Nursing, like all other health care professions

Introduction

Nursing, like all other health care professions, is a practice discipline which requires continuous development of knowledge and skills in order to provide quality care to our clients. In order to do this, we need to develop certain skills to adjust to a continually evolving knowledge based practice. A great part of learning within healthcare professionals is done through clinical practice, which requires the need for a supervisor in practice, who is aware of the mentorship process and who will perform its facilitation. An effective mentor will provide future professionals with sufficient and effective knowledge and skills, making them suitable for safe practice.

The aim of this essay is to provide a critical analysis of my assessment of my learner’s knowledge and competence and critically reflect how I supervised and performed as a mentor for this learner. I have included in this essay through appendices a weekly diary that we kept showing how we both identified and how we could accomplish the objectives that we have set.

Neary (2000) states that a good learning environment for a student makes way for better learning opportunities. At the start of the module, I spoke to my supervisor about mentoring a member of staff and was given this learner. My supervisor is my line manager in which myself and the learner is a member. The workforce in the unit is divided into a flexible structured team and each team has a line manager (Band 6 or Band 7) and one to two junior line managers (band 6) then there are experienced staff nurses (Band 5), and staff nurses (band 5) of which my learner belongs.

These flexible teams facilitate mentoring and allow learners to be mentored by the mentor and available senior staff. In order to these learners are being supported effectively by their mentors and progress are followed-up not only by the mentors but also other senior staff nurses who altogether provide feedback to the learner and to the line manager. Gopee (2008) identified that some of the factors that promote learning are the correct time to teach and adequate staffing levels. We make sure mentors work next to the learners and this is being done during patient allocation at the end of the general handover. However, this does not always happen and in this case the nurse-in-charge makes sure that the learner is working next to a senior staff in the same team. This does not only promote the team-work but also that feedback can be made to the mentor and the line manager.

I conducted an initial interview with my learner to assess how she feels working in the unit and to identify her learning needs, and what she identifies as her strengths in terms of her knowledge and skills (Appendix A). Assessment of professional knowledge and competence is essential to identify subsequent learning needs and would imply being supportive to the learner (Gopee, 2008). Nicklin and Kenworthy (2000) define assessment as a measurement that directly relates to the quality and quantity of learning and is therefore, concerned with students' progress and attainment. The assessment of my learner's current knowledge and awareness of her areas of further learning was conducted to suggest progress and identify those areas that needed to be improved. I have allowed the learner to conduct a self-assessment which will enable her to own the learning and to control the way she meets her needs (Gopee, 2008).

A learning contract (Appendix B) and plan of action (Appendix C) has been agreed between me and my learner. This is part of the knowledge and skills framework competency book that she is required to do. The use of the learning contracts was advocated by Knowles et al (1998) in the context of adult learners needing to exercise some self-direction in their learning. These learning objectives gives the learner some control over their learning, stimulates their motivation to learn and to engage with the learning experience (Gopee, 2008) and therefore, gives them the self confidence and sense of empowerment. The benefits of the learning contracts have been reported by Ghazi and Henshaw (1998), who found that learning contracts help the learner's performance in assessments. There are, however, mixed views among authors about whether learning contracts are legally binding. Neary (2000a) argues that they are not but Mazhindu (1990) suggests that they are legally binding. It is useful to note that NMC (2005a) has stressed their stance on good record keeping, and written records can be used as evidence of actions taken or omitted. It is for this purpose that I have kept a written diary (Appendix D) was made in agreement with the learner.

During the first week working together I have noticed that my learner can define some of the terms that are included in our goals and have not demonstrated in-depth knowledge of the subject area. (Appendix D). When she was given feedback about this, she does not take it very well and became frustrated. She expressed that her self confidence had dropped, and that she does not feel motivated to study and learn. Students can be too self critical (Gopee, 2000) which may worsen their poor self image and may have a detrimental effect in their self confidence. In our unit nurses are being

empowered to make a sound judgment and good decision-making in delivering care to the patient. To do this you need to acquire knowledge and skills by demonstrating and articulating an aspect of care that is in question. However, the learner has not shown this and has not demonstrated the level of competence that is expected of her.

On reflection, I think that motivation is the key in which my learner would learn especially with her being frustrated with her progress and her plummeting self confidence (Appendix A). Having recognized this, I feel that I needed to build rapport and build a good working relationship with her. According to Brown (2002) he defines rapport as ‘ a state of deep spiritual, emotional or mental connection between people’, including understanding and empathy. The requirement for effective working relationships are recognized by the NMC (2006a).

