion chapters. Inter-subjective experience benefits both subjects: for the researcher, it yields knowledge, for the interviewee it is an arena where their thoughts and feelings are heard respectfully (Holloway and Wheeler, 2010).

Interviewing the same participant more than once can enhance the process because a relationship has already been established (Munhall, 2012). The length of time the interview takes is dependent on the topic, the interviewees and the methodological approach (Holloway and Wheeler, 2010). Phenomenological interviews usually focus on specific phenomena and are not concerned with 'extraneous issues'. Due to the nature of this type of interview and the focus on feelings, meaning and perceptions, subjective experience (Crotty, 1996) can make the interviews shorter in duration. Each interview in the first data collection was no longer than 30 minutes. The second interviews were much longer lasting up to 60 minutes. Each interview came to a natural close as recommended by Denscombe (2003), and rich deep data was presented. On reflection, I wonder if the participants were more forthcoming because this was their second interview experience with me (Munhall, 2012). However, what was revealed in the data was that the transitional process produced much more dialogue (Munhall, 2012). Further issues relating to quality will be discussed in section 4.5., of this chapter. Here the survey will be discussed next.

4.3. <u>Stage two: The survey</u>

4.3.1. <u>Aim, design and administration of the survey</u>

The aim (see aims, 1.1.) of this survey was to:

Aim 1: Explore how the role of the mentor affects the training of student mental health nurses in clinical practice.

A mainly qualitative open ended survey questionnaire (Bryman, 2008) was used as this would elicit more data relevant to the above aim of the study and because it was impractical to interview live mentors, due to time constraints (Moule and Goodman, 2009). Surveys can provide data on behaviour in clinical practice and can highlight 'where evidence based action needs to be introduced' (Holland and Rees (2010, p.118). The literature review produced evidence which suggested that the practice of mentoring needs to change.

This form of data collection was therefore relevant to the study and the questionnaire responses did contribute to the value of the findings, particularly as it was administered at the time of the first interview (Holland and Rees, 2010), and because some of the students interviewed could have been mentored by the mentors in this sample. However, whilst some important points were made by these participants, in hindsight this part of the process has affected the trustworthiness of this methodological approach (Moule and Goodman, 2009), because it was prescribed, linear and was more epistemological than ontological in its method (Munhall, 2012). What cannot be captured from a questionnaire is the conversation which is used as a vehicle to develop an understanding of the meaning of the phenomenon under consideration (Munhall, 2012). Nevertheless these already qualified nurse mentors provided a fortuitous rich insight into the role of the mentor and the training of student nurses (Niedderer, 2007), thus allowing a comparison to be made between the students and qualified mentors (Moule and Goodman, 2009). This method consequently addressed the first aim

of this study (see previous page) and made contemporary comparisons with the first interview in the findings and discussion chapters.

4.3.2. <u>Survey approach</u>

The survey provided a snapshot of mentoring (Holland and Rees, 2010) and gathered relevant qualitative data. Gray (2009) suggests that this survey could be compared to descriptive surveys which tend to use open-ended questions to gather data about individual's views or perceptions. McKenna et al. (2010, p. 216) believes that the one of aims of surveys is to understand 'what exists'. However, Holland and Rees (2010, P. 118) suggest that descriptive surveys can be useful when change is implicated, because they can establish the 'nature of the problem', Munhall (2012) does believe that using different data collection methods can enable the researcher to compare and contrast the data.

Gray (2009) suggests that there are many disadvantages to survey methods, in that the researcher does not know if the answers are always honest, and the answers cannot be verified, while McKenna et al. (2010) proposes that the respondents may just be telling the researcher the answer they think they would like to hear. Jones and Rattray (2010) agree and believe that although descriptive surveys can aim to gather peoples perceptions, this may not always be the truth about the clinical environment. Although very large samples can be targeted (Burns and Grove, 2011) completion and return cannot be guaranteed, and surveys often have a very low response rate, thus the researcher may not have a representation of the sample (Burns and Grove, 2011). However, Jones and Rattray (2010) point out that surveys are convenient can collect a lot of data quickly and are not affected by researcher bias. Thus the purpose of this strand of data collection was to target a large population than would otherwise have been possible in order to gather data about their experiences and role as mentor, (study aim 1, see section, 4.3.1.).

4.3.3. <u>Survey: sampling</u>

The chosen sampling strategy for the survey was necessarily non-probability based and the sample framework used was purposive (Bryman, 2008). The strength of this sampling method in meeting the methodological criteria (Moule and Goodman, 2009) is that the potential participants are judged to have valuable knowledge and experience about mental health nurse training, specifically being a student, mental health nurse and mentor. The participants also provided an understanding of the social mores of nurse mentorship in which nurse's move during their careers.

The participants were live mentors, that is, practising qualified mental health nurses who had completed extra mentorship training and had received an annual live mentors' update (NMC, 2008a, Standards to Support Learning and Assessment in Practice SLAiP). The sample had varying degrees of experience and knowledge about mentoring in practice (Gray, 2009). Variance of experience can enhance the 'special knowledge' participants can give a research study (Holloway and Wheeler, 2010). The exclusion criteria (Burns and Grove, 2011) were staff on another part of the NMC registers, e.g. adult nurses, unqualified staff, and professionals who were not nurses e.g. doctors. Only one mental health trust was approached due to the time limitations on this study, this rational which is acceptable according to Holloway and Wheeler (2010). The volume of qualitative data returned for analysis was subsequent (Holland and Rees, 2010).

4.3.4. <u>Survey: data collection</u>

The postal surveys (see appendix, VI) an invitation letter (see appendix, VII), and the participant information sheet (see appendix, V), were sent out initially through internal mail, by a trust administrator to preserve anonymity (NRES, 2008) in 2010 to 270 mental health nurse mentors. The follow-up reminder was sent four weeks later again by the Trust administrator via the e-mail. E-mail was used

because McKenna et al. (2010) believe using different methods of administration can increase the response rate.

A survey can be designed to elicit factual information about the participants, or subjects that are known to them (Burns and Grove, 2009). However, surveys can also explore the perceptions of the respondents about their beliefs (Gray, 2009) or to understand a subject about which they have experienced knowledge (Burns and Grove, 2010). The design of the questionnaire can have a list of closed pre-coded questions, or open ended questions that have space for a written response (McKenna et al., 2010). Or it can be a combination of the two. However, the design of the survey must be a reflection of the research question (Jones and Rattray, 2010). The survey designed for this study used a combination of open and closed questions (see appendix, VI). Seven out of the 12 questions were open questions, and there were five closed questions.

The design of the questionnaire was influenced by the research subject, and aim one (see section, 4.3.1.) of this study (Davies, 2007), the length of the questionnaire and the nature of the questions was guided by the theoretical framework. McKenna et al. (2010) suggests that in order to increase the response rate the questionnaire should be 4-6 pages long. Taking this into consideration, the questionnaire designed for this study was less than three pages long (Bryman, 2008). Also the actual questions needed to be comprehensible and unambiguous, making them user-friendly and easy to read (McKenna et al., 2010). Because as Jones and Rattray (2010) suggest, the respondents will not be able to ask clarification questions and the researcher will also not be aware of the accuracy of the responses, both these issues affect the validity and quality of the responses. This questionnaire (see appendix, VI) was scrutinized by the researchers' supervisors, and then revised. The questionnaire was then piloted with 12 mental health nurse lecturers to check for validity (McKenna et al., 2010), and style, presentation, ambiguity, format and clarity (Gray, 2009). The pilot was also undertaken to ensure the questions were not irrelevant, thus checking the validity (Gerrish and Lacey, 2010). The questionnaire following the pilot was revised (see section, 4.5.2.).

Three closed questions opened the questionnaire, primarily to initiate a response through easy-to-answer questions (see, appendix, VI). Ultimately the purpose of these questions was to ensure the correct target sample had been reached, that is, live mentors (these were questions, 1 and 3), while question 2 gave the researcher insight into the varying experience the respondent had had in mentoring (NMC, 2008a). Questions 5 and 6 then asked a closed question about the effectiveness of mentoring. The rationale for this was to collect statistical evidence on this subject, which would then be compared and contrasted with the last seven open questions (Jones and Rattray, 2010). The open questions elicited more detailed data from the respondents about their perceptions of mentoring (Moule and Goodman, 2009). The detailed mentor response was surprising but welcome. Presumably these participants felt freer to express contentious opinions because the questionnaires were anonymous and the researcher was absent (Burns and Grove, 2009).

I did not experience any anticipated problems whilst reading the responses (Gray, 2009). However, some questions were potentially leading, rather than neutral, and focused on the effectiveness of mentoring rather than mentorship itself and this may have affected the rigour of the survey (Munhall, 2012), (see section, 4.5.).

Another disadvantage with a postal questionnaire is the response rate, which is usually low unless the respondents are tempted by rewards (Gray, 2009). The response rate for this survey, even following a reminder, was 63 out of a possible 270 giving just 23.5%. This is low and affects the reliability of representation (LoBiondo-wood and Haber, 2010). It can be justified to a certain extent due detailed responses to the qualitative questions, which were very extensive and specific (Lacey, 2010). Holloway and Wheeler (2010) and Lacey (2010) all suggest that sample size will differ and it is the quality of the data that is important, and the depth of detail given from those who did respond was very good. This will be presented in the findings and discussion section (see, chapters five and six). Time had been saved in gathering the data, and ethically the respondents' anonymity has been guaranteed (NRES, 2008; Bryman, 2008).

Furthermore, from the closed questions it was evident that these participants had varying degrees of experience about being a mentor (Holloway and Wheeler, 2010). This variance enhanced the unique knowledge that these participants brought to this study through their written responses (Burns and Grove, 2009). The qualitative data collected from this survey was analysed using the same phenomenological method as the interviews and will be presented in section 4.3. The statistical analysis of the closed questions will now be presented.

4.3.5. <u>Data analysis of the closed survey questions</u>

It is important to note for transparency purposes that the five closed questions in the questionnaire were analysed using SPSS (version, 12) and each answer from each question was typed into the data base. Data was also cross referenced to try to add 'scope to the findings' Moule and Goodman (2009, p.281); e.g. length of time mentoring was cross referenced with effectiveness of mentoring system. These results did not raise any broader issues and it was decided that the data had no significant value (Jones and Rattray, 2010) in terms of adding meaning to the findings or the aims of this study, and therefore with the agreement of the supervisors the results were not included in findings chapter of this study (see, appendix XIII, for results from the closed questions).

4.4. <u>Data analysis of the interviews and the qualitative data from the survey</u>

The experience of the individual is where the inquiry starts; the information that was gathered is not separate but interrelated. Todres and Holloway (2010) suggest that deeper insight about the lifeworld/lived experience is analysed through the individual's everyday experience. This generates insights between individual cases, and new discovery of meanings is often found in the 'detail' of each case and across cases, *"revealing the essential meaning of the phenomenon under study" (*De Castro, 2003, p.46).

This data analysis was complex and challenging not just because of volume of data to be analysed, but the type of data, and the most important aspect of this data analysis was to accurately interpret the hermeneutic meaning. In order to allow the categories to arise from the data without the researcher imposing their own interpretations; the researcher needs to be immersed in the data (Crotty, 1996). This is done through 'reflection on the data', that is the whole text, re-reviewing certain details within their context (Todres and Holloway, 2010). This will then enable common themes to emerge from 'meaning units'. There is, in phenomenological research, a fine line between interpreting the phenomena objectively and subjectively, and it is the researcher's subjectivity that affects the analysis of the data (Davis, 1991). The emphasis is on the reflexivity of the researcher, who through the reflective process understands and makes transparent what impact the researcher has had on this study (Crotty, 1996) (see section, 4.5.). The researcher's own social identity (Lathlean, 2010), their own lived experience and their own conscious meanings about mentorship independently or as a whole can affect neutrality, and bias aspects of the analysis of the essential meaning of the data (Gray, 2009).

"*The danger of imposing interpretations on the data is ever present. For this reason, some of the data analysis systems have inbuilt precautions. One such precaution is to have other people review the process….to check out the categorisations and interpretations. Another precaution lies in returning, perhaps more than once, to the data and to the participants to check the validity of the interpretations*" (Crotty, 1996, p.23).

Many academic writers on phenomenological analysis (Crotty, 1996; Todres and Holloway, 2010; Holloway and Wheeler, 2010) recommend similar methodological techniques, for example Van Kaam (1966), Colaizzi (1978) and Giorgi's (1985) stepped approaches. However, these three approaches are from the 'Duquesne school' of phenomenology (Holloway and Wheeler, 2010, p.219). The structure is on the eidetic and mainly focuses on description of the 'meaning

of an experience' by identifying 'essential themes'. Hycer (1985) and Munhall (2012) criticize these approaches because they are too focused on the process. In fact Munhall (2012) suggests that following a prescribed method in phenomenological research can blinker the researcher from seeing the unforeseen, which is Being-in-the-world, because it is largely unknown at the commencement of a study and only reveals itself, if the researcher can 'liberate' themselves from a rigorous method.

Other methods recommended for data analysis are from the 'Dutch school', such as Van Manen (2006). Van Manen's (2006) focus is on a combination of interpretation and description. Again the aim is the same as the Duquesne school, that is to 'grasp the essential meaning of the experience' (Polit and Beck, 2008, p.519). However, Van Manen's (2006) phenomenological approach clearly focuses on the writing of the results and the presentation of the essential meanings of the lived experience. Van Manen's approach is similar to Gadamer's (2004), regarding the importance of the process of writing the interpretation of the lifeworld experiences, and it is the writing up of the research that provides the insight according to Gadamer (2004).

"Qualitative writing may be seen as an active struggle for understanding and recognition of the lived meanings of the lifeworld, and this writing also possesses passive and receptive rhetoric dimensions. It requires that we be attentive to other voices, to the subtle significations in the way that things and others speak to us. In part, this is achieved through contact with the words of others. These words need to touch us, guide us, stir us" (Van Manen, 2006, p.713).

All methods of data analysis for phenomenological studies tend to overlap and have similarities (Holloway and Wheeler, 2010). Each approach has different stages. However, in the main whichever method is chosen by the researcher it is often adapted or methods are fused, meaning that the analysis method is never rigidly followed (Crotty, 1996).

Data analysis should be a rigorous and transparent process and section 4.4., will explore how that rigour was undertaken through the transparency of the dialogue. The complexity of the process of analysis of the data (Groenewald, 2004) has been highlighted through the previous discussions, although the process followed the precautions described by Crotty (1996). Part of the process of transparency is honesty, and there are no certain guarantees that the researcher has been completely neutral, or that the essential meanings have not been tainted in any way (Gray 2009). The next section discusses how the data from the interviews and questionnaire were analysed.

4.4.1. <u>Analysis of the interview data:</u>

The interview data (the digital recordings) were listened to and transcribed. After transcription all eight recordings from the first interview, and the six from the second interview, were listened to again and each transcript was read through to check for errors as Lathlean (2010) suggests. This allowed the researcher to become immersed in the data, and note any inferences, 'subtle significations' (Van Manen, 2006), or pauses, and ensured every single word had been documented correctly. It also allowed me to grasp a sense of the whole. This is part of the holistic process of phenomenological analysis, focuses on what Holloway and Wheeler (2010) term the 'gestalt' (or the whole). The transcripts were then returned to the participants for verification (Gray, 2009). This ensured that it was not an interpretation of what was said (Crotty, 1996) but a true account of the process. This validates the genuineness and exposes the consistency of the method (Gray, 2009). However only 50% of the transcripts were returned verified, which possibly could affect credibility (Guba and Lincoln, 1989, see section, 4.5.).

These initial phases followed Van Manen's (1990) holistic approach, and while the recordings were being heard and the transcripts read, meanings were captured. For this process to be effective the transcripts and the recordings were read and listened to concurrently, because capturing the essence of meaning

and selecting the essences (participants' statements) for extraction are best undertaken by the researcher through multi-sensory immersion in the data. This Parse (2006) terms 'extraction synthesis':

"Extraction-synthesis is the process of drawing out the essences of the participants descriptions of lived experience through dwelling with each (recording) description, while immersed in the (participant's transcribed) dialogue" (Welch, 2007, p.268).

Whilst immersed in the data, I concentrated on the material and then began the process of 'extraction-synthesis' (Parse, 1990) or as, Van Manen (2006) termed it, the 'selective approach'. I searched for remarks, expressions or statements that appear important to the 'lived experience'. To ensure this was a seamless process it was necessary to dwell in the material, reading every sentence (Van Manen 2006), going backwards and forwards in order to arrive at a 'structural formulation of the phenomenon under study' (Welch, 2007, p.268). Thus, I began to select essences, (Parse, 2006). These were written carefully (Van Manen, 2006) in the participant's own voice. These selected essences are the participants' core perceived lifeworld views about the phenomena being studied (Parse, 2006), that is, mentorship. An example of an essence from Sal (pseudonym) in her own voice, about her views on the current mentoring system:

"I don't think it is very clear, I've had really good mentors, and some that just, leave me on my own on the ward all day, to sit in the office all day, there's no clear structure to the way they work….they're not very good at keeping to the theme of it" (Sal).

Following this process I began to identify themes, which are termed core essences in this study (Van Manen, 2006). Parse (2006) argues that such interpretation of the selected essence involves the 'core concept' (core essence in the results), which should be identified in the results as the researcher's own

conceptualized ideas, and acknowledged that this is written in the researcher's own language, not that of the participant. As the selection process progressed, I began to identify core essences and my own conceptual ideas formed titles of core essences. Parse (2006) refers to this as 'language art', an 'artistic expression', which is a process of integrating the essences into 'human becoming theory' Welch (2007).

For Parse (2006) artistic expression is:

"*A personal rendering or choosing by the researcher of an art form. It incarnates the transfiguring moments for the researcher as the structure of the lived experience surfaced through the research process"* (Welch, 2007, p.268).

The data was then colour coded according to the chosen core essences, and the data synthesized from each participant's transcript (still in the participant's own voice) into core concepts, using the colour to aid the process, Parse termed this 'synthesizing essences':

"…*a synthesized essence is an expression of the core idea of the extracted essence conceptualized by the researcher"* (Parse, 2006 in Burns and Grove, 2009, p.531).

I then repeated this process with every interview transcript and recording, by '*extracting-synthesizing core concepts from the language art of all the participants'* (Parse, 2006, p.52). This was a lengthy, thought-provoking and detailed process. The findings of the analysis are in the next chapter 5.

The research then had two data sets (first and second interviews) of synthesized essences within two core concepts.

The first interviews produced 22,548 words, and were synthesized into two core concepts, which contained separate core essences:

4.4.2. Table 2: First interviews, core concepts and core essences

	Core concept	Core concept
	Contextual issues	**Mentoring issues**
Core essences	Effective mentoring	Issues in mentoring
	Ineffective mentoring	Time to mentor
	Experience of mentoring	Mentors role
	Student responsibilities	Sustaining improving the process
	Coping with anxiety	

The second interviews produced 43,907 words and were synthesized into three core concepts, which also contained separate core essences; the first two concepts were the same as the first interviews.

4.4.3. Table 3: Second interviews core concepts and core essences

	Core concept	Core concept	Core concept
	Contextual issues	**Mentoring issues**	**Concept of transition**
Core essences	Effective mentoring	Mentoring issues	Becoming a qualified mental health nurse
	Student responsibilities	Views on mentoring	Period of preceptorship
	How to improve mentoring	Barriers to mentoring	Developing a sense of self as a qualified nurse
			Learning from

			experience
			Becoming a mentor
			How to sustain and improve mentoring

However, the final synthesis combined the second interview data into one core concept for the results chapter that is - 'concept of transition' - because the core essences from contextual issues and mentoring issues were discussed in each core essence in the concept of transition.

4.4.4. Table 4: Second interviews final core concept and core essences

	Core concept
	Concept of transition
Core essences	Becoming a qualified mental health nurse
	Period of preceptorship
	Developing a sense of self as a qualified nurse
	Learning from experience
	Becoming a mentor
	How to sustain and improve mentoring

4.4.5. Data analysis of the qualitative data from the questionnaire

The selection process was again repeated with the seven qualitative questions (questions 7-12, see appendix, VI), in the 63 returned questionnaires

However, before the selection and synthesizing (Parse, 2006) process began each questionnaire was numbered. The text was then typed word for word and the essences were placed under sub-headings related to the context of the comments: the mentor, the student, general issues, practice area and improvement. The selected data was then read and crossed referenced from the questionnaires in order to check for error Lathlean (2010). I became immersed in the data while at the same time checking for accuracy; sub headings were also reviewed. This data was still in the participant's own words. The process of selection synthesis was then undertaken, and again written mostly in the participant's own words (Van Manen, 2006).

The data collection from the questionnaires produced 6,438 words and presented in two core concepts:

4.4.6. Table 5: The qualitative analysis from the questionnaire

	Core concept	**Core concept**
	The quality of the mentor	**Mentoring issues**
Core essences		
	The mentors role	Student responsibilities
	Effective mentoring	Improving/sustaining the mentoring process
	Ineffective mentoring	Time to mentor
	Experience of mentoring	

4.4.7. Final analysis

The essences from the first and second interviews were compared along with the essences from the qualitative component of the questionnaire, and the lived experience began to emerge. The next stage involved all the qualitative findings, which were then interpreted (Parse, 2006), but using many carefully chosen quotes to indicate the participants' personal perceptions (Holloway and Wheeler, 2010) into the procedure of analysis. Many of the quotes presented the meaning of the text without interpretation being needed, as Van Manen (2006) said it should do. Colour coding was used to aid this process. The text was highlighted when it was transferred to the findings chapter to ensure the same text was not used twice. With so much data the system had to be efficient and transparent (Todres and Holloway, 2010).

The research then had two core concepts (see below for explanation) which will be presented in two parts in the findings (chapter Five). The findings chapter connects and interweaves the selected material in order to present to the reader an essential meaning of mentorship from the textural temporal transformations ascribed by the participants:

"*Heuristic interpretation is weaving the structure (the findings of the study) with the principals of human becoming and beyond to enhance knowledge and create ideas for further research*" (Parse, 2006, p.52).

The first part of the process of the data analysis was guided by Van Manen's (2006) holistic approach and Parse's (2006) phenomenological theory method of data analysis. This enabled the researcher to extract and synthesize essences which were part of the whole hermeneutic lifeworld (Schleiermacher, 1768-1834 cited in Cuddon, 1991). Furthermore, the synthesized essences produced a deeper understanding of the nature and meaning of the participants' lived experience of mentoring, which was both temporal and spatial (Van Manen, 1990).

92

Whilst the previous process of analysis could read to some critics as linear, and not itself a true analysis of phenomenology because it does not really reveal the phenomena, I would challenge that. It gives to the research a portrait of what the meaning of the experience of mentoring was at the time to those who participated; a part of the whole, and a part of the 'organic relationship' to each other in regards to the whole (Cuddon, 1991). This analysis is the understanding of Dasein (there-Being) itself, involving different relations of 'Being-in-the-world' (Crotty, 1996). On reflection I now realize that without the initial analysis and immersion, the phenomena would not have revealed itself in such a significant manner.

An explanation of the two parts of the analysis follows:
Part one: **The conceptual elements of mentoring**

This title has combined the core concepts - contextual issues, the quality of the mentor and mentoring issues - from the data from the students' interviews and the qualified mentors' qualitative questionnaires, into one core concept for this part of the analysis. The findings will be presented in the next chapter. Thus part one will present the selected synthesized data from qualified mentors and the data from the students in the first interview, because these data sets were collected during the same timeframe, and the students and mentors in these collections could have been mentor and mentee in clinical practice. Furthermore, an aim of this study was to make a comparison of the qualified mentors' views, with the students' views of mentoring in clinical practice (see aim 1, 4.3.1.). Part one has been synthesized into one core concept, 'the conceptual elements of mentoring', which incorporates the core essences from these data sets.

The only core essence that was not common to both data sets was 'coping with anxiety'; this was only mentioned briefly by the qualified mentors. The common core essences or themes from each data collection formed the subheadings in the results.

Part two: The concept of transition

The core essences from the second interview were named concepts of transition. Whilst part one of the findings in the next chapter will present results of the fundamental perceptions of the mentoring process, the concept of transition is the pivotal concept of the actual research question, that is, the 'shifting perceptions of mentoring in mental health nursing'. Again the core essences formed the subheadings.

4.5. Establishing quality and trustworthiness

According to Holloway (2008) every qualitative study is 'unique', and each researcher brings a unique quality to each study. This section presents the ways in which the quality or the true value of this study was established, and also how the trustworthiness was compromised at times (Holloway and Wheeler, 2010). It is very difficult to completely eliminate researcher bias in a qualitative study (Holland and Rees 2010). The following discussions will therefore consider how the study adhered wherever possible to making the study rigorous and transparent, in order to demonstrate 'credibility, dependability, conformability and transferability' (Lincoln and Guba, 1985). This criterion of 'authenticity and trustworthiness' was chosen as opposed to other criteria such as validity, because judging the quality of a study is often variable (Moule and Goodman, 2009). The method appeared more appropriate for judging the quality in this phenomenological study, as it incorporates the criterion of rigour, and the aim of this process was to demonstrate that the participants experience was reflected in the interpretations and conclusions of the study

4.5.1. Stage 1: Interviews

Bryman (2008) clearly identifies the need for ethical transparency from the researcher, in the attention given to and presented about the sampling methods used. Purposive sampling was selected and for this phenomenological study, in that the sample had been selected with a 'specific purpose in mind' (Denscombe, 2003, p.15). The exclusion and inclusion criteria and method of sampling was transparent (LoBiondo-Wood and Haber, 2010) eliminating any coercion (Holloway, 2008).

The participants recruited through purposive sampling were willing to share their perceptions (see consent form appendix, III) about their own lived reality (Holloway and Wheeler, 2010) and consequently this helped to produce a much deeper focus as suggested by Moule and Goodman (2009). The process of recruitment through the independent administrator (NRES, 2008) also prevented coercion, in that the participants did not feel obligated to take part because the researcher had directly asked them to (LoBiondo-Wood and Haber, 2010). Eight students participated in the first set of interviews, six in the second set, which according to Morse (2000) is a sufficient cohort. Holloway (2008) suggests that phenomenological studies use low numbers of participants because it is the essence which is being searched for, thus the number of participants who were included appears justified adding to the trustworthiness of the study (Moule and Goodman, 2009).

However, it was important to take into account that these participants may have agreed to participate so they could express or project their frustrations (Holloway and Wheeler, 2010) about any aspect of their training or present views which were influenced by the culture of the learning environment.

  The data collection used semi-structured interviews because more structured methods are too rigid in phenomenological research (Crotty, 1996) and because this study was interested in the meaning attached to the phenomenon (De Witt, 2006). Furthermore semi-structured interviews allow space for clarity about meaning to be achieved (Bryman, 2008), thus confirming as far as possible that

this was a true account as it was told (Holloway, 2008). The use of semi-structured interviews therefore also increased the trustworthiness of the study (Burns and Grove, 2011). As noted earlier, one participant from the first interview did not consent (Tod, 2010) to the second interview, but did not wish to withdraw from the study (NRES, 2008), thus the first interview data remained in the study. Another participant from the first interview did not participate in the second due to contact issues (see section, 4.1.5.). Holland et al. (2006) believes it is common to lose participants during a longitudinal study. However, what could have affected the credibility of this study is that these participants were passionate enough about mentoring and mental health nurse training, and this could have biased the study, because other, less passionate students may have presented a less consistent, or even a more critical response (Moule and Goodman, 2009). However, this is not an essential issue in a qualitative study (Holloway and Wheeler, 2010), and all methods attempting to understand the philosophical meaning of existence are flawed in this respect. The study may have produced very different results, though, if the participants were not so concerned about nurse education. However, the fact that three-quarters returned to complete the second interview indicates that the interviews were conducted professionally (Holland et al., 2006), and that the study was not just a platform for projection, but a vehicle they felt could instigate change in a system, which they told me needs improving.

The interviews were arranged following the return of the consent form (see appendix III) in the pre paid envelope which followed ethical guidelines (DH, 2005). They took place in a quiet room maintaining confidentiality. The first task of the interviewer was to ethically address the purpose and process of the interview, which was done thoroughly but quickly (Gray, 2009). The information and consent forms were verbally explained at each individual interview, and all participants consented to proceed and agreed to the recorder being used, confirming continued consent (Lincoln and Guba, 1985).

These processes guaranteed confidentiality and helped to establish trust and respect (Tod, 2010). Credibility is *"strengthened by using interview techniques*

that build rapport and trust" (Arksey and knight, 1999, in Gray 2009, p.375). The interview process itself was presented as transparently as possible using an audit trail ensuring the study was dependable (see section, 4.2.3.), (Lincoln and Guba, 1985). Trustworthiness can also be limited through the actual interview (Burns and Grove, 2011) and although I have skills as a nurse and therapist my skills at research interviewing were limited and this could therefore have affected the trustworthiness of the study. However this was acknowledged and made transparent during the process and Munhall (2012) suggests that whilst interviewer bias may affect the rigour, it is reasonable because it is acknowledged. Another concern was that the interview itself could cause a 'Hawthorn effect', due to researcher bias, and it was my responsibility to consistently take this into account through the data collection process and especially during the data analysis (Tod, 2010).

Interviewing the same participant more than once can enhance the process because a relationship had already been established (Moule and Goodman, 2009). Munhall (2012) suggests that the participant may also be more reflective and forthcoming in a subsequent interview. I was more relaxed and more reflective during the second interview, and these interviewees presented as more receptive. However, at times I did ask leading questions during both interviews, although reflection (Polit and Beck, 2014) helped to reduce this, as I was able to acknowledge it and reframe the question. Crotty (1996) suggests it is difficult to prevent such presupposition, what is important is to acknowledge it, making the process more credible (Moule and Goodman, 2009). Writing reflective notes during the interviews could have helped analysis of reactions by linking participant's observed behaviour to their statements' (Holloway and Todres, 2010), however, the participants appeared to me to hesitate when eye contact was broken to take notes, thus note taking was stopped.

It was important to listen and hear what was being said, and not attempt to anticipate the response. In this respect, paraphrasing clarified the responses, making sure that I was not fashioning my understanding of the meaning, which could be biased and based on assumption (Munhall, 2012). This open-ended

approach is central to the credibility of phenomenological data collection (Crotty, 1996).

The data was triangulated (Holloway, 2008) through collecting the data over time, adding credibility to the study. Also once qualified the participants had migrated sufficiently for me to gain a rich deep understanding of mentoring from the qualified nurse's perspective (Holland and Rees, 2011). They were also employed by a range of different organizations which added to the rigour. Furthermore Munhall (2012) suggests that participants can be more forthcoming in a second interview.

Crotty's (1996) criticism of phenomenological nursing research is that too often the research is descriptive and a mere symbolic interaction rather than a critical method which "*invites us to revisit our conscious experience and open ourselves to the emergence of new meaning or at least the authentication and renewal of our present meanings*" (Barkway, 2001, p.192*).*

The essential meaning of the experience of the participants was exposed during this study through the constant revisiting of the data during analysis. Barkway (2001) recommends that researchers who use a phenomenological method should ensure that the 'essential phenomenon' is identified. The approach of Crotty (1996, p.174) was followed by revisiting the data many times, leaving subjective preconception behind in order to ensure the 'description is free from extraneous considerations', thus bringing new meaning to life. The data analysis process (see section, 4.4.) was transparent (Gerrish and Lacey, 2010). However, there is a fine line between interpreting the phenomena objectively and subjectively in phenomenological research and it was the researcher's subjectivity which would have affected the analysis of the data. It is important to be open to such criticisms in phenomenological studies (Crotty, 1996).

The data from the interviews was lifted in its original form (in the participants' own words) and placed under headings as essences in the first stage of the analysis. Crotty (1996) suggests that other people or researchers should be involved or be there to check the interpretations the researcher has made as a precaution against imposition. Whilst study supervisors have read the interpretations in the

findings chapter from the earliest drafts, they have not, due to time restraints, read the original transcripts or the early processes. Thus the quality of the process could be open to criticism as Crotty (1996) suggests. However the transparency and consistency (Gray, 2009) in the process has helped to ameliorate this criticism. Nevertheless, it would have increased the credibility of this study if the early processes and the transcripts had been read and reviewed by another researcher. The transcripts were returned to the participants for verification, Crotty (1996) suggests this verifies a true account, but only 50% were returned affecting the trustworthiness of this process (Gerrish and Lacey, 2010). The data analysis process again was clear (see section, 4.4.) and mainly presented in the findings (chapter five) in the first person as Van Manen (2006) recommends, allowing the participants to voice and own their own perceptions (Crotty, 1996), making the process more trustworthy (Holloway, 2008).

4.5.2. **Stage 2: The survey**

Gray (2009) suggests that the design of the questionnaire must take into consideration the research aims. McKenna et al. (2010) suggests that in order to increase the response rate the questionnaire should be a maximum of 4-6 pages long. Taking this into consideration, the questionnaire designed for this study was less than three pages long (Gillham, 2000 in Gray, 2009), with five closed and seven open questions. Also the actual questions needed to be comprehensible and unambiguous, making them user-friendly and easy to read (McKenna et al., 2010). Because the respondents will not be able to ask clarification questions and the researcher will also not be aware of the accuracy of the responses, both these issues affect the trustworthiness and quality of the responses. The questionnaire was scrutinized by the researcher supervisors, and then revised. It was then piloted with 12 mental health nurse lecturers to check for style, presentation, ambiguity, format and clarity (Gray, 2009). The pilot was also undertaken to ensure the questions were not irrelevant, thus checking the validity (Gerrish and Lacey, 2010). Jones and Rattray (2010) believe that the design of

the questionnaire has an impact on the trustworthiness of the responses, which are dependent on the quality of the questionnaire. In this case as a result of the pilot some questions were deemed to be irrelevant, and were deleted. The general format and the sequence of the questions were revised, and the quality and clarity of the questions was improved (Gray, 2009). Then the questionnaire was then finally checked by the research supervisors before going for ethical consideration. The approving ethical bodies (NRES, 2008) did not advise any changes to the questionnaire.

The packs containing the questionnaires, information sheets and stamped addressed envelopes were sent out by a Trust administrator through the internal mail to preserve anonymity (NRES, 2008), while the follow up was sent to all participants via email as multiple methods of reminders can increase the response rate (Jones and Rattray, 2010). However, the questionnaires were sent as an attachment and Bryman (2008) suggests this makes it more complicated to return than an embedded questionnaire in the email.

A potential difficulty with the seven open questions was the legibility of the hand-written replies, and then the sheer amount of data that had to be analysed. I did not experience any anticipated problems whilst reading the responses (Gray, 2009) but, what I did realize was that the linear style of how I worded questions may have restricted some of the meaning (Munhall, 2012). The questions were potentially leading, rather than neutral, and focused on the effectiveness of mentoring rather than mentorship itself. In fact one question was badly worded given that it asked '*have you had an update this year*', which is misleading (Gray, 2009) as it could interpreted only to mean an update in 2010, instead of meaning in the last year, thus establishing they were live and could mentor students (NMC, 2008). It was surprising this was not identified in the pilot study.

Another disadvantage with a postal questionnaire is the response rate, which is usually low unless the respondents are tempted by rewards (Jones and Rattray, 2010). The response rate for this questionnaire, following the reminder, was 63 out of a possible 270 (23.5%), which is rather low and affects the adequacy of representation. However this is offset to a certain extent due by the depth of the

responses in the qualitative questions, which were very extensive and detailed (Lacey, 2010).

The qualitative data was analysed using the same phenomenological approach as the interview data. The data was typed up and proof read for errors (Lathlean, 2010). The analytic process was also transparent (Gray, 2009) and increased the credibility (see section, 4.4.4.). The results from the five closed questions was analysed using SPSS (Version 12) and cross referenced (Bryman, 2008) with the qualitative data, producing no significant findings. As noted earlier with agreement from the supervisors this data was therefore excluded from study.

4.6. <u>Ethical Considerations</u>

'Examining and understanding the complexities of moral life' is a definition of the generic meaning of ethics. However, in research the term 'ethics' means much more. The purpose of ethics in nursing research is to guide the researcher's behaviour towards the subjects involved in a moral and appropriate manner (Gray 2009), so that research process from outset, the planning stage, has at its core a benevolent approach (Beauchamp and Childress, 2009).

The governance of research ethical issues became imperative following the atrocities of World War 2, and the Nuremberg Code was introduced in 1947 regarding the principles of human research. The 10 standards included the right to free will and informed consent (Moule & Goodman, 2009). The Nuremberg Code was replaced in 1964 by the Declaration of Helsinki and adopted by the World Medical Association. The declaration is updated regularly to take into account evolutionary views. The latest version is 2008, and its principles include voluntary informed consent, safeguarding and the well-being of the participants.

Also, in 2005 the Department of Health (DH) formalized the Research Governance Framework for Health and Social Care (RCFHC), which states:

"Proper governance of research is essential to ensure that the public can have confidence in, and benefit from, quality research in health and social care. The

public has a right to expect high scientific, ethical and financial standards, transparent decision making processes, clear allocation of responsibilities and robust monitoring arrangements" (Department of Health, 2005, p.2).

Also in the UK the Economic and Social Research Council (ESRC) (2005) published significant guidelines on ethical principles (Bryman, 2008) which include the quality of the research, conflict of interest, avoidance of harm, confidentiality and voluntary participation.

This qualitative research study gained ethical approval firstly to interview human subjects (mental health student nurses), secondly to interview the same human subjects once they became qualified nurse mentors, and thirdly to send mainly qualitative questionnaires to qualified nurse mentors in the mental health practice areas from the NHS National Research Ethics Service (NRES), (Essex 1 research ethics committee), on 17th November 2008 (see appendix, I).

Ethical governing approval was obtained from one NHS Trust (mental health) in December 2008, and another NHS Trust (mental health) in 2011.

The procedures in regards to the ethical principles of this research study will now be explained. The ethical principles of DH and ESRC (2005) were adhered to. Gray (2009, p.73) suggests that these principles are addressed in four main areas:

"Avoid harm to participants
Ensure informed consent of the participants
Respect the privacy of participants
Avoid the use of deception"

4.6.1. <u>Informed consent</u>

Informed consent is one of the moral and ethical principles proposed by Beauchamp and Childress (2008) it is about respecting autonomy.

According to the Royal College of Nursing (RCN, 2006), the principle of informed consent means that human potential participants have been given 'sufficient' information about what the participating in the study will involve, and the degree of risk and the benefits of the research study, so that they can make a voluntary informed decision about participating. Gray (2009) regards the term 'sufficient' as crucial in regards the information given to the degree of risk involved. The RCN (2006) emphasizes the importance of the ongoing requirement of continued consent, and the participants must be informed of any changes in the study at any stage of the process. This is because the nature of a qualitative inquiry is its flexibility (Holloway and Wheeler, 2010). Any changes in the study also have to go through all ethical governing bodies that approved this study in the first instance. To not fully inform potential participants or to not inform participants of any change is an act of deception (Johnson and Long, 2010) and contravenes the Human Rights Act of 1998.

Informed consent should also include (RCN, 2006) issues on confidentiality, what will happen to the results, the consent form and their right to not participate and to withdraw at any time:

"Informed consent is at the heart of ethical research. Most studies involving individual's must have appropriate arrangements for obtaining consent, and the ethics review process pays particular attention to those arrangements. The law gives special protection to people who are unable to give consent on their own behalf" (The DH 2005, p.7).

Following ethical approval (NRES, 2008), the participant information sheet (see appendix, II) and two copies of the consent form (see appendix, III) and an invitation letter (see appendix, IV) were sent by an approved administrator

(NRES, 2008) to a cohort of third-year mental health nursing students at their home addresses.

It should be noted here that I was not a personal tutor to any of these students. The Declaration of Helsinki (2008) makes it clear that dependent relationships can affect the ability to give autonomous informed consent, and can cause 'duress' to the potential participant, and a personal tutor could be considered a dependent relationship. Furthermore, Holloway and Wheeler (2010) believe that interviewing someone who is dependent for other reasons on the researcher is unethical and creates a biased power imbalance.

Continued consent (RCN, 2006) was very pertinent to this part of the study, because those who consented agreed to take part in both interview stages (in the first instance as mental health student nurses, and secondly once they became qualified nurses and mentors). These students were deemed capable of making informed consent in accordance with the Mental Capacity Act (2005) because they were studying on a graduate programme (NRES, 2008). The consent form and participant information sheet were shown to each participant at the beginning of every interview to ensure consent was informed and the decision to participant was made autonomously (Johnson and Long, 2010).

The third part of the research process relating to informed consent involved sending questionnaires to qualified mental health nurse mentors in the practice area. The anonymous questionnaire (see appendix, VI) was sent with an invitation letter (see appendix, VII) and a participant information sheet (see appendix, V). Informed consent was assumed when the completed questionnaires were returned.

The veracity (Holloway and Wheeler, 2010) of the information sent to the all the potential participants was imperative to ensure an accurate and comprehensive account of what would be involved in participation (Schneider, 2006), and the benefits of the research itself, in regards to Beauchamp and Childress's (2009) principle of *Beneficence*. The following discussions will present how this was achieved in each stage of informed consent and the research process itself.

4.6.2. <u>Confidentiality and anonymity</u>

Privacy is a connective component of confidentiality and both are associated with the principle of autonomy (Beauchamp and Childress, 2009). Researchers have a duty to respect the privacy of the research participants, because it is their right in a democratic society (Gray, 2009).
The Declaration of Helsinki (World Medical Association, WMA, 2008, p.3) states:

"Every precaution must be taken to protect the privacy of the research subjects and the confidentiality of their personal information and to minimize the impact of the study on their physical, mental and social integrity."

The right to privacy is linked closely to informed consent according to Bryman (2008), and the freedom to withdraw that consent at any time (Gerrish and Lacey, 2010). Participants should have the autonomy to refuse to answer any questions they may find invasive or intrusive (Gray, 2009). It is the researcher's responsibility (Bryman, 2008) to ensure that it is made very clear to the participants that their participation is voluntary.
For the participants who volunteered to be interviewed, the informed consent information was transparent (Gray, 2009), clear and understandable. These issues of privacy were addressed in section B. 2 & 3 of the participant information sheet (see appendix, II). The issues of refusal to participate and the right to withdraw from the study were discussed prior to each interview. No participant withdrew, no personal information was discussed during the interviews, and no question was refused (Bryman, 2008), (see interview schedules, 1 & 2 in Appendix, VIII). The questionnaires were completely anonymous and potential participants had the autonomy to complete and return them via Freepost, and if that choice was made then they had the freedom to choose which question they answered (see appendix, VI). These issues were made clear in the information sheet sent with the questionnaire in section B. 2 &

3 (see Appendix, V). A completed questionnaire was taken as informed consent (Bryman, 2008).

The privacy and confidentiality of the participants who were interviewed was also respected through the environment where the interviews were held (Gerrish and Lacey, 2010). The first interviews were conducted in a quiet private room on university premises, and the second interviews took place in either quiet rooms at their place of work premises or in the same quiet rooms at the university; Moule and Goodman (2009) state this is another responsibility of the researcher.

Confidentiality was respected throughout the research process. Holloway and Wheeler (2009) state it is the researcher's responsibility to ensure they adhere to the legal and ethical issues to protect confidentiality, and to ensure that relevant systems are in place in accordance with the Data Protection Act 1998 and the Research Governance Framework for Health and Social Care (DH, 2005).

Confidentiality and anonymity were protected through systems and procedures (Polit and Beck, 2008) for the collection of data from the qualified nurse mentors. The qualitative questionnaires were completely anonymous and this anonymity was clearly explained in the participant information sheet. Although this data was completely anonymous it was imperative, as opined by Gray (2009), that the data was stored securely in accordance with the governing bodies and protecting Acts. The returned questionnaires were stored in a locked filing cabinet, in a locked study at the researcher's home address. All analysed data was stored on a removable hard drive and stored in a separate filling cabinet in the same locked study as approved by NRES (2008). The stringent method of storing the data securely was handled in exactly the same manner for each data set, and the participants were made clearly aware of these systems and how the results would be disseminated, avoiding any deception, in the participant information sheets (Holloway and wheeler, 2010).

For the participants who were interviewed the issues of confidentiality needed to be handled with much more transparency and sensitivity (Johnson and Long, 2010). Again all issues related to confidentially and dissemination was transparent in the participant information sheet and these issues were again

discussed with each participant before each interview to ensure full comprehension of the issues (Denscombe, 2003). The participants were informed that all coded personal data would be locked in a filing cabinet and the digital recorder would be locked in a separate cabinet. The transcripts would be coded with a pseudonym, and printed transcripts would be again locked in another filing cabinet. All work done on the personal computer would be saved only on a removable hard drive that would also be locked separately away. These cabinets are in a locked study at the chief investigator's home address. These strict adherences to handling confidential data are in accordance with NRES (2008) and RCN (2006). Full confidentiality is difficult to completely guarantee (Holloway and Wheeler, 2010) because it was made clear to the interviewees and questionnaire participants in the participant information sheet that direct quotes would be used in the results and future publications. Although these would be anonymous and would use a pseudonym e.g. Sal, they could, however, be recognizable.

The participant information sheet (see appendices, II and V) also made it clear to the participants that the digital recordings and returned questionnaires would be destroyed at the end of the study. Under the governance of NRES (2008) it was also made clear to all participants in the information sheet that should malpractice be disclosed this would be reported to the relevant institution.

"Any comments that you make will normally remain anonymous. However should you disclose breaches of professionalism or criminal activity these would have to be reported to those with managerial responsibility for your service" (Participant Information Sheet, 2008).

The above issues relate to protecting the participant's rights, the following discussion will discuss avoidance of harm.

4.6.3. <u>Avoid harm to participants</u>

The principal of nonmaleficence, (Beauchamp and Childress, 2009).

Gray (2009, p.74) suggests that the principle of nonmaleficence is about ensuring the participants come to no physical harm. This risk is not relevant in most social research studies:

"*However, there may be dangers of causing participant's psychological damage, or causing anxiety, stress, embarrassment or loss of self-esteem.*"

Gray (2009) argues that avoiding harm can include simple organizational skills of the researchers, such as ensuring that the scheduled interview is convenient to the interviewee's time and commitments. It also means ensuring that the study is robust enough to achieve results that are meaningful if the researcher fails in this it could be deemed disrespectful to the participant (Bryman, 2008).

It is the researcher's ethical duty according to Denscombe (2003), to take issues of risk into consideration before collecting any data. This was certainly the case in this study, as all systems put into place to avoid harm (safety considerations were documented and presented to all approving bodies (NRES, 2008) and were in accordance with the DH (2005) research governance framework. Bryman, (2008) believes that it not always possible to know all the possible risks that could occur. However, appropriate strategies can certainly work towards an elimination of risk.

