

Sustaining and assuring the quality of student nurse mentorship: what are the challenges?

Providing mentorship to nursing students is the cornerstone of the Nursing and Midwifery Council (NMC) education standards, which ensure nurses are fit for practice at the point of registration (1). Assuring the quality of mentorship is a concern to the higher education and healthcare providers who share responsibility for it, particularly at a time when nursing competence is much in the public eye (2). Drawing on NNRU research, this Policy Plus focuses on perspectives of HEI and service personnel on sustaining and assuring the quality of mentorship within a difficult economic climate and at a time of debate about its future direction (3, 4).

A quality assurance framework for mentorship

A quality assurance framework aims to reassure all stakeholders that a system meets the defined standards. Mentorship sits within several such frameworks. The NMC sets standards for: mentor preparation, course attendance and professional updating; the proportion of time students should spend with mentors and sign-off mentors; and auditing of educational suitability of students' placements (NMC 2008); it audits compliance with these standards in HEIs and healthcare providers. The mentorship course is also audited by individual HEIs and the Quality Assurance Agency (QAA) and healthcare providers are regulated by the Care Quality Commission (CQC).

Factors facilitating and constraining the quality of mentorship were identified in a study that explored capacity for mentorship provision within the complex network of relationships between organisations and individuals involved in nursing education (3). Semi-structured interviews (n=37) were held with senior personnel whose brief included a remit for mentorship in two London-based HEIs and in seven partner trusts for nurse education (selected to include NHS hospital, community and primary care trusts and encompassing adult, child and mental health services).

Assuring quality through mentor recruitment

- Sufficient numbers of mentors were in post to meet the requirement that all students have a mentor in practice.
- Most trusts complied with the standard that nurses have one year's practice before commencing training but pressure to increase mentor numbers led to staff sometimes being selected before they were perceived as ready to take on the role.
- Requiring nurses to qualify as mentors prior to accessing other courses or applying for promotion led to concerns that this might be the main motivation for becoming a mentor rather than a genuine interest in nurse education.
- Much diversity of view existed over whether the current approach of enabling all nurses to become mentors was the best approach for achieving high quality mentorship as opposed to developing a specialist career pathway for mentors (5).

Assuring quality through preparing mentors

- The mentorship course (study days and supervised practice) was regarded as good or adequate preparation for the role of mentor.
- Anxieties were expressed about the impact of increasing the proportion of on-line learning; whilst it was seen as suitable for information sharing, it was not appropriate for topics requiring more discussion, such as managing poor student performance.
- There was considerable variation in organisational compliance with the NMC recommendation of five days' protected learning time; some expected on-line sessions to be undertaken in staff's own time which was perceived as detrimental to the quality of their learning experience.

- The quality of supervised practice was influenced by experience of mentor supervisors and practice learning cultures.

Assuring quality mentorship in practice

- When mentors had concerns about student issues, the presence in practice settings of PEFs (practice education facilitators) and link lecturers enabled these to be addressed without delay. But continuation of this support was uncertain given short-term funding for PEFs' posts and the increasing time pressures on link lecturers.
- Little reduction in workload was reported to accommodate standards on student time with mentors and sign-off mentors; hence both often completed documentation outside working hours.
- Mentorship in practice was supported by substantial cross-organisational activities (planning and review meetings, developing websites and materials). Some of these working relationships however were being disrupted by trust mergers and changes to education contracts and service delivery.
- The requirement for annual updates and triennial reviews was welcomed but reservations expressed that attendance might be the measure of compliance rather than the quality of the encounter.

Assuring quality through monitoring and assessing learning in practice

- Mentors' abilities to judge student competence could be limited when placements were short, providing insufficient time to make assessments, and by mentor inexperience.
- Cross-organisation working groups streamlined instruments to measure quality to help ensure consistency of approach. Whilst welcomed, concerns were raised about the instruments becoming 'tick box' exercises that failed to capture the quality of learning.
- Governance measures of assessment decisions in clinical practice were seen as less robust than those in higher education. In higher education several people assessed work through marking, moderating and external examination. Whilst in clinical practice outcomes stemmed from a series of individuals making assessments: the mentor assessing the student; the sign-off mentor assessing the final destination student; and the supervising mentor verifying the learner mentor's outcomes.

Conclusions and implications

HEI and service personnel worked in partnership to deliver mentorship but were challenged by a range of factors in meeting the standards in the quality assurance framework.

Maintaining mentoring partnerships: Partnership working was challenged by growing and conflicting pressures on staff time and disruption caused by changes to service and education delivery. Hence clarification of respective responsibilities is needed as is recognition of the time and commitment required to sustain existing and develop new partnerships.

Resourcing mentorship: The resource intensive nature of mentorship was under pressure from growing financial constraints. Providers face the dilemma of having to respond to short-term demands to reduce costs but which may undermine the delivery of high quality care that depends, in part, on the long-term commitment required for providing mentorship.

Debating mentorship: Debates about assuring the quality of mentorship in the future included: length of time qualified before becoming a mentor; alternatives to current model of all nurses becoming mentors; developing instruments that allow consistency but also measure the quality of learning, and developing assessment systems for practice as robust as those for higher education.

Key points for policy

Assuring that mentorship meets its quality assurance standards requires:

- A strategic and collaborative approach from the profession, providers and the NMC.
- Recognition of the time and costs of preparing and supporting mentors, delivering mentorship and for personnel to develop and sustain the partnership working that underpins its provision.
- Development of a planned rather than a piecemeal approach to debating the future of mentorship in order to achieve a coherent strategy that includes recommendations from The Willis Commission (6) and revalidation for nurses.

References and information

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