臨床實習（精神科護理）

Practicum (Mental Health Care)

Mentoring Nursing Students

Manual for Honorary Clinical Tutors and Continuing Clinical Assessment Assessors

香港公開大學
THE OPEN UNIVERSITY OF HONG KONG

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OF HONG KONG

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Contents

Introduction

Welcome to the OUHK! First of all, on behalf of the University, let me express our gratitude to you for kindly participating as an *Honorary Clinical Tutor* and/or a *Continuing Clinical Assessment Assessor* in the Mental Health Care Nursing programmes of the OUHK: Bachelor of Nursing with Honours in Mental Health Care, Higher Diploma in Nursing Studies (Mental Health Care) and Higher Diploma in Mental Health Nursing.

The purpose of this manual

As you shall see, the major role of an Honorary Clinical Tutor is to facilitate our nursing students' experience of and hands-on practice in various client-care clinical situations, while the major role of an Honorary Continuing Clinical Assessment Assessor is to assess their clinical competence. This manual is a self-study learning module that helps you prepare for your mentoring and assessment roles during the clinical component of the Mental Health Care Nursing programmes: the Practicum.

The manual draws on adult learning theory to provide some theoretical explanations of the mentoring and process and clinical assessment. It also outlines key mentoring and clinical assessment skills, and suggests management techniques for giving feedback to your students and for evaluating the clinical performance of your students.

More specifically, the manual provides:

- important background information on the OUHK Mental Health Care Nursing programmes, our students and the clinical component: the practicum
- some discussion of the mentoring process
- information on learning and teaching theories to help you better understand the mentoring process
- assessment and evaluation guidelines for the practicum.

Learning outcomes of this manual

It is expected that on completion of this self-study learning module, you will able to:

1 *Describe* the background of OUHK nursing students and the model of clinical placement.

2 *Explain* a mentor's roles and the characteristics of effective mentoring.

3 *Apply* principles of teaching and learning to the mentoring process.

4 *Conduct* an evaluation of your nursing student's clinical performance and provide assessment feedback on her or his performance in a clinical context.

Using this training manual

This manual takes an *active* approach to learning. As you work through it, you will be asked to pause and to complete some activities and self-tests. Activities ask you to apply your background knowledge and the professional expertise that you have gained from your daily work to the topics discussed. Self-tests help you check your understanding of the topics. You will find feedback on activities and self-tests at the end of the manual. This is intended to help you focus your ideas; however, please try to give your own responses to activities and self-tests *before* you look at my ideas.

It is OUHK policy that a course is usually presented entirely in English or in Chinese. You will note that although the course materials for students are presented in Chinese, this training manual is presented in English. This is because most of the materials and research that deal with nursing mentoring have been written in English, and we understand that you have no problem receiving information in that language.

As a mentor you will be able to best judge what language should be used in practical situations with your students. Therefore, feel free to use Chinese during the actual mentoring process.

In this manual, you are also given a number of supporting readings. You can refer to these readings to strengthen your theoretical understanding of the topics in this manual. Please refer to this manual throughout your mentoring process during the practicum.

The content of this manual is the equivalent of a four-day face-to-face workshop. Please take your time working through the manual. If you have any questions or need any extra information, please contact:

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Some background information on the OUHK's nursing programmes and students

Before undertaking the role of an Honorary Clinical Tutor and/or a Continuing Clinical Assessment Assessors, it is essential to have some basic understanding of:

- the Mental Health Care Nursing programmes;
- the background of our nursing students; and
- the model of clinical placement.

Let me take you through each of these issues briefly.

Mental Health Care Nursing programmes

The Open University of Hong Kong first launched a Higher Diploma Programme in 2003 in order to provide Enrolled Nurses (Psychiatric) with an opportunity to upgrade themselves to Registered Nurses (Psychiatric). On completion of 90 credits, graduates are awarded a Higher Diploma in Mental Health Nursing and are eligible to register with the Nursing Council of Hong Kong as a Registered Nurse (Psychiatric).

In 2005, the OUHK launched a 4-year full-time undergraduate Mental Health Care Nursing Programme. On completion of 160 credits, graduates are awarded a Bachelor in Nursing with Honours in Mental Health Care and are eligible to register with the Nursing Council of Hong Kong as a Registered Nurse (Psychiatric). With the introduction of 3-3-4 education system, the Bachelor of Nursing with Honours (Mental Health Care) is changed to 200 credits, 5-year full-time study, effective from 2012/13 academic year onward.

In 2010, the OUHK launched a 2-year full-time Higher Diploma in Nursing Studies (Mental Health Care) programme. On completion of 90 credits, graduates are awarded a Higher Diploma in Nursing Studies (Mental Health Care) and are eligible to enroll with the Nursing Council of Hong Kong as Enrolled Nurse (Psychiatric).

Nursing Programme	**Professional Qualification issued by the Nursing Council of Hong Kong**
Bachelor of Nursing with Honours in Mental Health Care Programme - A pre-registration nursing programme (Psychiatric)	Graduates are eligible to register as Registered Nurse (Psychiatric)
Higher Diploma in Nursing Studies (Mental Health Care) Programme - A pre-enrollment nursing programme (Psychiatric)	Graduates are eligible to register as Enrolled Nurse (Psychiatric)
Higher Diploma in Mental Health Nursing Programme - A conversion pre-registration nursing programme for Enrolled Nurse (Psychiatric)	Graduates are eligible to register as Registered Nurse (Psychiatric)

Underlying philosophies of the programmes

The *Mental Health Care Nursing* programmes are underpinned by the beliefs that:

- A *human* is a *holistic* being who reacts constantly to his or her changing environment as a unified whole in his or her own unique way.

- *Health* is a *dynamic* state of well-being of physical, emotional and social functions. Any alteration in the state of health affects the total being's adjustment to and of the environment.

- *Nursing* is a profession that involves promoting health, preventing illness, and facilitating coping with or adapting to changes in health status. Professional nursing involves the application of biological, behavioural and nursing knowledge in a systematic and problem-solving way and within the context of an interpersonal caring relationship to promote human sustenance, comfort and well-being. Safe, competent and quality nursing practice is underpinned by demonstrable competence (knowledge and skills), understanding and caring, which much be attained by each nurse and which are independent of the time taken to attain them.

- *Mental health* is a dynamic process in which an individual's biopsychosocial and cultural dimensions interact with each other and with the environment. It is a state in which the individual realizes his or her own abilities and capabilities, can cope with the normal stresses of life, pursues life goals and fulfills one's own life purpose.

- *Psychiatric nursing* is the promotion of mental health, prevention of psychiatric illnesses, and provision of holistic care to clients

with bio-psycho-social problems both within the hospital and in the community. It involves the application of biological, behavioural and nursing knowledge in a systematic and problem-solving manner and within the context of an interpersonal caring relationship to promote human sustenance, comfort and well-being.

- *Education* is a learner-centred process of inquiry and discovery involving learners, learning resources and facilitators in dynamic relationships leading to change and growth in each individual.

- *Adult learners* have the capability of increased independence and self-direction to progress through a programme of learning.

Aims of the programmes

The OUHK Mental Health Care Nursing Programmes aim to equip the students with the essential academic knowledge, professional skills, and clinical problem-solving capability to become Registered Nurses (Psychiatric) and Enrolled Nurses (Psychiatric) in Hong Kong.

On completion of the programmes, students will be able to:

Programme outcomes

Upon completion of the programmes, students should be able to:

- *Conceptualize* mental health as holistic and multidimensional;

- *Recognize* clients as biological, behavioural and developmental beings;

- *Identify* the uniqueness of clients and the distinctiveness of their mental health needs and/or problems;

- *Promote* and *maintain* mental health;

- *Apply* nursing knowledge and clinical skills in formulating holistic mental care plans and implementing comprehensive psychiatric nursing interventions to enhance the client's positive mental health;

- *Evaluate* critically the implemented interventions, and *conduct* appropriate and constructive modifications;

- *Determine* their roles and responsibilities in a multidisciplinary health care team;

- *Participate* continuously in personal and professional development.

If you would like further information on the OUHK nursing Programmes, please go to the following website:

http://www.ouhk.edu.hk/~sctwww/nursing/index.htm

Programme structure

As mentioned earlier, the Open University of Hong Kong is offering three Mental Health Care Nursing Programmes.

The Bachelor of Nursing with Honours in Mental Health Care is a 200-credit (2012/13 academic year and subsequent intakes) /160-credit (2011/12 academic year or before intakes) full-time face-to-face programme. The programme offers pre-service professional nursing education in mental health care to students who, upon graduation, will be able to function safely and competently as a Registered Nurse (Psychiatric) in Hong Kong.

The Higher Diploma in Nursing Studies (Mental Health Care) is a 90-credit full-time face-to-face programme. The programme offers pre-service professional nursing education in mental health care to students who, upon graduation, will be able perform safely and competently as an Enrolled Nurse (Psychiatric) in Hong Kong.

The Higher Diploma in Mental Health Nursing is a 90-credit distance learning programme to provide Enrolled Nurses (Psychiatric) an opportunity to upgrade to the Registered Nurse (Psychiatric).

All programmes are composed of theoretical input and practicum. Details of the programme structure are listed in the following pages.

Bachelor of Nursing with Honours in Mental Health Care programme (200 credits) (from 2012/13 academic year)

NURS S101F	Human Anatomy and Physiology 人體解剖生理學	10 credits
NURS S103F	Fundamental Nursing Practice 基礎護理實務	10 credits
BSCI A121F	*Behavioural Sciences: Principles and Application* 行為科學：原則與應用	10 credits
NURS S221F	*Behavioural and Social Sciences for Nurses* 行為及社會科學 - 護士科目	5 credits
NURS S211F	*Health Assessment* 健康評估	5 credits
NURS S208F	*Health Promotion* 健康促進	5 credits
NURS S313F	*Nursing Research* 護理科研	5 credits
NURS S309CF	*Chinese and Alternative Medicinal Nursing* 中醫及另類醫療護理學	5 credits
NURS S310F	*Professional Nursing Practice* 專業護理實務	10 credits
NURS S307F	*Nursing Management* 護理管理學	5 credits
NURS S311F	*Primary Health Care* 基層健康護理	5 credits
NURS S401F	*Nursing Project* 護理學專題研究	10 credits
NURS S114F	*Nursing Therapeutics in Psychiatry I* 治療性精神護理學（一）	10 credits

NURS S214F	*Nursing Therapeutics in Psychiatry II* 治療性精神護理學（二）	10 credits
NURS S314F	*Nursing Therapeutics in Psychiatry III* 治療性精神護理學（三）	5 credits
NURS S228F	*Specialty Nursing (Mental Health Care)* 專科護理學（精神健康護理）	10 credits
NURS S414F	*Integrated Nursing (Mental Health Care)* 綜合護理學（精神健康護理）	10 credits
NURS S109F	*Clinical Practicum I (Mental Health Care)* 實習（精神健康護理）（一）	5 credits
NURS S209F	*Clinical Practicum II (Mental Health Care)* 實習（精神健康護理）（二）	5 credits
NURS S219F	*Clinical Practicum III (Mental Health Care)* 實習（精神健康護理）（三）	10 credits
NURS S319F	*Clinical Practicum IV (Mental Health Care)* 實習（精神健康護理）（四）	10 credits
NURS S419F	*Clinical Practicum V (Mental Health Care)* 實習（精神健康護理）（五）	10 credits
	General Education I 通識科目 (一)	5 credits
	ENGL E101F Effective Use of English I	5 credits
	General Education II 通識科目 (二)	5 credits
	ENGL E102F Effective Use of English II	5 credits
	General Education III 通識科目 (三)	5 credits
	General Education IV 通識科目 (四)	5 credits

Bachelor of Nursing with Honours in Mental Health Care programme (160 credits)

NURS S100CF	Fundamentals of Nursing 基礎護理學	5 credits
NURS S101CF	Life Sciences 基礎生命科學	10 credits
PSYC A124CF	Foundation of Social Sciences: Psychology 社會科學基礎課程：心理學	5 credits
SOCI A123CF	Foundation of Social Sciences: Sociology 社會科學基礎課程：社會學	5 credits
NURS S221F	Behavioural and Social Sciences for Nurses 行為及社會科學 - 護士科目	5 credits
NURS S202CF	Behavioural Sciences for Nurses 行為科學 (護士科目)	10 credits
NURS S208CF	Health Promotion 健康促進	5 credits
NURS S301F	Comparative Studies in Health 比較衛生學	10 credits
NURS S305F	Health Assessment & Primary Health Care 健康評估及基層健康護理	10 credits

NURS S307F	Nursing Management 護理管理學	5 credits
NURS S308CF	Perspectives in Professional Nursing I 護理專業透視（一）	5 credits
NURS S309CF	Perspectives in Professional Nursing II 護理專業透視（二）	5 credits
NURS S310F	Professional Nursing Practice 專業護理實務	10 credits
NURS S401F	Nursing Project 護理學專題研究	10 credits
NURS S114CF	Nursing Therapeutics in Psychiatry I 治療性精神護理學【一】	10 credits
NURS S214CF	Nursing Therapeutics in Psychiatry II 治療性精神護理學【二】	10 credits
NURS S204CF	Mental Health 精神健康	5 credits
NURS S133CF	Practicum I (Mental Health Care) 臨床實習（精神科護理）（一）	5 credits
NURS S233CF	Practicum II (Mental Health Care) 臨床實習（精神科護理）（二）	10 credits
NURS S333CF	Practicum III (Mental Health Care) 臨床實習（精科護理）（三）	10 credits
NURS S424CF	Practicum IV (Mental Health Care) 臨床實習（精神科護理）（四）	15 credits

Higher Diploma in Nursing Studies (Mental Health Care) programme

NURS S102CF	Life Sciences 人類生物科學	10 credits
NURS S150CF	Essential Nursing Practice (I) 護理實務概論 [一]	10 credits
NURS S205CF	Language and Communication in Health 保健語言及傳訊	5 credits
NURS S206CF	Integrated Studies in Health 綜合保健教育	5 credits
NURS S208CF	Health Promotion 健康促進	5 credits
NURS S250CF	Essential Nursing Practice (II) 護理實務概論 (二)	5 credits
NURS S161CF	Clinical Nursing [Mental Health Care] (I) 臨床護理學【精神科】(一)	10 credits
NURS S261CF	Clinical Nursing [Mental Health Care] (II) 臨床護理學【精神科】(二)	5 credits
NURS S262CF	Clinical Nursing [Mental Health Care] (III) 臨床護理學【精神科】(三)	5 credits
NURS S163CF	Practicum (Mental Health Care) 臨床實習【精神科】(一)	10 credits
NURS S263CF	Practicum (Mental Health Care) 臨床實習【精神科】(二)	10 credits
NURS S363CF	Practicum (Mental Health Care) 臨床實習【精神科】(三)	10 credits

Higher Diploma in Mental Health Nursing programme

NURS S101C	Life Sciences 精神健康	10 credits
NURS S104C	Mental Health 精神健康	5 credits
NURS S114C	Nursing Therapeutics in Psychiatry I 治療性精神護理學【一】	10 credits
NURS S202C	Behavioural Sciences of Nurses 行為科學【護士科目】	10 credits
NURS S208C	Health Promotion 健康促進	5 credits
NURS S214C	Nursing Therapeutics in Psychiatry II 治療性精神護理學【二】	10 credits
NURS S300C	Perspectives in Professional Nursing 護理專業透視	10 credits
NURS S223C	Practicum (Mental Health Care) 臨床實習【精神健康護理】	30 credits

Practicum

Students are placed in the University's approved training grounds for Registered Nurse (Psychiatric) and Enrolled Nurse (Psychiatric) to go through the minimum clinical placement hours in a variety of clinical and health care settings as stipulated by the Nursing Council of Hong Kong. The aims and details of the required clinical exposures are:

- To provide an opportunity for students to integrate and apply theoretical and technical nursing knowledge in different clinical situations.

- To develop students' clinical competence across the spectrum of nursing practice as stipulated in the Nursing Council of Hong Kong's Syllabus of Subjects and Requirements for the Preparation of Registered Nurse (Psychiatric) / Enrolled Nurse (Psychiatric).

The clinical component of the *Bachelor of Nursing with Honours in Mental Health Care Programme* (200 credits) (starting from 2012/13 academic year):

Clinical Placement	**Weeks**	**Hours**
Acute psychiatric nursing	8	352
Rehabilitation psychiatric nursing	8	352
Community psychiatric nursing and mental health outreaching services	8	352
Subacute and long-stay psychiatric nursing	3	132
Psychogeriatric nursing	4	176
Learning disability nursing	2	88
Child and adolescent nursing	2	88
Substance abuse nursing	2	88
Medical and surgical nursing	4	176
Patient Social Centre/Psychiatric out-patient department	2	88

The clinical component of the *Bachelor of Nursing with Honours in Mental Health Care Programme* (160 credits):

Clinical Placement	**Weeks**	**Hours**
Acute psychiatric nursing	10	440
Rehabilitation psychiatric nursing	10	440
Community psychiatric nursing and mental health outreaching services	10	440
Subacute and long-stay psychiatric nursing	4	176
Psychogeriatric nursing	4	176
Learning disability nursing	2	88
Child and adolescent nursing	2	88
Substance abuse nursing	2	88
Medical and surgical nursing	4	176
Others	2	88

The clinical component of the *Higher Diploma in Nursing Studies (Mental Health Care) Programme*

Clinical Placement	**Weeks**	**Hours**
Acute/Subacute psychiatric nursing	8	352
Rehabilitation/long-stay psychiatric nursing	8	352
Community psychiatric nursing and mental health outreaching services	6	264
Psychogeriatric nursing	4	176
Learning disability nursing	2	88
Child and adolescent nursing	2	88
Substance abuse nursing	2	88
Medical and surgical nursing	3	132
NGO for psychiatric rehabilitation in community settings	2	88

The clinical component of the *Higher Diploma in Mental Health Nursing Programme*

Clinical Placement	**Weeks**	**Hours**
Acute psychiatric nursing	7	308
Rehabilitation psychiatric nursing	7	308
Community psychiatric nursing and mental health outreaching services	7	308
Psychogeriatric nursing	3	132
Learning disability nursing	2	88
Child and adolescent nursing	2	88
Substance abuse nursing	1	44
Medical and surgical nursing	3	132

Students, as nurse learners, are expected to integrate into the work patterns of a variety of clinical areas, which includes participation in morning, evening and night shifts. The allocation of students to various clinical areas for placement is jointly coordinated by academics from the Open University of Hong Kong and administrators of the approved clinical education centres.

Honorary Clinical Tutors (HCTs)

Students placed in these clinical areas should be closely supervised and coached by Honorary Clinical Tutors (HCTs). HCTs are qualified clinical staff that must have at least two years' post-registration clinical experience and have gone through a course of training in clinical mentoring. The HCTs should, in accordance with the OUHK's clinical learning outcomes that are set up in every ward of the clinical training grounds, select clinical learning opportunities for students and coach and supervise students throughout their placement. To ensure students have adequate clinical supervision and exposure during their placement, the student-HCT ratio is expected to be set at 2–3:1.

Student assessment and examination

Assessment and examination of the clinical placement are based on the concept of *clinical competency*. The formative clinical competency of each student is continuously assessed by the HCTs who supervise students' satisfactory completion of the OUHK *Clinical Learning Outcome Records*.

Summative clinical competency of each student is determined by obtaining a pass in *Continuing Clinical Assessment (CCA)* of the following three natures of psychiatric nursing:

1 Acute psychiatric setting/Subacute psychiatric setting

2 Rehabilitation psychiatric setting/long-stay psychiatric setting

3 Community psychiatric nursing/mental health outreaching services

These three types of clinical assessments are to be conducted by the OUHK-appointed CCA Assessors in a clinical context. Assessment of these three types of continuing clinical assessment should normally be completed within the period of clinical placement. Students are permitted to have two more attempts at each type of clinical assessment should the student fail the initial attempt. Students are required to retake the Practicum should they fail to achieve a Pass after two further attempts.

To assure the quality and standard of clinical placement, academics and external course examiners / external examiners of the OUHK will closely monitor the performance of students, HCTs and CCA Assessors. The core components of the monitoring mechanism are written performance appraisals, clinical education committees (which consist of staff of the OUHK, HCTs and CCA Assessors), clinical consultative meetings, and regular clinical visits by OUHK staff. The monitoring system also provides useful feedback to the concerned personnel.

Mentoring

As mentioned earlier, your fundamental contribution to the mental health nursing programmes is to participate as an Honorary Clinical Tutor in the practicum component. Being an Honorary Clinical Tutor of the Open University of Hong Kong involves acting as a mentor. This section of the training manual describes the mentoring process and gives you some guidelines to become an effective mentor.

What is a mentor?

The term 'mentor' is said to originate from Greek mythology. In Homer's *Odyssey*, Mentor was a wise and trusted friend of Odysseus who had responsibility for rearing *Odysseus'* son, *Telemachus* in his absence (Bracken and Davis 1989; Donovan 1990; Barlow 1991). The concept of mentor, therefore, originally implied a 'father figure' relationship and in many ways suggested that a mentor was an older, wiser person who took on the responsibility for a younger person's learning and development. A mentor was more than a guardian (Oliver and Enders, 1994; Andrews and Wallis 1999).

However, authors such as Darling (1984), Oliver and Endersby (1994) and Morton-Cooper and Palmer (2000) point out that the concept of a mentor 'guiding the inexperienced' is a classical one. These authors further argue that the mentoring role can be defined from a more contemporary perspective. According to them, mentoring:

- is concerned with the building of a *dynamic relationship* in which personal characteristics, qualities, philosophies and priorities interact to influence the direction, duration and resulting partnership;
- consists of *shared*, *encouraging* and *supportive* elements and is based on mutual attraction and common values, which, in turn, facilitates personal development and professional socialization;
- involves self-development, self-directedness, mutual understanding and negotiation;
- requires vital ingredients, such as attraction, action and effect;
- presents the mentor as an exemplar, counsellor, teacher, sponsor, developer of skills, intellect and host.

Let's stop and think about why mentoring is used for professional training such as clinical nursing instruction.

Activity 1

1 What benefits do you think a mentoring situation might bring to:
the mentor, (e.g. the supervising nurse)?

the mentee (e.g. the nursing student)?

the organization (e.g. the hospital)?

2 What kinds of problem of difficulty might arise in a mentoring situation?

After you've given your response, compare your ideas with my ideas in the feedback section.

Mentoring in nursing and health care

The application of the concept of mentoring to the nursing and health care discipline appeared on the English National Board (ENB) in 1987 (Andrews and Wallis 1999). The Board defines mentors as appropriately qualified and experienced first-level nurses who by *example* and *facilitation* guide, assist and support students in learning new skills, adopting new behaviours and acquiring new attitudes. Hence, mentors are there to assist, befriend, guide, advise and counsel students (ENB 1988).

Following in a similar vein, authors such as Morton-Cooper and Palmer (2000) suggest that a mentor is:

- *an adviser* who builds the mentee's self-image and confidence by offering career and social advice;
- *a coach* who sets mutual guidelines for instruction in which mutual exchange of feedback is allowed;
- *a counsellor* who facilitates the mentee's self-development and gives psychological support and who acts as a listener and sounding-board to facilitate self-awareness and encourage independence;
- *a networker* who socializes the mentee into the values and customs of the mentor's profession;
- *a role model* who provides an observable image for imitation and demonstrates skills and qualities for emulation;
- *a sponsor* who facilitates entry to organizational and professional culture and makes recommendations for advancement;
- *a teacher* who shares knowledge through experience and inquiry, facilitates learning opportunities focused on individual needs and learning styles, and assists in fulfilling the mentee's intellectual and practical potential;
- *a resource facilitator* who shares experiences and information, and provides access to resources.

Mentors are also skilled nurses who have the most recent clinical practice-related information. They help nursing students obtain clinical knowledge, build skills, develop judgements, increase clinical competence, ease transition to the work environment, and orientate themselves to the nursing profession (Ferguson 1996).

By now, you should have some basic understanding of mentoring and how it applies to nursing. Now, you may want to look at some literature to deepen your understanding of the mentoring relationship. The first reading in your reader (Jarvis 1995) argues that mentoring is a one-to-one learning relationship that must involve *dialogue*. The reading also suggests that the mentoring relationship allows both parties to *reflect* on nursing practice and to use practical knowledge and expertise to solve *practice-based problems*. Please read the article if you'd like to further explore these ideas.

Reading 1

Jarvis, P. (1995). Towards a philosophical understanding of mentoring. *Nurse Education Today*, *15*, 414–419.

The process of mentoring

Let's turn now to look at some issues that relate to the mentoring process. We first see that mentoring is a process that consists of different *stages*. We then explore some aspects of the *mentoring relationship*.

Stages in the mentoring process

It is argued that the process of mentoring occurs in various stages. For example, Morton-Cooper and Palmer (2000) suggest that the process of mentoring consists of three different stages:

- *Initiation* or a getting-to-know-each-other stage. In this stage, the mentee is dependent on and relies on the mentor.
- *Development*, in which both parties develop mutual trust and closeness. In this stage, the mentee is more readily able to move to a solid partnership in which mutual reliance and support are evident. At this point, mentees begin to make informed decisions and become more confident to go it alone.
- *Termination*. This stage signals a maturing of the relationship, in which the mentee acts on her or his own initiative and becomes independent.

It has also been suggested that mentoring begins with a 'settling in' period, in which the mentor and mentee assess each other and then proceed to a more open and relaxed state of friendship and trust (Earnshaw 1995).

Andrews and Wallis (1999) further propose a four-stage model of mentoring:

- *Selection*: The mentor and mentee choose each other and define the relationship.
- *Protection*: The peak period of relationship in which the mentee takes a subordinate apprentice role to work under supervision and instruction.
- *Breaking up*: This occurs anytime, ranging from weeks to months after the relationship has been established. In the breaking up stage, the mentee becomes more independent and develops a more equal relationship, moving from apprentice to colleague under less supervision.
- *Establishment of a lasting friendship*: Both parties become friends after the mentee finishes practice placement.

In addition, Morton-Cooper and Palmer (2000) remark that the mentoring relationship changes during different stages. According to them, during the initial stage, mentees are more dependent on the mentors' support; in the later stages, a more dynamic, reciprocal and emotionally intense partnership develops, in which the mentees have better understanding of their needs and are able to be self-selecting about the help they require. In the later stages, mentees are able to make informed decisions about personal development; mentors attempt to facilitate personal growth and career development and to guide mentees through the clinical, educational, social and political networks of the working culture.

Relationships in the mentoring process

There are two important components inherent in the mentoring relationship — *cultivating* and *enabling*. Hence, a mentoring relationship:

- involves personal, functional and relational aspects, in which purposes and helper functions are mutually set;
- offers support and facilitates guidance;
- assists in empowering mentees within the working environment; and
- enables mentees to use and discover their own talents and unique contributions.

The process of mentoring calls for an intense involvement between nursing students and skilled nurses in a specific clinical context. Palmer (in Oliver and Endersby 1994) thus argues that there are three different types of mentoring relationship.

Relationship	Nature of the relationship	Example situations
Formal mentoring An artificial relationship created for specific purposes that are essentially work related.	Programmes are for: specific purposes, functions and aims; selected individuals; assigned mentors; forced matching of mentors; possibly for material incentives for mentors.	Guide nurse or preceptor for new staff
Informal mentoring A naturally chosen relationship for the purposes and functions as determined by the individuals involved. An enabling relationship in professional, personal and emotional terms.	No defined programmes. Fewer specific purposes and functions. Self-selection by individuals; shared wish to work together; no explicit gains for mentor.	Informal role models, e.g. senior nurses
Pseudo mentoring Quasi/partial mentoring — created for a specific purpose that is essentially work related. Induction/ orientation programmes.	Mentoring approaches in appearance only as suggested in academic involvement with thesis preparation. Specific tasks, organizational issues of short duration.	Not applicable in clinical context

Activity 2

Think about your professional nursing career so far. Which of the above mentoring relationships have you experienced so far? Did you experience relationships that were empowering, mutually respectful, supportive and developmental? What made these relationships positive or negative?

At this stage, you might like to have a look at Reading 2 (Andrews and Wallis 1999). This article is an overview of literature that has been written on mentoring in nursing and should serve to consolidate your understanding of what we have discussed so far. The article makes the point that there are several models of mentoring in nursing and no single model is necessarily the best. However, it also notes that the process of mentoring is staged and that mentoring is based on successful relationships. Page 204 of the reading describes a study (Darling 1984) that looked into the characteristics of good mentors. Do you agree that these qualities are important?

Reading 2

Andrews, M., & Wallis, M. (1999). Mentorship in nursing: a literature review. *Journal of Advanced Nursing*, *29*(1), 201–207.

Self-test 1

Skim Reading 2. Locate the section that describes effective mentoring. Try to identify the prerequisites, requirements and roles of effective mentors and list them in the table below.

Characteristics of effective mentors

Prerequisites	
Requirements	
Roles	

Students' perceptions of the mentoring process

Our discussion so far has tended to centre only on what effective mentoring should be without addressing the issue from *students' perspectives*. Let's now turn to look at some studies that unfold students' perceptions of effective mentoring.

Using a qualitative approach for exploring students' attitudes to the student-mentor relationship, Spouse (1996) identified five aspects that students most valued in the relationship. These aspects were:

- *Befriending*: This involved the mentor initiating social interactions to promote trust, warmth and interest; being concerned with the student's welfare and regarding the student as a person through sharing; encouraging the student to identify weaknesses and to mature both professionally and personally.
- *Planning*: This involved the mentor providing a menu of experiences, helping a student identify relevant learning needs, and organizing suitable nursing care activities to observe or practise.
- *Collaborating*: This involved the mentor treating the student as a partner, sharing skills and knowledge, and delegating appropriate care to the student.

- *Coaching*: This involved the mentor providing specific guidance related to the skills practised, giving challenges, and evaluating the student.

- *Reflection*: This involved the mentor clarifying the student's thinking, engaging in dialogue, and helping the student to locate resources for self-learning if needed.

If you'd like to know more about what students value from the mentoring relationship, please turn to the following reading, which reports Spouse's study in full.

Reading 3

Spouse, J. (1996). The effective mentor: A model for student-centred learning. *Nursing Times*, *92*(13), 32–35.

Suen and Chow (2001) also conducted a similar study to investigate students' perceptions of the effectiveness of mentors in *Hong Kong*. These authors found that a mentor's effectiveness was perceived according to how well they performed the following roles:

- *Assisting*: organizing learning opportunities and facilitating learning in accordance with different learning objectives and levels of students.

- *Guiding*: developing students to become 'future nurses'.

- *Advising*: evaluating and giving feedback, and assisting in reflective learning rather than just task-oriented learning.

- *Befriending*: being friendly and warm, and having mutual respect.

- *Counselling:* sharing personal experiences and showing concern to learning needs.

Activity 3

How do you think you can facilitate these roles as you mentor? Briefly list some strategies that you can take to assist, guide, advise, befriend and counsel your mentee.

The following reading further explains what your mentoring roles entail. You might like to skim through the 'Results' section at the end of the reading to see how Hong Kong students perceived their mentoring experiences.

Reading 4

Suen, L. K. P., & Chow, F. L. W. (2001). Students' perceptions of the effectiveness of mentors in an undergraduate nursing programme in Hong Kong. *Journal of Advanced Nursing*, *36*(4), 505–511.

Clinical teaching and supervision

By now you should be familiar with your mentoring role and have a better understanding of the characteristics of a good mentor. Have you noticed that the terms 'clinical teaching' and 'supervision' are often mentioned in the discussions of mentoring? Indeed, these terms are sometimes inextricably linked with mentoring and are considered essential elements in the mentoring process. So, let's now turn our discussion to these two issues.

Clinical teaching

What is meant by clinical teaching? According to White and Ewan (1991), clinical teaching involves:

- transferring basic principles into clinical performance;
- reinforcing the learned material;
- preparing students to integrate previously acquired knowledge with performance-oriented skills and competencies;
- orchestrating relevant activities for students to experience; and
- searching for ways to build nursing theory from the rich texture of clinical practice.

White and Ewan also argue that someone who is engaged in clinical teaching takes up several roles. A clinical teacher is a *facilitator* who helps students develop skills in critical thinking and problem-solving, self-directed learning, and self-evaluation. She or he is also a *designer* who provides students with learning tasks within the complexity of the clinical setting and plans learning strategies to help students reflect on specific thought patterns or practices. She or he is a *role model* who demonstrates both technical and theoretical proficiency in client care. And lastly, she or he is an *assessor* who evaluates students and assesses learning needs and performance.

The clinical teacher's roles may be better understood by looking at what the teacher does at different stages in the clinical teaching process. The following diagram summarizes these roles at different stages.

