

PROFESSIONAL DEVELOPMENT IN THE CLINICAL SETTING:
NEONATAL INTENSIVE CARE UNIT

by

S. LYNN NEWTON

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Queen's University
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ABSTRACT

Mentorship program in nursing is designed to nurture and develop new faculty and foster faculty retention (Blauvelt, 2008). Nurses supporting nurses programs are developed to support collectively the mentor and mentee promoting success in achieving their learning objectives. Engaging mentors in providing high quality education to graduating nurses often becomes a challenge for expert nurses. Mentors often have extensive clinical experience and are willing to share their knowledge but the barrier relates more to the transference of that knowledge. This project is practical tool that explores relationship building, behavior, self-reflection and competence of a mentor as it relates to the clinical practice in the Neonatal Intensive Care Unit. Topics related to mentorship, simulation in education and professional education are described in this project. The final product (the handbook) provides information about the roles and responsibilities of the mentor, evaluation tools, rubrics and workshops. There is also a presentation of the role of the mentor for future workshops related to professional development in nursing.

DEDICATION

To Ken, Katherine and Allison:

The wind beneath my wings.

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CHAPTER 1 – OVERVIEW OF THE CHANGING CONTEXT IN NURSING EDUCATION

Introduction

Nursing education has changed significantly in recent times. Nursing students no longer live in hospitals; nursing training has evolved into nursing education; hospitals no longer control nursing education; and some nursing students don't see the inside of a hospital until they are in their second or third year of their programs. Many positive changes have accompanied this shift away from hospitals as the centre and focus of nursing education. However, one challenge that has arisen is students' limited access to practice opportunities with patients. Nursing practice extends well beyond hospital walls and clinical experiences involve much more than physical assessment skills and the application of those skills in patient care. It is important that the development of those physical assessment and intervention skills as alternative strategies to help nursing students achieve practice competencies are developed.

Rapid changes in technology and advances in health care in the last decade have mandated major revisions in the basic and continuing education of health professionals. Mentors that are engaged in providing high quality education for graduating nurses, often becomes a challenge for expert nurses. Mentors often have extensive clinical experience and are willing to share their knowledge but the barrier relates more to the transference of that knowledge. The literature suggests that the acute shortage of nurses in this country is evident in many publications through employment recruitment strategies from hospitals and health care facilities. As a practice profession, nursing encompasses both academic and clinical domains; therefore educators face dual expectations of being knowledgeable and having expertise in academia and clinical settings.

Mentorship in Nursing

Mentorship provides another avenue for younger nurses to develop strong relationships with senior nurses that contribute to the development of both individuals and plays a role in the retention of nurses within an organization. Mentors provide information, advice and support to less senior nurses over an indefinite period of time. Both the mentor and mentee invest a significant amount in the relationship emotionally, allowing for self-directed growth and learning. During my professional experience, mentoring provides many benefits: bridge the gap between theories and nursing practice; provide guidance for transformational leadership; enhance critical thinking and career development; increase self-esteem, job enrichment and willingness to take risks; enhance productivity, managerial skills and a sense of professionalism; and act as a recruitment and retention strategy. Nurses who are mentored are more likely to remain in their current position.

Benefits and Challenges

Despite mentorship's many benefits, there are some major hurdles for implementation. For example, there are fewer nurses in leadership positions to act as mentors. The high number of part-time and casual nurses does not provide a supportive environment for mentoring, yet mentoring has never been more important as the approaching retirements of many senior nurses means new nurses must be recruited. The emotional demand of mentorship also makes it more difficult to recruit a nurse into a mentorship role, particularly when those nurses already face higher levels of stress treating patients with higher acuity levels.

To overcome these challenges, mentorship should be a key recruitment and retention strategy. Individuals can support mentorship programs by advocating for funds to develop

programs, supporting mentorship through continuing education and staff recognition, and by individually seeking out mentors through networking opportunities, developing working relationships and learning from more experienced nurses. Nurses who participate in mentorship programs will provide better patient care while increasing their own knowledge and professional growth; participating in mentorship provides the opportunity for life-long learning and helps retain and develop the best nurses for today and tomorrow.

From an adult education perspective, academic and workplace mentoring can be considered as a one-to-one relationship in which mentors are similar to adult educators and mentees to adult learners. Individuals who enter mentoring programs designed to highlight one-to-one learning as a central approach to their career and professional development must be prepared to assume the basic collaborative obligations (Cohen, 2006). Based on the principles of adult education, Cohen developed a list of behaviors that students exhibit as a reflection of the effective mentor. Descriptors and attributes of the adult mentor, as described by Cohen are: relationship (trust); informative (advice); facilitative (alternative); confrontive (challenge); mentor model (motivation) and mentee vision (initiative) will have positive outcomes for the student. Behaviors that students would exhibit, as it relates to previously mentioned mentor behaviors are: offers detailed explanations; provides facts & records; explains choices and decisions; reflects on initiatives; expresses main concerns and visualizes own future. Knowledge transfer and assessment of a qualified mentor are tools that are used efficiently in the UK and Australia (English National Board, 1989).

Mentorship Programs in Hospitals

In Canada, formal mentorship programs do not currently exist due to lack resources and funding. Yet, data support the business case of educating mentors would improve the retention and recruitment of nurses. At Kingston General Hospital, there are currently no selection criteria for choosing a mentor for their students. Mentors are chosen by the unit's manager and clinical educator. Minimal education is provided to mentors about their roles and responsibilities during the sixteen weeks that they spend with their students. In fact, they meet the students during their first shift and do not have an opportunity to perform self-assessment on the students as the assignment overrides this priority.

Based on the last two years experience, a closer collaboration with the school of nursing the faculty advisor and the clinical educator has been initiated. Creating transparency in knowing learning objectives, roles and responsibilities for both students and mentors has been beneficial for all parties involved. Bridging the gap between students and mentors, nursing schools and consolidation placements such as acute care hospitals, will hopefully foster a smoother transition for the graduate nurse and rejuvenate the mentor in finding value and worthiness in his or her profession. By creating a curriculum for both students and mentors will facilitate this relationship and promote growth and development of both engaged parties. This project achieves this goal by creating a mentor Handbook that includes: student expectations, evaluations and timetables; student assessment tools; and documentation of completion of requirements. There is also a mentor workshop presentation (three parts – progressive) and on-line website for both students and mentors.

This project will be used for our mentors and students in the NICU with the hope to provide useful assessment tools and competencies in order to provide a successful experience for the students.

Mentorship Workshop

Creating a website that includes a welcome page, role of the student and mentor, learning objectives and goals, timelines, and evaluation criteria for the students and mentor meets the needs of the adult learner in that it provides accessibility of knowledge, clarifies expectations, can motivate learner to seek out new knowledge and over the sixteen weeks. There is opportunity for the learner to experience transformational learning depending on the experiences acquired during his or her clinical rotation. The creation of this website is to invite end-users with novice computer skills to navigate the site and to ensure clarity of the expectations that is required from all participants.

Additionally, this method of on-line transparency of information alleviates anxiety for both the mentor and the student. Mentors can focus on sharing knowledge with the student by using the evaluation criteria as a guide for information dissemination. Similarly, the student is then able to use the toll to seek out new opportunities and ask questions related to their objectives and goals.

This project will highlight the literature that supports the changing context of nursing, simulation based education, and mentorship. Based on these literatures, a mentorship workshop is outlined with accompanied resources.

CHAPTER 2 – PROFESSIONAL EDUCATION IN NURSING

Introduction

Continued professional development in nursing is a planned educational activity that is intended to build on its educational and experiential base. Its theoretical knowledge should be seamless to the feasibility and clinical utility in the clinical setting.

Market-driven economic policy, dramatic technology developments, changing demographics, and the knowledge explosion are rapidly changing health care and educational institutions as well as creating a climate of continuous rapid change. Nurses' contract with society requires the profession to be responsive to these changes.