For this study, the anonymous questionnaire posed very little risk (Bryman, 2008), and this statement was endorsed by NRES (2008) and the approving governing bodies. However, there could have a potential risk to the interviewees. Therefore systems were put into place prior to the interviews taking place (Denscombe, 2003). Firstly, the interviews were arranged at a convenient time for the interviewee (Gray, 2009) and secondly the interviews took place at university, or on the employer's premises, not at the interviewee or the

interviewers own home. This is to ensure support for either party is available should the need arise (NRES, 2008).

Thirdly, an independent person from a different research team in the faculty agreed to be available during and after the interviews, if the interviewee needed additional support as recommended by DH (2005) in the Research Governance Framework for Health and Social Care. The interviewees at all interviews were aware of these safety systems, which were clearly detailed in the information sheet and again discussed before each interview took place. They were also aware that should the need arise the interview could be stopped at any time and that in the first instance the interviewer would offer support. Harm was avoided and there was no reason encountered to stop any interview at any time. There was also no reason for the nominated independent person to become involved.

It is very important that social research should be ethical (Denscombe, 2003) in the data collection and analysis, and also in the dissemination of the findings:

"Those conducting health and social care research must open their work to critical review through accepted scientific and professional channels" (DH, 2005, p.14).

Finally avoiding deception, it was important as suggested by Beauchamp and Childress (2008) to be honest with the participants and the previous discussions have highlighted this openness, ensuring the participants knew how long the interview would be. Sharing the interview schedule with the participants at the start of each interview (Gray, 2009) so the participant was clear about the content of the discussions. It was important as discussed that the participants had enough information so they were not deceived (Johnson and Long, 2010)

Chapter Five: Findings

The principal data used within this research is drawn from the two sets of interviews with students and the questionnaire responses from mentors. While the latter had a relatively poor response rate (23.5%), the responses (Jones and Rattray, 2010) to the seven open-ended questions in the survey from sixty three mentors were often full and lengthy statements, conveying much of their experience with students and the agencies involved. These responses provide qualitative data from the mentors that would appear to be internally valid, but cannot be considered representative of the population of mentors surveyed (Holloway and Wheeler, 2010).

5.1. Qualitative findings from the first interviews and survey

Analysis of the findings has been organized into two parts. Two sets of synthesized essences under the concept headings (Parse 2006) which are presented in Part One and Two. Part One and Part Two follow a phenomenological process of analysis (Van Manen, 2006; Parse, 2006). Munhall (2012, p.119) suggests that for the meaning of the experience to be revealed, the researcher has to liberate themselves from a prescribed methodology and become open to where 'Being reveals or conceals itself'. The process of selecting essences which Munhall (2012) believes are just reactions to situations, could alone justify the criticism of part one and two of the findings (Crotty, 1996). This may be considered as linear, and is not itself a true analysis of phenomenology. I would challenge that, as it provides the meaning of the experience of mentoring at the time to those who participated; a part of the whole, and a part of the 'organic relationship' to each other in regards to the whole experience of the participants (Cuddon, 1991). It presented an understanding of Dasien (there-Being) itself, involving different relations of 'Being-in-the-world' (Crotty, 1996, and Munhall, 2012).

5.2. Part One of the Findings

The conceptual elements of mentoring (First interviews and qualitative data from the questionnaire)

Core essences:

5.2.1. Experience of mentoring

5.2.2. Coping with anxiety

5.2.3. Student's responsibility

5.2.4. Mentor's role/responsibility

5.2.5. Time to mentor

5.2.6. Sustaining the mentoring role

The core essences of effective and ineffective mentoring are incorporated into all the above.

Each essence is not solitary, but comments and discussions in each subheading interweave with each other creating the texture (Van Manen 2006) about the potency of mentoring. The texture of this core concept will be summarized and considered in the discussion chapter.

Direct quotes from the participants are in italics and the participants are identified as:

- Questionnaire participants: QP1-63
- First interview participants' pseudonyms: Sal, Bea, Pip, Kat, Dee, Jed, Eli and Flo. Second interview participants' pseudonyms Sal, Bea, Pip, Kat, Jed and Eli.

Sal said in the first interview:

"*I think that mentorship can be really good when done properly, as with everything within nursing and life.*"

5.2.1. <u>Experience of mentoring</u>

The following presents an overall view of the participants' perception or lived experience of mentoring. Both mentor and students emphasized the importance of the quality of mentorship in terms of knowledge, experience and enthusiasm for the role.

"*Mentoring is effective in practice, but it depends on the quality of the mentor and also on the ability of the student*" (QP1)

Many of the qualified mentors believed that effective mentoring depends on the attitude, motivation, experience and the quality of the mentor. Some mentors they said are excellent and some are poor. Mentoring is as effective as the individual;

"*The process is as effective as the person mentoring*" (QP3).
"*It depends on the attitude and experience of the mentor*" (QP21).

The comments of the students in the first interview were similar to the qualified mentors. They believed that the attitude and motivation of the mentor affects the mentoring and how effective the process was.

"*When you have a good one* (mentor) *it improves everything 100%, you learn a lot more and you feel a lot more confident" (*Eli).

112

Pip believed that mentoring is dependent on the '*keenness of the mentor*' and Flo said: "*It depends who your mentor is.*" Thus it is as effective as the individual. The students in the first interviews also felt some mentors are poor: Pip thought that mentoring is not dealt with seriously, and Sal believed that some mentors are not very good at adhering to the mentoring role. In Sal's experience some mentors have just left Sal on her own all day, with no clear structure:

> "*and some that just, and leave me on my own on the ward all day, to sit in the office all day , there's no clear structure to the way they work, I've never been reminded about doing my outcomes or anything like tha*t" (Sal).

Sal's view was that these mentors do not seem to have a clear structure in how they work either, and that they have lost sight of what the basic needs are for students. Dee believed that some mentors were 'laid back' and this was very frustrating:

> "*Sometimes you are lost on placement, it can be a big ocean and you don't know where to turn sometimes*" (Dee).

There was a sense of feeling lost because Eli expected the mentor to be a guide. Instead she had to ask the mentor for help which she said was frustrating:

> "*I had to say look I need to do this and this, to meet my learning outcomes, what can you suggest and he would throw it back 'well what do you think?*" (Eli)

Flo also felt frustrated because she had experienced some unsure and anxious mentors and found it difficult to learn in these circumstances:

> "*I've found if I've got a bad or an anxious or an unsure mentor, then I don't really learn as much as compared to someone's that's confident in what*

they are doing, but if they're anxious, I can't do anything at all, I just turn into a bit of a state" (Flo).

Kat also had problems, with especially one mentor, who had not been qualified very long. Kat felt that it was hard to approach this mentor, because the mentor was moody and she told Kat that she was not doing enough. However, Kat believed she was working hard and this mentor just wanted to show her who was the boss:

"*However, I was able to work with her because I knew how to dance with her moods! It shouldn't be the case, she is the mentor, she's qualified and she should be more professional, you just have to keep dancing"* (Kat).

However, the qualified mentors suggested that they did not always have time to mentor, and that mentoring students put increased pressure on their clinical time. Many of the qualified mentors suggested their workload was already too heavy thus they don't have…:

"*time to teach, shadow work and preparation of materials for students, amongst the demands of our work and responsibilities, when we are faced with urgent and emergency work with a reduction of staff in the team"* (QP16).

The qualified mentors also said the workplace is often too noisy and crowded and the nature of the work is hectic, and this is not always conducive to learning. They also stated that the difficulty was mentoring a lot of students at the same time:

"*It can be very demanding, especially when all the students are from different years or different universities, lots of time is needed which as a nurse you don't have"* (QP52).

However Dee made an important point in the first interview:

"*I think there's pressure everywhere, but sometimes mentors forget that they were students themselves*" (Dee).

<u>Summary</u>

The mentoring experience is affected by the attitude and motivation of both the students and the mentors; it is evident that qualified mentors feel frustrated when barriers prevent the mentoring from being effective. The students found it difficult to learn when they experienced poor mentoring; they ended up feeling lost and needy. However, there are many issues which affect the experience of mentoring, one of which is coping with anxiety.

5.2.2. <u>Coping with anxiety</u>

If the students felt comfortable and welcome and they 'got on with their mentor', they felt more secure and less anxious and were more open to learning. An effective mentor is someone who helps to reduce the students' anxiety and creates a secure base in which to learn. This was very important to the students in the first interview. A good mentor, the students said, can calm and settle the students down, which allows them to become more open to learning the craft of caring:

"*I think having a mentor calms you down a bit, because when you first get on a ward, all the risks around you, and things like and it's good to have a mentor because they can settle you down, so you can chill out and find out this is how the ward works*" (Sal).

115

Being able to feel that you can go to your mentor for support when feeling anxious was also important to the students, Dee declared:

"*You have anxiety, and you go to the mentor, and they would make you feel welcome, part of the team, I've never felt isolated wherever I've been*" (Dee)

The students also felt that it is important to have someone there to answer questions, someone to go to if they have problems:

"*if I need to know something, if I haven't been taught something, it's the support I suppose, because obviously going into a new environment is quite a daunting experience, and it's knowing that there's somebody there for you, I'd say that's the best thing about having a mentor*" (Bea).

Sal, like Bea, also believed that you need a key person to be there for you in the clinical area, especially in mental health nursing, when there are major incidents, for example, violence and aggression, on the mental health wards:

"*It's nice to have that one person to go back to discuss things openly with, and to have the confidence in somebody, it's like when you fall over as a child it's always nice to go back to your mum*" (Sal).

However, not all Sal experiences were positive because some mentors:

"*Just left me on my own on the ward all day, with no clear structure*" (Sal).

The students said moving from placement to placement is anxiety provoking, Dee feels the frequent change of placement is:

"*overwhelming…..you are there for a few months and when you get used to the place you have to move on and then the anxiety*", [not knowing if the next mentor would welcome you].

Flo also felt lost when returning back to placements

"*You are not always in the community, you're not always at university, you're not always on the same job, so you miss that kind of social network and contact*" (Flo).

The students in the first interview believed that their anxiety was raised even higher when they arrived at a placement and they were not expected or a mentor had not been allocated to them.
 Bea stated:

"*well especially as you're nervous, you're worrying about your placement…and then you're there and then they don't know who your working with, and maybe they haven't even got you a mentor the next week, so you are still wondering who you're going to be working with and some kind of placements are short, so you're like, oh God, I really need to find out and you're worrying and they're worrying, it's just a bit of a nightmare sometimes*" (Bea).

Kat's views were similar:

"*When I went in there* [placement] *and nobody knew that I was going there, and it took probably a week before somebody gave me a mentor*" (Kat).

Kat had phoned the unit prior to commencing her placement, and therefore believed she was expected. Thus she found this embarrassing, and daunting, especially when she felt she was "*looked at, as if why are you here?*" The students said it was much more reassuring to be welcomed by a mentor who was

expecting you. Dee said in some placements she'd waited up to two weeks to be assigned a mentor, in other placements maybe three or four days. Bea said it made the placement good when the mentor had been allocated before the student arrived. It made Kat feel part of the team. Ensuring a mentor was allocated before they arrived would make the students feel more comfortable and secure.

However, Bea believed that mentors often have no choice:

"*they are being chucked in at the deep end, like sometimes you turn up to placement, and they're like, oh we didn't know you were coming, or we haven't allocated you a mentor yet, so like they just ask somebody on the spot if they could be your mentor*" (Bea).

Bea said as a student you then do not know if you wanted or not, thus the student feels they are in the way or "*being a pain to somebody*" and this can increase anxiety.

Summary

Feeling welcomed and having a good mentor allocated who helped to reduce their anxiety was very important to the students, and very important to their learning experience. The qualified mentors did not make specific comments about reducing the student's anxiety, although one mentor said the difficulties experienced with the students not being expected by the clinical area were linked to insufficient notification, then last minute changes from the placements department at the university, *'and no shows'* by the students. Students also have a responsibility in the mentoring process which will be discussed next.

5.2.3. Student's responsibility

It was acknowledged by both students and qualified mentors. That students as well as mentors have to responsibility in the mentoring process. Many of the

qualified mentor respondents declared that effective mentoring is dependent on the type of student, and also the ability, skills, motivation and attitude of the student:

> *"Difficulties with students are lateness, poor dress, bad attitude"* (QP26).

Many of the qualified mentors stated that some students were not motivated to learn and it then took much more time and effort to coach them:

> "*Students have no interest in what they are doing, they don't like the placement"* (QP57).
> "*Some students fail to complete tasks or learning it, some have a poor attitude towards client interaction, and some* are *lazy*" (QP32).

Some of the students in the first interview believed it is both the student's and the mentor's responsibility to ensure mentoring is effective, but the students need to be proactive. Bea made similar comments to the qualified mentors, and thought that the experience of the placement is affected by the student's attitude, perception and willingness to learn: "*Some students are more willing to learn than others."*
Flo felt the student needs to be proactive:

> "*I think it's the student's responsibility as well, because I would do as many shifts as I could with my mentor"* (Flo).

The qualified mentors suggested that mentoring is rewarding when students are enthusiastic and willing to learn, but some students appeared to have little interest in the job:

"*It is more about the student's attitude. There is nothing less rewarding than having a student who barely speaks to you or the client, and shows little interest*" (QP15).

However, one qualified mentor believed that some of these problems were linked to the fact that some students are young and still growing up themselves, whilst others are mature students who are also parents, trying to manage two stressful lives. The qualified mentor respondents also found students who were over confident and difficult to manage, stating that they often felt like a social worker to students *"who think they know it all"* (QP45). Alternatively, they said some students could have prepared better for the placement, and some could have performed much better than they did. However, it was suggested that there are reasons for this:

"*Sometimes this is nerves and they do calm down and take in what they need to learn*" (QP22).

Some mentors believed that students are responsible for their own development and it is important that they need "*to know what they hope to achieve.*" (QP40) Some students, the qualified mentors said, need to put themselves forward more in order to learn, be more assertive. They need to learn to use their initiative and ask questions, challenge clinical practices, and as they develop, manage their own duties with minimal supervision. The qualified mentors felt that the students want too much spoon feeding:

"*Students want to be given all the information, not willing to do their own research*" (QP10).

However, some of the students felt that mentors sometimes had unrealistic expectations:

"*It was like I was expected to know everything, and it was quite mind boggling really, and if you don't* (know) *it is oh, she doesn't know this, she doesn't know that and that puts pressure on you*" (Dee).

Furthermore, some qualified mentors stated that some students have no motivation and are '*utterly disinterested*', and some students asserted that:

"*They don't want to be nurses at the end of the course, but doing it for the 3 years is enough to keep them in the country*" (QP17).

A student told one mentor that it was…

"….*only job I could get to get a visa*" (QP26).

The mentors said other students are only doing their training for what "*they can get out of it*" or as a "*soft and easy option*" (QP33). Many agreed and think that some students do not think they have to work hard to get a qualification.
Another common problem for the qualified mentors was that the students want to be selective about when they can work and this is not always conducive to the clinical environment or the mentors' needs. The students they suggest:

"*make many excuses why they should work certain days and times*" (QP20).

Some qualified mentors felt the reason for this was that some students' do extra-curricular activities, which include agency work. The mentors linked working bank shifts, especially nights, with "*the students having a poor attitude*" (QP21). The qualified mentors' attitudes in the main were negative towards the students, and many felt the lack of support from the university and poor admission processes were to blame.

Sal also felt that some of her peers (students) were not safe to practise, and that the mentors were passing these unsafe students:

"*What is really scary is that some people you go to work with, or your colleagues you are learning with, and you know they are not safe to be practising and then you find out they passed that placement"* (Sal).

This made Sal feel that if these students can pass so easily why should "*I try so hard".* Sal believed that allowing unsafe students to pass affects the mentors' perceptions of those students in other placements:

"*I think it affects every single person, and the qualified nurses are thinking oh my God the students that are coming through these days, and they end up with a bad perception of students, and you have to fight really hard to make yourself known as a good student"* (Sal).

This could be one reason why the qualified mentors' perception of students is so poor. Pip felt that it is often lack of knowledge that makes the students appear unwilling, and it is the mentor who can give the students some of the knowledge. Pip said this knowledge is important because not everything is learned at the university, and often in practice the student is not aware of what they should know:

"*but if you don't know what you are supposed to know then you are in darkness, you end up not asking because you think you know but you don't"* (Pip).

Eli had similar views, that unless the student gets feedback from the mentor they do not know if what they are doing is correct:

"*but once you're actually out there in the workplace and you're applying theory to practice, you need somebody there to say to you you're actually applying the right theory to the practical situation and you're doing this properly*" (Eli).

Summary

The findings presented above suggest that the student needs to be committed, act professionally and take responsibility, but the student also has to learn and has to be shown how to nurse mental health patients. It is a co-relationship. The student and the mentor therefore need to be committed to the job. The student has a responsibility to ensure that they are willing to learn, while the mentor's role is to create a learning environment which enables the students to reach their full potential. Furthermore, it was important to the mentors that the students were committed to the role for genuine reasons. This helped confidence to develop and established trust. The students also needed to be able to trust the mentors, and passing students who are perceived as not competent does not instill confidence. The mentor's role is important in the facilitating the student's progression as explained next.

5.2.4. <u>Mentors' role/responsibility</u>

The mentors believed that a mentor needs to be a good role model to ensure that the students know what to expect and what to do, and to ensure they are safe to practice whilst making allowances for them as students. Thus the mentor needs to be a safe practitioner, and be committed to the mentoring role:

"*Effective mentoring is enabling and facilitating students to practise their knowledge and skills in the clinical area, and enhancing their practice through reflection in and on practice. It is rewarding to share my knowledge and skills with others and to learn from each other, and it motivates me to update my knowledge and skills*" (QP19).

123

The students in the first interview said that they had experienced some good mentoring:

"In my experience it has helped me a lot and I wouldn't be able to have done all the things I have achieved if they (mentors) *were not there to point directions to me"* (Kat).

Eli said an effective mentor is someone who is very realistic about what the job entails. She had one good mentor who explained:

"…what the job entails about the whole issue of accountability and responsibility, and what it actually means once you've actually got your PIN number…..they've already trodden the path you are treading…they've been there, they've done it, they are experienced they can relay their experience to you as a student" (Eli).

Furthermore, the mentors' role is to act as:

"a signpost to point me, to what I should do and also in fact let me know my limitations, I am supernumerary and if there was anything I shouldn't do, so mostly they were guides to my learning and also encouragement really" (Dee).

Many of the mentor respondents said that they find the mentoring role satisfying because they are passing on their knowledge; the role is easier if it is rewarding. That is, a good mentor should help the students to develop the necessary communication skills, share knowledge and information, and also support the student in carrying out a whole task, whilst giving the student the opportunity to take some responsibility.

Certain qualified mentor respondents said they liked having students and they encouraged them to ask questions:

"I enjoy having students, I like them to ask questions and even challenge my practice as this can be more rewarding for both of us" (QP15).

Other respondents embraced the mentoring role because it builds their confidence to know they can teach someone else;

"it gives me the opportunity to revisit things I normally forget about, it makes my practice more effective as I have to be ready for question" (QP44).

Dee said the mentors guided her through issues like restraining patients and they ensured that she was safe. Many students in the first interview felt this guidance, support and sharing of knowledge was a very important component of their training in clinical practice. Eli in her third year of training, said she had a very good mentor who;

"…bestowed upon me all of her knowledge and it was a wealth of knowledge, and I used to take notes. Whilst I was working through my practice document she would just hit me with scenarios, and say how would I handle this and if I came back to her with a response, she would say, perhaps it would be better to do it in such a way. Oh it was brilliant because that gave me the impetus to go out and do the research I needed to do. It helped with my assignments" (Eli).

The students also felt more confident about their development as mental health nurses if the mentors questioned them about their competence in regards to their learning outcomes, and made the students demonstrate and explain clinical skills. Some mentors made them research theory related to their clinical work:

"*She* [mentor] *signed all my nutrition bits, but she made me actually do the practical and talk to her about the effects of nutrition on mental health, it does teach you more, so it's more beneficial in the long run*" (Bea).

Pip agreed with these points and believed that an effective mentor is someone who will not sign the practice book until convinced the student is competent:

"*He* [the mentor] *would say I am not going to sign your book until you answer every question, if I didn't know he would say you go and research and you come and tell me. That kind of mentorship is excellent*" (Pip).

Eli also believed the role of the mentor is very important because:

"*It helps to instill a sense of confidence in you as a student, you feel as if you're being guided*" (Eli).

Flo said it is the mentors who can make sure they are applying theory to practice, but she suggested that many mentors *"don't know the current up-to-date practice."* Flo said she was wary about mentioning it, in case it made the mentors feel inadequate. However, Flo was impressed when a mentor admitted they did not know the answer to a particular issue, and encouraged her to:

"*…find out the research and we'll look at it together, and I'll learn from it as well, so we've both learnt something. They're actually learning as well….and given you time and sat down and discussed things with you, just because they want to, rather than they have to*" (Flo).

Many of the mentors commented that mentoring is rewarding when students achieve their learning outcomes, develop confidence and an understanding of the patients' needs. Some said that often you saw them qualify, secure employment and climb the ladder, and you saw them become senior nurses and

managers. It was also important to the mentor to know that the students had enjoyed their placement with them.

However, it was also very evident from the participants that effective mentors produce effective nurses, who then in turn become effective mentors:

"*I think it's helped that I have a good mentor and a consistent mentor, I think it's really helped and it's made me enthusiastic about becoming a mentor and I am looking forward to the day I start my mentorship course*" (Sal).

One of the barriers to effective mentoring for the qualified mentors was the students' practice books. The qualified mentor respondents believed that the practice documents are very time consuming and complicated, and are not always clear about how to complete them correctly:

"*It would help to be provided with current samples of documentation and explanations prior to the students coming on placement*" (QP1).

Many of the mentors agreed and said they should have a copy of the book before the student arrived, so they could prepare. They also said that the students' learning outcomes need "*to be more relevant*" (QP25). They believed the students should only have one practice book for the whole three years of their training, and there should be one which is common to all universities.

Bea and many of the students in the first interview thought that sometimes the practice book is signed too easily, and it is better when the mentors go through the book and make sure the student knows:

"…*what you're talking about, and demonstrating it in practice as well*" (Bea).

Although Kat felt the practice documents were understandable, in some placements like inpatient units, there is not enough time to go through the documents and look through everything:

"*and they (mentors) get daunted, sometimes we cannot always sit down and discuss things. And sometimes it's all done in a rush, all the document signing and all the assessments, not have time to discuss it in depth, in hospital time is precious*" (Kat).

Pip stated that sometimes because the mentors do not understand the practice book, they sign the student outcomes as passed, and this was not right. They should go through the learning outcomes together to ensure the student is competent:

"*because it's not about passing it's about getting the knowledge*" (Pip).

There were also concerns from many of the qualified mentor respondents about those mentors who pass students, even though the students' competence had been questioned:

"*I think that occasionally unsuitable students are 'nodded through' the system*" (QP48).

Students in the first interview also considered that sometimes the learning outcomes in the practice book were passed too easily. This led to concerns about students being passed who were not competent:

"*I think it's not failing students that has shocked me, they are* (students) *not safe to be practising and then you find out they passed that placement and passed another placement, and then they pass another one and another one and*

then they end up as qualified nurses and you think, oh my God they are going to be my colleagues" (Sal).

.

Jed became quite angry when discussing the assessment process because he said he often did not have a formative assessment. He believed that sometimes the mentors just pass the students without really assessing if the student is competent:

"*You do not get a lot until it is time for the summative* (final assessment pass/fail), *then they look at the paper ask you one or two questions, they just mark it"* (Jed).

Discussing the mentors' competency made Bea express concern for the mentor, and focused on the responsibility of the role. This led Bea to reflect on what it would be like to be a mentor when she is qualified:

"*You don't take into account what responsibility they have, and if you have built up a rapport with them, I think they kind of feel a bit more obliged to sign your book, even at a recent lecture, they were saying that mentors should feel ok to fail people, and I know from that point of view, if it was me, I'd be like, I don't really want to fail that person, I'd feel bad, but I suppose it's just such a big responsibility to have, because you're letting those people be nurses in the end"* (Bea).

Some mentor respondents said they do find failing students difficult, and often the student's poor practice and time keeping is not challenged:

"*It is challenging to fail a student."* (QP14) "*The most common problem is knowing how to fail a student and having the confidence to do so."* (QP44)

Another issue which has an impact on effective mentoring is the fact that mentoring is a requirement and is seen as part of their professional development by the governing bodies. Some of the qualified mentors felt resentful about the obligation to be a mentor and considered that this requirement affects the quality of the mentor. They said only nurses who want to be mentors should undertake the training, and there should be some reward for the extra work. Some believe this accountability should be the responsibility of the education establishment not the clinical area:

"*I don't mind helping anyone to learn, and I am glad to share my knowledge, but not under duress and to be accountable for someone else's failing in the future, especially if there is no incentive for that burden. It is not the teaching part so much, as it is taking on a responsibility for something the education system is responsible for*" (QP13).

Some of the students in the first interview made similar points and believed that only nurses who are interested in the role should train to be mentors, because in their experience some mentors are reluctant to take on this role and nurses need to have enthusiasm to take on the role of mentor:

"*Some do it* [mentoring] *reluctantly, you need to have a passion for mentoring.*" (Dee) "*Everyone cannot be a mentor, it's like nurses, everybody cannot be a nurse*" (Jed).

However, Bea believed that mentoring has to be a required obligation because the students have to be supervised. Kat also stated that mentoring is a requirement of newly qualified staff. However, Jed feels that many nurses are not interested in mentoring and therefore should not be required to enlist.

Some of the student's had being taught skills which were out of date, Bea knew from her experience at university that she had seen and been taught clinical

practice which was out of date. Bea called this unprofessional practice and linked it to clinical areas which had become set in their ways. Flo also said she had also witnessed some out of date practice:

"I'm not really comfortable with, something small and they've been doing it for ages and so used to it, and it just seems normal to them" (Flo).

Flo said she did not witness bad practice, otherwise she would have reported it. Pip said working with many different nurses at times created confusion and contradiction when learning nursing skills. Pip discovered that some nurses, just want to be in their world and do not reflect or consider that research may have developed nursing practice. Thus sometimes they taught Pip skills which are out of date, or considered in the world of nursing as poor or inadequate practice. However, reporting poor practice is not always easy, even with the universities systems in place because:

"If you complain too much they won't sign the book [practice document]*, you end up keeping quite"* (Pip).

Flo said that if you complained other areas would be told and then as a student you would not feel comfortable anywhere in the Trust, because Flo believed that students are not expected to question practice.

Summary
Effective mentors, the participants believed, value their reputation, making sure they guide, supervise and teach their students, but they also need to be aware of the students' strengths and weaknesses. Mentors needed to address the students' weaknesses with them and involve the university in these discussions. Mentors need to be there for the student and encourage the student to develop confidence and achieve their full potential. It is important that mentors ensure that students understand the application of theory to practice, and students

should not pass practice if they cannot prove their competence. All qualified nurses are role models; therefore all should be able to support students. However as the participants stated not every nurse wants to be a mentor, or has the skills to mentor competently. Also it is not easy for students to question mentors practice. Time to mentor affects the mentor's competence and effectiveness, and issue to which I now turn.

5.2.5. <u>Time to mentor</u>

"*The results of this study highlighted the effective working relationship that encourages learning in the environment is affected by external factors, including time. Allocation of time is essential for these mentoring relationships to be developed. However, both the mentors and students referred to the lack of time available to mentor effectively*" (Teatheredge, 2010, p.21).

Time to mentor was another issue that the participants felt affected the mentoring process. Many believed that if they had protected time to mentor it would be facilitated much more effectively. The qualified mentors stated that due to heavy workloads and emergencies there was not always time to work with their mentee (student):

"*Time is always a significant factor in juggling practice and mentoring students*" (QP19).

It is not just being with the students but having time to:

"*Teach, shadow work*" (QP16), "*time for quality supervision*" (QP18).
"*I enjoy teaching but the time constraints to give one-to-one to students can be challenging*" (QP20).

Time was a subject that nearly all the qualified mentors commented on, with many saying it was a massive pressure for them:

"*The main difficulty is time pressures*" (QP43). *"It can be very challenging finding sufficient time to formally mentor and supervise"* (QP54).

The qualified mentors stated that they should be supported to secure protected time to mentor. Often due to lack of time, the needy students did not get the input they require. Some said they do not have enough time to nurse effectively let alone mentor effectively.

One student in the first interviews believed that the lack of time spent with the allocated mentor "*creates anxiety in the student."* (Eli)
Pip felt that the mentors are often not there for the students, so the student has often not worked with their mentor for the required time:

"*The mentors are normally not there at times for the students, one because they go on leave, and two because of the shift pattern, the student might choose their shifts to link with the mentor, but the mentor sometimes because of his or her problems is not there"* (Pip).

Pip also said that in one eight-week placement he'd worked with the allocated mentor only three times, and this he felt was unsupportive. Jed also stated he did not have a supportive mentor in some areas, and, not having this support:

"*it makes me to be weak and I mean weak like feeling not confident"* (Jed).

The qualified mentors noted that they should be given secured or protected time to mentor effectively, to be able to give quality supervision to the students, so

they could teach and assess the students' more accurately, and that the protection of this time would not compromise their workloads:

"*Mentors should be given protected time away from regular duties and be able to devote time to teaching and assessing students*" (QP8). "*One day to be given to mentoring every week, where learning can be planned more effectively*" (QP31).

However, one qualified mentor commented that on busy acute mental health inpatient units securing protected time would be almost 'impossible', due to the unpredictability of the unit.

The students made very similar comments to the qualified mentors, suggesting that there should be protected time for mentoring:

"*Protected time allotted to them each week because we need that. We need to be able to sit down and not be disturbed.*" (Kat) And Jed said: "*They would tell you some wards are just too busy, the time is not there, but I believe you can always create time*" (Jed).

Eli agreed with Kat, and felt that time for mentoring should be protected, and that the mentor and the student should sit down together weekly, because:

"*mentors need to spend time with students, important dedicated time. Initially to work out how to meet the learning outcomes; what are the goals that we're going to set for each week; for the mentor to set the student work to ensure they're meeting the learning outcomes, and then to have time at the end to evaluate all of that*" (Eli).

Summary

Time to mentor is a major factor in the role of effective mentoring if the mentors are to be prepared to take the role seriously and help the students develop and

reach their potential, to become qualified colleagues. The mentors need time to facilitate the role, time to be with the students, time to teach and guide the students and this time should be protected, pre-planned but realistic. The mentor participants and the students also had some other ideas which could help sustain the mentoring role and these are now considered.

5.2.6. <u>Sustaining the mentoring role</u>

The mentor and student participants had views on the support they should receive to help sustain and improve the mentoring role: Most of the qualified mentor respondents felt they needed more support from the trusts and especially the universities:

"*Regular involvement from managers and link lecturers*" (QP53). "*Mentors need support from the university especially with communication problems, and problems with too many students at one time*" (QP 59).

Another qualified mentor stated;

"*I said this as a student and I still believe we should have more educators on the wards, we still need to bridge the gap, and I think there is room for a new role of ward-based tutor/practitioners to stop those poor students slipping through the net*" (QP22).

Mentors felt that more contact from university staff, including regular meetings would help develop collaborative working relationship:

"*More visits from the facilitator from the university where the student and mentor as well as the facilitator meet together*" (QP22). "*The university needs to sharpen up practice in relation to establishing and maintaining links with the workers who are doing the mentoring*" (QP38).

Closer working relationships with the university would they said, *"enhance the quality of future nurses"* (QP59), because if the tutors communicated at the beginning and at the end of the students' placements with the mentor:

"it would enable the mentor to know what to give to students, extra help if they need it, or issues that may need to be addressed" (QP59).

The qualified mentors also suggested this collaborative relationship should start before the student arrives at the clinical area:

"Closer working relationships with educational establishments, the university to arrange meeting between the student and mentors prior to the formers clinical placement, in this way learning needs can be planned early" (QP19).

The students in the first interview made some similar comments about the responsibility of the universities and trusts in the mentoring process. Pip believed that mentors should get support from the university which should define mentoring, and do follow-ups, to ensure things are done correctly, and that there should be a contract between the university and the trusts:

"There should be contract, like I have been in placement for two weeks I should be able to say to my manager this is what I have done, what do you say, we sign and we send it to the university if I am not doing well" (Pip).

Pip believed that unless the universities check the mentoring, they do not know if:

"the student has achieved a comparable standard with other students" (Pip).

Pip and Jed's remarks support the comments made by the mentors. They declared that there should be more frequent visits from the lecturers to have discussions with the mentor and the students. Pip believes without this checking there is a "*lack of consistency.*"

"*Talking to the student and bring in the mentor and say how is he doing, and was the student able to answer this and that, because lecturers and nurses they know*" (Pip).

Jed thought it would be a good idea for the link lecturer to visit more often and meet with the mentor and mentee, weekly or fortnightly to see how the student is developing in the real world of nursing, not just through looking at the practice book:

"*The link lecturer is not even aware of what exactly is going on, what is the true story, what has gone on in the ward*" (Jed).

Pip thought that the practice mentors know the students better than the lecturer this is why the meetings are important:

"*The mentor is closer with the students than the actual teacher*" (Pip).

However, Bea viewed the mentoring role from her future perspective and acknowledged that mentoring is a hard responsible job. She believed that the mentors should have more support through supervision, or support from the ward manager as the manager should know how the student and mentor are doing:

"*I suppose looking at it from my point of view, thinking one day I'm going to be a mentor, like I'd want there to be somebody I could go to, to make sure that the things that I have signed off have been double checked by somebody else maybe, it's just me being a worrier I suppose*" (Bea).

Some qualified mentors had similar views to Bea

"*I think there should be more formal supervision of mentors to ensure mentors are maintaining appropriate standards of mentoring and practice*" (QP54).

Summary

The mentors and students believed that the mentoring of students in clinical practice should be supported and overseen by the lecturers from the universities. Closer collaboration and working relationships should be established by the university, to ensure the mentoring is effective, but also to support the mentors and the students through the whole process. In this way the lecturers would know exactly what is going on, and a consistent approach which is both supportive and enlightening would result. Participants recommended that this tripartite relationship should be established prior to the students arriving on the ward, or as one mentor suggested there should be ward-based educators. Furthermore, it was recommended that there should also be regular supervision for mentors, and this could be provided by the employing organizations.

How the students learnt during the transitions will be analysed in depth in the next section [part two].

5.3. Part Two of the Findings (second interviews)

 The Concept of Transition

The term transition or 'transitional period' in this research means:

"*A transitional period…..terminates the existing life structure and creates the possibility for a new one. The primary tasks of every transitional period are to question and reappraise the existing structure, to explore various possibilities for change in self and world, and to move commitment to the crucial choices that*

138

form the basis for a new life structure in the ensuing stable period" (Levinson1978:49).

As the purpose of this research was to explore the shifting perceptions of mentoring in mental health nursing (see aim 1, section 4.3.1.), these perceptions form a significant part of learning their craft. These perceptions of mentoring highlighted their temporal views of Being-in-the-world (Heidegger 1962) as once a student, becoming and then being a nurse and nurse mentor.

Transitional periods

There are three types of transition related to this study:

- Life structures -student –nurse-nurse-mentor
- End of a period student becoming a nurse (1st interview)
- Stabilizing the new period process of becoming a professional nurse and then nurse mentor (2nd interview).

This section explores the experiences of those who were interviewed when firstly, they were students, and then when they became qualified nurses and nurse mentors two and a half years later. It therefore presents the perceptions of Sal, Bea, Pip, Kat, Jed and Eli.

The participants stated they had been involved with the training of students on the units they worked in, though those who had not yet been annotated on the register as mentors were not able to assess students in practice. Sal was the first in the group to qualify as a nurse mentor, and the first to secure a position of charge nurse. The now qualified nurses had experienced a wide diversification of mentoring when they were students. The concept of transition is an analysis of their perceptions of the transitional experiences, and how the transitions affected their existential lifeworlds, and the meaning of mentorship

The following is a summary of participant's perceptions which leads into the concept of transition.

The students in the first interview and the nurses in the second interview all stated that the role of the mentor is very important in the student nurses' training in clinical practice. They believed that if mentoring is done effectively and

139

consistently, the student at the end of their training will be fit for purpose and practice.

The mentoring process whatever course it takes, affects the person. To quote Pip:

> "*And actually they must know* [mentors] *that they are a very important part in the training of students, very, very important. Whether the mentor is bad or good, still is very, very important because they change your path and also change your past, and your future"* (Pip).

The students in the first interview recognized the importance of effective mentoring, and some said they would have left the training if they had bad mentors throughout their training. They also recognized that it is a requirement of their professional development for them to train to be mentors when they qualified, and some students believed that when they had good and enthusiastic mentors it had inspired them to become mentors themselves:

> "*I think it's helped that I have a good mentor and a consistent mentor quite recently, I think it's really helped and it's made me enthusiastic about becoming a mentor and I am looking forward to the day I start my mentorship course"* (Sal).

Sal became the first in the group to qualify as a nurse mentor, and the first to secure a position of charge nurse.

Kat had similar ideas in the first interview about becoming a nurse mentor:

> "*As a newly qualified, we should aim to be mentors ourselves, because I would love to mentor a student because I've had such lovely experience, I had a lot of good experience with my mentors and I would be able to share that with my students"* (Kat).

140

Bea recognized that the mentor's role is another huge responsibility and when Bea was nearing the end of the three-year nurse training, she was thinking about:

"…*what it's going to be like when I become a mentor, you don't take into account what responsibility they have*" (Bea).

Bea also felt that when she qualifies as a mentor it would helpful to have someone double check the outcomes she had signed off, because at the end of the day "*you're letting those people be nurses*",
In regards to becoming a qualified mental health nurse, Kat felt that as a third-year student the thought of being a qualified nurse was:

"…*challenging and daunting, because you have a lot of pressure and abilities ahead of you*" (Kat).

The students in the first interview also believed there should be much more pre-planning on all the mental health units prior to the students' clinical placement, that the training the mentors received was inadequate, and that mentor training should give:

"*guidance on how to mentor effectively*" (Sal).

What was clear from part one of the findings was that the now-qualified nurses had experienced a wide variety of mentoring experiences when they were students. The following analysis presents their perceptions of the transitional experiences, and how the transitions affected their existential lifeworlds, and the meaning of mentorship.

The concept of transition relates to the participants perceptions on becoming qualified nurses. This is presented using the core essences from the interviews

under six sub headings. The transitional process of becoming and being a nurse, had consciously developed their own individual identities, and consequentially each person had learned from the whole experience. Then their journey of becoming a mentor is presented, and finally what they had learned about sustaining effective mentoring. These essences are the sub-headings in this part of the analysis:

Concept of transition (second interviews)

Core essences:
5.3.1. Becoming a qualified mental health nurse
5.3.2. Period of preceptorship
5.3.3. Developing a sense of self as a qualified nurse
5.3.4. Learning from experience
5.3.5. Becoming a mentor
5.3.6. Sustaining the mentoring role

5.3.1. Becoming a qualified mental health nurse

Whilst many of the students in the first interviews had anxieties about qualifying, and although they were excited to be completing their training, the results of the second interview clearly highlighted the significance of their transition from student to qualified nurse was immense. They commented on feeling overwhelmed and unprepared for the responsibility and accountability of being a nurse, let alone a nurse mentor.

Sal's response was quite emphatic in regards to becoming a qualified nurse. She said it was:

"Terrifying! [Laughs] Terrifying, not what I expected. It was like going from GCSE's to A levels, it was like a massive jump, I wasn't at all prepared for it" (Sal).

Bea's views were similar, and although the daily routine was not a problem, as a qualified member of staff on a forensic unit she felt very vulnerable in regards to the unpredictability of the patients, knowing she had no mentor, and that if a situation was not handled correctly she was directly responsible:

"Tougher than I thought, massively tougher, and especially the environment in which I qualified into was a medium secure forensic admission unit. I felt, a massive responsibility. I kind of thought that obviously before I qualified anyway, but being there and doing it was a different story" (Bea).

Kat's views on becoming qualified nurse were linked to the metaphor of learning to swim:

"It was quite daunting at first because, it's like being thrown in the deep end" (Kat).

Jed's feelings about the transition were not as strong as the other participants;

"Well initially um you feel a little, initially when you go to the environment, you feel a bit uncomfortable …..the difference, now you have more autonomy, and you feel some air of freedom, but you are making decisions that if things go wrong it can affect the whole establishment. You now make decisions which you are accountable for, and though it feels lighter, but again have to be very careful" (Jed).

Pip and Eli, when discussing the transition to qualified nurse also focused more on this accountability and responsibility:

"It's a huge responsibility I would say, a huge responsibility; the differences are responsibility. Yes, you have to be able to set an example" (Pip).

"The difference [between being a student and a qualified nurse] *oh, well, the responsibility, yeah, the responsibility, it's quite nerve-racking, you know, whilst you're a student you're sort of like cocooned, aren't you, by not only the university but, you know, you're cocooned in every way really, you're not responsible as such, and then when you sort of like qualify and you're right there in the field then all of a sudden, you know, you're accountable"* (Eli).

These comments suggest that as students they felt they were protected from certain aspects of mental health nursing, mainly the tasks which have the most responsibility and accountability (including decision making). Consequently the participants felt because they had not experienced the responsibility they were not prepared for it, when they qualified. Kat concurred and expanded on what she had meant by 'daunting':

"It was quite daunting because it was from being a student who couldn't do all the decisions, you go in the ward one day and then you have to become the nurse in charge, or you have to make decisions, the clinical decisions, so it was quite daunting, very scary" (Kat).

Bea said that each individual will deal with the transitional process in their own way:
"but I think people will take it in a different way, some people love it and would thrive off of that responsibility and being the qualified nurse after all of that hard training. Some people would approach it a bit like, oh dear, I don't want to do anything wrong" (Bea).

Bea admitted that the responsibility of being a qualified nurse was very anxiety provoking for her. Pip summarized what accountability as a newly qualified nurse meant to him:

144

"It's like everything that you do, you have to, as a matter of fact, to summarize this, you are accountable for your actions, so everything you do, you can't blame anybody, it's all about yourself " (Pip).

Some participants linked the responsibility and accountability to their NMC registration (their PIN number as they call it), and fear of losing their registration if something goes wrong, and how previously the mentor had this responsibility. The participants during the discussions on transition made the link to being cocooned, that is, the mentor being responsible for countersigning everything when they were students. Then when they became newly qualified nurses, they no longer had the mentor's protection and had to take on the responsibility and be accountable:

"Because of the nervousness and because of the thought that you're going to be qualified with a PIN number to protect, that was the scary bit, as when you were a student you had the mentor to hide from, or hide behind" (Kat).

Jed also said that if an error is made he could lose his PIN (NMC registration);

"In my time I have seen people go to panel for disciplinary hearing, some people have lost their PIN" (Jed).

The participants continued on this theme of losing the mentors' protection and taking responsibility and fear of losing their registration. From the intense focus of some of the discussions it was evident that this meant a great deal to the participants, in regards to the 'massive change' and the fear this evoked, during the transition:

"My change after the three years, as I say, is I don't sit back anymore. As a student you can sit back and let the qualified deal with issues, but now I have to deal with the issue, that's the major change" (Pip).

Pip also said that as a qualified nurse, you have to make decisions and other people are relying on you to make those decisions, like the unqualified staff. What the participants did not realize was that the transition would happen so fast and how much would be expected of them very quickly:

"*When you're a qualified nurse like they do, they expect quite a lot from you quite quickly, you have like one week of supernumerary and then after that you're acting on your PIN and, you know, being a full on qualified nurse. I felt, a massive responsibility. I kind of thought that obviously before I qualified anyway, but being there and doing it was a different story*" (Bea).

"*Yeah, there was so much more expected of me as a qualified nurse, and so many more decisions I had to make on my own*" (Sal).

Continuity on the same ward helped:

"*But um I slowly got into the routine of the ward, I think it's more about finding your feet on the ward and placing together all of the things you've learnt, and when you've got the continuity of going in day after day you can actually do that, where as a student, you've got two or three weeks in placement, two or three weeks at uni, so the continuity isn't always there*" (Sal).

Sal also stated that you had to learn very quickly:

"*Really quickly. I did a lot of maturing and a lot of developing within the first six months of qualifying. I really learnt a lot more about interpersonal skills and how to treat people and how not to treat people within the first six months. Thankfully it was by seeing I learnt how not to do things by watching others rather than, I didn't make too many mistakes me*" (Sal).

The participants in the second interview also felt it was unfair to be put under pressure when making decisions. There were consequences to making these decisions that they were not really aware of when they were students, as in not getting it right, and receiving feedback which was contradictory:

Sal's experience:

"But then they expected me to make decisions. Yeah, there was a lot of contradiction in the first few months, it was, well, you know, go off and run the shift and then if something went wrong, if maybe I, I don't know, maybe if I sent somebody off in an ambulance when really they could have stayed on the ward, but I was just a bit panicky that they'd broken a hip or something, then it was kind of like, well what do you know? You're only newly qualified, you shouldn't have done it. But you left me on my own to make the decision anyway. It was a bit... lots of contradiction" (Sal).

The participants stated that one of the differences between being a student and becoming a qualified nurse, is that not only can they make decisions (that could have consequences), but the transition had enabled them to become empowered. This allowed them to make changes, all of which they were unable to do as students. In their own words:

"Everybody wants their freedom, but again I know when I was a student I go to work I come back and it's ok, sometimes I get frustrated because there are things I want to do, it's good, positive, but I wouldn't do it, when you qualified you are part of the team, but as a student people don't take you serious" (Jed).

Jed is saying that as a student he could see things that could be improved, but was unable to make changes, but once qualified his opinion about change was taken much more seriously:

"whereas before I as a student you cant make a decision it wouldn't be right, people wouldn't allow you to put those things in place" (Jed).

During the interview Jed used clinical experiences to make his point: one patient who was in seclusion had become very disturbed, displaying some inappropriate behaviour. Jed felt very sorry for this patient and decided that further seclusion would only exacerbate the patient's distress, and with the manager's agreement the patient was taken out of seclusion, and the patient became much more relaxed and the behaviours ceased:

"Took him out and then took him to his place. I tell you from that time he didn't go back to the seclusion; this is nursing, you try to your ability, try things which will work" (Jed).

Jed said his idea would not have been taken seriously as a student, but as a qualified nurse, the managers were prepared to listen to him and allow change to occur. Pip's views were very similar to Jed's about becoming qualified and having more autonomy:

"If you are a student you are going onto the ward, you've got people controlling you, it's difficult to have influence, but if you are a staff nurse it's different. When you are heading the shift you can introduce some things which don't disturb the running of the ward, but is something you can say when you handover – I've done this, I thought it was worthwhile. You can take it up or you can discuss about it. That's the major difference, you can make changes" (Pip).

However, Pip stated that as a qualified nurse he had put forward ideas for change, which he felt could improve patients' care but he was surprised when staff were resistive to change. Pip thought some nurses and managers who have been qualified for some time can be quite opposed to change:

"You've got more power. But it's not that easy because while you are a staff nurse you are number three in the hierarchy, and some managers or a team leaders will think you are thinking big, what's wrong with what you are doing at the moment, so it will be difficult to put your ideas through. Sometimes you meet brick walls" (Pip).

