Mentor Relationship as a Tool of Professional Development of Student Nurses in Clinical Practice

By

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Abstract

This is a condensed version of a research project relating to the design and development of a research instrument concerning ‘Clinical learning environment and Supervision of student nurses’. This research paper is taken from and reproduces the research work undertaken by Saarikoski (2002). The main themes of the study refer to development and validation of the evaluation scale (CLES) to assess the quality of clinical learning environment and supervision of student nurses during their clinical placements.

This report strongly suggests that there is clear evidence that the supervisory relationship is the most important single element of pedagogical activities of staff nurses. The total satisfaction of students correlated most clearly with the method of supervision and that those satisfied students had a successful mentor relationship and frequently enough access to private supervision sessions with mentor. In the sample of this empirical study (n=279 student nurses in Finland) individualised supervision system was most common on psychiatric wards.

All nurse educators and clinical practitioners working across Europe in clinical learning environments will find this paper very useful in helping them to improve and quantify the supervisory process. This study starts bridging the gap between using and integrating both at a National and European level assessment systems that relate to the learning and supervisory process. The study encourages the need for professionals to test these new instruments in other nursing cultures and reflects upon the need for further research work in this area.
Introduction

Nursing is a practical profession where nurses meet lot of patients in their critical phases of life. Student nurses live in similar situation than staff nurses. This can be more difficult because they have not so much readiness to meet these kind situations than experienced staff nurses have. Often these situations are impact by painful and stressing experiences because illness is holistic phenomenon that influences to the whole life of a human being. Patients are many times in unstable emotional state and they cause many kind of emotional reactions also in a nurse. These kinds of experiences can’t be left without attention because the strong untreated feelings can cause stress in a nurse. Just that figure makes the difference between nursing profession and other service professionals.

This issue is still little recognised phenomena in nursing and in nurse education. Only on some fields of nursing this matter has been come aware and it has been taken account in the planning of supervision models for nursing staff and student nurses. In this paper different kind of supervision models will be observed from the viewpoint of different nursing fields: medical, psychiatric and surgical wards. The empirical study where the experiences of student nurses on their clinical placement (on these ward types) will be presented in this paper.

Theoretical background: context and concepts

In the nursing practice, good learning environment can bee defined as a unit where teamwork is evident, communication is effective and the ward manager is aware of the physical and emotional needs of nursing staff and students (Orton 1983). A clinical ward setting is an environment where several factors promote or inhibit students’ learning and enjoyment. The ward atmosphere and organisation of nursing team are the most important factors (Wilson-Barnett et al. 1995).

The leadership style of the ward manager is the most important element in this context because it determines the relationship between ward manager and nursing staff (Ogier & Barnett 1986; Saarikoski & Leino-Kilpi 1999). Their can be seen some analogous features in the relationships between ward manager and staff and between staff nurses and nursing students (Dunn & Hansford 1997; Saarikoski & Leino-Kilpi 2002).

One crucial element in student’s clinical learning is the supervision system. In this paper, the concept of supervision has been understood as an umbrella term, which can include different kind dimensions of supervisor's role; teaching, assessing and mentoring (Butterworth & Faugier 1992). The supervision model of students’ nurses during their clinical placements can be divided in two main types: individualised supervision and group supervision. In the individualized supervision model, student has a named mentor. The term mentor is used to denote the role of personal supervisor who facilitates learning and supervises and assess. Mentor has an understanding of the context of the student’s learning experience and he or she is often self-selected by student for the purpose of providing guidance and support. (ENB 2001.)
In the group supervision same supervisor has several students. During the 1980’s and 1990’s, it has happened in nurse education culture the clear transition from team supervision to individualised supervision both in the USA and in the UK (Anforth 1992; Vance & Olson 1992; Craddock 1993; Dibert & Goldenberg 1995). Individualised supervisory relationship is more intimate and it can be concluded logically that the dimensions of personal and professional growth are easier to work on than in the team supervision. One question is, how near the roles of mentor and clinical supervisor are?

Clinical supervision is a clinically focused professional relationship between individual supervisee (or nursing team) and experienced practitioner. This relationship involves the clinical supervisor applying clinical knowledge and experience to assist colleagues to develop their clinical practice. (UKCC 1995.) It is important to recognise that the focus in clinical supervision is in the development of patients care (Butterworth & Faugier 1992) but in mentor relationship the focus is in the learning and professional growth of student nurse (Anforth 1992; ENB 2001).