Educational research has developed new insights into learning that must be incorporated into nursing education. These insights include active learning, personalization, individualization, contextual learning, and learning to learn. External accountability means that nurse educators must prepare nurses for the emerging health care system and not the system of the past or one that they wish were in place (Lindeman, 2000).

An increasing number of nursing courses are available through virtual universities. In the past, a school of nursing could define its target student body geographically. With little competition in the geographical area, a school could count on a certain level of student demand. Virtual universities have changed that by increasing access to education offerings for almost any potential student. Where one lives is no longer a determinant of access. Nursing programs will have to clarify a niche in the market place and work hard to maintain that student demand.

Those reforming higher education are committed to the principle that there should be no barriers between the segments of the educational system; education from cradle to grave should be one seamless whole (Langenberg, 1997). Inherent in this principle is the assumption that education involves more than passing courses. It involves the development of personal qualities and skills associated with success in the work world, i.e., initiative, persistence, integrity, effective communication, critical and creative thinking, and teamwork. The educational system that exists is based on the notion of layers with each layer having a distinctive role. The degree associated with a given layer is a code word for the knowledge, skills, and qualities the graduate possesses. Unfortunately this system does not match reality on two counts. First, there is a great chasm between what schools claim they are doing and what is actually achieved in terms of student outcomes (the preparation of critical thinkers). Second, the current layered system does not account for what we know about learning, i.e., people learn in different ways and rates. A seamless system would emphasize student assessment and adapt the delivery of instruction of the student's circumstances. It would include linkages between and among colleges and universities. Students could take classes simultaneously from an array of institutions without penalty. Nurse educators must be prepared to defend the multiple entry multiple exit system of nursing education. Is it an asset or a fossilized educational layered cake? At a minimum, nurse educators will be pressured to clarify and differentiate the competencies of graduates from different segments of the system.

Changing Financial Context

One tool commonly used in a market driven economy, especially when outcome measures are hard to quantify, is benchmarking. Benchmarking refers to the comparison of

program costs across similar institutions. If, for example, the University of Phoenix can offer quality educational programs and report profits, why can't other institutions of higher education? The University of Phoenix is part of the Apollo Group, Inc. that reported profits of \$21.4 million in 1996 (Strosnider, 1997). Although some in education frequently criticize Phoenix for its approach, it has a satisfied and growing student body and positive relationships with the business community. Some traditional institutions are now designing programs after the Phoenix model. The techniques used by Phoenix to reduce costs of programs are those every institution must consider: unencumbered governance structure, standardized curricula, emphasis on teaching, more part time than full time faculty, and a mission for a specific type of learner. Nurse educators and nursing students have traditionally provided significant service to the community. More often than not this has been without a return of revenue to the institution. Some schools have responded to this pressure by creating faculty run health clinics, consultation services, etc. Although some of these services have produced revenue for the institution, others have not. It will not be easy in the current climate for nursing to produce significant revenue through services provided by faculty and students. It will not be easy because of reimbursement issues, these services may have a history of being provided without cost, or because other faculties are also trying to develop reimbursable services. The process of developing revenue producing services requires faculty and administrators to alter the conception of the role of faculty to include revenue generation. In addition to securing research and training grants, faculty may be expected to produce a minimum amount of tuition revenue from their teaching or clinical activities, or to secure contracts with community agencies for consultation services.

In the literature, the Chronicle of Higher Education carried stories of new methods of funding higher education in South Carolina (Schmidt, 1999b), New York (Schmidt, 1999a), and Oregon (Schmidt, 1999a). The new models are based on institutional performance such as student achievement, strength of academic programs, quality of campus services, and enrollments. Basically the models require institutions to serve more students efficiently and effectively. In terms of student achievement and strength of academic programs, nurse educators will probably find it easy to respond to this pressure. Most nursing programs have very positive records for graduation rates, nursing exam scores, accreditation, and job placement. However, nursing is an expensive program largely because of the costs of clinical instruction. When compared with nonclinical majors, nursing looks very expensive. Nurse educators must be prepared to defend these costs using data from accrediting agencies and comparable schools of nursing, and support from the clinical agencies used for experience.

Nursing practice extends well beyond hospital walls and clinical experiences involve much more than physical assessment skills and the application of those skills in patient care. The focus of this article, nonetheless, is the development of those physical assessment and intervention skills as alternative strategies to help nursing students achieve practice competencies are imperative.

Rapid changes in technology and advances in health care in the last decade have mandated major revisions in the basic and continuing education of health professionals. Nurses employed in pediatric settings have been particularly affected. Children with acute and chronic conditions who would have been hospitalized 10 years ago are now cared for on an out-patient

basis. The level of acuity for those who are hospitalized has increased dramatically, and many children who are coping now with chronic conditions would not have survived in the past.

Interprofessional Education

Health care improvement and continuing professional education must be better understood if we are to promote continuous service improvement through interprofessional learning in the workplace. We propose that situating interprofessional working, interprofessional learning, work-based learning, and service improvement within a framework of social learning theory creates a continuum between work-based interprofessional learning and service improvement in which each is integral to the other. This continuum provides a framework for continuing interprofessional development that enables service improvement in the workplace to serve as a vehicle through which individual professionals and teams can continually enhance patient care through working and learning together (Wilcock, Janes, & Chambers, 2009). The root of this lies in understanding that undertaking improvement and learning about improvement are codependent and that health care professionals must recognize their responsibility to improve as well as complete their everyday work. We believe that significant opportunities exist for health care commissioners, service providers, and educational institutions to work together to promote continuing interprofessional development in the workplace to enhance patient outcomes, and we outline some of the opportunities we believe exist. High-quality health care has been described as that which is clinically effective, personal, and safe. Effective interprofessional working is central to achieving this and thereby the outcomes required. However, despite the best efforts of hard-working committed health professionals, this is a surprisingly rarely achieved goal. Achieving continuous quality

improvement necessitates improving the care delivered at the front line, and depends upon synthesizing the professional and technical knowledge and skills of caregivers with care-delivery processes (Wilcock, 2009). Improvement in practice results from people learning together through interprofessional endeavors in the workplace that can provide a supportive learning environment, although work-based learning has not been a traditional part of continuous interprofessional development (CIPD) for many disciplines. Fusing learning about improvement with application of the learning has become a key driver and provides a practical vehicle through which interprofessional working is facilitated and supported. In essence learners cannot learn about improvement in isolation from their fellow health care colleagues.

Sustainable improvement requires teams to maintain continuous improvement through continuous learning by and within the team. In this way learners experience improvement in action as experiential learning through “reflection in” and “reflection on” practice. Caring for patients and learning from this process integrates practice-based learning with improvement leading to changed behavior in the workplace. Learning how to do quality improvement and actually carrying it out is essentially the same thing and are both forms of experiential learning. Practice-based learning for improvement should be expected, encouraged, and rewarded, because it leaves a legacy of improved care for patients and transferable skills for learners. Framing continuous quality improvement and CIPD within social theories of learning connects learning about improvement and improvement as learning in a continuum between practice and education (Wilcock, 2009). This represents a shift from the traditional focus on individual learning to considering the social context and interaction on practice-based team learning. Social theories emphasize the need to consider learning “for, at, and through work” and link

continuous professional development and interprofessional working by positing the notion of learning as social participation. Learners are seen as active participants in natural “communities of practice,” defined as “groups of people informally bound by shared expertise and interest in a joint enterprise.” It is a characteristic of these groups that their members do not necessarily work together every day, but meet because they find value in their interactions as they share information, insights, and advice. The practical value of such contact creates a body of common knowledge, practices, and approaches underpinned by personal relationships and established ways of interacting (Wilcock, 2009). These ideas apply very well to interprofessional teams in health care whose members may be meeting every day, formally or informally, as they carry out their daily tasks with the shared purpose of improving their patients’ health status.