Summary

Many of the participants had found the transition to staff nurse overwhelming and 'terrifying', stating that they had not felt prepared for this immense developmental life change. As students they had been protected and were able to let the mentors make the decision, the mentors being accountable. As qualified mental health nurses the participants had become more autonomous, but were responsible and accountable for the choices they made, and the decisions they took, which could affect the patients' lives. Furthermore, poor clinical decision making could have dire consequences, the outcome of which could be losing their registration. Thus there was a combination of feelings about becoming a nurse: anxiety and exhilaration. Whilst the participants found the transition to staff nurse quite a shock, they did have a period of preceptorship as soon as they were employed as newly qualified staff nurses.

5.3.2. Period of preceptorship

A preceptorship is "*a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as a autonomous professional, refine skills, values and behaviours and to continue on their journey of life long learning" (*Department of Health 2010a:11).

All the participants had undergone a period of preceptorship, and a qualified nurse mentor was usually the preceptor. The participants had a variety of experiences during their preceptorship period, very much like their mixture of

experiences of being mentored as students. The preceptorship phase which is usually six months does not protect the nurse from being accountable

Kat said she had a very good preceptorship, but this period did not protect her from the accountability:

"With the preceptorship programme I already have a PIN to protect, and even though I was being supervised I was accountable for my own actions and decisions or omissions. It's like being mentored as a qualified, by a qualified, so that they treat you equally, but at the same time they try to guide you to what you needed to be accountable for, what you need to achieve, because you still have learning outcomes as well" (Kat).

Jed believed preceptorship was like mentoring in that it is as good as who is doing the mentoring, and he felt some preceptees had it easier than others. This was like when they were students, but it:

"has to do with understanding communication and establishing a good relationship with your mentor (preceptor)*, because in my own experience, I have to actually go out my way to make a lot of researches to prove to my mentor* (preceptor) *that I'd been able to achieve what she expected of me"* (Jed).

Jed felt this process helped to make him a better nurse, because his preceptor wanted the best from him:

"She's had so much experience she wants everything near perfection, she is very ambitious and she wants you to follow that line. But then she stretched me further to ask more questions which today, I believe is helping me in my practice, it made me a better nurse" (Jed).

Jed also said there was variations in the how his peers experienced the preceptorship, that some preceptors just sign the practice books as passed, like when they were students. Jed believed you learn more by doing the research, and felt some people passed the preceptorship for the wrong reasons:

"*Why some people* [preceptees] *got it* [preceptorship] *in [name of clinical placement] because they are short of staff, or for some other reason which is not known to me"* (Jed).

Thus Jed believed that no-one should be passing the outcomes without proper assessment, and he feels he learned much from his experience:

"*It wasn't the worst experience like I said, it makes me a better practitioner"* (Jed).

However, Sal did not have a good preceptorship experience, thus making the transition harder. Sal said her preceptorship was such a bad experience that she would go home and cry. She applied for another job before her preceptorship was completed, but she stayed in the end and did not explain why.

"*Oh, my preceptor was rubbish, he was terrible, I think I taught him more than he taught me during preceptorship"* (Sal).

This preceptor was like the one Jed was referring too, just signing the preceptee off as passed, without really assessing the nursing skills as a qualified nurse, and:

"*he was an anxious nurse, he was really anxious, really, um didn't have confidence in himself, in his own knowledge, he assumed, if I could answer one or two questions he assumed I could answer it all, so just signed me off, and luckily for him my knowledge was good and I could have passed"* (Sal).

Sal said though looking back she wished she had got more from her preceptorship:

"But looking now I see how some people have got longer preceptorship periods, even though they're at the same standard as I am, it's more for them to settle in longer, I think I could have used that, I think I could have done with him being less anxious and more kind of decisive" (Sal).

Jed said that at times he felt pressure from senior staff to take charge of the ward, when they were short staffed, and this was not conducive to learning as a preceptee Sal also said:

"we do feel a bit of the pressure to say, oh no, fine, I can do it, I can do it, because although I know I could do it, I haven't practiced it enough to be fully confident that I could do it" (Sal).

Eli also did not have a good preceptorship experience:

"I spent six months in [name of trust], yeah, and that was supposed to be a preceptorship process, however it wasn't very good, I wasn't very impressed with that at all. I'm kind of, I suppose nurses that had been sort of like in the system for a long time that weren't really keen on the idea of giving nurses a preceptorship" (Eli).

Eli moved to another trust where the preceptorship was much better;

"and I had a fantastic preceptorship, it was a brilliant preceptorship pack put together, time was spent going through it with me, and I thought it was just really, really good, yeah, I felt very safe there you know" (Eli).

Making a link here to effective mentoring and feeling secure, Eli also stated that this support helped with the transition:

"It was great for that sort of like transition, the transition from being sort of like a student to a nurse; it was a nice safety net, yep? And it gave you time to sort of like leave behind the student cap, if you like, and take on the cap of a fully qualified nurse" (Eli).

However, whilst Eli said for her this second preceptorship felt like a bit of a safety blanket, once this was complete she felt it was:

"…just a massive difference really, the decisions I make now are, you know, people's lives could depend on them really, and I have to be very careful when I'm assessing situations and I have to be very careful when I'm assessing risk in particular and, you know, you have to really get to know your patients very well, and you have to have your eyes open at all times and, you know, constantly be observing for what's happening, and the group dynamics, you know, things change so quickly on the wards as well" (Eli).

Eli is referring here to the unpredictability of working with patients whose mood is affected by mental illness, and to the way in which the atmosphere of the unit can change rapidly, according to the patients' moods. Managing these changes is part of being a mental health nurse.

Bea said she had an effective preceptorship:

"I had a really good mentor for my preceptorship; it took me seven months to complete. Yeah, I had a really good mentor (preceptor)*, she was on the ward, she was one of my charge nurses, very supportive"* (Bea).

Bea also believes that the preceptorship process helped her develop more confident as a qualified nurse:

"I'm a lot more confident, I can feel that in myself which is great. Yeah. A lot more confident, I like the responsibility that I've been given, like there's been different responsibilities on the ward which were kind of a bit of a privilege at the time" (Bea).

Summary

Some of the participants experienced an effective preceptorship; others did not. Those who did felt it had been a positive experience and believed that although they were still accountable, the preceptorship period had helped them through the transition, and had helped to make them feel safe enough to develop their confidence as qualified mental health nurses. It also enabled them to reach their potential in Being-in-the-world of mental health nursing as newly qualified nurses. Those who experienced an ineffective preceptorship period felt that they had missed out, that they had not been given the same quality time to adjust and achieve their own potential.

However, during the process of becoming a mental health nurse, and through the transitional processes, their conscious sense of self had developed, which will be discussed next.

5.3.3. Developing a sense of self as a qualified nurse

The participants continued on the theme of personal and professional development through this transitional period, an integral part of the process of individuation: *"Individuation is a process of personal development whereby a person becomes more conscious of who they are. The term is normally employed to denote a process that encompasses the whole person and spans the whole course of his or her development"* (McGlashan 2003:19*)*.

Sal said she had some self-understanding prior to her nurse training:

> "*But I don't feel I really developed much until I did my training, I think I came out of myself in that way through my training. I think I came into the training as a certain type of personality and I think the training has helped me develop that, and it's helped me identify really who I want to be as a person and how I want to be perceived, and I can therefore with confidence teach my students that, and try to teach them about how they want to practise*" (Sal).

Sal said that the nurse training, that is learning all the different theories (including human development theory), and the inquiry based learning process had helped her to develop a sense of self:

> "*All of those different theories I've managed to have, through during my training, I've looked at, you know, I've had access to, and have been able to place myself within them and kind of develop a sense of myself, understanding and insight into myself and my own behaviours*" (Sal).

Eli has made several moves to different wards in different trusts and each has helped to develop her confidence:

> "*But I'm finding every time I make a leap, you know, my confidence has grown, obviously, you know, because it's different challenges and, you know, getting involved in doing 136's* [Mental Health Act, section] *and all that sort of thing now, and, you know, when I look back and I reflect on how nervous I was when I first qualified. Oh for goodness sake, you know, it's just by, again, you have to go through that process, don't you? It's all a process, you know*" (Eli).

For Pip being qualified and understanding himself was about realizations, learning the depth of the work, seeing the bigger picture, instead of just viewing the surface as he did as a student:

"It teaches you to control yourself, to be aware of the next day and what happened yesterday, and what's happening today" (Pip).

Kat has developed into a reflective practitioner, who wants students to view her as approachable, and how important it is being a qualified nurse not to bring your own problems into work with you. While also realizing that she is only human, her aim is to be:

"a professional, a professional nurse who should be professional in all aspects" (Kat).

The participants mentioned several times in different discussions how it wasn't just about developing their sense of self, but also learning from their own personal experiences of being a student then becoming a nurse. Sal was surprised that as a student she had not understood the complexities of working within an organization. One issue that particularly impacted on her was the culture of the ward, because as a student, Sal said, you were not in a placement long enough to understand the internal politics. Once you started work on a unit as a qualified nurse, and you had to learn the routine, and settle in, it's then:

"You're more susceptible to learning about the politics. Once you get involved in the politics you're in from the neck up! It's the politics that you can get involved in for being there longer, you get a bit of everything. It's a bit about the hierarchy between the nurses and the HCA's (health care assistants)*, also about what the managers are wanting us to do, what boxes we need to tick and if we agree with that or not, if it's doable or not, but yeah, also the politics between the staff, the dynamics and what they kind of believe in. You're an HCA, you do as I*

tell you to or you're a new nurse, you don't know anything, like it's that kind of, what do you know? You've only just qualified" (Sal).

Sal again said that she had learnt by watching others:

"*Thankfully it was a lot of kind of watching and learning rather than doing and making my own mistakes and learning"* (Sal).

Sal also did not realize how much office work qualified nurses have to do, and felt this paperwork takes them away from the mental health nursing care:

"I didn't have a clue, how much went on behind the scenes. I always watched the charge nurses sat in the office for shift on shift doing, I don't know, what paperwork they were doing, but now I see all the audits, and all the kind of silly little things, like having to walk round with the manager to check that a bit of Sellotape been taken off of a wall, little things like that, that's what I just didn't see when I was a student" (Sal).

Sal now encourages her students to be with the patients rather than sit behind the computer, because she feels when the students see the qualified nurses working on the computer, the students think that it's alright to do that too. Sal said that is not what mental health nursing is all about and the students need to understand "*the basics"* and that is to be with the patients.

Bea, like Sal, felt that as a student she did not realize exactly what was involved in being a qualified nurse:

"*I just think that as a student you don't realize exactly how responsible it is* (nursing)*, but I think you do realize how much responsibility it is once you're qualified, because you've been through that transition of students who's qualified,*

and that is the biggest load of responsibility in regards to nursing that I feel like I've experienced so far" (Bea).

Bea found it hard to believe how much the qualified staff let her do as a student and, now having learnt from the experience of becoming a staff nurse, believes it is not always right to give students that much responsibility:

"*I think it surprised me some of the things that in the past people have let me do as a student, and whereas I would now be thinking, oh my God, like should I be letting them do that or should I be doing that myself, and them watching or me just being more vigilant and watching them do it, and then so I can sign it off confident in myself as a registered nurse"* (Bea).

Eli also commented on the competence of the students:

"*So it's very important for you as a mentor to ensure that the students, you know, are very competent at what they're doing, you know, because you are, you've got people's lives in your hands in effect, haven't you really?"* (Eli).

Sal believed it is important to make sure the student is mentored and assessed properly, and that feedback is timely. Bea reflected back to when she was a student and how she felt learning outcomes were not assessed correctly:

"*Just remember like one of my outcomes was to do a risk assessment in clinical placement, and the person who was my mentor at the time just said, oh yeah, you can speak to our psychologist about CBT, and that somehow I got my risk assessment signed off through that, and that really worried me, oh my God, I need to do that at my next placement because I haven't done it properly in this one, even though it has been signed off"* (Bea).

Bea said she could not do that herself, because these students then become qualified nurses who are accountable but not competent. Eli stated:

"*It's very important for you as a mentor to ensure that the students are very competent at what they are doing, because you've got people's lives in you hands*" (Eli).

Bea said that as a student she felt lucky when on quieter units staff let her work on the theory assignments, but now she realizes that students learn much more on busy wards about what they need to know about mental health nursing when they qualify:

"*But obviously on the other side if you were working in a really busy environment you're getting to learn the absolute necessary, things that you're going to need to know when you are qualified*" (Bea).

Sal's insight had also developed, and like Bea she felt students need to make the most of every learning experience, because it helped her to develop her own identity:

"*I'd love for them* [students] *to have the same experience that I've had, I think, although I've had some negative experiences, especially when I first qualified, I wouldn't be the person I am now without it, so I can't just, I can't say, oh I wish that had never happened, you've got to take the good with the bad, and I'd like for the other students to come out as insightful and aware and prepared and professional*" (Sal).

Jed believed now that he has qualified that students should be treated as individuals, learners, and they should be treated as part of the team. The team he works in has a good leader and he now understands how important that is, for good team work and for his own development and that of the team, which

includes the student. Jed felt that without sound leadership the team would crumble. Jed would like to move on with his career, but understands that what is holding him to this particular unit is the security of a good safe team:

"*I really want to move on, but I'm lazy, because I don't want to leave a good team behind*" (Jed).

Pip's experience was similar; he had learned and now believed too that the teamwork was the crux to good mental health nursing:

"*We work as a team, if you don't participate well as a team the team is not effective*" (Pip).

<u>Summary</u>

Learning about identity as a qualified nurse was part of the developmental process for the participants. Learning about who they want to be, and how they wish others to view them in a professional capacity was very important. Part of this process was developing an insight into how they behaved as qualified nurses, not just with patients, but also with students. As their confidence grew they came to understand the complexities of nursing and mentoring and exactly what is involved. They had come to understand the importance of leadership and teamwork in this professional and accountable environment of mental health nursing. All these developmental enlightenments helped the participants to learn from experience, as presented next.

5.3.4. <u>Learning from experience</u>

"*I see it from the other side of the fence now, its very time consuming for nurses to try and incorporate having time with this student, in their 7 ½ hour shift as well as everything else they have to do, so therein lies the problem*" (Eli).

The participants believed most sincerely about learning from experience, making sure to lead by example, be a good role model, but also that they wanted to make sure their students did not experience some of the bad mentoring experiences they had as students:

"*I had a few, well, not a few, I had a not so good experience with one of my mentors and I have seen a few of my fellow students who had the same experiences, and that is something that I don't want my students to experience. Well, I try to be sensitive of their needs and what they want*" (Kat).

"*What happened to me as a student, it affected me but in a positive way, it brought out the better side of me, knowing what I experience, I don't want others to experience this if they are under my umbrella. So what would make me a good mentor or what is actually starting to build in my head now, is my experience in the practice environment what I see people do, what I have experienced, and how I think it should be*" (Jed).

Bea had also realized that students can learn from all experiences on the units, and do not have to be with their mentor all the time to get a good experience:

"*I can see like even though it's the same unit, on one ward you'd get to spend a lot more time learning and actually doing with your mentor, but actually on the other side you might not get that much time to spend with your mentor, but you'll probably be learning a lot more like valuable things at the same time*" (Bea).

Eli said it was important that the students have a good experience, and one of the ways to facilitate that was to reflect as a qualified nurse on the experiences she had as a student:

161

"*Well, like looking at them* [students] *and sort of reflecting back on my own sort of experience, probably thinking, oh well, I need to be careful here and sort of like*" (Eli).

Eli was saying that she did not want her students to experience, ineffective mentoring. Eli also said that she would not like it if the students left the inpatient unit bemoaning their experience, because it's:

"*a fantastic sort of like arena, to sort of like really like learn their craft*" (Eli).

Bea expressed similar thoughts:

"*I suppose my ambition would be to make sure that all my students were happy with their placement at the end of it and competent in what they need to do at that time*" (Bea).

Furthermore, Kat intends to make sure she upholds high standards of effective mentoring in her future practice;

"*I'm a reflective learner as well and I reflect on things that I have done, and sometimes when I am with students, we do reflect quite a bit, to think of how we may improve our practice and what we can do to have a better relationship as mentor and student*" (Kat).

Kat did not experience reflective practice as a student, and feels this is important part of mentoring. Kat also wants to make sure that mentoring is consistent for her the students and not haphazard, and this consistency was something she did not get with her mentor as a student. Kat also stated that protected time is the key to a good mentoring experience. The importance of consistent mentoring was mentioned by many of the respondents. Jed has learned from his experience of ineffective mentoring:

"*It affected me in a positive way, it has helped me to understand that what I expected to get, I didn't get, I have to give it back to the people who are behind me* [students]" (Jed).

Jed said that it is important to make it clear to the students what is expected of them; this was something he felt was lacking during his studentship:

"*Because nursing is all about confidence, what you do, how you present it, so clear statement on what the problem is and how it needs solving, because if you don't state it clearly people certainly will not know what to expect of you and so can take the wrong decision*" (Jed).
Therefore Jed encourages the students:

"*I said I know you are a third-year student, I am only trying to help you, take the handover, we do community meeting every morning sit down there organize it, this is you building your confidence ,and if think there is something you need to know you need to ask me*" (Jed).

Jed reflected on his experience, and he would have liked somebody to encourage him, and help him build his confidence, but also be there for him:

"*When I was a student I didn't really have this, somebody on my back telling me ok come you ought to come and do an injection. Sometimes you would offer to, they would tell you no which is understandable when the patient says no, because patient centered care all through practice, but sometime they wouldn't even ask you, they would just go and do it, and when you want to join them their attitude and body language, you don't feel like asking*" (Jed).

Jed stated he had learnt through these past experiences and what he should give to the students is what he did not get. Pip felt the same and as a student he felt excluded:

" I felt they thought I had nothing to contribute. So I said, I will never do it too, well, when I am in charge I will never do that" (Pip).

Sal reflected back to her experience as a student, and felt that she could have been encouraged by her mentors to experience the whole process of nursing, Sal has learnt from her experience and intends for her students to experience the nursing process, in her own words:

"I think if the mentors that I had were more aware of their mentoring processes, and just the idea of looking at a shift on a whole, even though I'm supernumerary it doesn't mean I can't do anything within the shift, it doesn't mean I couldn't have done anything that the mentor was doing, we could have done it together, and there were times when we just touched on it and then the mentor went off and finished it, when I could have been a whole part of the process. And I think it's about... now I feel as a nurse and a mentor, it's about me taking the student along the journey of the shift with me, um and if I'm able to, if they're there for long enough as a student, to take them through the patient's journey, um so they can see it as more of a complete picture rather than just bringing them on shift by shift for different patients" (Sal).

Summary
The reflective process documented above is an integral component of the process of being a nurse. The participants were reflecting back to their own experience of being mentored and considering future needs, not just their own needs as nurses and mentors, but the students' needs within those relationships. It was clear from these comments that they want to be better mentors for their students; to encourage the student, to instil confidence, to let them know what is

expected of them in the clinical environment, and take them on the journey of the shift. Students have a lot to give, and what the participants have also learned is that students can learn from other team members as well as the mentor. These reflections are also part of the process of becoming a mentor, which will be discussed next.

5.3.5. <u>Becoming a mentor</u>

Training to become a mentor had also enhanced the beliefs and issues discussed above, that the participants had about being a nurse and mentoring. Bea said that as a student she could not understand why the mentors did not have time for her, but now as a qualified nurse she can understand why time is in short supply and it concerned her:

"*But then being in that situation* [being a nurse] *you just think, oh my God, I don't know how people deal with this"* (Bea).

Bea has not done the mentorship training yet, but is aware that she has to become a mentor because it is 'mandatory' as she understands it:

"*It's a mandatory, like mandatory course to do once you're qualified to be a qualified* (mentor)*. So it's like a responsibility that you don't ask for in a way, but you've got to take it on, so I suppose you can see where negative attitudes do come from. But as a professional and qualified person you're going to have to just get over that and feel like, you know, you have to do it and so do it to the best of your ability kind of thing"* (Bea).

Sal is already a qualified mentor; the training gave her time to think about becoming a mentor:

"It was quite interesting (mentorship training)*, it gave me the opportunity to reflect on myself a lot and reflect on my good experiences and how I want to make experiences for my future students"* (Sal).

Kat commenced her mentorship training just before the second interview. This training has helped Kat to understand how she wants to mentor students:

"Having started this mentorship course has opened a lot of ideas and a lot of options that I want to pursue with my students, so we can either encourage them more, or we can help them more with their learning objectives by knowing what type of learners they are, and trying to make sure that we create the right environment for them, that it's supportive and open and accountable" (Kat).

Bea, though, feels quite anxious about becoming a mentor:

"I always thought as a student, oh, I'll be a great mentor, I will be making time for my students, I'll be doing this, I'll be doing that, but when you're there and you're doing it and you've got this full-time job (nursing)*, plus another full-time job* (mentoring) *at the same time of looking after a student, and making sure that they are like looked after and taught the right way and doing things in a way that you would be happy with signing them off, it's the challenge to get that time and depth with them"* (Bea).

Nevertheless, Bea believes that anywhere she works will have students learning in the clinical environment, so she is hoping the training will help:

"So if you've had that extra bit of training to help you to see what the real mentor role is, then it should just be fine, I'm positive about it" (Bea).

Eli has completed the taught sessions and just has to pass the mentorship assessment process, and is excited and looking forward to the challenge:

"*I think I'm going to enjoy it, because I like sort of like kind of passing on knowledge, so I'm looking forward to that*" (Eli).

These participants also had aspirations for their role in the mentoring process, which is supporting students to reach their potential and mentoring students so they are fit to become qualified nurses and to mentor themselves:

"*When I start mentoring I would like the experience that my students have, is something that they can nurture and later on impart to their students in the future, because that's what I want, because there are a lot of students here, and even when I was training, who were not really given the potential to achieve their best. Because if we do that then every student that we mentor and who will mentor in the future, will be achieving the same thing and will produce good nurses*" (Kat).

"*I just think the whole sort of like, you know, student-nurse kind of like mentorship process is really important, you know, you're guiding the next kind of like generation of qualified nurses, you know*" (Eli).

Sal reflected on how she likes to try to teach the students without putting them under pressure:

"*I like to try and teach my students now, that's it's ok not to know everything. I just go in slowly and just try and work out, rather than running in saying, you're being lazy, and finding out that they're dyslexic or something. I try and figure the person out first*" (Sal).

Eli also said nurses should not forget what it is like to be a student. She overheard recently-qualified nurses [with two years' experience] bemoaning the students and Eli thought:

167

"*Hey guys, it's not that long ago since you were going through that yourselves, you know, and it is stressful. It is a stressful time for some people, not everybody, but for a lot of people it is, you know, people forget very quickly*" (Eli).

Kat, who has two and a half years of experience as a qualified nurse and has just completed her mentorship training, feels more confident to mentor students now,

"*There's a big difference because you've honed your skills, you've done a few years of practising as a qualified* [nurse]*, so the way you practise is more as a professional really, and all the experiences and all the skills that I have achieved and mastered, I could share much more readily with my students. And being a role model to them I teach them what the trust expects me to be as a qualified* [nurse]*, that's what I impart to my students*" (Kat).

Eli had similar thoughts:

"*I feel quite confident about doing it, you know, I think I can pass on quite a lot of knowledge to people, I know that I'm coming from the right place and that*" (Eli).

Sal referred to the responsibility involved in being a mentor, and guiding the next generation of nurses:

"*Oh, so responsible, so much responsibility as a mentor to teach your students, they are going to be your future colleagues and you want them to be fit for practice because that's just a whole other headache if they're not, you know, it's totally up to us and the placement. I feel really quite strongly about mentorship and that, um and I've made like a student pack, it's turned into like a massive ring binder with all the information a student would know about the placement and it's just little things like that, you need to give them the basics, the*

groundings of being a good nurse, and yeah, I get really passionate about student mentoring [laughs], I feel that we are the key to their future" (Sal).

Sal said management had been so impressed with the student pack that it has been copied and placed on all the other units in the area where Sal works. Sal's experience of not realizing how much you don't know about being a nurse when you are a student, especially about the politics of the units, made her decide to help her students understand the reality of being a nurse:

"*Yeah, they'll often find me harping on about politics, oh you're so lucky as a student, you don't get involved in any of the box ticking"* (Sal).

Eli had learned through her own experience and by becoming a nurse and training to be a mentor what the student needs:

"*I still hold the view that students need to be given time, you need to sit down with them, you need to go through their learning contracts with them properly, set out the objectives, of what they're here for in this placement, what can they get out of this placement. Then to get them involved, not just for the students to be sort of like helping out on the shop floor, though that's important too, because I think, you know, the students get a chance to sit and have one to ones with the patients, which is really good, and to build up that kind of like rapport and stuff with them, they're learning all of that, that kind of art of communication, aren't they, when they're out on the shop floor?"* (Eli).

Eli believed that giving the student structure and direction in regards to what they should be doing helps the student to feel safe, because spending time with the student and discussing the student's needs, helps to make them feel valued as well:

"*If you put some sort of like structure in place for them, that makes them* [students] *feel safe, doesn't it, it's like patients with boundaries, you know, it just*

helps people feel safe when they know what's going on, they know what it is they're supposed to be aiming for" (Eli).

Pip believed that mentoring is teaching the students about how to care for the patients:

> "*It's about learning how I should apply what I have learnt to the patient and how there are changes. Before I went for the training* (nursing) *and now that I'm trained, there should be a change in how I treat my patients. Yes. This is what I think it should be about mentoring and this is what I have observed in mentoring, it's effective communication with the patient"* (Pip).

Kat had stated during her preceptorship that she wanted to do the mentorship training, but she said it took a long time, and she was due to qualify as a nurse mentor shortly after the second interview. Nevertheless Kat had already developed ideas about what type of mentor she would be, and had developed an understanding of the responsibility involved:

> "*As a mentor I should be more sensitive to the learning styles, learning preferences, and not just impose all my views to them, because, having started my mentorship course, we're talking about how to mentor students according to their learning skills and learning preferences, whereas before as a student I was just learning, but now I try to mentor students according to what they need and what their skills are. Being able to share my knowledge and not force everything to them and being aware of how they learn, and I can adapt my way of teaching to their learning preferences. And as a mentor now to a student I am more aware about how I model myself to them, because being a qualified now and being accountable I need to be able to demonstrate to them that what I am teaching them is the right thing"* (Kat).

Bea believed:

"But at the end of it I want them to be good nurses, I want them to have a better experience than the one I've had and I want them to be able to do their job" (Bea).

Jed believed that being a mentor is more than supporting and guiding the student, it's about encouraging them to understand the theory behind the nursing practice, the evidence base. Building their confidence and treating the student as an individual and encouraging them to reach their full potential were important to all the participants. They felt it was important to prioritize the clinical work to ensure the student receives the correct supervision according to their needs. Jed felt he needs to give the student the kind of effective mentoring which he did not get:

"I have to give it back to the people who are behind me" (Jed).

Summary

The participants now realized that it was a challenge to find the time to mentor effectively, balancing the needs of the patient with the needs of the student. Those who had done, or were doing, the mentorship training had realized that the training helped them to think about what type of mentor they would like to be; that is, supportive, passing on the knowledge, sharing the reality of being a nurse, and helping the students to reach their full potential. What they also wanted was to be 'good' mentors, because good mentors produce good students who become good nurses and mentors. It was also very important that as mentors they should not forget what it feels like to be a student. Through the process of becoming, the participants had developed ideas and thoughts about how the mentoring system could be more effective in the future. This is discussed in the next section.

5.3.6. <u>Sustaining the mentoring role</u>

Some of the participants in the second interview had learned through the transitional process: that is, reflecting back and exploring how mentoring could be improved in the future. They had ideas about some methods of sustaining the mentoring role. Their aim was to give to mentoring what was missing from some of their experiences of being mentored as students.

Kat had already implemented a method of ensuring she spent time with her students, based on forward planning:

"Well, when I meet up with my students, because there are two qualified staff on a shift all the time, we talk to each other because we both have students, we talk to each other about what time we want to talk with our students and we book a room and announce it to the team; I am going to meet up with my student, so whoever is the qualified [nurse] *left, will run the ward that hour and then vice versa. We include the students when we're planning the shift as well, what can be done, what learning can we give, it depends on what time of day as well, so again, forward planning is important"* (Kat).

Jed believed that the student should be embraced as part of the team, rather than just be 'the student':

"You need to see the student as part of this team, and not just as a student then you treat the person differently. If he makes a mistake you can call the person to order, but until then see them as part of the team, they can make decision under supervision, that's why they have a mentor" (Jed).

Jed was explaining about how important it is for the student to feel part of the team, to make decisions and mistakes under supervision of that team. However,

172

Eli felt that the qualified staff should be careful not to deflate the students' confidence when managing students' mistakes. Eli said the mentor should not be 'heavy-handed' in how they deal with the students' mistakes, but create a secure teaching environment, one in which the student can learn from their mistakes:

"*By allowing the person to sort of like make mistakes, you know, to sort of like get into the middle of the bed if you like, sort of like, and learn as you're going, and sometimes mistakes will be made and then you can grow and learn from that, yeah, but under the guidance of your sort of like mentor and other sort of like qualified nurses round about you. Well, if somebody's coming down too heavy handed on you it just makes you a nervous wreck, It just absolutely shakes your confidence completely and that's not good, nobody knows until they're shown, it's as simple as that*" (Eli).

Eli also felt reflection is important tool in guiding the mentor to become more effective:

"*Well because, you know, it's not that long ago since I was a student myself, you know, and I remember sort of like the kind of like fears that I had around sort of like, you know, being on practice placement and stuff*" (Eli).

However, Sal believed that whatever is done to improve the effectiveness of mentoring, you cannot change personalities, and a good mentor is passionate about the role:

"*And I think you can't do anything about somebody's personality, if they're going to go into a job just to do a job rather than go into a job to really get something out of it and to have some passion about it, I think the only reason, you know, I'm only so passionate about mentoring because it's part of my personality and who I am. I notice some people coming into the job who are only doing it for so long until they can get to be a manager, and I think it's about... it's kind of a never-ending vicious cycle*" (Sal).

All the participants in the second interview also referred to time being a problem but again some had ideas about the management of time:

"Time is an issue, a good mentor will work around it, to be honest because I, people say ok I will come early to help you out, it's all about bending rules, yes the ward have been very chaotic ok, so it's not been good time to do anything, ok can you stay back maybe you need to go, I've been doing this job 5, 20 minutes time, tell the ward manager I need to have time with my student yea, that's why I use the word prioritize your work to accommodate support for the student" (Jed).

Bea believed management can help with time management:

"I know this is an ideal world again, but sometimes I think, I suppose you could even negotiate with your manager, if you feel like you're really snowed under with your work anyway, and you go to your manager and say look, I've got a student as well and I'm kind of neglecting them, and I haven't done this with them, I said I'd do that with them, but I just haven't had the time, maybe there can be a time when they just give you half a shift, or pay you for an extra hour or something, just to come in and sit down and do that work with your student" (Bea).

For Eli making time to mentor was all about pre-planning:

"Well I would sort of like try and diarize it, that's what I've been doing, you know, just putting it in the diary that I need to have this time, and that I'm going to spend this time, so I've been doing it sort of after handover, so after handover, sort of like in that period between sort of like two and three o'clock I'll say right, do my diary, I'm sort of like sitting with the student, and that's how I've done it for the past two times that I've sat with a student" (Eli).

174

Eli uses the time between hand-over and going home for her diary time with the student, and advises other mentors and newly qualified mentors to do the same, (this advice would be acceptable from Eli as she is now a charge nurse).

Sal, like Jed, said it is about making the time:

"*I make time. We've all got to time manage our own shifts, and if I've got to take time to do something like write up a care plan, I'd rather it take ten more minutes with the involvement of the student, than for me to just bash it out and the student not get anything from the shift, so I just make the time to mentor*" (Sal).

Jed implemented a method when the wards are busy and they are short of staff:

"*What we do differently when the ward is chaotic is you have, you will look for extra staff, yea, we call nets, what you call it net bureau* [agency staff]*, and look for extra staff and after the shift, and prior to the shift ending, I need to have time with my student, take your time go to quiet room to sit with your student*" (Jed).

Pip believed that most students do not get to spend 40% of their time with their mentors, thus it is important for the mentor and the student to check the rota and ensure time is allocated for them to work together on the unit:

"*So I'm saying it would be better to look at the timetable so that the student, so that you see that the student has more time with the particular mentor*" (Pip).

Making the student feel welcome is also important. In the trust where Bea works, there is a system in place which ensures that the student is made welcome when they arrive, and that is, ensuring a mentor has been delegated:

"On our ward we've got somebody that's allocated as like the head of students, so as soon as our ward manager knows there's a student coming, they will let that person know and they will need to delegate a mentor, be their mentor themselves, and I've realized things like our ward manager would put the student on the rota so... like quite in advance, like I'd say about a month in advance and you'd see them there, and they would have been in the process of either allocating or would have allocated a mentor way before that person started" (Bea).

Pip believed that if you do not involve the student they will not know what to do, and often then they will just go and work alongside the health care assistants (HCA); so he said that firstly he welcomes the student, and then tries to calm them by getting them involved in the work on the unit:

"What I do myself is I say come, I do it for the student possibly to calm them, or sometimes, as I say, they are scared, so I make sure the student is involved and that the student does not gets scared. Often getting into things, that's the best way of learning, you know. Get into things, OK, tomorrow, well, we'll do that and that, yeah? Go and get the research and you come and discuss. Well I don't want to dish out (theory)*, because if I dish out it's easily forgotten, but if someone researches a subject, that's fine. And I also learn from there"* (Pip).

Having experienced a six month preceptorship with one mentor has taught Jed that consistency improves the mentoring process:

"So being with one mentor for a period of 6 months required standard, I think is the best you can get" (Jed).

176

Kat believes it is more than learning from experience, because it is important to encourage the students, meet regularly, and check their progress:

"When I was a student I was quite proactive with my learning, and now as a mentor I try to encourage my students to be proactive as well, and to take responsibility of what areas of skill... what areas they want to improve upon, and we try to meet up... make sure that we meet up regularly at least three or four shifts, that I spend time with them, and we try to work out a schedule as well, where we meet up and do a bit of reflection every now and then to see how they are coping and to just check their progress, and to see if they have any problems. So being involved in my students' progress all the way, and being, as I've said, being supportive of their learning and being flexible as well when they have issues at home. So if they can't work with me three or four shifts a week then we can make it up during the weekends" (Kat).

Eli had an idea to enhance the students' experience that has not been implemented yet:

"To have some sort of kind of student pack, yeah, and depending on the unit that the student was in, sort of like say, for example, have, a student pack for first-year students, second-year students, third-year students and the expectations of what would be expected, you know, because within that the competences, say, for example, you know, you need to be looking at risk assessment, care planning, their interpersonal skills , that sort of stuff, but kind of like set the benchmarks for their appropriate sort of like level, and so that you don't have like the student getting to the end of third year and then all of a sudden, right, I need to know this, this and this, and feeling a little bit shaky that perhaps they don't know all of that" (Eli).

Summary

The reflective comments presented above about improving the mentoring role highlight the issues learnt from participants' experiences of being a student, and

being mentored as a student in the world of mental health nursing. The participants used this reflective process to consider their future potential possibilities as mental health nurses and becoming and being nurse mentors. Being-in-the-world of mental health nursing as a nurse and mentor was a shock to many of the participants'. However they adapted to the role, and learnt through the process, whilst taking the role of nurse and mentor both professionally and seriously.

The participants believe the student should be made to feel welcome by the team. It is also important that the mentor has been allocated to the student before they arrive, and then the student knows that the team has prepared for their arrival. The participants' believed that being expected and involved in the students in the daily routine helps to make students feel secure and supported. This supportive atmosphere should encourage the students to learn the craft of caring under supervision, to learn from their mistakes and to develop confidence. The nurse mentor needs to remember what it feels like to be a student, and to remember that if the student is not shown, they do not necessarily know. It is important to spend consistent time with the student, being there for them, and to plan inventive yet practical methods of protecting that important time.

Thus, this transitional process highlights that on the whole students are not as prepared for clinical practice as qualified nurses as they could be. What the transition has taught these nurses is that preparation for transition can be enhanced through effective mentoring whilst people are still in student status. It is easier to change ineffective nursing practice with a student than it is once they are qualified. The students of today are the nurses and mentors of tomorrow who could be nursing family and friends or working alongside these participants as colleagues. Passing students who are not competent is not acceptable in these participants' view. The values and belief systems of these now qualified nurses had been developed through the transitional process, developing a sense of identity through the process of becoming, an identity of who they want to be as nurses and mentors, but also how they want to be perceived by others.

5.3.7. <u>Conclusions</u>

The findings presented an essence of Dasein in regards to how the participants told their stories of Being and becoming. This narrative unfolded the becoming of the student through the transitions. Being mentored had altered their 'paths' to their profession. As Pip said, their experience had become embedded in their histories and it became clear that their own histories had affected how they consider their future possibilities. Their past and present everydayness, the interactions and in-betweeness of familiarity and fear of the unknown became revealed through the existential experience.

The temporal understanding of Dasein was clarified to some extent through their expressions of Being-in-the-world of mental health nursing, and reflecting on the studentship, whilst considering the future of how they nurse patients and mentor students. The Heideggerian concept of care (Sorgen) was useful in understanding their related student/nurse experiences of Being-in-the-world.

The participants' Being in this study was also expressed through their relationships with others which were temporal and related to their care and concern for others, but also concern for the self. These individuals' actions and choices enabled them to relate their own perceived existence, the meaning of what it meant to be human, Being-in-the-world of mental health nursing. The uniqueness of each individual unfolded the intricate relationships and highlighted the nursing world as complex and inconsistent, but it always was ready-at-hand (Heidegger, 1962) to offer potential. However, the potentiality provoked strong feelings of anger, and anxiety, linked to the fear of not succeeding, or losing what they had already achieved. Success was viewed at times as the responsibility of the mentor, reflecting their need to conform to others demands and fall into inauthenticity, struggling to belong, be accepted and to be authentic.

The students in this study generally believed people need passion to become and be a nurse, and not everyone can be a mental health nurse and not everyone can be a mentor. It is evident that on occasions they were disappointed when they perceived nurses and mentors to not have that passion.

179

As students what these participants did not want to learn was 'empty busywork' (Heidegger, 1978), they wanted to understand the deep meaning of the craft of caring, to understand its real significance. Adherence to the craft appears to have become central to their Dasein. They had expected this understanding of the craft would be taught by mentors who had concern for their education, and their development as future practitioners. However, this was not always the case, and at times the lack of concern from the mentors created more anxiety and frustration, even anger in these participants. They thought their mentors would be empathic because they had been students themselves once, and this empathy would inspire the mentors to share their knowledge of the real meaning of the craft. Often these participants felt mentors had no real understanding of the task they were undertaking. At other times they understood that the craft of caring was facilitated in a manner which was outdated, and their concern for this was inhibited due to the fear of punitive repercussions. Whilst the student's in this study at times felt concern for their mentors, without the deep knowledge about all the intricacies of the craft, they could not really comprehend the reality of the everydayness of mental health nursing, thus they could not always understand why the mentors where not there for them, or did not care for them.

These participants learnt some of the craft from effective mentors, and they learnt how to learn from Being-with-others, when mentors were not there for them (ineffective mentors). They also learnt from effective and ineffective mentors, their own understanding (potential) of how they wanted to be as a nurse's and mentors.

The journey which the participants took through the transitional process developed their understanding of their mode of Being, and the unfolding of their sense of self in becoming registered mental health nurses. This self-awareness surfaced through their Being-in-the-world of mental health nursing, and experiences of Being-with-others and caring-for-others. The interpersonal interactions they each experienced further developed this sense of self which involved them being in the present, considering the past and contemplating their future.

The experiences of being mentored had taught them about the meaning of effective mentoring, because until they had experienced good mentoring, they did not realize that some of the mentoring they received was poor. Effective mentoring, these participants believe, is: the mentor being there for the student, caring for them as a nurse would a mental health patient: Communicating effectively and nurturing the student: and building a trusting relationship which allows the student to feel secure and reach their full potential and become more independent. The participants' goal now is to make each student feel welcome and wanted, and take them on the journey of the craft of caring, teaching them the real significance of the craft, and all the intricacies involved, ensuring the students practice is safe and competent. However, most were aware that balancing the needs of the student with the needs of the mental health unit and the needs of the establishment will not always be easy. These participants' views highlight the importance of care and concern, not just for the self, but for the patients and the students. These participants' views for me, expressed a passion for craft of caring, which conveyed care and concern for all involved in the craft of caring. However, these participants had also come to understand that when Being-with-others in the caring role that they cannot always be true to themselves, be authentic, because the need to conform will always be ever present, the understanding of this formed part of their development of their sense of self, their understanding of their own Being.

The above intuitive statements should be treated with caution, and on reflection I would suggest it is an essence of their Dasein which has been captured, a part of the whole which has highlighted new meanings. Crotty (1996) states that the researcher needs to ensure that the essential phenomenon is identified, thus bringing new meaning to life. What this study has done is bring to life the lived experience of the participants' basic mode of Being-in-their-worlds as they told it, but as I heard it, experienced it and interpreted it. The danger of imposing my subjective view into the process of interpretation was, as Crotty (1996) said 'ever present'. What needed to be taken into account is what has been presented in these findings. That is, the understanding of what I saw, heard and experienced,

181

which has not become something different, it has as Heidegger (1962) said, 'become itself'. Existential analysis of the transcripts involved the intuitive understanding of the participants' evolution into mentors:

"*Understanding does not become something different. It becomes itself. Such interpretation is grounded essentially in understanding; the latter does not arise from the former …it is rather the working-out of possibilities projected in understanding*" (Heidegger, 1962, p.188).

These findings has exposed a meaning of their views, that is, what has been presented is a 'fundamental possibility' of being human, a 'non-categorical manifestation of Being'.

Chapter 6: Discussion of the findings

6.1. Introduction

This aims of this study were to:

1. Explore how the role of the mentor affects the training of student mental health nurses in clinical practice.

2. Gather and interpret data about the essential meaning of being a student, becoming a nurse, being a nurse and becoming a mentor.

3. Understand the everydayness of Being for the individual through the different transitional stages and within different social contexts.

4. Explore how the process of Being-in-the-world of student nurse training reveals an understanding of self within the world of mental health nursing, and how this personal meaning of nursing is assimilated into their approach to nursing. (See table 6, 6.4.3 p.252 which demonstrates how this study has contributed to knowledge and how the aims were addressed).

The study has explored how mentoring was perceived during the transitional stages of nursing, that is: being a mental health student nurse and becoming a nurse, being a nurse and becoming a nurse mentor, and being a nurse mentor. The national and international evidence clearly indicates that the mentoring process and experience is highly inconsistent (Gidman et al., 2011, Hubbard and Foley, 2010, Rungapadiachy et al., 2006). Students sometimes get their needs met and reach their full potential in the craft of caring, and at other times students are left on their own with no direction, feeling insecure and full of anxiety Kilgallon, (2012). Gopee (2011) suggests that not only does this leave them impotent it also makes them feel incompetent, learning can then be blocked due to these negative feelings. A cycle of inaccurate perceptions at these stages can be damaging to the ambition of the student mental health nurse. If this neglect was protracted then many students will leave the course, while others will be viewed by their establishments as incompetent students, due to their lack of

knowledge and skill, who can become incompetent qualified nurses (Kinnell and Hughes, 2010).

This chapter discusses the findings with current and established literature in order to highlight what has been learned through this study about supporting current knowledge and what has been perceived as a potential contribution to this current knowledge base. The discussion presents findings which clearly support what current and established literature, including research, has already offered to this complex subject. However, the nature of this inquiry has also revealed a much deeper understanding of the process of Being and becoming. Highlighting how much the participant's sense of identity is determined through the transitional experiences of being a student, becoming as nurse, being a nurse and becoming a mentor. It is these findings which offer fresh insights into the nature of the mentoring process.

The participants made many references to supporting mentees who would become future practitioners, their peers, managers or even their carers. The findings of this study identified certain layers of meaning, about the concept of mentoring: as a student, nurse and mentor: but this existential study also revealed what it means to become a nurse and to become a nurse mentor, that is, the shifting perceptions of mentoring in mental health nursing.

The first discussion will focus on the findings from Part One: the qualified mentors and the students, 'the conceptual elements of mentoring', 'being and becoming a mental health nurse'. The second discussion will focus on Part Two of the findings that is 'the concepts of transition' and 'being a nurse and becoming a mentor'. It will be seen that the aims of the study have been met and these are linked to each part of the discussion below (see brackets) and to the findings in table 6, 6.4.2.

6.2. Part one: The conceptual elements of mentoring (1st interview and qualitative data from the questionnaire).

Being a student, becoming a mental health nurse

The core essences from Part One of the findings below are reviewed in this first discussion and used as subheadings:

Core essences:
6.2.1. Experience of mentoring
6.2.2. Coping with anxiety
6.2.3. Students' responsibility
6.2.4. Mentors' role/responsibility
6.2.5. Time to mentor
6.2.6. Sustaining the mentoring role

6.2.1. Experience of mentoring, (research aim 1, see 6.1.)

"*Effective mentoring produces effective students who, in turn, become competent, confident registrants who will have mastered the art and craft of caring for patients with mental health needs*" (Teatheredge, 2010, p.21).

The qualified mentors in this study stated that the effectiveness of mentorship depends on the ability and attitude of the student, and the professional qualities of the mentor. The students agreed and in their experience some mentors had been effective but others had not. Some students had found themselves during their clinical placements not being expected by the team and even if they were expected often a mentor was not allocated to them. Some students felt their mentors just left them on their own during a shift with no clear direction, support or supervision. Gray and Smith's study (2000) found that poor mentors are often distant with the student, and lack the ability to create structure. Experiencing

ineffective mentoring left many of the students in this study feeling uncared for, frustrated, lost and anxious. These emotions did at times block (Mullins, 2007) the students' ability to learn the craft of caring (Barker, 2009).

Levinson's (1978) theory would suggest that the students' needs would not have been met when experiencing ineffective mentoring, and the student could possibly be left feeling demotivated and uninspired. This experience was not necessarily the 'toxic mentoring' Darling (1984) referred to, but caused by pressure of work, which the qualified mentors' alluded to in their written responses. Lindsey-Ochoa (2009) emphasizes that time is precious for nurses, and time for mentoring is even harder to find (RCN, 2007), the mentors in this study reported having students puts increased pressure on their clinical time, which in the world of mental health nursing is very busy, and as unpredictable as the unstable mind (Barker, 2009). The mentors felt this pressure left them little time to teach or support the students, hence creating the sense of abandonment the students described. The NMC Code (2008b, p.2) states '*make the care of people your first concern, treating them as individuals and respecting their dignity':* thus the mentors were following their code of practice by caring primarily for their patients, but they also had to commit to the role of mentor. The NMC (2008a, p.31) standards to support learning and assessment in practice (SLAiP) state that it is the responsibility of mentors to commit to supporting the students and '*their workload needs to reflect the demands of being a mentor'.* Therefore, it is arguably the employer's responsibility in meeting the NMC requirements to give the nurses' time both to nurse and mentor.