Nursing care as a context of student’s professional development

The content of nursing care is an important issue in clinical studying as it provides an environment for students’ experiences. Contacts with patients are an important element in learning nursing in clinical practice. Students are exposed to authentic life stories – e.g. people with serious illness and these experiences can arouse strong emotions and yet they also offer meaningful learning experiences. These kind of clinical situations are important impulses to student’s professional development. (Loftus 1998; Turunen 2002.) This is important challenge to supervisor system; does it include the elements that can help student to cope his or her emotions and can the supervisory system offer the provisions to student’s professional growth?

There is lot of evidence that in the individualised supervisory relationship, students’ emotions can be handled. E.g. Grey and Smith (1999) found that the mentor is the linchpin of the students’ emotional experience. In their study some students who had a ‘good’ mentor relationship developed their intuition and skills to meet patients also in emotional sense. In the study of Crawford et al. (2000) mentor relationship was perceived by student as pivotal to their development. A good mentor relationship is equal, delicate and open for mutual feedback. By Jones et al. (2001) there is question about common time and contact frequency; the relationship between student and mentor must be active enough.

Students see mentorship working only if they have regular contacts with their mentor. There are only few studies evaluating the learning environments from the viewpoint of ward type. From these limited studies, students have commonly experienced the worse learning environments as being those lesser technically orientated departments, in which the patients’ stay is long. In the main, these were surgical wards, noted being often ‘good’ and both medical and geriatric wards as ‘poor’ learning environments by students. (Fretwell 1980; Parkes 1980; Lewin & Leach 1982.) However, some later studies have demonstrated that understanding what a ‘poor’ learning environment means is more complex. Supervisory system can be one important issue in this matter.
In Finland, there are some differences between ward types in tradition of supervisory system. By the nature of clinical speciality, it has always been emphases more on individualised supervision on psychiatric wards. In the study of Saarikoski and Leino-Kilpi (1999) students evaluated psychiatric wards being best learning environments on the all dimensions of their study. The dimensions were: (a) Atmosphere; (b) Leadership style of ward manager; (c) Quality of nursing care and (d) Premises of learning on the ward. Remarkable difference between ward types was the supervisory system: the individualised supervisory model was most common on psychiatric wards. The other ward types in this comparison were medical, paediatric and surgical ward.

**Empirical study - the aim and the research questions of the study**

The aim of the study was to explore how different kind ward types are distinguished as a clinical placement of student nurses. The chosen ward types were medical, psychiatric and surgical wards. The research questions were:

- What were the students’ experiences of wards as a learning environment?
- What is the most common supervision model on each ward types?
- How intensively student worked with his or her supervisor?

**The sample**

Finnish student nurses form the sample of this study. The duration of general nurse examination in Finland is three and a half years. The proportion of clinical practice is 36-40% of the total course. It can vary about 4% by the colleges. This examination is a degree programme and its academic level is BA. The Finnish nurse education system occurs in multidisciplinary polytechnics. MA level studies occur in the Universities (after basic degree level studies). These programmes are orientated to administration, education or to the expertise of clinical nursing (clinical nurse specialists).

The sample (n=279) of this study is the part of wider research sample. That main sample was collected from four nursing colleges for validation of a research instrument (CLES evaluation scale) (Saarikoski & Leino-Kilpi 2002). There were three equal, nearly same size parts in this sample. The biggest group were students who had had their clinical placement on medical wards (115 students), second group (84 students) had their experience on surgical wards and third group (80 students) had practiced on psychiatric wards. Other ward types were so low represented in that main sample that they were outlined.
Instrumentation

The data was collected using Clinical Learning Environment and Supervision (CLES) evaluation scale (Saarikoski & Leino-Kilpi 2002). There are 27 items, which are divided to five sub-dimensions: Ward atmosphere (4 items); Leadership style of the Ward Manager (WM) (4 items); Premises of nursing care on the ward (4 items); Premises of learning on the ward (6 items) and Supervisory relationship (8 items). Students were asked to evaluate the clinical placement that they have just completed (not general evaluation of clinical studying).

Students' total satisfaction is assessed using three separate items. CLES is utilizing five-step Likert type scale. This instrument is valid research tool: internal consistency reliability using Cronbach's alpha coefficient varied from 0.73 to 0.94 by sub-dimensions. The test-retest reliability varies between 0.71 and 0.91 by the sub-dimensions (Saarikoski 2002).