The term “clinical microsystem” is defined as small groups of people who work together on a regular basis to provide care to discrete subpopulations of patients and who can be considered as communities of learning that engage individuals in actively refining practice. Health care improvement principles and methods provide a common purpose, common language, and common knowledge leading to shared actions that stimulate and maintain an upward spiral of shared learning and improvement and nurture a common sense of identity. Their members’ learning is multidimensional and involves learning as doing, learning as belonging, learning as becoming, and learning as experience, which relate well to elements of learning for improvement (Wilcock, 2009).

Simulation in Nursing Education

Simulation is designed to resemble reality and involves replication of specific aspects of a clinical situation. The purpose of integrating simulation into nursing curricula is to increase

the level of understanding and ability to manage a simulated situation when it actually occurs in the clinical setting (Hovancsek, 2007). The current nursing shortage has impacted all areas of nursing, including neonatal (NICU) and pediatric intensive care units (PICU), where nurse to-patient ratios are at their lowest. Many hospitals have abandoned the requirement of a minimum of one to two years of experience for nurses to work in PICU and NICU. Because of this increasingly common practice, it is not unusual for newly graduated nurses, novice nurses, or agency nurses with limited experience to be assigned to these areas. Additionally, novice nurses often spend less than three months with a preceptor in preparation for these specialized areas, resulting in minimal experience and untested levels of clinical judgment, critical thinking, and organizational skills while working in areas with the highest acuity (Decker, Galvan, & Sridaromont, 2005). The outcome is that nurses who are unprepared for the stress of the PICU and NICU environment may leave the profession or transfer to less intense clinical settings. Because of these workforce factors, the use of simulation in education is quickly being recognized as a strategy for preparing nurses for the challenges of pediatric nursing practice, and may bring the nursing profession one step closer to bridging the gap between nursing school, unit orientation, and real clinical situations (Broussard, 2009).

The human patient simulator is a teaching strategy currently receiving much attention in nursing education. Despite its popularity, little is known about how the simulator should be used in nursing education and how it compares to other simulation activities already in use. In this paper, the authors discuss reasons for implementing simulation as a learning approach. Also discussed are simulation activities applicable to nursing education. Benner's theory of the

development of nursing skills and Kolb's experiential learning theory are used as frameworks to examine the use of simulation in the context of nursing education (Waldner, 2007).

While health teaching is a primary component of nursing practice and a dimension of nurse caring, nurses are legally and professionally expected to teach. Simulation can help nursing students broaden their knowledge of the teaching-learning process, identify common experiences, generate explanations and analyses, and address a number of issues important to their practice experiences. This study investigated the effect of classroom simulation on third-year baccalaureate nursing (BScN) students' confidence related to health teaching. Bandura's (1977, 1986) theory of self-efficacy provided the conceptual framework.

Technology in Nursing Education

The number of continuing education initiatives in the health professions that are offered in electronic form has grown exponentially in the past decade and simulation being a key component to this education strategy. Electronic continuing education can be an effective tool for advancing knowledge and changing practice patterns among health practitioners. E-CE interventions consisting of purely flat text information are of limited value and should be avoided if possible.

E-CE, electronic continuing education programs, offers many advantages including easy access, flexible timing, the possibility of adaptation to individual learning styles, and low cost. E-CE has the potential to provide many of the elements that have been found to be effective in traditional continuing medical education such as interactivity, multiple sequenced sessions and reinforcing materials. Interactivity can take many forms such as e-mail, asynchronous or

synchronous discussion boards, video Web-conferencing, cases with scripted interactivity, and others (Lam-Antoniades, 2009).

Multi-component E-CE interventions including interactivity have the strongest evidence to support them and therefore should be the preferred option for E-CE delivery.

Self-Directed Learning in Nursing Education

In terms of lesson planning, self-directed learners show participative decision-making, readiness and can evaluate themselves by mutual assessment of self and collected evidence. Majumdar, Roberts, Knechtel, Noesgaard, Campbell and Tkachuk (1998) compared the effectiveness of self-directed learning (SDL) and faculty directed, demonstration-return-demonstration learning (DRD) for psychomotor clinical nursing skills and level of knowledge of second year baccalaureate nursing students. Students using the SDL method received higher grades in only one of the marker stations and, although, the outcome appeared not to differ, more students indicated satisfaction with the faculty-directed (DRD) approach. Mature students may be more self-directing, and learning styles and readiness to learn need to be assessed when judging the appropriateness of using self-directed learning approaches. However, there are many potential benefits, including increased confidence, autonomy, motivation and preparation for lifelong learning (O'Shea, 2003).

Summary

Nursing education is ever changing, transformational and is dependent of socioeconomic variables. Developing partnership with academic centres, creating seamless curriculum and validating the self-efficacy of nurses are imperative for fostering an environment of professional development and positive learning experiences. Encouraging self-

directed learning in a supportive milieu that supports principles of adult education via technology, simulation and mentorship programs can only enhance knowledge, skills and confidence in the novice to expert learner (Benner, 1994).

CHAPTER 3 - MENTORSHIP IN NURSING EDUCATION

Introduction

Globally, the nursing faculty shortage is imminent and university programs are trying to develop curriculum, produce qualified nursing professionals in order to alleviate the issue that is arising. In Canada, more than 400 faculty members were recruited in 2004, with projections of an additional 500 faculty vacancies in 2005 (Emerson & Records, 2005). Factors contributing to this looming crisis include inadequate numbers of available potential faculty. In 2004, graduates of Canadian master's and doctoral programs numbered less than 500. Moreover, the aging professoriate is a reality; the proportion of aging nursing educators exceeds the rest of the aging nursing workforce (Canadian Association of Schools of Nursing, 2005; Canadian Institute of Health Information, 2004). Retirements and resignations will drastically reduce this workforce within the next few years (Emerson & Records, 2005). Also, the salary gap between nursing educators and their clinical counterparts (i.e.: physicians and clinical consultants) is increasing at an unprecedented rate, thus contributing to the issues of recruitment and retention.

New nursing faculty often face a multitude of stressors. Sorcellini in 2004 noted a dramatic increase in newcomer work stress over the 5 years of a longitudinal study of new faculty. Common themes and concerns reported included time constraints in research and teaching; lack of collegial relationships; inadequate feedback, recognition, and reward; unrealistic expectations; insufficient resources; and lack of balance between work and personal life (Brendtro & Hegge, 2000; Sorcinelli, 1994). Similarly, most nurses are inadequately prepared for the multiple roles and expectations of academia and consequently are less likely

to assume and/or remain in the teaching role (DeYoung & Bliss, 1995). Therefore, new strategies for recruitment and retention are central to the ongoing integrity of nursing education.

A strategy used to engage, retain and develop in nursing is mentorship. Mentorship capacitates and enriches the transition to the teaching role. Mentoring novice nurse educators within formal programs has never been more relevant and timely (Sawatzky & Enns, 2009). Furthermore, “accepting responsibility for mentorship of other faculty members and students, either naturally or by appointment moves a school towards excellence” (Brown et al., 1995, p. 29). Although there is a substantive body of literature related to mentorship within the academic milieu, the focus tends to be on career development and success. There is a dearth of publications specifically related to the mentoring of nurses as educators (Sawatzky & Enns, 2009). Moreover, although caring theory is central to most nursing curricula, it is generally not reflected in the mentorship programs of novice educators. The purpose of this chapter is to describe the concept of mentorship; relationship and roles; benefits and barriers; preparation for the role; effective mentorship; and a mentorship program for nursing that is being used in the United Kingdom and in Canada.

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 (Barlow, 1991; Bracken & Davis 1989; Donovan, 1990). 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, and started to appear in nursing literature in the early 1980s and resulted in a wealth of published material in the 1990s (e.g.: Donovan 1990; Armitage & Burnard 1991; Anforth, 1992; Jinks & Williams 1994; Neary, Phillips & Davies 1994). The majority of this 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).