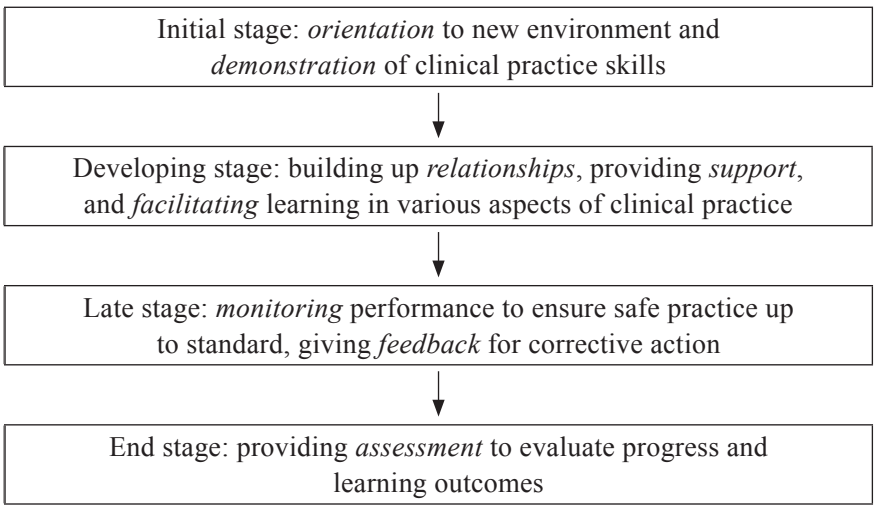

Figure 1 A mentor's roles during the different stages of the mentoring relationship

(Source: White and Ewan 1991)

Activity 4

What do you think makes a good clinical teacher? List the skills and attributes that you think good clinical teachers should have. Then compare your list with those in the feedback at the end of the unit.

How about students' perceptions of effective clinical teaching? In studying students' perceptions of good and bad clinical teaching, Metcalfe and Marthura (1995) found that students want clinical teachers who:

- increase responsibility
- regularly observe their work
- give opportunities to practise technical and problem-solving skills
- give clear and ready answers to problems
- give patients first priority
- are enthusiastic
- are ethical and caring health professionals.

Nahas, Nour and Al-Nobani (1999) also found that students valued clinical teachers' professional competence, relationship with students, and personal qualities.

Hong Kong students' perceptions of good clinical teaching are examined in the next reading from your reader. The reading compares educators' perceptions of good teaching practice with students' perceptions. The study also contrasts junior students' perceptions with senior students'

perceptions. For summaries of the study's findings, look at Tables 2, 3, 4 and 5 in the Findings section. Page 1257 notes that there was some agreement between teachers and students about what constituted good teaching. This page of the article lists six behaviours that teachers and students agreed contributed to effective clinical teaching.

Reading 5

Li, M. K. (1997). Perceptions of effective clinical teaching behaviors in a hospital-based nurse training programme. *Journal of Advanced Nursing*, *26*, 1252–1261.

Now let's turn to issues that relate to clinical supervision.

Clinical supervision

What is clinical supervision? Butterworth and Fraugier (1995) define clinical supervision as an interpersonal process in which the skilled practitioner helps a less skilled or experienced practitioner to achieve professional abilities appropriate to his or her role and, at the same time, offers counsel and support. The UKCC (1995) defines clinical supervision as a process based on a clinically focused professional relationship between the supervisee engaged in clinical practice and a clinical supervisor. The clinical supervisor applies clinical knowledge and experience to help the supervisee develop his or her practice, knowledge and values. According to Bond and Holland (1998), clinical supervision is regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop high-quality practice through focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of her practice. This reflection is facilitated by one or more experienced colleagues who has expertise in facilitation.

The Hong Kong Nursing Section of the Hospital Authority has issued a position statement on clinical supervision, which defines it and puts it into a wider professional context. This position statement is given in the next short reading. Please turn to Reading 6 now.

Reading 6

Nursing Section, HAHO. (1998). *Position statement on clinical supervision nursing*.

According to Power (1999), clinical supervision occurs in three different phases:

- *Establishment phase*: student and teacher gather information on each other.

- *Middle/game-playing phase*: student and teacher make supervision contract, formally or informally, and set date, time, venue, frequency, duration, responsibility and content of interactions.

- *Ending phase*: teacher provides debriefing and feedback, facilitating reflection, and both parties keep a brief record on date, time, names, brief issues raised, time for next session.

Having looked at some definitions of clinical supervision, let's now discuss its functions and characteristics.

Procter (1992) identifies three core functions of clinical supervision:

- formative functions: i.e. the processes of *learning* and developing the supervisee's skills, understanding and abilities

- restorative functions: i.e. the *supportive* and helpful function of supervision

- normative functions: i.e. overseeing the quality of *professional* practice.

What does a good clinical supervisor need to do? Effective clinical supervision involves certain key activities (Power 1999). First, the supervisor needs to give *specific ideas* and *directions* to the student about intervention and use role-play to demonstrate the intended practice. Then the supervisor provides *feedback* on performance. At all times, the supervisor should try to create *a warm and supportive relationship* and *promote autonomy* and encourage the use of acquired skills. A supervisor needs to be *competent* and offer guidance with reinforcement. She or he also needs to *allow supervisees to observe* clinical practice and provide them with relevant *literature*.

Effective clinical supervision also demands that the clinical supervisor shoulder the following responsibilities and:

- be *available* at the specified time and place without interruption

- keep the *timing* of the session

- ensure the supervisee is *informed* of any change in meeting

- maintain *focus* on the practice

- maintain *confidentiality*

- *listen* carefully to the supervisee

- promote *professional development*

- pay and maintain attention to challenge any inappropriate, negligent or dangerous nursing practices of supervisees; report supervisees' *unprofessional* conduct whenever necessary

- seek any *specialist* help if needed.

In essence, clinical supervision in nursing is a dynamic, practice-focused, interpersonal process in which the supervisor makes the interests of patients the highest priority, promotes the learning and advancement of supervisees' clinical skills, and encourages safe and independent practice.

By now, you probably realize that the characteristics and skills of effective mentoring, clinical teaching and clinical supervision are inter-related. That is to say, when you are performing mentoring, you are also engaged in clinical teaching and clinical supervision.

Activity 5

To reflect on what you've learned so far, make a list of key characteristics that describe effective mentoring from your own perspective. Recollect your own experience of being a mentee when you were a student nurse. Do you think that your mentor was effective? Why or why not?

Learning and teaching

To be an effective mentor, it's important to have some understanding of how people learn and the skills involved in the teaching process. In this section of the manual, we discuss various theoretical perspectives on learning, and we look at how you can be an effective teacher. Let us, first of all, look at issues related to learning.

What is learning? According to Rogers (1996), learning, initiated by an inner drive, is an *active* and *voluntary* receipt of knowledge and skills that seeks *satisfaction*. Santrock (2001) further points out that learning is a relatively permanent change in *behaviour* that occurs through *experience*. These definitions of learning clearly suggest that it involves more than passive acquisition of facts and information. It is a personal, experience-based, active process. Several psychologists and educational theorists have attempted to explain how individuals learn. In the next few pages, we introduce you to the most prominent theories of learning. You will see that sometimes, these theories conflict and that no one theory of learning is able to explain how and why people learn effectively. However, each theory does give us some valuable ideas on how to plan for, implement and reflect on learning and teaching in a nursing mentoring context.

Theories of learning

Some of the theories that attempt to explain how an individual learns are described in the next reading. Oliver and Endersby (1994) discuss these theoretical perspectives from the context in which they are applied. Many educators agree that using and building on *prior knowledge* is crucial to learning, so before you read this article (and learn about learning!) try the next activity. This activity asks you to apply your prior knowledge and use your existing beliefs about learning to better understand the reading.

Activity 6

Read the statements below. Decide whether you agree or disagree with each of the statements. Put a tick √ in the box that best describes your belief for each statement.

What are *your* beliefs about learning? Do you have theories about learning that are not given above? How do you best learn? Do you think all people learn in the *same* ways?

The statements in the activity above basically summarize detailed descriptions of various schools of learning that are given in the next reading. Please skim through the reading, and focus on the conclusions and summary at the end of the article. When you have read these sections, try the self-test that follows.

Statements	Agree	Disagree	Don't know
Positive *self-esteem* is very important to learning.			
Learning occurs throughout life and emerges from *experiences*.			
Learning involves changes in behaviour and is acquired in *step-by-step* stages.			
Learning should be teacher-centred; great emphasis should be placed on how the teacher organizes and presents information.			
Learning should be student-centred; students should have opportunities to *experiment*, *discover* and *explore*.			
Learning should be related to what a student *already knows*. Effective teaching therefore requires teachers to have a good understanding of learners and their past experiences and knowledge.			

Reading 7

Oliver, R., & Endersby, C. (1994). Learning theories. In *Teaching and assessing nurses: A handbook for preceptors* (Chapter 5, pp. 51–63). London: Balliere Tindall.

Self-test 2

The table below helps you summarize the key approaches, theorists and learning theories described in Reading 7. Use the reading to match the theorist to the approaches and theories listed in the table.

Approach to learning	Key theorist	Key theory
Humanistic approach		Unconditional self-regard
Experiential learning		Learning process is cyclic and focuses on describing learning competencies
Behaviourist school		Operant condition
Behavioural theorist		Hierarchy of learning
Cognition		Insightful learning
Student-centred approach		Discovery learning
Assimilation theory		Four dimensions of reception learning

Two other learning approaches, *social cognition* and *reflection*, have also contributed to explaining learning in the clinical context. Let's now look at the social cognitive approach to learning.

The social cognitive approach to learning

The social cognitive school maintains that an individual's thoughts affect his or her behaviour and learning. Bandura's social cognitive theory best explains this school of thought. The social cognitive theory states that *social* and *cognitive* factors, as well as behaviour, play important roles in learning. Cognitive factors might involve the individual's *expectations* for success, beliefs and attitudes; social factors might include an individual's observing the mentor's behaviour. In addition, Bandura points out that learning occurs when an individual *observes* and *imitates* someone else's behaviour in a particular context. He has termed this process 'observational learning'. He highlights the importance of modelling and imitation in learning (Ormrod 2000).

The following short reading from Santrock summarizes Bandura's theory of observational learning. The Bobo Doll study is very interesting and clearly illustrates Bandura's theory.

Reading 8

Santrock, J. W. (2001). Observational learning. In *Educational psychology* (Chapter 7, pp. 256–258). New York: McGraw-Hill.

Activity 7

It's probably true to say that no book or reading has taught you how to deal with difficult patients, yet this is a skill that all nurses learn at one time or another. How did you learn to deal with difficult patients? Do you think Bandura's model of observation at learning facilitated your learning? If so, how?

Having briefly looked Bandura's observational theory, let us now turn our discussion to a learning approach that is frequently used in the clinical context: reflection.

Reflection

Reflection is the process of *internally examining* and *exploring* an issue of concern, *triggered* by *an experience*, which creates and clarifies meaning according to self, and which results in a *changed conceptual perspective* (Boyd and Fales 1983). Palmer, Burns and Bulman (1994) further point out that reflection is initiated by an awareness of uncomfortable feelings and thoughts that arise from a realization that the knowledge one was applying in a situation was not sufficient to explain what was happening in that unique situation. According to these

authors, the focus of learning is on *critical analysis* of these unique practice situations. It is therefore important that this analysis involves an examination of both *feelings* and *knowledge* so that the knowledge required for professional practice is illuminated. The following diagram illustrates the process of reflection:

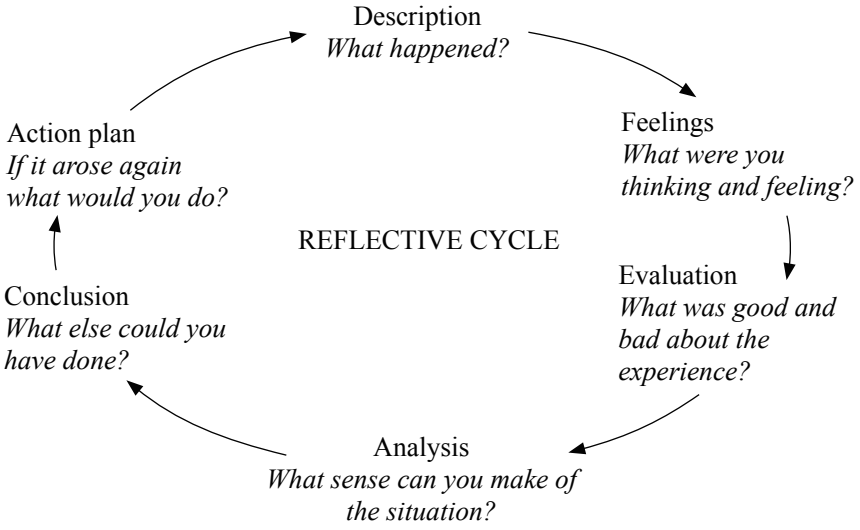

Figure 2 The process of reflection

(Source: Gibbs 1988, Figure 3.2)

Schon (1991) notes that there are two types of reflection:

- reflection-*in*-action and
- reflection-*on*-action.

Reflection-in-action occurs *while practising*. It influences the decisions made and the care given, whereas reflection-on-action occurs *after* the event and contributes to the development of practice skills. According to Schon (1991), an individual learns from both types of reflection and both need to be facilitated within a practice setting, such as a practicum, i.e. in a structured environment where individuals, supported by experienced practitioners, are encouraged to reflect on simulated or actual practice situations, *during* and *after* the situation. How can you facilitate reflective situations? The figures below offer some practical questions that you and your students can ask as you reflect on practical situations. These questions are frameworks that have been created to foster reflective practice in nursing.

Burrows' (1995) framework for reflection on action:

- Describe events as you understood them.
- Describe your feelings about this event.
- What have you learned from this event?
- Given a similar situation in future, how would you behave?
- In what ways do the theories of psychology, sociology, biology, philosophy and nursing research underpin the situation you have witnessed?

John's (1995) framework for reflection on action:

(a) Aesthetics

- What was I trying to achieve?
- Why did I respond as I did?
- What were the consequences of that for the patient? Others? Myself?
- How was this person (people) feeling?
- How did I know this?

(b) Personal

- How did I feel in this situation?
- What internal factors were influencing me?

(c) Ethics

- How did my actions match my beliefs?
- What factors made me act in an incongruent way?

(d) Empirics

- What knowledge did or should have informed me?

(e) Reflexivity

- How does this connect with previous experiences?
- Could I handle this better in similar situations?
- What would be the consequences of alternative actions for the patient? Others? Myself?
- How do I now feel about this experience?
- Can I support myself and others better as a consequence?
- Has this changed my ways of knowing?

Figure 3 Two frameworks for reflective practice

(Source: Greenwood 1998, 1048–53)

To get a more detailed picture of how reflective practice has been used in Hong Kong nursing education, please take a look at the next reading (which is in Chinese). In this reading, Li (1998) describes a recent and successful reflective practice model.

Reading 9

Li, P. (1998). P Li's reflective practice model. Chapter 4 & 5.

It's important to note that reflection in clinical learning is not without problems. Fowler and Chevannes (1998) suggest that the introspection of clinical reflection does not suit everyone's personality or learning style and that reflection should not be imposed as the only form of learning. They argue that if reflection is the only model of clinical supervision that is used, some students may withdraw from the supervision. As with any learning approach, you need to be sensitive to

your students' preferences. If the process of reflection is being met with resistance, it would be wise to seek other forms of clinical supervision.

Self-test 3

Using the questions asked in Figures 2 and 3 as a starting point, try to do a reflection-*on*-action for a clinical procedure, such as an IMI injection, that you have recently performed.

- What questions did you ask yourself about the procedure?
- What did you learn from the reflection?
- Could you use the same questions during the procedure for a reflection-in-action with your mentee?

Factors that affect learning

Educational theorists agree that certain key factors greatly influence learning. These factors are:

- learner's characteristics;
- the learning environment; and
- teacher's characteristics.

Let me take you through these factors one by one and briefly explain how a better understanding of each factor should help you in your mentoring role.

Learner's characteristics

Seamon and Kenrick (1994) argue that a learner's personal characteristics strongly affect an individual's learning. These factors include:

- pre-exiting knowledge and experience
- emotions
- motivation
- memory
- intelligence
- learning styles.

According to these authors, *pre-existing knowledge and experience* of an individual influence the ability to visualize, process and memorize new information. Moreover, pre-existing knowledge can help a learner examine the correctness of new knowledge. For example, the side-

effects of a new type of medication may be best explained by comparing them to the side-effects of existing kinds of medication: In this way, our knowledge of the existing medication helps us better understand the new medication. *Emotions*, especially negative ones such as anxiety, fear and low self-esteem, can impede learners' ability to learn or, to some extent, put the learner in a state that makes learning more difficult. As a result, some understanding of your mentee's emotional state is important. *Motivation* is also key factor in the learning process. Ormrod (2000) remarks that both intrinsic motivation (based on inherent personal desires and needs) and extrinsic motivation (imposed on the learner, such as an exam) serve to provide learners with direction and goals and energize and sustain an individual's participation in the learning process.

Santrock (2001) defines *memory* as the ability to acquire, retain and retrieve information, knowledge and experience. There are two types of memory that influence learning. Short-term memory has limited capacity (around seven brief chunks of information) and can only retain information for about 20 seconds unless it is maintained by repetition, is linked to existing knowledge or is consciously noted and mentally rehearsed. Long-term memory is the permanent repository of all learned information and experience. There is no limited capacity for long-term memory, and it can be stored for a lifetime. The key point to be noted here is that as an educator, your goal is to help mentees turn short-term memory into long-term memory by making information relevant, putting it in a familiar context and allowing students the time to process, note and rehearse the information before they are required to call on it.

Intelligence is the ability to learn from experience, to be adaptive in a new environment, to think abstractly, and to solve problems creatively. It is the end result of skillful information processing and is culture-specific (Henson and Eller 1999; Ormrod 2000). Intelligence fosters learning and speeds up the learning process. Psychometric approaches, such as the IQ test, are a common measure to evaluate intelligence (Seamon and Kenrick 1994).

Learning styles relate to how an individual processes information. Not everyone processes information in the same way, so it's important as a mentor to recognize that you and your mentee may process the same information in very different ways. For example, you may prefer to learn by actively solving problems, whereas your mentee may prefer to watch others, reflect on the situation and then talk about concepts after much quiet consideration. The following table summarizes the characteristics of different kinds of learner, their key learning strategies and their preferred learning activity.

Kinds of learners	**Preferred learning activities**
Active learners	Welcome new experiences, enjoy problem-solving; tend to learn through games, competitive teamwork, tasks and role-play but can become bored easily
Reflective learners	Prefer watching and listening, act only after all information is made available; they prefer observational learning activities
Theorists	Prefer exploring the interrelationship between ideas, principles and general application, and learn by investigating the evidence according to general rules and logical steps
Pragmatists	Like to try out ideas in practice and prefer learning activities as close as possible to real working situations

(Adapted from Seamon and Kenrick 1994)

By now you should have some idea of learners' characteristics and how they help us to better understand the learning process. It is also very important, at this stage, to remind ourselves that the kinds of learner that we are going to deal with are *adults* and that *adult learning is unique and may be very different from childhood learning*. Rogers (1996) describes the following unique characteristics of adult learners:

- They are at different levels of maturation, i.e. adults can be both *dependent* and *autonomous*.
- They are growing and developing at *a different pace* in *different directions*.
- They bring with them their *own experience and values* and use them to complement learning to various degrees.
- They learn with *set intentions and needs*, i.e. job- or subject-related.
- They have certain *expectations* about education, such as being 'taught' or being encouraged to be independent.
- They have competing interests and specific ways of learning, i.e. learning styles.

Activity 8

1 What kind of learner do you think you are? Identify your learning style and your preferred learning activities.

2 Based on the above discussion, make a list of the characteristics that distinguish you as an adult learner.

3 Are you autonomous or are you dependent on others' directions and guidance?

4 What are your expectations and beliefs about teaching and learning?

5 What motivates you to learn?

The learning environment

What kind of environment is most effective for enhancing learning? Obviously there is no one perfect learning environment, and different kinds of learner prefer different kinds of environment. However, Manley (1997) suggests that effective environments have the following characteristics:

- *readily available resources*, such as teaching personnel, audio-visual aids, books and journals, and conferences and clinical meetings/ rounds);
- an atmosphere that is *supportive*, *constructive and non-threatening*; and
- learning content that is *relevant, useful and clearly organized* around exploration of problems perceived as significant by the learner.

Oliver and Endersby (1994) further argue that environments that facilitate learning, particularly in the clinical context, should have six dimensions:

- *access to services*: availability of mentors and resources to the students;
- *relevance to need*: compatibility of clinical practice with student learning outcomes;
- *effectiveness*: effective learning facilitated through appropriate strategies by professional credible mentors;
- *equity*: equality for all students, within the context of curricular objectives, of experience and opportunity;
- *social acceptability*: compatibility of clinical experience with student, university and disciplinary requirements;
- *efficiency and economy*: a uniform, economic and high-quality integration of practice and education.

Activity 9

With reference to the above characteristics, do you think that your ward, as a clinical learning environment, is safe and effective for students to have their placement? Why or why not?

Teacher's characteristics

It is generally argued that certain teacher characteristics influence learning. These include the teacher's *attitude and personal qualities*, teaching *style*, and teaching strategies. Some of these characteristics have been examined in our discussions on the mentoring relationship. For example, we've seen that successful mentors (and effective teachers) are caring, patient, sensitive, supportive, flexible, willing to admit to errors, innovative, enthusiastic, professionally competent, and knowledgeable.

Good mentors (and teachers) are also proficient and experienced in clinical practice, demonstrate self-confidence, and have a clear understanding of the teaching-learning process. They are skilful in developing good interpersonal relationships with students, view students as worthwhile individuals, accept students as they are, and develop honest means of communication.

Hinchliff (1986), and White and Ewan (1991) outline five types of teaching that occur in clinical teaching:

- *supporting*, which gives learners different forms of support (such as nonverbal support, informed support, social support, learning support and silent support)

- *observing*, which gives instructions in advance on agreed situations and provides feedback on a particularly commendable performance or points out areas for improvement afterward

- *guiding*, which gives instructional action (such as leading, directing, influencing, motivating, advising and counselling) within different learning contexts

- *facilitating*, which shows interest in learners, responds to learners' needs and feelings, recognizes learners' effort and progress, provides prompt discussion on patient care, and fosters positive self-confidence

- *resourcing*, which activates relevant opportunistic happenings in clinical settings and gives directions to help learners go through these situations.

DeYoung (1990) points out that teaching style is a blend of certain ways of talking, moving, relating and thinking. He also believes that teaching style is indeed an outgrowth of the teacher's personality and character. Oliver and Endersby (1994) suggest that particular styles of teaching can also either impede or enhance communication between teacher and student. Although it is impossible and unreasonable for a teacher to forever re-invent himself or herself, it is important for teachers to try to understand and acknowledge their students' preferred style of teaching and to try to accommodate students' preferred teaching and learning situations.

Most teaching takes the form of either teacher-or learner-centred strategies. Teacher-centred teaching is the methods that involve giving *direct* and *structured* instruction, usually through lectures and demonstrations. This strategy is good for introducing new material and information. Learner-centred teaching moves the focus away from the teacher and toward the student. It emphasizes active, reflective learning and aims at helping learners actively set goals and plans, think deeply and creatively, solve real-world problems, and collaborate with others. It is especially good for promoting elaboration. Simulations, group discussions, debates, case studies and seminars enhance learner-centred teaching.

The following diagram is a good summary of the factors that influence the learning process. Note the reference to learner characteristics, teacher characteristics and the learning environment.

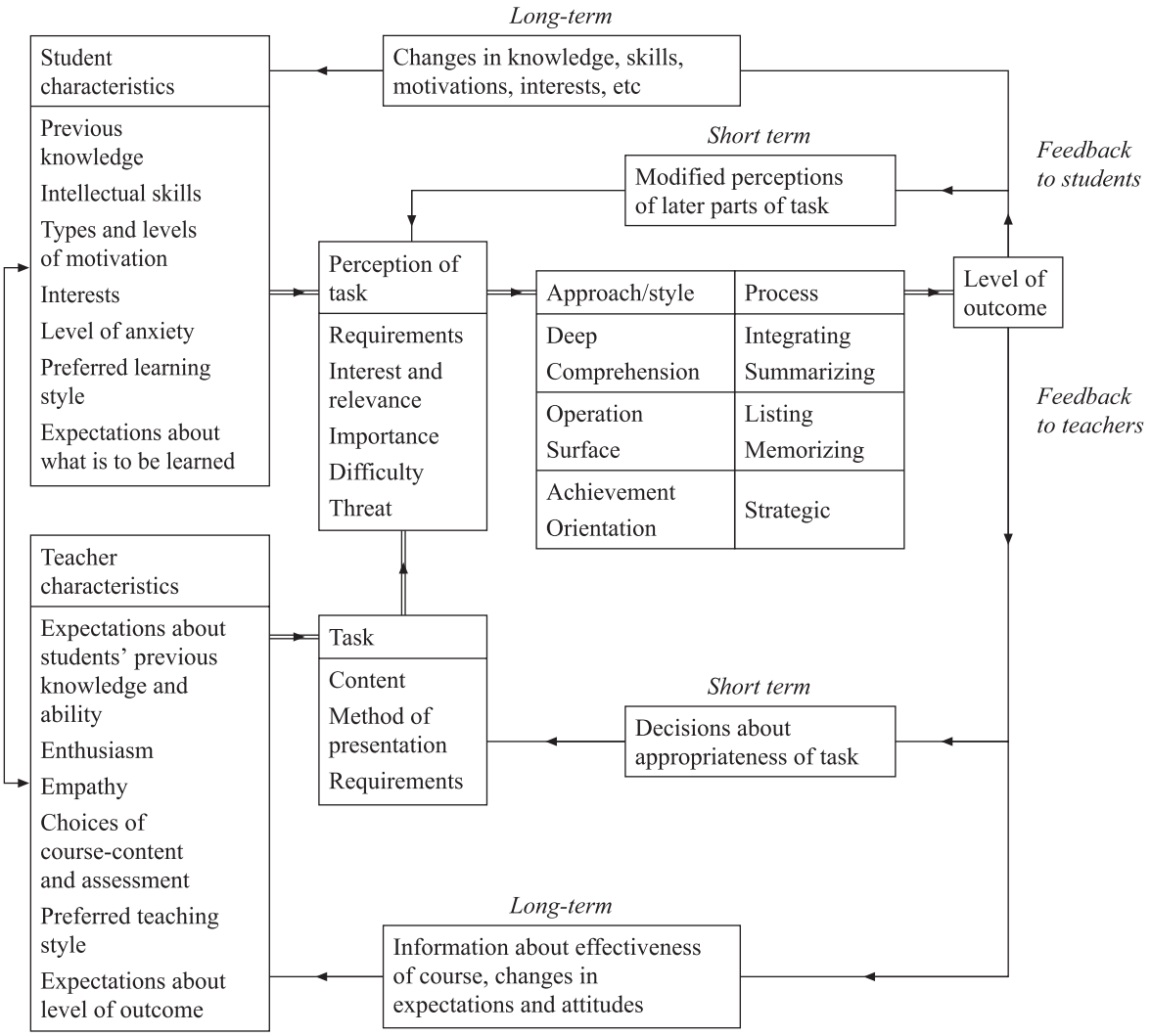

Figure 4 A summary of factors that influence the learning process

(Source: Entwistle 1988, Figure B3)

Teaching skills and activities

By now you should have some basic understanding of issues related to learning. You probably also realized that teaching skills and teaching activities were also implicitly suggested as key factors in the learning process. Let's now turn our focus to some skills and activities that are essential for mentoring students.

Lecturing

Giving lectures to learners is most appropriate when learners all have similar backgrounds and abilities. The strength of lecturing is its *efficiency* (Henson and Eller 1999). Through lecturing, a great deal of information can be covered in a short time. It is also an efficient means for introducing learners to new topics (DeYoung 1990). However, lecturing is rather rigid, didactic and restricted. Above all, when lecturing, teachers are limited in how much they can teach by their own interpretation and understanding of content. Nevertheless, Oliver and Endersby (1994) remark that it is difficult in some instances, such as clinical teaching, to completely avoid lecturing. In such instances, it would be most useful to follow lectures with activities that reinforce the content of the lecture (such as demonstrations and simulations).

Demonstrations

A demonstration usually involves the *visual* explanation of facts, concepts and procedures (Oliver and Endersby 1994). It allows learners to have some idea of the way in which skills should be performed and, most importantly, the application of learned concepts. However, teachers sometimes find demonstrations to be anxiety-provoking, because they require so much planning and preparation. DeYoung (1990) offers the following guidelines for demonstrations:

- Well before the demonstration, ensure that all necessary equipment is in working order.
- Make sure that all learners will be able to hear you and see what you are doing.
- If feasible, prepare explanatory notes for the learners, or refer learners to the textbook with relevant information.
- Perform the procedure step by step and go slowly; explain your actions as necessary and the rationale for each step.
- Whatever skill you are demonstrating, be sure that you adhere to all principles and theories taught.

Questioning

Asking questions is an essential component of effective teaching. Questions help learners recall, form links between previously isolated information, analyse statements, and evaluate the worth of ideas.

Indeed, questions can be formulated to stimulate specific levels of cognitive activity in students (DeYoung 1990). The following are some examples of questions at each cognitive level:

	Category	**Examples**
Low Level	Knowledge	What is the definition of glaucoma?
		At what age do infants begin to crawl?
	Comprehension	What does the nursing process have in common with the scientific method?
		Why does intravenous tubing have to be free of air?
	Application	Given these arterial blood gas results, what nursing interventions are needed?
		How would you get a blood pressure reading on a person with third-degree burns of all extremities?
	Analysis	What is the major premise behind KüblerRoss's theory of death and dying?
		What data would you need to support this nursing diagnosis?
	Synthesis	Given all of the data in this case study, what nursing diagnoses can be developed?
		Think of a way that we could research the relationship between those variables.
High Level	Evaluation	Of the two possible nursing interventions in this situation, which would be more appropriate?

Do you notice that *specific* kinds of question are needed to generate the higher cognitive skills of synthesis and evaluation? Do you ask these sorts of question when you are demonstrating a procedure? Sellappah et al. (1998) found that in the clinical situation that they studied, teachers mostly asked low-level questions and very infrequently asked higher cognitive level questions. Similarly, Phillips and Duke (2001) found that clinical teachers and preceptors asked relatively few higher cognitive level questions. Specifically, they found that clinical teachers tended to mostly ask 'knowledge' and 'comprehension' types of question and very rarely asked 'synthesis' or 'evaluation' questions.

Activity 10

Assume that you are at a post-clinical conference with your mentee. You have just finished applying abdominal thrust to a demented patient who was choking and seen a patient who was under the delusion that he was the Chief Executive of the Hong Kong Special Administrative Region. Make a list of some questions to ask your mentee. Make sure that you

ask *a range of cognitive questions*, including an analysis, a synthesis and an evaluation question.

Questioning techniques

In addition to asking a range of cognitive questions, you need to make sure that you are asking both *open* and *closed* questions. Closed-end questions (or 'yes/no' questions) are best used for confirming that your mentee has received your ideas or message; open-ended questions (that begin with wordssuch as what, how,why) stimulate thinkingand encourageelaboration. If you really want your student to demonstrate understanding of a case or patient ask her or him an open-ended evaluation question.

It is also important to give learners adequate *time* to respond to the questions asked, simply because they need time to consider questions and to retrieve any information relevant to possible answers (Ormrod 2000). In addition, Henson and Eller (1999) suggest some guidelines for questioning techniques:

- Avoid using a long series of questions. Ask questions *one at a time*.
- Delay questions about content until a knowledge base has been established.
- Use a combination of *levels of questions*.
- *Do not* expect students to be able to guess what the teacher means.
- Encourage students to ask questions.
- Listen carefully to students' responses.

Giving feedback

Feedback is a response to students' questions or an evaluation of students' performance. It may be verbal (i.e. making observations and conclusions about performance followed by further instructions) or visual (demonstrating correct performance) The ultimate goal of feedback is to help learners progress to a point at which they are able to *judge their own performance*, identify resources for their learning, and use these resources to develop competence further (Oermann and Gaberson 1998).

We suggest the following principles for giving feedback:

- Give *precise* and *specific* information to students.
- Include both *verbal* and *visual* cues, especially for procedures and skills.
- Give feedback to students about their performance *at the time of learning* or immediately following.

- Adapt the feedback to *the learner's needs*.
- Remember that feedback is intended to be *diagnostic*.
- Give feedback on your mentor's *behaviour* rather than her or his personality.
- Base feedback on your *observations* rather than assumptions.
- Focus on *information sharing* rather than instruction giving.

(Adapted from Oermann and Gaberson1998; White and Ewan 1991)

Simulations

A simulation is a technique that teaches about some aspects of a clinical situation by *imitation* or *replication* (Henson and Eller 1999). It is essentially *an extended role-play* with structure and rules (Oliver and Endersby 1994). Simulations should be student-centred and are often very motivational to students. Their major advantage is that students learn by interacting in a manner similar to the way they would in real situations (Henson and Eller 1999). DeYoung (1990) further points out that simulations are intended to help students practise decision-making and problem-solving skills and to develop human interaction skills in a controlled and safe setting. Through simulation, students have a chance to apply principles and theories they have learned in a safe environment and to see how and when these principles work. The teacher's role in simulations has three facets: *planning*, *facilitating* and *debriefing*. Students should be guided during simulations to work towards clear outcomes. An example of a simulation could be an activity in which students learn about dressing abdominal wounds by practising preparing for the procedure, 'performing' the dressing and then discussing the procedure.

Discussion

Discussion, in which students are free to speak, ask questions and present their ideas and opinions, appears to be the easiest of all the teaching activities to set up and run. It allows learners to share others' experiences, change attitudes, improve communication skills, and promote critical thinking (Oliver and Endersby 1994). However, good discussions do not just happen spontaneously; they require careful *planning*. DeYoung (1990) remarks that before discussion, the teacher must develop objectives and choose appropriate topics, such as controversial issues, clinical problems, and emotionally laden topics, e.g. death and dying. After choosing a topic, the teacher has to provide some structure for the discussion, i.e. the contents and the ground rules. Once the discussion is under way, the teacher takes on the role of facilitator and leader, encourages the exchange of ideas and directs the discussion. Finally, when the discussion comes to an end, the teacher should give some concluding remarks and point students to resources that build on the discussion topic.