Chambers (2007) suggests that pressure of work and lack of protected time result in poor mentoring. Chambers (2007) also suggests when working within these pressures the mentor could consciously or unconsciously be discouraging the mentoring through the neglectful behaviour (as described in this study). Whilst as students the participants could at times understand that the mentors were busy, which was also identified in Gray and Smith's (2000) study, this understanding did not relieve the anxiety and frustration, and the neglect resulted

in the students feeling more concern for themselves, becoming self-absorbed and very needy (Bowlby, 1969).

Whilst the NMC has delivered a blueprint for mentoring in practice (SLAiP, 2008), it is a standard and not a regulation. Thus the healthcare providers are charged with implementing standards which creates ambiguity and inconsistency (Gopee, 2011). Furthermore, the NMC was reviewed in 2012 by the Council for Healthcare Regulatory Excellence (CHRE) this review was at the request of the Department of Health (DH). The initial review described the NMC as 'unsatisfactory and dysfunctional'. The final report (CHRE, 2012) stated that the NMC had not protected the public as well as it could do, and that it had not inspired confidence in 'professional regulation'. Arguably the NMC could be challenged about the mentors' standards (SLAiP, 2008), as being unrealistic, that the reality in clinical practice makes it difficult to mentor effectively (as my study has highlighted), certainly without protected time. The implementation of the standards (NMC, SLAiP, 2008) would have been more functional if the NMC had stipulated that time be protected for mentoring, rather than just advocating it. This would make sure students are supervised and practising ethical care and so protecting the public.

Lindsay-Ochoa (2009) believes it is important that the student understands that the mentor has many other responsibilities during the day. However, whilst some of the students in my study said they did understand this, they believed that the mentors should be more open in their communication. Explaining to the student their absence or lack of support, in an honest and congruent manner which students believed and understood, this does not necessarily solve the problem, but it helps in sustaining the relationship (Jokelainen et al., 2011). Johns (2009) suggests that reflection is important, in regards to thinking in the moment in order to view the consequences and possibilities of our choices and decisions. Dee pointed out mentors need to remember that they were students themselves once, and reflection would help the mentor to empathize and be more concerned about the student's needs (Johns, 2009).

Effective mentors should inspire students to become effective nurses, who deliver effective care to their patients (Gopee, 2011), and an effective mentor can also inspire the student to become an effective mentor themselves once they have qualified.

Summary

Gopee (2011) suggests that the effective nurse cares for the patients and aims to achieve the goals in the personal care plan with the patient, and strives to ensure quality of care is continually improved. The effective nurse mentor strives to ensure the student develops confidence as they gather clinical knowledge and understanding about the delivery of quality mental health care the mentor nurtures the student so they can reach their full potential (Wallace and Gravells, 2007). My study clearly identified that the mentor needs to be reflective and communicate why they have been unable to give the student their time. Through reflection the mentors will have more clarity about studentship, be more empathic and explain to the student the everyday intricacies of mental health care which sometimes take priority (Barker, 2009). However, this study has also shown that some mentors did not have care for their students, were often distant, absent or just not interested. Hubbard and Foley's (2010) study revealed similar problems. Hubbard and Foley (2010) believe that to improve the effectiveness of mentoring the barriers or difficulties in mentoring have to be acknowledged, and managing the students' anxiety was a potential barrier highlighted by the students in the first interview.

6.2.2. <u>Coping with anxiety, (research aims: 1 and 2, see, 6.1)</u>

The student nurse is a 'novice apprentice' according to Levinson's (1978) theory, who will possibly form an attachment to the mentor in order to develop a secure base (Bowlby, 1969). Levinson suggests that individuals need to attach to connecting persons in the world, and attach to elements of the world itself, in order to belong, and learn from others in the process of becoming. Anxiety to

belong in the clinical environment drives the student to seek stability and security, which may come from the mentor or the team. The need to feel secure (Bowlby, 1969) is heightened in the student, especially on a new clinical area; if the student is anxious the ability to learn can be reduced or blocked, as Kilgallon (2012) suggests. However, Bowlby (1962) believed that the need to find a secure base drives the individual to attach to effective and ineffective caregivers, thus if the care given (albeit in this case mentoring) is ineffective the experience of the secure base is likely to be tenuous. However, it is only when one experiences effective care (mentoring) that one understands the previous experience was not as it should have been. Some of the participants in this study were anxious, and not having or being with the mentor, made them more concerned for themselves, because their needs were not being met (Levinson, 1978). This study also indicated that it was not until the students had experienced effective mentoring, which reduced their anxiety, that they realized how ineffective the previous mentoring had been.

A Heideggerian approach would suggest that the anxiety is also manifested through concern for the self, concern about what is needed from the mentor to become a mental health nurse. All modes of Being-in-the-world have concern (Heidegger, 1962). The students chose to commit to studentship, but they needed the mentor to guide them in the actions of becoming a nurse in-the-world of mental health nursing (Gaarder, 1995). These mentoring relationships in the nursing world were complex and inconsistent. As the findings are discussed it will become apparent that these relationships provoked feelings of anger, frustration and anxiety. These feelings were intrinsic to the fear of not succeeding or losing what they had already achieved (Hubbard and Foley, 2010). Success was viewed at times as the responsibility of the mentor, thus their need to conform and fall into inauthenticity, struggling to belong, be accepted and to be authentic (Heidegger, 1962).

Ashton and Hallam (2011) believe that anxiety in the student is not just about feeling secure, but it is also caused through the student's lack of knowledge and skills in mental health nursing, as well as not knowing how the unit functions, not

189

knowing who their mentor is, or how they are going to address their learning outcomes. These factors are similar to what the students in this study said (see section, 5.2.2.).

The NMC (2008a, p.31) standards to support learning and assessment in practice (SLAiP) state clearly that mentors: '*should be allocated prior to commencement of the placement'.* This is not always evident in everyday reality as many of the students in my study stated (see section, 5.2.2.). In the first interview Kat said that she had even telephoned the unit to let them know she was coming, but it was evident when she arrived that those on duty did not know she was coming, and it took a week to be allocated a mentor. Dee said she had waited up to two weeks to be allocated a mentor, and according to Gopee (2011) this is unacceptable. These situations create deeper feelings than anxiety, for example, rejection, and also impede learning as the anxiety only increases as time goes on, as Darling's (1984) study revealed. The attachment to the mentor is further complicated when that mentor is ineffective, unresponsive or unavailable (Hubbard and Foley, 2010). The students in this study alluded to this being their experience on occasions (see section, 5.2.3.).

Downie and Basford (2003) believe that if the mentor is ineffective, this will have a negative effect on the student's confidence, and Walsh (2010) suggests this reduces their self-esteem and potential of becoming mental health nurses. This then increases their anxiety, preventing them from exploring the world of nursing, all of which obstructs the capacity to learn further

Walsh (2010) suggests students cannot concentrate efficiently if they are anxious; if the students are not receiving and processing the information then they are not learning. The qualified mentors in my study said the students do need to take responsibility for their own learning and it is important that they "*know what they hope to achieve"* (QP22). However, the NMC (2008, SLAiP, p.31) states it is '*the mentor's responsibility is to plan and coordinate the student's whole learning experience'.* Thus it is important that a clear balance is negotiated between the mentor's responsibility in facilitating the learning and the student's ability to become more independent. If the learning is not facilitated, the

students said (in my study) that they then worried more about what they needed to learn creating more anxiety in them, and this initiated a drive to find their mentor (Ashton and Hallam, 2011). Dee said whenever she felt anxious she went to find her mentor who, when effective, helped her to settle, and was a signpost to her about what she should do, or where she should be. Sal said a good mentor '*calms you down':*

The students in the first interview said the care from an effective mentor could make them feel calm and this helped them to settle, and if they felt comfortable and welcome, especially on a new clinical area, then they would feel more secure and open to learning.

"*Effective mentoring from a student perspective is about having a mentor who is able to calm their anxiety, especially in a new placement; this then helps them to settle, focus, learn and understand how the unit works*" (Teatheredge, 2010, p.20).

The anxiety was not always derived through the need for support, but working in an unknown mental health unit can be daunting because of the unpredictability and risks of violence and aggression. A mentor, some of the students said (see, 5.2.2.), can help reduce the anxiety by being there and sharing their concern, but explaining and teaching the skills of mental health nursing (Barker, 2009) when dealing with the unpredictable nature of mental illness.

<u>**Summary**</u>

Anxiety is a barrier to learning, (Mullins, 2007), in their first interview, the students felt that feeling welcome on placement and having an effective mentor helped to reduce their anxiety, calmed them and made them feel more open to learning. My study revealed that in mental health nursing it is important for the mentor to explain and be there for the student, especially during risky unpredictable periods. Ineffective mentoring increased the student's anxiety and the lack of structure made the students feel lost and insecure in the clinical

placement. The NMC (2008a) standards make it clear that mentors should be allocated before placement begins and that the mentor is responsible for planning the whole learning experience. However, this study highlights and supports previous evidence (Jokelainen et al. 2011, Hubbard and Foley 2010, Ferguson, 2011), that in reality this does not always occur. In addition, for the mentoring relationship to be effective the student also has to take responsibility for managing themselves and their learning needs.

6.2.3. <u>Students' responsibility, (research aims: 1 and 2, see section, 6.1.)</u>

The students in my study acknowledged that some students were more capable than others, also that some were not motivated or dedicated, and this was problematic for mentors (see section, 5.2.3.). Sal, though, felt sometimes it was more about the student not having the confidence to ask for help (Foster-Turner, 2006). Kinnell and Hughes (2010, p.59) believe that learning in practice is 'reliant' on the student as well as the mentor, and the student needs to be motivated to learn.

Kinnell and Hughes (2010) suggest that there can be many reasons for lack of motivation, including previous negative experiences of placements and also the mentor's lack of knowledge. However, they also believe it is the mentor's role to explore with the student the reasons why the students are not motivated. The mentors (in my study) found it hard to work with unmotivated students and those who had a poor attitude. The mentors believed these students could perform much better if they made more effort. The mentors suggested that some of these students had admitted to them that they had only commenced the nurse training to stay in the country; they had told the mentors it was that nurse training was the only available job that came with a visa. This is a serious issue which needs addressing at local and national levels, and one which the NMC and RCN should be made aware of as it is a potentially professional issue (Walsh, 2010). The concern is that these students may not uphold the professional Code (NMC, 2008b), due to lack of interest, concern or motivation, caused by choosing a

deceitful incentive to become nurses. Furthermore undertaking a professional training involves commitment, courage and compassion (Francis, 2013) these students's may not be committed to delivering quality care to patients, these are possible professional concerns (Kilgallon, 2012).

The mentors also linked the lack of interest of the student to the students working bank shifts (Walsh, 2010), suggesting that this extra work interfered with their ability to concentrate, and that the student would request shift changes to accommodate the bank work which resulted in them not working with their mentor. Walsh (2010) suggests lack of motivation can also be caused by life pressure. Some of the qualified mentors did link poor performance with the students' life work pressures and anxiety. However, if the mentor has explored all avenues to support the unmotivated student then, Walsh (2010) suggests the students need a 'professional rude awakening', because the students are not meeting the required competences (NMC, 2008a).

The students in my study, however, believed that often their mentors were not there for them when they needed them (see section, 5.2.3.). This created more anxiety and frustration for these participants, and their concern for their own needs drove them to seek solutions. They consequently took some responsibility and found creative methods to deal with their anxiety and cope with feelings such as abandonment. Instead of allowing the ineffective mentoring to erode their confidence and corrode their self esteem (Hubbard and Foley, 2010), creating impotence (Scherer, 2010), the students developed resilience to cope with the adversity (Newman, 2004). Pip said in his experience everyone in the team can support and educate the students. All have knowledge, even the cleaner, so Pip said that if his mentor was not there he would find someone else to act as his mentor. Walsh (2010) also makes this point that students do not always need to work with their mentor.

Darling (1984) referred to this type of support as the student drawing on their 'own personal strength' (resilience), to find alternative solutions to the problem of poor mentoring, through utilizing other resources with in the team. Through the

process of becoming (Levinson, 1978) the students found their potential had emerged, albeit through adversity.

May (1953) suggests this allows the individual to become 'realized', and when this occurs they are able to declare their presence in the world. The students at this juncture declared their presence to others-in-the-world, and made a decision to ask for their help in furthering their becoming-in-the-world. This took existential courage (May, 1975), and this courage gave them the creativity to move on.

The NMC (2008a, SLAiP) clearly highlights that mentors may need the support of other team members to fulfill their responsibilities, but that this should be coordinated by the nominated mentor who is accountable for these decisions. It was evident from the first interviews that due to lack of coordination the students began to manage their own learning experience, which contravenes the NMC (2008a, p.21) standards:

"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".

Students can learn knowledge and skills from all members of the healthcare team, but this should be managed by the mentor; which the findings in this study suggested was not always the case (Kinnell and Hughes, 2010). The clinical placement areas are monitored by the NMC and the university (RCN, 2007). However it is becoming evident from this study that local monitoring arrangements need to be more thorough.

Kat's lack of confidence as a student, and her experience of poor mentoring, increased her need to be with other members of staff, and thus she realized that she could learn about the craft of caring by Being-with-others who were not her mentor. Like Jed and Pip, Kat's need to become a mental health nurse (Levinson's, 'dream') helped her cope with feeling abandoned, and not project her anxiety by being needy (Bowlby, 1969). Kat allowed herself to become receptive to other members of the team, and get the most out of her placement

194

by Being-with-others. This creativity made the students feel more confident (Gopee, 2011) about Being-in-the-world of mental health nursing. This was an inherent component of their temporal development of becoming a nurse.

The students began to realize that they needed to be less dependent on their own mentors, and take responsibility utilizing a self-directed approach as adult developers (Downie and Basford, 2003). In the person-centred approach to mentoring, Hatton-Yeo and Telfer (2008) state it is the effective mentor who encourages the student to explore the world of mental health nursing, and be self- directed in learning the craft of caring (Barker, 2009). The students in this study had realized, through inadequate mentoring, that they did not always need the mentor's guidance or coordination (NMC, 2008) to take charge of their own learning. Their internal need to learn and develop motivated them to find the courage (May, 1975) to get their needs met.

However, even when the mentoring was adequate, incongruence and misinterpretation could occur (Hubbard and Foley, 2010). The balance between the mentor meeting the needs of the students who are seeking proximity to the mentor for reassurance (kilgallon, 2012), and the mentor at the same time encouraging them to become more independent and initiate care giving, could create contradiction and affect the relationship as Downie and Basford, (2003) suggest (see section, 5.2.3). Whilst the mentor attempts to promote self direction, Sullivan and Decker (2005) suggest communication can distort the meaning causing misinterpretation. Consequently the student can then believe that the mentor has too high an expectation of the student's capability.

This pressure appeared to be an inherent part of the anxiety or frustration which was ever present during the students' training. The students also believed that gathering courage and becoming self-sufficient was part of the developmental process (Hatton-Yeo and Telfer, 2008). However, for confidence to grow, the student needs some reassurance that they are getting it right, learning and facilitating the craft of caring correctly and meeting the patients' needs (Foster-Turner, 2006), the students in this study believed they did not always receive this reassurance.

Summary

The students understood that they needed to be motivated, and the mentors believed it was much harder to support students who were not interested in nursing. It is the responsibility of the mentor to coordinate the student's experience, including learning from other members of the team. However, in this study the students found that they had to become independent, and found others to learn from, because their mentors were not always there for them. It could then be argued that some mentors were not fulfilling their obligations as recommended by the NMC, and that the students through neglect were perhaps developing adaptive coping strategies, and through experiential learning developing confidence in taking responsibility for their own learning needs. Thus I could conclude that the students learnt from both effective and ineffective mentoring experiences, which is not clearly identified in current literature. However, once qualified the students believed they could have achieved much more during studentship if the mentoring had been more effective. This study highlights that the NMC standards and guidelines are not always effective in practice. I would suggest that if the NMC stipulated the governance of the standards in a more direct manner, rather than in a passive approach (CHRE, 2012), then perhaps the mentoring system would be more efficient and effective for the students. Furthermore, some of the comments made in the report by CHRE (2012) about governance being more effective could be applied to the NMC (SLAiP, 2008a) standards.

Eli said it is essential to receive constructive feedback to ensure the craft under development is effective, correct and caring. It is the mentor's responsibility to guide the student towards competence, which will be discussed next.

6.2.4. <u>Mentor's role/responsibility, (research aim, 1 see section, 6.1)</u>

Gray and Smith (2000) highlight that effective mentors need to spend time with their students, in order to reduce misinterpretation and to understand the needs of the developing student, and also to give constructive feedback and guidance. The students and the qualified mentors in my study made similar comments (see section, 5.2.4.). The participants said mentors should also be good role models and take time to teach the students, as prescribed by Kinnell and Hughes (2010), Walsh (2010) and Gopee (2011). This includes facilitating a learning environment which allows learning through experience and also permits the students to learn from their mistakes without ridicule which was highlighted in Hubbard and Foley's (2010) study. Eli believed that mentors can be overly critical when students make mistakes and this just makes the student more nervous. The NMC (2008a, SLAiP, p. 20) states that mentors have to support students, choose appropriate 'learning opportunities', use different methods to facilitate learning and ensure learning is evidenced based. However, how this should be facilitated is not prescribed, thus interpretation and implementation will inevitably vary, as my study highlighted. The participants in my study had some different experiences to the ones prescribed by the NMC. Jed believed that even when teaching, the mentor put pressure on the student to hurry up because the ward is busy, not always giving the student sufficient information to complete the task competently, and Jed feels this was not always a safe way to learn how to practise. Good safe practice which is evidence-based is in the NMC (2008b) Code which states that nurses must '*provide a high standard of practice and care at all times'.* However, putting pressure on students to hurry clinical skills is not a good safe method of teaching (Walsh, 2010).

The NMC (2008a, SLAiP) states a nurse mentor needs to commit to be a life-long learner. Keeping up to date and adhering to this commitment can ensure that the mentor reflects 'in and on practice' (Schon, 1991), and is a role model of sound ethical evidenced-based practice, not outdated unprofessional practice (Rose and Best, 2005). The students did discuss issues, not of actually unsafe

practice, but Pip felt he was sometimes taught skills which were out of date, by mentors who had not developed their professional practice according to the evidence base (NMC, 2008a). Bea knew from her experience at university that she had seen clinical practice which was out of date. Bea called this unprofessional behaviour, and linked this practice to clinical areas which had become set in their ways, and had practised in the same way for years. Flo also said she had witnessed this type of out of date practice.

Flo said she did not see bad practice, just out of date practice, otherwise she would have reported it to the university (see section, 5.2.3.). However, reporting poor practice is not always easy, as the students felt there was a culture of not whistle blowing, because they had witnessed others complaining and seen the students ostracized by the mentors. The issue of not reporting unsafe or out of date practice was highlighted in the Francis report, and Francis (2013) recommends this practice has to cease, and a culture needs to be developed where staff feel safe to challenge mistakes and poor practice. These issues need to be locally monitored by the trust and the university. Whilst at this university clear guidelines are in place to report these issues, from these findings it is clear the students do not feel safe to do so, as Francis recommends. However, Klage (2013) foresees problems with the overall implementation of the Francis (2013) recommendations, stating it will take years to change the culture of the NHS.

The students had also witnessed mentors refusing to sign the students' books after making a complaint, this behaviour by mentors is similar to the '*horizontal violence*' Hubbard and Foley (2010) described in their study. Flo and Pip said they had not reported this outdated practice, because they wanted to be part of the team (Foster-Turner, 2006) and not be excluded or punished, but stressed that if it had been unsafe practice they would have reported it as required by the NMC (2008b, code). Not keeping up to date may be one aspect of ineffective mentoring, or linked to nurses who do not wish to professionally develop, including those who are not interested in becoming mentors. Taylor (2008) stated that not every nurse is suited to mentoring and this was highlighted in the

findings of this study as another barrier to effective mentoring (see section, 5.2.4.).

The NMC (2008a, SLAiP) stipulates that mentoring is part of the nurse's role and responsibilities, a requirement of their professional development. Hatton-Yeo and Telfer (2008) suggest that whilst many nurses have the necessary skills for mentoring and others have the capacity to learn these skills, some nurses do not want to be mentors and others never master the skills. Those who are reluctant or not competent are in the main ineffective in the art and craft of mentorship (Ashton and Hallam, 2011). Some qualified mentors and students in my study believed that only nurses who want to be mentors should undertake the training (Taylor, 2008), and there should be some reward for the extra work. The mentor respondents also said that the accountability of assessing students in practice should be the responsibility of the education establishment, not the clinical area.

Both the mentors and the interviewees in this study supported the theory that not all nurses can be mentor's, therefore mentoring should not be a requirement. Some of the mentor respondents felt that they should be given the option to be a mentor (Hatton-Yeo, 2008), and it should not be a requirement, because the mentors felt they aren't given adequate recognition for this role. The students interviewed in this study said they had not really taken into account what a responsible role the mentor has, being accountable for the success or not of future practitioners (Ashton and Hallam, 2011). Dee had experienced some nurses who were very reluctant to mentor students, and believed that to be an effective mentor the nurse had to have a '*passion*' for the role. Clutterbuck (2004) suggests some people are not interested in mentoring and are not concerned with meeting the students' needs, and often lacked the insight to realize they were being ineffective. Gopee (2011) also said that the mentoring process is not effective if the mentor has a negative attitude and tries to prevent development in the student. This lack of interest can lead to toxic mentoring which Darling (1984) described, where the mentors avoid the student, and do not help reduce anxiety or meet the student's needs, which undermines the student's confidence (Foster-Turner, 2006). Hubbard and Foley's (2010) study revealed that mentors

sometimes sabotage the student's experience of learning to be a nurse. Jed also believed that many nurses do not have the necessary skills to be a mentor.

Whist there could be a shortage of mentors if mentoring was made completely voluntary, mentoring as this study highlighted is much more effective if nurses have a passion for mentoring. If nurses are not interested or do not want the responsibility of mentoring, then this can cause many problems and mentoring can become ineffectual (Hatton-Yeo and Telfer, 2008). It could also be said that nurses who show antipathy towards having to mentor could just be doing empty 'busywork' (Heidegger, 1978), slumbering in the routine. Also poor mentoring can lead to an ineffective assessment of the student's competence. Taylor (2008) believes the mentoring experience for the student is 'highly variable', and Gray and Smith (2000) suggest that having an effective mentor is often down to luck. Hubbard and Foley's (2010) study highlighted that some mentors were not competent, committed or interested in the role of mentor. Some of the qualified mentors said in this study that students pass practice when they should have failed.

The mentors in this study said students were passed even though they were not competent (see section, 5.2.4.). The NMC (2008a, SLAiP) says that mentors are accountable for the decisions they make when assessing students. The Duffy report of 2003 highlighted that mentors were not failing students who were not proficient, the NMC standards (2008a) were implemented to ensure that unsuitable students were not passed in practice. However, a survey by the Nursing Times in 2010 found that 740 (37%) of the 2,000 qualified mentor respondents had passed students who were not competent (Gainsbury, 2010). Lack of time and confidence were stated as some of the reasons for this, and also lack of support, because it is hard to fail a student. The NMC (2008a, SLAiP) suggests that mentors should seek guidance from more qualified and experienced peers (e.g. practice teachers) to support the mentors failing students, because the NMC recognizes it is difficult to fail someone. However the NMC (2008, code) states the nurses will deliver the best quality of care, and mentors not failing students in clinical practice can lead to these students

200

becoming incompetence qualified nurses, who may jeopardize patient safety through delivery of poor care (Francis, 2013). However, it is clear from the evidence above that students are still being passed when they should have failed, and this is a cause for concern, because this does affect the quality of care the patient receives, and effectiveness of the clinical environment (Duffy, 2003). The university and the trusts have responsibility (NMC, 2008a) to ensure the assessment process is fair and consistent and that the student only passes if they are competent (RCN, 2007). From these findings it is evident that the assessment process needs scrutinizing.

The students in this study believe that effective mentors will ensure the students are competent before they pass the practice book. This would be done by ensuring that the students are capable in the craft of caring (Barker, 2009), understand why they are facilitating the craft in a certain manner, and demonstrate the theoretical knowledge to support the decisions they made as stipulated by the NMC (2008a). However, these findings suggest that the assessment process needs to be locally monitored (Walsh, 2010). Pip, Bea and Eli said the effective mentor would ask them to go and research concepts they did not understand or comprehend, as recommended by the NMC (2008a). Flo said good mentors would say go and find the evidence and then we can both learn, thus learning together (see section, 5.2.4.), sharing knowledge and developing competency in the craft of caring (Kinnell and Hughes, 2010).

The students in this study reflect the beliefs of the participants in the Nursing Times study (Gainsbury, 2010) that sometimes less effective or capable mentors, do not always ensure the students are competent before signing the practice books as passed, thus passing students who should have failed. Gopee (2011) maintains that mentors could give some very convincing reasons why they pass a student in practice who are not competent, but none are 'justifiable'. Duffy's (2003) study found that mentors often passed incompetent students due to lack of experience. Mentors though can face a disciplinary hearing for misconduct if they pass students who are incompetent (Duffin, 2005). However, whistle-blowing is not easy for qualified staff either as highlighted in the Francis (2013)

report, and this could be a reason why passing incompetent students is still common place, or it could be that this is not being regulated at a local level. The Willis (2012) report called for tighter collaboration and regulation. The governments (DH, 2013) response to the Francis (2013) report stipulates that staff in clinical environments should feel safe to challenge mistakes and bad practice routinely. Bea, though, felt that the role of the mentor is a huge responsibility and felt that if the mentor has built a rapport with the student they feel obligated to sign the practice book. The mentor respondents said they found failing students difficult, '*challenging*' and they do not always have the support from the organisation or the university to fail. These points warrant further investigation.

<u>Summary</u>

The mentors have a responsibility to commit to the role, to take it seriously and make the mentoring effective for the student. The mentors should be role models and teach ethically sound evidenced-based practice, so the students understand the craft of caring and all that is involved in caring for a person with mental ill health. This is made more difficult if mentors do not want the responsibility of this role. The findings of this study suggest that some mentors are set in their ways and present out-of-date practice which is not evidence based as a role model. Some mentors clearly stated they did not really want this role, and many respondents agreed that not all nurses are suited to the mentor role. Ineffective or incompetent mentoring may still occur in clinical practice, but without any monitoring processes and with punitive responses to whistle blowing it will be difficult to facilitate change. This discussion has already highlighted that students can adapt and cope with inadequate mentoring, but these circumstances are not ideal learning situations, and passing the practice of students who are not competent is, in my opinion, negligent.

The respondents said that mentors need to feel supported when making decisions about the students' competence, and seek guidance if required during the assessment process. The students in my study stated that they liked to be

asked to research relevant clinical topics and share this knowledge with the mentor ensuring all are keeping up to date and that the student is confident in understanding their learning objectives in regards to the craft of caring.

In order to be effective, the mentor has to struggle to manage many different roles within-the-world of mental health nursing and time to meet all these demands is precious. Lack of time can affect the process of mentoring, thus the last barrier, time to mentor will be discussed next.

6.2.5. <u>Time to mentor, (research aims 1 and 3, see section, 6.1.)</u>

"*The results of this study highlighted the effective working relationship that encourages learning in the environment is affected by external factors, including time. Allocation of time is essential for these mentoring relationships to be developed. However, both the mentors and students referred to the lack of time available to mentor effectively*" (Teatheredge, 2010, p.21).

Time to mentor was an issue that the research participants felt affected the mentoring process. Many believed that if they had protected time to mentor it would be facilitated much more effectively (see section, 5.2.5.).

Stuart (2007) and Kinnell (2010) both suggest that mentoring can only be effective if there is time to mentor, time to build effective relationships, time to teach and to assess accurately, and time to be with the student and support their development. The NMC (2008a) recommends that managers should try to allocate protected time for their mentors, but these are only recommendations. The Royal College of Nursing (RCN, 2007) also advocates that time should actually be protected. Protected time to mentor has now been advocated by the governing bodies of nursing for ten years, but not made policy (Gopee, 2011). Lack of time to mentor students was an issue that most of the qualified mentors commented on stating that time pressure was the main difficulty in mentoring. The mentor respondents said they did not have enough time to nurse effectively,

203

let alone mentor students, and they should be supported to secure quality time with their students (RCN, 2007). Furthermore the mentors felt that students who needed more support did not get it because of their restrictions on time. However, one of the mentor respondents commented that on busy acute mental health units securing protected time would be almost 'impossible', due to the unpredictability of the unit. The mentors and the students also felt that time should be protected at least on a weekly basis, time which is undisturbed.

Eli believed that lack of time spent with the mentor created more anxiety in the student. Pip often felt uncared for by the mentors when they were not there for him, and said that in one eight-week placement he had worked with the allocated mentor only three times. This contravenes the NMC (2008a) standard to '*directly manage the student's learning in practice to ensure public protection',* and for the mentor and student to work together for forty percent of the time per week (NMC, 2008a)*.* The everyday busyness of the wards can interfere with working together, and the participants' comments reflected this. However, the students do need to be managed in facilitating and learning the craft of caring, and ensuring this is administered is the responsibility of all involved in nurse education (Stuart, 2007). Jed said many of his mentors said there was not time because the wards were so busy, but he believes that a mentor can always find time*,* Jed felt he lost confidence when the mentors were busy and unavailable. Gopee (2011, p.43) believes that mentors working within these tight time constraints may be consciously or unconsciously 'taking actions to discourage learning'. The mentors stated that the lack of time was exacerbated when they have a lot of students from different universities. Hubbard and Foley's (2010) study also indicates that lack of time and the unavailability of the mentors are major issues. Mentors' work loads and managing multiple roles were the reasons cited for this issue.

Eli also felt that time for mentoring should be protected, and that the mentor and student need 'dedicated' time together every week, to plan the learning for the week by setting goals.

Summary

Time to mentor can have a huge impact on the effective mentoring process. If the mentors are prepared to take the role seriously and help students to develop and reach their full potential, they need time to mentor, as all the research states (Ferguson 2011, Po-Kwan Siu and Sivan, 2011). The mentors and the students need dedicated time to build effective professional relationships in which the student can feel secure enough to learn the craft of caring. The mentors need time to teach and guide the student. This time should be protected and pre-planned but also realistic. The study findings clearly highlight that lack of time with their mentors caused students anxiety and reduced their confidence, while many participants suggested that it is often the unpredictability of the mental health in-patient units which causes time allocated to mentoring to be cancelled. It is this unpredictability that the students need to understand and learn how to manage and time is needed to do this. However, some of the students believe that time could be created, and the students turned to other staff members for support when feeling unsupported.

Such barriers can be reduced, as the mentors and students stated, with more support from the university and the employers for clinical practice. The participants' ideas about improving and sustaining the mentoring role are presented next.

6.2.6. Sustaining the mentoring role, (research aims, 1 and 4. see section, 6.1.)

The participants believed that mentoring could be more effective if the link tutor from the university visited the clinical placement more often (see section, 5.2.6.). Price et al. (2011) also highlight that students value visits from the link tutor as these visits help to enhance mentor-student relationships and clarify learning needs. The participants in this study believe closer working relationships need to be established between the university and the clinical areas, and these relationships should be much more collaborative. Walsh (2010) suggests that

good links with mentor, student and the link lecturer can improve the mentoring process. The link tutor can advise the mentor of changes, for example to the actual training programme or the learning outcomes (Walsh, 2010).

Pip believed the link lecturer from the university should be aware of the student's progress. A three-way meeting between mentor, mentee and university representative would be helpful, he said. These meetings would support the mentor and the student, promote effective mentoring and ensure the assessment was fair (Price, 2011). Both the mentors and the student participants believed the initiation of these regular tripartite meetings needs to commence before the student's clinical placement begins, to establish collaborative working relationships (NMC, 2008a) and to reduce the student's anxiety caused by lack of pre-planning. Walsh (2010) believes the university tutor can help the mentor to plan the learning needs of the student in the clinical area, supporting and guiding the mentor on the competencies the student has to achieve. Jed said these tripartite meetings were essential and should happen on a regular basis. Without this input, he said, the university does not know if the students are being mentored and assessed effectively.

A study by Gidman et al. (2011, p.466) recommended *"the need for a collaborative approach between the HEIs and placement providers to develop effective support systems."* This concurs with what the mentors and student participants said in my study. Jed also said it is not enough for the university to train the mentors; they need follow them up post-qualifying from the university. Jed also felt that unless the university visited the mentor and the student they would not know *"the true story, what is going on, on the ward"* (Jed).

One of the mentor respondents identified that there is a need for a ward-based tutor to be in place (see section, 5.2.6.). The mentors and the student participants also emphasized the need for adequate support for the mentors in practice *'formal supervision'* (QP54) and also support from managers. Foster-Turner (2006) believes that the organization needs to promote a culture for learning, and mentoring should be integrated into that culture. Wallace and Gravells (2007) state that the managers need to lead by example, mentoring the

staff that mentor the students. Downie and Basford (2003) suggest that if these cultures are not adopted the attitudes towards mentoring can become negative, which this study has already highlighted. Price et al. (2011) conducted a survey at one Scottish university where it normal practice for the students to be visited once on each clinical placement. (This is not common practice to the university involved in this study). The results of Price's (2011, p.783) survey were very favorable towards this support of 'monitoring the mentoring relationship'. It forged good collaborative relationships (tripartite), and also gave the mentors a valid reason for taking time to be with the student when the link tutor visited. In addition, it encouraged the mentor to give constructive feedback to the students. This is a model which could be implemented in order to address some of the issues discussed above. However, it does have financial implications.

In New Zealand (NCNZ, 2008) a nurse is named as placement coordinator for each clinical area by the organization. The placement coordinator manages and oversees the student's clinical experience and allocates a preceptor (mentor) before the student arrives. The preceptor is supported by the placement coordinator and the programme coordinator from the training establishment (university). The programme coordinator is present during the assessment process of the student. This is a model which has been used in the UK, but is not common practice for pre-registration nursing. This is another effective model but again has financial and resource implications for implementation in the UK.

<u>Summary</u>

This section of the discussion being a student and becoming a nurse is now complete. On the whole, being a student emerges as quite anxiety provoking, and the mentoring experience as far from adequate at times. The mentor respondents felt that not all students were committed to their training, and the students interviewed believed that not all nurses want to be mentors. The governing body (NMC) could consider how the implementation of the standards (SLAiP, 2008), could be monitored more closely, because some issues discussed, especially poor practice and monitoring students in delivering care,

have implications for protecting the public, which is the NMC's key responsibility (CHRE, 2012).

Evidence already published has validated many of the comments made and issues raised by the mentor and student participants in this study. However, the problems remain unresolved, as my study highlights. These include: ineffective mentoring, lack of time, failing to fail, and inadequate facilitation of the mentoring role which only increases the student's anxiety and affects the ability to learn.

The findings of my study also emphasized how valuable the participants felt the link lecturer's role can be in ensuring that the mentoring role can be more effective. Regular visits and collaborative relationships can, they believed, improve the mentoring experience for all involved, but this too has resource implications. Nevertheless, the university and the employers have a responsibility to ensure that good collaborative practice is maintained (Price et al., 2011).

6.3. Part 2: Concept of Transition
Being a nurse and becoming a mentor (second interviews)

This section includes discussions of the actual transition from being a student to becoming a qualified mental health nurse, and nurse mentor, while linking in some areas the first and second interview. One of the objectives was to explore how perceptions about mentoring may have shifted during the transitions. This discussion also included the core essences (as subheadings) from the 'concept of transition' as listed below.

Core essences:
   6.3.1. **Becoming a qualified mental health nurse**
   6.3.2. **Period of preceptorship**
   6.3.3. **Developing a sense of self as a qualified nurse**
   6.3.4. **Learning from experience**
   6.3.5 **Becoming a mentor**
   6.3.6. **Sustaining the mentoring role**

The study has raised issues regarding nursing as a craft. Knowledge and concern for the craft is part of the development of a professional's identity in mental health nursing. Craft is considered be Heidegger to have particular significance and he provides a useful analogy.

"*A cabinetsmaker's apprentice:*

His learning is not mere practice, to gain facility in the use of tools. Nor does he merely gather knowledge about the customary forms of the things he is to build. If he is to become a true cabinetmaker, he makes himself answer and respond to all the different kinds of wood and to shape slumbering within wood, to wood as it enters into man's dwelling with all the hidden riches of its essence. In fact this relatedness to wood is what maintains the whole craft. Without that relatedness, the craft will never be anything but empty busywork" (Heidegger, 1978, p.269).

6.3.1. Becoming a qualified mental health nurse, (research aims, 1-4, see section 6.1.)

Bea and Sal both said the transition between being a student and becoming a nurse was 'massive' jump, and the reality of being a mental health nurse was quite different to what they had expected (see section, 5.3.1). Most of the participants felt they were not prepared enough to become a qualified nurse, some found it terrifying, others daunting. This in itself creates a dilemma: that students may not be prepared enough for this transition by the mentors and the university, but they will only understand this when they have qualified, Sprinks', (2012, p.7) findings concurred with this point.

"Only a third of nurses think today's training adequately prepares newly qualified nurses for the workplace".

The students, though, would have had to meet the NMC Proficiencies for Pre-Registration Nursing Education (2004, reviewed in 2010), in order to pass the course. Thus they had been deemed competent to become qualified mental health nurses by the professional governing body, but not necessarily prepared. However, the NMC (2004) competencies suggest that the training the students receive should prepare them to become qualified nurses:

"The standards of proficiency define the overarching principles of being able to practise as a nurse; the context in which they are achieved defines the scope of professional practice" (NMC, 2004, p.4).

However, the standards of proficiency do not fully equate with preparedness to practise. Roberts (2009) suggests that some skills learned during studentship are not always learned in clinical practice, and that whilst the students develop sound theory and comprehension of clinical skills in university, this does not necessarily mean they are competent in practice when qualified. The students in my study said that they did not want to pass outcomes for which they did not feel competent, for the reasons Roberts (2009) suggests. The evidence from the participants also suggested that students who are not competent pass practice, again suggesting that some students are not necessarily prepared or competent to become a qualified mental health nurse.

Competent or not, prepared or not, the students had made the transition and become qualified nurses. The understanding of the experience of being mentored as students is evidenced as affecting their future Being-in-the-world (Heidegger, 1962), the process involved in becoming was now 'a historically effected event' (Gadamer, 2004, p.299). Levinson's (1978) human development theory identifies transitional periods in the person life structure where change is initiated through a series of tasks that are undertaken, in order to develop oneself self and create a position in society.

Thus the now qualified nurses were reviewing what was familiar (studentship), and what now to them what was strange (being a nurse), and thus they were

being-in-between, as Gadamer (2004) suggests reflecting on the past whilst considering their future possibilities, as part of the process of unfolding (Mills 2003).

Ferguson's (2010) study suggests that becoming a qualified nurse is very anxiety provoking and full of uncertainty. The qualified nurses reported in the second interview that as students they did not have a clear idea of what the reality of being a mental health nurse really entailed; furthermore this reality was quite a shock. Thus the anxiety they had felt as students changed over time into stress and the uncertainty of not knowing how to be a mental health nurse. The pressure was exacerbated by their view of the future, reflecting on their past experiences and concern for themselves as nurses and carers, in-the-world of mental health nursing.

Levinson (1978) states that the transition from student to achievement (being a nurse) is more successful if the previous mentoring the individual experienced had been effective, or it had been good enough to give them the courage (May, 1975) to begin the new phase.

Having time to settle was also problematic for the newly-qualified nurses, as most clinical areas are extremely busy and unpredictable. The participants also said that a lot was expected from them as newly-qualified nurses. A survey by Sprinks (2012) also revealed that too much is asked of newly-qualified nurses, and that the expectation of their competence was too high. The NMC code (2008b, p.2) states:

"As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions."

The nurse can be taken before a fitness-to-practise hearing (NMC) if their performance is deemed incompetent or dangerous (e.g. sleeping on duty puts patients lives at risk). If the case is proved the nurse can be removed from the register and be unable to practise. However, the CHRE (2012, p.5) review stated that the NMC needed a better 'streamlined' strategy, critiquing the NMC's

competence in these hearings, which then questions the validity of a disciplinary process, leaving the nursing profession with a lack of confidence in its governing body (CHRE, 2012).

The participants felt what they were not prepared for what the reality of being accountable and taking responsibility, making decisions and clinical judgements, because as Eli said, as students they were 'cocooned', protected from these concepts of nursing care (see section, 5.3.1.). Sharples and Elcock (2011, p.110) suggest that whilst students would have practised professional behaviour in clinical placements, accountability and responsibility were probably just 'theoretical concepts' which were studied at the university, but become a reality once qualified. Sprink's (2012, p.7) survey for the Nursing Standard revealed that:

"*Two thirds of the 2,554 respondents said today's nurse training failed to prepare nurses.*"

Furthermore, nearly all the participants in a Swedish study by Rungapadiachy et al. (2006) said they felt unprepared for the responsibility and accountability involved in being a newly-qualified nurse. The evidence from these two studies substantiates the qualified nurses' concerns, and highlights that accountability should not be learned in theory only. The qualified nurses in the second interview in this study felt that although being qualified gave them more autonomy, the clinical decision making was a *'huge responsibility'* (Pip), for which the individual was accountable and could affect the whole organisation. Jed pointed out that the decisions he made could affect the whole organisation.

Some of the participants were also more confident in being a qualified nurse than others. Roberts (2009) suggests that when students qualify they often do not have confidence in their abilities. Bea and Kat did not appear to be as confident as the others. Bea said that some newly-qualified staff would '*thrive on the responsibility',* but for Bea it was very anxiety provoking, full of the fear of doing anything wrong. Bea stated that one day you are a student unable to make

212

decisions, next you are the nurse in charge making all the decisions. Clark and Holmes (2007) study revealed that often managers do not expect a lot from their newly qualified staff, and that it is often the new nurses' expectations of themselves to undertake clinical skills they are not competent in, which causes the anxiety. Nevertheless the evidence (Sprinks, 2012) suggests that student nurses are not adequately prepared.

Some participants did not realize how vulnerable they were as qualified nurses in the unpredictable world of the unstable mind in mental health nursing (Foster-Turner, 2006). They were also uncertain if they had acquired the competence and confidence to manage these precarious situations (Sharples and Elcock, 2011). The participants all referred to the fear of getting it wrong; not assessing the situation correctly, as Eli said, and then making a clinical decision which could affect the whole unit, or cause risk to life. Higgins' et al. (2009) review highlights that coping and managing the responsibility and accountability as newly-qualified nurse are major sources of stress and anxiety. Clark and Holmes (2007) suggest this anxiety is manifested because as students they were protected from the reality of decision making, and, as newly-qualified nurses, these decision making processes are a new experience for them. Mooney's (2007) study also suggests that it is the supernumerary status of students which hinders their preparation for qualifying; this status also obscures the reality of being responsible as a qualified nurse. Thus Being-in-the-world of mental health nursing increased the participants' concern for themselves, but it was also about making the right choices and decisions. For the participants in my study, getting it wrong could mean losing their NMC registration (their PIN as they called it). This was very important to them, their PIN formed part of their identity of who they are in the world of nursing. For Sal it was her trophy, her reason for doing the training.

Being-in-the-world of nursing as a qualified member of staff was quite a shock, which was filled with stress and anxiety about getting it right, but the participants continued through this transitional phase to struggle to achieve their potential. They also had to be what was expected by the NMC (2008) and, Kat commented

213

on the expectations of her as a qualified nurse by her employers, sometimes conforming to the point of feeling compromised. Pip also learned that he could make changes once he was qualified, but only if other staff agreed or if you conformed to their ideas. Pip said you need to be persistent in order to be able to implement your own ideas (authenticity), so you can be true to yourself.

<u>Summary</u>

The pressure to conform brought its own anxiety, and Higgins et al. (2009) suggests this is exacerbated because the transition process is ill-defined and confusing, and these issues can cause role conflict. Some of the participants in this study said they had to learn very quickly, maturing and developing, they made clinical decisions under pressure, due to staff shortages and lack of time (Rungapadiachy, 2006). This pressure was also full of conflict for them because even when a decision had been made, they would be criticized as being over cautious by others on the unit. Ferguson's (2010) study suggests that newly-qualified nurses need a supportive environment to enable confidence and competence to develop in regards to their clinical judgement.

Thus the participants had believed that their anxiety would decrease when they qualified, but the transitional period was also anxiety provoking and full of conflict. Furthermore, becoming a qualified nurse was daunting, and most participants in my study felt unprepared for this transition. They felt unprepared also for the reality of being responsible for decision making, which could not only put peoples lives at risk but which, if they made the wrong decision, could also result in them losing their registration, for which they had worked so hard. Questions regarding preparation for the transition need to raised at the universities and the Trusts

The transition was a steep learning curve for the participants, and some of the participants found the support from preceptor helpful, which will be discussed next.

6.3.2. <u>Period of preceptorship (Research aim 2, see section, 6.1.)</u>

"From the moment they are registered, practitioners are autonomous and accountable. Preceptorship should, therefore, be considered as a transition phase for newly registered practitioners when continuing their professional development, building their confidence and further developing competence to practice" (DH, 2010, p.10).

In England there is a formalized period of preceptorship, which is usually for a period of six months; the newly-qualified nurse has a range of learning outcomes to achieve during this period. The employer is guided by the DH (2010a) 'Preceptorship framework'. The preceptor is a registered practitioner (not necessarily a qualified mentor), who will formally support the student through this transitional process. The preceptor's role is to promote autonomy through the development of clinical competence, building confidence and self awareness as a qualified nurse (Sharples and Elcock, 2011), fostering a belief in life-long learning as prescribed by the DH (2010).

Eli had two preceptorships (see section, 5.3.2.) and she did not realize how bad the first one was until she changed employers and experienced a preceptorship package which instilled confidence in her (Sharples and Elcock, 2011). She then felt secure in the process of becoming an autonomous qualified nurse. Hatton-Yeo and Telfer (2008) suggested that some nurses do not make good carers of trainees, be it students, newly qualified nurses or new members of staff. Levinson (1978) suggested that ineffective support can interfere with the tasks required during the transitional period, because this period is crucial in the development of the individual in regards to accepting change in the self, within-the-world of being a qualified nurse, and the creation of a new life structure and a new secure base (Ashton and Hallam, 2011).