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 health care agencies, of terms such as preceptor, coordinator, facilitator and supervisor. A study by Wilson-Barnett J., Butterworth, White, and colleagues (1995) concerning clinical support for 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 coordinator, practice facilitator and preceptor being used.

Within nursing the term mentor carries a multiplicity of meaning. The English National Board (ENB) in an early document (ENB, 1987) loosely refers to mentors as 'wise reliable counselors' 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. The use of a variety of terms for 'mentors' only serves to confuse both clinicians and educationalists and the continued lack of clarity has led to

some programs 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, advice and counsel” (ENB 1989, p. 17). 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 have recognition of potential and a concern for the individual's well-being, advancement and general progress.

This definition 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 thus 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).

Quality of Mentor Relationship

There are several references in the literature that identifies the benefits with mentorship programs 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 process 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.

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 student's 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 develop.

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), for example, 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 (1983) 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 model 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 he or she requires 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 and mentee partnership. They propose using a non-didactic counseling 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, while belonging needs may affect being accepted as part of the ward team.

Benefits and Barriers

Mentoring benefits the individual mentor and mentee, as well as the broader faculty community. For the individual mentor, there are numerous benefits of the mentoring relationship. In an evaluation of a mentoring program in a nursing faculty, Brown (1999) reported that the mentors found their protégé's knowledge, experience, and fresh insight to be very beneficial. Mentors also gain satisfaction in seeing the mentee's successes (Cangelosi, 2004). Also, mentoring provides an opportunity to reflect on one's own beliefs and teaching practices (Ehrich, Tennent, & Hansford, 2002). Some would argue that the protégé or mentee

gains the most in the mentoring relationship. In a review of empirical literature related to mentoring in education settings, Ehrich et al. (2002) found “that for beginning teachers in particular, mentoring could provide unrivaled professional and emotional support, as well as career affirmation of teaching as a career” (p. 260). Although the benefits are often mutually advantageous, it is important to realize that some mentoring relationships may be very task oriented and as such may dissolve once the task has been completed, whereas others “may find themselves using their synergy to explore problems and topics that go far beyond the boundaries of what brought them together” (Hiemstra & Brockett, 1998 , p. 50).

The faculty as a whole also benefits from mentoring relationships. Mentoring programs enhance recruitment, promote retention, and create an environment that fosters personal and professional growth (Feaster, 2002). Faculty members, who are aided in their professional development and are subsequently more productive and fulfilled in their role, are more likely to stay with the organization (Ehrich et al., 2004). In fact, Greene and Puetzer (2002) reported lower attrition rates among new teachers who had been in mentoring relationships. Mentoring also increases the research skill development and consequently the research productivity of junior faculty (Cangelosi, 2004; Ehrich et al., 2004; Paul, Stein, Ottenbacher, & Liu, 2002; Records & Emerson, 2003). For example, Cangelosi (2004) reported that article presentations and manuscript authorships were the direct result of mentoring. In addition, mentoring can revitalize senior faculty (George & Peace, 1997). According to Peters and Boylston (2006), “collegial mentoring relationships can provide a place that promotes communication, connection, and caring” (p. 63).

Mentorship is, however, not without barriers. Without commitment, time, and supportive structure, mentoring cannot be effective. For example, “senior faculty time, which may be graciously offered to the mentoring process, nevertheless is time that cannot be spent on other activities” (Selby & Calhoun, 1998, p. 211). Also, mentoring programs that are grounded in paternalism are likely to fail. The unintended message within formal mentoring programs may be the assumption that the newcomers would not be able to succeed on their own (Selby & Calhoun, 1998). Therefore, preparing mentors to excel in their new role will facilitate success by both mentor and mentee.

Preparation for the Role of Mentor

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 closeness 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: first, that mentorship should be implemented throughout training; second, that there should be opportunities for mentees to change mentors; third, that student learners should be able to direct mentorship sessions; and lastly that mentors should be appropriately trained. 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. 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 programs 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 finding apparently indicates that the more extensive programs 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 it before; they see students as partners at appropriate stages in their education. They suggest that these aspects should be included in preparation programs. 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). Engaging clinical nurses in leadership roles and developing their mentoring skills would then provide them with the tools to for a positive mentorship experience.

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 also identified three absolute requirements for successful mentoring: mutual attraction, mutual respect and subscription of time and energy. Intrinsic to the absolute requirements she identified 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. She also defined the mentor role within 14 parameters, those of model envisioner, energizer, investor, supporter, standard-prodder, teacher-coach, feedback-giver, eye opener, door-opener, idea bouncer, problem solver, career counselor and challenger. These characteristics 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 Registered Council of Nursing (RCN, 1992) and Open Learning Programs 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 similar 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 rotational 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). 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 modeling. Although the studies were similar but not exactly comparable, we can generalize that 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).

Mentorship Programs in Nursing

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. Knowing this, mentorship programs were born in the United Kingdom for decades. In Canada, mentorship programs are being implemented in many organizations and institutions. Literature identifying key aspects about mentorship will be available in the future.

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 supervision of students. The majority of these classic studies were undertaken prior to the inception in the United Kingdom 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.

Although informal mentorship programs were evident prior to the initiation of this new program, they became integral to pre-registration education in the late 1980s, as the new program was introduced. By 1997, all students have some form of mentorship throughout the clinical practice elements of their course and in the main clinical component 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 preregistration students is the English National Board for Nursing, Midwifery and Health Visiting (ENB) 998 course or its 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 program, the value of which may be questionable.

The aim of this program is to examine the nature of mentorship in relation to the supervision of students in practice settings. In reality, little attention prior to the program 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). Mentorship 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 and 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 to 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 a greater level. The gap poses an issue when in either setting and strategies to bridge theory to practice becomes a challenge. 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).

The new program challenges the way in which students were traditionally supervised in practice settings and, as a consequence, students currently undertaking preregistration programs 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).

Summary

Amongst the many issues, Project 2000 raises 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 variance in mentorship schemes.

Whether future mentor roles are dictated by custom and practice, or by guidance from professional bodies, remains equivocal. There is, however, 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.

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. 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. Perhaps in the future, organized mentorship programs will be developed in order to foster growth in learning and experience for both mentors and mentees.

CHAPTER 4 - SIMULATION IN NURSING EDUCATION

Introduction

The use of simulation in many academic centers has become a useful tool for knowledge translation in health care education. As stated in previous chapters, hospitals no longer have the capacity for students to have the required clinical placement to meet curriculum standards. Therefore, the use of simulation is used in lieu of their clinical placement and an alternative to practice clinical skills in a "similar" environment than the hospital. Simulation is a technique that uses a situation or environment created to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human action (Perkins, 2007). Simulation is used as a strategy, not a technology. To mirror, anticipate, or amplify real situations with guided experiences in a fully interactive way. Simulators are types of equipment that replicate a task environment with sufficient realism to serve a desired purpose. The types of learning that occur during the simulation experiences are: experiential learning; active learning; participative; adult learning; multi-dimensional and learner focused. The benefits of simulation are that it closely mimics real life situations; there are no risk learning; and therefore it occurs in a safe environment. Experiential and active learning is most effective way of learning for adults (Kolb, 1984, Benner, 1984). Simulation can provide the opportunity for active and interactive learning without risk to an actual patient (Gaba, 2004). Students can analyze their own actions; reflect on their own skill sets and critique the clinical decisions of others (Jeffries, 2007). Simulation is much safer than practicing on real patients and engages the student in active learning.