Ethical standard of the study

All ethical standards of research were observed. Written permission to carry out the study was obtained from the Principals of the nursing colleges. The principals were informed that comparisons between colleges would not be undertaken. Data was collected at the end of a clinical placement using an anonymous questionnaire. All respondents volunteered to take part in the study and they gave their consent verbally. The respondents were informed also that they could become acquaint with research result through the libraries of their institutions at the completion of the study.

Results of the study - different ward types as learning environment

The respondents were mainly satisfied with their clinical placements. The mean of the sum-variable of total satisfaction was 3.82 (in scale 1-5) and there can be seen differences between the ward types. The psychiatric ward were evaluated with highest scores (mean 3.95) and lowest was evaluated on medical wards (mean 3.71) but the difference between ward types was not statistical significant. There are in the CLES four dimensions considering a ward as learning environment. The dimensions are: (1) Ward atmosphere; (2) Leadership style of the ward manager; (3) Premises of nursing care on the ward and (4) Premises of learning on the ward. The differences between ward types have been presented in the Table 1.
Table 1: The differences between three different ward types on four sub-dimensions of the CLES

<table>
<thead>
<tr>
<th>Ward type</th>
<th>n</th>
<th>Atmosphere</th>
<th>WM</th>
<th>Premises of nursing</th>
<th>Premises of learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical</td>
<td>(115)</td>
<td>3.70</td>
<td>3.18</td>
<td>3.37</td>
<td>3.40</td>
</tr>
<tr>
<td>psychiatric</td>
<td>(80)</td>
<td>3.98</td>
<td>3.59</td>
<td>3.54</td>
<td>3.71</td>
</tr>
<tr>
<td>surgical</td>
<td>(84)</td>
<td>3.83</td>
<td>3.34</td>
<td>3.35</td>
<td>3.66</td>
</tr>
</tbody>
</table>

Standard dev. 0.80 0.88 0.81 0.82
p 0.04* 0.001*** 0.26 0.02*

Supervision model on the ward types

The respondents assessed psychiatric ward with highest scores on all four learning environment sub-dimensions. The differences were statistical significant on three sub-dimensions and the biggest difference was on sub-dimension 'Leadership style of the WM'. There were remarkable differences between the ward types how supervision system was organised. Individualised supervisory relationships were most common on the psychiatric wards. There are in the CLES six different options to choose to illustrate supervisory relationship experience. All poor options (e.g. 'The mentor was named, but the relationship did not work', 'Mentor changed') were engaged for 'Unsuccessful supervision experience' for the statistical analyses. Also all variations of group supervision were engaged to one class 'Team supervision'. Third category formed by option 'Supervisor was so-called personal mentor and the relationship worked in practice'. In the table, this option has nominated as 'Successful individual supervision'. The deviation between these three options (by the ward types) has been presented in Table 2.

Table 2: Students' supervision experiences on medical, surgical and psychiatric wards (n=279)

<table>
<thead>
<tr>
<th>Type of ward:</th>
<th>Unsuccessful supervision experience</th>
<th>Team supervision</th>
<th>Successful individual supervision</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical ward</td>
<td>29 (24%)</td>
<td>43 (38%)</td>
<td>43 (38%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=115)</td>
<td>59%</td>
<td>41%</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>Surgical ward</td>
<td>14 (17%)</td>
<td>31 (37%)</td>
<td>39 (46%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=84)</td>
<td>29%</td>
<td>30%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Psychiatric wards</td>
<td>6 (8%) 30</td>
<td>(38%)</td>
<td>44 (54%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=80)</td>
<td>12%</td>
<td>29%</td>
<td>35%</td>
<td></td>
</tr>
</tbody>
</table>

49 104 126 279
100% 100% 100%

p value in Chi test .019*
There can be seen that the distribution of supervision models occurred very evenly. The proportion of team supervision model was quite same on all ward types. Also the numbers of 'Successful individual supervision' cases distributed nearly evenly by the ward types (from 31% to 35%). Remarkable difference was in 'Unsuccessful supervision experiences': that kind of relationships was agglomerating in medical wards (59% off all unsuccessful experiences). Only small portion of them (12%) was locating on psychiatric wards and only 6 students (8%) of all students practising on psychiatric ward had an 'Un-successful supervision experience'.

There is in the CLES a question that explores how often student has separate private supervision sessions with the mentor (in which the link nurse teacher was not supposed to take part). The options were: 'Not sessions at all'; 'Less than once a week' and 'Once a week or more often'. In this issue, the differences between ward types were strongly statistical significant (Table 3).