The preceptorship experience is similar to that of being mentored; some experiences are good, some are not (as Jed said). Ferguson's (2010) participants said what was important for them was to feel cared for by others (preceptors) in this newly-qualified role. Ferguson (2010) study suggested that

the newly- qualified nurses would seek out experienced staff who were receptive to their needs and willing to teach them. Eli, through effective preceptorship, learnt how to be with patients and to become confident and skilled in the craft of caring (Barker, 2009). Sal took a proactive approach to being a nurse, as she had when being a student, because Sal had learned from experience during studentship that mentors were not always there for her. As she learned once qualified that her preceptor was not there for her, Sal did not have a good preceptorship experience stating the preceptor was ineffectual and she believed she taught him more than he taught her.

In Sal's view her preceptor did not meet the DH (2010) requirements. The employers under this DH Framework (2010) have a responsibility to monitor the preceptorship period and ensure it is effective. Sal even considered leaving the unit because the lack of support often reduced her to tears; thus Being-with-others is not always quite as it seems, and can often cause internal conflict and overall dissatisfaction. Higgins's et al. (2009) review found that the preceptorship experience for the newly-qualified nurse is highly variable (much like mentorship experiences), and many newly-qualified nurses lack the support and guidance required for this important transition process. Jed in my study was also concerned that some preceptors passed preceptees who were not competent, mirroring poor practice of mentoring students.

Higgins et al. (2009) suggests that those who experienced a supportive (effective) preceptorship found the 'transition process easier'. The other participants in this study had a good and effective preceptorship experience Kat said she was treated as an equal, but guided and supported at the same time. Jed's preceptor was very experienced and encouraged him to research what he was learning, and encouraged him to be inquisitive which helped him to develop and '*made me a better nurse'.* Ferguson's (2010) study highlighted that new nurses valued preceptors who had a good knowledge base, and assisted them to think critically and supported their decision-making process. Jed, Bea and Kat certainly experienced this type of effective preceptorship.

Summary

The participants in this study who had a good preceptorship felt it had helped them to feel safe enough to develop their confidence and begin to reach their potential as qualified nurses in-the-world of mental health nursing, as stipulated in the DH framework (2010). Those who had a poor experience felt they had missed a developmental opportunity, and they did not have quality time to adjust, develop and reach for their own potential.

The DH (2010, p.19) preceptorship framework expects this process to give the new registrants a 'flying start' to their future careers, building confidence and evidence-based practice, because during the three years of studentship everything the nurse needs to know and understand cannot be achieved. It is evident from the findings of this study that some issues are only understood once the person has qualified. The participants in this study who had a good preceptorship found it helpful and supportive of making the transition from student to nurse. However, the findings showed that an inadequate preceptorship can affect the person's professional and personal development, which in turn affected their ability to adjust to the new role, and reach their potential.

During the transitional process the participants had moved from being-in-between (Gadamer, 2004) and began to feel secure and stable in this new life structure as qualified mental health nurses. They had started to become autonomous practitioners, being authentic at times, and had begun to understand the conscious modes of their Being-in-the-world, a process of unfolding (Mills, 2003). The next section explores the development of the sense of self.

6.3.3. <u>Developing a sense of self as a qualified nurse, (research aims, 1-4, see section, 6.1.)</u>

Developing a sense of self is about understanding how Being-in-the-world affects the unique individual. Levinson (1978) believes that the individual acts out some aspects of the self but that other aspects are inhibited or neglected; the self is partly conscious but mainly unconscious. The self, according to Levinson (1978),

is complex and contains wishes, beliefs, anxieties, values, feelings, thoughts and so forth; but also the self has the means to deal with and cope with these complexities. Furthermore, our past experiences in life, including childhood development, affect our present and future selves (Gadamer, 2004, p.295), and we exist 'somewhere in between our once and future selves'.

"Our self-awareness then, emerges from world of exchange and interaction, involves being in between our past and our future, and being aware of what we understand ourselves to be and what others think us to be" (Davey, 2006 cited in McCloughen et al., 2011, p.11).

The participants in this study (see section, 5.3.3.) have reached their goal (or boom as Levinson 1978 terms it) of becoming a qualified mental health nurse. Upon reaching this point the individual will still strive to be more successful, to reach their potential in this new role (Walsh, 2010). However, through the process of becoming they have developed an understanding of the self, and the self-in-the-world at any given time, as well as becoming autonomous and self-sufficient (Levinson, 1978). May's (1983) view is that existentialism is the pivot of the individual's existence, and through the process of becoming the person's unique potential emerges. This is similar to Levinson's (1978) theory. May (1953) also believes that the transition through this process of becoming, develops a new sense of self, and when this is understood, the person is able to use existential courage to declare their Being-in-the-world, be authentic them-selves (Heidegger, 1962) and be able to make decisions whilst acknowledging their limitations. The findings from this study highlighted how the participant's sense of self had developed, and their confidence increased with time, through the knowledge gained. As the skills in the craft of caring deepened, these transformations enabled them to be-in-the world of mental health nursing as qualified practitioners.

The participants also realized how important it is to learn from their own past experiences and develop their sense of self or identity in-the-world of mental

health nursing; and to learn about who they want to be and how to reach their full potential. Learning how others view them was important and linked to the organizations and their own reputation. Part of this existential process (May, 1983) was developing insight into how they behaved as qualified nurses, within the team, Being-with-the-patients and the students. As their confidence developed, the participants came to understand the complexities of being a nurse and being/becoming a mentor, becoming more conscious of who they are as distinct individuals, yet part of the whole world of mental health nursing. This is termed individuation (McGlashan, 2003).

Pip realized self was able to view Being-in-the-world of nursing from a bigger viewpoint, instead of viewing the surface as he did as a student. He also became aware of how important the past was to the future (Gadamer, 2004). Pip said that he now understood that he had to be aware of what happened yesterday, as well today and tomorrow. Pip also said that the craft of caring (Barker, 2009, p.4) is a 'gift'. Barker (2009) refers to it as a 'specialist craft' which is about 'extraordinary human support'. Pip also believed that the journey through studentship changes you past and your future (Gadamer, 2004). Bea did not realize how much responsibility a qualified nurse has, and she now understood how much responsibility was involved in being a nurse, and felt it was huge responsibility.

Mentoring is only one role the nurse has to manage, amongst many other roles during a day's work. Mooney's (2007) study reveals that newly-qualified nurses only understand the pressure nurse mentors are under once they are qualified. Eli had a similar experience to the participants in Mooney's study. As a student she did not have a clear understanding of what the reality of being a mental health nurse was, and this reality was quite a shock. The anxiety Eli felt as a student had not gone when she had become a nurse, but manifested itself as pressure and the stress of managing the many roles in nursing.

Kat had learned to believe in herself through the transitional process. She had developed what May (1975) terms 'existential courage', which enabled her to overcome her anxiety and understand that she did not always have to be-with-others to learn and develop (Foster-Turner, 2006). This courage had enabled Kat

219

to overcome her fear of losing what she had hoped to achieve (becoming a nurse) through believing in herself, but becoming conscious of her need to conform and accepting (May, 1975) her capacity to be able to now make decisions as a qualified nurse, within the confines of the limitations within the real world (Clark and Holmes, 2007). Jed used some case studies during the second interview which illustrates May's (1953) theory more clearly. Jed had developed confidence through his new understanding of his potential to be good at the craft of caring. He clinically reviewed a patient who was becoming very distressed. He courageously decided to take a clinical risk, but he could not due to the confines of the policies make that decision alone and had to seek permission from managers. His belief in his craft won their trust and Jed's clinical judgement had a very positive outcome for the patient and the staff.

Part of developing a sense of self was reflecting on the past experience of being a student and considering their own potential as mentors and guides in practice to students, developing a sense of themselves as potential mentors (see section, 5.3.3.). Levinson (1978) believes that when a novice reaches their goal (being a mental health nurse), they no longer need their mentor or preceptor, and it is at this stage that he believes the individual is ready to become a mentor themselves.

Jed now understands the importance of good leadership in a team, which can cultivate the learning environment as a positive learning culture. Gopee (2011) suggests managers should encourage and promote effective mentoring and lead through example by mentoring staff in their own team. Mooney (2007) suggests that when students do not feel part of the team, they do not feel prepared in the role of becoming a nurse, and this lack of confidence transfers with them when they qualify. Jed in my study said the student should be accepted by the staff as part of the team, an individual within the collective, because Being-with-others as part of the team will create a sense of belonging for the student. This security, which Jed has learned through reflecting on the past into the present (Gadamer, 2004), was what he needed as a student.

Sal, like many of the participants in the second interview, realized that studentship gives a muted picture of what a nurse's role really is (Higgins et al. 2009). Kinnell and Hughes (2010) suggest that some nurses and mentors may not clearly give the students a full picture of what being a nurse really means. Sometimes this is because they believe the students are not competent or confident enough to fully understand some of the intricate complexities of mental health nursing, or they have no interest in being mentors (Hatton-Yeo and Telfer, 2008). Sal said that from her perspective the training had helped her to develop '*who I want to be as a person and how I want to be perceived.*' This self awareness developed Sal's insight of herself and her own behavior. Studying human development theory had also created this insight Sal said, and she wanted to teach her students how important self awareness is in mental health nursing (Barker, 2009), in order to teach them about whom they want to be as a nurses, but as part of Being-in-the-world of mental health nursing. Wright (2009) describes below the importance of knowing oneself in mental health nursing:

"*It is relatively easy to learn the instrumental things of nursing, the practical and know-how of problem-solving. It is a much tougher call to know one-self and others so that we can relate more fully more meaningfully, for such expressive skills touch the very depths of us and what it is to be human. Our effectiveness, or otherwise, falls upon our willingness and ability to connect with others, and in turn is dependent on knowing ourselves"* (Wright, 2009, p.647).

An effective mentor enables the student to begin to develop their identity as they move towards qualification (Clutterbuck, 2004); this is Sal's intention for her students. The participants in Ferguson's (2010) study during the process of development as newly-qualified nurses were drawn towards members of staff as role models, who emulated the quality of nursing care that they themselves aspired too. Gopee (2011) said role modeling is about demonstrating good quality of care to the patient. Jed's identity was developed through experiencing poor role modeling which he felt '*made me a better nurse'.* Because as a student

221

Jed had felt disempowered, unable to challenge the poor nursing care he witnessed (Francis, 2013), he had felt frustrated at not being able to care in the manner he had come to believe was effective and person-centered (the craft, Barker, 2009). Jed now aspires to be a good role model and to be a much better nurse and mentor to others, (modeling the craft of caring). Pip had similar experiences; the existential process of becoming had developed Pip's view of how he wants to nurse, and how others will view his ethical concern. Pip's main concern was to ensure the patients received quality of care, and that the students learnt the craft of caring (Barker, 2009) effectively. Pip's view of the craft is about not viewing the person as they are when unwell but seeing a bigger picture, seeing that this person is in trouble now and needs the help of the nurse to start them on the road to recovery, no matter how long it takes.

Pip has captured in his dialogue Barker's (2009) essence of the craft of caring, and Heidegger's (1978) essence of the wood used by the apprentice cabinet maker. For Pip as a student it was always about getting the knowledge in the craft of caring, because without that knowledge Pip could not be the nurse he aspired to be (Walsh, 2010). This knowledge about caring is what Pip believes is the fundamental characteristic of becoming and being a mental health nurse; it is concerned with the 'healing of the soul' Barker (2009, p.4). A study by Po-Kwan Siu and Sivan (2011) results highlighted the importance of mentors showing the students the uniqueness of mental health nursing. Kat said that she will make sure the students in her care do not experience the ineffective mentoring she received. The student mental health nurse in the clinical environment needs a mentor who will facilitate the student's development in their own unique craft of caring.

Summary

Learning about their identity as qualified nurses was part of the developmental process for the participants, reappraising the new structure of their existence (Levinson, 1978), and exploring the possibilities for them therein. As their insight and confidence developed, they began to understand the complexities and

multiple roles of being a nurse and what nursing really meant to them, learning who they were in this new structure and developing their identity as nurses in-the-world of mental health nursing. They looked towards the future potential of being a nurse and nurse mentor, thus further exploring what being a mentor meant to them in the real world of nursing. The uniqueness of these insights was only really captured through the existential analysis. What has been understood from these findings is that these participants learned from both effective and poor experiences of being mentored. Through the development of their sense of self they became inspired to be effective mentors, ensuring that their students understand the deeper meaning of the craft of caring, enhancing their care for the craft, and helping them to reach their full potential as students and to develop their own sense of self. The participants in this study valued their reputation and did not want to be viewed by others as ineffective as mentors, and their care and concern for their patients motivated them to ensure their students are competent in the craft.

6.3.4. Learning from experience, (research aims 1-4, see section, 6.1.)

"*The only source of learning is experience*" Albert Einstein (1879-1955)

Reflection in and on practice (Schon, 1991) is an essential component of being an effective nurse. Reflecting on the past, whilst considering the present and future possibilities, is part of the temporal process of Being and becoming (see section, 5.3.4.). The participants in my study reflected back to being a student many times during the second interview, reviewing their experiences of being mentored and considering future needs, not just their own needs as nurses and mentors but the needs of their potential students. Eli said as a qualified nurse she understands how time consuming the role was. The participants made it clear that they want to be better mentors and that they had learned from past experiences how much ineffective mentoring affected their development as students. The participants in this study were striving to become what Gopee

223

(2011) termed 'effective mentors', who continually strive to develop their own potential as nurse mentors.

Sal in this study was surprised that as a student she had not understood what nurses actually do behind the scenes, that actually as a student she had been protected from the everydayness of nursing, and this was linked to being unprepared for registration (Sprinks, 2012). Rungapadiachy (2006) suggests it is inadequate training of students which causes the newly-qualified nurse to feel ill-prepared, and unable to understand the complexities of the role. In my study this lack of knowledge led to assumptions being made when the participants were students; and as Sal is now qualified, those assumptions have been challenged by the reality of what it means to be a nurse. As a student Sal said she assumed some qualified nurses to be office dwellers rather than clinical workers. However, as a qualified nurse Sal now understands the immense amount of paperwork that the nurses are required to complete everyday (Chambers, 2007).

Learning from this experience using reflection (Kolb, 1984), Sal now believes that when students see qualified nurses on the computer all day, the student assumes that this behavior is permissible as a role model. Sal believes this is not what mental health nursing is all about. The students need to understand '*the basics',* which is, being with the patients (Barker, 2009). Thus Sal now explains to the student about the many roles the nurse has, including being an office dwelling paper worker, and encourages the students to learn the basics and be with the patients. These explanations are what the students in the first interview said they needed from the mentors and what Lindsey-Ochoa (2009) believes is the 'hallmark' of the mentoring relationship, which is effective meaningful communication.

Bea, on reflection, now feels that when she was a student she was allowed at times to undertake clinical skills which were beyond her competence (see section. 5.3.4.). Now, as a qualified nurse, Bea feels at a loss at times about how much clinical activity she should allow the student to undertake, and at what level (Sharples and Elcock, 2011). Bea works in an extremely unpredictable and volatile clinical environment. Bea worried as a student, and is still worried, about

being a nurse and supporting students in this environment. Stuart (2007) believes that the competence of students in clinical practice is not straightforward: the learning outcomes from the HEI are often ambiguous and unclear, and the mentors in this study confirmed this point. The NMC (2010) provides clear details of the competencies student nurses need to achieve to become registered practitioners, but not clear guidelines on how they should actually be achieved (Gopee, 2011). However, Duffy's (2003) study and later studies (Gainsbury, 2010) indicate that mentors are passing students who are not competent in practice, which suggests that NMC (2010) guidelines need to be more explicit and less passive (CHRE, 2012) in the details regarding the assessment of students. Bea's anxiety emanates from achieving competencies as a student, which Bea did not feel competent doing, so she wants to make sure her students feel competent. Also, if Bea allows a student to undertake a clinical skill and it goes wrong Bea is accountable. Eli stipulated how important it was for her to ensure her students were competent.

These pressures are what the participants did not see, experience or understand as students (Clark and Holmes, 2007). As a student, Bea valued quiet placements where she could get on with her research for assignments, but she now realizes this is not an effective use of a clinical placement. Bea learned through experience that students actually learn much more in very busy clinical environments. In fact, Bea now believes that on busy wards the student learns more about what the reality of being a qualified nurse is, as Ferguson's (2010) study indicated. Bea has now understood that students can learn from all experiences, although Gidman el al (2011) suggests this is dependent on the motivation of the student. The qualified mentors in my study also made this point. But like the students in Gray and Smith's (2000) study, Bea had come to realize that as a student and now a nurse, you do not always have to be with your mentor to learn, that learning can achieved from every encounter on the unit.

Some of the participants in this study are still working towards their own potentiality in their profession as nurses (May, 1975), and nurse mentors. What they have learnt through experience is that their mode of being is temporal and

225

ever-changing (Levinson, 1978), in regards to the relationship between him/her self and Being-in-the-world of mental health nursing and Being-with-others. As students, they cared about themselves and were concerned about how competent the mentoring they received was because their need was to succeed and their journey was filled with difficult and rewarding experiences. Levinson (1978) says the journey is never easy and disappointments will have to be overcome, with the mentor's help, which often for these participants did not happen (see section, 5.3.4.).

Now they have qualified there is so much more for them to be concerned about, and so many others that need to be cared for. The struggle was to be authentic (Heidegger, 1962) to be true to themselves as nurses and nurse mentors, and to be more effective in these roles than their own experience as students. However, lack of time, the needs of others, the unit, the manager, and the organization instigate a 'falleness' (Heidegger, 1962) into a conformity, which was not necessarily a mode of Being they were always comfortable with. This vacillation between being authentic and inauthentic, though, was a positive component of Being-in-the-world, a mode of Being, becoming more conscious of themselves and who they are in the world of nursing, what their professional beliefs were, and what their potential was within the world (Heidegger, 1962).

Sal believes she has learnt from all experiences (good and bad). She suggested that one needs to make the most of every learning experience, because it develops our own identity in the world, and helps to secure the life-structure (Levinson, 1978). Sal said she would like her students to develop insight and finish their training prepared for transition.

Kolb's (1984) theory of experiential learning suggests that reflecting on experiences helps the individual to think, act and change. Kat said she had a poor experience of being mentored and she witnessed other students who had similar experiences. This has made Kat think, reflect and act differently when she mentors students, by trying to be sensitive to their needs.

Kat intends to make sure that she tries to maintain a high standard of effective mentoring in her future practice. She uses reflection to facilitate change. Gopee

(2011) suggests that reflection in practice is essential in learning and it generates new knowledge and understanding, which in turn can promote more effective client care. Kat also uses reflection when she is with the student, teaching them to also reflect in clinical practice, but also reflecting with the student on the mentoring relationship and the needs of the student. Kat did not experience this as a student, and believes this is very important part of nursing and mentorship. Kat also believes now that it is important that she mentors in a consistent manner, and protected time is the key to this type of mentoring (RCN, 2007).

Jed said his experience of being mentored ineffectively has also developed his sense of self, and what he believes to be his potential as a mentor to students (Gadamer, 2004). Jed felt disempowered and frustrated as student, because he felt that he was not getting what he needed from his mentors to become a competent mental health nurse, and that the mentors were not allowing him to learn the craft and develop confidence (Ashton and Hallam, 2011). Jed felt the mentors were not there for him and did not have concern for his learning or emotional needs. Levinson (1978) suggests it is the mentor's role to meet the needs of the student, which include emotional needs. However, Jed said his experience '*has brought out the better side of me'.* He means he has given the role of being a mentor much thought and reflection, and can see more clearly how the effective role should be, and part of being a mentor, for Jed is being effective. Effective mentoring for Jed is similar to what many of the theorists suggest (for example: Gopee, 2011; Walsh, 2010; Hubbard and Foley, 2010). That is, Jed gives the students time. He believes you can always make time, but he gives the student support and the encouragement to do nursing tasks which will build their confidence. Because this concern for others is what he expected (as the theory suggests, Jokelainen et al., 2011) and needed as a student but did not get, it was largely the positive experience he received from his preceptor which helped him to develop his mode of being a mentor.

Eli knew what she wanted as a student, and what she needed to reduce her anxiety so she could be open to learning. Eli believes (like Jokelainen et al., 2011) that the mentoring relationship should be about a partnership. Eli believes

227

that the mentor should respect and trust the student, showing the student care and understanding and taking an interest in their needs, and that this can help the student to feel secure and to know that the mentor believes they are capable. Eli's views reflect the findings in Hubbard and Foley's study (2010, p.141):

"*Mentoring…includes open communication between mentor and protégé, the development of collegial relationships, having a commitment to the professional, being accessible and a supportive environment*".

Eli said it is important to reflect back and learn from the experience of being a student and time is one of the key issues, because mentors need to spend dedicated time with their students as Rungapadiachy (2006) highlighted. Eli said this time is needed to set weekly goals which reflect the student's learning outcomes. The mentor and the student need time to evaluate the process and what has been achieved (Chambers, 2007).

"*Mentors need protected time to develop effective, committed working relationships, which support learning that is evidence-based and to promote accurate assessment processes* (Teatheredge, 2010, p.20).

Pip had a negative experience of being mentored and like other participants, it wasn't just about passing and becoming a nurse; what he wanted from the mentors was the 'knowledge' about the craft of caring that he needed to become a competent nurse (Barker, 2009). He has learned from the experience of being mentored, which even as a student he knew was not good or effective (Gopee, 2011). Pip said when he is in charge he does not treat the students in the manner in which he was mentored because students have a lot to give. Pip's experience has taught him that students are often scared and anxious (Bowlby, 1962). Stuart (2007, p.48) said 'special efforts' must be undertaken to make the student feel welcome, secure, and reduce their anxiety so they are more open to learning. Pip uses these core conditions of person centred care (Rogers, 1980;

Barker, 2009), and endeavors to make that 'special effort' (Stuart, 2007) with each student who was placed on the unit where he works, even though Pip is not a mentor, nor training to be a mentor. These core conditions are at the centre of Barker's (2009) craft of caring; Pip is acting as a role model, of effective care and demonstrating how to care for others (see section, 5.3.4.).

Pip's concern for these students was learnt through the experience of not being cared for in the clinical environment. For Pip 'special effort' includes a smile, a gentle word, a warm welcome and a cup of tea, which he believes soothe the student into readiness. Pip then encourages the student to be open to learning about the craft of caring (Barker, 2009) from all the staff. He shares his knowledge and encourages the students to undertake nursing skills, whilst he observes at a distance, encouraging independence but being there if needed (Kilgallon, 2012). This is what Pip and the other participants wanted and needed when they were students. This example highlights that good effective mentoring (without training) reduces anxiety and makes the student feel cared for and feel part of the team, and that these conditions help to make the student feel secure and open to learning (Foster-Turner, 2006).

This type of mentoring is what Miller (2002) terms 'holistic' mentoring, and what Downie and Basford (2003) suggest moves the student from 'subject-centred to 'performance-centred'. Pip also encouraged the students to research what they did not know, this also helps Pip to keep up to date, as stipulated by the NMC (2008, SLAiP). Pip's craft of caring for the patients is also how he cares for the student; he includes them, because as a student he felt excluded. Pip believes that by treating the students in this person centred (Rogers, 1980) manner, they will treat the patients using these same core conditions, which is how effective mentoring should be.

Students in university can comprehend the theory which underpins clinical practice (Walsh, 2010). They can role play simulations and they can develop self-awareness but they can only truly learn the craft of caring (Barker, 2009) in the clinical environment. Wilken (2009) suggests that the mental health nurse can only comprehend the craft of caring by taking time to see the whole picture,

otherwise the nurse fashions assumptions which are a muted picture of the patients' reality. Sal believes now that as a student she could have been encouraged by her mentors to experience the whole process of nursing care, the meaning of the craft, but also the everydayness of what being a nurse really means (Higgins et al., 2009). Sal believes, like many of the other participants that the student needs to experience the whole journey of the craft of caring, the journey of the shift, take the student through the patients journey so they can experience the meaning of the craft.

Summary

Albert Einstein said 'the source of learning is experience'. These nurses, through experience and reflection, had begun the process of unfolding (Mills 2003), and not just think, but act out a role of mentoring which was, they believed, much more effective than what they had received. Their perception of what a mentor should be had been crafted, albeit as a muted version, when they were students. However, it was through the temporal and historic journey of experience, which unfolded what being a mentor meant to each unique individual participant over time, which has been highlighted because this distinctive study followed the participants' journey of becoming. The findings indicate that the participants in this study want their students to not just understand the craft of caring, but to comprehend what it means to each individual in the clinical practice area and most importantly to the patient, to become competent in the quality of the craft of caring, and to understand a clearer picture of the journey of the care, during the patients' potential recovery process. These attributes and desires are alluded to in literature but are rarely presented in such a detailed and passionate manner. Rather than shifting perceptions, there was an existential movement in their perceptions of mentoring. Some of these discussions will overlap with salient points made in the next section on becoming a mentor.

6.3.5. <u>Becoming a mentor, (research aims, 1-4, see section, 6.1.)</u>

"*True. Teaching is even more difficult than learning. We know that; but we rarely think about it. And why is teaching more difficult than learning? Not because the teacher must have a larger store of information, and have it always ready. Teaching is more difficult than learning because what teaching calls for is this: to let learn. Indeed, the proper teacher lets nothing else be learned-than learning. His conduct, therefore, often produces the impression that we really learn nothing from him*" (Heidegger, 1978, p.269).

The newly-qualified nurses in Mooney's (2007, p.1614) study said *'they felt guilty if they spent insufficient time with students',* and as students they did not realize why the mentors were so busy. Gray and Smith's (2000) participants commented that charge nurses who are mentors have even less time to mentor. The participants now realized how difficult it was to try to meet the needs of everyone and everything which required their attention as qualified nurses. The findings also highlighted that this role conflict causes stress for newly-qualified nurses. By the time of the second interview Eli and Sal were now charge nurses, with much more responsibility (see section, 5.3.5.). Bea said that as a student she could not understand why the mentors did not have time for her, and it concerned her that now as a qualified nurse she had such little time,

Levinson (1978) believes that once the individual has reached their goal they are then ready to become mentors themselves and the NMC (2008a) suggests that staff nurses train to become mentors one year post qualification. However, Taylor (2008) thinks that not every qualified nurse is suited to become a mentor, and Hatton-Yeo (2008) believes some nurses even with training will not become effective as mentors. A participant in Gidman's (2011) study stated '*some people are naturally good mentors some are not'*. Bea had not yet started her mentor training and during the second interview she considered issues about becoming a mentor. Bea thinks it is another responsibility that she has not asked for. As such, she now understands some of the negative attitudes mentors have in their

compulsory role (Chambers, 2007), but Bea's need to conform to the NMC's expectations overcame her anxiety, and Bea stated that as professionals it is important to try to do the best you can.

Chambers (2007) suggests that in the business orientation that nursing has developed, it is difficult for the nurse to manage all the mandatory requirements, let alone find time to mentor. Bea's fear is that she will not have time to be the good enough mentor she aspires to be (Gopee, 2011) the mentor she never had. Because now she realizes that she has one full-time job being a nurse and mentoring is another full-time job, Bea thinks this juggling of roles is challenging. Bea thinks that the mentorship training will help her to understand what the 'real' mentorship role is, and how she will cope in that role: '*then it should be fine*' (Bea).

Gidman's (2011) study revealed that students have some understanding of the pressure mentors are under. Bea had some concern and understanding for her mentors, and she now hopes that her students will understand the pressure she is under and show her some concern. Because for Bea being a good mentor is important, for her it's important to make sure the student is looked after and taught the right way, and as well as making sure they are competent. Hubbard and Foley's (2011) study suggested these characteristics are important for effective mentoring. Bea advocates good open communication, as Lindsay-Ochoa (2009) suggests, but just explaining to the student that you do not have enough time due to pressure is not enough, because the student as already established cannot fully comprehend that pressure until they become a qualified nurse.

However, Sal also strongly believes in making sure her students know more about the reality of nursing than she did so they are not so surprised when they qualify, and she wants them to become good nurses and have a better experience than she had.

Bea's belief was more in depth than others statements made by literature. Bea believes that the mentor has to be with the student to explain and be congruent, and to mean what you say, develop plans to readdress the situations, find

232

solutions, make these plans and follow them through (Lindsay-Ochoa, 2009). She believes that this will build trust and will make the student feel supported and secure through the professional commitment (Kinnell and Hughes, 2010). Bea would ask her manger for extra solutions, like giving her time to mentor, or even pay her overtime to be with the student because like Sal, Bea wants her students to have a better experience than she did, because she wants the students to become good nurses.

Bea said she hopes the mentorship training will give her guidance; Kat's experience of mentorship training gave her what Bea hopes for. The mentorship course helped Kat to develop ideas about what type of mentor she aspired to be. Kat believes now, through learning from experience and the training, that as a mentor she should be sensitive to the students' learning styles and preferences, which will help the student to develop and meet their learning objectives. Kat's new philosophy is similar to what was highlighted in Gray and Smith's (2000) study: an effective satisfactory relationship which can inspire the student. Kat believes waiting two and a half years post registration has enhanced her ability and confidence to become an effective mentor. This challenges the NMC (2008a) requirements of one year.

Kat is also suggesting that this longer time frame has developed her experience and confidence and Kat felt more prepared to take on the mentoring role.

Eli too had, due to circumstance waited two and a half years to become a mentor (see section, 5.3.5.). She felt confident about becoming a mentor at the time of the second interview, believing she now had the experience to pass on her knowledge (Levinson, 1978). This perhaps suggests that individuals do not reach their potential to become mentors till extensive time has passed following qualification.

Kat feels now she can be the professional mentor the establishment expects her to be, because she has the nursing experience.

Gopee (2011) suggests that mentoring will have an effect on the students' future careers, the past influencing future possibilities. Kinnell and Hughes (2010) believe the personal features of the mentors also have an effect on the student.

233

This study has clearly demonstrated the influence mentoring had on the participants. Kat believes that if she is an effective nurturing mentor the student will become an effective, nurturing nurse and nurse mentor to future students, because what matters most to Kat is that good nurses are produced to deliver the highest quality of care to the patients (NMC, 2008b). Eli felt responsible because she believed that as a mentor she is guiding the next generation of nurses. This point was made by all the participants and highlighted their care and concern for their students as well as for mental health nursing.

Walsh (2010) suggests the mentor needs to get to know their student and give the student structure. Kinnell and Hughes (2010) believe that mentors need to take time to understand their students' needs and learning styles. Eli, like the other participants, believed that the student needs to be given time, to sit with the mentor, and put structure into place. This structure, Eli believes, makes the student feel safe and helps them to understand what they can achieve in this clinical placement, what they need to be aiming for according to their learning needs. Eli likened this type of mentoring to part of the craft of caring (Barker, 2009), and acting as a role model of good interpersonal connectedness (Barker, 2009). For Eli it is about instilling confidence (Downie and Basford, 2003) where the student can make mistakes without ridicule and can learn from experience.

Jokelainen et al. (2011) believes that the mentor should respect the student, treat them with care and take an interest in their needs, and that this will help the student to feel secure and be more confident. Jed, like Eli, felt it was important that the student receives the correct supervision according to their needs. Jed said he believes in building the student's confidence by giving them time and support. Jed also believes in treating them as individuals and showing them respect. Jed like many of the participants wants to give the student the type of effective mentoring he did not receive, and now he believes '*I have to give it back to the people who are behind me',* the new generation of students, the future nurses (see section, 5.3.5.).

Sal, like her peers, knows how important mentoring is, and how much responsibility is involved in mentoring effectively (NMC, 2008a), because she

234

believes they need to be fit for practice since they will be her future colleagues. Sal has seen students who are not competent pass their proficiencies and become qualified nurses, as indicated in the Duffy (2003) report. Sal now works alongside these qualified incompetent nurses and has reached the conclusion that it is easier to teach the correct method of the craft when the individual is a student.

Kinnell and Hughes (2010) state that planning is essential for mentoring to be effective. Sal believes that mentors are the key to the students' future, and believes a slow, planned approach to learning is more effective, letting the student know that they are not expected to know everything. Ferguson's (2010) study highlighted that the sharing of this knowledge is important for students, newly-qualified nurses and new members of staff. Sal, since qualifying as a mentor, has put a student pack together, which is helpful and welcoming to the student because she realized that there is a lot the students need to know about each placement. The pack contains the basic information about the placement they will need and what skills are required to become a competent nurse. Sal's pack has been implemented on other units within the organization she works for.

One topic that many of the participants referred to was that of reputation: many were concerned about their own reputation as nurses and nurse mentors. They were concerned about what others thought about their abilities, which challenged the consciousness of their realized Being (May, 1983). They were afraid that history might repeat itself, and they would become the mentors their students complain about, just like they had complained when they were students. Protection of this reputation is why some now feel it is important to ensure the students have a good experience on their units. It is not just their personal reputations at stake, but the reputation of the unit and the organization are also at risk. This issue is rarely referred to in the literature, but it is a very valuable point, which should be addressed during mentorship training, as an integral component of the development of the potential mentors identity.

Summary

It is a challenge to find time to mentor and to meet all those expectations which have been assigned to the qualified nurse. However, those who had experienced the mentorship training found it helped them to consider there their future possibilities as nurse mentors. They had begun to have concern for their reputation. In caring for themselves and conforming to the needs of the organization, they had become aware that this struggle can be harmful to the ideal mentor they want to be, because all too often the needs of the organization interrupted the effective mentoring process. Finding a balance between the needs of the self and the needs of the organization, whilst Being-in-the-world of mental health nursing, is important. However, accepting the world's reality and limitations also allows the individual to be themselves in the world, and use the existential courage (May, 1953) to create possibilities for the students and reach new potentials as nurses and mentors. This study has enabled knowledge (which to some qualified nurses remains relatively unconscious), to become conscious. Interviewing these participants over time has enabled them to reflect and learn from the whole experience of Dasein, and be able to understand through care and concern how their role can be challenging, but also how their passion drives them to care for their students as effectively as possible. The next section of the discussion will focus on new possibilities of how mentoring can be improved and sustained; this too was learned through experience and the process of developing the self in-the-world of being a nurse and nurse mentor.

6.3.6. Sustaining the mentoring role, (research aims, 1-4, see section, 6.1.)

"When we are no longer able to change a situation, we are challenged to change ourselves" (Victor Frankl, 1905-1997).

The participants had learned through the transitional process, through reflecting back and exploring how mentoring in practice could be improved in the future (see section, 5.3.6.). Their aim was to give to their mentoring what was missing

from their experience of being mentored. From previous discussions there are many different reasons why the participants wanted to instigate change. Like Heidegger's (1978) cabinet maker, they wanted the students in their care to learn their craft, but they want their students to care about their craft, as they do. Barker's (2009) theory suggests this is how mental health nursing should be, but in my search I have not found evidence which substantiates the participants' aspirations. Furthermore, some of the ideas these participants have put forward for improving the mentoring role are quite inspirational and, I believe, are grounded in their care and concern for themselves, the patients and the students, these ideas will be discussed in this section.

Foster-Turner (2006) believes that the organization where the learning takes place needs to adopt the cultural characteristics of a positive learning environment, which is led from the top down. This culture will then nurture its protégées (students) to reach their full potential (Mills, 2003) as trainee nurses in-the-world of the craft of caring. Mullins (2007) termed this type of positive culture as the 'learning organization' and it is a setting:

"*where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspirations are set free, and where people are continually learning how to learn together"* (Mullins, 2007, p.351).

Levinson (1978, p.318) suggests that, having gone through a period of transition, first the individual needs to find stabilization. Having achieved that, they then need to appraise the new life structure and consider future possibilities for the 'self and the world'. The participants in this study reflected in and on the mentoring process (Schon, 1991) in clinical practice and formulated new possibilities (see section, 5.3.6.). Motivated to become good mentors, they struggled with what they believed a good effective mentor should be, and what restrictions would be imposed on the learning environment by the organization,

due to extenuating sets of circumstances: lack of space, time, opportunity and so forth, regardless of the fact:

"*Service providers are responsible for ensuring that learning opportunities and support for learning and assessment is available in the practice learning environment*" (NMC, 2008a, p.46).

Thus Kat believes that mentoring should be planned and that communication is a key component of successful mentoring. Kat came to realize that time to mentor on the busy unit she works was hard to find, but the development of herself (Levinson, 1978) had developed creativity (May, 1953) and improved the equilibrium between her needs as a mentor and that of the unit, and the external world.

Kilgallon (2012) believes reflection helps clinicians to develop new perspectives in practice. However, Walsh (2010) believes that for mentors it is difficult to find time to reflect and have a discussion with students. Mentors, he said, have to be creative in finding time. Reflection was very important to Kat and she devised a plan to make time to mentor and reflect. There were two qualified staff on duty at any given time on Kat's ward, Kat and one other, and each had a student. Through pre-planning and effective communication Kat was able to secure time and space with her student in a quiet room away from the pressure for an hour when needed, while the other qualified nurse took responsibility of the unit during this period. Kat then returned the favour for the other qualified nurse, so she/he too could have quality time to mentor. This effective model is announced to the team during handover, so communication is open and action clear Lindsay-Ochoa (2009). Hubbard and Foley (2010) think that planning is essential; mentors have to be committed and involve the students in the planning of care. Jokelainen's et al. (2011) results highlighted that a co-operative relationship, in which the mentor and mentee are partners enhances the mentoring process. Kat and the other mentor also made sure the students on this unit were involved with planning each shift, so learning opportunities are discussed together and become

part of the everyday process. Kat tries to ensure this meeting with the student happens on a regular basis. Kat also encourages the students to take a proactive approach towards their learning by explaining which nursing skills they need to develop. Kat teaches her students to learn through reflection; she nurtures her students to make them feel secure and open to learning (because this is what she wanted as student). Kat wants her mentoring to be effective because these students are the future mental health nurses, and nurse mentors who may be-in-the-world with Kat, and in-the-world of mental health nursing whom Kat cares for. It is important to reflect and remember how it felt to be a student.

These participants have now trodden the very path the student is undertaking (Daloz, 1986) (see section, 5.3.6.). Stuart (2007) also suggests that a good mentor will empower the student to find their own answers and solve problems, guided by the mentor (Kilgallon, 2012) and learning through the experience. Hatton-Yeo and Telfer (2008) believe that most students are much more capable than they think. For Eli, effective mentoring and sustaining this role is about reflecting (Johns, 2009) on how she felt as a student, which makes Eli sensitive and empathic to the students, treating each student as an individual with individual needs. Eli believes in fostering an environment of potentiality for the student where they can learn to understand what they have the capacity to achieve in mastering the craft of caring (Barker, 2009). Eli thinks the student should be able to develop without ridicule, with Eli as the guide leading them along a journey of becoming in-the-world of mental health nursing. Eli has concern for her students' Being-in-the-world, and hopes this concern is reciprocated, so the student understands when Eli conforms to the needs of the organization and is too busy to care for the student as she would like.

Eli, like Kat, had thought this through and experiential learning has shown her a model of effecting time to mentor. Eli used the ward diary to 'diarize' time, as she calls it. Eli is using the time when the morning and afternoon staff are together initially for a handover meeting. Then there is a period of time before the morning staff go home where a space in time is filled with double the amount of staff required for a shift. Putting it in the diary announces to the whole team that being

with the student for Eli is an integral component of the day's work, and therefore it is permissible and respected by the team. Thus for Eli, like Kat, making time to mentor is about pre-planning and effective communication. Eli advises other mentors to use the same model and, as a charge nurse, this advice is accepted and respected.

Eli also had another idea to enhance the student's learning experience which she has not yet implemented: that is a student pack, but more specific than these packs generally are. This pack needs to be tailored to the unit's specific learning opportunities for students, and should set benchmarks for the level of learning to be achieved for each year level, that is, first, second and third-year students. These benchmarks will be linked to the specific mental health skills the students need to be competent in by the end of each training year. Eli believes this will prevent third-year students being incompetent in year-one skills.

Sal wants the students-in-her-world to have a better experience than the one she had. Sal is passionate about mentoring, and believes this is part of what she came to understand about herself (Mills, 2003) through the developmental transitions (Levinson, 1978). Sal wants to be there for her students through the good and the bad times, during their experience on this journey of enlightenment in the craft of becoming. Sal will make the time to be an effective mentor, for example, Sal said that she would take the time to make sure the student understood care planning process and link it to the craft, developing the student's understanding.

Sal is dedicated to the role of mentoring. She believes that students who are not competent should not pass and become qualified nurses (Duffy, 2003), thus Sal believes getting the mentoring right will ensure that incompetent students do not become incompetent colleagues who are dangerous in-the-world of mental health nursing. If Sal gives the students a better experience than she had, and they are still not competent, then they will fail, as Duffy's (2003) research advised. Rungapadiachy's (2006) participants believed they were unprepared for the role of qualified mental health nurse, and this was linked to skill deficit. The participants in my study also mentioned being unprepared, but Bea was more

concerned with the emotional needs of students (see section, 5.3.6.). Bea had learned from her experience of a year's training in adult branch, before she transferred, that in mental health nursing the students need much more emotional support than in other branches of nursing. Bea believes that the emotional stress in caring for patients with a mental illness, in the unpredictable world of the mental health nursing, needs to be acknowledged and coped with, and that students need to learn and understand how to cope with their emotional needs (Barker 2009). Bea believes that in learning environments where staff care for each other, a secure base is created which makes the environment more supportive for the students (Foster-Turner, 2006). Bea's insights into the extra support for the mental health student are not clearly indicated in the literature, and these points should be considered in the future curriculum.

Bea believes that the system in place for students where she works is effective. They have a nurse nominated as head of students who manages the student placement. This head informs managers well in advance of students' placements, so a mentor can be allocated in advance as well. The manager will put the new student on the rota a month before they arrive, so all members of the team are aware of that student's pending placement. This ensures, as Downie and Basford (2003) suggest, that the student feels welcome and wanted, and the mentoring process is pre-planned (Hubbard and Foley, 2010).

Most of the other ideas and comments made about improving and sustaining the mentoring role were discussed under previous headings, for example, Pip's person centred holistic mentoring (Miller, 2002) and Jed's ensuring the student is part of the team in a cooperative relationship, as Jokelainen's et al. (2011) study suggested.

Jed believes that finding time to mentor will always be a problem, but a good effective mentor will make time. Jed said often the ward is chaotic, there is no time to mentor, but he will offer to stay late to have time with the student if the student is willing. Jed, like Bea, will when necessary ask the manager for time to mentor, but Jed said the most important aspect of being a mentor is to prioritize your work, as many of the other participants also said. Jed is concerned for the

students and gives them the time, the support and encouragement to do the nursing tasks which he feels will build their confidence, because this is what he expected as a student and did not get.

These participants have obviously thought through their role as mentors and devised some good plans in which to maintain and manage the students' experience, this brings this chapter to a close, following a summary of the whole chapter.

6.4. <u>Chapter summary</u>

This discussion presented some of the findings which clearly support what current and classic literature, including research, has already offered to this complex subject. This included the fact that students are often unable to understand why their mentors are not there for them, because they do not fully understand the role of the mental health nurse. The students could understand that the mentors are busy, but this did not relieve their anxiety or frustration. Students do not get their needs met when mentoring is ineffective, and there are many barriers which prevent effective mentoring, including lack of time and toxic mentoring. The students and mentors both have a responsibility in the relationship, and both need to be motivated. It is hard to teach unmotivated students. However, not all nurses want to be mentors, and not all nurses make good mentors and this affects the students' experience. Poor mentoring can lead to poor assessment, and students who are not competent pass practice and become incompetent nurses and mentors. Time to mentor has been and will continue to be a problem, until its necessity is properly established with employers and the NMC.

This study also supported some literature which relates to the transition into qualified nurse and mentor. It is assumed, especially by the NMC, that students are adequately prepared for the role of staff nurse, but the literature and the evidence from this study suggests otherwise. The preceptorship period is supportive if effective, but the students are not prepared for the accountability

and preceptorship does not protect them from this. Thus it was a shock to these participants, and the anxiety they had as students manifested itself as stress because they felt ill-prepared for the role. The participants now understood the pressures mentors are under, and made plans to make sure their students felt secure and developed satisfactory relationships with students as they developed their skills.

However, the method of this inquiry has revealed a much more in-depth understanding of the process of Being and becoming. It has highlighted how much the participant's sense of identity is determined through the transitional experiences of being a student, becoming a nurse, being a nurse and becoming a mentor. These findings offer fresh insights into the nature of the mentoring process, and the existential process enabled deeper and clearer understanding of what being an effective mentor means, and how to sustain that effectiveness.

Whilst the mentors in this study looked to the wider organizations for solutions to mentoring barriers, the qualified nurse participants in this study learned through the transitional experience, and began a process of unfolding which included also looking in themselves for the answers. This journey of experience through the transitions of becoming had developed in these participants an understanding of self, and created an element of self-sufficiency. Relations between the individual self and others identified within Heideggerian concepts, particularly around care, can be seen to be useful. This discussion highlighted how perceptions developed existentially through the participants' progression, in becoming a qualified nurse and nurse mentor in-the-world of mental health nursing. Through these processes and experiences they came to comprehend the meaning of being a student from the student's, the nurse's and the mentor's perspective. Through interaction and becoming nurses they began to deeply understand what it means to be a nurse and to mentor students whilst caring for their patients and caring for themselves. Having concern for themselves helped them to realize their full potential. Within this potential is the struggle to care for others in their believed mode of Being, but at the same time having to conform to ideals which were not always congruent to their mode of Being and believing. However, this struggle

only enabled the participants to develop a greater understanding of who they are in regards to the self and the world, developing their individual personalities.

Once qualified, the participants understood that studentship did not clearly teach them the real meaning of mental health nursing. They learnt through experience what the craft of caring (Barker, 2009) meant to them. They came to understand its depth, rather than a muted version of caring (empty busywork), but they would have liked to have learnt this as students. They learnt not only the art of the craft, but what that craft means to others-in-world, what the essence of the craft means to them, and how best to let others learn that craft (Heidegger, 1978) through the concept of mentoring. The participants clearly had a passion for the craft, and wanted to teach and assess the craft properly, making sure they were role models of effective mental health nursing care, modeling the craft of caring for the students, making sure that the role of the nurse is clearly explained, and taking the student on the journey of the shift, instead of cocooning them from the everydayness of mental health nursing. These participants believe that qualified staff need to remember what it is like to be a student, and be empathic and concerned for the student's needs.

They believe it is important to try, through efficient and effective communication to help the student understand the complexity of the role of the nurse mentor, and why mentors are sometimes not available to the student, but that this does not mean they do not care. This active communication can reduce misunderstanding, promote understanding and encourage the student to learn from others as well, so reducing anxiety and creating security within the whole team. Mental health nursing is stressful and students in this branch require more support, so it is important to be there to calm the student and to explain complex and risky situations, encouraging the student, building their confidence, respecting them and treating them as a member of the team, and so helping them to reach their own full potential and better preparing them for the transition into qualified nurse. Because the participants, once qualified, valued their reputation and did not want to be ridiculed, they used the courage and

confidence which they had acquired over time to develop their own identities as nurses and mentors. The above values were the result.