Overview of Simulations

Various forms of simulation can be used in teaching and learning environments. For example, role play has been used for centuries in many disciplines, and provides a live sample of human behavior in which learners spontaneously act out roles in situations involving problems or challenges (DeYoung, 2009). Through unrehearsed dramatization in a non-threatening environment, learners assume a character role, do and say things they perceive about that person, and practice behaviors without risk. Immediate feedback from peers and faculty helps learners appreciate problems through the eyes of others—an effective strategy for increasing awareness and understanding of human relations. Immersion in the scenarios helps participants examine and develop their own professional value systems, become more accepting of others, develop problem-solving skills, and creatively explore subject matter.

The student-centered case study method of teaching has also been used extensively (Dowd & Davidhizar, 1999) in schools of business, law, and medicine, and may present actual problems encountered by practitioners. Learners analyze and discuss cases, retrace and critique steps taken by the characters, try to deduce outcomes, and apply didactic content and theory to the case, all of which enhance critical thinking, problem-solving skills, retention, and recall (Andrews & Wallis, 2001). Case studies can be modified to the discipline and students' learning stage and, therefore, are particularly suitable for adult learners who desire peer interaction, recognition of prior experience, connection to everyday situations, active participation, and validation of thinking. Many authors have suggested nursing students fit into this category of learner (e.g., Green, 1987; Martin, 1989; Patton & Goldenberg, 1999;

Simulation Studies in Health Care

Studies of case study and role play simulations for undergraduate, RN (College prepared Registered Nurse) -to-BSN (Baccalaureate Nursing), and graduate nursing students have included simulations of a typical hospital day (Hodson, Brigham, Hanson, & Armstrong, 1988; Sullivan et al., 1977), an emergency room experience (McDonald, 1987), care of visually impaired individuals (Reichman & Weaver-Meyers, 1984), surgical clients (Madorin & Iwasiw, 1999), oncology and health assessments (Peterson, Hennig, Dow, & Sole, 2001), and leadership and health care issues in an international partnership (Andrusyszyn et al., 2001).

Advantages consistently identified for use in simulation, were the addition of realism and decision making to client situations. Enhanced cognitive, psychomotor, communication, discussion, and teaching skills. Improved the learner's organizational, observational, and integrative skills. Increased confidence, shifted attitudes, and smoother transition from the classroom or laboratory to the health care setting. Benefits are of immediate feedback and the increased ability of faculty to identify students' performance levels. In addition to these advantages, simulation was found to be fun, interesting, and motivational to learning.

Self-Efficacy Studies

Self-efficacy or self-confidence has been studied extensively regarding health-related behavior (Armitage & Conner, 2001); student and teacher achievement, classroom performance; health promotion counseling of baccalaureate nursing students' undergraduate nursing and medical students and baccalaureate nursing students and preceptors after a preceptorship experience. Thus,

Although numerous studies have investigated the effects of simulation on student learning, few have examined the effects of classroom simulation on nursing students' confidence related to health teaching using self-efficacy theory. The self-efficacy theory was conducted to contribute to the evidence supporting the strategy of classroom simulation.

Conceptual Framework

The conceptual framework, drawn from Bandura's (1997) self-efficacy theory, concerns individuals' perception of self-confidence to successfully complete a task. This theory posits that individuals' behavior is determined through continuous interaction among cognitive, behavioral, and environmental factors. Expectations of self-efficacy are derived from four principal sources of information (i.e., performance accomplishments, vicarious experiences, verbal persuasion, physiological state) and vary along three dimensions inherent to the self-efficacy level (i.e., magnitude, strength, generality) (Bandura, 1997). Bandura concluded that people are more influenced by how they perceive their performance than by actual success. Therefore, people tend to undertake behaviors within their range of self-efficacy and avoid those they perceive would exceed their ability.

Self-efficacy in Nursing

Given the many challenges and responsibilities associated with health care, nursing students' perceptions of their level of self-efficacy could either augment or interfere with their health teaching performance. Because the greatest influence on self-efficacy perception is derived from the behavioral factor, it was expected that students who actually perform health teaching using simulated case studies and role-playing would become more confident in this task. Incorporating techniques to improve student performance in health teaching is essential

because nurse educators are accountable for enhancing student learning. Planning, designing, and implementing teaching-learning strategies (e.g., simulations) may involve considerable faculty time and effort, but the payoff exceeds the effort. According to self-efficacy theory (Bandura, 1997), students who actively participate in role playing and case study simulations develop increased confidence in their ability to perform skills related to cognitive, psychomotor, and affective domains.

It is important to ensure the strategies selected meet learners' needs and capabilities, match the content, develop practical skills, make use of the time and materials available, and take into account the willingness of teachers and students to participate. Faculty need to recognize that some students may not be comfortable with role playing and may be reluctant to participate. Student preparation is essential. In addition, some faculty may not possess sufficient questioning skills, or be willing to relinquish their preference for more teacher-centered approaches or update simulations (Bandura, 1997).

Consequently, orientation, faculty development programs, and administrator support will be necessary to increase faculty comfort with these participative teaching strategies (Goldenberg, 2005).

Nursing Education in the Pediatric setting (Neonatal Intensive Care Unit)

Today's nurses must remain abreast of the latest advances in technology as they prepare to provide the most up-to-date pediatric nursing care in this changing population. The current nursing shortage seems to have grown in tandem with changes in technology and patient acuity. As a consequence, it has become common practice across the North America to

fill open positions in pediatric clinical areas with new graduates, a rare practice as few as ten years ago.

Nursing educators are challenged to prepare graduates skilled in the use of complex technology and able to make decisions at levels not required of previous generations of new nurses. Adding to the challenge is the competition for pediatric clinical practice sites that exists among baccalaureate, associate degree, and vocational nursing programs. In addition, once the nurses' enter pediatric nursing practice; they face the continued demand for mastery of complex skills and nursing care management.

As pediatric educators look for innovative teaching methods to deal with challenges in nursing education and staff development, simulation based learning offers great potential. This rapidly emerging teaching modality provides learners with the opportunity to address multiple domains of critical thinking and skills performance. In contrast to traditional clinical teaching, simulation gives learners exposure to events that they may not encounter in the clinical setting (Lathrop, Winningham, & VandeVusse, 2007), as well as the opportunity to assume leadership roles in simulated emergencies involving sick infants and children. These innovative teaching strategies also can be used to help nurses prepare to re-enter the workforce, to enhance specialty training, and to provide learners with the opportunity to work with other health professionals in interdisciplinary practice scenarios.

It is important to acknowledge the use of clinical simulation, the emergence of simulation in nursing education with an emphasis on pediatric nursing, and the role of simulation based learning in continuing education.

Simulation in Nursing Education

Simulation is designed to resemble reality and involves replication of specific aspects of a clinical situation. The purpose of integrating simulation into nursing curricula is to increase the level of understanding and ability to manage a simulated situation when it actually occurs in the clinical setting (Hovancsek, 2007). The current nursing shortage has impacted all areas of nursing, including neonatal (NICU) and pediatric intensive care units (PICU), where nurse to-patient ratios are at their lowest. Many hospitals have abandoned the requirement of a minimum of one to two years of experience for nurses to work in PICU and NICU. Because of this increasingly common practice, it is not unusual for newly graduated nurses, novice nurses, or agency nurses with limited experience to be assigned to these areas. Additionally, novice nurses often spend less than three months with a preceptor in preparation for these specialized areas, resulting in minimal experience and untested levels of clinical judgment, critical thinking, and organizational skills while working in areas with the highest acuity (Decker et al., 2008). The outcome is that nurses who are unprepared for the stress of the PICU and NICU environment may leave the profession or transfer to less intense clinical settings. Because of these workforce factors, the use of simulation in education is quickly being recognized as a strategy for preparing nurses for the challenges of pediatric nursing practice, and may bring the nursing profession one step closer to bridging the gap between nursing school, unit orientation, and real clinical situations (Broussard, 2009).

The human patient simulator is a teaching strategy currently receiving much attention in nursing education. Despite its popularity, little is known about how the simulator should be used in nursing education and how it compares to other simulation activities already in use.