Case studies

Case studies use cases as educational vehicles to give students an opportunity to put themselves in the process of problem-solving. Through the process of personal analyses, identification of options, and the discussion of action and implementation, the student gains an opportunity to develop analytical and planning skills. Case studies relate theory and practice and fully involve learners in what they are studying (Henson and Eller 1999). Case studies are commonly used as a teaching activity in the clinical context to teach students to identify important clinical cues, ask pertinent questions, and make logical judgements. Case studies help students gain work experience from clinical staff in a real work situation and handle ambiguities in the clinical context (White and Ewan 1991).

However, case studies are not without problems. In the real and 'unstructured' learning environment of a clinical case, learners may miss some learning points or may be unsure of what is expected of them. Clinical case studies are more suitable for senior students who already have a solid knowledge foundation. Teachers, when selecting clinical cases, should clarify learning guidelines, base cases on learners' learning needs, and clearly indicate the level of performance expected of students during the case.

Self-test 4

Assume that you are going to teach the following nursing skills to your student during mentoring:

- administration of oral medications
- nursing management of a client with schizophrenia.

1 Make a teaching plan that lists the *teaching activities* that you are going to use for each skill. (e.g. will you use a lecture, a demonstration, a discussion, a simulation, a case study, or a combination of these activities?) Briefly explain *why* you will or won't use each of the above teaching activities. Use the information in the above discussion to justify the use of your chosen activities.

2 Make a list of some questions that you will ask your mentor as you teach both skills. Include some higher cognitive questions such as synthesis and evaluation questions.

Assessment and evaluation

Having explored some learning and teaching issues, let's now turn to the final topic of the manual: assessment and evaluation.

What is assessment?

Assessment is a process of observing students' behaviour and drawing inferences about their knowledge and ability (Ormrond 2000). It occurs whenever the teacher in some kind of interaction, direct or indirect, with the student is conscious of obtaining and interpreting information about the knowledge and understanding or abilities and attitudes of this student (Walton and Reeves 1999). Assessment involves factors which relate to how students learn, how they put their learning into practice, and even the psychological and logistical factors involved in attempting to ascertain how much learning has taken place (Oliver and Endersby 1994).

Santrock (2001) further points out that assessment is more than giving tests or assigning grades. *It is everything a teacher does to determine if students are learning*. Without assessment, a teacher can never know if instruction is effective. Done effectively, Santrock argues, assessment not only documents what students know and can do, but also fosters their learning and motivation. It also provides a teacher with valuable information for providing an optimal learning experience. Thus, Santrock maintains, assessment is not an isolated outcome done after instruction is finished but a means to foster the development of both teachers and student.

What is evaluation?

Evaluation is the process of obtaining information for *making judgements about the quality* of students' learning, achievement, performance, or competence. It involves systematic collection and interpretation of information as a basis for decisions about students. Through evaluation, the teacher determines the progress of students toward meeting the educational objectives and developing competencies and their achievement of them; evaluation is a continuing, open-ended process closely interwoven with teaching and learning (Oermann and Gaberson 1998).

From the above discussion, it is obvious that assessment and evaluation, as an integral part of the teaching-learning process, is a process within which the teacher examines the quality of students' work and infers their level of performance. Assessment and evaluation are also used to determine students' learning outcomes and to promote the growth and development of both teacher and students.

Activity 11

We have suggested that assessment and evaluation promote the growth and development of the mentor, as well as the mentee.

1 In what ways do you think the assessment of your mentee may contribute to your own professional growth?

2 How ready do you think you are for taking up the role of assessor?

Why do we conduct assessment?

Let's now look at some of reasons for conducting assessment. We conduct assessment:

- to discriminate between high and low achievers;
- to maintain standards;
- to motivate students to get intrinsic (achievement) and extrinsic (praise) rewards;
- to provide feedback to students;
- to provide feedback to teachers, in measuring the attainment of students and identifying problem areas in learning, to learn and develop their own teaching approaches;
- to instigate learning (i.e. to increase students' motivation to learn, to encourage students to review previously learned information and therefore to process it further);
- to promote self-regulation, i.e. to foster self-monitoring (and make students aware of how well they are doing) and self-evaluation (and enable students to assess their own performance accurately);
- to protect clients, to promote development, and to identify general clinical problem areas.

[Adapted from Ormrond (2000), Walton and Reeves (1999)]

Types of assessment

There are two types of assessment—formative and summative. Let me take you through these two concepts briefly, one by one.

Formative assessment

Authors such as Oliver and Endersby (1994), Walton and Reeves (1999) and Santrock (2001) define *formative assessment* as the process of ascertaining a student's progress during a course of study or experience by a continuous review of the student's performance. Formative assessment is usually *informal*, *individual* and *diagnostic* (i.e. indicating areas needed for further learning or development). It serves as a basis for additional instruction, guides further learning, and serves as a *progress report* for students. Formative assessment should reinforce learning and increase students' confidence and understanding before final judgement of their ability or performance (summative assessment) is made.

Summative assessment

Summative assessment refers to the *overall judgement* of students' achievement within the course as a whole. It usually takes place after instruction has *finished* and is often typified by a final *examination*. Summative assessment is a decisive tool for *grading* students and awarding certification and indicates whether students are ready for the next course or level of learning.

Some guidelines for assessing mentees

Whichever types of assessment are used, try to:

- accommodate individual *differences* among students;
- make assessment an integral part of curriculum design (i.e. don't include assessment tasks at the last minute);
- use objectives to specify learning outcomes, i.e. *specific behaviours*, skills and kinds of thinking;
- *link assessment closely* to learning objectives and to what students have done;
- explain clearly the *purpose* of the assessment to students;
- give clear and explicit assessment *criteria*;
- provide students with *meaningful and useful feedback* and encourage them to reflect on performance.

[Adapted from Walton and Reeves (1999) and Ormrond 2000)]

Qualities of good assessment

Effective assessment should have the following qualities:

Fairness

- All students have an *equal opportunity* to learn and demonstrate their knowledge and skill. Teachers should provide appropriate learning content and instruction, and choose assessment that *reflects* the content and instruction.
- Assessment should be *unbiased* and not discriminate against certain students because of their background.

Reliability

- Assessment tools should yield *consistent* results for each student.
- Assessment tools should clearly show the aspects to be covered and the *criteria* for achieving a pass.

Validity

- Assessment should measure *what it is supposed to measure*.
- Assessment should reflect what the student is able to carry out.

Practicality

- Assessment should be relatively *easy* and *inexpensive* to implement.
- Assessment should be *applicable* within the confines of the situation.
- Assessment should be *practical* in time and resources.

Sources: Oliver and Endersby (1994), Walton and Reeves (1999), Ormrond (2000), and Santrock (2001)

Assessment and evaluation tools

Various measurement tools can be used in assessment and evaluation. Below are some common examples.

Table 3 Assessment and evaluation systems

System of assessment	Advantages	Disadvantages
Tick system ✓: used with a word or phrase, such as 'satisfactory' or 'unsatisfactory', to describe the level of performance	*easy* to use	difficult to calculate *precise* level of mastery
Numerical rating scale or grading scale such as a Likert scale from 1 (poor) to 4 (good) is given to show the level of performance	good *indicator* of performance level	correct *sequence* of skills of a task cannot be measured
Descriptive rating scales: A precise description of performance level is attached to each score, e.g. 0 – has some knowledge but cannot perform satisfactorily 1 – can perform partly satisfactorily but requires considerable assistance 2 – can perform satisfactorily but requires periodic assistance and supervision	allows the assessor to *differentiate* score at different levels	
Outcomes or competence statements: Measure achievement of competence statements through use of criteria or production of evidence, e.g. verbal or written description or demonstration		may be *too broad;* thus requires assessors to specify a set of standards for satisfactory achievement

Criteria for selecting assessment and evaluation measurement tools

In the clinical context, assessment and evaluation measurement tools should:

- provide *information* on how well the clinical objectives or competencies are met
- use *different evaluation methods* to reflect different abilities and increase the validity
- be *realistic* within the clinical context and resources available
- *differentiate* methods intended for *formative* from *summative* evaluation
- be considerate as far as time elements are concerned.

(Oermann and Gaberson 1998)

Performing effective assessment and evaluation in the clinical context

Let's conclude this section by looking at some recommendations for performing effective assessment and evaluation in the clinical context.

Be accountable to the patients

- Introduce your mentee to the patient involved and ask the patient for permission.
- Decide whether to proceed or not if a patient's condition changes.

Maintain safety during assessment

- State all safety requirements to students explicitly.
- Ensure that a student is ready and fit for assessment.
- If a situation becomes unsafe, stop assessment and take action to restore safety. Then let students know about the safety issues and try to turn the situation into a learning session.

Be accountable to the learner and give a fair judgement

- Beware of your own non-verbal cues or verbal communication affecting the assessment.
- Be a bystander unless a situation becomes unsafe or you are asked for assistance.
- Reduce bias and subjectivity.
- Use explicit measurement criteria.
- Be aware of potential influences from prejudices of self, students and others.

Other psychological considerations

- Minimize your student's stress.
- Be on time.
- Create a supportive environment.

Give constructive and thorough feedback after assessment

(Sources: Neary 1997; Power 1999)

Conclusion

Thank you very much for participating as an *Honorary Clinical Tutor* in the Mental Health Nursing programmes.

As an *Honorary Clinical Tutor* you facilitate our nursing students' experience of and hands-on practice in various client-care clinical situations. We hope that this manual helps you in your mentoring role.

The manual has drawn on adult learning theory to provide you with some theoretical explanations of the mentoring process. It has also outlined key mentoring skills and suggested some management techniques for giving feedback to your students and for assessing and evaluating your students' clinical performance.

If you have any questions or require assistance or further information, please do not hesitate to contact us.

We wish you all the best. Thank you again for your kind and professional assistance.

Feedback on activities

Activity 1

1 Morton-Cooper and Palmer (2000) and Chow and Suen (2001) point out that the advantages of mentoring are:

- The mentor gains personal satisfaction and leadership development.
- The mentee obtains job satisfaction, advancement and successful socialization.
- The organization sustains a satisfied and motivated workforce with positive outcomes.

2 Darling (1984) and Andrews and Wallis (1999) note that the mentoring relationship can be problematic when:

- It becomes *disabling* rather than enabling, i.e. when a mentor dominates with overprotection and establishes a dependent, non-developing position for the mentee.
- It turns into a *directive* rather than facilitating situation with an emphasis on manipulation and conforming.
- The relationship is *not built on mutual trust* and one person takes advantage of the other.
- Mentors are facing unresolved difficulties, such as *role conflict* and *lack of time* to achieve optimum mentoring.

Activity 4

In a study that evaluated the effectiveness of clinical teaching, Copeland and Hewson (2000) proposed that good clinical teachers:

- establish a good learning environment
- stimulate independent learning
- allow appropriate autonomy
- organize time to allow for both teaching and clinical work
- offer regular feedback
- clearly specify what should be learned and done
- adjust teaching to learners' needs
- ask questions that promote learning
- give clear reasons and explanations
- adjust teaching to diverse settings
- coach clinical and technical skills
- incorporate research data and/or guidelines into teaching
- teach diagnostic skills
- teach effective patient and family communication skills
- teach principles of cost-effective care. How do these characteristics and skills compare with your list?

Suggested answers to self-test questions

Self-test 1

Characteristics of effective mentors

Prerequisites	approachability, effective interpersonal skills, adopts a positive teaching role, attention to learning, provides supervisory support, and professional development ability
Requirements	mutual attraction, mutual respect, and subscription of time and energy
Roles	inspirer, investor, supporter, envisioner, energizer, idea bouncer, feedback-giver, career-counsellor, problem-solver, eye-opener, standard-prodder, and challenger

A checklist provides by Morton-Cooper and Palmer (2000) complements the information taken from Reading 2. According to these authors, effective mentoring is characterized by:

a *Competence*

- to have appropriate knowledge and experience to command respect from others
- to build on a mentee's strengths and offer constructive feedback on limitations
- to exercise and keep the skills associated with the helper functions up-to-date
- to provide a reliable source of information and resources
- to promote good judgement

b *Confidence*

- to share a network of valuable personal contacts and have personal power
- to be able to deal with personal problems
- to be imaginative, to seek new challenges and be able to take risks
- to lead and offer clear direction but allow mentees to develop within their own terms
- to be successful and share the credit of achievements

c *Commitment*

- to staff development by motivating self and others
- to be people-oriented and see others develop and advance
- to invest effort in building working relationships
- to share personal experiences, knowledge and skills d *Positive qualities*
- to be flexible, approachable, accessible, proactive, responsive and patient
- to have a sense of humour
- to be able to balance the requisites of a long-term, intimate working relationship.

Self-test 2

Approach to learning	**Key theorist**	**Key theory**
Humanistic approach	Roger	Unconditional self-regard
Experiential learning	Kolb	Learning process is cyclic and focuses on describing learning competencies
Behaviourist school	Skinner	Operant condition
Behavioural theorist	Gagne	Hierarchy of learning
Cognition	Gestalt	Insightful learning
Student-centred approach	Bruner	Discovery learning
Assimilation theory	Ausubel	Four dimensions of reception learning

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Reading 1

Towards a philosophical understanding of mentoring

Peter Jarvis

This paper commences with a brief introduction during which the foundations are laid for the ensuing discussion, in which learning, practical knowledge and expertise, and reflective practice are briefly analysed. Thereafter, it is argued that mentorship is best understood as relationship and function, neither of which is necessarily the same as that of the teacher-practitioner.

INTRODUCTION

When Odysseus left his home to participate in the siege of Troy, Homer says that he appointed a guardian to take care of his son, Telemachus. For ten years this guardian acted as teacher, friend, advisor and surrogate father to the son – the guardian's name was Mentor. It was not unusual in ancient Greece for young males to be paired with older male citizens so that they could learn from and be guided by them. Similarly, when Dante made his journey through the underworld, he had a mentor – Virgil.

Throughout the history of humankind there have been many instances where older and more experienced individuals have mentored those who were younger and less experienced. The re-discovery of this concept is nothing new. Many an apprentice master was the mentor to his apprentice – guiding, directing, advising and teaching a craft – and the success of the master craftsman was to be discovered when the young apprentice graduated into a master craftsman, able to take charge of the older man's business.

But the world of apprenticeship is one which modern education has abandoned! This 'sitting by Nellie' seems so old fashioned – and so it is, if all that happened then was that the young learner (apprendre = to learn) sat there and merely tried to copy the master craftsmen and learn from him if he had time to explain. Perhaps this image of apprenticeship is a discourse trying to justify it as wrong, rather than an investigation seeking to discover the whole process and what, if anything, was good about it! But this is no defence of a system that had little or no theoretical knowledge to impart, although it is a claim that the practical knowledge might best be learned from master crafts people rather than from teachers of theory in the classroom. It is also to suggest that in some ways the skills of professional practice might best be learned in practice and from those who are experts, even though this might not make them mentors.

Now this latter claim raises a number of questions that are to be explored in this paper: these relate to learning, practical knowledge and expertise, and reflective practice. In the first part these four elements are discussed and it is suggested here that these lay the foundations for a discussion of mentorship, which occurs in the second part in which it is argued that mentorship is best understood as relationship and function, neither of which is necessarily the same as that of the teacher-practitioner. In the conclusion, it will be argued that this is a successful method of developing human beings, although there are both the risks and the exhilaration of human being and of being human in such relationships.

LAYING THE FOUNDATIONS

In this first, brief section it is necessary to explore the underlying concepts that impinge upon the practice of mentoring and, fundamentally, these appear to be the four mentioned above. They are discussed in the following three sub-sections, since expertise and practical knowledge are linked together, which are: learning from experience, practical knowledge and expertise, and reflective practice.

Learning from experience

The process of learning is central to the whole process of human living and this has been very fully developed elsewhere (Jarvis 1987, 1992a) so it is not the author's intention to revisit all this old ground again. However, it is important to make the point that all learning stems from experience, whether it be a practical skill or the most abstract theoretical exposition. Indeed learning may be defined as the process of trans-

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Source: Jarvis, P. (1995). Towards a philosophical understanding of mentoring. *Nurse Education Today*, *15*, 414–419.

forming experience, of one kind or another, into knowledge, skill, attitudes, values, senses, emotions, and so forth.

However, there are fundamentally two forms of experience from which this learning occurs: primary and secondary. In primary experience the individual learns as a result of either sense experience or experimentation, i.e. an individual sees and feels an object and knows of its existence and can describe it, or an individual tries out a procedure and finds that it works and can be repeated. A great deal of learning from primary experience involves direction interaction with people, talking with them, watching their behaviour and learning from both their strengths and mistakes. This is almost a natural way of learning and occurs frequently in professional practice.

In secondary experience, a person is informed of a discovery or a procedure, etc, and is told how it works and remembers it. This is learning from a mediated experience, and it may be seen that learning theory in the classroom is learning from a secondary experience. It will be recognised immediately that the mediated experience is much more common, since people are bombarded with information from a variety of media in contemporary society.

Significantly, however, a lot of secondary experiences are mediated through communication from other people, or in dialogue with them, rather than merely receiving a communication via the radio or television. The closer and more trusting the personal relationship, i.e. the primary experience, the greater the possibility that difficult truths can be mediated through such an interaction and, also, the greater the willingness of individuals to subject their practice to the scrutiny of the other person in the relationship. The interaction is a primary experience, although the message being transmitted might provide a secondary experience from which learning also occurs.

Practical knowledge and expertise

Through experiencing, individuals learn and acquire knowledge, but knowledge is not a unitary phenomenon. Indeed, there are a variety of ways by which it can be analysed and, for the purposes of this paper, an extension of the one first proposed by Ryle (1949) is employed here. Ryle made the distinction between 'knowledge how' and 'knowledge that' and this has subsequently become widely used. Benner (1984), for instance, uses it in her well known study *From Novice to Expert*. The distinction is well made that 'knowledge how' is about practice and 'knowledge that' about theory. But this is an over-simple and rather misleading distinction, since 'knowledge how' is not the same as having the skill to perform an action, and 'knowledge that' is about knowing that something will most likely occur given specific circumstances in the practical situation – it is still knowledge of practice. In other words, both are forms of practical knowledge. There is at least one other form of knowledge: 'knowledge why', and this is associated with the conceptual framework within which practice can be analysed, and it is based in and driven by the internal logic of the disciplines rather than the practice. 'Knowledge why' is theoretical knowledge and may be less important to basic training for some types of practitioners than the other forms of knowledge, but this level of theory is ignored at practitioners' peril since it is fundamental to any understanding of the context of practice.

The combination of skill plus both 'knowledge how' and 'knowledge that' is vital to improving practice: the skill can only be learned in primary experience (either practice or simulation – and the latter is not precisely the same as practice itself) while 'knowledge how' and 'knowledge that' may in the first instance be learned through mediated experience, but later they are also learned as a result of primary experience. (See Jarvis 1994, for a discussion of learning practical knowledge).

It is this process of learning, and perhaps teaching, through which the practitioner becomes an expert (Benner 1984). Following the Dreyfus model, she suggests that practitioners go through five stages to become an expert – novice, advanced beginner, competent, proficient and expert. She acknowledges that not all practitioners reach the stage of expertise and elsewhere Jarvis (1992b) has suggested that for some the process of repetition of performance leads to habitualisation rather than expertise. In that paper it was suggested that there are three forms of practice: thoughtless practice, thoughtful practice and reflective practice.

Reflective practice

Reflective practice occurs when practice is problematised for the practitioner. This may occur when a taken-for-granted procedure miscarries in some way and the practitioners are forced to ask why a certain event has occurred. But, it can also occur when practitioners stop and problematise their own practice for themselves, when they ask themselves why their practice was a success or why it was a failure. This is similar to the approach of analysing critical incidents.

The point is that when the question 'why?' is posed, a disjuncture is created between the practitioners' knowledge and the knowledge

required to deal adequately with the experience of the current situation. It is this disjuncture, this 'why?', which is the start of the process of learning. When practitioners reflect on their practice, learn from their experience and adapt their practice accordingly, then they are reflective practitioners and they are moving along the part towards expertise. Benner (1984) suggests that many practitioners do not move beyond the competency stage, and this may well be because they do not respond to the challenge of problematising their practice, or because they do not have others who will help them problematise it. Peers may occasionally fulfil this role, managers might also do so – perhaps they should more than they do, but then they are often not trained to act as a teacher-practitioner or a supervisor, nor do they necessarily see themselves in a mentoring role. Practitioners need someone who will problematise their practice for them or help them reflect upon it when they have problematised it for themselves. It is here that the mentor can play an important role.

MENTORSHIP

Mentorship has suddenly taken on a respectability in professional education and those who use it try to differentiate it from the image of the apprentice master, the teacher-practitioner, etc. Indeed, there are a variety of attempts to define the term. Fish & Purr (1991, p 47), for instance, say that 'nurses who supervise the clinical practice' are called mentors, and they briefly go on to highlight the relationship between the mentor and the student. Sloan & Slevin (1991, p 20) suggest that, while there is no real agreement in the literature:

> as new entrants progress through the early experiences, they require considerable personal support (mentorship) and directive teaching-learning (preceptorship). Later they require more space, and the clinician's role is more of a facilitator – providing tuition at a more advanced level, being available on request, acting as a critic and a 'stimulator' of reflection in practice.

The passage then goes on to discuss yet another function, that of the role model. Obviously, these are all different functions in the teaching and learning process in practice and, if they were agreed upon as all being relevant, it would be possible for one, or more than one, person to perform the various functions stipulated here, and elsewhere. To have a variety of role players, however, as different occupational categories, would perhaps be excessive, so that these may merely reflect the different roles that one person might play. Such a person might be a teacher-practitioner, a manager or a supervisor of professional practice – or even a mentor!

Defining the concept of mentor has run into several of these difficulties in recent years, as Hagerty (1986) demonstrated when she claimed that the literature confuses the person, the process and the activities. But this is no less true of a word like 'teacher' and so the problems surrounding the concept of mentorship are not insurmountable, even though any resolution will not necessarily gain universal support. In this second part, therefore, the concept of mentorship is discussed and this is followed by a discussion on the functions of the mentor.

The mentor

There seems to be almost universal agreement that mentoring involves a relationship with the learner. Consequently, it is possible to begin to define the mentor relationship as one in which two people relate to each other with the explicit purpose of the one assisting the other to learn. The fact is that this relationship is explicitly a personal one-to-one relationship, and this is the crucial difference between the roles of mentor and teacher; in this the relationship lies in mentors assisting the learners, or mentees, or protégés, to learn and to perform their role more effectively. Whilst there may be occasions when this involves direct teaching, there are many occasions when the mentor is not the teacher, but may be a facilitator of reflective practice or an opener of doors that provide other learning opportunities. This appears to be another crucial difference between mentoring and teaching. However, it must be pointed out that this is by no means necessarily a relationship which is formed only between teachers and students on educational courses, it is one which exists between adults, and between adults and children, at all levels of society, even between people who are firmly established in their profession, and even well known within it.

Murray (1991) points out that there are two schools of thought about mentoring: the one suggests that it can be structured or facilitated, while the other maintains that it can only happen when the 'chemistry' between the two people is right. However, these are not automatically exclusive, since a facilitated relationship might actually develop into one where the chemistry appears to be right for the relationship to continue and to deepen. Clearly, in education and training, structured or facilitated mentoring is called for – but this is not something that can just be turned on and off with

the passing of every two month's modules, etc. This has already been discovered in nursing when, as Barlow (1991) reports, short-term mentorship did not seem appropriate for clinical practice with students. Indeed, these mentors were often new staff nurses who would no doubt have benefited from being mentored themselves.

It is the relationship which is important in mentoring – in Buber's (1959) words, it is an I-Thou relationship. Buber (1959) takes it even further in his characterisation of the educative relationship:

> I have characterized the relationship of the genuine educator to his (sic) pupil as being a relationship of this kind. In order to help the realisation of the best potentialities in the pupil's life, the teacher must really *mean* him as the definite person he is in his potentiality and his actuality; more precisely, he must not know him as the mere sum of qualities, strivings and inhibitions, he must be aware of him as a whole being and affirm him in his wholeness. But he can only do this if he meets him again and again as his partner in a bipolar situation.

In the beginning, for Buber, is relationship and it is here in that relationship that mentoring is to be discovered. But, since Buber is describing an educative relationship between a teacher and a child, there is a possibility that it could be interpreted in a non-adult educational manner. This is a fear of some writers about mentoring in general, e.g. Burnard (1990), who claim that the mentoring relationship cannot be compatible with the principles of adult education, since the mentor is likely to create dependence and conformity. Such a claim is perfectly understandable, and it is justified if the mentor seeks to be domineering in any way. But in the spirit of the *I-Thou* relationship, this fear has less potency. Elsewhere, Buber (1961) illustrates his concern for humanistic principles that relate closely to those of adult education: 'The relation in education is one of pure dialogue'. He (1961) explains this:

> A dialogical relation will show itself also in genuine conversation, but it is not composed of this. Not only is the shared silence of two such persons in dialogue, but also their dialogical life continues, even when they are separated in space, as the continual potential presence of the one to the other, as an unexpressed intercourse.

Such a relationship is at the heart of mentoring. It is in this primary relationship that the mentor can help the mentee reflect on practice and learn. In a relationship of trust and concern it is possible to enable reflection to occur, even about the most difficult and personal concerns, and for practice to improve as a result.

Such a close relationship, which can be rich and rewarding, may also have the potential to become personal and emotionally charged. Where mentor relationships are facilitated, this possibility has to be recognised and where the relationship emerges because the chemistry just matches there is the possibility that emotional relationships might occur. This, then, is one of the other realities of such a relationship which has to be acknowledged – with all its positive and negative possibilities. Murray (1991) cites one way of overcoming the potentiality of emotional involvement between the mentor and mentee when a mentor from AT&T Laboratories claimed that 'having a protégé from a different department helps her to bring an objectivity to the relationship that a supervisor might not have'.

But who is the mentor? On occasions the mentor can be the teacher, but on others the mentor may be an advisor, a senior colleague or an expert. Occasionally, it can be the manager – but it might be difficult to enter such a relationship with an immediately junior colleague, so that where there is a facilitated mentor relationship the mentor is usually at least two rungs higher than the protégé.

The functions of the mentor

It is clear from this discussion that mentoring is not regarded here in the same light as coaching (Schon 1987) or supervising in clinical practice, or even personal tutoring (Barlow 1991). However, there is a sense in which the personal tutor can become a mentor with students, as Daloz (1986) demonstrates in liberal adult education where adults are returning to college to study. But if the mentor is to play a role in education and the professions, especially after the mentee has graduated, then the personal tutor may not be able to perform it and, in some cases, the ex-students may not want it. Hence, it seems that Murray's (1991) distinction between facilitated and unstructured mentoring becomes even more important. During studentship, some form of mentor role might be performed by the personal tutor, especially one who is acknowledged to be concerned about excellence in practice. Mentorship might also be facilitated for junior qualified staff, in the way that Murray indicates. She (1991) records a top level executive as saying:

> I'm always mentoring, both formally and informally. My role is to help by subordinates make decisions. I let them bounce ideas off me and I give my input. But ultimately, I want them to make decisions. If I

were making all the decisions for them, I wouldn't need them, would I? So taking on what you call an 'additional protégé is no great hardship for me in terms of time. It's what I do anyway.

Here the distinction between formally and informally is important – perhaps the informal mentoring relationship which just emerges, or which emerges after the formal relationship has been created, is at the heart of mentoring.

In his excellent book on mentoring, Daloz (1986) suggests some of the major things that good mentors do in the situations of mentoring adult students, and he does so under three headings – support, challenge and provide a vision. Each of these subdivided into a number of different functions:

Support – listening, providing structure, expressing positive expectations, sharing ourselves, making it special.

Challenge – setting tasks, engaging in discussion, heating up dichotomies, constructing hypotheses, setting high standards.

Vision – modelling, keeping tradition, offering a map, suggesting new language, providing a mirror.

In a sense, in these instances, the role of the mentor is to help the protégés to reflect on their practice, to learn from their experiences and to improve their practice so that they might exercise even more expertise. In mentoring, this is done through an in-depth relationship whether it is structured or informal, a primary experience, or Buber's educative relationship. Indeed, it is the relationship that makes mentorship so important – not just to professional practice but to life itself. It is then not only in practice the mentee gains, it is also a life-enriching relationship – but should the mentor also gain from such a relationship?

> But connections achieve ... only in so far as they make the existence of the connected into being for each other, not merely being with each other. My continued being 'makes sense' only in as far as there are others who go on needing me. Beckoning to me, making me attentive to their plight, filling me with the feeling of responsibility for them, they make me unique, irreplaceable, indispensable individual that I am: the entity whose disappearance would make a hole in the universe, create that void ... Unless 'I am for, I am not'. (Bauman 1992, p 40)

Being open to others is at the heart of human being, but if the mentor smothers the mentee, then the fears expressed by Burnard are justified. Mentorship is about exercising this human characteristic in genuine dialogue, so that ultimately both develop and feel needed through the relationship.

CONCLUSIONS

It might be asked whether mentoring actually works. Murray (1991) reports the following:

> An international management-consulting firm, Heidrick and Struggles, surveyed 1250 prominent men and women executives in the later 1970s (Roches 1979) to determine the factors contributing to their success. Nearly two-thirds of those surveyed reported having had a mentor or a sponsor. The positive results were both measurable and had less tangible indicators. 'Executives who have had a mentor earned more money at a younger age, ... are happier with their progress and derive greater pleasure from their work'.

But if this materialistic assessment is insufficient, then turn to Deloz's (1986) human story of the mentor and see the successful struggles of those adults endeavouring to achieve and doing so, sometimes against great odds, and the way that the mentor is able to be there with support when times are difficult. See the human side of the story – the I-Thou relationship which helps people to reflect upon their life, to transform their experiences and to learn and grow. For at the heart of all human being is relationship which helps to draw out the human essence from the existent, to create life from existence and to show that human being is always in the process of becoming.

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Reading 2

Journal of Advanced Nursing, 1999, **29**(1), 201–207 *Integrative literature reviews and meta-analyses*

Mentorship in nursing: a literature review

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ANDREWS M. & WALLIS M. (1999) *Journal of Advanced Nursing* **29**(1), 201–207
Mentorship in nursing: a literature review
The recent increase in published work relating to the supervision of nurses and in particular mentorship suggests that nurses value the opportunities that such schemes present for developing practice. Much of the literature surrounding mentorship concerns the supervision of students in practice settings but more recently, especially following the changes to post-registration education, attention has shifted to the supervision of qualified nurses. Although the principles of supervision for students and qualified nurses are the same, differences do occur in supervisory practices. This review examines the literature associated with the supervision of student nurses and focuses on the nature and practice of mentorship in practice settings. The literature reveals that confusion exists regarding both the concept of mentorship and the role of the mentor. Many authors propose models or frameworks for mentoring activities. These tend to outline the stages of the mentoring process and the relationship between mentor and mentee. No one model is seen as more appropriate than another and choice usually depends upon the mentor's familiarity with a particular framework. It is also evident that there is inconsistency in the length and level of preparatory courses for mentors. As yet there is in the United Kingdom no national minimum requirement or common preparation route and in practice mentors are prepared by way of the appropriate National Board Teaching and Assessing module and/or short local 2-day course.

Keywords: mentorship, supervision, post-registration education and practice (PREP), practice, preparation, education

INTRODUCTION

Many practice-based professions, including nursing, traditionally rely on clinical staff to support, supervise and teach students in practice settings. The underlying rationale is that by working alongside practitioners students will learn from experts in a safe, supportive and educationally adjusted environment (Benner 1984).

However, practice-based learning has not been entirely problem free. Some of the early British research relating to the 'ward learning climate' and the 'role of the ward sister' has illustrated both the positive and negative aspects of learning in practice settings, especially in relation to the

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supervision of students. The majority of these 'classic' studies were undertaken prior to the inception in the United Kingdom (UK) of the Project 2000 nurse education reforms (Orton 1981, Ogier 1982, Alexander 1983, Fretwell 1983).

Until the introduction in the United Kingdom (UK) of Project 2000 curricula (United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1986), clinical learning was conducted via an apprenticeship-type model, whereby students learnt 'on the job', simultaneously providing a service contribution. Project 2000 changed the way in which nurses are clinically prepared by affording them supernumerary status for the majority of their course and by raising the minimum academic level to that of higher education diploma, contributing 240 credits towards a 360-credit first degree.

Although informal mentorship programmes were evident prior to the initiation of Project 2000, they became integral to pre-registration education in the late 1980s, as the new programmes were introduced. Currently, in 1997, all students have some form of mentorship throughout the clinical practice elements of their course and in the main it is staff nurses who take on much of the day-to-day teaching and supervision of students (Neary *et al.* 1994).

The main preparation for becoming a mentor for pre-registration students is the English National Board for Nursing, Midwifery and Health Visiting (ENB) 998 course or it's equivalent in the other three countries of the UK. However, the quality and effectiveness of such schemes varies (Rogers & Lawton 1995). Some areas of the country, as a result of a shortage of mentors and an increasing demand for courses, rely on a 2-day mentorship preparation programme, the value of which may be questionable.

The aim of this literature review is to examine the nature of mentorship in relation to the supervision of students in practice settings. The majority of the literature examined is British; however some of the significant American literature is also included.

