Mentoring and facilitating your own and other professions

Introduction:

The aim of this assignment is to demonstrate my knowledge and understanding of learning theories and methods for facilitating learning with the student and how this has enabled me to complete a competent learning contract to fulfil the students learning outcomes. I will also discuss the features of an effective learning environment reflecting on the SWOT[1]analysis undertaken, from this identify, and make appropriate adjustments within the clinical learning environment. On a final point I shall explain accountability as a mentor and how this applies to the assessment of the student also reflecting on the testimony completed for the student.

Learning theories and methods:

The committee of inquiry into higher education (1997) endorsed learner-centred approaches and emphasised that learners should come to know their own learning style. As all individuals learn in various ways Honey & Mumford, (2006) identified four learning styles: Activist, Reflector, Theorist, and Pragmatist.

By encouraging the learner to undertake the Honey & Mumford (2006) learning styles questionnaire the learner and myself we able to understand their personal type of learning style. The questionnaire concluded that the student was a reflective learner. A reflector learning style is summarised as a person who stands back and observes, is cautious, collects and analyses experiences and is slow to reach a conclusion. However, with all learning styles it is important to acknowledge that there are strengths and weaknesses within all styles of learning. As Rassool & Rawaf (2007) explore

from a study with student nurses in the UK they found that a reflector learning style was common in undergraduate nursing students. By understanding the learners learning style we were able to incorporate these into the clinical environment, by encouraging the student to reflect more upon previous incidents, letting the student gather information from the patients, analysis then treat the patient in the appropriate manner. Through bringing this into practice, we have both been able to develop as a mentor and a student. This has also encouraged the student to become a self-directed learner, from reflecting it has given the student the chance to explore procedures and illnesses in which a paramedic may encounter.

Learning theories have been used within the health care sector for a long period especially in the nursing environment; however, it is a newly adopted role within the ambulance service. There are many types of learning styles such as behaviourism, humanism, gestaltist, congnitivis, sensory stimulation and experimental learning theories. When undertaking the learning contract I used Kolb's experimental learning cycle (1984) as it was the most beneficial and helped structure a good quality-learning contract. Kolb's cycle (1984) consists of four stages- concrete experience, reflective observation, abstract conceptualisation and active experimentation. The cycle can be started at any stage and there is no limitation to how frequently the cycle can be used. The conclusion of the learning style questionnaire enabled the learner to reflect experiences, develop an understanding of their weaknesses within practice, what further information is needed to complete the learner outcome, how to find this information required, how the student will put this into practice and is the student with all the previous information ready to

undertake the clinical procedure and finally how the student will put this into practice. Due to this cycle being able to be used again once the learner had tried the objectives set within the learning contract.

As well as using Kolb's cycle (1984), I also incorporated the sensory stimulation theory (Laird, 1985) in the learning contract. As part of the paramedic role, it is a hand on experience as Dunn (2000) suggests this theory claims that if multi senses are stimulated, greater learning takes place. Laird (1985) influenced this theory quoting ' research found that majority of knowledge held by adults is learned through seeing'. By planning practical elements to the learning contract with scenarios in cooperating the learners needs an optimum learning experience will take place and help prepare them for their registered profession.

A Learning contract is defined as a written agreement between teacher and student, which makes explicit what the learner will do to achieve specified learning outcomes (Wai- chan & Wai- tong, 2007). Learning contracts give the student a structural learning plan outlining what the learner will learn, how the learning will be achieved, how the learning will be addressed and a realistic time scale to when the objectives should be achieved by. By understanding and using learning contracts with the student, we have gained knowledge of their learning styles from Honey & Mumford (2006), reflected on experiences, observations and areas of improvement within their clinical scope. From using the Kolb's (1984) cycle, we were able to achieve an action plan in the learning contract and in cooperate the sensory stimulation theory to accomplish the objectives at this stage in their course.

Overall, by having this deeper knowledge of learning theories, methods and

learning contracts has helped me as a mentor understand what is required in a learning contract.

Learning environment:

As with many health care courses, a clinical learning environment is unstable and unpredictable. However, within the ambulance service the learning environment is very different from a theatre or ward setting as it is difficult to control. This is due to the number of emergency responded to each day and the variety of environments, which we are exposed to as a profession, and furthermore, the pressures of the job its self adds further instability to the learning environment. Papp et al (2003) explains the clinical environment is constantly changing and sometimes very unpredictable, which makes it hard to plan an optimal clinical environment for students. Although the clinical learning environment is difficult to control, it is difficult for a mentor to plan pacific clinical skills.

To ensure the student has a positive learning experience it is fundamental that the learning environment is practically, professionally, and psychologically supportive to the student. Clarke et al (2003) comments that education puts a high value on learning in the clinical environment and this places numerous demands on staff. The quality of the clinical environment has a significant influence on the learning process of student. By providing a good environment students have to feel wanted and as part of the team as this can enhance or hinder the students learning environment. By adopting a good atmosphere, relationship and communication with the learner brings a good learning environment where they feel appreciated and therefore an

optimum learning experience can be gained. Furthermore, by not adapting these fundamental elements into the learning environment a student and mentor will have a negative influence on the environment. Newton and Smith (1998) back this up by stating that effective communication and good interpersonal relationships and teamwork are necessary factors in the creation of an environment conductive to learning. Nolan (1998) also references that until students feel accepted; learning cannot proceed, as fitting in takes up most of their time and energy.