I interpreted that their perceptions had shifted, what occurred through these processes was an existential movement, which has enriched the participants' existence (Heidegger, 1962) in-their-world of mental health nursing.

The participants who were the students in the first interview and became the qualified nurses and nurse mentors in the second interview, presented some thoughtful ideas on how to sustain and improve mentoring in many sections of this discussion: Kat and Eli's ideas about making time; Pip's craft of caring through holistic mentoring; Sal's and Eli student information packs. All want their students to have better experiences than they had.

Pre-planning mentorship is essential. Having someone in charge of the student's experience in the placement areas can ensure all the team know about the student's pending placement, and that a mentor is already allocated, again reducing anxiety for all involved. Reviewing the involvement of the university in the mentoring process may increase support for the mentors and students, and mitigate against students who are incompetent passing. However there are resource implications with many of these ideas. It may also be worth considering the length of time needed before undertaking the mentoring role. Lastly, the NMC has been discussed in regards to the CHRE (2012) report, and it is evident that the NMC guidance for mentoring needs to be less passive, and more specific, focused on the quality rather than the process and making facilitation of the role clear, yet realistic. The Trusts and the HEIs also need to take a closer look at their processes, and although good in some respects (NMC report, 2012) it is evident from these findings that failing to fail was still occurring poor practice is not being reported (Francis, 2012) and that students are cocooned from the real meaning and understanding of the craft of caring.

6.4.1. <u>How the research aims were met</u>

The above discussion has demonstrated how the study aims were met by linking each aim to each essence. However the table below presents this in a more methodical manner.

Table 6, below links the study's findings to the research aims.
The aims of this study were to:
1. Explore how the role of the mentor affects the training of student mental health nurses in clinical practice.
2. Gather and interpret data about the essential meaning of being a student, becoming a nurse, being a nurse and becoming a mentor.
3. Understand the everydayness of Being for the individual through the different transitional stages and within different social contexts.
4. Explore how the process of Being-in-the-world of student nurse training reveals an understanding of self within the world of mental health nursing, and how this personal meaning of nursing is assimilated into their approach to nursing.

6.4.2. Table 6: Contribution to knowledge and how the aims were addressed:

Insights from the study	Research aim addressed
1. The students realized that they had not learnt the craft of caring, they had been cocooned from the real meaning of the craft	Addressed aim 1
2. The students learnt from effective and ineffective mentors	Addressed aims 1 and 3
3. The participants learnt how to be effective mentors through their poor experience	Addressed aims 1 ,2, and 3

4. The participants learnt how to teach the real meaning of the craft of caring through their poor experience	Addressed aims 1, 2, 3 and 4.
5.This study highlighted that poor practice is not reported	Addressed aim 2.
6. Students do not want pass if not competent.	Addressed aim 1
7. It is easier to change a students poor practice than a qualified nurses poor practice who has passed when they should have failed	Addressed aim 4
8. The interview participants learned to value their reputation.	Addressed aim 1, 2, 3 and 4.
9. People need a passion to become a nurse and more passion to become a mentor. Only nurses with a passion for mentoring should do the training	Addressed aim 1
10. It takes extraordinary effort to teach on top of nursing	Addressed aim 4
11. Students who report poor practice are punished or think they will be punished.	Addresses aim 1
12. Some students are training for punitive reasons, e.g. just to get a visa.	Addressed aim 2.
13. The NMC guidance needs much more structure, and detail on implementation.	Addressed aim 4
14. Students are not prepared for the transition or the responsibility because they had been protected from the reality of the real role of the nurse.	Addressed aim 2 and 4 This issue was already known but the findings from previous studies were not as intense as these findings.

15. It is important once qualified to remember what it like to be a student when you are a mentor in order to feel empathy.	Addressed aims 3 and 4
16. These participants learnt how to teach the craft effectively even through inadequate facilitation.	Addressed aims 1, 2, 3 and 4
17. Inadequate facilitation taught the participants how to reduce anxiety by using resilience to cope and making sure that they worked with other members of the team.	Addresses aims 1 and 4
18. The evidence highlighted that learning in clinical practice is not always dependent on the mentor	Addressed aims 1 and 2.
19. The participants learnt though effective and ineffective mentoring how to communicate effectively to students, explaining why the time was lost, explaining why patients needs take priority, but explaining how this is part of the craft	Addressed aims 1, 2, and 4.
20. The evidence showed that bank working affects the mentoring relationship	Addressed aim 1
21. The findings showed how putting pressure on a student to hurry tasks, can result in unsafe practice and learning	Addressed aim 1
22. The participants suggested that the mentor training is inadequate, the	

What the findings have confirmed	Research aims addressed
training needs to teach nurse's how to mentor effectively.	
What the findings have confirmed	**Research aims addressed**
1. Demonstrated inadequate facilitation of education in clinical practice	Addressed aim 1
2. Students reach their full potential when they feel part of a team, have adequate mentoring, and feel secure enough to develop confidence.	Addressed aim 1
3. The findings showed how failing to fail is still an ongoing serious issue.	Addressed aim 1
4. Lack of time to mentor	Addressed aim1
5. Inadequate facilitation of mentoring	Addressed aim 1

The above table highlights how the research aims were met. Furthermore the table identifies how the study findings contributed to knowledge, or confirmed what was already known. This knowledge has brought new meanings into mental health nurse education, and has highlighted the need for change.

6.4.3. Limitations of the study

Polit and Beck (2014) suggest that the limitations of a study should be presented in the discussion section so that the implications for the trustworthiness of the findings can be reviewed and critiqued. Creswell (2003) is of the opinion that the researcher in this section should highlight the 'weaknesses' of the study, also stating deficits which may have been beyond the researchers control (Holloway, 2008). According to Holland and Rees (2010) the limitations should be presented clearly and in a professional manner.

Moule and Goodman (2009) state that it is almost impossible to eliminate researcher bias from qualitative studies, and the qualitative methods in this study were no exception. However, as far as possible the study has been presented in

a transparent manner to increase the trustworthiness: that is, during the sampling, data collection and analysis (see section, 4.1-7.) (Lo Biondo-Wood and Haber, 2010). There is however, a fine line between interpreting phenomena objectively and subjectively in phenomenological research and it is the researcher's subjectivity that affects the analysis of the data (Crotty, 1996), and this could have affected the dependability (Guba and Lincoln, 1989). It should be acknowledged as stated in chapter 4 section 4.4.1 that my experience at research interviewing is limited, although I am a trained psychiatric nurse and therapist. I did initially ask some leading questions, albeit I retracted them, but this lack of experience might have slightly affected the dependability of the study (Burns and Grove, 2011). I did, though, ensure I paraphrased and member checked (Guba and Lincoln, 1989) with the participants to ensure I had captured on record the intended meaning of their words.

The original sample of mental health nursing students is also limited by their recruitment from only one UK University. However, the two-stage process in this research meant that the same participants in the second interview had migrated once qualified to different geographical areas, and were employed by various NHS and private organizations, widening the sample's regional experience (Todres and Holloway, 2010). The sample size is sufficient for a phenomenological study (Munhall, 2012) but it is still quite small and limiting (Morse 2000), and the study could therefore have been more trustworthy if the student cohort in the first interview had been generated from a cluster of universities. It also is questionable if these participants would have considered the mentoring process so deeply if they had not been part of this longitudinal study, however this could also be considered a strength of this study (Munhall, 2012).

The participants' care and concern for the craft of caring may have motivated them to participate in the hope that this research could influence change, and these issues can limit the findings (Holloway, 2008) because their selective accounts might .not reflect the whole student collective view. For the purpose of transparency, I believe that at times during the analysis, I may have transferred

my own values and beliefs into the process. As Crotty (1996) stated it is very difficult not to. It is important to acknowledge that my own experience of being a student, mental health nurse and mentor influenced this process. Also my own knowledge and understanding of the establishment and the pressure to conform may well have had an effect on the interpretation. Another issue is that many of the participants' comments related to educational needs, that is learning theories. This could be viewed as being influenced by my educational background. However, reviewing the transcripts again these comments were participant-led and I suspect it emanated from their mentorship training.

The survey of mentors is not fully consistent with an ontological (Crotty, 1996) phenomenological approach (Heidegger, 1962). Even though the qualitative data was analysed using the same method as the interviews, this data collection method did limit the study. What was missing was the phenomenological conversation which clarifies meaning (Munhall, 2012), thus as Jones and Rattray (2010) suggest there is no means to verify the responses. Although the questionnaire was piloted (Holland and Rees, 2010) on reflection some of the questions had a narrow focus (Bryman, 2008) on effective mentoring rather than the experience of mentoring and this was very rather limiting (Holloway and Wheeler, 2010). The response rate was poor at 23.5% (McKenna et al., 2010) and confines the study considerably, although the qualitative responses were readable, comprehensive and relevant (Lacey, 2010) mitigating not eliminating the low response rate. The role of the researcher was addressed briefly in the above discussion: the importance of the role will be reviewed next.

6.4.4. <u>The role of the researcher</u>

The researcher like the nurse is responsible and accountable for their actions (Gerrish and Lacey, 2010). The roles are similar because they involve complex and critical thinking and reasoning (Burns and Grove, 2011). These skills help both the nurse and the researcher to discover and identify new phenomena and information (Burns and Grove, 2011). Thus it is important that the researcher

ensures that the research process is safe, professional and transparent (Holloway and Wheeler, 2010). Whilst I am relatively inexperienced at undertaking research I have taught the process and supervised students for twelve years. This study applied a benevolent (Beauchamp and Childress, 2009) approach from the start. The research proposal, participant information sheet, consent form and other relevant documents were approved by the National Research Ethics Service and relevant trusts before the research commenced. This approval was ongoing with annual reports sent to NRES, and an annual appraisal by the university (ESRC, 2005). Throughout the study, ethical issues were addressed on an ongoing basis (see, 4.6). The researcher ensured ethical principals were upheld and not compromised (Bryman, 2008).

The interview and survey participants (see appendices, 2 and 5) were fully informed of the research process and their participation (Gerrish and Lacey, 2010). For the survey consent was assumed through the return of the anonymous questionnaires and consent was ongoing with the interview participants (RCN, 2006). The participant information sheet and consent form were revisited before the start of each interview, ensuring the participants knew what would be involved and their rights (NRES, 2008,). Quiet appropriate rooms were used for the interviews to ensure privacy and confidentiality (Moule and Goodman, 2009).

Risk was taken into consideration (Beauchamp and Childress, 2009), but no incident occurred, no interview had to be stopped and the independent person identified was not required. Confidentiality was maintained and adhered as stipulated by NRES (2008). Holloway and Wheeler (2009) state it is the researcher's responsibility to ensure they adhere to the legal and ethical issues to protect the participants, and to ensure that relevant systems are in place in accordance with the data protection Act 1998 and the Research Governance Framework for Health and Social Care (DH, 2005).

On reflection on the three-year period between the data collections, I felt after immersing myself in the findings over weeks totally gripped, at times stuck, but

also committed still to my original belief that the educational needs of mental health nursing students in the clinical setting is a central pivot in nurse training.

Reading through the transcripts again and listening to the interviews helped to assimilate the data, in regards to separating out my own perspectives, and expectations of that lived reality, in order to view the world mainly from the participants' perception. I learned that it was very difficult for any researcher to completely put aside presuppositions; what is important in a phenomenological study is to be open and identify them (Crotty, 1996). There is in phenomenological research a fine line between interpreting the phenomena objectively and subjectively, and it is the researcher's subjectivity that affects the analysis of the data (Davis, 1991). The emphasis is on the reflexivity of the researcher. It is through the reflective process that the researcher understands and makes transparent what impact the researcher has had on this study (Crotty, 1996), in regards to their own social identity (Lathlean, 2010), their own lived experience and their own conscious meanings about mentorship, which independently or as a whole can affect the neutrality of the study, and bias aspects of the analysis of the essential meaning of the data (Gray, 2009). For the purpose of transparency, I believe that at times during the data analysis I may have transferred my own values and beliefs into the process. As Crotty stated it is very difficult not to. It is important to acknowledge that my own experience of being a student, mental health nurse and mentor influenced this process. Also my own knowledge and understanding of the establishment and the pressure to conform may well have had an effect on the interpretation of meaning.

The research process itself was clear (Holloway, 2008). The quality of the study was transparent (see section, 4.4.1.) and the researcher has acknowledged the study's limitations and weaknesses (Holloway, 2008). Qualitative research is always open to refutation (Munhall, 2012) due to its subjective nature. The study also produced significant and unique findings (Heidegger, 1978), which demonstrates its purpose, fulfills its aims and contributes to knowledge, and the original findings have significant implications for nurse training and clinical

practice (see 7.3. and 7.4. for the researchers reflections on learning through the process).

Chapter 7: Conclusions and recommendations

7.1. Introduction

This study investigated the transformations ascribed to the lived experience and intricacies of mentoring in mental health nurse training in clinical practice. The phenomena the study explored were the stated experiences of mental health nurse training presented to me by nursing students as they became qualified nurses, and by experienced mentors. These experiences are shaped by their interaction with others and things involved in-their-world and by the interpretation of what that interaction means to them, and to me.

This study found that the craft of caring for mental health patients was not fully comprehended by the student nurses at the end of their training. Furthermore these students did not feel competent in applying the craft, nor did they fully understand how or why the care was crafted. This lack of knowledge and competence affected their transition into qualified nurses, and the whole process had significance for their development, because what also became apparent is that these participants learned how to become competent mentors teaching the craft through their own complex experience of being mentored (see, 6.4.1. for originality).

Although much research has been undertaken to explore the concept of mentoring in nursing, this study is unique in regards to the exploration of perceptions of mentoring in mental health nursing, in different social contexts over time. This approach developed a deep understanding of the conscious multiple transitions of Being (Dasein, Being-there/there-Being Heidegger 1962): that is, being a student, then becoming a nurse, being a nurse then becoming a mentor in different social contexts. The research provides an understanding of the essential meaning of the lived reality of being a mentor in mental health practice, and the inter-subjective process of constructing meaning in that social

reality, capturing the essence of the reciprocal relationships between mentor and mentee in relation to space and time.

This chapter will summarize the salient points of the thesis, critically analyzing the process and methods and exposing some of the limitations, as well as highlighting the reflexivity and transparency of the process (Crotty, 1996), making the integrity of the study as evident as possible. The recommendations for clinical practice will also be presented. These discussions will commence with a presentation of the quality of this study.

7.2. <u>Quality issues</u>

The research involved encounters in the lived world and experience of others, and this has been a very creative process for me. Bringing this creation to a close can be regarded as part of my own unfolding, reflecting on the past endeavour's of this research process, and exploring future possibilities; as this is not the end, but another beginning. I am between what has past and what will become the future (Gadamer, 2004), in which recommendations may be implemented in clinical practice, and future research undertaken. Change may improve the mentoring experience for the students so they learn and master the art and craft of caring, to become competent mental health nurses who have concern for, and care competently for their patients utilizing the very best evidence base. Fundamental to the ontology of the study is the nature of craft. Mental health nursing is as Barker (2009, p.4) suggests:

"*The proper focus of nursing is the craft of caring. The value of care is defined by those who receive it. Yet, the nurse brings value, expressed through carefulness and expertise. Knowing when to talk, what to say and when to remain silent, while nursing a depressed, distressed or dying person takes great skill. This is not something that can be learned on a course, far less from books. It requires a life-long apprenticeship, where the human tools of the trade are sharpened with every encounter.*"

The mental health apprentice or student needs a good mentor as was established in this study. The good enough mentor or teacher will enable and facilitate the apprentice 'to let learn', as Heidegger (1978) said. For the patient to begin to start on the journey of recovery and for the healing process to start, the nurse has to genuinely care and have concern for the patients' needs, and nurse with sensitivity. This craft which Barker (2009) believes is an art (aesthetics) and science (knowledge) can only be truly learned in clinical practice under effective mentorship. In order to become skilled in the craft of caring the apprentice has to understand the essence of the craft, its hidden depths, because without this depth of understanding, the '*craft will never be anything but empty busywork*' (Heidegger, 1978, p.268). For this understanding of the craft of caring to be revealed the apprentice (the participants said), needs a teacher (mentor) who cares and has concern for the craft of caring.

The mentoring that the students experience will influence those students' attitudes towards the craft of caring for years to come, and affect the quality of care the patient receives. Because these students are tomorrow's nurses and the future nurse mentors, the interaction and development affects their future, through the past experiences. The findings of this study also revealed that in the presence of others (including mentors) we become aware of who we are in this world of mental health nursing. From this theoretical position, this research, establishes how much effect the mentoring process has on the students' journey through clinical practice development.

It is evident that mentorship needs to be effective, not only in order to enable the craft of caring to be learned and deeply understood, but also how it affects the apprentice developing a sense of self. The discussions in the literature review and in the findings of this study suggested that for mentoring to be effective mentors have to be keen, motivated and committed to the role. This has implications for NMC policy.

From the comments the participants made in the second interview, it was clear that the participants in this study were keen to be effective mentors. Furthermore,

257

these participants had care and concern not only for themselves but for others, and were committed to the role of student, nurse and nurse mentor. These qualities could be the reason why they volunteered to participate and continued to participate in this study. This bias could affect the trustworthiness of this study, because these participants' were committed to become effective mentors, and the findings may have been different if the participants were not so concerned about the process of mentoring.

This study used more than one method and because the study was longitudinal, it increased the reliability and certainly contributes to its internal validity (Gray, 2009). Temporal studies about transitions in health care can be useful as evidence to influence policy contexts (Holland, 2006). Furthermore, as Holloway and Wheeler (2010) suggest, the student participants in this study could have used the interview process to project their frustrations. Whilst I am aware their keenness to participate could be construed as frustration, it is my belief, that their arguments were well balanced, because this process revealed the participants' authenticity. The continued participation of the interviewees indicated that the study was conducted professionally (Holland, 2006), and that the study was not just a platform for projection but a process, I assumed they felt could instigate change in a system, which they told me needs improving.

The original sample of mental health nursing students is limited by their recruitment from only one UK University. However, the temporal process in this research meant that the same participants in the second interview had migrated once qualified to different geographical areas, and were employed by various NHS and private organizations, widening the sample experience (Gray 2009). Nevertheless, future researchers using similar methods should consider inviting participants from more than one university. I believe it should also be stated that the response rate achieved through the facilitation of the questionnaires was low, although the amount of qualitative data it generated was substantial and this was justified in chapter four. The interview participants' numbers were also minimal. However, I believe the depth of the data justified the low numbers.

The essential meaning of the experience of the participants was exposed during this study through the constant revisiting of the data during analysis, this process also ensured that subjective preconception was left behind to ensure the 'description was free from extraneous considerations', thus bringing new meaning to life (Crotty, 1996, p.174). Furthermore the conceptual elements of mentoring and the concepts of transition were written mainly in the words of the participants (Van Manen, 2006), and were deliberately more first person accounts (Crotty, 1996). Barkway (2001) recommends that researchers who use a phenomenological method should ensure that the 'essential phenomenon' is identified.

To study the essence of the lived experience, in particular the original transcripts were reviewed, re-reading the dialogue in the participants' own words and listening to the digital recordings (VanManen, 2006). Through the existential experience, the participant's past and present everydayness, interaction and the in-betweeness of familiarity and fear of the unknown was revealed, exposing a deep care for the craft of mental health nursing, and concern about others-in-their-world including themselves. Their lived experience and views of mentoring in mental health nursing were also highlighted, including the barriers which cause mentoring to be not as effective as it could be.

There also was the danger of imposing a symbolic interaction or subjective view (Crotty, 1996) into the process of interpretation. This has been taken into account that what is presented in the findings, is the understanding of what was seen, heard and experienced, which has not become something different, it, had as Heidegger (1962, p.188) said, 'become itself'. The analysis of the transcripts involved the intuitive understanding of the participants' evolution into mentors:

"*understanding does not become something different. It becomes itself. Such interpretation is grounded essentially in understanding; the latter does not arise from the former …it is rather the working-out of possibilities projected in understanding*" (Heidegger, 1962, p.188).

In processing the data in this manner it had exposed a meaning of their journey, that is, what has been revealed is a 'fundamental possibility' of their human Being, a 'non-categorical manifestation of Being'. This process is a central component to the contribution to knowledge.

The data from the interviews was lifted in its original form (in the participants' own words) and placed under headings as essences. Crotty (1996) suggests that other people or researchers should check the interpretations the researcher has made as a precaution against imposition. The study supervisors did read the interpretations from the earliest drafts, they did not read the original transcripts or the early processes, due to time restraints. Thus the quality of the process could be open to criticism (Crotty, 1996). However I believe the transparency and consistency (Gray, 2009) in the process helped to ameliorate this criticism. Nevertheless, it would have increased the credibility of this study if the early processes and the transcripts had been read and reviewed by another researcher.

The study of the essential meaning and the essence of what being human means is taken from a hermeneutic stance, thus the research process linked philosophical positions of inquiry together. The originality of evaluating these transformations in the life structure of mental health nurse training gives a clearer understanding and meaning in regards to what factors influence the mentoring experience, and how these issues impact on mental health nurse training in the practice area. Ideas and concepts on how to improve the mentoring process became apparent through the analysis of the transitional process. However, I wonder if these participants would have considered the mentoring process so deeply if they had not been part of this longitudinal study. Furthermore, their care and concern for the craft of caring may have motivated them to participate in the hope that this research could influence change.

7.3. <u>Thoughts and reflections</u>

On reflection over the past three years, I still firmly believe that the educational needs of mental health nursing students in clinical practice are pivotal to nurse education, because as Barker (2009) says the craft cannot be learnt from books. An effective, capable mentor is the key in teaching, supporting, guiding and assessing the students' competence in clinical practice. If the mentoring is good enough, the students will become nurses who can deliver the craft of caring which is effective to our mental health patients (NMC, 2008a) from the patients' point of view.

The mentor is the person who struggles to motivate the uninterested student, and attempts to understand through concern why the student has a poor attitude, or why the student is not as competent as they should be at this stage in their training. While the mentor is mentoring they are also nursing; this is at times as this study has shown, complex, demanding and pressured. The needs of the ward, management and the organization, as well as policy makers (NMC; DH) have to be considered, adhered to and managed as well as the activities of mentoring and nursing. As well as being students, nurses and mentors the participants in this study are also unique individuals (Gaarder, 1995). It was the existential reality of becoming a nurse, being a nurse and being/becoming a nurse mentor that this study presented.

The ontological elements of this study also linked Levinson's (1978) theory of becoming, and to Heidegger's (1962) concepts of Being and Time. These approaches could be seen as controversial, but this adds to its original features. Neither theoretical approach was followed precisely but both informed the analysis. This thesis did not do justice to Levinsons (1978) ten-year study 'The Seasons of a Man's Life', because Levinson's (1978) theory refers to the whole of a man's life, which includes many transitions, whilst this study only explored the transitions from student to qualified nurse and from qualified nurse to mentor. However, what was important to the conceptual schema of this study was Levinson's (1978) concepts of mentoring, the dream and the transitional process.

The nurse's journey starts with a dream of becoming a mental health nurse Levinson (1978) suggests it is the informal and formal mentoring that the trainee receives from the mentor which facilitates the dream. The journey of becoming is not easy according to Levinson (1978), but it is the mentor's role to support the mentee through the harder times, which can be full of disappointment. Once the mentee has reached their goal, achieved their dream, a transitional period occurs (Levinson, 1978) in which the individual reviews the past structure in which they have successfully passed through and explores the possibility of change in themselves in their new world, and make crucial choices which will form the basis of the new life structure. Levinson (1978) also said that if the mentoring has been effective the individual will then feel ready to become a mentor themselves.

Heidegger's philosophical concepts were also reinterpreted to assist the analysis. A key component of the study is the concept of Being-in-the-world (Heidegger, 1962), to explain the process of being a student and becoming a nurse in the first transition, then exploring the transition of being a nurse and becoming a mentor. It proved important in understanding the essence of each transitional stage and how capable the mentor was in enabling the mentee to achieve their goal. It was also important to understand Dasein (Being-there, there-Being) itself in each temporal transitional stage (Heidegger, 1962), to explore the life-structure of that individual's relationship with the world, and Being-with-others within each transitional stage, and the significance of the mentor's role, from the mentee's and the nurse mentor's perspective. This study also revealed the existential notion (May, 1953) of the potential for change and the choices the individuals made at each transitional stage. Levinson (1978) suggests that through these transitional stages the individual will come to understand them-selves in the world and make sense of their own self in the new structure. This study highlighted the developing sense of self and how the participants learned through the transitional experiences. However, it was through the process of analysis using the Heideggerian (1962) concepts of the participant's care and concern for themselves and others, that the essential meaning of Being and becoming (Levinson, 1978) emerged through each transitional stage.

This is an important conceptual framework that contributed to the originality of this study. Whilst the conceptual elements of mentoring, and the concepts of transition contributed to the new knowledge. This knowledge can be used to improve student nurse education in clinical practice, and it can influence policy makers.

Analysis of the existential states of the authentic and inauthentic self (also from Heidegger, 1962), revealed how the interview participants constructed their own identities of being students, becoming mental health nurses and mentors through the process of developing an identity which they believed was true to themselves, whilst understanding at the same time, within each temporal social context, that they did at times need to conform to the needs of others.

This study revealed an essence of the meaning of the transitional mentoring process, a part of the whole, which highlighted new meanings, but which has already become history. What it did reveal was how important it is to learn the fundamental nature of the craft of caring, and not empty busywork (Heidegger, 1978). In order to learn the craft the mentee needs a good teacher, and it is harder to teach than it is to learn according to Heidegger (1978). A good teacher/mentor will inspire and motivate the student (Levinson, 1978), to develop confidence in the craft of caring, and to develop an understanding of one's self through each transitional stage reaching and realizing ones own potentiality, but like the participants in this study, they will understand the restrictions on the life structure.

In reality, because the mentors had already trodden the path the students were following, the students expected their mentors to have concern for them, and be good teachers, but they were not always caring or capable. Furthermore these findings revealed that often there were unrealistic expectations of the participants, and whistle blowing was treated with punitive responses.

Those mentors, who did not have concern or care for their students, were also only doing empty 'busywork'. I make an assumption here that these nurses did not want the responsibility of mentoring, believing it to be the responsibility of the university as was highlighted in these findings. Furthermore, uncaring mentors

263

may just be unable to facilitate the role of mentoring effectively, not all nurses make good mentors.

The anxious and angry students did not always understand why their mentors were not there for them, but learnt through the experience that others cared enough to guide them along the way. The point here is that these students were able to learn from effective and ineffective mentoring. However, these participants believed that if they had had consistent, effective mentors, they would have learnt much more about the depth of the craft of caring and the role of the mental health nurse. This knowledge, they believed would have better prepared them for the transition into qualified nurse. Whilst they understood that the needs of others-in-the-world would demand their time, the mentoring experience taught these participants that they had the potential to become better mentors (carers) to their students. They were able care for their own students in a holistic manner, meeting their needs and taking them on the journey of the shift, instead of cocooning them from the real meaning of the craft of caring. Their passion was evident (my interpretation) during the second interview, but I stress that it could be this passion which inspired them to take part in this study. The findings may have been quite different if the participants were not so concerned about mentoring.

The core of the finding of this study revealed that there are methods which can be applied that reduce the barriers in the mentoring process, but the individual has to really care and have concern for teaching the craft of caring to the student who really wants to learn.

7.4. <u>Reflections on the research process</u>

Having reflected on this study, I believe it is important that I present what I have learnt through this whole experience and what I would do differently.

Before I began to write this thesis my supervisor said that I would need a note pad 'What for?' I said. 'To reflect' he said. I dismissed his advice as irrelevant. However, I filled nearly three note books, and it was to these I returned whilst

pondering on the whole experience. The lesson here was that from the very start I learned to listen to those more experienced than myself.

It is an imperfect world we live in. These imperfections are presented to us daily through the media. Rarely are the exemplary achievements of the world shared openly, for example the effective mental health nurse's daily routine Being-in-the-world, which highlights the care and concern she/he has for their craft, which enables the patient to begin their journey of recovery. A student mental health nurse is also on a journey, a journey of discovery, but in order to do this they need a guide, a mentor to lead them through this difficult yet enlightening process. The mentor is a central figure for the student during this process of becoming, and I began my journey to understand this process four years ago. The journey was not always easy especially in the latter stages, but it has been enlightening. I believe it has developed and expanded my knowledge and understanding about the world of imperfection and the meaning of Being, but I have also learned more deeply about the research process itself. Imperfections about my own capabilities have also been understood and my own sense of self has been more clearly understood and developed.

An important point I would like to make, especially in a study when you are following participants over time, is not to give up hope. I had not been prepared for the amount of effort it took to arrange the second interviews. I almost gave up hope and thought I would at one point only have three participants involved in the second interviews. Arranging these interviews was complicated by the fact that the participants had migrated and all worked shifts. It was difficult to contact them, let alone make appointments. In the original ethical application I had not sought permission to interview them in their work time, thus finding time was complex. In hindsight I do not think I would have applied to interview in work time, as I would not be ethically comfortable about taking their time from their patients and students. However, it would have made arranging this second interview much easier. It took me nearly six months to facilitate the second interviews.

265

I always thought myself to be a reflective person, especially being a mental health nurse, before becoming a lecturer. However, producing this thesis led me to realize that I needed to be much more reflective, taking time, when my natural instinct is to hurry but be effective. This thesis could not be hurried, because I needed to reflect on the theory to understand its meaning, I had write about it, then rewrite, draft upon draft before sound comprehension was achieved, and the text presented a clear discussion. This important experience has already been passed on to my students, this need to take the time to discover the meaning and depth of the theoretic material. I also did not realize how long it would take to analyze the data, and there was so much of it, all of which was important. Even having the split sabbatical (two three month periods, eighteen months apart) did not give me enough time, although it was used wisely and efficiently. I also learned from my mistakes, and the processes I used to analyze the qualified mentors' qualitative comments was not robust, and certainly not as thorough as the one used for the interviews. I had started analyzing this data before the methodology chapter had been written, thus a method with no evidence base was used in the first instance. Naturally I then had to return to this data and analyze it using the same approach as I had used with the interviews, which was very time consuming. Again, my enthusiasm over took my common sense.

I also used reflection and supervision during the data analysis, and realized that I had at times imposed my own values and beliefs about mental health nursing and the organizations' requirements into the process, especially when referring to in/authenticity. I have learned from this experience and realize that these problems are normal, but can have far-reaching consequences for the trustworthiness of the study if they are not identified. When I started to explore and discuss the Heideggerian concepts to be used in the analysis of the data I believed in/authenticity would be the primary median. However, once I started the data analysis it became clear that care and concern were the most valuable concepts of the process. Once again I learned that a clear open mind is an

essential tool for the researcher allowing insight to develop, and not trying to make the process fit into the original beliefs.

I also think with hindsight I could have been more reflective during the interviews, reflecting during the actual interview not just on the collected data afterwards. I stopped taking contemporary notes because the participants appeared to me to hesitate when I broke eye contact. Reflecting during the interview could have helped me to write process notes afterwards, which could have been helpful during the analysis, increasing the reliability. Also, reading the interview transcripts again, I am aware that maybe my enthusiasm led to a few leading questions. However, it takes great skill and experience to be completely neutral. Reflecting during the process could have prevented this, as a leading question is to a certain extent an assumption.

My mental health nurse training taught me not to judge others or make assumptions. I relied on that skill during the research process and I believed that I could achieve this, but this belief was soon refuted. As I complete this work, my passion has moved to the implementation of the recommendations. However, this passion needs to be contained for the purpose of this PhD. Therefore I will next discuss briefly how the research will move forward.

7.5. <u>Taking the research forward</u>

This study has revealed that mentoring is not always effective and that there are many barriers which hinder its effectiveness. The mentors in this study felt they needed more support, that communication between the organization and the HEI should be more open and accurate, and that managers from the organization should be more involved in the mentoring process supporting the mentor. The mentors believed that a ward-based tutor would reduce the mentoring barriers and enhance effective mentoring, promoting good working relationships, guiding the students and the mentors, ensuring the assessment process is fair, and that weak students are supported, and that students who are not competent fail clinical practice. The students in this study really needed to feel welcome and

have a mentor already allocated to them, which would help to reduce their anxiety and make them more open to learning. The students did not want to pass if they were not competent, but they also wanted to be guided and given good constructive feedback on their developmental skills in the craft of caring. The students wanted to understand early in their studentship that if the mentor was not there, that other members of the team would support them. The participants who became qualified mentors in this study gave detailed accounts of how they felt the mentoring process could be improved, including their belief that time for mentoring could usually be found. If time could not be found, then they believed it to be important that the mentor clearly explained why and discussed when it could be rescheduled.

There are six recommendations which are presented in much more depth in appendix IX. It is beyond the scope of this thesis to discuss these in detail therefore they are just briefly presented.

7.6. <u>Recommendations</u>

The recommendations are important outcomes from the findings, thus it is essential that they are presented in this final chapter, however, the details of each recommendation are more in depth in appendix IX. I have tried to include all the important issues highlighted in the findings, thus presenting some solutions to these barriers and problems in the mentoring experience. There are of course financial implications because these recommendations would be expensive, and who would pay for these is another issue.

1. **<u>To nominate a clinical placement coordinator (CPC) for clinical areas.</u>**

This is similar to the Model used by the Nursing Council of New Zealand (NCNZ, 2008). The Clinical placement coordinator (CPC) will be an experience qualified live mentor or sign off mentor, or practice teacher or equivalent.

1) The clinical placement coordinator (CPC) would be responsible for clusters of clinical areas, which are both inpatient and community, and will be responsible be for managing the student's whole experience.

2) The CPC would be responsible for all the pre-planning of students clinical placements in their areas, and would ensure a live mentor was allocated to each student in advance of the students' placement.

These points address many issues highlighted in the findings including: reducing the students' anxiety through knowing a mentor is there for them, and helping the student to feel part of the team which can reduce feelings of isolation and anxiety. Ensuring the students are competent to pass and that the students feel supported and know what to do and are aware of what they need to know. Students are to be encouraged to research the evidence base and taught in the clinical area by a mentor who is there to answer their questions. Having small cluster areas will allow the CPC to have knowledge of the mentoring experience, and the clinical activity on the wards/units as well as sickness and absence. It will also help to prevent inaccurate assumptions being made by all involved through poor communication and misinterpretation.

2. Commitment from the university

1) To arrange collaborative visits with the student, the mentor, the CPC at significant stages e.g. formative and summative assessment if necessary. In order to build collaborative relationships and develop efficient and effective methods to enhance the learning process in the craft of caring.

2) Students practice books to be sent to the mentor prior to the start of the students' placement.

Feeling cared for is the central component in the craft of caring, the participants in this study felt more confident and open to learning when they felt cared for by

others, especially the mentor. The students/qualified nurses and the mentors in this study, felt that the lecturers from the Universities who teach them, have much more experience in nursing, mentoring and teaching and as such, it would increase confidence and esteem if the lecturers felt enough care and concern to make time to be there for the students and mentors. To share experience and give wise support, reduce anxiety and build good collaborative professional relationships. Furthermore the students may feel more comfortable discussing personal issues which are affecting their performance in clinical practice with a lecturer rather than a mentor they do not know so well.

3. Commitment from the employer

1) To commit to continue to be a learning organization
2) To commit to giving mentors protected time to mentor students, through instructing managers to negotiate this protected time. In the case of emergencies, when the protective time slot has to be cancelled, time should be made available before the end of the shift for de-briefing, explanation and re-booking of the protective time slot.
3) To nominate a CPC.

These recommendations address the important issue of time management which all the participants mentioned many times, and I feel it is important to boundary this time. Too often recommendations are unclear from governing bodies (Gopee 2011), as such the employers and the HEI's to some extent, place their own interpretation into the recommendations which are not always implemented as they were primarily intended. These recommendations address many of the issues the mentors, students and qualified nurse mentors highlighted throughout this study; which was lack of time to mentor effectively

4. Student information booklet (hard and online copy: to be made available to all interested parties)

1) To include how to prepare for clinical practice areas community and inpatient.

2) Expectations of the student, including: a) as a first year; b) as a second year; c) as a third year.

3) What it means to be professional as a nurse, what is accountability and responsibility.

4) The mentors' role: what to expect from a mentor; to include a comprehensive discussion about teaching learning and assessment

These recommendations address many of the issues highlighted in the findings from the mentor, students and qualified nurse/mentors. They give clear guidelines to the students about being professional and what will be expected of them in clinical practice. This will eradicate some of unknown aspects of being a student in clinical practice; it will also reduce assumptions of what being a student means in reality. It also presents clear guidelines of what the mentors' role is.

5. **Mentor guidelines (hard and online copy: to be made available to all interested parties)**

1) Levels of expectations from students in year 1, year 2, and year 3

2) A copy of the NMC proficiencies to enter the register, a copy of the DH Preceptorship Framework.

3) A copy of all the practice learning outcomes for all three years in chronological order. A copy of a practice document should be available, so the mentors have a clear understanding of what needs to be addressed during the clinical placement.

4) How to access support.

These recommendations again cover many issues which were highlighted in the findings It is important that the role is clearly defined, but also that the mentors feel supported and know how to access that support. Many of the qualified

mentors in this study stated that more support was needed to mentor, and the supervision groups may provide a space in which recurring issues and complicated concerns can be shared and this can help to reduce tension in the role.

6. Information booklet for the newly qualified MH nurse (hard and online copy: to be made available to all interested parties)

1) Definitions of the craft of caring

2) Explanations of the differences between being a student and being a qualified nurse and the roles and responsibilities of a newly qualified nurse.

3) What is meant by accountability?

4) What the employer expects from the newly qualified member of staff.

These recommendations address many of the issues highlighted in the second interview. This booklet will give the newly qualified MH nurse some guidelines in regards to their role and how it has changed. Actually working on the unit and facilitating the craft of caring is very different to reading about it, like Barker said (2009), however, some guidance is an improvement on no guidance.

7.6.1. <u>Table 7. Summary of recommendations</u>

POLICY AND PROCEDURE	PRACTICE
- Dedicated time to mentor - Employment of clinical placement coordinators (CPC). - Protected time for teaching and supervision. - Student and mentor packs consistent and available on every clinical unit. - Clear procedures for supporting struggling students. - Support staff in failing students. - Ensure the environments are safe to report poor and bad practice	- Nomination of a clinical placement coordinator who will oversee and be responsible for the whole of the students and preceptors experience. - The university to be involved in the mentoring/preceptorship process, tripartite meetings during assessment process.
EDUCATION	**PROFESSIONAL ISSUES**
- Regular weekly teaching session for students on the units. - Support groups for mentors. - Supervision groups for students. - Expectations of mentoring - Teach students the reality of caring the compassion strategy. - Ensure competency at all levels	The clinical placement coordinator to be responsible for: - Ensuring that the placement is audited. - The mentors will be allocated before the student arrives. - Ensuring the mentoring follows due process according to NMC standards.
FUTURE RESEARCH	**NOTES**
- A qualitative study on service user views of student education in clinical practice. - Evaluation of Implementation of the recommendations from this study. - Replication of this study in other areas of the UK - More systematic reviews on mentoring.	The CPC to take full responsibility for ensuring that the mentoring system is efficient, effective and safe.

7.7. **Dissemination**

Findings from this study were published after the first set of interviews and the return of the mentors' questionnaires: Teatheredge, J. 2010 Interviewing student and qualified nurses to find out what makes an effective mentor. *Nursing times* vol106 48 19-21 (see appendix, X). The findings have been presented at three international conferences, once in Berlin: European Doctoral Conference in Nursing Science 17-18 September 2010, the feedback from this presentation was helpful to the production of this thesis. Because at this conference I presented the early findings from the students and qualified mentors, and was asked, how the findings were specific to mental health nursing, it made me realize how generic the presentation was. The second was a poster presentation (see appendix, XI) in Baltimore USA, at the 4th Nurse Education Conference 17-20th June 2012, and the third in Canada in May 2013 at the International Psychiatric Nursing Congress. All presentations were well received and many delegates were interested in the findings, especially by representatives from countries who did not have mentoring schemes, or had just developed them.

Other papers on the studies findings and on the methodology have also been prepared and are ready for submission. It is my intention that the findings and the recommendations will also be presented to all local employers and HEI's (universities). The aim would be to ensure policy makers and were present. The presentation of the findings and recommendations could be staged to a wider geographic audience, including clinical commissioning groups.

The findings and the recommendations need to be presented to the governing bodies and policy makers of nursing: that is, the Nursing and Midwifery Council, The Department of Health, and the Royal College of Nursing. I spoke to the relevant people at the NMC and DH before commencing this study; I will reestablish communication and take advice on the best mode of presenting this data to them. This could be presenting at their conferences, sending written

communication or visiting in person. I have also considered applying for a grant to facilitate a pilot study to implement some of the recommendations.

However, making recommendations may not produce effective policy making from the NMC. The theory discussed in this thesis has highlighted that the NMC is not specific in its details when it comes to implementing standards. Furthermore the NMC's credibility was called into question by the CHRE (2012, p.5), concerning many issues, including problems with the 'regulatory function in fitness to practice'.

7.8. <u>Further research</u>

I would recommend further research into mentoring, which involves the service users and their perceptions of the mentoring process. Secondly any implementation of some of these recommendations will need to be evaluated and published. Thirdly this study should be replicated in other areas of the UK and in other countries where the systems are different so that comparisons can be made. There is also a wealth of research on mentoring and it would be useful to do more systematic reviews on mentoring. I also think that further research on mentoring in mental health should be undertaken to explore more deeply how the skills and knowledge in the craft of caring are taught and assessed in clinical practice. The findings may give a justification for mentoring training to be field/branch specific.

Also, over time policy context and social constructs change, thus meanings and understandings change. I would recommend this study be repeated again after a significant period of time to explore the transitional meaning of the mentoring process.

7.9. <u>Final words</u>

I think that there are not many words left to say, but I can say with hand on heart I did not once give up on this thesis, because I believe in education, in good

education in the clinical environment, for our students who will become tomorrow's nurses and mentors. Teaching, learning and assessment in clinical practice are the central components of learning the craft of caring, because the craft is about delivery of good quality of care which is tailored to the service user's needs.

The more extensively I read the theories of Levinson (1978) and Heidegger (1962) the more intrigued I became because the very notion of interpretation was taken to extreme, as each new text presented another interpretation of the original data hence I used wherever possible the original text.

I am aware that some of the recommendations will be expensive, and have resource issues for example, the implementation of a CPC in small cluster areas, the extended role of the university lecturer. The overall recommendations are not unrealistic or unmanageable but a commitment to the resource implication may be difficult to attain.

What is important is that the views of Eli, and her peers stories were told, that the current practice of mentoring is improved, and that people are given the support they need to do this. The participants in this study demonstrated that their perceptions about mentoring did change over time, and through experience their existential views shifted; highlighting and projecting the needs of the student, nurse and mentor in the-world-of-nurse education in order to develop, improve and enhance the nurse's capabilities in the craft of caring, with the patient who has mental health needs.

What I have achieved through the facilitation of this study is to develop a theoretical and practical understanding of the application of existential phenomenology. This was used to reveal a much deeper understanding of the mentoring process, these new meanings and understandings have produced recommendations which if implemented will improve the mentoring process. However, if the mentoring process is improved, the education of our future mental health nurses will also be enhanced. This equates to enabling nurses to have care and concern for their patients' needs, and to be capable and competent in the craft of caring.

Reference list

Alter, T. and Walter S. V. eds., 2007. *Phenomenal concepts and phenomenal knowledge new essays on consciousness and physicalism.* New York: Oxford University Press.

American Association of Colleges of Nurses., 2007. *The essential clinical resources.* [online] Available at: <http://www.aacn.nche.edu> [Accessed 10 June 2010].

Arksey, H. and Knight, P., 1999. *Interviewing for social scientists.* London: Sage.

Ashton, L. and Hallam, P., 2011. *Successful mentoring in nursing.* Exeter: Learning Matters.

Aristotle, 384-322 BC. *Ethics.* Translated from Greek by J. A. K. Thomson 1976. London: Penguin.

Australian Nursing and Midwifery Council., 2002. *Principals for the assessment of national competency standards for registered and enrolled nurses.* [online] Available at: <http://www.anmc.org.au>
[Accessed 11 June 2010].

Barker, P. ed., 2009. *Psychiatric and mental health nursing, the craft of caring.* 2nd ed. London: Hodder Arnold.

Barkway, P., 2001. Michael Crotty and nursing phenomenology: Criticism or Critque? *Nursing Inquiry,* 8(3), pp.191-195.

Beauchamp, T. L., and Childress, J. F., 2008. *Principles of biomedical ethics.* 6th ed. Oxford University Press.

Benner, P., 1996. Book Review. Phenomenology and nursing research. *Nursing Inquiry.* 3(4), pp,257-258

Best, D., 2005. in Rose, M., and Best, D., 2005. *Transforming practice through clinical education, professional supervision and mentoring.* London: Elsevier. Ch. 5.

Boore, J., and Deeny, P., 2012. *Nursing Education, planning and delivering the curriculum.* London: Sage.

Boghussian, P., and Peacocke C., eds. 2000. *New essays on a priori.* Oxford: Oxford University Press.

Bowlby, J., 1969. *Attachment and loss. Vol 1 Attachment.* Middlesex: Penguin..

Bowlby, J., 1997. *Attachment.*2nd ed. London. Pimlico.

British Association of Occupational Therapists., 2008. *Pre-registration standards.* .Available at: http://www.baot.co.uk [Accessed June 2010].

Brooks, T., 2005. in Denker, A & Vater, M., eds. 2003. *Hegels phenomenology of spirit: new critical essay.* London. Humanity Books University of Notre Dame, Philosophical Reviews.

Bryman, A., 2008. *Social research methods.* 3rd ed. Oxford: Oxford University Press.

Burns, N., and Grove, S.K. 2009 *The practice of nursing research appraisal, synthesis and generation of evidence.* 6th ed. Missouri: Sanders.

Burns, N., and Grove, S.K. 2011. Understanding nursing research, building and evidence-based practice. 5th ed. Maryland Heights: Elsevier.

Chambers, D., 2007. Is the modern NHS fit for nursing students. *British Journal of Nursing,*16(2), pp.74-75.

Clark, T., and Holmes, S., 2007. Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal for Nursing studies,* 44, pp.1210-1220.

Clutterbuck, D., 2004. *Everyone needs a mentor, fostering talent in your organisation.* 4th ed. Wiltshire: CIPD.

Colaizzi, P., 1978 Psychological research as the phenomenologist views it. In Valle, R. S. and King, M., eds. 1978. Existential phenomenological alternatives for psychology. New York: Oxford University Press. PP. 48-71

College of Occupational Therapists., 2008. *Pre-registration educational standards* 3rd ed. [online]. Available at: <http://www.cot.co.uk> {Accessed May 2010)

Comte, A., 1798-1857. in Hughes, J., 1990 *The Philosophy of Social research.* 2nd ed. New York: Longman Group.