Rogers and Freiberg (1994) state that, a working relationship can be built by ensuring that the individual are being accepted as who they are, that is, for their individual strengths and weaknesses, and mutual respect. One should show genuineness as a person, honesty and also should show empathic understanding- being able and willing to view situations from the other person’s perspective which is exactly what I am trying to do. I have encouraged her to read the resource file in the teaching area and have photocopied an article from a journal relevant to this topic. I have assumed the role as a supporter (Darling, 1984). I have advised her that she should not be too hard on herself and not get frustrated easily because I could support her and teach her if she does not know. I have explained that everybody has experienced what she is experiencing at the start, and that

she should not feel bad about it and should not stop her from learning. This is the role of mentor as energizer (Darling, 1984) as I have inspired interest and motivation.

I asked her what she thinks could help her to prevent her from forgetting what she has read and learned and pointed out that taking notes makes her retain information that could help her remember things. I have encouraged her to do this, whenever we discuss things in the clinical area. In doing so, I have assumed the role of a problem-solver in which I was helping her to find ways of resolving and preventing a problem (Darling, 1984). This is also supported by one of the principles of learning (Knowles et al. 1998) which states that when given responsibility for their own learning, the students are highly motivated and likely to learn and retain more. Equally, Carl Rogers (1983) advocated that the use of empathic understanding, genuineness, and being non-judgemental promotes or facilitates student-centered learning. I feel I have achieved this by creating a good learning environment, empowering my learner to become responsible, to develop self-awareness and to let her think of alternative ways of learning.

Overall what I was trying to do is to discover my learner’s learning style and creating a good learning environment for her. Everyone learns throughout their lives, and they learn new knowledge and skills for a lot of reasons, some of which are for self improvement and to acquire comprehensive relevant knowledge because they take pride in their craft (Gopee, 2008). My learner is keen to learn because of the need for more responsibility as she wants to be an experienced staff nurse, and also she wanted to do the

intensive care course. However, she needs to be deemed competent first before she would be able to do this.

Competence is a term that has several definitions, as identified by Bradshaw (1997). Being competent as Benner (2001) sees it, is being at the midway point in the stages of skill acquisition. This is the point where the learner is seen as able to perform the skill unsupervised, but further learning is required to become proficient or expert.

Benner (2001) further suggests that competence is an interpretively defined area of skilled performance identified and described by its intent, function and meanings. The NMC (2005b) identifies competence as relating to the student demonstrating their capability in certain skill areas to a required standard at a particular point in time, and that competencies are component skills that contribute to be competent and to achieve the standards of proficiency for registration. The NMC (2004c) sees a competent nurse as one who consistently demonstrates the fitness for practice. Policy and research documents, therefore, indicate that the terms competence and competent apply to the person, that is, the professional’s overall knowledge, skills and attitudes, and their fitness to practice (Gopee, 2008).

My learner’s lack of competence was evident on the third week of us working together. In the second week, she was able to identify the normal blood gas values (Appendix E) but on the third week she was not able to demonstrate understanding of the significance of the blood gases in relation to the condition of the patient and subsequently was not able to interpret blood gas results accurately (Appendix F). This is concerning as treatment and

interventions are dependent on the practitioner’s expertise in interpreting these results and not knowing these poses a great danger for the patient as they could receive the wrong treatment.

One thing that I found while I was working with my learner is that she needs motivation to learn. How individual learn has been researched and defined over a number of years.

Curzon (2001) defines learning as the ‘ apparent modification of a person’s behaviour through his activities and experiences, so that his knowledge, skills and attitudes, including modes of adjustment, towards his environment are changed, more or less permanently’. In healthcare professions, learning is a lifelong process of skill and knowledge acquisition and updating them through planned participation in focused reading and structured programmes of study.

My learner has her own learning style and finds even constructive criticisms hard to accept which her former mentor identified, and I do agree, that it makes her stop learning and become disappointed and frustrated with herself which. Consequently, bruises her ego and self confidence (Appendix I). How I develop the right approach on my mentoring has posed a great challenge for me, especially on how I would express my statements when giving feedback and asking questions. I have to develop a plan and systematic approach so my learner could learn more effectively.