The aim of a SWOT analysis is to alert mentors, students and colleagues of the Strengths, Weaknesses, Opportunities and Threats related to the learning environment where adjustments can be made. From undertaking the SWOT analysis and reflecting on the outcome, I have gained more knowledge into the learning environment and identified various elements that can be adjusted to improve the learning environment. While there are many strengths and opportunities within the pre-hospital learning environment my aim is to adjust the results found in the weakness and threats in the SWOT analysis.

Due to the stress of some critically ill patients, it is hard for them to get good hands on experience, as there is no time to stop and explain or for the student to do things at their own pace. Due to this, sometimes the student feels more like a gofer as they are constantly asked to fetch and carry equipment. Webb and Shakespeare (2007) research shows that this can have a negative impact as one student states ' I feel like a gofer because its constantly go for that, go for this'. To adjust this treat within the learning environment as a mentor I should explain to my crew member that I am

working with to help ensure that the student has a more on hand approach to the incident and hopefully they shall be the one to fetch and carry necessary equipment. Moreover, by reflecting and verbally asking the student what happened and procedures, which took place this, shall ensure the full understanding and ensuring they have full knowledge of the incident.

However I have also identified some elements during the SWOT that are difficult to amend due to the impacted of the job and current policies in place such as no time on station for the students to use the computer facilities or practice procedures on station or set up scenarios. However during current standby it is possible to help the student go through equipment and some procedures that would take place in the vehicle at present unfortunately this is the only alternative as a mentor that I have.

Accountability and Assessment:

The Cambridge dictionary (2010) defines accountability as someone who is accountable and completely responsible for what they do and must be able to give satisfactory reason for it. Accountability as a mentor means that a student is working on your registration. Therefore, if work is delegated to a person who is not registered it is the mentor accountability is to ensure that the student who undertakes this work is able to do so and they have appropriate support and supervision (RCN[2], 2007). Therefore practicing within the HPC conduct and ethics for student. Nonetheless, it is also the student's responsibility to make sure that they are appropriately supervised for the task they are carrying out and should ask for help when needed (HPC[3], 2009). The role of a mentor is intended to support the student and

help their learning experience. Although mentors also act as a role model, commence clinical teaching, supervise student's clinical practice and ensure good clinical care and clinical safety, and assess the students practice. (Andrews, Brodie, Andrews, et al, 2005)

The importance of assessment by mentors is critical to ensure students become competent in practical skills. As Hand (2006) states the competence of all healthcare professionals must be assessed to protect the public. Rutkowski (2007) summaries competence as knowledge, skill and attitude of a student.

Throughout the learner's course, they are constantly assessed on placement and within the university settings. Nonetheless, it is essential that the mentor is familiar with the learning outcomes and objectives that are relevant to the clinical setting (Wilkinson, 1998). By the process of the learning contract, I have been able to assess the learner on areas, which have been identified, by the learner-undertaking scenario based practice, verbal tests, active participation and self-directed learning with written evidence. I have been able to assess on more than one occasion to conclude the competence of the student. Watson (2000) backs this by adding that recent methods tend to involve continuous observation and that incorporate relative practice. Additionally I have used these methods of assessment to assess the student on learner outcomes in her clinical competency booklet provided by the HEI[4].

However, not all students will be competent and therefore mentors are required to have the courage and confidence to fail a student. Although Duff

(2004) warns passing students who fail to meet assessment requirements, in hope they will improve put patients at risk. In spite of that it is thought by many that failing students will reflect on mentors own abilities (Rutkowski, 2007). As a mentor and autonomous practitioner, it is our duty to address any concerns with the HEI, so support and guidance is available. Thus, action plans and meetings can commence so that if students fail it will not come as a surprise (RCN, 2007).

A good testimony has clear evidence of the learner skills, knowledge and attitude at the present stage of learning. By completing a testimony for the associate mentor, I was able to explain what stage the learner the student was at, what the student and I had completed from the learning contract and areas, which still needed further development. Within the testimony, I made clear objectives for the student to develop and how the associate mentor was to assess these objectives, this was all clearly planned within a table. Thus, feedback would be required via email or verbal handover to ensure I had full understanding of the student's development or lack of development during their time with them.

Conclusion:

Overall in this module, essay and undergoing the learning tasks I have gained more knowledge and confidence now when completing the documentation, and will be able to fulfil my role as a competent mentor in the future. I have also gained insight into the learning environment and through discussions with students and colleagues have been able to adjust area within the clinical practice, which in turn will help develop a positive

learning environment for current and future students. Moreover, I have developed more knowledge incompetency of a student what accountability I have as a mentor and how to gain support from the HEI when I am concerned about a student. Overall, I have developed as a mentor and shall continue to do this by the means of mentor updates and self-address learning through journals to keep my newly found skills as a mentor.