BACKGROUND

In reality, little attention prior to Project 2000 was given to the learning needs of students in practice settings, since the emphasis was on 'getting the work done' and in providing a service contribution (Melia 1987). This led in many cases to students being seen as 'valuable' members of the ward team rather than as students with specific clinical learning needs. Beckett (1984) believes that the apprenticeship model had many positive aspects and suggests that when good student supervision was evident, it was a useful way of linking theory to practice. However, qualified nurses only spent a small proportion of their time supervising learners (Fretwell 1983) and when student supervision did occur it was not always used as an opportunity by supervisors to relate theory to practice (Jacka & Lewin 1986, Sloan & Slevin 1991). Just being with a qualified nurse does not guarantee learning (Burnard 1988).

Discrepancies between theory and practice, commonly referred to as the theory–practice gap did and still do exist (Millar 1985, Wilson-Barnett *et al.* 1995).

Melia (1987) found that students consistently see theory as classroom-based learning and practice as ward work and in some cases find it difficult to justify the need for theory. Millar (1985) accounts for the disparity by suggesting that educationalists and clinicians value different things and use different language. Elkan and Robinson (1993), in a study of Project 2000 students, found the theory–practice gap still evident. Findings demonstrate that practitioners rate specific clinical skills as the most important aspect of ward-based learning but that educationalists value interpersonal skills much more.

It has long been accepted that educating nurses by apprenticeship is problematic; if students are to learn effectively then placing them in practice environments alone is insufficient (Pembrey 1980, Ogier 1982, Farnish 1983, Fretwell 1983).

Project 2000 challenges the way in which students were traditionally supervised in practice settings and as a consequence students currently undertaking pre-registration programmes in the UK are supported by mentorship schemes. The nature and effectiveness of these schemes vary but it is widely accepted that there are specific advantages for students (Attwood 1979, Chickarella & Lutz 1981, May *et al.* 1982, Darling 1984, Burnard 1988, Earnshaw 1995). Some would argue that there are also benefits for mentors (Davidhzir 1988, Andrews 1993).

THE CONCEPT OF MENTORSHIP

The origin of the concept of mentorship is well documented; it is said to originate from Homer's Odyssey, in which Mentor, a wise and trusted friend of Odysseus took on the rearing of his son in his absence (Bracken & Davis 1989, Donovan 1990, Barlow 1991). This image depicts a mentor as an older, wiser male who takes on the responsibility for a younger male's learning and development, rather like that of a guardian. The term has been traditionally associated with professions such as medicine, law, and business, but started to appear in nursing literature, in the early 1980s and resulted in a wealth of published material in the 1990s (Donovan 1990, Armitage & Burnard 1991, Anforth 1992, Jinks and Williams 1994, Neary et al 1994). The majority of the literature is concerned with defining the concept and determining the nature of the mentoring role, and a lack of agreement regarding the role and functions of mentors is a common feature (Morle 1990, Donovan 1990, Armitage & Burnard 1991, Barlow 1991). This situation has led Hagerty to refer to a 'definition quagmire'. There is overwhelming support

for the need for a consensus definition of the role and function of the mentor (Neary *et al.* 1994, Wilson-Barnett *et al.* 1995), although this remains elusive.

The picture is further confused by the interchangeable use by some, of terms such as preceptor, co-ordinator, facilitator and supervisor. A study by Wilson-Barnett *et al.* (1995) concerning clinical support for Project 2000 students found that in practice the terms 'mentor', 'assessor', and 'supervisor' are used inter-changeably to depict the same role. Neary *et al.* (1994) discovered additional terms such as co-ordinator, practice facilitator and preceptor being used.

Within nursing the term mentor carries a multiplicity of meaning. The ENB in an early document (ENB 1987) loosely refers to mentors as 'wise reliable counsellors' and 'trusted advisors', very much in line with conventional notions. Later reference (ENB 1988) however, places emphasis on the supervising and assessing elements of the role. Further elaboration by the ENB highlights the importance of students determining which role the mentor is undertaking at a given time. This only serves to confuse both clinicians and educationalists and the continued lack of clarity has led to some programmes discarding the term altogether (Barlow 1991).

By 1989 the ENB redefined a mentor as 'a person who would be selected by the student to assist, befriend, guide, advise and counsel' (p. 17 ENB 1989). In 1994 the ENB continued in the same vein making no further reference to assessment and supervision (ENB 1994).

In 1992 the Welsh National Board for Nursing, Midwifery and Health Visiting (WNB 1992 p. 13) provided the following definition of mentorship:

> Reserved for long term relationships between people, one of whom usually is significantly older and/or more experienced than the other... the nature of the relationship is implicit in the term protégé suggesting as it does a recognition of potential and a concern for the individual's well-being, advancement and general progress.

This clearly outlines the nature of the mentoring relationship and the role of the mentor. Later in the same paper the term preceptor is defined and the major differences between the two are highlighted. The WNB outline preceptorship as a more short-term arrangement than mentoring, with preceptors being responsible for teaching and assessing clinical performance. By 1992 the National Boards appeared to have a common notion of what mentors should do, or perhaps more importantly what they should not do.

In a study relating to Project 2000 Adult Branch students, Andrews (1993) found that the term mentor was consistently used in a generic way and that the role also incorporated aspects of preceptoring and supervising. Both students and mentors had a similar understanding of the concept. Although the interpretation of the role was not wholly in line with recommendations made by the National Boards, it did, however, mirror what was occurring elsewhere in the UK (Anforth 1992, Wilson-Barnett *et al.* 1995). Although both ENB and the WNB have identified specific role requirements, in practice mentors appear to adopt a generic role.

One of the major issues relating to the role of the mentor concerns the assessment of student performance. The National Boards for England and Wales both suggest that the roles of mentor and assessor are separate. However, in many practice settings, mentors do act as assessors (Anforth 1992, Wilson-Barnett *et al.* 1995).

RELATIONSHIP AND ROLE

There are several references in the literature to difficulties with mentorship in the UK (Donovan 1990, Armitage & Burnard 1991, Barlow 1991, Marriott 1991). It appears that the nature and quality of the mentoring relationship is fundamental to the mentoring process. Many studies highlight that when this is based on partnership and mutual respect the outcome is effective clinical learning (Earnshaw 1995, Spouse 1996). The importance of the personal characteristics and interpersonal skills of the mentor are also highlighted as significant.

It appears that the essence of effective mentorship hinges on the relationship between the mentor and mentee. Some propose that this should be highly intense, personal and emotional (May *et al.* 1982) but others suggest that it should be a more formal alliance (Hunt & Michael 1983).

May *et al.* (1982 p. 23) define the mentoring relationship:

> An intense relationship calling for a high degree of involvement between a novice in a discipline and a person who is knowledge and wise in that area.

Earnshaw (1995), in a study evaluating the mentoring experience from the students perspective, identified certain stages through which the mentoring relationship develops. Initially there is a 'settling in' period during which student and mentor 'assess' each other. The relationship then becomes more open and relaxed and friendship and trust develops. Students saw the type of relationship that developed as positive and mutually beneficial.

Others also highlight sequential stages in the relationship, Hunt and Michael (1983) suggest that the relationship is similar to a partnership which progresses through four phases; selection, protégé, breaking up and lasting friendship. In the initial stage the mentor and mentee 'choose' each other and define the nature of the relationship, rather like Earnshaw's (1995) 'settling in' period. The protégé stage which Hunt and Michael highlight as the peak period of the relationship, allows the mentee to work under supervision and instruction. Hunt

and Michael (1983) believe that the breaking up phase occurs between 6 months and 2 years after the establishment of the relationship and depends on factors such as moving on or a change of career. In reality, students in practice placements rarely remain in one place for longer than 8 weeks and are always in a position of moving on.

Myers Schim (1990) describes the Dalton/Thompson career development model in which four discrete stages in the mentoring process are identified: dependence, independence, supervising others and finally managing and supervising others. The stages form part of a model of professional development (The Dalton/Thompson Model) and although this has essentially been developed with trained nurses in mind the initial stages are not dissimilar to those experienced by students and mentors.

In the first stage Dalton and Thompson suggest that the new nurse is fairly dependent on the mentor and undertakes a subordinate role in which they require close supervision. The duration of the apprenticeship stage varies. The second stage sees the nurse and mentor developing a more equal relationship and the nurse moves from apprentice to colleague as less direct supervision is required. Myers Schim (1990) proposes that many nurses remain at this level for the remainder of their professional life. Some move on to become mentors themselves by demonstrating the personal and professional qualities of a mentor. Finally, stage four involves them becoming responsible for the performance of others and is characterized by a change in role to manager or supervisor, by which they not only become responsible for client case load but also personnel.

Williams and McLean (1992) use Maslow's hierarchy of needs to assist in the development of the mentor–mentee partnership. They propose using a non-didactic counselling approach and via individual mentee assessment outline seven specific categories of personal learning needs: psychological, belonging, esteem, cognitive, aesthetic and self-actualization. The mentor explores problems at each level with the mentee. For example, safety needs may concern the mentees' ability to recognize their limitations in the clinical setting, belonging needs may affect being accepted as part of the ward team.

EFFECTIVE MENTORING

A common theme in the mentoring literature is the significance of the personal characteristics of the mentor. Important characteristics as prerequisites of a 'good' mentor include, approachability, effective interpersonal skills, adopting a positive teaching role, paying appropriate attention to learning, providing supervisory support, and professional development ability (Darling 1984, Andrews 1993, Earnshaw 1995, Rogers & Lawton 1995). The literature illustrates a comprehensive catalogue of personal attributes and skills required for effective mentoring.

Darling (1984) conducted a 2-year study to determine what nurses want from a mentor and which characteristics they particularly valued. Darling (1984) identifies three 'absolute' requirements for successful mentoring, mutual attraction, mutual respect and subscription of time and energy. Intrinsic to the absolute requirements she identifies three basic mentoring roles: inspirer, inventor and supporter. Darling's study demonstrates that there are no differences between what nurses want from a mentor relationship and what other occupational groups, such as policemen, physicians or health care executives, require.

Darling (1984) defines the mentor role within 14 parameters, those of model envisioner, energiser, investor, supporter, standard-prodder, teacher-coach, feedback-giver, eye-opener, door-opener, idea bouncer, problem solver, career counsellor and challenger. These were used in a scoring system of 1–5 (1 = low, 5 = high) to measure the mentoring potential of individuals. This became known as the Darling MMP (measuring mentor potential). In the UK to date, the MMP instrument has only been adopted within the literature of the RCN (1992) and Open Learning Programmes of mentorship preparatory schemes. There are no further studies demonstrating the validity of the MMP instrument.

Evaluative studies conducted in the UK illustrate contrasting findings from mentor and mentee perspectives. Foy and Waltho (1989) evaluated the effectiveness of a scheme used for RGN (registered general nurse) and ENG (enrolled nurse general) students introduced 4 years previously. The findings indicate that having a mentor was beneficial for the majority of students, whilst only 8.3% indicated that there were no benefits. Jowett *et al.* (1992), 2 years later, however, found that as much as one-third of students felt that mentorship had not worked for them. The first of these studies was prior to the introduction of Project 2000 and the latter was conducted in the Project 2000 demonstration sites. The major benefit for students in Foy and Waltho's study was that professional development had been improved by having a mentor (60.4% of respondents). Foy and Waltho highlighted that third-year students felt they needed less time with a mentor than more junior students, something which in practice appears to be the case (Jowett *et al.* 1992).

Wilson (1989) studied mentorship from the mentor's perspective. Findings demonstrate that despite mentorship being seen as a positive activity there are difficulties relating to role conflict and lack of time to achieve optimum mentor supervision. Similar findings have been identified in other studies (Wright 1990, Andrews 1993, Atkins & Williams 1995, Rogers & Lawton 1995).

A study by Neary *et al.* (1994) involving four colleges of nursing in Wales, examined how educationalists, managers and practitioners defined and understood the role of practitioner-teachers. They purposefully chose not to use the term mentor because of the inherent lack of clarity of

the term. Key findings from this study demonstrate that students were allocated to mentors rather than choosing them, and that this selection, usually by the ward sister, was mainly on a rota basis, and in some cases as a result of 'chance versus choice' by the individual student.

Many of the recommendations in Neary *et al.*'s (1994) study mirror those identified in earlier work (Jowett *et al.* 1992, White *et al.* 1993). These latter two studies were conducted in England, which indicates that the picture in England and Wales is not dissimilar:

With specific focus on the mentor's perspective, Atkins and Williams (1995) analysed 12 practitioners' experiences of mentoring undergraduate students during a 9-week clinical placement. Again problems concerning role conflict and availability of time to mentor were evident. The potential for mentoring to foster 'personal and professional development' is evidenced in the study and supports the findings of earlier work (Wilson 1989, Wright 1990).

Earnshaw (1995), in a small study examining mentorship from the student's perspective, identified that students saw mentors as having a significant role in their clinical learning. Students in this study identified the role of supporter as a key role for the mentor. Students saw that mentors had a significant role in shaping their views on how they themselves would act as mentors, thus highlighting the importance and influence of role modelling.

Generally when mentors have frequent and appropriate contact with students, mentors are appreciated by students. Some authors do highlight barriers to effective mentoring, most notably lack of time and ineffective planning (Omerod & Murphy 1994, Earnshaw 1995, Wilson-Barnett *et al.* 1995). When contact between mentor and student is minimal and the organizational arrangements are poor, the mentoring process is, predictably, seen as less effective (Wilson-Barnett *et al.* 1995).

PREPARATION FOR THE ROLE

Who should act as mentors and what constitutes adequate preparation for undertaking the role is not well addressed in the literature. Earnshaw (1995) found that students preferred D grade staff nurses as mentors (this is usually the first employment grade awarded to a newly registered nurse in the UK). The reason students gave was that they felt closest to them in a hierarchical sense and because of this they (the mentors) would be more understanding of their (the students) needs. There is little further reference in the literature to this aspect other than that students in the majority of the more recent studies were mentored mainly by D and E grade staff nurses (Jowett *et al.* 1992, Andrews 1993, Neary *et al.* 1994).

From their findings, Foy and Waltho (1989) make four recommendations: firstly that mentorship should be implemented throughout training; secondly, that there should be opportunities for mentees to change mentors; thirdly, that student learners should be able to direct mentorship sessions; and lastly that mentors should be appropriately trained. It is interesting to note that these recommendations were reinforced by the English National Board (1990) and the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1986) for Project 2000 students. However, a later study by Wilson-Barnett *et al.* (1995) demonstrates that mentors are still ill prepared and that preparation varies from area to area.

In the main, educational preparation for mentorship is usually in the form of the ENB 998 Teaching and Assessing in Clinical Practice (or the Welsh National Board, WNB, equivalent) module and/or local short workshops. However, Wilson-Barnett *et al.* (1995) and Neary *et al.* (1994) identify shortcomings with this practice. The content and effectiveness of preparatory courses varies and research studies highlight that courses such as the ENB 998 (or equivalent) are inadequate (Wilson Barnett *et al.* 1995). In reality most mentors learn 'on the job'.

Jinks and Williams (1994), in a study evaluating the effectiveness of preparation programmes for teacher-assessors of Project 2000 community students, found that those practitioners who had undergone a 5-day preparatory workshop rather than the more formal ENB 998 course felt 'short changed'. This apparently indicates that the more extensive programmes are perceived as better preparation by practitioners. The findings of this study generally indicated that those who had undertaken a formal teaching and assessing course (50%), such as Community Practice Teacher/ENB 998, felt significantly more able to undertake the role.

Wilson-Barnett *et al.* (1995) highlight that where mentors understand supernumerary status and have experienced this, they see students as partners at appropriate stages in their education. They suggest that these aspects should be included in preparation programmes. Other requirements such as curriculum knowledge and the mentor's role in assessment strategies are highlighted by Spouse (1996) and course details and assessment criteria by Jinks and Williams (1994) and Rogers and Lawton (1995).

DISCUSSION

Amongst the many issues Project 2000 raises is the question of who is responsible for teaching and supervising students in practice placements? Some would propose that the nurse teacher is best placed to undertake this role, yet in practice there is little evidence to suggest that this is the case (Crotty 1993). The responsibility for the clinical supervision of students has shifted to clinicians. There is a common acceptance that the mentoring of students and all that this entails is firmly the responsibility of practitioners.

Current literature illustrates various interpretations of the role of mentors, differences in the selection and

preparation and variance in mentorship schemes in the United Kingdom.

Although the more recent literature, including that produced by the UK National Boards for nursing education, is now fairly consistent regarding a definition of mentorship, current practice does not reflect this and mentors tend to undertake a multi-functional role. With this continued disparity, brought about by the lack of clarity in the earlier literature, the potential for role conflict is great, making it difficult for new mentors to differentiate between the numerous roles in operation.

Whether future mentor roles are dictated by custom and practice or by guidance from professional bodies remains equivocal. There is, however, an urgency for educational bodies to monitor and regulate practice to avoid ambiguity and confusion. Most of all, role titles for practitioners need rationalizing and standardizing to ensure that all involved have a similar understanding.

Some nurses are not mentors by choice, it is thrust upon them as the student population increases relative to the clinical placement opportunities available. In addition, educationalists rely on clinical colleagues to select staff to act as mentors for students and in many cases the criteria for selection have not been identified and made explicit. This *ad hoc* arrangement does nothing to ensure that appropriate staff are utilized or that staff training needs are identified. A more formalized selection process is needed whereby individuals are chosen against identified criteria.

Students recognize that having a mentor is beneficial and most accounts recall positive aspects of the mentor/mentee alliance (Andrews 1993, Earnshaw 1995, Wilson-Barnett *et al.* 1995). Rewards for the mentor are less obvious and tend to be intrinsic, such as a personal satisfaction when seeing a mentee progress or development of teaching and learning skills. In the main, both students and mentors support mentorship and rarely question its value.

Most of the literature reports mentoring in a positive light and there is little that challenges the present *status quo*, despite there being little empirical evidence that having a mentor improves clinical learning. Reports from students usually highlight interpersonal skills, such as being 'approachable' and 'supportive', as important in a mentor. This is not to say that they do not see skills more directly associated with learning as necessary, just less important (Andrews 1993). It may be that when students feel better supported and more ' comfortable' in a clinical area they learn and that learning is less to do with direct transference of knowledge than with the nature of the relationship between mentor and student.

Perhaps in reality no one person has all the attributes of a 'good' mentor and students would be better served by a mentoring team, rather like a supervisory team instituted by some higher education establishments for students undertaking postgraduate research.

Mentors sometimes feel inadequate in mentoring roles, either because their own nurse training did not equip them for current practice or they have not been adequately prepared as mentors. The majority of practitioners have not undertaken diploma level education and feel that their practice experience and expertise does not wholly compensate for what they see as lack of theoretical background. They have doubts about their own level of preparation (Andrews 1993). This may just be a case of lack of confidence on the practitioners' part but will probably be evident until mentors have achieved a higher academic level than the students they supervise.

Mentors are prepared for their role in a variety of ways, ranging from just observing how others 'do it', to attending a formal course like the ENB 998, teaching and assessing in clinical practice. In the main, practitioners undertaking more formal routes feel better prepared than those who have completed short specific courses (Jinks & Williams 1994). However, some studies indicate that the present arrangements for preparing mentors are still inadequate (White *et al.* 1993, Neary *et al.* 1994). Several studies highlight the inadequacies of the present courses of preparation, especially in relation to content and academic level, but little has yet been done to address these omissions. There is no nationally recognized course which adequately prepares practitioners for a mentoring role.

In conclusion, if mentorship schemes are to be effective there is a need for stronger communication links between mentors, practitioner teams and those responsible for nurse education. Nurse teachers have an ongoing responsibility for quality monitoring aspects for their courses and for mentoring practitioners undertaking a mentoring role.

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Reading 3

RESEARCH IN PRACTICE

The effective mentor: a model for student-centred learning

KEY WORDS
mentorship, nurse training, students' experience

ABSTRACT
This paper is concerned with the relationship between student and clinical supervisor (known as a mentor) and its influence on nursing students' development of professional knowledge during his or her clinical practice. The paper is based on the results from a longitudinal naturalistic study of eight nursing degree students during their four-year programme. The study was concerned with investigating and describing how nursing students develop their professional knowledge while working in clinical areas. During the data collection and analysis it became evident that the influence of the clinical mentor and the nature of the relationship were central to students' knowledge growth. By undertaking a content analysis for the relevant data and using an inductive approach, five key aspects of the student-mentor relationship emerged. These five aspects will be presented and discussed along with the implications for nurse education and the role of clinical staff. This paper is abstracted from the original version, which appeared in *NT Research* 1996; **1**: 2, 1

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IN TRADITIONAL TRAINING schemes, student support has been a rather haphazard affair owing to students' intense work commitment and the lack of qualified staff available to supervise them. This is unsatisfactory for the student,[1,2] qualified staff[3] and patients.[4] Schools of nursing have attempted to resolve the problem by assigning students to a designated mentor.

This system of supervision in clinical practice has been in place since 1985 in the hospitals used for this study.[5] Now that nurses are educated on diploma or degree programmes where they spend the majority of their clinical experience as supernumerary members of the clinical team, an effective system of educational support is essential for their ultimate success as professional practitioners.

A Scottish study has shown that students who were given support from a mentor were more likely to feel part of the ward team and to value demonstration and supervised practice than those who did not.[6] These findings were supported by an Australian study which found that feeling accepted by the clinical staff, working with a practitioner who was familiar with the clinical setting and having opportunities to question practice were significant influences on students' learning.[7]

An essential part of the supervisory role is the transmission of practical or craft knowledge by clinical staff. Recent research has described the nature of clinical supervision experienced by diploma students and highlighted the extent to which it was influenced by clinical management structures.[8] It was also demonstrated that in areas where clinical staff felt well supported and were using a system of professional nursing care (primary or team nursing) the quality of supervision was high and students were in a better position to benefit from their placement. In the region where this study was conducted, degree course students were allocated to a member of the nursing team. From the findings of the study it became clear that the quality of supervision was not consistently good. This paper will describe the activities involved in providing good mentorship support.

Editor's notes

Project 2000 has attracted a number of criticisms since its introduction. One aspect that has been a centre of attention is the support that students receive in practice from their mentors. The study reported here provides valuable data about how the relationship between student and mentor can work. Mentorship is a skilled and rewarding facet of the nurse's role which should benefit both parties. Trusts and educators need to ensure that the role is properly valued and supported to improve the quality of care in the future.
Rob Garbett, practice development editor, ONursing Times

Method

The aim of the main study was to describe the lived experience of becoming a nurse and to understand the processes that influenced that experience. A qualitative approach known as naturalistic inquiry was employed.[9]

Tesch describes naturalistic inquiry as a mixture between ethnography and phenomenology in that it employs characteristics shared by other forms of interpretative qualitative research such as the use of natural settings, use of tacit knowledge, purposive sampling, and the use of inductive methods to analyse data.[10] Further characteristics of naturalistic research include the way in which the design of the research develops throughout the investigation (rather than being predetermined), and the use of case studies to report the findings.

Data collection

The data were collected using informal unstructured tape-recorded interviews which were audio-recorded and focused on the students' placement experiences. Additional information was obtained from:

- Students' written assignments
- Reports of critical incidents
- Visits during clinical placements to observe practice followed by an interview to discuss the practical experience.

Analysis of the transcripts

A content analysis of each transcript was undertaken using the search and find facility of a word-processing program. This was supplemented by a manual search for material on supervision experiences.

More than 250 items were extracted. This material was collected under the student's chosen pseudonym and then, using open coding, sorted into themes using diagrams and memos. The data were then collated under their relevant category with an identification and location label.

Following transcription and analysis participants were asked to verify the

Source: Spouse, J. (1996). The effective mentor: A model for student-centred learning. *Nursing Times*, *92*(13), 32–35.

Key points

- Learning in clinical practice is most effective when the mentor is willing to develop a caring and trusting relationship with the student
- The mentoring activity requires planning a match between learning need and available learning opportunities
- Opportunities to work in a supportive, collaborative role with the mentor and then to receive coaching when leading care are essential
- Staffing levels should reflect the additional work required to mentor learners in clinical practice
- Research is required into the precise nature of the mentors' extra workload and the implications for optimum clinical staffing levels

authenticity of the material. This approach fits with the collaborative nature of naturalistic inquiry and recognises the importance of adhering to the perspective of the research participants, if their lived experiences are to be reflected in the outcome.

Seven female students from a selected group volunteered to join the study early in the first year of the four-year nursing degree programme. An eighth student started in his second year.

Results

Five of the identified categories that emerged from the data were concerned with the mentor-student relationship and the quality of their educational activities. These five categories were: befriending, planning, collaborating, coaching and reflection.

Befriending

The characteristics of befriending are:

- The mentor initiated social interactions designed to promote trust and a sense of warmth and interest
- Openness and interest in the student's welfare that reduces the student's sense of 'being a burden'
- Willingness by the mentor to be seen as a person through sharing personal feelings and experiences.

Befriending seems to be the key to all the other learning activities in clinical practice. Without effective befriending, students tend to feel isolated from practice and the other members of the clinical team. They seem to become invisible, ignored and idle or left to roam the wards looking for something to do or someone to talk to.

Daloz describes the liberating value of the mentor's acknowledgement of the student's personhood and how it promotes creativity.[12] The social and emotional security provided by such caring relationships enabled students to express their weaknesses and to receive help and to mature both professionally and personally.

Befriending was particularly important in the first two years of students' clinical placements and was partly related to their increasing recognition of patterns of professional behaviour and their development of technical skills, which helped them undertake a role perceived to be useful. The mentor is the gatekeeper to their membership of the community into which they have been thrown.

The students' ability to orientate themselves to a new culture at every placement was highly dependent upon the mentor helping them adjust to the new environment and to learn the rules.

The accounts provided by the participants suggest that levels of stress experienced are inversely proportional to the degree of familiarity and friendliness offered by their mentor.

Planning

The planning activity is concerned with designing a programme to meet students' educational needs. The characteristics of planning in this instance involve:

- Providing a menu of experiences available in the clinical area
- Helping the student to identify areas of curriculum interest
- Helping the student to organise learning opportunities
- Selecting suitable patients (and perhaps members of the clinical team) for the student to work with and thus to develop identified skills.

In this activity, the mentor and student discuss the nature of the placement and the experiences that are necessary for a successful outcome. It is a discrete and important part of the mentoring relationship in that effective planning acknowledges the individual needs of each student. He or she is not depersonalised but recognised as travelling a unique route.[13]

Inevitably, the planning activity requires mentors to have knowledge of the curriculum, and of the assessment strategy, as well as a good professional knowledge of the clinical location and the patients or clients. Students' ability to identify their own learning needs developed as they became more familiar with the curriculum and clinical practice.

Even so, they continued to feel like strangers when starting each new clinical placement and needed the support of expert local knowledge from their mentors to plan their learning programme.

RESEARCH IN PRACTICE

Characteristics of the students and mentors in the study

Students

50% of time in clinical practice

12 placements of between 10 and 30 days

Negotiated clinical experience around timetable and mentors shifts

Evaluated on the basis of written evidence on critical incidents that showed achievement of clinical competencies

Mentors

First-level nurse with at least one year's experience

Recognised and respected as both knowledgeable and skilled in the area of practice

Underwent short induction programme

Access to peer support

Key responsibilities of the mentor role were seen as a 'facilitative relationship which included time for reflection and honest, straightforward feedback, ability to role model and to articulate rationale for research-based clinical practice'.

Many had attended ENB 998 teaching and assessing in clinical practice

Collaborating

This category seems to contain two major concepts: trailing and partnership. Trailing results from a lack of collaborative partnership with the mentor and the students are left to follow or to trail around seeking learning opportunities. Effective collaboration takes place when the student is seen as a full partner, working with the mentor and engaged in explanatory dialogue.

Characteristics of collaboration are:

- The mentor allows the student to work alongside as a partner when giving care
- The focus on the activity is mentor-initiated and led, in that the mentor identifies the nursing actions and carries them out with the student acting as assistant
- During the activity the mentor shares his or her craft knowledge about the patient's care needs and the manner in which they are being met
- The student is delegated aspects of patient care which contribute to the whole, for example, contributing to a procedure which needs two nurses or to undertake a discrete task commensurate with level of skill achieved.

Collaborative activity is particularly important when the student is new to a clinical area and unfamiliar with the nature of the nursing work. It seems to be vital to developing cognitive, affective and psychomotor skills, as described by one student, Hannah Peters, on her first clinical placement:

'I was listening to her (the mentor's) instructions and helping her...when she's going through it she reflects on things that you might think in your head but wouldn't necessarily say. I felt at ease with her because she was helping me, as opposed to watching and criticising me.'

Ms Peters' feeling of security and her mentor's democratic approach seems to have helped her recognise more than was overtly being demonstrated. It is during such experiences that students were able to recognise and learn from their mentor's intuitive or craft knowledge.[14] Such collaborative activities helped students engage in care-giving and to recognise its component parts.

During this study, the mentors carried a full workload which had to be balanced with the needs of a student. Some mentors were particularly good at juggling their priorities effectively and identifying aspects of care that could be safely delegated to their students. Lave calls this type of action 'legitimate peripheral participation' and it is designed to ensure that novices are able to participate and develop skill in key aspects of nursing care while learning to recognise the relationship of the part to the whole and without being at risk of causing harm.[15]

It is disappointing that students had relatively little experience of this activity. When it did take place it was often memorable and worthwhile. Many conversations were concerned with the presence, or lack of, either a collaborative or a coaching partnership.

On the whole it seemed that students were often being left to work alone with little apparent supervision.

Their experience reflected the findings of earlier studies where trained staff were more likely to expose students to technical procedures than to help them in developing general skills.[16] When students were given the opportunity to work with a mentor whom they trusted, there was little doubt that they benefited.

The characteristics of coaching in this study were:

- The student is the key actor in the designated nursing activity rather than the mentor
- Coaching takes place within a supportive relationship where the student is able to respect and trust the mentor's skills
- The mentor supplements the student's performance by providing specific guidance related to the skills practised
- The mentor's dialogue includes questions designed to challenge the students' perspective or to consider his or her actions in relation to patient need or relevant theory
- Evaluation of performance is discrete and takes place away from the patient.

Inevitably, practical technical tasks preoccupied students more than any other aspect of nursing, possibly because of the public nature of their performance and their fear of doing the patient harm. Concern for the patient and a strong sense of professional responsibility were paramount with all the students.

Sense making

The final category in the activities of mentor relationship builds on the strengths already described. Because of the nature of their assessment and the heavy emphasis on reflection in the curriculum, students were keen to discuss their work experiences. The mentor role specification included 'making opportunities for reflection'. As indicated earlier, not all mentors were able to provide this facility, having had little personal experience themselves. When the relationship was fragile, students appeared to avoid any meaningful dialogue.

Yet for all the students, entering into a sense-making dialogue was crucial to their progress. If they were unable to use their mentor they frequently used other sources, such as peers, parents, seminar group members, their professional tutor or the interviewer.

The characteristics of sense-making are:

Limitations of the study

- The small number of students involved made it difficult to generalise

Strengths of the study

- Longitudinal study providing consistent contact with participants
- Use of multimethod approach for basis of date collection
- Participants verify findings
- Small sample studied in depth providing valuable insights less likely in large scale projects

- A dialogue between student and a trusted mentor with the intention of clarifying thinking
- Students sometimes perceived the activity as challenging the mentor's practice or perceive the mentor's questioning as helpful and/or challenging. It is sometimes also perceived as threatening unless the relationship has been based on trust
- If the mentor cannot provide information the student may seek information from another source, ensuring this does not jeopardise the mentor-student relationship.

Conclusions

In some ways the mentor's role as explored here seems to echo the role of the clinical supervisor in teacher education developed in the 1960s and 70s. In this model the supervisory relationship was conceptualised to enhance learning through student-initiated problem-solving. Acheson and Gall identified three stages: planning, observation and feedback.[16]

The evidence provided here suggests that this framework misses some important and subtle aspects of the mentor role. This may be because of differences in the professions — the complexity of the wider arena of classroom practice in contrast to the one-to-one nature of nursing. As this paper argues, the quality of the relationship is fundamental to a successful outcome.

The findings from this study suggest that an effective mentoring process is subtle, and while there may be recognisable development in the student's professional ability, the demands of the curriculum also increase, causing the student continually to move through a cycle of high dependence to independence within each placement.

With increased competency the length of time in the dependent stage shortens but continues to exist. The pace at which such progress is achieved seems to depend on a variety of factors, the most important being the quality of the micro learning environment of the mentor partnership. From such a learning environment the student is able to expand and explore his or her world view and to engage successfully in clinical practice.

Using the metaphor of a savings account, these experiences can either create a credit or a debit. Where the mentorship experience account is in credit the student adjusts more rapidly in each placement and learning is exciting and effective.

Conversely, where the balance of account is precarious or in debt owing to a number of uncomfortable experiences, the student's progress slows or a decision to leave the course is made.

The effective use of the five key mentor activities discussed here seems central to students' professional development. Learning about theory becomes relevant and an exciting part of practice. To help clinical staff to fulfil the mentor role effectively it is important to ensure that the clinical workload is adjusted to recognise the time and energy required.

Another key factor is the mentor's interpersonal skills and knowledge of the curriculum. These influence mentors' willingness and ability to respond to students' learning needs and hence ability to challenge and be challenged.

In addition, providing mentors with the opportunity to explore their own practice under conditions similar to those they are expected to create for students will help them to continue to develop professionally. Mentor preparation should include information about the curriculum as it applies to students visiting their area of practice and the mentor's role in assessment strategies.