What I suggested to her as in week two (Appendix E), is that of reflection. In order to retain information, she can draw from her past experiences and knowledge, so she would be able to put it into practice. It was apparent that

she already has the knowledge and skills as she has done them on her workbook in the past and has looked after patients like this before. The rationale for reflective practice in healthcare is that it is a means of constructing or generating knowledge from particular incidents (Kolb, 1984). This is being supported by Ausubel et al.'s (1978) assimilation theory one of the cognitive theories of learning, which is based on the view that most meaningful cognitive learning takes place as a result of interaction between the knowledge the individual already processes, and new information that the individual encounters. The factor that most influence learning is what the learner already knows, which forms the basis of transfer of learning. This also increases retention of knowledge and information (Gopee, 2008).

My learner felt motivated to learn when I praised her and gave her good feedback with the things she has done well. This was evident when she said that she felt valued and part of the team. Behaviorist learning theorists believe that learning occurs through response to particular stimuli resulting in classical conditioning. Classical conditioning refers to change in behaviour through stimulus- response, whereby desirable responses to particular stimuli that is, newly learned behaviours are rewarded (Gopee, 2008). Behaviorist learning theory could be applied to my learner as she learns more when she was positively reinforced both by the feeling of a sense of achievement and by me as a mentor acknowledging or recognizing her newly developed competence.

The third (Appendix F) and fourth week (Appendix G) were the most difficult times for my learner as she struggled to acquire competence and skill to interpret blood gas results and relate this to the condition of the patient and

had trouble understanding the principle behind the ventilator modes. According to Curzon (2001), a skill signifies having expertise in an activity which has been developed as the result of training and/or experience, enabling the individual to perform the particular task with effectiveness and flexibility.

Although my learner has acquired the necessary skills and knowledge and had completed her competencies on these aspects, it took her a longer time than expected.

How I facilitate her learning has proven to be a challenge for me. I have assumed the role of a learning facilitator. I have utilised the principles of teaching a skill or competency based from Curzon (2001), that skill acquisition lessons require supervised, reinforced, and carefully spaced practice by learners. Thus, it is only by my learner’s experiencing and repeating the essential task and skill that she has discovered the cues of being competent on this field. I have assessed her regularly making sure that she has transferred her newly acquired skill to related situations with other patients. I have utilised teaching aids such as practice blood gases analysis, which is located in a resource folder. Having done this, my learner has acquired not only competence but self confidence as in time; she was able to interpret blood gas results with ease. By allowing her to manipulate settings in the ventilator, she was able to understand the rationale or the principles behind ventilator modes.

The unit provides a good environment for learning as it gives the opportunity to new staff and to the pre-registration students orientation period before

they start work in the ward. These orientation programme and induction packs are carefully organized by the teaching sister. My learner has had this orientation already, and it is, in fact, included in her competency book. One characteristic of a good learning environment is that which allows both the learner and the mentor to discuss their hopes and expectations with each other whilst in the placement (Gopee, 2008). I have at the beginning of the formative meeting with my learner asked her what she hopes to achieve whilst I am mentoring her, and that she said that she hopes that I will be able to sign her off her competencies, she wanted to get promoted, and she hopes to be prepared to do the intensive care course (Appendix A). In my part however, I have told her that because she has been in the unit for a considerable period I expect her to go in depth with the topics that we need to discuss, and that she also has the responsibility for her own learning. This is evident in the learning contract that we have both agreed to do (Appendix B).

Fretwell (1980) identified the key components of the ideal learning environment as anti-hierarchy, teamwork, negotiation, communication and availability of trained nurses for responding to students' questions. In my experience, our unit has all of these features as the unit culture has become flexible in dealing with learners through time. I have said this because learners, although they have a named mentor or belong to a team, can ask any senior staff about any problem that they will encounter whilst in the placement. This has fostered a sense of teamwork and indeed our unit has survived with a great teamwork no matter how busy a shift becomes. Although there are others, as would happen to every unit, who would not

bother to help, although there are but a few in the unit, most senior staff nurses in the entire workforce would gladly extend their help.

Conclusion:

The mentor experience has taught me the importance of developing as a learning facilitator and has made me aware of the skills involved. I have learned as Morton-Cooper and Palmer (2000) suggest, facilitative and effective learning is based on trust, respect and valuing the abilities of others.

Establishing rapport and creating a good working relationship with my learner was a big task, but I have resolved this by conveying feelings of empathy and really listening to her grievances. This made her felt valued and part of the team. Our expectations about each other were discussed and have proven to be useful. We have mutually agreed to follow the learning agreement, although we have slightly extended achieving these on the fifth week of my placement.

Her motivation in learning has mostly been driven by boosting her ego and her self confidence, which inspired her to learn, and I have done this by utilising the learning principles and both the cognitive and behavioral theories of learning. It is amazing to know that if you tapped within the learner’s learning style and the utilisation of a good learning environment would result to a productive mentoring experience. I also have made use of the characteristics and roles of mentors in forging effective learning.