Benner's theory of the development of nursing skills and Kolb's experiential learning theory are used as frameworks to examine the use of simulation in the context of nursing education (Waldner, 2007).

Health teaching is a primary component of nursing practice and a dimension of nurse caring; nurses are legally and professionally expected to teach. Simulation can help nursing students broaden their knowledge of the teaching-learning process, identify common experiences, generate explanations and analyses, and address a number of issues important to their practice experiences.

Evidence of Effectiveness of Simulation Education

Although categories of simulation mentioned by Seropian, et al., (2004) are used in nursing education, little evidence exists that these simulations produce the same or better outcomes than either traditional lecture-based or clinical-based learning. The first category, computer-based simulations, may lack the degree of interaction required to facilitate higher level learning (Sims, 1997). For example, Madorin and Iwasiw (1999) found that although students who participated in a computer-assisted surgical patient simulation had higher self-efficacy scores immediately after participating in the simulation, scores did not differ from the control group once both groups had completed their clinical practicum experience. In Bauer and Huynh's (2001) study, students who only completed a CD-Rom education session on blood pressure measurement were less proficient than students who learned about it using the lecture method. Students who experienced both the CD-Rom session and the lecture session outperformed students who learned by either method alone.

Garrett and Callear (2001) describe how innovative computer strategies may improve computer-based instruction by increasing the interactivity between student and computer. They maintain that computer programs have not yet reached an artificial intelligence level comparable to that of a real-life tutor needed for optimal learning to take place. Research into the effectiveness of the second category of simulation, skill and task trainers, shows mixed results as to how effective they are in comparison to traditional classroom teaching methods and/or clinical experiences.

Alinier, Hunt and Gordon (2004), report on an ongoing study examining the effect of adding a human patient simulator session to traditional teaching methods on clinical performance. Initial results show that students who participate in the human patient simulator session perform better on their final exams.

Yoo and Yoo (2003) found that students who participated in a simulation session with standardized patients scored higher on written and performance tests than students who didn't participate. Griggs (2002), on the other hand, noted that students who participated in a human patient simulator session scored no better on knowledge test, and, in some cases, worse than the students who did not participate in the session.

Likewise, Ravert (2004) observed similar scores on written tests for critical thinking, performance, and self-efficacy by students who participated in a discussion about a case scenario and those who participated in simulation sessions. These research studies also direct our attention to an inherent problem in testing the effectiveness of simulation experiences. Although one expects knowledge, critical thinking, and/or self-efficacy to increase with experience, the purpose of simulation education is really to improve performance or clinical

competency. Performance or clinical competency is more difficult to measure than knowledge, critical thinking, or self-efficacy. In fact, simulations themselves are frequently used to test clinical competency (Johanson & Wertenberger, 1996; Nehring & Lashley, 2004).

Full-scale simulation in nursing education is the most time-consuming and labor-intensive to create. No objective studies involving nursing students were found. In all categories of simulation there is considerable evidence that students and faculty perceive simulation experiences to be generally well liked (Kenny, 2002; Ross and Tuovinen, 2001) and valued (Bearson & Wiker, 2005; Cioffi, 2001; Feingold et al., 2004). Several studies into perceptions of full-scale simulations report that students and faculty generally responded favorably to full-scale simulated sessions (Decker, Galvan, & Sridaromont, 2005; Mole & McLafferty, 2004; Yaeger et al., 2004).

Computer-based simulation differs from task and skill simulation and full-scale simulation in that there is still a fair amount of work to do around the interactivity of the programs. As research on interactive computer-based simulation is limited, this category of simulation education in nursing cannot be further explored at this point.

Simulation in Curricula

Infusing simulation into nursing curricula can be challenging at times as it relates to funding and time constraints. In nursing education adherence to fundamental skill acquisition has major implications as student's progress to higher-order skill sets (Starkweather & Kardong-Edgren, 2008). Faculty may view simulation as mode of education that they are not well prepared for to teach educationally or technologically. During simulation, faculty found that running scenarios, playing the part of the patient, remembering what happened in the scenario

to debrief the students a challenge. Yet the students find the simulation experience most challenging (Starkweather & Kardong-Edgren, 2008).

Using instructor made mind maps, similar to an algorithm of critical thinking; to help students achieve measurable learning during simulation has proven to be successful. Clinical pathways or mind maps using assessment, implementation and evaluation methods are known to be useful in enhancing critical thinking in nursing students. This method as a nursing education strategy has been found to be an effective educational strategy in nursing education. Students performance not only improved in the clinical setting (simulation) but also improved in the classroom. Students that received this method of education scored higher on quizzes and tests. The use of mind maps in first and second year nursing educations build on their transformational learning experiences and enhance their clinical assessment capabilities for the future (Bowley, 2008).

Challenges of Using Simulation

Funding for simulators and employing someone to maintain and educate others about their use can become very expensive. Static dedicated space is required to educate students and staff. Fear of using a technological system when one is not knowledgeable becomes a barrier to this educational strategy. Time to learn and educated other faculty during economic time constraints can become a challenge. Depending on the faculty and student's familiarity, computer literacy is an integral foundation of using simulators. Additionally, faculty resistance and adaptation to different methods of delivering higher level of adult education may pose a barrier.

Summary

In conclusion, although the categories of simulations in nursing education are generally well liked by faculty and students, the evidence of their effectiveness compared to traditional, lecture-based methods and clinical experiences is somewhat inconclusive. Despite this lack of evidence, nursing educators continue to view simulation education as the only available alternative to clinical experience. These authors contend that it is unlikely that nursing students will ever be able to practice all their skills on real patients again. As well, many educators intuitively believe that hands-on experiences, in particular with skill and talk trainers, improve learning outcomes (Seropian, et al., 2004). Adult, constructivist, and experiential learning theories support this intuition.

If simulation in education curricula is here to stay, how can educators ensure they are using the simulation experiences in the best possible way? Benner's (1984) model of skill acquisition and Kolb's (1984) experiential learning theory provide frameworks that can be used to help nurse educators guide their decisions about simulation experiences for nursing students. Simulation in adult education has proven to become an active adult learning strategy in the nursing curriculum today. It is important the educator is familiar with the scenarios, the use of the simulator, creates a mind map and has solid scenario's that engage adults learners or nursing students at all levels. Having support and physical resources to promote and facilitate this method of active learning is beneficial to all parties involved. And to say the least, it promotes a safe environment for students to practice their new knowledge and skills bearing no harm to others enhancing confidence in their critical thinking skills. Keeping in mind that

simulation is an interactive venue, it is important to instill in the learner that this is the science of learning and the art of caring for human emotions cannot be simulated – at this time.

CHAPTER 5 - HANDBOOK FOR MENTORS/PRECEPTORS IN THE NICU

The following handbook has been prepared for both mentors and mentees in the clinical setting of the Neonatal Intensive Care Unit. The purpose of the handbook is to provide them with the knowledge and tools in order to provide high quality education efficiently and successfully. Included in this final chapter is the outline for a mentor workshop. The workshop describes goals and objectives of each phase of the program. The purpose of the workshop is to develop, educate and transform the mentor into a skilled, knowledge translator to the mentee. Relationship building, communication techniques, conflict management, use of simulation, assessment and evaluation are provided during the educational program.

The next portion of the project is a handbook that includes roles, responsibilities, mentee assessment, timetables, evaluation descriptors and a contract for both mentee and mentor to sign. The intention of the handbook is to provide a comprehensive tool for both mentees and mentors to utilize in order to maximize their clinical experience. The handbook is an effective way of assessing and providing final evaluation in an objective and timely manner.

An overview of the website was created to facilitate transparency of roles and responsibilities of both mentee and mentor. It can be easily accessible and provided clarity about the expectations of their roles in the Neonatal Intensive Care Unit.

Finally, the PowerPoint presentation provides an overview about the concept of mentorship in nursing and its feasibility and utility in the health care setting.