Another activity essential to the successful relationship is for mentors to recognise and value their own knowledge and skills and to be willing to articulate the nuances of expert practice that constitute good patient care.

Perhaps the most important elements however are enthusiasm and commitment to the welfare and education of students. The rewards of such an investment are improved patient care, which is surely good for everybody concerned. **NT**

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Reading 4

ISSUES AND INNOVATIONS IN NURSING EDUCATION

Students' perceptions of the effectiveness of mentors in an undergraduate nursing programme in Hong Kong

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Students' perceptions of the effectiveness of mentors in an undergraduate nursing programme in Hong Kong

Aim of the paper. This paper reports the results of a multiple-phase study on a mentoring scheme for nursing students in one of the universities in Hong Kong. Using a qualitative approach, students' perceptions of the various roles of mentors were collected, and this information was used as the basis to design a tool for subsequent evaluation of the mentoring scheme.

Background. The nursing department in one of the universities in Hong Kong initiated and developed the idea of an 'Honorary Clinical Instructors' scheme (HCI scheme) for the supervision of the pre-registration nurses. The scheme was examined in a local context, where the Chinese culture dominated, so that a standardized protocol that takes into account the potential cultural dimensions could be established.

Design. The mentoring roles outlined by the English National Board (ENB) for Nursing, Midwifery, Health Visiting were used as a framework to identify undergraduate nursing students' perception of the effectiveness of mentors. Information gathered from interviews with Year 2 students ($n = 12$) and Year 3 students ($n = 10$) was used as the basis to design a questionnaire for subsequent programme evaluation. An evaluation questionnaire based on the interviewing results was developed for further evaluation of the mentoring scheme.

Findings. After the mentoring scheme was evaluated in semester one, a series of strategies were designed to improve the preparation of mentors and the implementation of the scheme. The strategies were identified as effective by the significant differences in the perceptions students had towards the mentoring scheme in semester one and semester two ($t_{189} = -4{\cdot}80$, $P < 0{\cdot}001$), with semester two ($n = 81$) having a mean score difference of 8·69 higher than in semester one ($n = 110$).

Conclusions. It was concluded that the questionnaire developed in the project could be adopted as a useful instrument to evaluate the effectiveness of mentoring programmes for nursing courses, and that the results of this study may also stimulate more research interest in this area to improve the quality of clinical teaching in the pre-registration nursing education programmes in the future.

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Keywords: nursing education, clinical teaching, mentoring, Hong Kong, student perceptions, evaluation

Introduction

The use of staff from the clinical areas to facilitate student learning in the field setting has been widely employed. A mentor–mentee relationship between clinically skilled nurses and students is often established for the purpose of helping students to acquire clinical competence and skills, increasing their decision-making abilities, and smoothing the transition to the workplace (Yates *et al.* 1997, Northcott 2000). Despite the fact that mentoring is considered a key in the successful preparation of professionals, until recent years, the majority of clinical placements for the nursing undergraduates in universities in Hong Kong were supervised by academic staff. In the latter half of 1996, the nursing department in one of the universities in Hong Kong initiated and developed the idea of an 'Honorary Clinical Instructors' scheme (HCI scheme), whereby a joint effort occurred between the academic institute and the participating hospitals in the supervision of the preregistration nurses. Under this scheme, the clinical staff who were appointed as 'HCI' were recruited to become mentors to the undergraduate students on a more regular basis, providing clinical supervision and mentoring to students in the assigned units throughout the semester. These mentors remained full time employees of the hospital, and held regular nursing duties in the units they were committed to, but at the same time took two students under their supervision during their span of duty.

As a standardized protocol that takes into account the potential cultural dimensions in evaluation of the mentoring experience in the clinical setting was not available, we proposed to examine the HCI scheme in a local context, where the Chinese culture dominated. The purpose of this paper is to explore the students' perceptions of the effectiveness of clinical mentors in an undergraduate nursing programme in Hong Kong.

Literature review

The concept of mentorship was first introduced within the academic and business worlds of North America, and has become an important and emerging tool for preparation of professionals (Laurent 1988, Earnshaw 1995, Spouse 1996, Northcott 2000). With the implementation of the Project 2000 in the National Health Services, the United Kingdom has witnessed the transfer of clinical supervision by teaching staff from schools of nursing to mentors actually working in the ward (Hunt & Michael 1983, Bracken 1989, Phillips *et al.* 1996). The idea of mentorship has been therefore widely adopted within the clinical setting in the last two decades. Under the British system, generally, the mentor–student relationship is arranged formally by the teaching institute, with students being assigned to mentors during their clinical placement (Foy & Waltho 1989), the emphasis is on facilitation of learning (Burnard 1988) and preparation for the uptake of the professional role.

As stated in many studies, clinical mentors have the most updated information on the practices in the clinical areas where students are having their placement (Marriot 1991, Myrick & Barrett 1994, Spouse 1996). While Hagerty (1986) examines the concept of mentoring from the organizational framework, defining the structural roles of mentors and exploring the importance of the interpersonal perspective of mentoring, Darling (1984) explores the absolute requirements for significant mentoring relationships. Bracken (1989) provides useful guidelines for the implementation of mentorship schemes; and Woodrow (1994), having explored the perceptions of mentorship, makes recommendations for managing the possible pitfalls arising from a mentoring relationship. After analysing the student–mentor relationship, Spouse (1996) suggests that mentorship could be developed into a model of student-centred learning. However, none of these studies have been able to offer a protocol for implementing or evaluating the mentoring experience, nor have the potential cultural dimensions that might affect the mentoring experience been examined. Therefore, we felt that it was necessary to examine the HCI scheme within a local context, so that a standardized protocol that takes into account the potential cultural dimensions could be established.

The study

Design

This study consisted of four phases. In the earlier phase of the study, a qualitative approach was adopted to identify the students' perceptions and expectations of the various roles of mentors. The information was used as the basis to design a tool so that the effectiveness of the mentoring scheme in subsequent phases could be evaluated using a quantitative approach. Details of the four phases are described below.

Phase I: Preparation of the mentors

Workshops of 1–2 days were organized for the mentors to prepare them for the mentoring role. Potential mentors were invited to join the workshop and mini-lectures, in which the different roles of a mentor were explored.

Phase II: Exploration of the student's perception of the roles of mentors

The second phase of the project involved a qualitative study to explore students' perceptions of the roles of the mentors and their general views on the mentoring scheme. The preregistration nursing undergraduates had been exposed to the new mentoring scheme and were invited to attend informal face-to-face interviews. A qualitative approach allowed us to amass useful data which were not available from previous research.

As there had been no existing framework for the evaluation of mentoring schemes in Hong Kong, the definition of mentor used by the English National Board (ENB) for Nursing, Midwifery and Health Visiting were employed. The ENB defines mentors as 'appropriately qualified and experienced first level practitioners, who by example and facilitation guide, assist and support students in learning new skills, adopting new behaviours and acquiring new attitudes...Mentors are there to assist, befriend, guide, advise and counsel students' (ENB 1988, p. 17). This definition was used as a framework for the development of the different roles of mentors, and a semi-structured interview was conducted to elicit information from students about their perceptions of the role of mentors. The use of a semi-structured interview guide helped the interviewers to remain focussed on the issue, and at the same time allowed room for the researchers to make clarifications whenever necessary throughout the interviewing process (Burns & Grove 1997, p. 354). Each interview was audio-recorded for data analysis. Supplementary interview notes were also taken.

The second phase of the project was conducted at the end of the semester when most of the students in the second, third and fourth year of their 4-year programme had at least 4 months' experience with the newly introduced mentoring scheme. In this phase, students were recruited on a voluntary basis from the second and third year of their study, with 12 from Year 2 and 10 from Year 3.

Taped recordings of the semi-structured interview were transcribed verbatim in Chinese. These statements were then clustered under the five categories of mentors' roles as suggested by the ENB. Inter-rater reliability was established by involving at least two members of the research team in examining the transcripts. The statements were also verified against the original transcripts for validation, and were then translated into English for subsequent uses in later phases of the study. Backward translation of the list was carried out to ensure that the original meanings in the Chinese version were preserved.

Phase III: Development of an evaluation questionnaire

After a detailed analysis of the data gathered from the Phase II interviews, the students' perceptions of the various aspects of the mentors' roles and the effectiveness of their mentors in performing these roles were identified. The information was subsequently used in the design of a tool to measure the students' perceptions of the effectiveness of mentors. The questionnaire which was developed from the students' comments in the second stage was sent to three experienced nursing academics with rich experience in clinical teaching for comments and validation. A high content validity index of 90% was obtained. The questionnaire was then refined according to the experts' advice. The revised questionnaire consisted of 33 items that related to the students' perception of the effectiveness of a mentor, namely befriending (seven questions), assisting (five questions), guiding (six questions), advising (eight questions) and counselling (seven questions). Responses were indicated on a 4-point Likert Scale from 'strongly agree' to 'strongly disagree'. The overall rating by students of the 'HCI scheme', the degree of satisfaction with the supervision of the mentor(s), demographic data, and qualitative comments or suggestions were also collected. A pilot study was conducted with 10 students. The evaluation questionnaire is displayed in Appendix 1.

Phase IV: Evaluation of the interventions and the 'improved' mentoring scheme

After the implementation of the mentoring scheme in the first semester, a full population survey of all students who had experience of the mentoring scheme was conducted ($n = 145$) by using the evaluation questionnaire. Questionnaires were distributed during classes to students who were under the mentoring scheme during the 1997/1998 academic year. The quantitative data obtained were then used to provide more concrete information about the students' perceptions of the effectiveness of mentors, and changes were made accordingly. The workshops for preparing the mentors were more structured and organized, the roles of the mentors were more delineated and made more explicit to the mentors. Printed material was offered to the mentors in a package form, including information on the programme structure and the curriculum of the students, the learning objectives of various settings, the students'

expected competency level, the evaluation mode and the modes of contact with the responsible staff team. After a series of strategies had been implemented, the evaluation questionnaire was distributed again to the students ($n=93$) for evaluating the effectiveness of the 'improved' mentoring scheme at the end of semester two. Year 1 and Year 4 students were not recruited after semester two because they were not under the 'HCI scheme' during the specified period.

Ethical issues

To ensure ethical clearance, all students who participated in the study from the second phase onwards were fully informed about the nature and purpose of the project, and emphasis was put on the voluntary nature of their participation. Students were informed that refusal of or withdrawal from the research at any stage would not affect their undergraduate study in any form. Informed consent was obtained and consent forms were signed prior to the interviews. Also, permission to audio-record the interview was asked. Names were not disclosed during the interview or in the reporting to ensure confidentiality of the participants. The participants were informed that any identifying materials such as the audiotapes would be kept locked in appropriate facilities, and would be destroyed after the completion of the report writing. In the fourth phase of the project, consent to participate in the project was demonstrated by the return of the completed anonymous questionnaire. Anonymity and confidentiality in treatment of the data were strictly observed.

Data analysis

The quantitative data collected from Phase IV of the study were analysed by Statistical Package for Social Sciences for Windows (SPSS) version 9·0. Descriptive statistics were compiled individually for data collected at the end of the first and second semester. The higher the scores achieved, the more effective the roles of the mentor(s) as perceived by the student. Parametric tests such as *t*-test and analysis of variance (ANOVA) were used to see whether 'gender' or 'year in bachelor of nursing course' affected the students' perceptions of the effectiveness of the mentors' in their roles. Chi-square tests were conducted when the impact of the above demographic data on the overall ratings of students and the satisfaction level of the supervision of their mentor(s) were examined. Data collected in both semesters were compared in order to determine whether any improvements had been made after certain strategies were implemented during the second semester.

Results

The following results focus on the evaluation of the effectiveness of the mentors in performing their roles in two semesters (i.e. Phase IV of the study). A total of 110 students (76%) returned the questionnaires distributed at the end of the first semester, and of these students, 41 students were from Year 2, 34 students from Year 3, and 35 studying Year 4. For the questionnaires distributed at the end of the second semester, 81 students (87%) participated in the study, with 34 from Year 2 and 47 in Year 3. Among the respondents in semester one, there were 19 males (16%) and 91 females (84%); while in semester two, 18 were males (22%) and 63 were females (78%).

Students' perceptions of the effectiveness of mentors

The students' perception of the effectiveness of the mentor in performing the roles, namely befriending, assisting, guiding, advising and counselling were indicated on a 4-point Likert Scale, from 'strongly agree' having a score of 4, to 'strongly disagree' with a score of 1. It was found that the perceptions of students about the roles was significantly different in semester one and semester two ($t=-4·80$, d.f. $=189$, $P<0·001$), with semester two having a mean score difference of 8·69 higher than in semester one (Table 1). Gender was found to be an insignificant factor as both female and male respondents had similar perceptions about the programme. The results also demonstrated that 88% ($n=94$) and 90% ($n=71$) of students in semester one and semester two, respectively, preferred to be supervised on a 1:2 mentor:student ratio during clinical placement, with a relatively smaller percentage of students preferred to be supervised on a 1:1, 1:3 or 1:4 ratio.

Overall rating of the mentoring scheme by students

Overall, students were more positive about the mentoring scheme in semester two than in semester one, with an average of 'fair' to 'good' experience in semester one, to an increase of 'good' to 'very good' experience in semester two (Figure 1). Moreover, students' 'satisfaction' level with the supervision of mentors increased from 47% in semester one to 61% in the second semester (Figure 2). Chi-square analysis showed a significant difference in the overall experience of students of the mentoring scheme ($\chi^2=20·06$, d.f. $=4$, $P<0·001$), and the satisfaction level of students with the supervision of their mentors ($\chi^2=11·19$, d.f. $=4$, $P=0·02$) between the two semesters. Further analysis demonstrated that there was a significant relationship between students' overall experiences of the scheme and their satisfaction level with the

Table 1 Perceptions of the mentoring scheme by students

	Semester one Mean (SD) ($n = 110$)	Semester two Mean (SD) ($n = 81$)	Mean difference	Level of significance
Befriending role (total seven questions, with a minimum score of 7 and a maximum score of 28)	19·98 (3·17)	22·16 (2·95)	2·19	$t_{189} = -4·80$, $P < 0·001$
Assisting role (total five questions, with a minimum score of 5 and a maximum score of 20)	13·54 (2·34)	14·71 (2·13)	1·17	$t_{189} = -3·51$, $P < 0·01$
Guiding role (total six questions, with a minimum score of 6 and a maximum score of 24)	15·83 (2·69)	17·46 (2·57)	1·63	$t_{189} = -4·16$, $P < 0·001$
Advising role (total eight questions, with a minimum score of 8 and a maximum score of 32)	21·80 (3·27)	22·92 (3·48)	1·12	$t_{189} = -2·26$, $P < 0·05$
Counselling role (total seven questions, with a minimum score of 7 and a maximum score of 28)	17·64 (4·31)	20·22 (3·02)	2·58	$t_{189} = -4·56$, $P < 0·001$
Total number of questions: (33 questions, with a minimum score of 33 and a maximum score of 132)	88·78 (12·33)	97·47 (12·02)	8·69	$t_{189} = -4·80$, $P < 0·001$

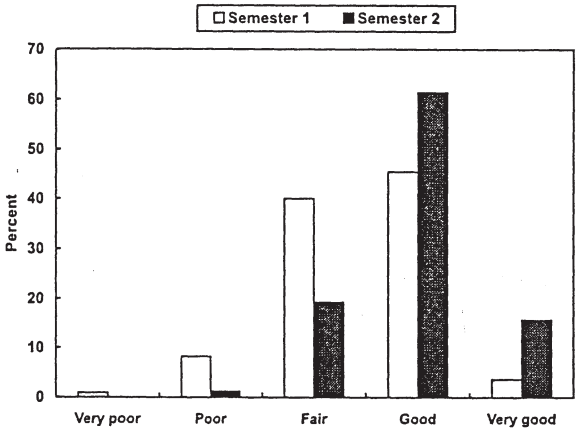

Figure 1 Overall experience of students towards the mentoring scheme.

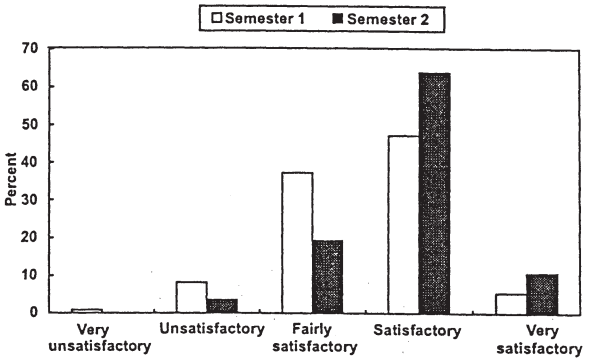

Figure 2 Overall satisfaction towards the supervision of the mentors.

supervision of the mentors in both semester one ($\chi^2 = 221·41$, d.f. = 16, $P < 0·001$) and semester two ($\chi^2 = 37·12$, d.f. = 9, $P < 0·001$).

The results of the analysis of variance (ANOVA) illustrated that there was a significant difference in the perceptions of the mentoring scheme among all levels of students in the first semester ($F = 9·25$, d.f. = 2, 104, $P < 0·001$), and a *post-hoc* test further illustrated that there is no significant difference in the perceptions of the scheme between Year 2 and Year 3 students ($P = 0·66$), but Year 4 students have a significantly lower mean difference than the second-year students ($P < 0·001$). As Year 4 students were not supervised by the mentors in semester two, a *t*-test was conducted to examine the perceptions of the mentoring scheme between Year 2 and Year 3 in semester two, and no significant difference between the students of these two years was seen ($t = -0·14$, d.f. = 77, $P = 0·89$).

Discussion

The data gathered from the Phase II interviews showed that majority of students agreed that the five roles of mentor as defined by the ENB were essential functions of a mentor. Many students thought that the assisting role of the mentors from the clinical setting was being fulfilled. It was common to find that mentors had a clear understanding of the client's condition, and were familiar with clinical practices current in the unit, and thus were able to assist students in performing the clinical tasks.

Most students agreed that the guiding and advising roles of the mentors were fulfilled in most settings. However, students found many mentors did not achieve the befriending role adequately. Most students prepared themselves to be a team member of the ward and tried to develop a sense of belonging to the wards, but were generally treated as 'guests' by the mentors or the ward team. As for the counselling role, this was considered to be least important and not very well taken up by the mentors. Students reflected that this should be an

important role, particularly when they encountered job stress in the ward setting. Many authors (Andrew & Wallis 1999, Watson 1999) also point out that when the contact between mentor and student is minimal, the mentoring process is seen as less effective and this makes it difficult for the mentors to exercise their roles realistically.

When comparing the results from the second and the first semester, it was noted that students' attitudes towards the mentoring scheme had improved, as reflected by a higher mean across the five roles. As Atkins and Williams (1995) emphasize, mentoring nursing students at undergraduate level is a complex and skilful activity, and requires educational preparation, support and recognition. After the implementation of a series of workshops and provision of necessary materials, mentors expressed a better understanding of the structure of the scheme and expectations of their roles. In addition, clinical seminars were added to allow students in the mentoring scheme to have a chance to meet with the academic staff. This arrangement helped students' clinical learning by acting as a bridge across the communication gap between the clinical setting and the university.

Conclusion

The findings of this project help to describe the learning experiences and concerns of Hong Kong nursing undergraduates about the mentoring scheme. The information gained from this project will assist with the improvement and facilitation of future mentoring schemes in Hong Kong. The questionnaire developed in the project could be a useful instrument for evaluating the effectiveness of mentoring programmes in other nursing programmes, for example, the Higher Diploma in Nursing. The limitations of this study lie in the short evaluation period of the mentoring scheme, and also in the difficulties of allocating enough mentors for clinical supervision across all years. Further studies are needed to evaluate whether significant differences in the perceptions about the mentoring scheme among different years of the nursing students exist, so that a comprehensive picture of the mentor–mentee relationship among students across all years can be developed. Moreover, as this is the first project of this kind in the local setting, it may stimulate more research interest in this area and help to improve the quality of clinical teaching in the preregistration nursing education programmes in the future.

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Appendix 1 The evaluation questionnaire

Students' perception of the effectiveness of the roles of a mentor
(Responses were indicated on a 4-point Likert Scale from 'strongly agree', 'agree', 'disagree' to 'strongly disagree')

How do you think your mentor has achieved his/her befriending role?

1. My mentor introduces me to the ward staff/team.
2. My mentor orientates me to the clinical environment.
3. My mentor always calls me by my name.
4. My mentor has a warm and friendly attitude.
5. My mentor is concerned about my occupational safety during placement.
6. My mentor does not make me feel 'under pressure' during his/her supervision.
7. My mentor makes me feel that I am being respected.

How do you think your mentor has achieved his/her assisting role?

8. My mentor helps me adapt to the clinical setting.
9. My mentor helps me fulfil my clinical learning objectives by giving me appropriate learning opportunities.
10. My mentor helps me develop the identified psychomotor skills.
11. My mentor sets a role model for me on how to interact with the clients.
12. My mentor introduces me to new clinical ideas and concepts.

How do you think your mentor has achieved his/her guiding role?

13. My mentor assigns clinical tasks by taking into account of my level of ability.
14. My mentor facilitates the communication between the client and me.
15. My mentor is keen to teach.
16. My mentor gives hints and guidance whenever necessary.
17. My mentor guides me to perform the future role of a registered nurse.
18. My mentor helps me put theory into practice.

How do you think your mentor has achieved his/her advising role?

19. My mentor provides me with feedback on my clinical performance and ways of improving my practice.
20. My mentor stimulates me to thinking critically.
21. My mentor helps me explore clinical issues more deeply.
22. My mentor suggests me alternative ways of performing a task.
23. My mentor helps me understand the rationales behind the way I practice.
24. My mentor points out my mistakes in my performance without embarrassing me.
25. My mentor provides me chances to express my opinion on my performance.
26. My mentor recommends sources of relevant references to me.

How do you think your mentor has achieved his/her counselling role?

27. My mentor provides me with emotional support.
28. My mentor helps me examine my career interests.
29. My mentor enhances my confidence on practice.
30. There is a mutual understanding between my mentor and me.
31. My mentor shares his/her own professional experiences with me.
32. I am willing to share my learning experiences with my mentor.
33. My mentor expresses his/her concerns to my learning needs.

Overall rating:

1. Overall, I consider the mentoring scheme experience in this semester was:	very good [ ]	good [ ]	fair [ ]	poor [ ]	very poor [ ]
2. Overall, I consider the supervision of my mentor was:	very satisfactory [ ]	satisfactory [ ]	fairly satisfactory [ ]	unsatisfactory [ ]	very unsatisfactory [ ]

Demographic data:

(1) Gender	M [ ]	F [ ]		
(2) Year of study	1 [ ]	2 [ ]	3 [ ]	4 [ ]
(3) Semester	1 [ ]	2 [ ]		

Reading 5

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Perceptions of effective clinical teaching behaviours in a hospital-based nurse training programme

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Perceptions of effective clinical teaching behaviours in a hospital-based nurse training programme
Clinical teaching behaviour is a critical determinant for quality clinical learning experiences of student nurses. It is believed that a better understanding of the perceptions of clinical teaching behaviours between student nurses and nurse educators will enhance clinical teaching. This study examined the perceptions of effective clinical teaching behaviours of nurse educators by student nurses ($n=81$) and nurse educators ($n=10$) in a hospital-based 3-year general nurse training programme in Hong Kong. Knox & Mogan's Nursing Clinical Teacher Effectiveness Inventory (NCTEI) (1985) was adopted. The respondents were asked to rate the importance of each discrete behaviour on a seven-point scale. It was found that there was greater agreement in the 10 most important behaviours than the 10 least important behaviours among the four groups: students, junior students, senior students and nurse educators. No statistically significant difference could be identified in the perceptions between the nurse educators and students as well as between the junior and senior students regarding the five behavioural categories. The nature and the student status of the nursing programme was accountable for most of the discrepancies between the findings of this study and those of past studies.

Keywords: perceptions, clinical teaching behaviours

INTRODUCTION

Hospital-based nurse training is the major stream of nursing education in Hong Kong. In a 3-year hospital-based nurse training programme, student nurses are required to spend about 70% of the training period in the clinical settings. Clinical teaching not only enables the learners to integrate the knowledge and skills associated with caring for patients, but also gives learners the opportunity to internalize the role of the nurse as caregiver (Woolley & Costello 1988, DeYoung 1990). If identity as a nurse and identification with the nursing profession is not developed, the student nurses will have little incentive to stay in nursing (Flagler *et al.* 1988). Therefore, it is of utmost importance to ensure that students receive quality clinical practice which enhances their learning and retention in nursing. According to Windsor (1987), the quality of clinical practice depends on the quality of the clinical teaching which in turn, greatly depends on the characteristics of the clinical teacher.

LITERATURE REVIEW

The literature survey of past studies on effective clinical teaching behaviours mainly focused on the last 18 years (1978–1995).

Wong (1978) employed the critical incident technique to question the baccalaureate nursing students ($n=14$) in

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Canada regarding their perceptions of teacher behaviours in the clinical field. Her findings showed that the teacher's display of confidence in him/herself and in the students was helpful to student learning. Wong also found that first-year students were particularly sensitive to 'how the teacher made them feel', whereas students in the second year were more concerned with 'teachers' competency in teaching'.

O'Shea and Parsons (1979) studied the baccalaureate nursing students ($n=24$) in one university in the USA. The respondents were asked to list two sets of teacher behaviours that enhance or hinder their clinical learning respectively. It was found that the faculty considered role modelling to be an effective behaviour five times as often as students did.

Brown (1981) used a self-constructed questionnaire to study the perception of effective clinical teachers in one southern university in the USA. The sample included both faculty ($n=42$) and the baccalaureate nursing students ($n=82$). Respondents rated the relative importance of 20 characteristics, and then selected and ranked the five characteristics that they believed to be the most important ones. The results revealed that the students regarded the teachers' relationship with students as more important than professional competence. However, the faculty had an opposite perception. Both groups ranked 'provides useful feedback on student progress' and 'is objective and fair in the evaluation of the students' as the two most important characteristics.

Mogan and Knox (1987) conducted a research to identify and compare the characteristics of 'best' and 'worst' clinical teachers as perceived by the university nursing faculty ($n=28$) and students ($n=173$) in the USA and Canada. The Nursing Clinical Teacher Effectiveness Inventory (NCTEI) constructed by themselves in 1985 (Knox & Mogan 1985) was used to collect data. The findings showed that both groups perceived that 'being a good role model' was the highest rated characteristics for 'best' teachers and the 'lowest' rated characteristics of 'worst' teachers. Faculty and students' perceptions were similar regarding the characteristics of 'best' clinical teachers. Less agreement was noted about the characteristics of 'worst' clinical teachers.

Mogan and Knox's study (1987) was replicated by Nehring (1990) to study the baccalaureate nursing faculty ($n=63$) and students ($n=121$) in Ohio. Nehring's results showed that both faculty and students agreed that the best clinical teachers were 'being a good role model', 'enjoying nursing', 'enjoying teaching' and 'demonstrating clinical skills and judgment'. The most distinguishing characteristic between the 'best' and the 'worst' clinical teachers was 'being a good role model'. This finding was consistent with that of Mogan & Knox (1987).

In Australia, Kanitsaki & Sellick (1989) conducted a rather comprehensive study on the characteristics of effective clinical teachers from the students' perspective. They surveyed 402 nursing students to study their perception of the importance of clinical teacher behaviours and the extent to which perceptions were influenced by year of study, educational institution, student status and demographic characteristics. The respondents rated the importance of 20 clinical teaching behaviours on a seven-point Likert scale. Results revealed that there were significant differences for year of study, institution, student status, age and gender.

After exploring the perception of nursing students on the characteristics of effective clinical teachers, Sellick & Kanitsaki (1991) continued the study from the faculty perspective. Meanwhile, they compared the findings from this study with the previous one (Kanitsaki & Sellick 1989). The sample involved 42 clinical teachers. It was found that teachers rated all behavioural categories as more important than did students. There were statistically significant differences on all measures between the perception of students and faculty. However, both of them regarded 'teacher behaviours' to be the most important and 'evaluation behaviours' to be the least important clinical teaching behaviours.

The most recent study on effective clinical teaching behaviours was done by Sieh and Bell (1994) in associate degree programmes in two south-western community colleges. Knox and Mogan's (1985) Nursing Clinical Teacher Effectiveness Inventory was used. The results revealed no significant difference between the students' and faculty's perceptions.

Accordingly, the similarities and differences among the reviewed studies are identified for subsequent analysis. Firstly, the approaches of the previous studies can be generally grouped into three perspectives: student perspective (Wong 1978, Kanitsaki & Sellick 1989), faculty perspective (Sellick & Kanitsaki 1991) or both student and faculty perspectives (O'Shea & Parsons 1979, Brown 1981, Mogan & Knox 1987, Nehring 1990, Sieh & Bell 1994). In examining the studies with student perspective, only two studies (Wong 1978, Kanitsaki & Sellick 1989) explored the students' perception according to the level of the nursing students. Comparatively, Kanitsaki & Sellick's study (1989) was a rather comprehensive one and it involved the largest sample of nursing students ($n=402$). Nearly all the studies mentioned above focused on the perception of the baccalaureate nursing students (Wong 1978, O'Shea & Parsons 1979, Brown 1981, Mogan & Knox 1987, Nehring 1990). Only the studies done by Kanitsaki & Sellick (1989) and Sieh & Bell (1994) involved other nursing student status.

Secondly, the studies were either exploratory or descriptive in nature. A questionnaire was commonly used as the tool for data collection (Brown 1981, Mogan & Knox 1987, Kanitsaki & Sellick 1989, Nehring 1990, Sellick & Kanitsaki 1991). Nehring (1990) claimed that the clinical teacher behaviours were explored with different method-

ologies which made direct comparison among the studies impossible. Nevertheless, it is found that the characteristics of effective clinical teachers identified in the studies can be categorized into five major dimensions: teaching ability, professional competence, personal qualities, inter-personal relationships and evaluation.

Thirdly, there is little consensus on the effective clinical teaching behaviours among the past studies. This may be due to the differences in faculty and student samples across the studies as well as the teacher behaviours that have been investigated (Sellick & Kanitsaki 1991).

Fourthly, all the past studies have been carried out in countries like Canada, the USA or Australia where college-based nursing education and western culture are dominant.

RESEARCH AIM AND QUESTIONS

Regarding the importance of clinical practice for student nurses, the research aim is to investigate the perceptions of effective clinical teaching behaviours of nurse educators by nurse educators and student nurses in a 3-year hospital-based general nurse training programme. The following research questions will be addressed:

1 Which behaviours are the 10 most important clinical teaching behaviours of nurse educators as perceived by the nurse educators, the students, the junior students and the senior students respectively?
2 Which behaviours are the 10 least important clinical teaching behaviours of nurse educators as perceived by the nurse educators, the students, the junior students and the senior students respectively?
3 Is there a significant difference between the perceptions of the student nurses and the nurse educators on the five behavioural categories of clinical teaching behaviours of nurse educators?
4 Is there a significant difference between the perceptions of the junior students and the senior students on the five behavioural categories of clinical teaching behaviours of nurse educator?

Definition of terms

1 Student nurse — one who undergoes a 3-year hospital-based general nurse training programme and will be registered as a registered nurse on passing the Hong Kong Nursing Board Examination after training.
2 Junior student — a student nurse who is in the first year of the training period.
3 Senior student — a student nurse who is in the second or the third year of the training period.
4 Nurse educator — one who teaches in the hospital-based nursing school and is actively involved in clinical teaching with the student nurses.

METHODOLOGY

This study was a comparative study done in one nursing school. Two distinct target populations were involved: student nurses and nurse educators. In order to assure the samples were the representative ones for the study, all the respondents had to fulfill the following criteria according to their status.

1 For the nurse educators, they must have been actively involved in conducting clinical teaching for student nurses for not less than 1 year.
2 For the student nurses, they must have joined the nurse training programme for at least 6 months so that they will have enough experience of coming into contact with or being supervised by the nurse educators in clinical settings in order to be able to identify the effective clinical teaching behaviours of the nurse educators.

Knox & Mogan's (1985) Nursing Clinical Teacher Effectiveness Inventory (NCTEI) was used as the instrument with permission. The respondents were asked to rate the 48 effective clinical teaching behaviours according to their degree of perceived importance on a 7-point Likert scale (1 = least important, 7 = most important). It was a self-administered questionnaire. The respondents were reminded not to write down their names on the questionnaires in order to ensure anonymity and confidentiality.

FINDINGS

Ninety-one questionnaires were distributed to the sample who met the set criteria for the study. The response rate was 100%.

Demographic characteristics of respondents

The demographic characteristics of the respondents are summarized in Table 1.

Table 1 Demographic characteristics of the respondents

	Junior students (n=39)	Senior students (n=42)	Students (n=81)	Nurse educators (n=10)
Race				
Chinese	100%	100%	100%	100%
Age				
Mean	20·7	22·6	21·6	36·0
SD	2·55	2·98 (missing cases: 5)	2·91 (missing cases: 5)	2·07 (missing cases: 2)
Sex				
Male	10·3%	19%	14·8%	30%
Female	89·7%	81%	85·2%	70%

Effective clinical teaching behaviours

Ratings for the individual clinical teaching behaviours

Based on the mean score of each clinical teaching behaviour, the top 10 most important and the bottom 10 least important clinical teaching behaviours from the four groups (nurse educators, students, junior students and senior students) were identified and listed in Tables 2, 3, 4 and 5 respectively. Those teaching behaviours with equal mean scores are also included in the lists for comparison.