Having all these in mind, I should work on improving my mentorship skills further, both by example and facilitation through attending mentorship

updates and reading evidence based literature on mentorship. Becoming a good role model so I can support learners in acquiring new skills, adapting to new behaviour and attitudes. I have learned new ways of giving out descriptive, non judgemental and constructive feedback to the learner (Neary, 2000). Becoming a mentor is a new and challenging experience and has opened my mind to emphasize learner autonomy and encourage the learner to be more active in learning, promoting more freedom of choice, which will make the learning experience as empowering as possible.

APPENDIX A

Formative assessment

I assessed her learning needs by asking what has she done so far with regards to the required study days that she has to attend as part of the requirements in her role as a staff nurse in accordance with the knowledge and skills framework. As she has already done all the study days I asked her about what she finds difficult in her practice that she feels she needed to work on.

She has identified areas to learn such as ventilator modes, what they do and their application to take care of the patient. She also would like to learn about continuous renal replacement therapy works and how to use different modes of therapy for a specific patient. She also feels that she needs more knowledge on cardiac output monitoring such as a pulmonary artery catheter and the LIDCO.

She has expressed that she needs to do her competency book signed off as she will need to complete them as one of the requirements for doing the intensive care course that she is planning to do soon. She is worried that she

is not progressing as expected in terms of her completing the competencies because she thinks that as it is always busy in the unit, it is difficult if not impossible to get senior staff to sign her book off. I reassured her that we will endeavor to do this, whilst I am still mentoring her.

Due to limited time-frame that I have to do with her whilst still on this course I feel that it is best to focus on specific areas such as the respiratory system as our patients are mostly ventilated, so then we can set goals and objectives on this area that is achievable ideally in four-week time.

APPENDIX B

LEARNINGCONTRACT

At the end of one week period the learner should be able to:

Demonstrate an in depth knowledge and understanding of the anatomy and physiology of the respiratory system and interpret arterial blood analysis results with regards to the following:

Outline the gross anatomy of the lungs.

Outline the mechanism of breathing

Describe the surfactant and its function.

Define compliance, resistance and work of breathing.

The relationship between ventilation and perfusion.

Describe intrapulmonary shunting

Define the following:

Partial pressure of a gas in blood.

Alveolar ventilation.

Pulmonary ventilation.

Dead space.

Vital capacity.

Functional residual capacity.

Peak flow.

APPENDIX B

At the end of the two-week period:

Describe the physiological – nervous and chemical control of respiration.

Describe the transport of oxygen in the blood:

Describe carbon dioxide transport in the body and why is it produced by the cell.

Articulate normal arterial blood gas values.

At the end of the three-week period:

Demonstrate skills to obtain and interpret ABG:

Sampling procedure

Processing procedure

Refer to Standard of Clinical Practice

Interpretation

Describe and outline the significance of abnormal blood gas results:

Respiratory acidosis

Respiratory alkalosis

Metabolic acidosis

Metabolic alkalosis

APPENDIX B

At the end of four-week period:

Define mechanical ventilation modes and terms, state when they are used:

SIMV

VC

PC

PS

CPAP

PEEP

Trigger sensitivity

Airway pressure

Tidal volumes (Vt)

Minute volume (Ve)

Define the following mechanical ventilation modes and terms, state when they are used:

Inverse ratio ventilation

Inspiratory pressure

FiO2/SaO2

APPENDIX C

Plan of action:

We will try to take patient who is ventilated and ideally with respiratory problems, so she would be able to link theory into practice.

We will try to work next to each other for support.

Read the Respiratory Resource File in the teaching room.

Utilize internet sites such as the RCN website, and also access to KA24 or Athens account to access for medical journals and articles.

Borrow books from the City University Library or from the intensive care unit library.

Meeting every week to evaluate progress and identify areas of improvement.

Revisit and review the workbook and the test that she has done on her respiratory study day and metabolic study day.

Read the Intensive Care Unit Standards and Policies Folder

APPENDIX D

WEEK ONE

Day 1

The learner picked a patient with respiratory failure who has now developed ventilator acquired pneumonia wit high oxygen requirements.

