

Role of a mentor within pre-registration midwifery education



The aim of this assignment is to critically analyse the theoretical principles involved in teaching and learning for personal and professional practice. I will critically evaluate the role of a mentor within pre-registration midwifery education through personal reflection. I have attached details in appendix one which explores the experience and my feelings. To maintain confidentiality and to act in accordance with the Nursing and Midwifery Council's professional standards (NMC, 2015) all names have been changed.

The role of a mentor has been enshrined in midwifery practice and pre-registration education for a number of years now with the NMC (2008) defining the role as “ making judgments about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register”. The role is seen as critical in helping facilitate development of future generations of midwives as well as preparing students for life as a professional and enabling students to register as competent practitioners and become mentors themselves (Lawson & Bunyan, 2013). Mckimm, Jollie and Hatter (2007) further identifies benefits to organisations such as increased staff morale and job satisfaction, increased inter-professional working and co-operation while for the mentor this can improve leadership and communication skills while raising profile in the organisation. To undertake the role existing midwives must work within a defined framework meeting outcomes in eight domains (appendix two) and for this assignment I am going to reflect on my experience relating to these (NMC, 2008).

Bloom, Engelhart, Furst, Hill and Krathwohl (1956) divide learning into three domains: cognitive (mental skills), affective (feelings and emotions) and

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psychomotor (physical skills). Within each there is a taxonomy associated with the overarching aim of moving to higher levels through learning (appendix three). Learning can be defined as “acquiring knowledge, skills and attitude by study, experience or teaching (Jarvis, 1983). It can be argued that Bloom’s taxonomy is too simplistic and outdated for adult learners on clinical placement and mentors need to consider many other factors that lead to effective learning such as student perception, sociological influences and personal motivation (Hinchliff, 2009).

Kolb (1984) developed a learning theory that works on two levels. First a four stage cycle (appendix four) for a learner to progress through. A learner can enter the cycle at any stage as each is mutually supportive of and feeding into the next, Kolb concludes effective learning only occurs when a learner is able to execute all four stages of the cycle; no one stage is effective as a learning tool on its own. It can be argued that this cycle is simplistic as some learners may flit around the cycle instead of naturally feeding to the next (Dyke, 2006). Secondly, Kolb describes learning styles (appendix five) which are influenced by a variety of factors, for example social environment or previous educational experiences. By mentors knowing a student’s preferred learning style this enables learning to be orientated to individual needs or circumstances.

Learning styles were further developed by Honey and Mumford (1982) who identified four distinct styles which learners naturally prefer. To maximise potential learners need to understand their own learning style and seek out opportunities using that style. As mentor, if you teach according to preferred learning style, you are creating tailored learning experiences and meet

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outcomes of domain two (NMC, 2008). Mentors and students should also take opportunities to improve learning skills and processes where there are known weaknesses so one should always strive to develop ability to teach and learn in other styles too (Stuart, 2013). Honey and Mumford's (1982) learning styles can be used alongside Kolb's cycle of learning (appendix six). However, some students may get stuck in one part of the cycle so mentors need awareness of this to help move students forward.

During placement my mentor and I did not know if I would have the opportunity to perform an episiotomy so Suzanne worked through Kolb's cycle. We simulated this on a model using my existing knowledge. I was able to identify dexterity problems (being left-handed) and weakness in my rational knowledge; from this I knew I needed to practice more and do more research. Suzanne also reflected on her own experiences and we agreed for me to research the evidence base so I could demonstrate improved knowledge and understanding of rationale, outcomes and implications for recovery. A week later we simulated the process again and because I had had time to analyse this I was much more confident, explaining rationale and what I would do in a real life situation. It was interesting to see the change in my own confidence as my knowledge increased. I know in future I will take more opportunities to use similar formats of learning as it works well for me and by repeating quickly I know my confidence will grow. Simulation has roots in behaviourist theory; it allows practice in a safe environment so there is a degree of familiarity (Hinchliff, 2009). Gibbs (1988) believes simulation is invaluable while Quinn & Hughes (2013) debate validity of transferrable skills so students need to assess the value of this method for themselves. Suzanne

successfully demonstrated meeting outcomes of domain two (NMC, 2008).

When the opportunity presented in real practice, I was confident in infiltration and performance, Suzanne was supportive throughout and despite me being nervous inside I completed it safely and effectively and we were able to reflect again afterwards. I am a dual pragmatist/theorist (appendix seven) but I think I would have been happy to get stuck in and do this with someone talking me through it but I can now see benefits from this method. As a learner if I were to just do things, I could become competent but without feeling, watching and thinking so when matched together, one can see how some types of learners may get stuck in one part of the cycle and a good mentor can recognise this, and help to move the student on.

In contrast, if mentors do not move through the cycle then this can be frustrating for the student. I had completed the cycle in a similar way as above for applying a fetal scalp electrode and was ready for the active phase. However, when opportunities arose with Helen she did not offer me the opportunity to demonstrate the clinical skill and failed to meet outcomes in domains five, six and eight (NMC 2008). Under the pre-registration standard for midwifery education (NMC, 2009) students should have a range of clinical experiences and in practice Stuart (2013) identifies that mentors may be influenced by personal bias for, or against the student. I think this can also be a problem for students having personal bias for, or against a mentor so in future will consider critical thinking in relationship problems. At the time, I was concerned I was unable to build experience but can now see that I should have been more active in discussing concerns and looking at how to overcome these together.