Table 3: Separate private supervision sessions by ward types

<table>
<thead>
<tr>
<th>Ward types</th>
<th>Not sessions at all</th>
<th>Less than once a week</th>
<th>Once a week or more often</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical wards</td>
<td>49 (43%)</td>
<td>47 (41%)</td>
<td>19 (16%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=115)</td>
<td>56%</td>
<td>45%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Surgical wards</td>
<td>31 (37%)</td>
<td>34 (40%)</td>
<td>19 (23%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=84)</td>
<td>35%</td>
<td>32%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Psychiatric wards</td>
<td>8 (10%)</td>
<td>24 (30%)</td>
<td>48 (60%)</td>
<td>100%</td>
</tr>
<tr>
<td>(n=80)</td>
<td>9%</td>
<td>23%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>88 (31%)</td>
<td>105 (38%)</td>
<td>86 (31%)</td>
<td>279 (100%)</td>
</tr>
</tbody>
</table>

p value in Chi test . 000***

The sample distributed quite evenly in relation private supervision sessions: weak thirdly (31%) of students did had private supervision sessions at all, fear thirdly (38%) has a session less than once a week and again weak thirdly (31%) had a session once a week ore more often.

Also in this case, the ward types were different kinds. Tradition of individual supervision was most common in the psychiatric wards: 60% of students practising on psychiatric ward worked intensively with their mentors. Correspondingly the majority (56%) of students without separate supervision sessions had been on medical wards. Only 16% of students practised on medical wards had high frequency of supervision sessions.
Discussion

The results of this study promote the interpretation that the mentor relationship is the most important element of clinical experience of nursing student. This experience is very overwhelming: if a student has a 'good' experience he or she tends to evaluate all features of clinical experience similar way. This result comes clearly in the samples of CLES validation process (Saarikoski 2002). This can be seen also in this study. On the psychiatric wards where the individualised supervision model with named personal mentor was most common, students' evaluated all learning environment sub-dimension with higher scores (Table 1).

We cannot say that psychiatric wards should be best learning environments for student nurses but what we can say is that the supervision culture of student nurses is different. On the psychiatric wards they have been reserved an opportunity to discuss with their mentor about their experiences and emotions. The results can be interpreted so that the main ideas of the clinical speciality are influencing also to the supervision culture of student nurses. In the clinical practice of psychiatric nursing, one-to-one relationships have been always seen as essential.

The research report states that students’ experiences are very similar in psychological meaning on all ward types. Specially, if we think that professional nursing demands also the skills to meet human troubles, stress and anxiety. Only the working in one-to-one relationship gives readiness to this kind of ‘emotional labour’ (Smith; 1987; 1991). Psychiatric nursing really has something to give to other fields of nursing: a longstanding and developed tradition of individualized supervisory culture of nursing students.

This condensed research paper provides an important illustration of how student nurse mentorship and supervisory relationships are being developed in clinical practice. It helps to provide the means through which to address critical elements of nursing involvement in therapeutic relationships. It raises the important questions on how the future strategies should integrate and deal with the personal and professional development of student nurses and how important it is to plan and assimilate future research in all areas of nursing supervision.

This shortened research paper on student nurse relationships reflect upon the needs to advocate and encourage at every clinical level nurses to be active in developing their creative skills in planning innovative strategies for the integration of such research data into their daily practice. Supporting and facilitating this process is one of the greatest challenges facing supervisors of student nurses who are in a unique and privileged position to act as student supervisors.

Clinical supervision is not a new idea to many areas of nursing practice but it still can arouse apprehension. All nurses need to grasp the theoretical implications and maximise the benefits that are to be derived from a supervisory environment in which to contemplate improving practice. We all need at times a chance to confront feelings of clinical uncertainty and verify what is good clinical practice. Jones (1996) said:
“The thinking time afforded through clinical supervision, permits the opportunity to consider practice and as such to avoid the abrogation of professional responsibility.”

The research development of a theoretical base for the delivery of clinical supervision in nursing practice and student mentorship is now well established. The rich diversity of the provision of nursing care requires the unique circumstances of each area of specialism to be considered and integrated into a conceptual framework.

Conclusion

The productive variety of nursing practice would indicate that a single definition of clinical supervision be impractical. An insight into the dynamics of relationships through the supervisory process is essential to successful mentorship. Clinical supervision of nursing practice will be enhanced through existing frameworks but the author of this paper suggests that further research and clinical integration into practice is essential for its continual survival and maturity.

References:


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