On questioning she is able to outline the gross anatomy of the respiratory system and she has showed me the illustration that she did for the respiratory study day about the anatomy of the respiratory system. She was able to define surfactant, where it is produced and what its role in ventilation and breathing. However she was not able to demonstrate in depth knowledge about resistance and compliance and how it affects breathing and how it improves ventilation and perfusion although she was able to define these terms. She finds it difficult to articulate both the definition and physiology of intrapulmonary shunting. She was able to define the terms partial pressure of gases, vital capacity, and functional residual capacity. She has limited knowledge of alveolar and pulmonary ventilation, and dead space.

I have advised her to read the respiratory resource file and find out this information. I also have photocopied an article from a journal. She has as well during her break browse through the internet to look for those terms she finds difficult to understand.

We have agreed that we will try and revisit these terms on the next day.

Day 2

For the purpose of continuity of care we picked the same patient. Still, she wasn't able to go through in depth discussion of alveolar and pulmonary shunting and how it applies to the patient. She was able to define dead space as a general term and was not able to differentiate between anatomical dead space and alveolar dead space. On questioning she said she has already read about these terms but she can not remember them as she is already tired. I suggested that she needs to write down and take notes in a piece of paper to help her remind herself what she has learned and read.

Evaluation:

The learner finds it hard to remember what she learned both in theory and in the clinical setting. She gets easily frustrated and disappointed with herself when these things were emphasized. She feels that her self confidence has plummeted and does not feel motivated to learn. I have considered this and reflected to change my approach when asking questions and when supporting her.

Although she has achieved these goals at a much later date, she has needed a lot of encouragement and support.

APPENDIX E

WEEK TWO

The learner chose to pick a patient with COPD who is still sedated and ventilated. We are working next to each other and on the first day I have lent her my book for her to read on the next topic that she needs to discuss. She has said that she could not find it in her book and through the internet. She finds it difficult to even do some research at home because of personal

reasons at times. I have reiterated that she needs to get balance between work and family life. This information would have been discussed in their respiratory study day and that she needs to revisit the workbook that she has done. I have explained that she needs to reflect on the actual patient's condition and she needs to relate the knowledge that she has learned into practice. In this way she might be able to remember what she has learned. I also have explained that she is right to ask my help if she thought that she could not find out any information about the topic. I have boost her confidence by always praising her on what she did good in the clinical setting and I was careful on giving feed back for the things that she needs to work on and improved.

On the second day, on questioning she was able to discuss about the physiological and chemical control of respiration and describe the transport of carbon dioxide and how it was produced in the body. She was able to relate her knowledge to the actual patient scenario that she has to deal with. She also has a good knowledge of the normal arterial blood gas values.

Evaluation:

With good motivation and the right approach the learner felt that she is being valued as a staff nurse therefore it brings the best out of her. I also felt that I have provided her with a good learning environment by redirecting her to where she could find this information. I have emphatised with her situation that it is difficult to balance work and personal life especially dividing time between family and her job that she couldn't find time to borrow books from the library. I have therefore lent her my book.

APPENDIX F

WEEK THREE:

This is a continuation of part of week two about blood gases. She has shown great technique in how to take sample and how to do the whole procedure. However she was not aware that there is a policy for taking blood gases in the Standards and Policy folder. I have instructed her to read on this as policies keep changing through time and she needs to regularly update herself with these.

She was not able to interpret the results of the blood gases and she gets confused with base excess and deficit in relation to the pH and pCO2. She also was not able to outline the significance of the results in relation to the patient status. I have advised her to revisit the workbook that she did in her metabolic and respiratory study day. We also have done a lot of practice on interpretation of blood gases that could be found in the folder in the teaching room. I taught her how to do this systematically but she finds it hard to comprehend.

She can not remember the causes of abnormal blood gases and finds it difficult to relate to the patient status. I have explained these to her and we agreed that she would study and read about these more.

Evaluation:

It took four weeks for the learner to understand fully the significance of the abnormal blood gas results and how it relates to the patient. This is also after I have constantly and regularly go through with her on how to interpret blood gas results and did a lot of practice every after she did blood gas for her patient. She now feels confident in doing it on her own.

APPENDIX G

WEEK FOUR:

It is now week four of our working together and the learner is more confident doing things on her own. This is a week that we will be discussing about ventilator modes and when it is used. On the first week I have already explained these modes to her as part of the introductory information and was not discussed in depth.

On questioning she is able to define the terms airway pressure, tidal volume and minute volume, and PEEP but finds it hard to explain the modes of ventilation such as SIMV, VC, PS, and CPAP. She has absolutely no knowledge of inverse ratio and what it does for the patient. I have again emphasised that she should read the respiratory resource file in the teaching room and I have photocopied an article on different ventilator modes and also from the intensive care book.

I also have reiterated that it