Mentor Development

New Mentor Workshop

Aim

To enable nursing staff new to the role of mentor to explore what a mentor is, what the role of the mentor is, what the skills required to be a mentor are, and how to make practical arrangements for your student's clinical experience.

Objectives

By the end of the session participants will:

- Be able to define what a mentor is
- Be able to discuss the role of the mentor
- Be able to identify the skills required of the mentor (active/passive communication)
- Be able to identify the arrangements to be made for the student learning (principles of adult education)

Use of role play, didactic, self-evaluation, and simulation as part of the education methodology.

Duration

Half day (3.5hrs)

Mentor Development and Update Process

Purpose

To enable staff to feel confident about the knowledge and skills in mentoring and assessing students. The content of the update will include curriculum issues, the assessment documents being used, how to mentor students and working with unmotivated/failing students.

Objectives

By the end of the session participants will:

- Be able to discuss the changes to the nursing curriculum (review curriculum and best practice)
- Be able to complete assessment documentation more effectively (review all documents)
- Be able to mentor students more effectively (communication skills)
- Feel more confident about mentoring and assessing students
- Be able to work more effectively with the unmotivated/failing student

Use of role play, didactic, self-evaluation, case studies and simulation as part of the education methodology.

Duration

1 day (8hrs)

Mentor Development and Update Process

Purpose

To enable staff to feel more confident and up-to-date in their knowledge and skills in mentoring and assessing students. The content of the update will include curriculum issues, the assessment documents being used, how to mentor students and working with unmotivated/failing students.

This stage of the mentor update is designed to extend your knowledge and awareness of the failing student scenario giving the opportunity to practice giving negative (objective) feedback and 'failing' the student.

Objectives

By the end of the session participants will:

- Be able to discuss the changes to the nursing curriculum
- Be able to complete assessment documentation more effectively
- Be able to mentor students more effectively
- Feel more confident about mentoring and assessing students
- Be able to work more effectively with the unmotivated/failing student

Use of role play, didactic, self-evaluation, case studies and simulation as part of the education methodology.

Duration

1 day (8hrs)

Students – objectives and evaluation

Mentors/Preceptors in NICU

Objectives

- Students are to follow the preceptor's schedule. Any change in scheduling should be negotiated between the student, preceptor and faculty advisor, if necessary.
- Students will follow the course syllabus as described.
- Descriptors and behaviors of the student are well defined in the handbook. Students will provide the preceptors with the evaluation form prior to when they are due for submission.
- Students require 40hrs of leadership experiences.
- Advanced competencies that are permitted in the NICU are: **Venipuncture and IV initiation.** (Preceptors or delegates must supervise)
- Preceptors: please read the preceptor handbook that was placed in your mailboxes.
- Preceptors: Please use the descriptors attached in order to assist in providing clear and comprehensive evaluations.

If you have questions or concerns, please contact the Faculty Supervisor.

Thanks for sharing your expertise with the students.

Student's timetable requirements:

Week of Course	Requirement
Before placement	<input type="checkbox"/> Submit personal objectives to faculty
Week 1	<input type="checkbox"/> Review personal objectives with preceptor. <input type="checkbox"/> Review preceptor handbook with preceptor.
Week 2	<input type="checkbox"/> Submit reflective journal #1.
Week 4	<input type="checkbox"/> Submit reflective journal #2. <input type="checkbox"/> Submit objectives for management and leadership assignment.
Week 5	<input type="checkbox"/> Complete self evaluation providing evidence of how outcomes have been met and suggestions for improvement. <input type="checkbox"/> Review objectives from week 1 and adjust objectives as necessary. Address progress with personal objectives in self-evaluation. <input type="checkbox"/> Ensure your preceptor completes the midterm evaluation. <input type="checkbox"/> Ensure self evaluation and preceptor evaluations have been discussed. Mail mid-term evaluation and copy of time sheet to School of Nursing.
Week 6	<input type="checkbox"/> Submit reflective journal #3.
Week 8	<input type="checkbox"/> Submit reflective journal #4.
Week 10-11	<input type="checkbox"/> Complete final self evaluation and preceptor final evaluation including discussion.

	<input type="checkbox"/> Submit leadership and management assignment to faculty.
Week 12	<input type="checkbox"/> Return to respective university for final group review session with your Faculty Advisor. Return with all documentation. This includes: <ul style="list-style-type: none"> <input type="checkbox"/> Cover page (signed by preceptor and student) <input type="checkbox"/> Final self-evaluation signed <input type="checkbox"/> Final preceptor evaluation signed <input type="checkbox"/> Time sheet signed

Assessment and Evaluation Tool

Descriptors for student's evaluation in NICU
Knowledge base - applies theory to practice (pathophysiology TTN, RDS, BPD, jaundice, sepsis)
Communication skills: Peers, MD, patient advocate, presents on rounds Parents: encourages participation, teaches, offers emotional support
Use of nursing process (assess, plan, implement, evaluate)
Responsibility for own actions
Understands & integrates philosophy of family-centered care
Understands & integrates philosophy of developmentally supportive care
Documentation - uses flow sheet and updates kardex prn (min duplication)
Basic nursing care (repositions infant, changes probe site, mouth care, etc)

Admission of a patient

Discharge of a patient (teaching, appointments, ABAER, car seat)

Physical Assessment:

Newborn (head to toe, gestational age assessment, measurements)

Interprets vital signs and initiates appropriate action

Thermoregulation (S&Sx cold stress, ISC probe, isolette, humidity)

Respiratory (assess air entry, apnea, cyanosis, oxygen saturation levels)

Cardiac (pulses, bradycardia, tachycardia, PDA)

Gastrointestinal (TFI, ,NEC, NG feeds, PN)

Neurological (state, tone, activity level, fontanel, Dev care)

Medication Administration and drug calculations (including PN)

Pain Management (sucrose, tylenol, morphine, fentanyl)

NRP and airway management (positioning, oral/nasal suctioning, PPV/CPAP)

Breastfeeding promotion

appropriate gestational age and expectations

Kangaroo care

Assesses position, latch, suck and swallow

identifies problem areas (inverted/cracked nipples, sleepy baby)

pumping, collection, storage of EBM

Equipment:

cardiac, oxygen saturation monitors

phototherapy (lights, biliblanket)

oxygen administration (NP, isolette)
<p>Skills:</p> <p>TFI calcs</p> <p>venipuncture (PIV, BW)</p> <p>capillary (observation)</p> <p>NG tube insertion (observation)</p> <p>IV push meds(observation)</p>
Interpretation of lab data
<p>Other (NCPAP)</p> <p>Need for suction</p> <p>Intervention during A's and B's</p> <p>Systems assessment – intuitive of impending illness/improvement</p>

Systems Assessment – student is able to identify differences (please highlight)

	NORMAL	COMMON VARIATION	ABNORMAL
COLOUR	pale pink pink	mottling acrocyanosis ecchymosis jaundice (after 48 hours)	pallor duskiness central cyanosis jaundice (in 1st 24 hours)
ACTIVITY LEVEL	deep sleep REM sleep		lethargic unresponsive to stimuli