Council for Healthcare Regulatory Excellence, 2012. *Strategic Review of the Nursing and Midwifery Council.* [online] Available at <http:// www.chre.org.uk> (Accessed July12)

Creswell, J. W., 2003. *Research design qualitative, quantitative, and mixed methods approaches.* London: Sage

Crotty, M., 1996. *Phenomenology and nursing research.* Melbourne: Churchill Livingstone.

Cuddon, J. A., 1991. *Dictionary of literary terms and literary theory.* 3rd ed. London: Penguin.

Cuddon, J. A., 1999. *Dictionary of literary terms and literary theory.* 4th ed. London: Penguin.

Daloz, L.A., 1986. *Effective teaching and mentoring.* San Francisco:. Jossey-Bass Publishers.

Darbyshire, P. Diekelmann, J., and Diekelmann, N., 1999. Reading Heidegger and interpretive phenomenology: a response to the work of Michael Crotty. *Nursing Inquiry,* 6, pp.17-25.

Darling, L. A. W., 1984. What do nurse's want in a mentor. *Journal of Nursing Administration,* 14, pp. 42-44.

Darling, L. A. W., 1984. in Gopee, N. (2008) *Mentoring and supervision in healthcare.* London: Sage.

Darwin, C., 1808-1892. In Boghussian, P., and Peacocke C., eds. 2000. *New essays on a priori.* Oxford: Oxford University Press.

Data Protection Act. 1998 (c.29), London: HMSO.

Davey, 2006. In Mc Cloughen, A., O'Brien, L., and Jackson, D., 2011. Nurse leader mentor as a mode of being; Findings from an Australian hermeneutic phenomenological study. *Journal of Nursing Scholarship.* 43(1), pp.97-104

Davies, M. B., 2007. *Doing a successful research project.* London: Palgrave.

Davis, K. 1991. *The phenomenology of research: The construction of meaning in data analysis.* Education Resource Information Centre. ED331049.

De B'run, C., Pearce-Smith, N., Heneghan, C. Perera, R. and Badenoch, D., 2011. *Searching skills toolbook finding the evidence.* Hoboken: John Wiley & sons.

De Castro, A., 2003. Introduction to Giorgi's existential phenomenological research method. *Psicología desde el Caribe. Universidad del Norte.* 11, pp.45-56.

Denker, A., and Vater, M. 2003. eds. *Hegel's phenomenology of spirit: New critical essay.* London: Humanity Books.

Denscombe, M., 2003. *The good research guide for small scale social research projects.* 2nd ed. Maidenhead: McGraw Hill.

Denzin, N. K., and Lincoln, Y. S., eds. 2008. *Strategies of qualitative inquiry.* 3rd ed. London: Sage.

Department for Health. 2001a. *Agenda for Change.* London: Stationary Office.

Department of Health. 2005. *Research governance framework for health and social care.* 2nd ed. London: Stationary Office.

Department of Health. 2010a. *Preceptorship framework for newly qualified registered nurses, midwives and allied health professionals.* [online]. Available at: <http://www.dh.gov.uk> [Accessed 10 January 2012]

Department of Health. 2012 Compassion in practice. Nursing, midwifery and care staff, our vision and strategy. [online] Available at http:// http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf. (Accessed May 2013)

Department of Health.2013. Putting patients first: government publishes response to Francis Report. [online} Available at https://www.gov.uk/government/news/putting-patients-first-government-publishes-response-to-francis-report. (Accessed May 2013)

Descartes, R. 1968. *Discourse on ethod and the meditations.* Translated from French by F. E. Sutcliffe. London: Penguin.

De Witt, L., 2006. Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing,* 2, pp.215-229.

Dilthey, W. 1833-1911 in Cuddon, J. A., 1991. *Dictionary of literary terms and literary theory.* 3rd ed. London: Penguin.

Downie, C. M., and Basford, P., 2003. *Mentoring in practice, a reader.* London: University of Greenwich.

Duffin, C., 2005. Pre-registration education to undergo a major review. *Nursing Standard,* 19(26), p. 4

Duffy, K., 2003. *Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice.* [online] Available at: <http://www.nmc.uk.org> [Accessed 30 April 2010]

Economic and Social Research Council, 2005. [online] Available at: <http://www.esrc.ac.uk> [Accessed July 2010]

Ely, C., and Scott, I., 2007 *Essential study skills for nursing.* London. Elsevier

Einstein, A. 1879-1955. [online] Available at http://www.quotecafe.com (Accessed January 2012).

Elcock, K., and Sharples, K., 2011. *A nurse's survival guide to mentoring.* London: Elsevier.

Ely, C. and Scott, I., 2007 *Essential study skills.* New York: Elsevier.

Ferguson, L. M., 2010. From the perspective of new nurses: What do effective mentors look like in practice. *Nurse Education in Practice,* 11 pp. 119-123.

Ford, S. 2010. *Student nurses call for longer clinical placements.* [online] Available at <http://www.nursingtimes.net>
(Accessed July 2010).

Foster-Turner, J., 2006. *Coaching and mentoring in health and social care.* Oxford: Radcliff Publishing.

Frankl, V. 1905-1997. [online] Available at http://www.quotecafe.com (Accessed January 2012).

Francis, R. 2013. (Chair) Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. London: The Stationary Office.

Gaarder, J., 1995. *Sophies world.* London: Orion Books.

Gadamer, H. G. 2004. *Truth and method.* 2nd ed. Translated from German by J. Weinsheimer, and D.G. Marshall. New York: Springer Publishing Co.

Gainsbury, S., 2010. Mentors passing students despite doubts over ability. *Nursing times,* 106(16). [online] Available at <http://www.nurisngtimes.net> (Accessed May 2010).

General Social Care Council. 2002. *Guidance on assessment in practice.* [online] Available at <http://www.gscc.org.uk> (Accessed May 2010)

Gerrish, K. and Lacey, A. eds., 2010. *The research process. inNursing.*6[th]ed Chichester: Wiley-Blackwell.

Gidman, J., McIntosh, A. Melling, K., and Smith, D., 2011. Student nurse perceptions of support in practice. *Nurse Education in Practice*. (6), pp.351-5

Gillham, B., 2000, Cited in Gray, D. E., 2009. *Doing research in the real world.* London: Sage.

Giorgi, A., 1985. Cited in Todres, L and Holloway, I., 2010. *Phenomenological research.* In Gerrish, K. & Lacey, A., eds. 2010. *The research process in nursing.* 6th ed. Chichester: Wiley-Blackwell.

Giorgi, A., 1985. *Phenomenology and psychological research.* Pittisburgh: Duquesne University Press.

Gopee, N., 2008. *Mentoring and supervision in healthcare.* London: Sage.

Gopee, N., 2011. *Mentoring and supervision in healthcare.* London: Sage.

Gorner, P., 2010. *Heidegger, phenomenology and the essence of technology.* University of Aberdeen. [online] Available at http://www.abdu.ac.uk (Accessed July 2010)

Gray, M. A. and Smith, L. N., 2000. The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study. *Journal of Advanced Nursing,.* 32(6), pp.1542-1549.

Gray, D. E., 2009. *Doing research in the real world.* London: Sage.

Gross, R.D., 2005. *Psychology: The science of mind and behaviour.* 5th ed. London. Hodder & Stoughton.

Gross, R.D., 2010. *Psychology: The science of mind and behaviour.* 6th ed. London. Hodder & Stoughton.

Groenewald, T., 2004. A Phenomenological Research Design Illustrated. *International Journal of Qualitative Methods,* 3(1), Article 4.

Guba, E., and Lincoln, Y., 1989. *Fourth generation evaluation.* California: Sage.

Guignon, C., ed. 2004. *The existentialists.* Oxford: Rowman and Littlefield.

Guignon, C., ed. 2004. *The existentialists critical essays on Kierkegaard, Nietzsche, Heidegger and Sartre.* Maryland: Rowman and Littlefield.

Guignon, C., ed. 2006. *The Cambridge companion to Heidegger.* 2nd ed. New York: Cambridge University Press.

Haralambos, M. and Holborn, M., 2004. *Sociology themes and perspectives.* 6th ed. London: Harper Collins.

Hatton-Yeo, A. and Telfer, S., 2008. *A guide to mentoring across generations.* [online] Available at <http://www.scotcip.org.uk>
(Accessed March 2010).

Health Professionals Council., 2009. *Standards of education and training.* [online] Available at <http://www.hpc-uk.org>
(Accessed May 2010)

Heidegger, M., 1962. *Being and time.* Translated from German by J. Macquarrie, and E. Robinson, 2008. New York: Harper Row.

Heidegger, M., 1962. cited in Guignon, C. ed. 2004. *The existentialists critical essays on Kierkegaard, Nietzsche, Heidegger and Satre.* Maryland: Rowman and Littlefield.

Heidegger, M., 1975. cited in Stewart, D. and Mickunas, A., 1990. *Exploring phenomenology.* 2nd ed. Ohio: University Press.

Heidegger, M., 1978. *Basic writings.* London: Routledge.

Hegel, G. W. F., 1806. *Phanomenologie des Geistes.* cited in Stewart, D. and Mickunas, A. ,1990. *Exploring phenomenology.* 2nd ed. Ohio: University Press.

Higgins, G., Spencer, R.L., and Kane, R., 2009. A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. *Nurse Education today,* 30, 499-508

Holland, K. and Rees, C., 2010. *Nursing: evidence-based practice skills.* Oxford: Oxford University Press.

Holland, J., Thomson, R., and Henderson, S., 2006. *Qualitative longitudinal research: A discussion paper.* Families & social capital ESRC research group. London: South Bank University.

Holloway, I., 2008. A-Z Qualitative research in Healthcare. 2nd ed. Chichester: Blackwell publishing.

Holloway, I., and Todres, L., 2010. In Gerrish, K. and Lacey, A. eds., 2010. *The research process. inNursing.*6thed Chichester: Wiley-Blackwell. Ch.14.

Holloway, I. and Wheeler, S., 2010. *Qualitative research in nursing and healthcare.* 3rd ed. Chichester: Wiley-Blackwell.

Homer, 1964. *The Odyssey.* Baltimore: Penguin Press

Hornsby. R., 2004. *What Heidegger means by Being-in the-World.* [online] available at http://royby.com/philosophy/pages/dasein.html
(Accessed January 2012)

Hubbard, C. and Foley, B., 2010. Mentoring: A nurse educator survey. *Teaching and Learning in Nursing.* 5 pp.139-142

Hughes, J., 1990. *The philosophy of social research.* 2nd ed. New York: Longman Group.

Human Rights Act, 1998. [online] Available at: < http://www.legislation.gov.uk/ukpga/1998/42/contents [Accessed June 2010]

Husserl, E., 1931. *Ideas: General introduction to pure phenomenology.* London: George Allen & Unwin

Husserl, E., 1983. *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy.* Translated from German by Kersten, F. Dordrecht. Kluwer academic publishers.

Husserl, E., 1859-1938. cited in Guignon, C., ed. 2004. *The existentialists critical essays on Kierkegaard, Nietzsche, Heidegger and Satre.* Maryland: Rowman and Littlefield.

Husserl, E., 1859-1938 .cited in Stewart, D. & Mickunas, A., 1990. *Exploring phenomenology.* 2nd ed. Ohio: University Press.

Hycer, R. H., 1985. Some guidelines for the phenomenological analysis of interview data. *Human studies,* 8(3), pp.279-303.

Inwood, M., 1997. *Heidegger - a very short introduction.* Oxford University Press.

Jarvis, J., Lane, D., A., and Fillery-Travis, A., 2006. *The case for coaching.* Norfolk. Chartered Institute pf Personnel and Development.

Johns, C., 2009. *Becoming a reflective practitioner.* 3rd ed. Oxford: Wiley-Blackwell.

Johnson, M. and Long, T., 2010. In Gerrish, K. and Lacey, A. eds., 2010. *The research process. in Nursing.* 6th ed Chichester: Wiley-Blackwell. Ch. 3.

Jokelainen, M., Turunen, H., Tossavainen, K., and Jamookeeah, D. and Coco, K., 2011 A systematic review of mentoring nursing students in clinical practice. *Journal of Clinical Nursing,* 20(19-20), pp.2854-2867.

Jones, A., 2006. Clinical supervision: What do we know and what do we need to know? A review and commentary. *Journal of Nursing Management,* 14, pp.577-585.

Jones, M. and Rattray, J., 2010. In Gerrish, K. and Lacey, A. eds., 2010. *The research process. In Nursing.*6thed Chichester: Wiley-Blackwell. Ch. 30.

Jung, C., 1939. In *Essential Jung selective writings.* London: Fontana Press.

Kalbfleisch, P. J., 2006. Communicating in mentoring relationships: a theory for enactment. *Communication theory,* 12 (1), pp.63-69.

Kant, I., (1724-1804) cited in Stewart, D., and Mickunas, A., 1990. *Exploring phenomenology.* 2nd ed. Ohio: University Press.

Kay, F. M., 2010. Is more the merrier?: Mentoring and the practice of the law. *Canadian Review of Sociology,* 47 (26), p1.

Kierkegaard, S., 1954. *Fear and Trembling.* Garden City New York: Doubleday.

Kierkegaard S., 1996. *Papers and journals.* Translated from Danish by Hannay. London: Penguin.

Kilgallon, K. 2012. The mentoring-student relationship. In Kilgallon, K., and Thompson, J., eds. 2012. *Mentoring in nursing and healthcare, A practical approach.* Chichester: Wiley-Blackwell. Ch.2.

Kilgallon, K., and Thompson, J., eds. 2012. *Mentoring in nursing and healthcare, A practical approach.* Chichester: Wiley-Blackwell.

Kinnell, D., and Hughes, P., 2010. *Mentoring nursing and healthcare students.* London: Sage.

Klage, C., 2013. *Will the Francis report make a difference in the long term.* [online] Available http:// http://www.guardian.co.uk/healthcare-network/2013/mar/25/francis-report-make-difference. (Accessed May 2012)

Knowles, M. S., 1984. *Andragogy in action applying modern principals of adult learning.* San Francisco: Jossey-Bass.

Kolb, D. A., 1984. *Experiential learning.* New Jersey: Prentice Hall.
.

Lacey, A., 2010. The research process. In Gerrish, K. & Lacey, A. eds., 2010. *The research process. In Nursing.* 6thed. Chichester: Wiley-Blackwell. Ch. 2.

Lathlean, J., 2010. *Qualitative analysis.* In Gerrish, K. & Lacey, A., eds. 2010. *The research process in nursing.* 6th ed. Chichester: Wiley-Blackwell. Ch.34.

Levinson, D.J., (1978). Cited in Gross, R.D., 2005. *Psychology: The science of mind and behaviour.* London: Hodder & Stoughton.

Levinson, D.J., Darrow. D. J., Klein, E. B., Levinson, M. H., & McKee, B., 1978. *The seasons of a mans life.* New York: A.A. Knopf.

Lincoln, Y., and Guba, Y., 1985. *Naturalistic Inquiry.* Newbury park: CA: Sage.

Lindsay-Ochoa, E., 2009. Effective mentoring relationships. *Probate and Property,* 23, p.1.

LoBiondo-Wood, G. and Haber, J., 2010. Nursing research, methods and critical appraisal for evidence-based practice. 7th. ed. Missouri: Elsevier.

Locke, J. 1632-1704. Cited in Crotty, M., 1996. *Phenomenology and nursing research.* Melbourne: Churchill Livingstone.

Mackey, S., 2005. Phenomenological nursing research: methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies,* 42(2), pp.179-86.

May, R., 1953. *Man's search for himself.* New York: W. W. Norton Inc.

May, R. 1975. *The courage to create.* New York: W. W. Norton company, Inc.

May, R., 1983. *The discovery of being.* New York: W. W. Norton company, Inc.

Mc Glashan, R., 2003. In Weiner, J., Mizen, R., and Duckham, J., 2003. *Supervising and being supervised a practice in search of a theory,* London: Palgrave.

McKenna, H., 2009. *Evidenced based practice in mental health.* In Barker, P., ed. 2009. *Psychiatric and mental health nursing the craft of caring.* London: Hodder Arnold. Ch. 4

McKenna, H., Hasson, F., and Keeney, S., 2010. *Surveys.* In Gerrish, K., and Lacey, A., eds. 2010.*The Research Process in Nursing.* 6th ed. Chichester: Wiley-Blackwell. Ch. 18.

Megginson, D., 2006. *Mentoring in action a practical guide for managers.* 2nd ed. London: Kogan.

Mental Capacity Act 2005. (c.9), London: HMSO

Miller, A., 2002. *Mentoring students and young people, A handbook of effective practice.* London: Kogan Page Ltd.

Mills, J., 2003. *A phenomenology of becoming.* In. Frie, R., ed. 2003. *Understanding experience.* London: Routledge.

Mooney, M., 2007. Newly qualified Irish nurses' interpretation of their preparation and experiences of registration. *Journey of Clinical Nursing,* 16, pp.1610-1617

Morse, J., 2000. Determining sample size. *Qualitative Health Research,* 10, pp.3-5..

Moule, P., and Goodman, M., 2009. *Nursing research an introduction.* London: Sage.

Mullins, L. J., 2007. *Management and organisational behaviour.* 8th ed. London: Financial Times, Prentice Hall.

Munhall, P. L., 2012. *Nursing research. A qualitative perspective.* 5th ed. Sudbury: Jones & Bartlett Learning.

Newman, 2004. In NCH the bridge child care development. 2007. *Resilience in children and young people.* London. [online] Available at <http://thebridge@nch.org.uk>
(Accessed March 2012).

NHS London Deanery, 2009. *Clinical supervisors.* [online] Available at <http://www.londondeanery.ac.uk> (Accessed May 2010).

NHS National Patient Safety Agency. 2009. National Research Ethics Service. [online] Available at <http://www.nres.npsa.nhs.uk> (Accessed March 2010).

Niedderer, K., 2007. *Mapping the meaning of knowledge in design research.* University of Hertfordshire.

Nursing Council of New Zealand., 2008. *Standards for competence assessment programmes.* [online] Available at <http://www.nursingcouncil.org.nk> (Accessed June 2010).

Nursing and Midwifery Council., 2004. *Standard for proficiency for pre-registration nursing education.* [online] Available at <http://www.nmc.uk.org> (Accessed May 2010).

Nursing and Midwifery Council., 2008a.. *Standards to support learning and assessment in practice*. [online] Available at <http://www.nmc.uk.org> (Accessed December 2009).

Nursing and Midwifery Council. 2008b. *Code, standards for conduct, performance and ethics for nurses and midwives*. [online] Available at <http://www.nmc.uk.org> (Accessed December 2009).

Nursing and Midwifery Council. 2012. *Working in partnership.* Project code: 307985/1414/C

Park. J., 2006. *Our existential predicament: loneliness, depression, anxiety, & death*. 5th ed. Minneapolis: Existential Books.

Parse, R. R. 1990 Health: A Personal Commitment *Nursing Science Quarterly* 3 (3), 136-140

Parse, R. R., 2004. A human becoming teaching-learning model. *Nursing Science Quarterly.* 17, p..33.

Parse, R. R., 2006. Feeling respected: A Parse method study. *Nursing Science Quarterly,.* 19. p..51.

Peplau, H., E., 1988. *Interpersonal relations in nursing.* 2nd ed. London: Macmillan.

Petticrew, M., 2006. *Systematic reviews in the social sciences a practical guide.* Oxford: Blackwell.

Playdon, Z., 1998. *Mentor the myth.* In: *An enquiry into mentoring. Supporting doctors and dentists at work.* Annex 3, Appendix 1, pp..32-35 London. SCOPME,

Plato, 2003. *The republic.* New ed. London: Penguin.

Po-Kwam Sui, G., and Sivan, A., 2011. Mentoring experience of psychiatric nurses: From acquaintance to affirmation. *Nurse Education Today,* 31(8), pp.797-802.

Polit, D. F., and Beck, C. T., 2008. *Nursing research generating and assessing evidence for nursing practice.* 8th ed. Philadelphia: Lippincott.

Polit, D. F., and Beck, C. T., 2014. *Essentials of nursing research, appraising evidence for nursing research.* 8th ed. Philadelphia: Lippincott.

Price, L., Hastie, L., Duffy, K., Ness, V., and McCallum, J., 2011. Supporting students in clinical practice: Pre-registration nursing students' views on the role of the lecturer. *Nurse Education Today,* 31, pp.780-783.

Procter, S., Allan, T., and Lacey, A., 2010. In Gerrish, K. and Lacey, A. eds., 2010. *The research process. inNursing.*6[th]ed Chichester: Wiley-Blackwell. Ch.12.

Redfearn, J. W. T., 1977. The self and individuation. *Journal of Analytical Psychology*, 22(2) pp.125-141.

Riddell, S., 2012. In West, S., Clark, T., and Jasper, M., 2007. eds. *Enabling learning in nursing and midwifery practice.* San Francisco: John Wiley and sons Ltd. Ch. 7.

Roberts, D., 2009. Newly qualified nurses: Competence or confidence. (Editorial) *Nurse Education Today,* 29, pp.467-468.

Rogers C., 1983. *Freedom to Learn for the Eighties.* Ohio: Charles E. Merrill.

Rose, P. Beeby, J., and Parker, D., 1995. Academic rigour in the lived experience of researchers using a phenomenological methods in nursing. *Journal of Advanced Nursing,* 21, pp.1123-1129.

Rose, M. & Best, D., 2005. *Transforming practice through clinical education, professional supervision and mentoring.* London: Elsevier.

Royal College of Nursing. 2006. *Informed consent in health and social care.* {online} Available at <http://www.rcn.org.uk> (Accessed May 2010).

Royal College of Nursing., 2007. *Guidance for mentors of nursing students and midwives.* An RCN toolkit. London. RCN.

Rungapadiachy, D.M., Madhill, A., and Gough, B., 2006. How newly qualified mental health nurses perceive their role. *Journal of psychiatric and mental health nursing*, 13, pp.533-542.

Russell, B., 1961. *A history of western philosophy.* 2nd ed. London: Allen and Unwin.

Russell, B., 1989. *Wisdom of the west.* New York: Crescent Books.

Rycroft, C., 1995. *A critical dictionary of psychoanalysis.* 2nded. London: Penguin.

Satre, J. P., 1958. *Being and nothingness.* London: Routledge.

Sawicki, M., 2005. *Edmund Husserl (1859-1938.) Stanford* encyclopedia of philosophy. [online] Available at http://plato.stanfor.edu/ (Accessed July 2010)

Scherer D.M., 2010. *Levinson's* dream *theory and its relevance in an academic executive mentoring program.* Columbia University USA.

Schleiermacher, F.,1768-1834. *Hermeneutic circle.* In Cuddon, J. A., 1992. *Dictionary of literary terms and literary theory.* 3rd ed. London: Penguin.

Schneider, J. L., 2006. Professional code of ethics: their role and implications for international research. *Journal of Contemporary Criminal Justice,* 22(2) pp.173-192.

Schon, D. C., 1991. *The reflective practitioner. How professionals think in action.* Aldershot: Ashgate Publishing.

Schwandt, T. A., 2007. *Dictionary of qualitative Inquiry.* 3rd ed. Newbury Park, CA: Sage.

Sharples, k., and Elcock, k., 2011. *Preceptorship for newly registered nurses.* Exeter: learning matters.

Spouse, J., 1996. The effective mentor. A model for student-centred learning in clinical practice. *Nursing Times research,* 1, pp.120-133.

Sprinks, J., 2012. Training fails to prepare students for modern workplace. *Nursing Standard.* 26, p.20.

Stewart, D., and Mickunas, A., 1990. *Exploring phenomenology.* 2nd ed. Ohio University Press.

Stuart, C. C., 2007. *Assessment, supervision and support in clinical practice.* 2nd ed. London: Elsevier.

Sullivan, E. J., and Decker, P. J., 2005. *Effective leadership and management in nursing.* New Jersey: Pearson/Prentice Hall.

Taylor, J., 2008. *Are You a good mentor.* [online] Available at, <http://www.nursingtimes.net> (Accessed March 2010).

Teatheredge, J., 2010. Interviewing student and qualified nurses to find out what makes an effective mentor. *Nursing times,* 106(48) pp.19-21.

Thompson, J., 2012. *The mentor as teacher*. In Kilallon, K. and Thompson, J., 2012. eds. *Mentoring in nursing and healthcare, A practical approach.* Chichester: Wiley-Blackwell. Ch. 3.

Tod, A., 2010. *Interviewing.* In Gerrish, K. and Lacey, A., eds. 2010. *The research process in nursing.* 6th ed. Chichester: Wiley-Blackwell. Ch.28.

Todres, L., and Holloway, I., 2010. *Phenomenological research.* In Gerrish, K. and Lacey, A., 2010. eds. *The research process in nursing.* 6th ed. Chichester: Wiley-Blackwell. Ch.15.

University of York. Centre for reviews and dissemination., 2008. *Systematic reviews, CRD's guidance for undertaking reviews in health care.* York: CRD, University of York

Van Kaam, A. L. 1966. *Existential foundations of psychology.* Vol. 3. Pittsburgh: Duquesne University Press.

Van Manen, M., 1990. *Researching lived experience.* Ontario: The Althouse Press.

Van Manen, M., 2006. Writing qualitatively, or the demands of writing. *Qualitative Health Research,* 16(5), pp.713-722.

Wallace, S., and Gravells, J., 2007. *Mentoring.* 2nd ed. .Exeter: Learning Matters.

Walsh, D., 2010. *The nurse mentor's handbook, supporting students in clinical practice.* Maidenhead: Open University Press.

Weber, M., 1947. *The theory of social and economic organisations.* Translated from German by Henderson, A.M. and Parson T. New York. Free Press.

Welch, A. J., 2007. The phenomenon of taking Life day-by-day: Using Parse's research method. *Nursing Science Quarterly,* 20(3), p.265.

West, S., Clark, T., and Jasper, M., 2007. eds. *Enabling learning in nursing and midwifery practice.* San Francisco: John Wiley and sons Ltd.

Wilken, P., 2009. Cited *in* Barker P., 2009. ed. *Psychiatric and mental health nursing, the craft of caring.* 2nd ed. London: Hodder. Ch.5.

Willis Commission. 2012. *Quality with compassion: the future of nursing education.* [online] available at
http://www.williscommission.org.uk/__data/assets/pdf_file/0008/485009/Willis_Commission_executive_summary.pdf. (Accessed Aril 2013).

Wright, S. G., 2009. *Spirituality, nursing and mental health.* In Barker, P., ed. 2009. *Psychiatric and mental health nursing, The craft of caring.* 2nd ed. London: Hodder Arnold. Ch.73.

World Medical Association Declaration of Helsinki., 2008. *Ethical principles for medical research involving human subjects*. [online] Available at <http://www.wma.net> (Accessed June 2010).

Bibliography

Aguinis, H., Pierce, C. A., Bosco, F. A,. Dalton, D. R., and Dalton, C. M. 2011. Debunking myth and urban legends about meta-analysis. *Organizational research methods,* 14(2), pp. 306-351.

Allen, S. L., 2002. Mentoring the essential connection. *Acorn Journal,* 75(3), pp. 440-446.

Andreas, B., 2000. in Zachary, L. J. 2000. *The mentors guide, facilitating effective learning relationships..* San Francisco: J. Wiley & Sons.

Atherton, M., 1999. *The empiricists, critical essays.* Oxford: Rowan & Littlefield.

Australian Nursing and Midwifery Council., 2006. *National competency standards for the registered nurse.* [online] Available at: <http://www.anmc.org.au> [Accessed 11 June 2010].

Avison, W., McLeod, J., and Pescosolido, B., eds., 2007. *Mental health social mirror.* London: Springer.

Bareson, G., 1972. *Steps to an ecology of mind.* London: University of Chicago Press.

Berne, E., 1964. *Games people play.* Middlesex: Penguin.

Benner, P., 1984. *From novice to expert.* California: Addison-Wesley Publishing Company

Bion, W., 1962. *Learning from experience.* London: Karnac.

Boghussian, P., and Peacocke C., eds. 2000. *New essays on a priori.* Oxford: Oxford University Press.

Bourke,D. D., ed.. 1962. *Rationalism* In Runes,. *Dictionary of philosophy*, Littlefield, Totowa, NJ. Adams, and Company.

Bournes, D. A., 2010. *Humanbecoming* international consortium of Parse scholars. [online] Available at: <http:// www.humanbecoming.org> [Assessed May 2010].

Brown, L., ed. 2002. *Shorter Oxford English dictionary.* 5th ed. Oxford: Oxford University Press.

Brown, S. J., 1999. *Knowledge for health care practice, a guide to using research evidence.* London: Saunders.

Buber, M., 1958. *I and thou.* 2nded. Edinburgh: T&T Clark.

Conner, M., and Pokora, J., 2007. *Coaching and mentoring at work developing effective practice.* Berkshire: Open University Press.

Conway, C., 1998. *Strategies for mentoring.* New York: Wiley.

Crotty, M., 1998. *The foundation of social research, meaning and Perspectives in the research process.* London: Sage.

Darwin, C., 1996. *Origin of the Species.* Oxford: Oxford University Press:

D'Cruz, H. and Jones, M., 2004. *Social work research :ethical and political contexts.* London: Sage.

Crookes, P. A., and Davies, S., eds. 2004. *Research into practice:* London: Bailliere Tindall

Dean, D. J., 2009. *Getting the most out of your mentoring relationships.* New York: Springer.

Denzin, N. K., and Lincoln, Y. S., eds., 1994. *Handbook of qualitative research.* Thousand Oaks: CA. Sage.

Durkheim, E., 1895. *The rules of sociological method* 8th ed. Translated from French by S. A. Solovay and John M. Mueller.1964. New York: Free Press.

Durkheim, É., 1892. *Montesquieu's Contribution to the Rise of Social Science* in Montesquieu and Rousseau. *Forerunners of Sociology*, translated from French by R. Manheim.1960. University of Michigan Press.

Dyson, S. and Norrie, P., 2010. *Fundamental aspects of research for nurses.* London: Quay Books.

Elliott, A., 2009. *Contemporary social theory: An introduction.* London: Routledge.

Ellis, P., 2010. *Understanding Research for Nursing Students.* Exeter: Learning Matters.

English Nursing Board., 1994. *Creating Life Long Learners Partnerships for Care.* London: English Nursing Board.

Esfhani, M., 2011. *Pain as Existentialia PhD thesis*. [online] Available at <http://www.inter-disciplinary.net>
(Accessed February 2012).

Finn, J. A., 2005. *Getting a PhD: an action plan to help manage your research, your supervisor and your project.* London: Routledge.

Flynn, T., 2004 *Jean-Paul Sartre.* Standford: Encyclopedia of Philosophy. [online] Available at http://plato.standford.edu/entries/sartre
(Accessed June 2010).

Frankl, V E., 1987. *Man's search for meaning*. London: Hodder and Stoughton.

Fox, V. J., Rothrock, J. C. and Skelton, M., 1992. The mentoring relationship, *Acorn J* 56. pp.858-867.

Frank, D. and Sullivan, L., 2008. *The lived experiences of nurses providing care to victims of the 2005 hurricanes.* [online] Accessed at <http;//onlinejournalofnursingresearch> 8 (3).
(Accessed January 2012)

Freud, S.,1911-1938. *On metapsychology.* Translated from German by A. Richards. 1955. Vol. 11. London: Penguin.

Frie, R., ed., 2003. *Understanding experience: psychotherapy and postmodernism.* New York: Routledge.

Galileo Galilei.1564-1642. [online] Available at http://www.quotecafe.com
(Accessed January 2012)

Gallway, T., 1974. *The Inner Game of Tennis.* London: Jonathan Cape.

George, S., 2010. *The learning mentor manual*. London: Sage.

Goleman, D., 1996. *Emotional intelligence.* London: Bloomsbury Publishing.

Gorman, P., 1998. *Managing multi-disciplinary teams in the NHS.* London: Kogan Page.

Gombrich, E. M., 1960. *Art and illusion.* Cited in Calvin, W. H., 1997. *How Brains Think.* London: The Orion Publishing Group.

Grady, J. E., 1970. Marcel hopes and ethics. *Journal of Value Inquiry.* 4 (1), pp. 56-64.

Guerlac, S., 2000. *Literary polemics: Bataille, Sartre, Valery, Breton*. Stanford: Stanford University Press.

Guignon, C., ed. 2006. *The Cambridge companion to Heidegger.* 2nd ed. New York: Cambridge University Press.

Guillaume A., 1913. *Alcools.* in Downie, C. M. & Basford, P., 2003. *Mentoring in practice, a reader.* London: University of Greenwich.

Hagler, P. & Casey, P., 1990. Games supervisors play In clinical supervision. *ASHA* 32 pp.53-56.

Halloran, M. S., 1982. Aristotle's concept of ethos, or if not his, someone else's. *Rhetoric review*. 1 1.

Hall, C. and Ritchie, D., 2011. *What is nursing.* Exeter: Learning Matters Ltd.

Hamilton, M. S., 1981. Mentorhood, a key to nursing leadership. *Nursing Leadership* 4 (1), pp.4-13.

Heider, F., 1958. *The psychology of interpersonal relations*. New York: John Wiley & Sons.

Hirsch, E. D., 1967. *Validity in interpretation.* Michigan: Bookcrafters.

Hinshelwood, R. D., 1991. *A Dictionary of Kleinian thought.* London: Free Association Books.

Illingworth, P and Singleton, L., eds. 2010. *Mental health nursing carving a path to practice.* London: Pearson.

Jarvis, J., Lane, D. A., and Fillery-Travis, A., 2006. *The case for coaching.* London: Chartered Institute of Personnel and Development.

Jaspers, K., 1955. *Reason and Existenz.*.Translated from German by Earle. New York: Noonday Press.

Johns, C. and Freshwater, D., 2005. *Transforming nursing through reflective practice.* 2nd ed. Oxford: Blackwell Publishing.

Keen, S., 1983. Cited in Daloz, L.A. ,1986. *Effective Teaching and Mentoring* San Francisco.: Jossey-Bass Publishers.

Krill, D. F., 1978. *Existential social work.* New York: Free Press.

Kripkes S., 1972. In. Alter, T. and Walter S. V., eds. 2007. *Phenomenal concepts and phenomenal Knowledge* New essays on consciousness and physicalism. New York. Oxford University Press.

Lakeman, R., 2009. *Ethics and Nursing.* In. Barker, P. ed. 2009. *Psychiatric and mental health nursing, The craft of caring.* 2nd ed. London: Hodder Arnold. Ch..69.

Lauterbach, S. S., 1993. *In another world: A phenomenological perspective and discovery of meaning in mothers experience of death of a wished for baby.* In Munhall, P.L. & Oiler, C., eds. 1993. *Nursing Research. A qualitative perspective.* Sudbury. MA:Jones & Bartlett.

Lauterbach, S.S. and Frank, D.L., 2012. *Exemplar: In the eye of the storm: A phenomenological inquiry of the parallel experience of victims of Katrina and nurses who cared for them: Exemplar of linguistic transformation in phenomenology and exemplar of longitudinal phenomenology.* In Munhall, P. L., 2012. *Nursing research. A qualitative perspective.* 5th ed. Sudbury: Jones & Bartlett Learning.

Lieberman, M. A., Yalom, I. D., and Miles, M. B., 1973. *Encounter groups: First facts.* New York: Basic Books Inc.

Lorenzo, T. Duncan, M. Buchanan, H., and Alsop, A., 2006. *Practice and service learning: exploring potential in context.* Chichester: John Wiley.

Mayes, L., Fonagy, P. and Target, M., eds. 2007. *Developmental science and psychoanalysis :integration and innovation.* London: Karnac.

Mahrer, A. R., 2002. *Becoming the person you can become.* Colorado: Bull Publishing Company.

Marcel, G., 1950. *The Mystery of being.* London: Harvell Press Ltd.

McCall, C. C., 2009. *Transforming thinking, philosophical inquiry in the primary and secondary classroom.* London: Routledge.

Maslow, A., 1970. *Motivation and personality.* 2nd ed. New York: Harper Row.

May, R., 1983. *The discovery of being.* New York: W. W. Norton company, Inc.

May, R., 1969. *Love and will.* New York: W. W. Norton company, Inc.

Mc Cloughen, A., O'Brien, L., and Jackson, D., 2011. Nurse leader mentor as a mode of being; Findings from an Australian hermeneutic phenomenological study. *Journal of Nursing Scholarship,* 43(1), pp.97-104.

McDowall-Long, K., 2004. Mentoring relationships: implications for practitioners and suggestions for future research. *Human Resource Development International,* 7(4), pp.519-534.

McKenna, H. and Slevin, O. D., in Barker, P., ed. 2009. *Psychiatric and mental health nursing, the craft of caring.* 2nd ed. London: Hodder Arnold.

McSherry, R., Simmons, M. and Abbott, P., eds. 2002. *Evidence-Informed nursing. A guide for clinical nurses.* London: Routledge.

Megginson, D. and Clutterbuck, D., 2009. *Further techniques for coaching and mentoring.* London: Butterworth-Heinemann.

Megginson, D. and Whitaker, V., 1996. *Cultivating self-development.* London: Institute of Self Development.

Miller, A., 1958. The Shadow of the Gods*. Harpers Magazine*, pp. 35-43.

Moran, D., 2002. *Introduction to phenomenology.* London: Routledge.

Murray. L.A., 1988. *An introduction to the process understanding of science, society and the self.* Queenston: The Edwin Mellen Press.

Newdick, C., 2005. *Who should we treat. Rights, rationing, and resources in the NHS.* 2nd ed. Oxford: Oxford University Press.

Nicklin, P. J. and Kenworthy, N., 2000. *Teaching and assessing in nursing practice. An experiential approach.* London: Bailliere Tindall.

Nolan, M. and Lundh, U., 2004. In Crookes, P. A. and Davies, S., eds. 2004. *research into practice.* London: Bailliere Tindall.

Paille, M., and Pilkington. F. B., 2002. The global context of nursing: A human becoming perspective *Nursing Science Quarterly,* 15, p.165.

Palmer, E. A.,1987..*The Nature of a Mentor.* London: South Bank Polytechnic. Unpublished thesis.

Parlett, m., and Hamilton, D., 1977. Evaluation as illumination. In Stuart, C. C., 2007. *Assessment, supervision and support in clinical practice.* 2nd ed. London: Elsevier.

Peate, I., 2006. *Becoming a nurse in the 21st Century.* Chichester: John Wiley and Sons.

Parse, R. R., 1990. Health: A personal commitment. *Nursing Science Quarterly,* 3 (3), pp.136-140.

Parsloe, E., and Leedham, M., 2009. *Coaching and mentoring, practical conversations to improve learning.* London: Kogan Page.

Petticrew, M. and Roberts, H., 2006. *Systematic reviews in the social sciences: a practical guide.* Oxford: Blackwell Publishers.
Plato, 429-347 B.C.E. [online] Available at http://www.quotecafe.com (Accessed January 2012).

Popper, C., 1959. *The Logic of Scientific Discovery.* London: Hutchinson.

Popper, C., 1963. *Conjecture and refutation.* London: Routledge Kegan Paul.

Quan, K., 2010. 150 tips and tricks for new nurses. Avon USA: Adams media.

Robinson, K., 1992. *Research awareness: module 3 What is research?* Distance Learning Centre.

Rugg, G. and Petre, M., 2004. *The Unwritten Rules of PhD Research.* Maidenhead: Open University Press.

Sadler, W. A., 1969. *Existence and love: A new approach in existential phenomenology.* New York: Scribner's.

Scrambler, G., 2008. *Sociology as applied to medicine.* 6th ed. London: Elsevier.

Schutz, A., 1962. *The frame of unquestioned constructs.* in Douglas, M. ed. 1973. *Rules and meanings.* England: Penguin.

Sellman,D. and Snelling, P., 2010. Becoming a Nurse. Harlow: Pearson Education Ltd.

Senge, P. M., 2006. *The fifth discipline :the art and practice of the learning organization.* London: Random House Business.

Shives, L. R., 2008. *Basic concepts of psychiatric-mental health nursing.* 7th ed. London: Lippincott Williams & Wilkins.

Sotto, E.., 2007. *When teaching becomes learning. A theory and practice of Teaching.* London: Continuum.

Steele, R. S., 1979. *Psychoanalysis and hermeneutics.* International review of psychoanalysis. 6, pp.389-411.

Stevens, C., Clark, C., Young, A., Thomas, K., and Hassell, D., 2009. *Developing activities to help students achieve learning outcomes in practice.* [online] Available at <http://www.nursingtimes.net> (Accessed June 2010).

Swann, E., 2010. *Worked Up selves, personal development workers, self-work and therapeutic cultures.* Basingstoke: Pagrave Macmillan.

Te Kaunihera. Tapuhi, O. Aotearo, Nursing Council of New Zealand. 2008. *Standards for Competence assessment programmes.* [online] Available at: <http://www.nursingcouncil.org.nk> (Accessed June 2010).

Tymieniecka, A.T., 2002. *Phenomenology world-wide: expanding dynamisms, life-engagments.* Cornwall: MPG Books Ltd.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1994. *Standards for specialist education and practice.* London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting., 1999. *Fitness for practice.* London: UKCC.

Webb, C, and Shakespeare, P., 2006. Judgments about mentoring relationships in nurse education. *Nurse Education Today,* 2008., 28(5), pp.563-571.

Wiener, J., Mizen, R., and Duckham, J., eds. 2003. *Supervising and being supervised A practice in search of a theory.* Basingstoke: Palgrave Macmillan.

Williams, M. and May, T., 1996. *Introduction to the philosophy of social research.* London: Routledge.

Winter, R., 1987. *Action research and the nature of social inquiry.* England: Gower.

Winter, R., 1989. *Learning From Experience.* Sussex: Falmer press.

Appendix I: Ethical approval (Including example of progress report)

NHS

National Research Ethics Service

Essex 1 Research Ethics Committee

Level 9
Terminus House
The High
Harlow
Essex
CM20 1XA

Telephone: 01279 413136
Facsimile: 01279 419246

17 November 2008

Mrs Julie Teatheredge
Senior Lecturer
Anglia Ruskin University
William Harvey Building
Rivermead Campus
Chelmsford Essex
CM1 1SQ

Dear Mrs Teatheredge

Full title of study:	**Shifting perceptions to nurse mentorship: student nurse to practice mentor**
REC reference number:	**08/H0301/101**

Thank you for your letter of 17 November 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Supervisor CV		
Questionnaire	1	21 August 2008
Interview Schedules/Topic Guides	1	21 August 2008
Compensation Arrangements		01 August 2008
Letter from Sponsor		14 August 2008
Covering Letter		20 August 2008
Protocol	1	21 August 2008
Investigator CV		
Application		21 August 2008
Response to Request for Further Information		20 October 2008
Response to Request for Further Information		17 November 2008
Participant Consent Form	2.1	06 November 2008
Participant Information Sheet: For qualitative semi structured interviews	2.1	14 October 2008
Participant Information Sheet: For mentor questionnaires	2.1	14 October 2008
Letter of invitation to participant	2.1	06 November 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
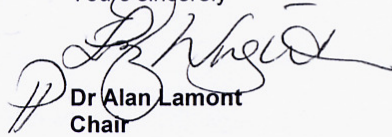
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

| 08/H0301/101 | Please quote this number on all correspondence |

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Alan Lamont
Chair

Email: liz.wrighton@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor D Humber
                   Executive Dean
                   Anglia Ruskin University
                   Floor 3 William Harvey Building
                   Rivermead Campus
                   Chelmsford
                   Essex CM1 1SQ

Example of progress report done each year

ANNUAL PROGRESS REPORT TO MAIN RESEARCH ETHICS COMMITTEE
(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript and submitted to the main REC by the Chief Investigator.
For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Julie Teatheredge
Address:	2nd Floor William Harvey Building Anglia Ruskin University Rivermead Campus Chelmsford Essex CM1 1SQ
Telephone:	0845 196 4846
E-mail:	julie.teatheredge@anglia.ac.uk
Fax:	

2. Details of study

Full title of study:	Shifting perceptions of nurse mentorship: student nurse to practice mentor
Name of main REC:	Essex 1
REC reference number:	08/H031/101
Date of favourable ethical opinion:	17/11/2008
Sponsor:	Anglia Ruskin University

3. Commencement and termination dates

Has the study started?	*Yes*
If yes, what was the actual start date?	March 2009
If no, what are the reasons for the study not	

commencing?	
What is the expected start date?	NA

| Has the study finished? *If yes, complete and submit "Declaration of end of study" form, available at http://www.nres.npsa.nhs.uk/applications/after-ethical-review/endofstudy/* | *No* |

If no, what is the expected completion date? *If you expect the study to overrun the planned completion date this should be notified to the main REC for information.*	**This year**
If you do not expect the study to be completed, give reason(s)	

4. Site information

Do you plan to increase the total number of sites proposed for the study? If yes, how many sites do you plan to recruit?	*No*

5. Recruitment of participants

In this section, "participants" includes those who will not be approached but whose samples/data will be studied.

Number of participants recruited:	
Number of participants completing trial:	*Actual number completed to date:* 8 interviews completed, 48 questionnaires returned to date still coming back, the original 8 participants from the first interview were invited to be interviewed again in autumn 2011. One declined the 2nd interview, 6 were interviewed.
Number of withdrawals from study to date due to: (a) withdrawal of consent	One participant refused to participate in the 2nd interview but has not withdrawn from the first interview
(b) loss to follow-up (c) death (where not the primary outcome)	none
Total study withdrawals:	

*Number of treatment failures to date (prior to reaching primary outcome) due to: (a) adverse events (b) lack of efficacy Total treatment failures: *Applies to studies involving clinical treatment only*	none
Have there been any serious difficulties in recruiting participants?	*No*
If Yes, give details:	
Do you plan to increase the planned recruitment of participants into the study? *Any increase in planned recruitment should be notified to the main REC as a substantial amendment for ethical review.*	*No*

6. Safety of participants

Have there been any related and unexpected serious adverse events (SAEs) in this study?	*No*
Have these SAEs been notified to the Committee? *If no, please submit details with this report and give reasons for late notification.*	*Not applicable*
Have any concerns arisen about the safety of participants in this study? *If yes, give details and say how the concerns have been addressed.*	*No*

7. Amendments

Have any substantial amendments been made to the trial during the year?	*No*
If yes, please give the date and amendment number for each substantial amendment made.	

8. Serious breaches of the protocol

Have any serious breaches of the protocol occurred	*No*

during the year? *If Yes, please enclose a report of any serious breaches not already notified to the REC.*	*No*

9. Other issues

Are there any other developments in the study that you wish to report to the Committee?	*No*
Are there any ethical issues on which further advice is required? *If yes to either, please attach separate statement with details.*	*No*

10. Declaration

Signature of Chief Investigator:	
Print name:	Julie Teatheredge
Date of submission:	30/01/13

Appendix II: Participant information sheet, interviews

PARTICIPANT INFORMATION SHEET for qualitative semi-structured interviews

Section A: The Research Project

1. Title of project:
How do nurses and student nurses view the concept of mentorship, and evaluate the standards to support learning and assessment in practice?