Table 2 Ten most important and 10 least important effective clinical teaching behaviours as rated by nurse educators

Clinical teaching behaviours	Mean	SD
10 most important behaviours		
*1. Does not criticize students in front of others (E)	6·60	0·52
*2. Explains clearly (T)	6·50	0·53
3. Takes responsibility for own actions (N)	6·50	0·71
*4. Is a good role model (N)	6·40	0·70
*5. Corrects students' mistakes without belittling them (E)	6·40	0·70
*6. Is open-minded and non-judgemental (P)	6·40	0·52
7. Stimulates student interest in the subject (T)	6·30	1·16
8. Provides frequent feedback on students' performance (E)	6·30	0·82
9. Identifies students' strengths and limitations objectively (E)	6·30	0·68
10. Gives students positive reinforcement for good contributions, observations or performance (E)	6·30	0·68
*11. Provides support and encouragement to students (R)	6·30	0·68
10 least important behaviours		
1. Demonstrates clinical procedures and techniques (T)	5·30	1·42
2. Remains accessible to students (T)	5·40	1·27
3. Provides specific practice opportunity (T)	5·50	0·85
*4. Shows a personal interest in students (R)	5·50	1·08
5. Observes students' performance frequently (E)	5·60	0·70
6. Is self-critical (P)	5·60	1·08
*7. Reveals broad reading in his/her area of interest (N)	5·60	0·84
8. Discusses current developments in his/her field (N)	5·60	1·43
*9. Directs students to useful literature in nursing (N)	5·70	0·95
10. Demonstrates a breadth of knowledge in nursing (N)	5·70	1·16

Items with * were behaviours rated by all the four groups. T = teaching ability; N = nursing competence; E = evaluation; R = interpersonal relationship; P = personality.

Ratings for the five behavioural categories

Comparison between students and nurse educators The ranges of mean scores for the five behavioural categories rated by the students and nurse educators are clearly shown in Table 6. The students' ranking ranged from the highest 'evaluation' (mean = 6·04) to the lowest 'nursing competence' (mean = 5·77). For the nurse educators, the ranking was from the highest 'evaluation' (mean = 6·13) to the lowest 'teaching ability' (mean = 5·91).

The *t*-tests revealed that there was no statistically significant difference for the five behavioural categories between the perceptions of students and nurse educators (see Table 6).

Table 3 Ten most important and 10 least important effective clinical teaching behaviours as rated by students

Clinical teaching behaviours	Mean	SD
10 most important behaviours		
*1. Explains clearly (T)	6·67	0·74
*2. Corrects students' mistakes without belittling them (E)	6·48	0·81
*3. Does not criticize students in front of others (E)	6·40	1·00
*4. Is open-minded and non-judgemental (P)	6·35	0·94
5. Is well prepared for teaching (T)	6·32	0·93
6. Emphasizes what is important (T)	6·30	0·95
*7. Provides support and encouragement to students (R)	6·24	0·99
8. Enjoys nursing (N)	6·24	1·06
*9. Is a good role model (N)	6·22	1·01
10. Appears organized (P)	6·16	1·02
10 least important behaviours		
1. Encourages active participation in discussion (T)	4·99	1·29
*2. Reveals broad reading in his/her area of interest (N)	5·32	1·08
3. Demonstrates enthusiasm (P)	5·46	1·16
*4. Directs students to useful literature in nursing (N)	5·46	1·16
*5. Shows a personal interest in students (R)	5·54	1·06
6. Demonstrates communication skills (N)	5·54	1·11
7. Questions students to elicit underlying reasoning (T)	5·57	1·06
8. Remains accessible to students (T)	5·58	1·04
9. Quickly grasps what students are asking or telling (T)	5·58	1·02
10. Gears instruction to students' level of readiness (T)	5·58	1·08
11. Discusses current developments in his/her field (N)	5·58	1·19

Items with * were behaviours rated by all the four groups. T = teaching ability; N = nursing competence; E = evaluation; R = interpersonal relationship; P = personality.

Table 4 Ten most important and 10 least important effective clinical teaching behaviours as rated by junior students

Clinical teaching behaviour		Mean	SD
10 most important behaviours			
*1.	Explains clearly (T)	6·74	0·68
*2.	Corrects students' mistakes without belittling them (E)	6·44	0·85
*3.	Is open-minded and non-judgemental (P)	6·39	0·85
*4.	Does not criticize students in front of others (E)	6·36	0·96
5.	Demonstrates clinical procedures and techniques (T)	6·31	0·86
6.	Answers carefully and precisely questions raised by students (T)	6·28	0·89
*7	Is a good role model (N)	6·23	1·11
8.	Emphasizes what is important (T)	6·23	0·99
*9.	Provides support and encouragement to students (R)	6·23	1·01
10.	Is well prepared for teaching (T)	6·21	1·00
11.	Makes specific suggestions for improvement (E)	6·21	0·86
10 least important behaviours			
1	Encourages active participation in discussion (T)	4·74	1·52
2.	Is a dynamic and energetic person (P)	5·33	1·18
3.	Questions students to elicit underlying reasoning (T)	5·36	1·18
4.	Demonstrates communication skills (N)	5·41	1·11
*5.	Reveals broad reading in his/her area of interest (N)	5·46	1·05
*6.	Directs students to useful literature in nursing (N)	5·54	1·05
*7.	Shows a personal interest in students (R)	5·54	1·07
8.	Promotes student independence (T)	5·54	1·43
9.	Discusses current developments in his/her field (N)	5·57	1·27
10.	Has a good sense of humour (P)	5·57	1·25

Items with * were behaviours rated by all the four groups. T = teaching ability; N = nursing competence; E = evaluation; R = interpersonal relationship; P = personality.

Table 5 Ten most important and 10 least important effective clinical teaching behaviours as rated by senior students

Clinical teaching behaviours		Mean	SD
10 most important behaviours			
*1.	Explains clearly (T)	6·59	0·80
*2.	Corrects students' mistakes without belittling them (E)	6·52	0·83
*3.	Does not criticize students in front of others (E)	6·42	1·06
4.	Is well prepared for teaching (T)	6·42	0·86
5.	Emphasizes what is important (T)	6·38	0·91
*6.	Is open-minded and non-judgemental (P)	6·30	1·02
7.	Enjoys nursing (N)	6·29	0·95
*8.	Provides support and encouragement to students (R)	6·23	0·98
9.	Appears organized (P)	6·23	1·93
*10.	Is a good role model (N)	6·21	0·93
10 least important behaviours			
1.	Encourages active participation in discussion (T)	5·22	1·00
*2.	Reveals broad reading in his/her area of interest (N)	5·29	1·11
*3.	Directs students to useful literature in nursing (N)	5·38	1·27
4.	Provides specific practice opportunity (T)	5·40	1·21
5.	Demonstrates a breadth of knowledge in nursing (N)	5·43	1·19
6.	Remains accessible to students (T)	5·45	1·04
7.	Quickly grasps what students are asking or telling (T)	5·48	0·99
8.	Gears instruction to students' level of readiness (T)	5·55	1·02
*9.	Shows a personal interest in students (R)	5·55	1·06
10.	Is a dynamic and energetic person (P)	5·58	1·15

Items with * were behaviours rated by all the four groups. T = teaching ability; N = nursing competence; E = evaluation; R = interpersonal relationship; P = personality.

Comparison between junior students and senior students The ranges of mean scores for the five behavioural categories rated by the junior students and the senior students are clearly shown in Table 7. The junior students ranked 'evaluation' (mean = 6·05) as the highest rank while 'personality' (mean = 5·82) was the lowest one. Similarly, the senior students also rated 'evaluation' (mean = 6·03) as the highest rank. Yet, the lowest rank order was ascribed to 'nursing competence' (mean = 5·71) by the senior students.

The *t*-tests revealed that there was no statistically significant difference for the five behavioural categories between the perceptions of junior and senior students (see Table 7).

DISCUSSION

The study aimed to identify the similarities and differences in the students' and nurse educators' perceptions of effective clinical teaching behaviours.

The mean scores of all clinical teaching behaviours ranged from 4·74 to 6·74. Since the lowest mean score (4·74) is well above the average score (4) in a seven-point Likert scale, it indicates that all the 48 clinical teaching behaviours are regarded as important.

10 most important clinical teaching behaviours

All respondents shared quite a similar perception for the 10 most important behaviours. Regardless of the different rank orders, six behaviours were concurrently rated within

Table 6 Means, standard deviations and *t*-tests for the five behavioural categories for students and nurse educators

	Students ($n=81$)		Nurse educators ($n=10$)			
	Mean	SD	Mean	SD	*t*-test	*P**
Teaching ability	5·86	0·64	5·91	0·56	0·21	0·961
Nursing competence	5·77	0·78	5·92	0·50	0·59	0·200
Evaluation	6·04	0·70	6·13	0·44	0·40	0·157
Interpersonal relationship	5·92	0·74	6·08	0·60	0·67	0·451
Personality	5·90	0·76	5·94	0·71	0·16	0·504

*Level of probability, $P<0·05$.

Table 7 Means, standard deviations and *t*-tests for the five behavioural categories for junior students and senior students

	Junior students ($n=39$)		Senior students ($n=42$)			
	Mean	SD	Mean	SD	*t*-test	*P**
Teaching ability	5·85	0·60	5·87	0·69	−0·15	0·827
Nursing competence	5·84	0·72	5·71	0·83	0·73	0·383
Evaluation	6·05	0·65	6·03	0·75	0·14	0·330
Interpersonal relationship	5·91	0·80	5·93	0·70	−0·16	0·491
Personality	5·82	0·80	5·99	0·73	−1·01	0·280

*Level of probability, $P<0·05$.

the top 10 most important behaviours by all the four groups. These six behaviours were: explains clearly (T); does not criticize students in front of others (E); is a good role model (N); corrects students' mistake without belittling them (E); is open-minded and non-judgemental (P); and provides support and encouragement to students (R).

Such mutual acknowledgement of the importance of these six behaviours signifies their value in the teaching-learning process in clinical settings.

'Is a good role model' was identified as one of the 10 most important behaviours in this study. This is in agreement with the results reported by Sieh & Bell (1994), Nehring (1990), Mogan & Knox (1987), O'Shea & Parsons (1979) and Rauen (1974). Two interesting phenomena can be identified with this teaching behaviour. The first phenomenon relates to its relative ratings by the four groups in this study. It is found that the nurse educators rated this behaviour on the highest rank order (mean = 6·4), compared with the other three student groups: students (mean = 6·22), junior students (mean = 6·23) and senior students (mean = 6·21). This can be explained by the fact that the nurse educator's definition of role modelling might be broader than that of students, who might just define role modelling primarily as a demonstration of nursing procedures (O'Shea & Parsons 1979). This is only a speculation because the respondents' definition of role-modelling is not addressed in the study. It is advisable to explore this issue in future studies.

The second phenomenon relates to its relative rankings in this study compared with past studies that were done at the baccalureate level. 'Is a good role model' was highly rated by Nehring (1990), Mogan & Knox (1987) and O'Shea & Parsons (1979). This behaviour was not rated so highly by all respondents in this study. The findings are consistent with those reported by Sieh & Bell (1994). Since the students in this study and the Sieh & Bell's study are non-baccalureate nursing students, the level of the nursing programmes studied may be accountable for their relative low ranking in this behaviour. Similarly to the associate degree programme studied by Sieh & Bell (1994), the hospital-based nurse training programme also has limited time allowed for professional role modelling compared with the baccalureate nursing degree programme.

'Emphasizes what is important' and 'Is well prepared for teaching' were two behaviours rated within the 10 most important behaviours by the student sample only. These two behaviours fell within the category of 'teaching ability'. It reflects that teaching ability is an important behavioural category for quality clinical teaching as perceived by the students. Yet, these two behaviours seem to be overlooked by the nurse educators as they are not included in the corresponding list rated by them. Similar findings were reported in Kanitsaki & Sellick's (1989) study in which the students assigned greater importance to the role of clinical teacher as 'teacher'.

The junior and the senior students shared similar perceptions on the 10 most important behaviours, in which eight out of the top ten behaviours were the same. The dissimilar perception of the remaining two behaviours may be due to their different learning needs at various stages of the training period.

According to Benner (1984), first-year nursing students are described as being at the novice stage of skill development. They not only need to follow the procedural steps and rules rigidly but also need more clinical guidance and demonstrations from the nurse educators. This explains why the junior students consider 'Demonstrates clinical procedures and techniques' and 'Answers carefully and precisely questions raised by students' as important clinical teaching behaviours.

During nurse training, the students gradually gain in confidence and practical skills to become more independent.

They start to have a greater need for direct nursing application and for help in synthesizing patient data from the teacher (Kanitsaki & Sellick 1989). As a result, the senior students respond differently from the junior students by putting much emphasis on the teaching behaviours of 'Enjoys nursing' and 'Appears organized'. These two behaviours can facilitate their learning process at this stage.

10 least important clinical teaching behaviours

The ratings of the 10 least important behaviours were in less agreement than the 10 most important behaviours. Only three behaviours were commonly rated by all groups. They were: reveals broad reading in his/her area of interest (N); directs students to useful literature in nursing (N); and shows a personal interest in students (R).

'Directs students to useful literature in nursing' was one of the 10 least important behaviours rated by all groups. The same findings were reported by Sieh & Bell (1994). Accordingly, the nature of the hospital-based nurse training programme may be accountable for its low rating in this study. In Hong Kong, the hospital-based nursing programme is of an apprenticeship nature. The student nurse is under full-time employment in which he/she is not only a learner in the clinical settings but also a worker who provides service to the health care consumers. Such a dual role puts much burden upon the student nurses and the majority of them claim to be both psychologically and physically fatigued after working in the wards. Under such circumstances, it seems unlikely that the student nurses would spend time reading the nursing literature after work.

The other two commonly rated least important behaviours by all the four groups were: 'Reveals broad reading in his/her area of interest' and 'Shows a personal interest in students'. In a hospital-based programme, the pursuit of knowledge might not be so intense and apparent compared with a college-based baccalureate programme. Furthermore, the teacher–student relationship is complicated with the dual role of worker and learner among the nursing students in a hospital-based programme. From the literature survey, there are very few studies on comparing the effect of different student status in a college-based and a hospital-based programme on students' clinical learning. Further exploration is needed in this area.

The behaviour on 'Encourages active participation in discussion' was rated the lowest by the whole student sample. It reflects the passive characteristics of the student nurses. From the early beginning, the traditional Chinese culture and educational system indirectly foster the passive characteristics of the students in Hong Kong. Such passivity is further reinforced during professional socialization in the hospital-based nurse training programme among the student nurses. So far, there is no study to be conducted on the characteristics of nursing students in Hong Kong. It may be an issue which needs to be explored in future.

The students are expected to be more independent as they progress toward graduation. As a result, whether the nurse educator is accessible or not seems to be unimportant to the senior students. This explains why 'Remains accessible to students' was rated as one of the least important behaviours by the senior students. This finding is in parallel with that reported by Windsor (1987).

The most important versus the least important behaviour

It is interesting to note that 'Demonstrates clinical procedures and techniques' was rated as the most important behaviour (mean = 6·3) by the students. The nurse educators, however, rated it as the least important behaviour (mean = 5·3).

The reasons for junior students rating this behaviour as so important have already been explored. Marriott (1991) states that teaching of practical skills was rated by tutors as stressful and extremely hard to find time to perform. This is because the nurse educators have been away from the clinical areas for a certain period of time. Together with the rapid advancement of medical technology, nurse educators may feel threatened or not competent in demonstrating clinical procedures and techniques.

Furthermore, it is believed that clinical staff should also be responsible for the clinical teaching of student nurses (Craddock 1993). They are regarded to be the suitable people to conduct clinical teaching as they have an in-depth knowledge of the patient and the ward environment (Fothergill-Bourbonnais & Higuchi 1995). These two reasons may account for the nurse educators rating this behaviour as the lowest one.

Comparison between the scores of nurse educators and students for the five behavioural categories

The five categories were perceived as important by both parties as the mean scores for the categories were much higher than the average scores (4). The mean scores ranged from 5·86 to 6·04 for the students and 5·91 to 6·13 for the nurse educators. High ratings on behavioural categories are an expression of high level of anxiety experienced by the raters (Knox & Mogan 1985). Accordingly, the high ratings in this study imply that all these five behavioural categories impose a certain degree of anxiety upon the students and nurse educators.

Knox & Mogan (1985) state that teaching and learning of clinical skills takes place in an environment where error can have grave consequences for a patient. Such stressful and unpredictable nature in clinical settings complicates the process of clinical teaching and learning. As a result,

both nurse educators and students are expected to experience various levels of anxiety during clinical teaching and learning respectively.

'Evaluation' was the highest rated category in this study and the past studies done by Sieh & Bell (1994), Brown (1981) and O'Shea & Parsons (1979). On the contrary, Sellick & Kanitsaki (1991) and Kanitsaki & Sellick (1989) revealed an opposite result in which 'evaluation' was rated the lowest. Evaluation is often expressed by the students as an anxiety-producing situation (Kleehammer *et al.* 1990). No matter how much anxiety that evaluation will impose upon the students, it is an inevitable and necessary component in order to assess the students' learning outcomes and to maintain professional standards. Both students and nurse educators find no way to escape from the evaluation-induced anxiety. They rate it the highest so as to express their feelings of high levels of anxiety induced by evaluation.

It is universally agreed that high levels of anxiety would hinder students' learning (Kleehammer *et al.* 1990). In order to facilitate the learning process, the level of anxiety needs to be reduced as much as possible. Therefore, those clinical teaching behaviours which are able to reduce the anxiety level are expected to receive high ratings. It is realized that students' anxiety will be increased in the clinical settings by their perceptions of non-supportive faculty (Kleehammer *et al.* 1990). Every student hopes to have his/her anxiety level reduced by attempting to establish good teacher–student relationships and clinging to nurse educators who possess the personality that can make them feel at ease. Accordingly, all students expect the supportive nurse educator to be open-minded, non-judgemental and able to provide support and encouragement to them. All these characteristics of a supportive nurse educator are under the categories of 'interpersonal relationship' and 'personality'. Nurse educators also share similar perceptions. This explains the relative ranking of the categories 'interpersonal relationship' and 'personality' in this study. Such findings are consistent with the past studies done by Sieh & Bell (1994), Nehring (1990), Knox & Mogan (1985) and Brown (1981). However, the result on 'personality' contradicts the studies done by Brown (1981), Knox & Mogan (1985), O'Shea & Parsons (1979) and Sieh & Bell (1994) in which 'personality' was the lowest rated category by all groups.

The only dissimilar perceptions between the nurse educators and students are in the categories 'nursing competence' and 'teaching ability'. The students rated the 'teaching ability' more important than the 'nursing competence'. The reverse was noted in the nurse educators' ranking. The nurse educators' rating is consistent with the findings revealed by Rauen (1974). Rauen found that the faculty member's role as nurse was significantly more important than his/her role as teacher. In this study, the average years of teaching experience of the nurse educators was only 3·5 years with a range of 1 to 5 years. All the nurse educators have a minimum of 5 years' clinical experience before they are qualified to attend the course for nursing education. With limited teaching experience and well-established clinical experience, nurse educators may be, subconsciously, remaining in their role as nurses rather than teachers. The rating by the nurse educators of 'nursing competence' and 'teaching ability' is probably a good reflection of their subconscious mind.

On the other hand, 'nursing competence' was rated lower than 'teaching ability' by the students. Such a comparatively low rating on 'nursing competence' may indicate the lack of opportunity for students to observe nurse educators practising in clinical settings (Knox & Mogan 1985).

The similarity in the ratings of the five behavioural categories between the nurse educators and students is also supported by the statistical test. The *t*-tests indicate that there is no statistically significant difference between the perceptions of the nurse educators and students as far as the five behavioural categories are concerned.

Comparison between the scores of junior and senior students for the five behavioural categories

Among the five behavioural categories, only 'evaluation' was commonly rated as the highest by both junior and senior students. Regarding the ratings by the junior students, there is slight discrepancy between the findings obtained in Knox & Mogan's (1985) study and this study. The year one students in Knox & Mogan's (1985) study rated 'evaluation' as the second highest whereas the junior students in this study rated it as the highest one. Such a difference may well be explained when the schedule for clinical assessment of the hospital-based programme is examined.

In the hospital-based programme, the students are required to have a total of four clinical assessments throughout the 3-year training period. In the first year, the junior students have their first clinical assessment at about 1 month after they have worked in the clinical settings. In other words, it is about 4 months after the commencement of the nurse training programme. Usually the first clinical assessment is conducted in the first ward. As mentioned before, evaluation is an anxiety-producing situation. The initial clinical experience is also regarded as an anxiety-producing situation (Kleehammer *et al.* 1990). When two anxiety-producing situations come together, one can imagine how much anxiety the junior students are exposed to. The situation is not much better for the senior students since they have three more clinical assessments in their second and third years in order to meet the minimal requirement for the Hong Kong Nursing Board Examination. All these contribute to the highest ratings on 'evaluation' by both senior and junior students, with their

mean scores greater than 6 (6·05 for junior students, 6·03 for senior students).

The 'personality' category was rated the lowest by the junior students in this study. It supports the belief that clinical teacher evaluations are not based on personality (Sieh & Bell 1994). However, this belief is challenged when the ratings of the senior students on 'personality' are taken into consideration. It is noted that the senior students highly valued 'personality' and they described it as the second highest rated category just after 'evaluation'. The rationale underlining the dissimilar ratings between junior and senior students on 'personality' needs further exploration.

In the first year, especially during the first clinical experience, junior students are confronted with concepts of pain, fear, anguish and emotional trauma and death. Such confrontation makes the students feel frightened and inadequate (Kendrick & Simpson 1992). A supportive student–teacher relationship is expected to lessen such anxiety. As a result, the junior students rated 'interpersonal relationship' higher than the senior students.

Apparently, the rank orders of the five behavioural categories between the junior and the senior students are rather different, except for 'evaluation'. However, the *t*-tests reveal that there is no statistically significant difference between the junior and the senior students as far as the five behavioural categories are concerned.

To sum up, there are significant differences among the five behavioural categories between the students and nurse educators as well as between the junior students and the senior students. However, when the *t*-tests are computed and interpreted, no statistically significant difference between the two pairs of comparative groups can be identified. This indicates that the respective parties in the comparison share quite a similar view on the perceptions of these five categories of effective clinical teaching behaviours.

IMPLICATIONS

Based on the identified effective clinical teaching behaviours, courses, workshops or orientation programmes should be organized to develop those clinical teaching behaviours. Moreover, the findings will be of great value in devising a valid and reliable evaluation tool to assess the effectiveness of clinical teaching, perform staff appraisal and assign staff to clinical areas.

One significant implication originates from the contradicting view between the nurse educators and the junior students on the behaviour 'Demonstrates clinical procedures and techniques'. As discussed before, the dissimilar perception may be partly because of the feeling of clinical incompetence of the nurse educators. Being the school administrators, they should make arrangements for nurse educators to have regular clinical placements in order to update and refresh their clinical skills and knowledge.

Nurse educators should incorporate the effective clinical teaching behaviours, especially those perceived as more important, into the clinical teaching sessions. At the same time, the nurse educators should be flexible and make appropriate modifications to their teaching behaviours, according to the level of the students, so as to meet the students' learning needs.

LIMITATIONS OF THE STUDY

Sampling flaws are the major limitations of this study. The sample sizes were relatively small: students ($n=81$), junior students ($n=39$), senior students ($n=42$) and nurse educators ($n=10$). In addition, the sample was only chosen by convenience in one nursing school. Therefore the findings of this study cannot be generalized.

CONCLUSION

The study reveals greater agreement on the perceptions of the 10 most important clinical teaching behaviours than the 10 least important ones. There is no statistically significant difference in the perceptions of the respondents regarding the five behavioural categories. Despite the limitations of this study, its findings are crucial for enhancing the quality of clinical teaching/learning through mutual understanding between nurse educators and student nurses in a hospital-based nurse training programme. Meanwhile, it is recommended that future studies:

1 Replicate the study with a larger sample size and include target populations who are attending other types of nursing programmes.
2 Employ a longitudinal study design to collect more useful data concerning the students' relative perceptions of effective clinical teaching behaviours as they move towards graduation.
3 Explore the following issues further:
   (a) definition of role modelling by the student nurses and the nurse educators;
   (b) role modelling behaviours in clinical settings;
   (c) students' and faculty's perceptions of role modelling behaviours of nurse educators;
   (d) characteristics of nursing students in Hong Kong and the anxiety-producing situations in a hospital-based nursing programme; and
   (e) effectiveness of the identified effective clinical teaching behaviours.
4 Incorporate the method of direct observation in gathering data on clinical teaching behaviours into future studies in order to obtain more reliable data.

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Reading 6

醫院管理局
HOSPITAL AUTHORITY

Position Statement on Clinical Supervision in Nursing

Introduction

The provision of appropriate support to professional nursing personnel is a key issue in improving and maintaining the quality of patient care. Nurses like other health care professionals will require a period of consolidation following graduation and continuing professional support and updating on clinical practice throughout their professional career. Recognizing this professional requirement, this position statement has been developed to provide hospitals a framework for supervision of nurses who may have a practice deficit as required by the particular work setting.

Context of Clinical Supervision

2. Clinical supervision is normally required in the practice context. In the context of the Hospital Authority hospitals we consider this in terms of clinical supervision available to nurses on an ad hoc, shift to shift and yearly basis. The potential impact on patient care and professional development should also be contributing to the organization's objectives. The model of clinical supervision used should therefore suit local requirements.

Definition of Clinical Supervision

3. Clinical supervision is a systematic process of providing appropriate clinical expertise to oversee/coach/support nursing practice so as to enhance the competence of staff with a practice deficit to assure the quality of patient care/outcome.

Process and Structure of Clinical Supervision

4. The process of clinical supervision should be considered in terms of mentoring and monitoring of new staff, learners and junior nurses through on the job coaching, tutorial, seminar, workshop, case discussion, staff development review (SDR), or clinical update etc. There should be a plan at the hospital level reflecting a structured relationship between supervisor and supervisee and a management system to support and monitor the establishment of such relationship.

Source: Nursing Section, HAHO. (1998). *Position statement on clinical supervision nursing.*

Expected Outcomes of Clinical Supervision

5. The primary purpose of clinical supervision is to improve the competence of staff with a practice deficit so as to assure the delivery of safe practice and improve the quality of patient care. It is also expected to enhance the skills and professional competence of individual staff.

Endorsed by
Coordinating Committee in Nursing
Hospital Authority
16 June 1998

Reading 7

chapter five

Learning theories

Introduction

It is very tempting when preparing a text which is aimed at the practical considerations of preceptorship to find a case for omitting a traditional approach of presenting learning theories. It is sometimes difficult to put over the work which is essential to each theory, whilst at the same time maintaining its practical application. It is in fact a waste of time if such theories cannot be applied to education in the clinical area. However, all of the major theories of learning, although they originate from different schools of thought and by implication will advocate different teaching strategies, nevertheless have their place, principally because we cannot define any form of nurse education as being the sole province of any one school of thought.

Various questions underlie the basis of this chapter and it has been organised in such a way as to provide some practical answers. For example, is the learning that takes place for a resuscitation procedure necessarily the same as that which will help us deal with the bereaved? Is the learning which occurs during social science education necessarily the same as that which will occur during the study of biological sciences? Many of the theorists mentioned below have argued, sometimes convincingly, that their theories can be applied to any subject and it appears that the debate here is mainly centred upon the context in which the subject is taught (i.e. in the clinical situation) rather than the subject matter itself. For these reasons as well as for convenience of the reader, this chapter is organised in a way which departs from the traditional approaches which examine each school of thought in isolation, and looks at the context in which they are applied.

One of the major areas which is continually debated in education is quite how individual learning can be, and further, how experience can contribute to the learning process. There are, quite naturally, those who are for and against this humanistic approach to education. Many have argued with some justification that whereas every individual is different, we nevertheless have to work, at least to some extent, to a preset curriculum and meet the criteria of a preset assessment strategy. The alternative argument is therefore discussed in relation to the behaviourist viewpoint which takes into account the educator being able to predict what the student will learn in response to a given situation. The arguments for each continue to rage in education circles, but it should be said here that the authors are expressing no preference for either, whilst at the same time appreciating the merits and disadvantages of each.

A slightly less contentious issue concerns the nature of concept formation and problem solving, but once again, purists will argue the merits of one school of thought or another. The cognitive theorists, on the one hand, describe a process by which problem solving can be achieved through education, whereas those advocating a gestalt approach place far more emphasis on the way in which information is presented. Once again, as with the previous instance, there does not appear to be a coherent reason why both arguments should not carry equal weight and be incorporated into teaching strategies successfully.

Source: Oliver, R., & Endersby, C. (1994). Learning theories. In *Teaching and assessing nurses: A handbook for preceptors* (Chapter 5, pp. 51–63). London: Balliere Tindall.

It is of course up to the reader quite how they use the information contained in this chapter, although it is intended to give them enough information to be able to examine their learning environment, the subject matter in hand and the outcomes they hope to achieve and then to be selective in the direction of their teaching.

It seems logical that the discussion should start with the person who is at the centre of the education process, namely the individual student.

The individual, experience and learning

The humanistic school of psychology is certainly not new, although the concepts that underpin it are still a matter of much debate in education. The underlying premise that each one of us is an individual who cannot have their behaviour predicted in any given situation is a difficult one to grasp because in its extreme form the implications are that we can never be sure that anyone will learn from any situation, thus preventing any tangible use of predetermined learning outcomes.

One of the earliest humanistic psychologists is Maslow, whose work (discussed in earlier chapters), though possibly the oldest, is still used as a framework for both nursing care (e.g. Roper *et al.*, 1981) and education. For the purposes of our discussion, we will look at the theory of self-actualisation mainly from the viewpoint of Rogers (1969).

Rogerian perspectives on education

Out of all of the humanistic psychologists, Rogers is possibly the most emphatic that one individual can never be totally understood by another. In order to arrive at this conclusion, Rogers makes several observations which have an enormous implication for the learning environment.

Rogers uses as the basis of his theory the fact that we all have a need for *positive regard*, in other words, we all need to feel good about ourselves. The ways in which we achieve such positive regard are naturally dependent, to some extent, on the reactions of other people to our actions. Put another way, do we do things that will please others, but may be against our true feelings? This is the case not only in childhood, but also happens during the course of our working lives and education.

Feeling positive regard as a result of what other people want or expect us to do leads to what Rogers terms *conditional positive regard* namely, positive regard which is conditioned by other people's reactions and approval. In education terms it could be said that somebody achieves conditional positive regard if in completing an assessment that they had no desire to complete they achieve a pass grade. If on the other hand we have positive regard despite what anybody thinks of us, we have *unconditional positive regard*, in other words, we feel valued by others even if we do not live up to their expectations.

It follows logically that if, as Rogers says, we exist substantially with conditional positive regard, we are operating to standards that we perceive, either rightly or wrongly, other people wish us to achieve. These are known as *conditions of worth* and are readily observable within the nurse education setting. Conditions of worth may take the form of professional behaviour, academic standards, achieving learning outcomes and even holding certain attitudes and values.

Eventually we will internalise these conditions so that we may behave and achieve in a way prescribed by the group or society in which we are operating and hence will gain the approval (or rather avoid disapproval) of others. Rogers terms this *positive self-regard* and it is

antagonistic to the individual reaching true self-actualisation. The reasons for this are immediately obvious in as much as if the individual cannot achieve growth without the restraints placed on them by others, then they will never reach their full potential, but will rather reach the potential approved of by others. Feeling good about ourselves for whatever reason, is of course by any other name, achieving positive self-esteem, and this is a major landmark that the individual strives to achieve and will often go to great lengths to maintain it. Because positive self-regard is self-esteem achieved through fulfilling the conditions placed on us by others, Rogers sees this as potentially damaging.

In order to achieve true self-actualisation, Rogers advocates helping the individual to achieve *unconditional self-regard*. This he does because of his belief that the incompatibility of an individual's true feelings with those of the conditions of worth placed on them is a major source of maladjustment. Although unconditional positive self-regard may possibly be achieved in small areas of an individual's life, it is difficult to conceptualise how this may be achieved in a more generalised sense, for to do so could be at the expense of the individual's standing in a group or society.

In its pure form, as with many other theories, the Rogerian concept of education, namely learning which fulfils totally the individual's need and does not place restraints upon them seems impossible to achieve within nurse education.

Applications of Rogerian theory to clinical education

No matter how much we may agree or disagree, getting a nursing qualification has a significant emphasis on achieving an end product which by its very definition means meeting standards laid down by others. This is not to say, however, that the process by which we achieve this end cannot, at least in part, have a humanistic orientation. Teaching strategies are discussed elsewhere in the text but, it is worthwhile at this juncture to list some of those which may illustrate individual learning.

1. *Unconditional positive regard.* This may in part be achieved by the use of negotiating, learning contracts with the student, individual tutorials, pastoral support, buzz groups, brainstorming.
2. *Conditional positive regard.* Attempting to achieve behavioural objectives, completing assessments, formal teaching methods, may all lead to the conditions of others being placed on the individual.
3. *Positive self-regard.* The acquisition of group values either from influential individuals or from the expectations and rules of societies/organisations.
4. *Unconditional positive self-regard.* This may be achieved with entirely self-initiated learning with no perceivable outside influences. Although virtually impossible to achieve, it seems most likely that those undertaking self-financed open learning courses can go at least some way to achieving this.