2. Purpose and value of study:
The aim of the study is to identify factors which shape student and staff perceptions of mentorship in mental health nursing.
The focus of the study is on the attitudes and outlook people express towards the role of the practice mentor/coach, and how these vary with experience and change of professional status, i.e. students becoming mentors. It is anticipated that perceptions may vary over time, and these may give us better insight into the role of a mentor. It is anticipated that this study could enhanced mentor to student's relationship, and draw clearer insights into the role of a mentor.

3. Invitation to participate:
I would like to invite you to take part in this study, which will require you to participate in two interviews: the first will be during semester 6 (when you are still a pre-registration student), and; the second interview will take place approximately 16 months later when you have become a registered nurse and have become a mentor (having undertaken the mandatory mentor training).

4. Who is organising the research?
I am the chief investigator for this study, and this primary research is a central component to my PhD studies at Anglia Ruskin University, this study will be supervised by two internal academics, Dr A Stevens and Dr T Shafer.

5. What will happen to the results of the study?
The results of the study will be used as evidence for my PhD, but will also be used to inform the Nursing and Midwifery Council and the Department of Health regarding their guidance for mentorship. The results of the study will also be published in your local Trust's magazines and relevant journals. These publications may include anonymous direct quotes from the interviews.

6. Source of funding for the research:
My PhD training is being funded by Anglia Ruskin University, all other costs will be met by the researcher.

7. Contact for further information
Mrs J Teatheredge
Anglia Ruskin University
Floor 2, William Harvey Building
Rivermead Campus
Chelmsford
Essex CM1 1SQ
0845 196 4846
Section B: Your Participation in the Research Project

1. Why you have been invited to take part:
You have been asked to take part because you are at the final stage of your pre-registration mental health nurse training, and when you will have more than 2 years experience of being mentored. These experiences are the central component of this research. Your experience as a professional qualified nurse and mentor will inform the 2nd component of this research.

2. Whether you can refuse to take part:
There is no reason why you are not able to refuse to take part, by not returning the consent form is an acceptable method of refusal. There is no financial incentive for taking part and no removed punitive repercussions if you do not wish to take part.

3. Whether you can withdraw at any time, and how:
It is your right to change your mind at any stage of the research and withdraw for reasons you do not need to share. It would help me if you could write a letter stating you wish to withdraw to the address below, but that is not a requirement of withdrawal:
Mrs J Teatheredge
Anglia Ruskin University
Floor 2, William Harvey Building
Rivermead Campus
Chelmsford
Essex CM1 1SQ
0845 196 4846

4. What will happen if you agree to take part?
You will take part in two semi-structured interviews (one in semester 6 of your pre-registration training, and another, approximately 16 months later when you are a registered nurse, and you have become a mentor yourself. The interviews in the first instance will take place in a quiet private room, in a safe area, at the university Rivermead campus during your study periods at the university. The second interview will take place in a similar suitable room arranged between ourselves at your new place of work, after a normal working shift, in your own time, and I will seek permission of your Trust.
All interviews will be tape recorded, and the transcripts of your interview will be returned to you, (with a stamped addressed envelope). You will be asked to read the transcript and asked sign to say it is a true account of the interview. Some direct quotes from the interview

11

transcripts may be cited in the results. These will be amended where necessary to protect the identity of individuals.

5. Whether there are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety:
There could be a question or a statement I may make that you may find offensive or upsetting, you may not wish to discuss this with me, therefore at each interview there will be an independent person available for you to discuss these issues should you feel you need it. Any comments that you make will normally remain anonymous however should you disclose breaches of professionalism or criminal activity these would have to be reported to those with managerial responsibility for your service.

6 Agreement to participate in this research will not compromise your legal rights should something go wrong.

7. There are no special precautions you must take before, during or after taking part in the study.

8. What will happen to any information/data that are collected from you?
The interview tapes will be transcribed, and the data will be analysed and presented in the results, some direct anonymous quotes may be used. The tapes will be destroyed once the study is complete.

9. Whether there are any benefits from taking part?
It is anticipated that the results will inform practice and improve the practice of mentoring.

10. How your participation in the project will be kept confidential.
The paper consent forms and personal data will be stored in a locked storage cabinet at the university. Transcripts and tapes will need to be stored in the university for four years until the publication of results and then destroyed. No personal data will leave the university. Interview tapes will be made anonymous with a coded label. Transcripts and other anonymous data will be kept on a removable storage device when being used for writing up the research. The storage device will be kept securely locked away when not in use.

Appendix III: Participant consent form, interviews

Participant Consent Form (interviews)

NAME OF PARTICIPANT:

Title of the project: The shifting perceptions of nurse mentorship: How do nurses and student nurses view the concept of mentorship

Main investigator and contact details:
Mrs Julie Teatheredge
0845 196 4846
j.teatherdge@anglia.ac.uk

Members of the research team:
Julie Teatheredge
Supervisors: Dr Andy Stevens and Dr Tim Shafer

	Please initial
1. I agree to take part in the above research. I have read the Participant Information Sheet version 2.1 which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction. I am free to ask any questions at any time before and during the study.	☐
2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.	☐
3. I have been informed that the confidentiality of the information I provide will be safeguarded (subject to professional and criminal disclosures) as stated in the Participant Information Sheet	☐
4. I agree to having my interview tape-recorded and transcribed and understand that any direct quotations used will only be used for the above research and will be made anonymous	☐
5. I have been provided with a another copy of this form and the Participant Information Sheet for me to keep	☐

Name of participant (print)…………………………..Signed………………...…..Date………………

Name of witness (print)…………………………...Signed………………...…..Date………………

Could you please give me your contact details in order to arrange the interview…………………………………………

Appendix IV: Invitation letter to potential interviewees

Invitation letter to potential interviewees

…………2008

Semi-structured interviews

Re: Invitation to participate in a research study in Mentoring in Mental Health Nursing entitled: 'Shifting perceptions to nurse mentorship'
Please find enclosed documents regarding the above study. Bearing in mind your experience of mentorship I would like invite you to participate in this study.

If you are willing to do so, please read the participant information sheet attached.
If you wish to take part in the study please sign 1 copy of the informed consent sheet and return this signed copy to me in the stamped addressed envelope provided.
The second copy of the consent form and the participant information sheet are for you to keep for your own records.

I will then contact you to arrange a convenient time for the interview.
If you have any additional questions please contact me on the number below.
Thank-you in advance for your participation.

Yours sincerely
Julie Teatheredge
Telephone: 0845 196 4846

Appendix V: Participant information sheet, questionnaires

PARTICIPANT INFORMATION SHEET for mentor questionnaires

Section A: The Research Project

1. Title of project
How do nurses and student nurses view the concept of mentorship, and evaluate the
standards to support learning and assessment in practice?

2. Purpose and value of study:
The aim of the study is to identify factors which shape student and staff perceptions of mentorship in
mental health nursing.
The focus of the study is on the attitudes and outlook people express towards the role of the practice
mentor/coach, and how these vary with experience and change of professional status, i.e. students'
becoming mentors. It is anticipated that perceptions may vary over time, and these may give us better
insight into the role of a mentor. It is anticipated that this study could enhanced mentor to student's
relationship, and draw clearer insights into the role of a mentor.

3. Invitation to participate:
I would like to complete a single questionnaire which should take you approximately twenty minutes. This
is about your views on the mentorship process and in particular your role as a mentor. The questionnaires
will be sent to you by post, and if wish to participate please complete and return them in the stamped
addressed envelope provided.

4. Who is organising the research?
I am the chief investigator for this study, and this original research is a central component to my PHD
studies at Anglia Ruskin University, this study will be supervised by two internal academics, Dr A
Stevens and Dr T Shafer.

5. What will happen to the results of the study?
The results of the study will be used for my PhD, but will also be used to inform the Nursing & Midwifery
Council (NMC) and Department of Health (DH) guidance for mentorship. The results of the study will
also be published in your local Trust's magazines and relevant journals.

6. Source of funding for the research:
My PhD training is being funded by Anglia Ruskin University, all other costs will be met by the
researcher.

7. Contact for further information
Mrs J Teatheredge
Anglia Ruskin University
Floor 2, William Harvey Building
Rivermead Campus

Chelmsford
Essex CM1 1SQ
0845 196 4846

Section B: Your Participation in the Research Project

1. Why you have been invited to take part:
You have been asked to take part because you are a qualified registered nurse, you have been trained as a mentor and currently you are able to mentor student mental health nurses

2. Whether you can refuse to take part:
If there is a reason why you do not wish to take part, simply do so by not returning the questionnaire. There is no financial incentive for taking part and no removed punitive repercussions if you do not wish to take part.

3. Whether you can withdraw at any time, and how:
If you decide you do not wish to participate in the study, please do not complete the questionnaire, as once they are returned they cannot be traced.

4. What will happen if you agree to take part ?
You will only need to complete the questionnaire which is enclosed, if you wish to take part please complete the questionnaire and return it in the stamped addressed envelope provided.

5. Whether there are any risks involved and if so what will be done to ensure your wellbeing/safety:
It is unlikely that any risks will be arise from your participation.

6 Agreement to participate in this research will not compromise your legal rights should something go wrong.

7. There are no special precautions you must take before, during or after taking part in the study.

8. What will happen to any information/data that are collected from you:
The data will be analysed and the results of the study will be used for my PhD, but will also be used to inform the NMC and DH guidance for mentorship. Questionnaires will be kept for four years and then destroyed after the results are published. The results of the study will also be published in your local Trust's magazines and relevant journals.

9. Whether there are any benefits from taking part:
There is unlikely to be any direct benefit to you but it is anticipated that the results will inform practice and may assist you in mentoring and supporting students in practice.

10. How your participation in the project will be kept confidential:
The returned questionnaires should not contain any identifying information.

Appendix VI: Questionnaire

Questionnaire on mentorship in mental health nursing

Could you please take a few minutes to fill in this questionnaire and return it in the envelope provided.

Q1. Are you a qualified mentor?
Please circle:

YES   NO
If no then please go to question 5

Q2. How long have you been a qualified mentor?

………..

Q3. Have you had an update this year?
Please circle

YES   NO

Q4. How easy is it for you to attend a mentors update?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………

Q5. In your opinion how effective is the mentoring system in supporting student's learning in practice?

Please circle:

Very effective   effective   not very effective   ineffective

Q6. In your opinion how effective is the mentoring system in producing students who are fit for practice?

Please circle:

Very effective   effective   not very effective   ineffective

Q7. Please state below your views on the effectiveness of mentoring in practice? (e.g. safe and professional)

………………………………………………………………………………………

………………………………………………………………………………………

…………………………………………………………………………

Q8. Reflecting on your role as a mentor, what aspects of your mentoring role do you find rewarding?

………………………………………………………………………………………

………………………………………………………………………………………

……………………………………………………………………………

Q9. Please give comments in regards to any difficulties you have experienced when mentoring students? (e.g. time, professional issues etc.)

....

....

....

Q10. Reflecting on your role as a mentor, what aspects of your mentoring role do you find least rewarding or challenging?

....

....

....

Q11. What in your opinion are the most common problems in practice for a mentor?

....

....

....

Q12. And how do you think that the system of mentoring could be improved?

....

....

....

Thank you for taking the time to complete this questionnaire, please put it in an envelope and return to the address stated in the e-mail

Julie Teatheredge

Appendix VII: Invitation letter, questionnaires

Anglia Ruskin
University

25 November 2009

Questionnaires

Re: Invitation to participate in a research study in Mentoring in Mental Health Nursing
titled: 'Shifting perceptions to nurse mentorship'

Please find attached documents regarding the above study which I am undertaking as part
of my doctoral thesis. I am inviting you to participate in this survey, which will assist me
in understanding your role. Please read the participant information sheet attached and if
you would like to participate please complete the attached questionnaire and return it to
me by post in the stamped (freepost) addressed envelope provided.

I thank you in advance for your assistance.

Yours sincerely

Julie Teatheredge

Appendix VIII: Interview schedule

INTERVIEW SCHEDULE first interviews:

A. Can you tell your opinions about mentoring system in practice?

B. What do your think is good about the mentoring system?

C. Could you tell if there are any problems, from your perspective, in the mentoring system?

D. What, in your opinion could be improved?

INTERVIEW SCHEDULE second interviews:

E. In your experience can you explain the difference between being a student and nurse/nurse mentor?

F. Thinking back to when you were a student nurse, have your views and opinions changed in regards to mentoring? Can you explain why they have changed?

G. Now you are a qualified nurse and or mentor what are your views on the effectiveness of mentoring students?

H. Do you think that the skills you have as a mental health nurse affect how you support students in the practice area?

I. How in your opinion could the mentoring system be improved or changed?

Appendix IX: Recommendations

Recommendations

These recommendations are quite detailed for a thesis, but are important outcomes from the results, thus it is essential that they are presented in this final chapter. I have tried to include all the important issues highlighted in the results, thus presenting some solutions to these barriers and problems in the mentoring experience. There are of course financial implications because these recommendations would be expensive, and who would pay for these is another issue.

1. **To nominate a clinical placement coordinator (CPC) for clinical areas.**

This is similar to the Model used by the Nursing Council of New Zealand (NCNZ 2008). The Clinical placement coordinator (CPC) will be an experience qualified live mentor or sign off mentor, or practice teacher or equivalent.

1) The clinical placement coordinator (CPC) would be responsible for clusters of clinical areas, which are both inpatient and community. The demographic area they would cover would fall naturally, e.g. two inpatient units and three community teams are based at Colchester general hospital, and one CPC would coordinate all five teams.

2) The CPC would be responsible for all the pre-planning of students clinical placements to their areas. This would involve coordination with the placement team at the HEI, in regards to knowing when students would be arriving for the clinical placement.

3) The CPC would ensure a live mentor was allocated to each student in advance of the students' attendance. The students would also be put on the off duty sheet in advance: a) to inform the whole team of the students pending

placement; b). to highlight their supernumery status; c). the student needs to be on the off duty sheet for insurance purposes; d). to help the student feel part of the team.

4) The CPC would nominate a preceptor for newly qualified staff in advance of their arriving. Supernumery status should be negotiated with the employers. I recommend only live mentors should be preceptors.

5) The CPC will have overall responsibility for managing and overseeing the students and preceptees experience. This will include facilitation of 3 tripartite meetings between the student/preceptee and mentor/preceptor and the CPC during the term of the placement or preceptorship.

6) The CPC will also manage the student and the mentor/preceptors sickness and absence issues. In regards to sickness and absence of the CPC duties will covered by the nearest geographical CPC.

7) The CPC will manage and facilitate supervision groups for the students on a weekly basis (during work time); Teaching sessions will be an inherent component of these groups, also assigning students relevant research tasks linked to clinical skills and practices, students may be asked to present their findings at subsequent meetings.

8) The CPC will manage and facilitate; supervision groups for the mentors/preceptors on a monthly basis, which will include reflective practice.

9) The CPC will ensure the students experience including the assessment is fair. It is not expected that the CPC will be part of the assessment process.

10) The CPC will ensure the sign off mentor has been nominated in advance and will manage this process to ensure it is efficient and effective.

11) The CPC will manage the live register for their cluster areas, ensuring migration of staff is documented immediately, and keeping the clinical audit up to date.

12) The CPC will ensure all mentors in their cluster area have a yearly update and they will manage and facilitate the tri-annual review.

13) The CPC will facilitate a monthly support group for newly qualified staff.

The management of these points will be overseen by the HEI and a clinical manger to ensure adhesiveness and to work collaboratively with all interested parties, keeping lines of communication open.

These points address many issues highlighted in the results including: reducing the students' anxiety; knowing a mentor is there for the students; a warm welcome for the students, helping the student to feel part of the team; reducing feelings of isolation; ensuring the students are competent to pass; ensuring the students feel supported and know what to do; being aware of what they need to know; students encouraged to research the evidence base; being taught in the clinical area; having someone there to answer their questions; mentors feel supported with all aspects of the role; feeling supported can reduce poor attitudes for the students and the mentors; reducing placement allocation errors; ensuring the live register is accurate; fair and accurate assessment; fair and supportive preceptorship; promoting independence. Having small cluster areas will allow the CPC to have knowledge of the mentoring experience and the clinical activity on the wards/units as well as sickness and absence. It will also help to prevent inaccurate assumptions being made by all involved through poor communication and misinterpretation. This list is not exhausted but is fairly comprehensive, the second recommendation follows.

The second recommendation is:

2. Commitment from the university

The University will:

1) To initiate a mental health nurse programme (including accountability and responsibility) for student nurses in their final two years of training; preparation for professional practice, which ensures the students are better prepared for becoming a registered mental health nurse. The HEI will involve clinical practice to prepare and implement this programme, to ensure the students have a better idea of what being a nurse really means.

2) To commit to visit each student once in each clinical placement.

3) To arrange collaborative visits with the student, the mentor, the CPC, and management responsible for training. In order to build collaborative relationships and develop efficient and effective methods to enhance the learning process in the craft of caring.

4) The mental health lecturers who are registered mental health nurses' will be present at the first formal meeting (to address any misunderstandings in the practice documentation), the formative and the summative assessment with the student and the mentor. This is to support both the mentor and the student, to ensure the assessment process is fair, but also to monitor the students' progress over the three year period, from both perspectives. To be at hand to offer extra support to the student and the mentor, but most importantly is the building of good professional relationships, so the mentors and students feel cared for by more experienced peers.

5) To be responsible for follow visits/ progress reports for newly qualified nurses and newly qualified nurse mentors.

6) Students practice books to be sent to the mentor prior to the start of the students' placement.

7) All these collaborative visits and partnerships will help develop curriculums; will ensure mentors and CPC's are kept up to date with current curriculum and developmental changes which affect the student and the clinical areas. They should also be used so students, mentors and CPC's can feedback concerns, exchange positive experiences, and put forward recommendations for change which will documented and forwarded to those with the power to make change.

8) The lecturers to offer to support the CPC with the weekly student supervision/teaching sessions, facilitating a session once every trimester.

9) To review the mentorship training curriculum, considering branch specific learning and to teach the practice of reflection.

The management of these points will be overseen by the education champion from the University, who will collaborate with all interested parties.

Feeling cared for is the central component in the craft of caring, the participants in this study felt more confident and open to learning when they felt cared for by others, especially the mentor. The students/qualified nurses and the mentors in this study, felt that the lecturers from the Universities who teach them, have much more experience in nursing, mentoring and teaching and as such, it would increase confidence and esteem if the lecturers felt enough care and concern to make time to be there for the students and mentors. To share experience and give wise support, reduce anxiety and build good collaborative professional relationships, the mentors in this study said this would improve the '*quality of future nurses'* (QP59). Furthermore the students may feel more comfortable discussing personal issues which are affecting their performance in clinical practice with a lecturer rather than a mentor they do not know so well.

These recommendations address many issues highlighted in the results including: supporting the mentor to support the student, especially weak students; understanding more of the reality of being a nurse; effective pre-planning; enhancing communication and collaboration between the practice area and the Universities; monitoring of progress; support students and mentors through the whole process; supervision for the mentor; being part of the assessment process; ensure time and effort is made to make these processes occur correctly, e.g. the formative assessment happening at the mid point in the placement; support the newly qualified mentors. Commitment from the employer was also an issue which was highlighted in the results.

The third recommendation is:

3. Commitment from the employer

1) To commit to continue to be a learning organization
2) To commit to giving mentors protected time to mentor students, through instructing managers to negotiate this protected time: A) To view windows of

opportunity for making this time, e.g. following handover, ensuring there are enough qualified staff on duty so there is someone to take charge during protected time. B) The protected time should be a minimum of 30minutes per week, and a maximum of one hour. C) The protected time slots should always be placed in the unit's weekly diary along with meetings with the CPC and university staff. D) In the case of emergencies, when the protective time slot has to be cancelled, time should be made available before the end of the shift for de-briefing, explanation and re-booking of the protective time slot.

3) To nominate a CPC, encourage and oversee the CPC duties, and support the CPC.

4) A preceptor should be a qualified live mentor, who should also have protected time to support the preceptee in clinical practice development, 30-45 minutes a week using the same core conditions as in 2.

5) To value and support student teaching sessions and mentor supervision groups.

6) To ensure each placement has an induction/welcome pack for the students: a) which explains the learning opportunities on the unit; b) resources available;

c) networking issues; d) learning expectations of the student at various stages of their training; e) professional expectations of the student; f) what they can expect from the mentor, the CPC and the manager.

7) To ensure there is a welcome/induction pack for the newly qualified staff: a) including ward routine and philosophy; b) learning opportunities; c) information about preceptorship and roles therein; d) information on where to locate important information e.g. policy documents; e) band 5 job description.

8) Instigate and maintain a support group for newly qualified staff.

The management of these points will be overseen by the education lead for the employing organization.

These standards address the important issue of time management which all the participants mentioned many times, and I feel it is important to boundary this

time. Too often recommendations are unclear from governing bodies (Gopee 2011), as such the employers and the HEI's to some extent, place their own interpretation into the recommendations which are not always implemented as they were primarily intended. These recommendations address many of the issues the mentors, students and qualified nurse mentors highlighted throughout this study; which was lack of time to mentor effectively. Also the induction packs will form part of the welcome process creating a sense of belonging and being wanted, reducing anxiety. Clear guidelines also help to eradicate the not knowing if you don't know factor which was also an issue in this research. Also the packs communicate clearly to the students and should give information about their role as a student on the unit, encouraging the student to take a proactive professional role. However, an induction pack is more relevant to the actual ward or unit, an information booklet which will be much more in depth, and address some of the issues presented in the results, is the next recommendation.

The forth recommendation is:

4. **Student information booklet (hard and online copy: to be made available to all interested parties)**

1) To include how to prepare for clinical practice areas community and inpatient. Including: a) dress code; b) time keeping; c) contacting the unit before placement begins; d) travel arrangements; f) work ethic, full shift system, including weekends and bank holidays etc. g) sickness and absence management; h) how to access urgent support.
2) Expectations of the student, including: a) as a first year; b) as a second year; c) as a third year.
3) What it means to be professional as a nurse.
4) What is accountability and responsibility.

5) The mentors' role: what to expect from a mentor; to include a comprehensive discussion about teaching learning and assessment (inc. SLAiP NMC 2008), and to incorporate points made in the other recommendations including time. It is important that this section is clear and realistic so expectations are obvious, and will reduce assumptions.

6) The student's role in clinical practice: a) knowing what learning outcomes you have to achieve before placement begins; b) drafting a learning contract; c) facilitating extra curricular activity which does not jeopardize the clinical placement; d) adhering to the off duty; e) using correct procedures for reporting sickness absence; f) learning the basics of the craft of caring with the patients; g) using the computer for clinical purposes and only when advised; h) not changing shifts at the last minute, but negotiating.

7) How to learn from all members of the multi-disciplinary team.

8) How to make a complaint.

9) Support systems and contact details (which will be updated by CPC)

10) Third year students: information about the transition to qualified nurse.

11) A copy of the NMC (2008) code of conduct.

12) An explanation of the roles of the CPC, University tutor, and manager of the units.

The management of these points will be overseen by the lecturers at the university and the CPC.

These recommendations address many of the issues highlighted in the results from the mentor, students and qualified nurse/mentors. They give clear guidelines to the students about being professional and what will be expected of them in clinical practice. This will eradicate some of unknown aspects of being a student in clinical practice; it will also reduce assumptions of what being a student means in reality. It also presents clear guidelines of what will be expected of the student including professional issues. In some respects these could increase the students' anxiety, however initially these should be discussed

in detail in the classroom, with the lecturer responding to questions which may reduce the anxiety. This booklet can again be discussed and linked to the induction/welcome pack at the first formal meeting, with the lecturer and the mentor present, to answer questions. This opens communication and presents expectations from the start of the relationship, reducing many barriers to mentorship at the commencement of the journey. To ensure expectations are clear for all parties' guidelines need to be made available for the mentor.

The fifth recommendation is:

5. **Mentor guidelines (hard and online copy: to be made available to all interested parties)**

1) Levels of expectations from students in year 1, year 2, and year 3

2) A copy of the NMC proficiencies to enter the register, a copy of the DH Preceptorship Framework.

3) A copy of all the practice learning outcomes for all three years in chronological order, this will give the mentor a good clear idea of the students journey and what they need to achieve during the three year period.

4) A specimen copy of a practice document so the mentors have a clear understanding of what needs to be addressed during the clinical placement.

5) A copy of the responsibilities of the CPC.

6) The role of the university in mentoring.

7) Details of protected time for mentoring procedures.

8) If protected time has not been agreed locally then suggestions on how to protect time to mentor: a) ward involvement in protected time; b) putting the time slot in the diary; c) using times when staff compliment is high, e.g. after handover; d) negotiate with other qualified staff and manager to create time slots.

9) Information about monthly mentor supervision with the CPC.

10) Procedures for students in need.

11) How to access support for student issues including all contact details (which will be updated by CPC).

12) Procedures on how to fail a student.

13) Employer and university expectations of being a mentor.

14) How to make a complaint.

15) Taking the student on a journey of the shift and encouraging them to take the initiate, and give constructive criticism without ridicule.

16) Arranging the first formal meeting with the student and lecturer, and the formative and summative assessment which should be booked in advance.

17) Encouraging the student to feel part of the team and ensuring they feel welcome.

The management of these points will be overseen by the CPC, lecturers at the university and the managers.

These recommendations again cover many issues which were highlighted in the results. It is important that the role is clearly defined, but also that the mentors feel supported and know how to access that support. Many of the qualified mentors in this study stated that more support was needed to mentor, and the supervision groups may provide a space in which recurring issues and complicated concerns can be shared and this can help to reduce tension in the role. Because the role is so complex having guidelines makes the role clearer. The students having access to these guidelines, this will also give them a clear understanding of the mentors' role, again reducing assumptions and giving them knowledge on which they can act, if important components of the process are missing. For the students in this study feeling part of the team was very important, being mentored in the craft of caring sharing knowledge was also what they said they needed form the mentor. The nurses in the second interview felt unprepared for the transition to qualified, and the 2 recommendation requires the

universities to develop a program which can help with this preparation, I also think an information booklet would be a resource for the newly qualified nurse.

The sixth recommendation is:

6. Information booklet for the newly qualified MH nurse (hard and online copy: to be made available to all interested parties)

1) Definitions of the craft of caring

2) Explanations of the differences between being a student and being a qualified nurse.

3) Ward routines and philosophies.

3) Roles and responsibilities of a newly qualified nurse.

4) What is meant by accountability?

5) What is a preceptorship?

6) Management of violence and aggression.

7) Risk management.

8) Location of all policies and procedures.

9) What the employer expects from the newly qualified member of staff.

10) What the employer will give to you.

11) Your responsibility in the team.

12) How to make a complaint.

13) Continual professional development (Key skills framework)

14) A copy of the NMC (2008) code of conduct, and DH Preceptorship Framework, copy band 5 job description.

15) Attendance at the monthly newly qualified staffs support group (preceptees only).

These points will be overseen by the CPC and the manager.

These recommendations address many of the issues highlighted in the second interview. This booklet will give the newly qualified MH nurse some guidelines in

regards to their role and how it has changed. Actually working on the unit and facilitating the craft of caring is very different to reading about it, like Barker said (2009), however, some guidance is an improvement on no guidance. Kat said that becoming a qualified nurse was like being thrown in the deep end of a swimming pool when you cannot swim, the guidelines I would suggest allow the newly qualified nurse to learn the craft in the shallow end. Reading about the ward routine and the responsibilities helps to understand, but comprehension can only dawn when the actual nursing begins. It is fair to say these recommendations can improve issues, but in reality the experience can be very different, depending on the capability of each individual. I think that some of the assumptions and contradictions the newly qualified nurses experienced can be reduced if all involved understand these requirements. The CPC facilitating the preceptorship period should also reduce the inconsistencies the participants experienced. The support group will facilitate the sharing of experiences and the communication of anxieties and issues, reducing feelings of isolation and encouraging sound reflective practice.

The policy makers should consider incorporating the above recommendations into the NMC (2008) Standards for learning and assessment in practice. Furthermore the NMC should consider reducing mentoring to non-compulsory status; thus only those with an interest in mentoring would train to become mentors. This would prevent nurses who will never be able to master the process of mentoring training to become mentors who are incapable and incompetent.
The results of this research also highlighted that the qualified nurses only felt really confident to undertake the responsibility of the mentoring role, once they had been qualified some considerable time, in this case two and a half years. Thus it should be recommended to the NMC that qualified nurses should be qualified at least two years before the employer considers putting them forward for mentorship training. In New Zealand the nurse has to be qualified for three years before they can train to become a preceptor (mentor). Some professions give monetary rewards for facilitating learning and assessment in clinical

practice. This too should be considered by the governing bodies. The nurses may feel more valued and be more motivated to facilitate the extra work and responsibility, if they were rewarded for their contribution.

Appendix X: Published article

Practice Research report

Interviewing student and qualified nurses to find out what makes an effective mentor

Being a mentor is an essential part of the nurse's role. Qualitative research was undertaken to discover how successful mentoring relationships are developed

AUTHORS Julie Featherledge, BSA, PG Dip, BSc, Dip HE, RMN, is a senior lecturer mental health and learning disabilities at Anglia Ruskin University, Chelmsford, Essex.

ABSTRACT Featherledge J (2010) Interviewing student and qualified nurses to find out what makes an effective mentor. Nursing Times 106; 48, 19-21.
Background A research project was undertaken to explore what constitutes a successful mentor.
Aim To increase understanding within the profession as to what makes an effective mentor.
Method The study mainly used qualitative methods, initially involving interviews with eight third year mental health student nurses, and postal questionnaires sent to 270 qualified mentors.
Results A positive attitude and being highly motivated are important attributes for both the mentor and student, if mentoring is to be effective. Mentors felt that having formal supervision would ensure they were supported appropriately. They also suggested they needed protected time to mentor to develop effective working relationships.
Conclusion Effective mentoring produces effective students, who in turn become competent, confident registrants.

INTRODUCTION

"Mentors are guides: they lead us along a journey of our lives. We trust them because they have been there before. They embody our hopes, cast light on the way ahead, interpret arcane signs, warn us of lurking dangers, and point out unexpected delights along the way" (Daloz, 1986).

Mentors are unless guides, as well as advisers and companions. Being a mentor is a vital part of the nurse's role and involves teaching, educating and supporting students to help them become confident and competent in their practice. However, being an effective mentor involves much more than simply fulfilling those requirements.

BACKGROUND

Over the years, much has been written about mentoring and what the main principles are in terms of encouraging nurses to be effective mentors.

The Nursing and Midwifery Council's (2008) Standards to Learning and Assessment in Practice presented the profession with a framework for mentors with identified outcomes to ensure "there is clear accountability for making decisions that lead to entry to the register".

The framework has eight domains, each of which has identified outcomes at four developmental stages. The domains are:
● 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.

These domains give mentors clear instructions about their responsibilities. However, meeting these requirements alone will not make a nurse a successful mentor.

According to Gopee (2008), effective mentoring encompasses "effective working relationships, relevant mentor-mentee communication, and includes generic and specialist communication skills. The characteristics... include the mentor as a role model for learnees and ascertaining own mentorship potential."

A good mentor, then, is much more than someone who guides and supervises the learning experience and assesses the student's competencies in the practice area. By empowering students, mentors can enable them to find their own answers and solve problems (Wallace and Gravells, 2007).

Downie and Basford (2003) said that mentoring began with the student nurse – or mentee – being in a state of anxiety, fostering dependence (Bowlby, 1997). Skilled mentors encourage their mentees to become more independent in terms of their learning.

This involves mentees being self directed and taking responsibility for their learning needs in the practice area (Downie and Basford, 2003).

Mentors can encourage this process by creating a secure base for their students, built on a trusting relationship (Rogers, 1983) in which students feel confident to begin to explore the world of nursing.

As students gain experiences, accumulate skills and assimilate some theory into their practice experiences, they will then become more confident about seeking out new experiences, demonstrating a keenness to learn while feeling comfortable about asking for help (Downie and Basford, 2003).

The person centred goal is for the mentee to move from being "subject centred to performance centred" (Downie and Basford, 2003). Miller (2002) described this type of mentoring as "holistic" mentoring, which involves tutoring, counselling and coaching, and stated it is likely that: "Holistic mentors will be very experienced and well trained individuals who are able to operate at a high level of skill."

EFFECTIVE MENTORING

Achieving a holistic style of mentoring requires effective mentors. The mentee has embarked upon the journey of nurse training with a vision of becoming a qualified nurse (Levinson et al, 1978).

It is through a reciprocal effective mentoring relationship that the mentee can make the transition from student nurse to registered practitioner. This relationship indicates effective communication and a willingness to learn from each other, which can enhance the mentoring process.

The quality of their mentoring relationships can affect students' achievement and progression (Foster-Turner, 2006). Mentees will expect their mentors to provide consistent support (Bowlby, 1997), so they can learn skills and experience the "craft work" (Barker, 2009) in the clinical environment (Foster-Turner, 2006). According to Foster-Turner (2006), students

Practice Research report

will also presume that, in this safe environment, they will be able to learn through experience, examine their mistakes without ridicule, share their lack of knowledge, and experiment in decision making and problem solving, supported by their mentor.

However, there are external issues that can influence the effectiveness of the mentoring relationship.

External influences on the effectiveness of mentoring

Organisations that are responsible for training student nurses also have a responsibility to promote a positive learning environment (Foster-Turner, 2006). This can have a beneficial effect on the mentoring process, and the nature of the mentoring relationship (Downie and Basford, 2003).

Dakos (1986) suggested students' development is not just influenced by the organisation, but also by the environment in which their development is being supported.

It may be that the organisation where students undertake their practice placement promotes an atmosphere where learning is encouraged. In addition, the dynamics and cultural background of the team and the individuals within that team can affect the mentoring experience and, ultimately, the mentoring relationship.

Dakos (1986) suggested that individuals working for the same organisation may not have identical views and beliefs, while Stuart (2007) noted that they may have different expectations of themselves and others.

These complex issues will influence the effectiveness of the mentoring experience and students' development. As a result, the mentoring experience is highly variable in different clinical environments (Taylor, 2008).

AIM AND METHOD

Hoping to increase understanding within the profession as to what makes an effective mentor, we conducted a study examining mentors' and mentees' views on the subject. The study is part of a larger piece of research carried out by Anglia Ruskin University into shifting perceptions of mentoring in mental health nursing.

The overall study is based on findings from a longitudinal survey, which looks at the changing attitudes of a group of nurses from being students to eventually working in professional practice. It aimed to understand the essential meaning of the everyday reality of being a mentee and a mentor in mental health practice.

The study mainly used qualitative

methods, initially interviewing eight third year mental health student nurses, and sending postal questionnaires to 270 qualified mentors. There was a 23% response rate to the questionnaire and the final data for the overall study will be based on interviews with the students once they have qualified as nurse mentors.

Data from the eight interviews with students was selected from transcriptions validated by interviewees, and from the seven qualitative questions in the mentor's anonymous piloted questionnaire. The latter proved valuable in that many respondents provided detailed responses. This research was designed to explore students' and nurse mentors' perceptions as trainees and trainers operating in mental health nursing.

Ethical approval was obtained from the National Research Ethics Service (www.nres.npsa.nhs.uk)

FINDINGS

The analysis of the data from the students and mentors clearly indicates that effective mentoring is dependent on a secure, productive relationship and that both parties have a responsibility to commit to this.

One student respondent believed that mentoring was about "a mentor passing their experience on to you as a student, and preparing you for what you're going to encounter, once you're actually a qualified nurse yourself".

The mentors said that effective mentoring depended on the attitude, motivation, experience and quality of the mentor. The students acknowledged that some mentors were not as good as others, and said one of the reasons for this is that nurses sometimes have no choice but to become mentors.

One student said: "Some do it reluctantly... you need to have a passion for mentoring." Another pointed out: "Everyone cannot be a mentor... it's like nurses – everybody cannot be a nurse." Some mentors agreed with this student's view that becoming a mentor should be optional.

Mentors believed that effective mentoring

also depended on the students' ability, skills, motivation and attitude. Mentoring, they said, was more beneficial to willing students. One student agreed that the experience of the placement was affected by the student's attitude, perception and willingness to learn, pointing out that "some students are more willing to learn than others".

Effective mentoring from a student perspective is about having a mentor who is able to calm their anxiety, especially in a new placement; this then helps them to settle, focus, learn and understand how the unit works. It is also good to have a mentor as a source of practice knowledge. "If I need to know something, if I haven't been taught something, it's the support, I suppose," one student said.

The mentors generally said that effective mentors guide, supervise and teach their students. They act as role models, ensuring students know what to expect.

Mentors felt they needed to be committed to the role and be aware of individual students' strengths and weaknesses. Students made similar comments and said that mentors should point out their weaknesses at the earliest stage possible in the placement so they could address the issues promptly.

The mentoring relationship

One student believed that mentoring was about the relationship between the mentor and mentee, and also "the interest of the mentor in imparting knowledge to you". This knowledge is important because not everything is learnt at university and in practice students are often not aware of what they should know.

Many of the mentor respondents believed that effective mentoring allowed for a professional relationship or partnership to develop, where the student is able to observe, learn new skills, ask questions and be supported. Students and mentor can then promote good standards, get results and ensure good practice is safely delivered.

One student described a good mentor who was able to admit they did not know

something "They said, 'Can you find out the research? We'll look at it together and I'll learn from it as well, so we've both learnt something'."

According to one mentor, effective mentoring is "enabling and facilitating students to practise their theoretical knowledge and skills in clinical areas and enhancing their practice through reflection in and on practice". Some of the student respondents agreed with this comment, and felt they learnt most from those who were both supportive and encouraging.

Many student respondents said they had mentors who would not sign the practice document until they were certain their students had a clear comprehension of the learning outcomes, even asking the students to research certain concepts first.

One student said that, in areas that were not so busy, mentors took the time to question their students before signing the book: "They actually sat there and questioned you about motivation and planning of care and things like that, instead of it being 'quick, quick, come and we can do your book now for half an hour'."

However, this was not always the case. One student said there was not always enough time to go through the documents and look at everything. "Sometimes it's all done in a rush, all the document signing and the assessment." The mentors did ask questions but, as one noted: "Sometimes we did not have time to discuss it in depth... in hospital, time is precious."

TIME TO MENTOR

Mentors and students made similar frequent comments on the paucity of time.

Students felt this was more of an issue in busy inpatient units. One commented on how busy nurses were in the acute inpatient settings, and that sometimes it was hard to find time to mentor. One said: "I had a very good mentor, but a lot of the time she was very busy, rushed off her feet, trying to keep up with the workload. At times she would be the nurse in charge and would have a lot of things to attend to."

Many mentors said that the practice areas were often too busy, crowded and noisy, that there was no time for students to get their needs met and that this was not conducive to learning. One mentor stated: "Mentors should be given protected time away from regular duties to devote to teaching and assessing students." Mentors also felt that they should be allocated time for formal supervision to enhance mentoring.

Another organisational issue for the students was that they felt much more secure and less anxious if the mentor had been allocated before they arrived in a new clinical environment.

Some students considered that having good and consistent mentors made them keen to become mentors themselves. One said: "I think it's helped that I have a good mentor and a consistent mentor... it's made me enthusiastic about becoming a mentor and I am looking forward to the day I start my mentorship contract."

DISCUSSION

It is important these results are explored in relation to the NMC's (2008) framework for mentoring; this can then be reviewed in regards to future implications for practice.

Mentors and students agreed that a positive attitude and being highly motivated are important attributes for both mentor and mentee if mentoring is to be effective. According to Gopee (2008), these characteristics will also form the basis of an effective working relationship, in which both parties learn from the experience.

One student taking part in the survey was encouraged by the mentor to research and then share the findings and learn together – an approach that fits in with the NMC (2008) framework in terms of "establishing effective working relationships".

The students in this study acknowledged differing levels of anxiety between different students (Downie and Basford, 2003). A skilled mentor can reduce this anxiety by ensuring the student feels secure (Bowlby, 1997), especially if the mentor makes the student feel welcome when starting on a new placement.

If the mentor is able to reduce the student's anxiety (Bowlby, 1997) the student is then able to explore the craft of caring (Barker 2009). As the students said, they are then more able to settle and focus on learning, so

REFERENCES

Barker P (2009) *Psychiatric and Mental Health Nursing: the Craft of Caring*. London: Hodder Arnold.
Bowlby J (1997) *Attachment*. London: Pimlico.
Daloz LA (1986) *Effective Teaching and Mentoring*. San Francisco, Co: Jossey-Bass Publishers.
Downie C, Basford P (2003) *Mentoring in practice, a Reader*. London: University of Greenwich.
Foster-Turner J (2006) *Coaching and Mentoring in Health and Social Care*. Oxford: Radcliffe Publishing.
Gopee N (2008) *Mentoring and Supervision in Healthcare*. London: Sage.
Levinson D et al (1978) *The Seasons of a Man's Life*. New York: AA Knopf.

facilitation of learning has begun (domain 2, NMC, 2008).

The committed mentor guides, supervises and teaches the student, acting as a role model, ensuring students are safe and that good practice is safely delivered. These effective mentoring relationships will help students develop (Foster-Turner, 2006), and encourage them to become performance centred (Downie and Basford, 2003) and more confident in learning new skills and asking questions, thus enhancing the learning environment (domain 5, NMC, 2008).

These results of this study highlighted the effective working relationship that encourages learning in the environment (NMC, 2008) is affected by external factors, including time.

Allocation of time is essential for these mentoring relationships to be developed. However, both mentors and students referred to the lack of time available to mentor effectively.

Foster-Turner (2006) suggested that mental health trusts have an obligation to ensure each practice placement fosters a positive learning environment, for their future workforce to become competent in the craft of caring.

Therefore, although the organisation may not always be able to monitor the effectiveness of each individual mentor (Daloz, 1986), it could take some responsibility in ensuring that some time is protected for mentoring.

As one student said: "I think mentorship can be really good when done properly, as with everything within nursing and life."

CONCLUSION

While this preliminary report only refers to a small section of the results of this study, effective mentoring featured strongly throughout the data.

Effective mentoring produces effective students who, in turn, become competent, confident registrants who will have mastered the art and craft of caring for patients with mental health needs. ●

Miller A (2002) *Mentoring Students and Young People: a Handbook of Effective Practice*. London: Kogan Page.
Nursing and Midwifery Council (2008) *Standards to Support Learning and Assessment in Practice*. London: NMC. www.nmc.uk.org
Rogers C (1983) *Freedom to Learn for the Eighties*. Ohio: Charles E Merrill.
Stuart GC (2007) *Assessment, Supervision and Support in Clinical Practice*. Second edition. London: Elsevier.
Taylor J (2000) *Are You a Good Mentor?* www.nursingtimes.net/good-mentor
Wallace S, Gravells J (2007) *Mentoring*. Exeter: Learning Matters.

Appendix XI: Poster

A STUDY TO EXPLORE THE SHIFTING PERCEPTIONS OF MENTORSHIP IN MENTAL HEALTH NURSING: HOW DO NURSES AND STUDENT NURSES VIEW THE CONCEPT OF MENTORSHIP?

Julie Teatheredge, Faculty of Health, Social Care & Education, Anglia Ruskin University, Cambridge & Chelmsford, England, United Kingdom

Appendix XII: Results from questionnaire

Results from the questionnaires

The questionnaires had five closed questions. The purpose of the closed questions was to commence the questionnaire with some easy to answer questions, it was however, important to gather this statistical information: Firstly to ensure that the sample targeted had been reached, that is qualified mentors (question 1), and to establish if those who responded were live mentors (NMC 2008) that is, that they had an update in the last year (question 3). However this question was badly worded it asked '*have you had an update this year*' which is misleading (Gray 2009), as it could interpreted only to mean an update in 2010, instead of meaning in the last year, thus establishing they were live and could mentor students (NMC 2008). It was surprising this was not identified in the pilot study. Secondly the purpose was to verify the length of time they had been mentors (question 2), so that length of experience could be cross referenced with the other closed questions. The final two closed questions (questions 5 and 6) were designed to gather statistical evidence on the effectiveness of mentoring in regards to supporting students in practice and if the system helps produce students who are 'fit for practice' (NMC 2004).

Question 1: *Are you a qualified mentor?*

	Yes	No
Are you a qualified mentor	*62*	*0*

There were 63 respondents and 1 non response (meaning the question was left blank) to this question, however the 62 remaining were the targeted population as all were qualified mentors.

Question 2: *How long have you been a qualified mentor?*

There was an extensive range of answers to this question. The range of time mentors had been qualified to support, teach and assess students varied from six months to 25 years, 2 participants omitted to answer this question.

Question 3, was the misleading question ***Have you had an update this year?***

	Yes	No
Have you had an update this year	*43/72%*	*17/28%*

There were two participants who did not respond to this question, however one participant had only been a qualified mentor for 6 months and was currently live and did not require an update for another six months (NMC 2008). Therefore 60 participants responded to this question and 43 that is, 72% confirmed they had been updated and were therefore live mentors, and in accordance with the NMC (2008) governance were suitably qualified to mentor students. However 17 participants stated that they had not had an update equating to 28% and this

49

figure is concerning, because this indicates if taken as a generalization that 28% of the mentoring population are unable to mentor students because they are not live (NMC 2008). However, this question was very misleading, using the words 'this year' indicates in the current year, it should have read 'have you had your yearly mentors update'.

Question 5: *In your opinion how effective is the mentoring system in supporting student's learning in practice?*

All participants responded to this question

	Very effective	Effective	Not very effective	Ineffective
Q6 How effective?	*15 24%*	*42 68%*	*5 8%*	*0*

In regards to the mentoring system being effective to support the students learning in practice 92% responded that it was effective or very effective, with only 8% believing it to not be very effective. However in the next question the results were slightly contradictory.

Question 6: *In your opinion how effective is the mentoring system in producing students who are fit for practice?*
All participants answered this question

	Very effective	Effective	Not very effective	Ineffective
Q6 How effective	8 13%	38 61%	15 24%	1 2%

Notably, whilst 92% of participants believe the mentoring system to be supportive for students learning in practice, only 74% participants felt that the mentoring system produced students who are fit to practice, and 26% stated that the system was not very effective in producing students who are fit for practice. This is of concern given the requirements of the new NMC standards (2008) which were executed in 2006 in all practice areas. Participant 4 (in the 26% category) and commented that they felt that a lot of students were not safe in practice. Participant 9 was of the opinion that the placement experience does not match the training needs of the student though participant 12 suggested that it depended on the placement area, and small specialist areas can be more conducive towards the students needs. These discussions will be expanded when the qualitative answers to questions 7 to 12 are presented, but firstly the opinion of effectiveness will be cross referenced with the length of time the mentor has been qualified.