It is not simply the case that a particular method will lead to any one of the above outcomes although the method chosen will have an effect. For instance, participating in a discussion group, may for some individuals lead to unconditional positive regard whereas for others it may lead to positive self-regard, depending on the subject in hand and those people present in the group.

Rogers (1969) places significant emphasis on the student-centred learning approach and as such advocates those methods which allow individuals to express themselves freely, and possibly most importantly for our discussion, he emphasises the essential nature of "doing",

rather than sitting down and learning. More especially, it is perhaps relevant to consider this in terms of the student's supernumerary status and to reiterate the unsatisfactory status of purely non-participative observation visits for the majority of the time.

The role played by experiential learning is a corner-stone of Rogers' theory and is also the basis of a more practical application of humanistic psychology, namely that expounded by Kolb (1984).

Experiential learning theory

Kolb (1984) views learning as a lifelong event and sees knowledge as emerging through the transformation of experience. Kolb, following extensive research, suggested that individuals whose learning styles did not match the environment in which they were learning were less satisfied and felt more alienated than those whose learning styles matched their environment.

Generally speaking, experiential learning theory can be described as a cyclical learning process in which Kolb describes four types of learning competencies

1. Feeling (concrete experience competencies).
2. Perceiving (reflective observation competencies).
3. Thinking (abstract conceptualisation competencies).
4. Behaving (active experimentation competencies).

The learning process cycle in its broadest terms could be said to comprise the individual experiencing an actual situation, perceiving it from different angles, reflecting on its significance, forming theories about what is happening and finally testing those theories out in practice.

Naturally, we are not all as good at some parts of the learning process as we are at others and our past experiences may, for instance, enable us to be rather better at being able to reflect on a situation than to form theories about it. This will be dependent on how the individual has developed through life and their past experiences. It should be re-emphasised that this is a cyclical learning process and that all of what Kolb terms as competencies need to be used. It should come as no surprise, however, that each one of these competencies requires rather a different learning style and since we are better at some competencies than others, the results of Kolb's research reveals that individuals will have predominantly one learning style in preference to others.

As stated earlier, dissatisfaction will occur if the learning style imposed on the individual is incompatible with the competency that they favour and it is appropriate at this juncture to examine briefly quite what these styles are, and loosely which competencies they are compatible with. Figure 5.1 represents diagrammatically the learning cycle and the learning styles.

If we use Kolb's own definition of learning styles as being a way of processing information, it makes sense to complete the equation and to examine which situations and teaching strategies would be compatible with each individual. Laschinger (1990) in reviewing Kolb's theory summarises learning styles which are most appropriate to the competencies.

Those with strong concrete experience and reflective observation skills (*divergers*) prefer concrete experiences as distinct from theoretical ones and tend to be more person orientated. Those with strong concrete experience and active experimentation skills (*accommodators*), will be better at carrying out practical plans and at the same time will also seek out new experiences. At the same time, these individuals will tend not to be particularly analytical and may be more instinctive in their actions. Those with highly developed abstract conceptualisation and reflective observation competencies (*assimilators*) tend to be rather better at forming concepts

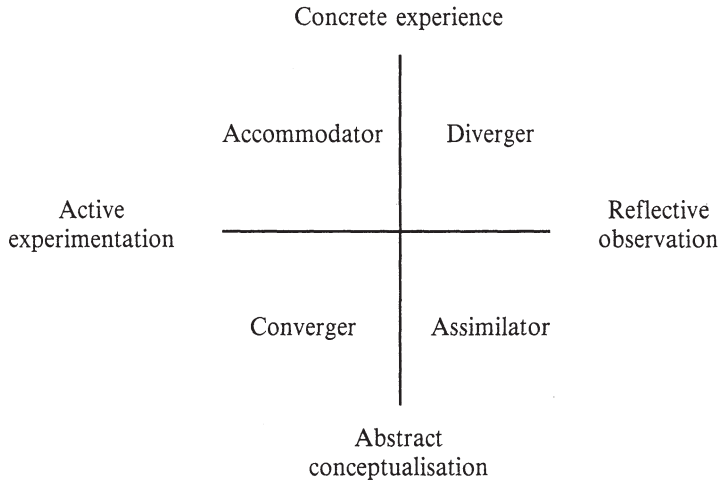

Figure 5.1. Learning cycle and learning styles (Kolb, 1976).

through experiences. Those with strong abstract conceptualisation and active experimentation skills (*convergers*) tend to exhibit skill in problem solving, particularly where a single answer is sought.

It should be remembered that although Kolb's theory gives us considerable insight into the differing learning styles of the individuals, it can only be used effectively if the individuals involved have been appropriately tested (Kolb, 1976; Kolb and Wolfe, 1981) to determine which competencies they excel in. Conversely, most individuals may be able to identify their own particular strengths and weaknesses and hence their most effective learning style.

The theories discussed so far can now perhaps be seen in a different light, in as much as it is ill-advised to make assumptions that all individuals will process information in an identical way in response to poorly selected teaching strategies which have not taken into account the diversity of learning styles that they may possess.

Achievement of predetermined learning outcomes

The behaviourist school of thought is prominent in theories of learning and was typified by Bloom (1956) in terms of education. It is perhaps unfashionable to consider a subject such as nursing as producing practitioners who will achieve predetermined outcomes rather than a diversity of perspectives and knowledge gained through experience. In many ways the behaviourist approach is far removed from, and even directly opposed to, the humanistic approach to education and it could be said that it only really has one thing in common with it, namely, that used in its extreme form, it is virtually unworkable. The originator of behaviourism, Watson, was at pains to point out that only observable behaviours should be examined rather than surmising about the mental mechanisms that were taking place. This gained great prominence in the early part of the century.

The situation in clinical education on first inspection is not behaviourist in the overall context but it can be seen by the examples given below that some learning experiences may be most appropriately explained using this approach. The theories of Pavlov seem most unlikely to fall under even this category but it is arguable that this type of learning in some situations forms the basis of higher forms of learning at a later stage. This is further expounded by Gagne (1974), whose work will be discussed later in the chapter.

Classical conditioning

The reflexes that Pavlov described were of two types, unconditioned and conditioned. **Unconditioned reflexes** (UCR) are innate, and include such basic functions as salivation. **Conditioned reflexes** (CR) are formed as a result of experience. The UCR is the normal response to an **unconditioned stimulus** (UCS) such as food. A conditioned stimulus (CS) is a previously neutral item which, through "pairing" with a UCS, produces a new response. An example which could perhaps clarify the picture can be seen in a nurse's response to a cardiac arrest. Before training, the nurse's response to an individual who has collapsed (UCS) could be a sudden release of adrenalin with all of its effects (UCR). Through training, the nurse can be taught to examine the patient's pulse, which if absent (CS), may elicit behaviours such as lying the patient flat, inserting an artificial airway, etc. (CR). It may be the case that the nurse has gleaned that asystole being recorded on the cardiac monitor is a sign of cardiac arrest, and this, if paired with a collapsed patient, may also act as a CS, and instigate the appropriate responses, if paired on several occasions. If, however, the nurse is confronted with an asystole trace due to the monitor being disconnected, eventually the CR will be "extinguished". The reflex can be regained by finding a new CS, in this case the one that should have been used in the first place, namely the pulse. This is known as "disinhibition". As the training progresses, the nurse will begin to "generalise" the CR to a variety of situations, rather than just a patient on a coronary care unit.

Operant conditioning

From numerous well-documented experiments in operant conditioning, in both animals and humans, Skinner (1938) proposed that the following factors should be present before learning can take place.

1. Each step of the learning process must be short and should grow out of previous learned behaviour.
2. In the early stages learning should be regularly rewarded and at all stages be carefully controlled by a schedule of continuous or intermittent *reinforcement*. This reinforcement is a feature of discovery learning in as much as reinforcement for students is a discovery of a concept by its own efforts. For instance, if students are given anti-a and anti-b antigen solutions they may work out for themselves which blood group they belong to.
3. Reward should follow quickly when a correct response appears. This is referred to as feedback and is based on the principle that motivation is enhanced when we are informed of our progress. Laboratory experiments provide such feedback. With careful explanation and supervision, the student will usually be able to achieve a predicted outcome.
4. The learner should be given an opportunity to discover stimulus discrimination for the most likely path to success.

It could be argued that all of learning can be explained in terms of operant conditioning as long as interpretation of positive reinforcement can be widened sufficiently to account for the diversity of situations that the learner may find themselves in. Certainly the immediate feedback from academic work is an obvious example but in the clinical area, more diverse reinforcers need to be identified. For example, in order for positive reinforcement to take place, the learner will have had to have done something in order for it to be reinforced such as improvement in a patient's condition or praise from their preceptor.

From these principles Skinner devised a scheme known as "Programmed Learning", now extensively employed using computer-assisted learning techniques, so that each student may progress at their own pace. Like discovery learning, however, the method is a relatively slow one, particularly in terms of preparation time for the teacher or instructor. It is of particular value with students of mixed ability and/or when a subject area is particularly difficult.

It is now more common practice, with the exception of programmed learning mentioned above, to use a behaviourist approach in the more basic skills training such as cardiac arrest procedures, although it should be mentioned that over a period of time problem-solving behaviour should develop.

Types of learning (Gagne's)

Gagne's theory of learning has a strong behavioural slant and, unlike Kolb, describes the learning process in terms of a hierarchy as distinct from a cycle. Behaviour according to Gagne (1975) should be compared before and after the learning situation to determine whether learning has taken place, and hence Gagne's interpretation of learning goes along the lines of the earlier behaviourists in as far as he defines it as a change in behaviour.

It has been discussed earlier in the chapter that nurse education is highly dependent in some areas on a product approach, in other words we need to be able to predict to an extent how much learning has taken place in order to ascertain whether an individual has attained a certain standard. The systematic approach that Gagne utilises may correlate well with aspects of the curriculum such as the nursing process (Condell and Elliott, 1989). In terms of more lateral thinking he can be seen as equally incompatible, in particular where problem solving utilising past experience is involved. Gagne advocates a teacher-centred approach by virtue of the fact that although he regards the student as having capabilities which are internal to them, the stimulation is nevertheless outside the learner (Gagne, 1985).

The hierarchy of learning is briefly described below and it will be noticed that at least up to the chaining level and possibly as far as multiple discrimination there are strong implications for psychomotor skills learning (Coulter, 1990).

Gagne's hierarchy of learning

1. *Signal learning*. This is equivalent to Pavlov's Conditioned Response.
2. *Stimulus–response learning*. This is equivalent to Skinner's Discriminated Operant Conditioning.
3. *Chaining*. A chain of two or more stimulus–response connections achieved by learning stimulus–response connections, carrying out the steps in the chain in a set sequence, carrying out all elements of the chain close together and repeating the performance to provide reinforcement.
4. *Verbal association*. Learning verbal chains.
5. *Multiple discrimination*. Learning to discriminate between stimuli which resemble each other.
6. *Concept learning*. Learning to make a common response to stimuli that can be organised into a class of objects rather than an individual example, with each component of the class sharing common characteristics.

7. *Principle learning*. A chain of two or more concepts.
8. *Problem solving*. Solving problems by the use of principles.

As a consequence of Gagne's assertion that the learning process focuses heavily on teacher-centred approaches, great emphasis is placed on how information is presented. From the behaviourist's point of view, this can be translated into how the stimulus is presented. This does not mean that the internal conditions of learning such as the student's capabilities are not important, indeed they are crucial. Methods of presenting material are covered elsewhere in the text but it should be mentioned here that Gagne's ideas on stimulus presentation and optimising learner's capabilities range from those factors which will gain the student's attention and facilitate recall, to presenting the actual stimulus/information and being able to facilitate information retention.

Building concepts and problem solving

Gestalt approaches

In Chapter four, Gestalt theory was explored briefly in terms of the psychological organisation of material. Here some concrete examples of its utilisation are discussed.

The Gestalt school would be in agreement with Gagne about the importance of presenting material but would most certainly be in opposition to the behavioural slant which underlies his theory. Gestalt (insightful learning) relies heavily on the individual being able to arrive at solutions as a result of being given information which they will then organise into a complete picture.

There are many occasions where adequate preparation is just not feasible, for instance, when an impromptu teaching session evolves from the admission of a new patient. However, by utilising Gestalt psychology which is concerned with organised forms and patterns in human perception, thinking and learning (Curzon, 1990), we will aid the student's learning process. Briefly, it can be applied as follows:

1. *Symmetry* – in other words the session should be divided into an introduction, development and conclusion. This stage, as with some others, is highly dependent on the student's previous knowledge.
2. *Contiguity* – ensure that any reinforcements, such as relevant observations on the patient, pieces of equipment, etc., are shown either at the time of the session or as soon as possible.
3. *Similarity* – try not to "jump" from subject to subject within the same session. If this is not possible, at least ensure that similarity is created by referring subjects back to a focal point. For instance, if the care of a patient is being discussed, and a diversion is needed to talk about the actions of certain drugs, then this will need to be individualized to the patient.
4. *Closure* – try to plan the session in such a way as to allow the student to complete some parts for themselves. This can be done in at least two ways. Firstly, it can be achieved by the use of questions, e.g. "so, if Mr Jones is retaining large amounts of sodium, what would you look for?" Naturally, care should be taken not to demotivate the student by making them feel threatened. Secondly, the student can be given something to observe or further research, but if this is done, then time needs to be put aside later to discuss their findings so that it can be integrated into the overall subject.

For a pictorial interpretation of Gestalt approaches, the reader is directed to Chapter four.

Discovery learning

It could be argued that more traditional forms of learning theory such as the behavioural theories place an emphasis on the information being presented to the student and then practical experience given in order that they may apply it (see also assimilation theory below). An alternative theory which runs contrary to this approach is discovery learning (Bruner, 1960), which is essentially a student-centred approach which assumes that knowledge will be internalised as a result of experimentation and experience.

Essentially, discovery learning is concerned with the development of concepts from processes which have enabled the individual to find common properties in objects or situations which will enable them to classify them into groups and to be able to apply general rules to them. Naturally, this process is a continual evolution and cannot be looked at as an isolated event as the student will continue to evaluate new experiences within the context of earlier concepts which have been formed. The logical consequence of this in terms of education is that the student will be able to revisit concepts throughout a course of study and to expand them in the light of new experience (spiral curriculum). The process of discovery, although quite a complex phenomenon, can be divided into two major activities with evaluation of what is happening occurring as an on-going feature:

1. *Induction* – (taking particular instances and using them to devise a general case) with a minimum of instruction.
2. *Errorful learning* – employing trial and error strategies in which there is a high probability of errors and mistakes before an acceptable generalisation is possible.

It could be argued that in terms of everyday life, discovery learning occurs naturally and is effective in helping us develop. In terms of more formal education its uses have also been advocated, but at times with reservations (Cronbach, 1966), in as much as its function is sometimes seen as specialised and limited, although at the same time it could increase motivation, resourcefulness and satisfaction.

The use of discovery appears to be centred upon certain conditions all of which may be decisions which a ward-based facilitator may be able to have some influence over. For example, in terms of the experience being process or product based, will the preceptor allow autonomy in discovery, or will the student be directed? Will the student be allowed to reach unique conclusions or be guided towards a particular solution to a problem? Probably more daring for the clinical area is the question of whether discovery will be accidental or planned and certainly it is very tempting to imagine (quite wrongly) the implications of employing errorful learning in patient care. It now seems appropriate that the best way of answering these questions is to give an example of how it may be implemented.

One example which is familiar to all individuals that have participated in the preceptorship of learners is that of how their teaching styles and approaches have developed over a period of time, and that with the best of intentions, no-one can ever cater for all the eventualities when teaching someone else to teach. It is in fact a discovery exercise on the part of the new teacher, and sometimes a very painful one! The development of an effective session may take the form shown in Table 5.1.

It can be seen, and indeed most of us have experienced, that the concept of timing for instance, can only be achieved through discovery and different facets of the concept will be visited as the preceptor gains more experience, so that eventually, factors other than just the session content will be taken into consideration. To return to our earlier point, we still have to take into account how we will form the concepts that we do. The example given above may be developed autonomously but more usually as the result of the direction given to us by

Table 5.1. Discovery learning session development

Activity	Developing concepts
Discovery through session planning	Theoretical content based curriculum/clinical needs Approximate timing based on content Teaching method appropriate to students, content and environment Perceived levels of student understanding Appropriateness of visual aid to content and environment
Discovery through session delivery	Actual levels of student understanding Actual timing based on student understanding and content Effectiveness of visual aids to content, environment and group Effectiveness of teaching method to group, content, environment and timing

student evaluations or through a teaching assessment. Whether we will develop our concepts in this instance in a process- or product-based manner will largely depend on what is being taught and the influences of others around us as to what outcomes need to be achieved, but it is certainly arguable that developing a teaching style is always a process activity.

Reception learning (assimilation theory)

In this theory, Ausubel (1978) discusses four dimensions of learning:

1. Rote.
2. Reception (existing relevant cognitive structure).
3. Discovery (new information).
4. Meaningful (new and old material incorporated to form a more detailed cognitive structure).

With this theory Ausubel attempts to resolve problems facing Bruner's discovery learning, namely subject matter organisation. Ausubel presents two main principles necessary for subject matter organisation:

1. *Progressive differentiation.* General ideas are presented first (advanced organisers) followed by gradual increase in details and specificity.
2. *Integrative reconciliation.* New ideas must be consciously related to previously learned material (subsumers).

By "advanced organiser" is meant that introductory material is presented ahead of the learning task and at a higher level of abstraction and inclusiveness than the learning task itself.

Three conditions are necessary for the attainment of meaningful learning which is essential for problem solving:

1. The learner must adopt a "set" to learn the task in a meaningful manner.
2. The task must have logical meaning.
3. The learner's cognitive structures must contain specifically relevant ideas with which new material can interact.

Discovery teaching alone does not necessarily guarantee meaningful learning.

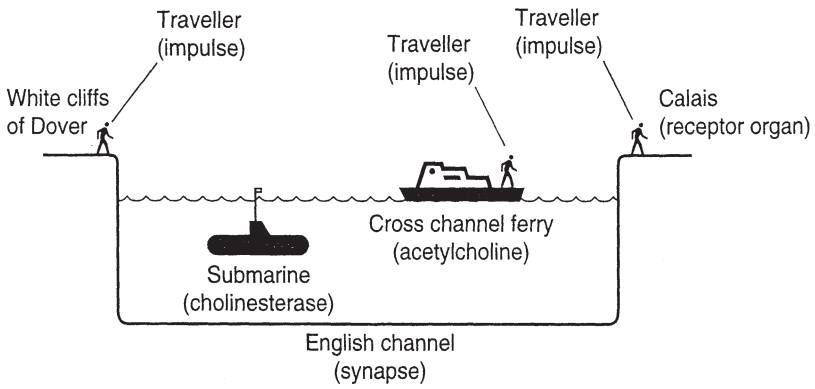

Figure 5.2. Example of reception learning: conduction of a nerve impulse.

Reception learning, on the other hand, is a highly functional conceptual framework for students.

Subsumers, which are such an essential part of the theory, enable us to integrate existing concepts with newly acquired ones. This in itself appears fairly straightforward, however, Ausubel goes on to postulate as to the existence of something that he terms "Obliterative Subsumption". In this he maintains that although much material has been forgotten residual concepts nevertheless remain and hence can be built upon. The inference of this theory as Ausubel himself points out, is that the student is the central focus of the learning process, in as much as the material to be learnt must be related to what the student already knows and that once this is established, learning will progress at a faster and more reliable rate. The implication of this is naturally that the person who is providing the instruction or experience to the student must know their student's past experiences and an honest relationship must be built up between them in order for learning to be effective. Consequently, teaching students in large groups is seen to have many drawbacks.

Ausubel accepts that not all meaningful learning involves new instances or modifications of previous learned concepts but may bear a "superalternate" relationship to a previous acquired concept. For example, superalternate learning occurs when we learn that man, cats and dogs are all mammals. As superalternate learning occurs so does integrative reconciliation, as existing concepts are rearranged into new order higher concept meanings. For example, the student recognises that different labels describe the same concept, e.g. sensory nerve/afferent nerve. A further example is given in Figure 5.2.

In this way we are enabling the student to progress in a logical manner from the known to the unknown. In other words it could be said that the student is progressing from the "concrete" to the "abstract".

Conclusions

The introduction to this chapter pointed out that there are a variety of theories of learning and that these theories are diverse and at times totally rejecting of other theories. For instance, the humanistic school is in direct contrast to the behaviourist approach. The caution appears to be that to adopt any one method to the complete exclusion of all others could lead to vital teaching strategies being overlooked. It would appear logical to suggest that information processing, which is essentially the topic of this chapter, would be dependent upon the subject being taught, the environment in which it is being taught, time available, resources and perhaps

most important of all, the personalities and preferences of both the students and preceptors. Kolb's theory, alone amongst all the others, goes to great lengths to advise us that certain learning styles are compatible with certain individuals and that care needs to be taken in how these are matched to the learning experiences available.

Summary

Rogers uses as the basis of his theory the fact that we all have a need for positive regard, in other words, we all need to feel good about ourselves. Feeling positive regard as a result of what other people want or expect us to do results in what Rogers terms conditional positive regard.

Conditions of worth may take the form of professional behaviour, academic standards, achieving learning outcomes and even holding certain attitudes and values.

Because positive self-regard is self-esteem achieved through fulfilling the conditions placed on us by others, Rogers sees this as potentially damaging. In order to achieve true self-actualisation, Rogers advocates helping the individual to achieve unconditional self-regard.

Experiential learning theory can be described as a cyclical learning process in which Kolb describes four types of learning competencies:

1. Feeling (concrete experience competencies).
2. Perceiving (reflective observation competencies).
3. Thinking (abstract conceptualisation competencies).
4. Behaving (active experimentation competencies).

Dissatisfaction will occur if the learning style imposed on the individual is incompatible with the competency that they favour.

It should be remembered that although Kolb's theory gives us considerable insight into the differing learning styles of the individuals, it can only be used effectively if the individuals involved have been appropriately tested (Kolb, 1976; Kolb and Wolfe, 1981).

The reflexes that Pavlov described were of two types, unconditioned and conditioned reflexes.

It could be argued that all of learning can be explained in terms of operant conditioning as long as interpretation of positive reinforcement can be widened sufficiently to account for the diversity of situations that the learner may find themselves in.

Skinner devised a scheme known as "Programmed Learning", now extensively employed using computer-assisted learning techniques, so that each student may progress at their own pace.

Gagne's theory of learning has a strong behavioural slant, and describes the learning process in terms of a hierarchy as distinct from a cycle. Gagne's assertion is that the learning process focuses heavily on teacher-centred approaches, and great emphasis is placed on how information is presented.

Gestalt (insightful learning) relies heavily on the individual being able to arrive at solutions as a result of being given information which they will then organise into a complete picture.

Essentially, discovery learning is concerned with the development of concepts from processes which have enabled the individual to find common properties in objects or situations which will enable them to classify them into groups and to be able to apply general rules to them.

Ausubel presents two main principles necessary for subject matter organisation.

1. *Progressive differentiation.* General ideas are presented first (advanced organisers) followed by gradual increase in details and specificity.

2. *Integrative reconciliation*. New ideas must be consciously related to previously learned material (subsumers).

By "advanced organiser" is meant that introductory material is presented ahead of the learning task and at a higher level of abstraction and inclusiveness than the learning task itself.

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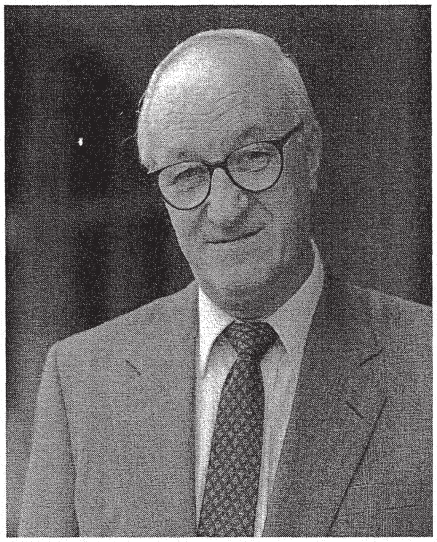
Reading 8



Albert Bandura has been one of the leading architects of social cognitive theory.

Observational Learning

Our exploration of observational learning focuses on the nature of observational learning, Bandura's classic Bobo doll study, and Bandura's contemporary model.

What is Observational Learning? **Observational learning,** *also called imitation or modeling, is learning that occurs when a person observes and imitates someone else's behavior.* The capacity to learn behavior patterns by observation eliminates tedious trial-and-error learning. In many instances, observational learning takes less time than operant conditioning.

The Classic Bobo Doll Study The following experiment by Bandura (1965) illustrates how observational learning can occur even by watching a model who is not reinforced or punished. The experiment also illustrates a distinction between learning and performance.

Source: Santrock, J. W. (2001). Observational learning. In *Educational psychology* (Chapter 7, 256–258). New York: McGraw-Hill.

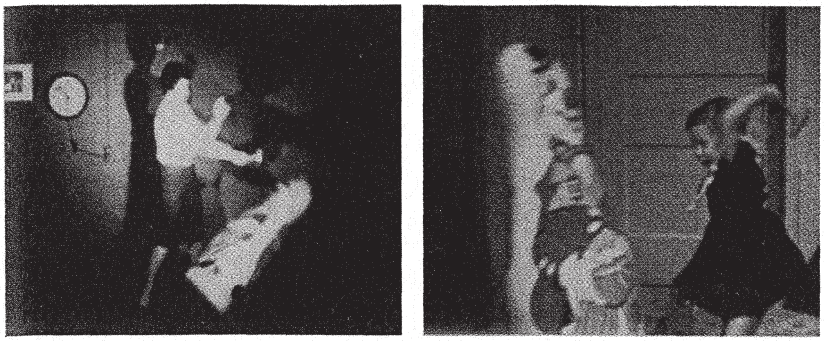


Figure 7.7

Bandura's Classic Bobo Doll Study: The Effects of Observational Learning on Children's Aggression

In the left frame, an adult model aggressively attacks the Bobo doll. In the right frame, a kindergarten-age girl who has observed the model's aggressive actions follows suit. In Bandura's experiment, under what conditions did the children reproduce the model's aggressive actions?

Equal numbers of kindergarten children watched one or another of three films in which a model beat up an adult-size plastic toy called a Bobo doll (see figure 7.7). In the first film, the aggressor was rewarded with candy, soft drinks, and praise for aggressive behavior. In the second film, the aggressor was criticized and spanked for the aggressive behavior. And in the third film, there were no consequences for the aggressor's behavior.

Subsequently, each child was left alone in a room filled with toys, including a Bobo doll. The child's behavior was observed through a one-way mirror. Children who watched the films in which the aggressor's behavior either was reinforced or went unpunished imitated the aggressor's behavior more than did the children who saw the aggressor be punished. As you might expect, boys were more aggressive than girls. An important point in this study is that observational learning occurred just as extensively when modeled aggressive behavior was not reinforced as when it was reinforced.

A second important point in this study focuses on the distinction between *learning* and *performance*. Just because students don't perform a response doesn't mean they didn't learn it. In Bandura's study, when children were rewarded (with stickers or fruit juice) for imitating the model, differences in the children's imitative behavior in the three conditions were eliminated. Bandura believes that when a child observes behavior but makes no observable response, the child may still have acquired the modeled response in cognitive form.

We are in truth more than half what we are by imitation.

Lord Chesterfield
English Statesman, 18th Century

Bandura's Contemporary Model of Observational Learning Since his early experiments, Bandura (1986) has focused on the specific processes that are involved in observational learning. These include attention, retention, motor reproduction, and reinforcement or incentive conditions (see figure 7.8):

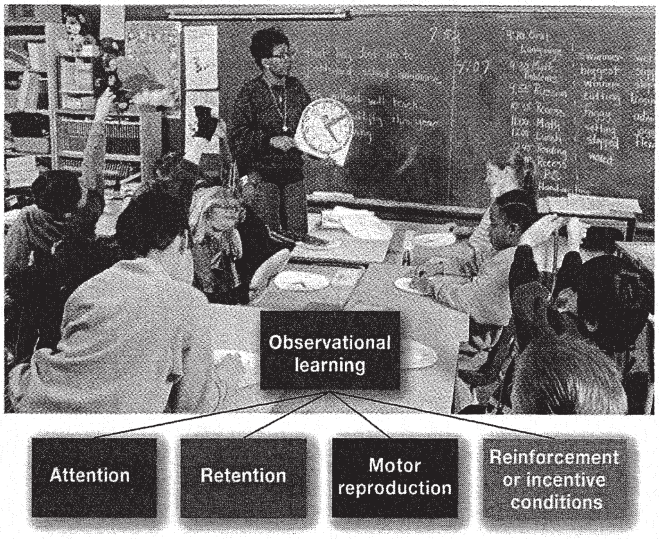


Figure 7.8

Bandura's Model of Observational Learning

In Bandura's model of observational learning, four processes need to be considered: attention, retention, motor reproduction, and reinforcement or incentive conditions. How might these processes be involved in this classroom situation in which a teacher is demonstrating how to tell time?

- *Attention.* Before students can imitate a model's actions, they must attend to what the model is doing or saying. A student who is distracted by two other students who are talking might not hear what a teacher is saying. Attention to the model is influenced by a host of characteristics. For example, warm, powerful, atypical people command more attention than do cold, weak, typical people. Students are more likely to be attentive to high-status models than to low-status models. In most cases, teachers are high-status models for students.
- *Retention.* To reproduce a model's actions, students must code the information and keep it in memory so that it can be retrieved. A simple verbal description or a vivid image of what the model did assists students' retention. For example, the teacher might say, "I'm showing the correct way to do this. You have to do this step first, this step second, and this step third" as she models how to solve a math problem. A video with a colorful character demonstrating the importance of considering other students' feelings might be remembered better than if the teacher just tells the students to do this. Such colorful characters are at the heart of the popularity of "Sesame Street" with children. Students' retention will be improved when teachers give logical and clear demonstrations. In the next chapter, we will further examine the role of memory in children's learning.
- *Motor reproduction.* Children might attend to a model and code in memory what they have seen but, because of limitations in their motor ability, not be able to reproduce the model's behavior. A 13-year-old might watch basketball player David Robinson and golfer Nancy Lopez execute their athletic skills to perfection, or observe a famous pianist or artist perform their skills, but not be able to reproduce their motor actions. Teaching, coaching, and practice can help children improve their motor performances.
- *Reinforcement or incentive conditions.* Often children attend to what a model says or does, retain the information in memory, and possess the motor skills to perform the action, but are not motivated to perform the modeled behavior. This was demonstrated in Bandura's classic Bobo doll study when children who saw the model being punished did not reproduce the punished model's aggressive actions. However, when they subsequently were given a reinforcement or incentive (stickers or fruit juice), they did imitate the model's behavior.

Children need models more than critics.

Joseph Joubert
French Essayist, 19th Century

Bandura believes that reinforcement is not always necessary for observational learning to take place. But if the child does not reproduce the desired behaviors, three types of reinforcement can help do the trick: (1) Reward the model, (2) reward the child, or (3) instruct the child to make self-reinforcing statements such as "Good, I did it!" or "Okay, I've done a good job of getting most of this right, now if I keep trying I will get the rest." We will have much more to say about such self-management strategies shortly.

As you can see, you will be an important model in students' lives and you have many options for providing students with an array of competent models. To evaluate the roles that models and mentors have played in your own life and can play in your students' lives, complete Self-Assessment 7.1. In the next section, we continue our exploration of approaches that have ties to behaviorism but believe that cognitive factors are important aspects of students' learning.

Reading 9

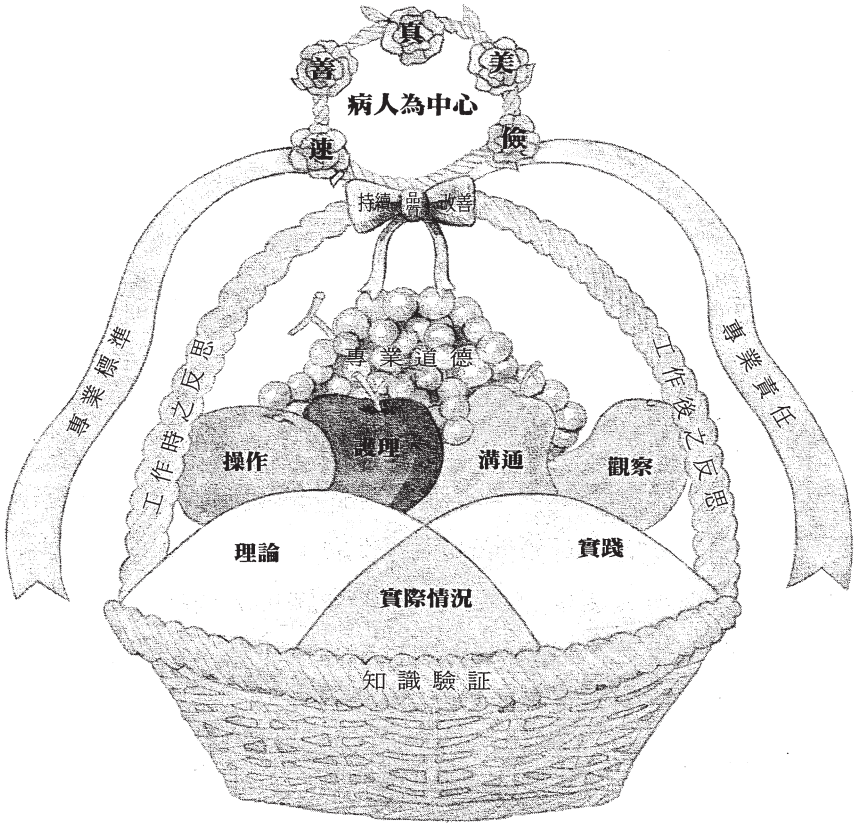
第四部

李氏反思練習模式的創立

由初步研究的成果和日後在其他班別中重覆研究的結果顯示，反思練習帶給同學的改變也是大致相同。（附錄 II pie chart ） 証明了這個反思方法，十分見效。這模式是實在能夠改善學生在學習實踐理論方面的狀況，可訓練護生邁向優質護理的領域。逐漸，我們嘗試把這模式推廣至其他的護理工作上，如派口服藥、注射法、基本護理項目、特別護理項目以至全人護理的項目上，發覺非常湊巧，特別在用來提醒同學派藥時之要點及反思疑點及防止不智之

Source: Li, P. (1998). P Li's reflective practice model. Chapter 4 & 5.

工作方法時，更是一矢中的！若用以作為臨床教導和考核預備，想必事半功倍。於是我們決定以李氏之反思練習模式納入護理課程內，藉此促進有效率和高質素的護理，用來改善臨床的教導和考核，這也成為了香港首創的護理教育和訓練模式（Reflective Practice Model for Nursing Education and Training）



李氏之反思練習模式

這是一個以“Q”優質標誌為題的生果籃圖案設計，以鮮果代表護理才幹，以優質標誌和其上的五朵玫瑰花代表著五個優質服務的要素（5Es），優質標誌的中央寫上「病人為中心」的標題，象徵著服務的焦點是病人至上。由於生果籃是什麼時候都適用的，可預表這模式的代表性和實用性，是無論在健康和疾病的護理實務上，在護理教育或臨床工作上，甚至用來訓練其他與醫療有關的工作人員和其他服務人群的專業人士，也是有著同等的實用價值，能開花結果的。

生果籃共分有四部份 a）生果 b）果籃 c）“Q”優質標誌 d）小彩蝶和大彩帶

a）生果：有五種鮮果

- 橙子代表操作技巧（Technical Skill）
- 萍果代表護理技巧（Caring Skill）
- 梨子代表溝通技巧（Communication Skill）
- 芒果代表觀察技巧（Observation Skill）
- 提子代表專業道德（Professional Ethics）

每個果實皆是獨立的個體，但在果籃中同時一起排列，是代表著各項獨立的知識或技巧實際上也有著同等重要的地位，有著連帶性的關係，若能一個跟一個的學習好，再串連起來一起使用，則可發揮更大的功效。若只懂

得運用一種技巧，必比不上同時運用多種技巧，特別在發揮具有專業色彩的服務時，有了多項才幹和能力比起缺乏這些才幹和能力的服務必然有着顯著的分別。

果實中以提子之性能最為柔軟甜美，十分可口，它能穿插於各果實之間，而又被擺放於各鮮果之上，豫表著專業道德的灌輸和影響力對專業是何等的重要，它可啟發和引導工作者去重視自己的專業道德，增加對服務的熱誠，使專業道德在工作上彰顯能力，加深了工作的意義，使專業變為「人性化」，又增強了專業責任感，訂定專業的方向和要求，包括行為模式和工作態度的表現，這樣優質護理方能實現。

b）果籃 - 分籃身與挽手的部份和其外層的包果紙：

籃身：

是代表知識驗証（Knowledge Validation）的重要，因它可盛載著驗証後的各樣真知卓見，放在籃內。有了驗証後的知識墊著生果，果實才得以保存穩健和新鮮，有價值和有吸引力，不易朽壞或被丟棄。

挽手：

左邊是代表工作時之反思（Reflection-in-action），右邊是代表工作後之反思（Reflection-on-action），籃邊是代表著驗証的行動（Validation），即引用科學化的研究精神和工作行動去認定事實，使知識經得起工作上的考驗，然後

成為實踐的根據。意思是透過了在工作時之反思和工作後之反思，護士便會培養到一種實事求事的精神，以實際行動去求証和體驗做事的好方法，從而瞭解知識的實用性與可行性，不至誤解，不會盲從。知識經過了驗証後則可以鞏固理論的基礎，支持技巧的運用，發揮實際的功效。

包裹紙：

覆蓋著生果的包裹紙，有三個小組合，就是理論（Theory）、實踐（Practice）和兩者之間的實際情況（Practical Reality）。藉此說明了在理論與實踐之間，還有「實際情況」的領域必須考慮，護理要因應實況作出協調，才能把理論實踐，不致出現分歧。這道理協助解釋了以往構成理論與實踐不相符的原因，就是因為課本中的理論，大多沒有考慮和關注實際情況的問題，以致在實踐理論的時候，便發生了障礙和困難，構成了理論不設實際的事實。

包裹紙表達了理論與實踐之間的第三領域「實際情況」，它是夾縫於理論與實踐兩者之間而又能影響兩者關係的一個第三者，必須同一時間加以處理，才可使理論與實踐互相配合，又可支持着各種知識和技巧的運用。這是本模式的最大發現，也由此改變了教學的路向，不但重視理論知識，也同時重視實際情況中的實踐能力。

c） “Q” 優質標誌

這是一個國際性的優質標誌（Quality symbol），本模

式在其上配上五朵玫瑰花，每朵花是分別代表優質服務的特徵：（即五個‘E’）

1. **真**（Effectiveness）：

工作真正有效，不是「做戲」，而是實事求事，使工作實際上有好的成果，才有意義。

2. **善**（Ethical）：

擁有崇尚的品格和社會珍惜的道德觀，如能善心善意待人，在工作時誠懇友善地去關懷病人，處處為病人着想，又能善待同僚和後輩，彼此造就，使護理更加專業，不愁沒有合適的接班人，就是發揮了至善的專業道德和專業精神。

3. **美**（Elegance）：

是指工作時要保持運作雅觀，齊整有序，不苟不且的專業表現。不因工作量大而手忙腳亂或有失專業水準；相反的，能保持冷靜，時常維持專業的標準和風範。

4. **速**（Efficiency）：

在達到真善美之要求後，便需要注意改善速度和效率；使工作敏捷熟練，靈活乖巧，應付實況隨機應變，不會無故耽誤工作或拖延時間，使病人不耐煩或多受煎熬。

5. **儉**（Economy）：

能夠精打細算，有計劃使用現有資源，包括物品、人力和時間，節儉有方，應用則用，應慳則慳，不要做成浪費。

這五個是優質服務的指標，要根據排列的優先次序，一個跟一個的去相繼練習，追求達成。切忌以速為首，以儉為先，本末倒置，得不償失。

在這"Q"優質標誌的中央，寫上以「病人為中心」的服務主題，意思是指優質的服務就是為了病人，所以必須處處為病人着想，不是凡事有求必應，而是護士必須考慮病人的立場和利益為首要，給予解釋，加以照顧，使病人在其照料下不會受忽視，卻得到應有的尊重、諒解和關懷，有合情合理的照顧，有滿意的解釋和交代，這就是以病人為中心的意義了。

d）小彩碟和大彩帶

小彩碟是代表不斷進取和謀求改善質素的專業精神（Continuous Quality Improvement - CQI）。兩旁的大彩帶，一邊代表著專業向服務對象承諾會提供之服務標準（professional standard），另一邊是代表著專業人士應負上的專業責任（professional accountability）；這兩者極為重要，能使專業配得上享有獨立（independence）和自主（autonomy）的地位。Schon指出，專業要享有特殊地位，就必須能夠提供合適的服務標準，能夠自我監管，自我改善，有追求完美的理想和能力，達到有品質保証的服務，使病人的安全有保障，身心受益，可以獲取公眾的信任和敬重。

李氏反思練習模式的特點

（一）說明了優質服務的意義是包括著真、善、美、

訓練學員達到。看似困難，實則很易。

(二)指出專業護理才幹不應只有精湛的操作技巧，還得擁有同樣精湛的護理技巧、溝通技巧、觀察技巧、專業道德的表現，實際情況的克服和驗証知識的本領。

(三) 以「病人為中心」的服務目標成為學員的學習目標，是採用現代教育原則和道德觀念來配合，這教學法也道出了如何去落實以病人為中心的服務理想，使病人受到尊重和得到週全的照顧。

(四) 演譯了Schon反思技巧的精絮，使其發揮活學活用的能力，學員工作時有反思，工作更加謹慎，技巧更能切合實際需要。工作後有反思，加強員工解決問題的能力，改善服務。李氏証明了反思練習是能夠培養學員發展獨立思想、正確判斷和產生排難解困的能力，並且可以不斷改善，不斷創新，大大地增進工作成效，在反思時也能凡事提高警覺，減少意外的發生。

(五)這是一個著重訓練專業才幹的量和質的一個教育模式，把學習的領域帶上專業道德和優質服務的領域。在「量」方面，不是單方面專注一種操作技巧，而是專注訓練七種技巧。在質方面，能提升訓練專業人員的道德觀，實際照顧病人的才幹和應付實際情況的能力。也能夠正視專業訓練的弊端，突破一面睹的「科技至上」之局面，是一個強調「以人為本和優質服務為基」的訓練模式“A people-

centred & a quality-based training model"。而且，它還配合了Doherty（1995）建議的優質教育必需具備的條件，就是要格、智、德、才、學兼備，這反思練習模式均可一一做到。

(六)提供老師和學員一個平等相向的學習機會，能夠建立自信、發展個人潛能而加深了工作滿足感。

（七）強調藝術與科學的配合，就是經驗和心得的掌握，理論與知識的驗証，工作方法的考驗。反思練習一方面注重科學知識和理論的根據、另一方面也重視實踐的能力和實踐的藝術，使理論不會與現實互不相符。回應和道出了Schön 所指的，專業在科技以外的藝術化的一面。

（八）由於這是一個循序漸進的教學方法和訓練模式，故不須額外資源，不用加強什麼措施，只要一開始就有計劃有系統地引入這前衛性的反思練習教學方法，在學校內，在臨床上，延續下去，同學便可逐漸懂得如何自我改善，不用依賴考試也能自強，長此下去，優質服務不難做到。

（九）由於同學曾經在臨床上實踐及驗証這模式的可行性，故此，它也可成為同業在臨床實踐優質護理的一個可以考慮的模式。

模式之哲學觀點：（是建立於四個概念上）

（一）人之概念：（King's and Roger's view of Man）

認為人是一個整體，有人的需要及人的生存價值，所

以每一個人都應受到尊重，要一視同仁，保持平等和互重。

（二）人道觀念及人性化之護理（Goffman's Concept of Depersonalisation and Humanism）

人是獨特的個體，有感情和感覺的，不是一種物件，而是一個無价的生命，固此，所有病人均應受到保障和安全的照顧，要有人道和人性化的對待。

（三）角式關係（Parson's concept of Role-Relationship）

挑戰"病人"與"照顧者"的傳統角式上的矛盾，因它鼓勵病人不被尊重，而要接受照顧者的支配 Parson主張改變這麼被動的病人角式，認為病人也應受到尊重，可以自主，與醫療人員應是一個平等和互動的角式關係。

（四）專業的定意（Schon & Freidson）

專業要認定其才能範圍，服務標準和執業守則，使執業者自律和遵從，以保障公眾利益不受損害。專業人士必須自我監管，把獨特的才能服務大眾，要有公信力，能向公眾負責和交代，才可獲得大眾信任，要多與服務對象交談和解釋，才能照顧到其感受和利益。

第五部

李氏反思練習模式的應用與效能

應用方法

李氏反思練習模式是一個可以應用在護理教育與臨床實務上的好工具，也是護理臨床督導和考核的一個好助手，它能為護理專業水平，提供一個統一而又有彈性的評核新標準，可以引導學員達至真、善、美、速、儉的境界，並且能不斷創新，把一個真正愛好學習、要求高質素護理的護士和不求上進的護士識別出來。首先，且看在無菌技術上的教

導，我們如何使用這模式去進行教導、督導和考核護生。

（一）老師先把基本無菌技術知識和一般應用原則在課堂上授予護生。例如：甚麼是無菌技術，使用之原則和方法，護士應該如何採用無菌技術施行傷口換症、及換症時的重點、程序與步驟、物品使用的方法等都一一說明。

（二）老師示範無菌技術的方法，例如 a）徹底洗手 b）戴口罩 c）戴無菌手套 d）開啟無菌布包及紙包物品 e）使用敷料鉗及棉球之方法 f）示範如何作簡單傷口換症、傷口拆線及其他無菌程序 g）指出執行時之重點所在。

（三）同學練習所示範之各種基本操作技巧，在熟練後便進行反思練習。

（四）介紹反思練習：向同學說明反思練習之意義和方法，並教導如何應用在實踐上。

（五）進行反思練習：同學分組進行無菌技術，老師以「現實模擬」形色，引入實際情況的常見問題，例如物品短缺，人手不足，地方擠迫，病人有種種的疑慮和不同的要求等之不同病例，融入實習中，使同學從中揣摩箇中道理，因應實際情況，靈活應變以完成任務。

（六）老師分派李氏反思練習模式之臨床教導記錄表，同學按照表格內列出之才幹和工作標準作為指引，在討論後嘗試執行藉此評核一下同學的表現是否做到合乎標準，能否使病人滿意？若未能夠，便需反思改善之方法。

（七）練習使用表格（見附圖三）

表格左部列有七項才幹，中部列有廿六項與各才幹息息相關的工作準則，右部就是用來寫上工作質素等級及評語，可分別由教師和同學用不同的表格填寫，以作比較。也可由同學單獨使用，進行課餘練習，自我評價，自我檢討，並與之前練習記錄作為比較，直至滿意表現，有信心可以在臨床上同樣發揮。例如：

（1）在操作技巧方面

強調好的操作技巧是護理的先決條件，然而要工作做得好，不是單單學會按步驟一一施行，還要懂得權衡輕重，把要點做好。強調的重點包括：

a）同學必須懂得選用合適的步驟去進行工作，目的是訓練同學在短時間內能評估有關事項，作出決定，選擇合適執行工作的最佳方法。

b）提醒同學要靈活使用無菌原則，不要過於執著小節。例如：鉗子的運用次序、棉球使用的常規和傷口抹拭的定例，應按情況而定，免得失去靈活性，只要緊記無菌原則最終目的是要傷口沒有被沾污，沒有受感染便可以了。

c）考慮使用合適的換症方法，例如洗大而廣的傷口、燒傷腐爛的傷口、小而深並含膿的傷口、面部或頭部的傷口、肢體或陰部的傷口等等，護理方法折然不同，需要使用不同的方法處理。

圖三：P.Li's Reflective Practice Model 之（臨床）教導記錄表（老師填寫）

AT 無菌技術

項目名稱：＿＿＿＿＿＿　　督導練習次數：＿＿＿＿＿＿

單位名稱：＿＿＿＿＿＿　　日期：＿＿＿＿＿＿

學生姓名：＿＿＿＿＿＿　　時間：由＿＿＿至＿＿＿（約 40 分鐘內完成）

屆次：＿＿＿＿ 級別：＿＿＿＿　　教職員姓名：＿＿＿＿＿＿

學生簽署：＿＿＿＿＿＿　　教職員簽署：＿＿＿＿＿＿

（將不適用部份更改或刪除）

才幹	執行準則 以病人為中心	＊（1,2,3）			請以"R"顯示學生有反思行動之項目：共＿次
		操作前	操作期間	操作後	工作時之反思指引： 1. 若你是病人，你願意接受同樣的護理服務嗎？ 2. 你的表現是否已達"真善美速儉"之專業水平？
1. 操作技巧	a. 選擇適切步驟				
	b. 靈活使用無菌技術原則				
	c. 換症方法：提防沾污傷口／物品				
	d. 有效處理傷口／縫線／引流／導尿管				
	e. 物品排列整齊有序				
	f. 工作熟練敏捷				
2. 護理技巧	g. 護理觀念：保障安全和舒適 預早察覺及處理病者之 心理反應：恐懼、焦慮、情緒 生理需要：私隱、保暖、止痛				
	h. 護理態度：溫文有禮，友善關懷				
	i. 護理行為：輕柔謹慎，小心照顧				
3. 溝通技巧	j. 告知／解釋／安慰／指導有關事項，回應問題，瞭解病者，使其安心並願意合作。				
	k. 記錄及報告工作成效，需關注之事項；聽取意見。				
4. 觀察技巧	l. 關注心理精神狀況				
	m. 留意病人整體病況				
	n. 觀察傷口癒合狀況和進展				
	o. 注意併發症徵狀				
5. 專業道德	p. 尊重病人及其權益				
	q. 善待病人及其同僚				
	r. 整潔專業儀容				
	s. 工作認真、運作雅觀				
	t. 善用資源：人力、時間、物品				
6. 實際情況	u. 掌握以往經驗和心得，用於工作上作判斷，解決問題				
	v. 考慮實況需要，靈活應付突發事件，善用已有資源，一氣呵成				
7. 知識驗証	w. 無菌技術原則及操作技巧				
	x. 病人之需要和感受				
	y. 防止傳染及沾污				
	z. 實際工作的體驗和改進建議				

d）由於無菌技術用途廣泛，故此把一般學生獨立處理的項目列出，使他們能按步就班地去熟習其工作範圍，又可擴闊這表格的使用範圍。

e）物品處理就是包括同學在程序進行前後和期間，必須練習如何處理物品，井井有條，把症車上之用品排列整齊有序，方便工作進行，不會因物品過份淩亂而做成感染。

f）要求同學不斷改善速度，以至因有熟練的操藝，能減省工作的時間，免病人多受煎熬，或影響病房人手，服務受到拖延。（表格右上角印有一般所需的時間供同學參巧）。但這是操作技巧最後的一欄，意思是要求同學先掌握到操作的技術，然後才訓練加快速度，千萬不要「未學行，先學跑」，然而每一次的練習，也得有改善速度的意念，做到合乎標準和超越標準時，就是有進步的証明。

（2）護理技巧方面

同學在掌握好操作技巧後，便要進一步懂得照顧病人身、心、靈的需要。抱有正確的護理觀點、態度和行為，才可對病人有悉心的關懷和照顧，重點包括下列的事情：

g）要求同學預先察覺病人之心理反應，如有不安情緒或恐懼之表現，需即時處理，例如透過溝通安撫病人，使病人心理困擾得到照顧，能夠安心接受治療。在生理方面：如保持病人私隱，不要因病床擠迫而不拉好屏風。也要為病人保暖，特別在冷天或有空氣調節的地方，小心孱弱的病人。

事先考慮如何為病人止痛：如應否給予止痛藥或運用深呼吸方法減痛，不要讓病人在不支時才臨時找尋補救。照顧病人的舒適，特別是那些不能自我照顧或神智不清或昏迷的病人、更要為他們的安全著想，做足預備功夫，有需要時請同僚協助換症，免得顧此失彼，影響病人的安全。

h) 提醒同學在與病人接觸時，必須注意自己的態度和禮貌，要溫文有禮，要友善交談，使他們覺得你態度誠懇，便喜歡和信任你，並按你的建議而行。

i) 替病人進行護理時，要愛錫病人，愛人如己，感同身受。體貼病人的不適和痛楚的感受，動作要輕柔，要小心謹慎，不要疏忽大意，釀成過錯！卻要時加留意病人的反應和感受，才萬無一失。

(3) 溝通技巧

其實，這才幹常與上述的操作技巧和護理技巧一起使用，是分不開的，現把它分割出來討論，是希望訓練同學們能留意溝通的藝術，懂得如何有效地與病人和同業溝通，因這是一門很深的學問，技巧更是難以掌握得好，但以下幾個重點則不難做到：

j) 根據大綱顯淺撮要的指導同學，使用這種溝通形式：在工作前知會病人要為他作什麼事，按病人之需要作解釋、指導、或安慰，務要病人明白和放心，願與護士合作。大家要研究和練習如何指導、解釋或安慰病人，更要懂得如何回應

問題，方不致引起誤會。

k) 指無論是口述或書寫的報告，要記錄詳細和正確的資料，報告整體的成效。與上司和同僚溝通時，更需把握機會，提出疑點和討論難題，尋求有效而又合乎原則之解決方法，聽取意見以求進步。

(4) 觀察技巧

這也是護理工作中不可缺少之才幹，良好的護理技巧是不可少的元素；在這兒分別處理，是要同學懂得如何觀察，不論在工作前後，或是進行程序時，都要有敏銳的觀察力。要留意病人的整體情況，若有極度不適之表情便要讓他休息，多加觀察提防情況突然惡化，不要過於埋頭換症而對病人情形一無所知。

l) 留意病人的心理精神狀況，在替病人工作之前，先瞭解一下他的情況究竟如何，適合進行換症嗎？工作後，又要看看他有否好轉？他心情如何？滿意抑不滿意？有否不尋常之表現？

m) 病人整體的狀況和一般反應如何，有否需要特別的觀察？如有關體溫、脈膊和血壓，是否正常？特別是心臟或呼吸方面有疾病的人，可有什麼不適的徵狀？其旁邊的醫療物品，（如靜脈輸入）是否運作正常？護士也要同時留意，不要以為換症完畢就等同大功告成。

n) 所處理之傷口狀況是否逐漸康復，還是沒有進展，

或每況愈下？要懂得比較。

o)病人有沒有併發症徵狀出現?如傷口是否清潔、是否出血、含膿？縫線是否已如數取出？有沒有炎症或爆裂之象徵？應該怎樣做？護士若能懂得及早處理，便可避免影響病人早日康復。

上述所提及的才幹，是每一個護理程序進行時都不可缺少的基本技巧，所以他們既是個別技巧，也是有連貫性的，同學逐一練習好後，便需同時一起混合起來使用，直至揮灑自如，在找到要領後，便要進入較高的學習層次，即為專業的領域。以下的三個才幹，就是踏進專業領域的途徑。

(5) 專業道德

這是專業的操守和行為的表現，包括禮貌和工作態度：

p) 護士要懂得有禮貌地尊重病人及維護病人之權益，如私隱、知情權和選擇權等（參巧病人約章）。護士也要訓練自己的專業影響力，運用自己的專業知識與病人交談，對事情有清楚交代，使病人也能尊重護士的專業意見，願意跟她合作，依她建議而行。

q) 提醒我們不單要對病人好，也要對自己的同僚好，有商有量，互相鼓勵和支持，十分重要。切忌互相排斥和挑剔，甚至在病人面前責罵同僚，有失專業的尊嚴和風範。

r) 為了維持我們的專業形象及贏取病人和公眾的信任，護士必須時常保持整潔的專業儀容，給人有穩重和可以

信賴的感覺。

s）護士對工作必須要認真，不苟且，無論何時，別人看見與否，（如在圍上屏風後）也得保持工作水準，運作同樣雅觀得體，不要草率，或因工作緊迫而草率了事，以免構成疏忽。

t）訓練同學多用思考，好好計劃工作所需之物品或人力支援，在現有的資源分配下，善於利用，不致構成浪費或額外開支。

（6）實際情況

這是本模式獨特之處，就是提示同學如何應付實際情況中出現的問題，要鍛練百般武藝，隨機應變！

u）同學要珍惜和反思以往的每一個工作經驗，取長補短，把工作心得應用到類同的情況上，能夠改善和培育自己的辦事能力。

v）提示護生要靈活應付工作，不要墨守成規，一成不變。如有物品缺乏，可考慮使用其他東西去補充不足，一樣可以完成任務的。例如發現無菌包裡少了一隻血管鉗或棉球不夠用時，不一定需要跑去治療室找回血管鉗包或棉球包，甚至另開個無菌包補充物品，費時失事，浪費資源，反而要思巧如何儘量利用現有物品，加以變通，完成工作。

（7）知識驗証

掌握了程序方面的有關知識後便要進一步，在工作中驗

証知識的實際性，要帶領護生到達更高的境界，必須懂得驗証知識，不要人紜我亦紜，「知其然而不知其所以然」！如工作時發覺與知識方面有不符合的地方，便要加以研究，把經歷到的困難及最後解決問題的方法提出來討論，再與課本的知識作一比較，加以驗証，把令人產生懷疑或不設實際的地方重覆研究，看看是否應作修改或更正。

w) 在無菌技術原則一項：如棉球抹拭法常常要求同學用一棉球抹拭一次，由內而外抹開。然而，這並不是一個千篇一律的事實，要按傷口的清潔程度和大小而定，有經驗的醫生和護士便可告訴你箇中道理。所以只有經過驗証後的知識，才可算為真知卓見，經得起考驗，可以作為實踐的基礎。

x) 在這無菌程序中，究竟病人還有什麼需要未受注視，病人的真正感受究竟如何？值得記下作討論，以求改善下一次的表現。

y) 在防止傳染的功夫上實際有效嗎？沾污情況出現後又可有什麼補救方法？同學可以學習發揮這種本領。

z) 同學的心得和體驗可在此盡量發表，留待日後作參巧。

（八）小組討論及老師回饋

反思練習的其中一個好處就是由一位同學以真實個案形式去執行一個無菌程序，完畢後，同學首先自我檢討，更聽

取「病人」的意見，然後由同學和老師即時給予回饋。綜合各點，大家反思一下工作的理由和方法，需要改善的弱點或值得欣賞的強項，互相交流意見，眾人皆得益不淺。

（九）模範表演

在老師觀察各組別的練習後，便選擇其中一組做得最出色的同學來作示範表演，加深同學記憶。

如此一步一步的訓練和發展學生的才幹，就有如砌積木一樣，一層一層地加建向上， 由基本做起，做妥當了又再加建第二層，如此類推，當學生到達了第七層之時，便是登峰造極的時候了。俗語說：「周身刀，無一利」；指人們樣樣都學，但無一精通，然而這個訓練方法就折然不同，每一把刀也是鋒利無比的，擁有七把寶刀，就能把護理難題一一迎刃而解了。

應用效能

為了使教學的內容和臨床的要求有一致標準，我們決定使用這表格作為臨床督導的工具。與此同時，亦設計了一張評核表格（見附圖四），作為臨床評核試的評核標準，並徵詢病室同事之意見。有約 90% 的同事都表示歡迎使用這表格，10%無意見，同意的都稱讚這表格目標清晰，執行準則鮮明，使用方便，表達貼切，對學生的表現有一定的評鑑能力。

考核表格大致上與臨床督導表格相同，有著一石二鳥的

果效。表格左部同樣是有七種才幹的名稱，中部同是一樣的廿六項工作標準，但是右面卻列有三種不同程度的工作表現，第一類是不合格的表現細則，第二類是合格的表現細則，第三類是優異的表現細則，融入了真、善、美、速、儉的優質條件。指標清楚易明。無論誰人用作評核，結果也是大緻相同。考列優異的，必然是大家公認的好學生和好護士。

然而無論評核試之結果如何，同學仍須填寫評核試後之反思表（見附圖五），以能回顧自己的工作，嘗試自我檢討一下，有什麼做得好的，有什麼做得不好的，都寫下來，並且考慮一下評核員的意見，或自行思考一些可行的改善方法，以能提醒學員日後注意改良不足之處。做得好的地方，獲得了正面的評價，又有鼓勵作用。

這模式大大改進了護理教育的能力，特別同學在臨床的實際情況中，大派用場，能減少灰色地帶，澄清學習疑點，正視工作方法，靈活應變以達到優質的護理。又因有真、善、美、速、儉的目標作為優質服務的評價，不論老師和同學，也認定了不可單求完成工作便了事，而要不斷思考那種工作方法可以更加收效，對病人更加安全週到，能增添專業智慧，收經濟效益和達到高質素的效果為最終目的。

我們自採用反思練習後，有了以下的成就：

真：

校長、老師和同學時常一起研究真正有效的護理方法，無論在基本護理如：打針、派藥和換症的工作上，或在病例的研究和護理診斷的應用上，也認真地引用比較實際的教學方法去考慮實況，驗証其可行性和有效性。發掘優點和缺點，利與弊，使同學不會盲從或不求什解去背誦和行事，例如：派藥物之三核五對原則並非萬全之策，只有靈活使用原則，及早澄清藥物或處方的疑點，加上反思病人的病因及實際所需，派葯物的理由，才會萬無一失。

善：

彼此真心善意互相協助，希望護理行業有進步，對病人有更多的貢獻，對後輩有更多的扶持，為自己的善行感到高興，讓護理的崇尚情操，在社會上得到表揚，提升護士的形象，為人所敬重！

美：

同學都有齊整的儀容，在工作時也能注意把病人的用品收拾齊整，症車和醫療物品也會保持乾淨，留意工作雅觀，保持病室環境清潔，維持專業的水準和風範，並且發展實踐之藝術價值。

速：

同學的工作速度大大提高，一般無菌技術由一小時減至不到半小時便可完成，即使是插導尿管也能一樣地有效率，

在半小時內有效完成。

儉：

在人力方面，懂得考慮實況需要作靈活安排，如插導尿管前會教導病人自助預備體位，若不能自助者則由同事在插入前一刻給予協助預備體位，可減省使用兩名人手的時間運用。

在物件節省上也有不少收獲：如同學反思什麼時候才需用墊巾和手套，能省回不少的不必要開支；特別是用後即棄的墊巾和手套，常用的棉球和敷料、消毒葯水和導尿管的使用。而且，又因同學們的無菌技巧有了改良，以前司空見慣的污棉球散跌在症車周圍的情景已是難得一見，減少了間接交互傳染的機會。這樣一來便可減少了抗生素之費用和導尿管的支出，也能達到環保的目的。

試想由一班同學開始便有這樣的成就，若推廣至整所學校，整間醫院，以至全港學校和全港醫院及至全世界，將來的護理質素會是怎樣？社會資源又會怎樣？是節省了，還是增加了？可謂不言而諭。

然而，在推行初期也許會需要多增人力，協助訓練和推廣，之後，當反思之文化和技巧已深入人心，潛移默化，便會收到"Quality without additional Cost" and "making savings"之效果了！

圖四：**P.Li's Reflective Practice Model** 之臨床評核表

AT 無菌技術

項目名稱：＿＿＿＿＿＿＿＿　督導練習次數：＿＿＿＿＿＿＿＿

單位名稱：＿＿＿＿＿＿＿＿　日期：＿＿＿＿＿＿＿＿

學生姓名：＿＿＿＿＿＿＿＿　時間：由＿＿＿至＿＿＿（約 40 分鐘內完成）

屆次：＿＿＿＿ 級別：＿＿＿＿　評核員姓名：＿＿＿＿＿＿＿＿

學生簽署：＿＿＿＿＿＿＿＿　評核員簽署：＿＿＿＿＿＿＿＿

（將不適用部份更改或刪除）

才幹	執行準則 以病人為中心	工作表現（請在適切的項目之□填上✓符號） 1. 不合格	2. 合格	3. 優異
1. 操作技巧	a. 選擇適切步驟	嚴重錯漏□	操作熟練淡效□	操作俐落□
	b. 靈活使用無菌技術原則	違反原則□	乎合原則□	應付自如□
	c. 換症方法：提防沾污傷口／物品			
	d. 有效處理傷口／縫線／引流／導尿管	例証：		
	e. 物品排列整齊有序			
	f. 工作熱練敏捷			
2. 護理技巧	g. 護理觀念：保障安全和舒適 預早察覺及處理病者之 心理反應：恐怔、焦慮、情緒 生理需要：私隱、保暖、止痛	疏忽大意□ 忽視病人感受□ 例証：	安全舒適□ 關注病人感受□	週全照顧□ 感同身受□
	h. 護理態度：溫文有禮，友善關懷			
	i. 護理行為：輕柔謹慎，小心照顧			
3. 溝通技巧	j. 告知／解釋／安慰／指導有關事項，回應問題，瞭解病者，使其安心並願意合作。	詞不達意□ 例証：	用詞洽當□	言詞精簡握要□
	k. 記錄及報告工作成效，需關注之事項；聽取意見。			
4. 觀察技巧	l. 關注心理精神狀況	資料不足□	資料正確□	資料詳盡□
	m. 留意病人整體病況	例子：		
	n. 觀察傷癒合狀況和進展			
	o. 注意併發症徵狀			
5. 專業道德	p. 尊重病人及其權益	缺專業精神□	有專業精神□	樹立榜樣，精神可嘉□
	q. 善待病人及其同僚			
	r. 整潔專業儀容	例証：		
	s. 工作認真、運作雅觀			
	t. 善用資源：人力、時間、物品			
6. 實際情況	u. 掌握以往經驗和心得，應用於工作上，選擇最佳方法解決問題	未按實況作應變□	能按實況作應變□	隨機應變，靈活發揮□
	v. 考慮實況需要，靈活應付突發事件，善用已有資源，一氣呵成	例証：		
7. 知識驗証	w. 無菌技術原則及操作技巧	墨守成規□	回顧經驗作反思□	回顧經驗印証理論□
	x. 病人之需要和感受	例証：		
	y. 防止傳染及沾污			
	z. 實際工作的體驗和改進建議			

圖五 **P.Li's Reflective Practice Model** 之臨床教導／評核試後反思表（學生填寫）

評核項目：_____

單位名稱：_____ 日期：_____

學生姓名：_____ 評核員姓名：_____

屆次：_____ 評核員簽署：_____

學生必須按導師評語作檢討，反思可取或不足之處，謀求改善，使最終達至"真善美速儉"之目標，把理論與實踐互相配合。

1. 操作技巧

_____

_____

_____

2. 護理技巧

_____

_____

_____

3. 溝通技巧

_____

_____

_____

4. 觀察技巧

_____

_____

_____

5. 專業道德

_____

_____

_____

6. 實際情況

_____

_____

7. 知識驗証

_____

_____

_____