	<p>Quietly awake</p> <p>active awake</p> <p>crying</p>		<p>jittery</p> <p>seizures</p>
CRY	<p>lusty</p> <p>vigorous</p> <p>strong</p>		<p>high pitched</p> <p>horse-like</p> <p>weak</p> <p>absent/constant</p>
RESTING POSTURE	<p>flexed position</p> <p>good flexion/ex- tension of limbs</p> <p>spontaneous and equal movement</p> <p>strength and tone</p>	<p>posture reflects intrauterine positioning, e.g., breech</p>	<p>restricted or asymmetric movement</p> <p>floppy</p> <p>lethargic</p> <p>hypertonic</p> <p>weak</p>
RESPIRATIONS	<p>normal 40-60/min</p> <p>unlaboured</p> <p>without effort</p> <p>very easy</p>	<p>periodic breathing (without bradycardia and cyanosis)</p>	<p>apnea</p> <p>periodic breathing with bradycardia and cyanosis</p> <p>grunting, nasal flaring, retractions</p>
AIR ENTRY	<p>equal bilaterally</p> <p>clear</p>		<p>grunting</p> <p>rales, crackles</p> <p>rhonchi, wheezes</p> <p>decreased</p>

			diminished
HEART RATE	120-160 beats/min	labile in first 1-2 hours brief dips, 80-100	bradycardia < 80 tachycardia >160 murmurs
BLOOD PRESSURE	mean BP about 5 mmHg greater than gestational age		mean equal to or less than gestational age
TEMPERATURE	normal 36.5 - 37.2°C (axilla)	slightly elevated at birth	outside normal range
HEAD			
SHAPE	symmetrical and round	molding caput succedaneum cephalohematoma	asymmetrical depressions irregularities

	NORMAL	COMMON VARIATION	ABNORMAL
SUTURES	palpable and slightly open		overriding widely spaced closed
FONTANEL	soft, level slightly rounded	size varies posterior fontanel not	absent anterior fontanel enlarged

		palpable	bulging, tense sunken
OVERALL	symmetric movement and appearance		asymmetric movement flaring of nares
EYES	symmetrical pupils equal and reactive to light	strabismus subconjunctival hemorrhage edematous	jaundiced sclera asymmetric unequal, non-reactive pupils cataracts purulent discharge
EARS	symmetrical	amount of cartilage depends on gestation	asymmetrical low set skin tags
NOSE	midline nares patent		flattened nasal bridge occlusion
MOUTH	symmetrical hard and soft palate intact moist and pink gag, sucking, rooting reflex	Epstein's pearls sucking blister on lip	circumoral or central cyanosis asymmetrical small lower jaw cleft lip or palate thrush
ABDOMEN	soft	intermittent bowel	scaphoid

	rounded slightly bowel sounds audible in all 4 quadrants symmetrical	sounds absent in first 2 hours	asymmetrical distended firm bowel loops visible masses absent or hyper- active bowel sounds
CORD	white, gelatinous 3 vessels (2 A+1V)	umbilical hernia meconium stained	2 vessels red, wet, foul odour
GENITALIA	appropriate for given sex - normal	uric acid crystals edema and bruising	ambiguous
MALE	testes descended bilaterally	partially descended testes	hypospadias/epispadias hydrocele undescended or absent testes

	NORMAL	COMMON VARIATION	ABNORMAL
FEMALE		hymenal tags pseudomenstruation	absent vagina or meatus

BUTTOCKS	patent anus creases of legs and buttocks symmetrical		imperforated anus absent or asymmetrical creases
BACK	straight spinal column		curved pilonoidal or sacral dimple spina bifida
EXTREMITIES	equal movement of all limbs full range of motion symmetrical appearance	transient positiodeformities	hip dislocation asymmetrical appearance and movement syndactyly, polydactyly, simian crease
SKIN	smooth, soft, elastic warm, moist vernix ecchymosis	dry, cracked erythema toxicum mongolian spots milia nevi	rash, pustules lacerations petechiae hemangiomas lesions

Student self-evaluation and faculty evaluation

Course Outcomes Critical Descriptors/Behaviour	Summary of Strengths	Areas Needing Improvement
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<p>1.0 Provides competent and culturally sensitive nursing care. Practice within ethical and legal guidelines of the profession; demonstrate professionalism, accountability and responsibility in practice and in professional growth.</p>		
<p>2.0 Use critical thinking, problem-solving, and scientific inquiry in the practice of nursing, and in monitoring and ensuring quality of health care practices.</p>		
<p>3.0 Communicate effectively in relationships with clients and health professionals.</p>		
<p>4.0 Use nursing knowledge and skills in partnership with individuals and families to maintain and promote health and well-being and provide care and support during illness.</p>		
<p>5.0 Appreciate how specific environments and socio-political conditions affect health behaviour, professional practice and public policy.</p>		
<p>6.0 Apply leadership and managerial abilities and political skills to attain quality care for clients and quality of work-life for co-workers.</p>		

7.0 Engage in self-directed learning, reflective and evidence-based practice.		
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CLINICAL EVALUATION CONTRACT

Student: _____

Preceptor: _____

Faculty: _____

Placement: _____

Self Evaluation Discussed: _____

Preceptor Evaluation Discussed: _____

Missed Clinical Time: _____

Dates: _____

Mentorship

Friend or foe ?



What does mentorship mean to you ?

- Round table ...

Apply theory to practice

Prepares students as practitioners

Counsellors or advisors



Roles

· Student

- Learner
- Applies theory to practice
- Transition
- Novice

· Mentor

- Knowledgeable
- Skilled
- Assessor
- Positive role model
- Facilitates learning
- Knowledge transfer

What are student's expectations of their mentors?

- Supportive
- Helpful
- Knowledgeable
- Experienced
- Enthusiastic about their role
- Committed to the students
- Develop a relationship

(Myall, 2007)

Connectedness – common variables from survey

· Student

- Mentors are good role models
- Quality of time – essential
- Consistency
- Felt a sense of belonging

· Mentor

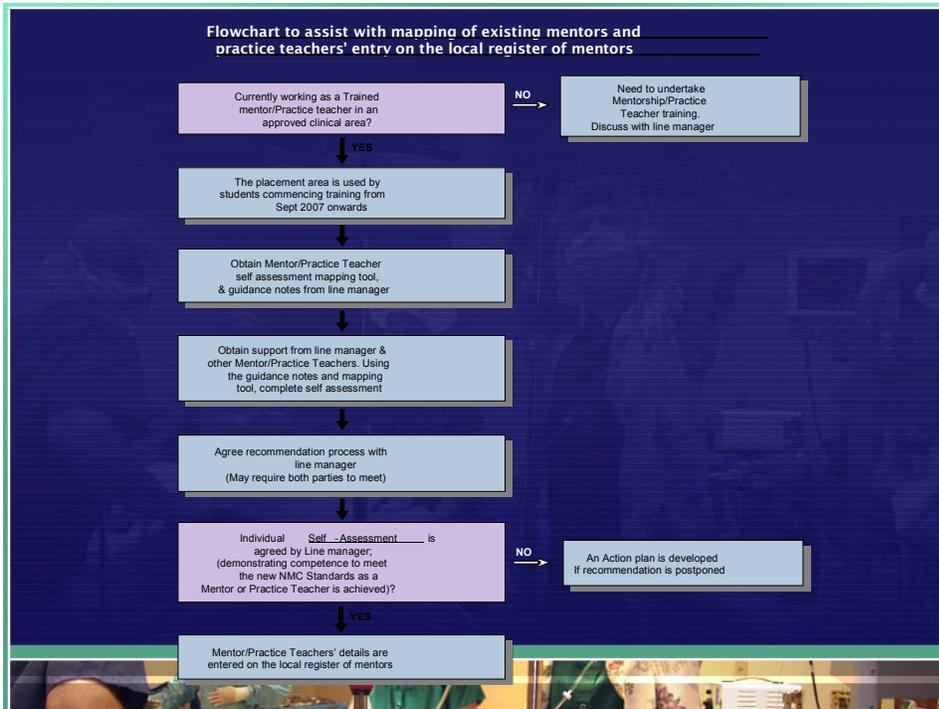
- Provides opportunities for learning
- Ongoing assessment and feedback
- Job satisfaction
- Welcoming students to transition to practice



Constraints of the role of mentorship

- Lack of education about being a mentor
- Increase workload
- Burden, inconvenience, imposition
- “Out-numbered” by students
- No time
- Not sure how to teach





Outcomes

- What are we striving for? Better teachers?
- How can we measure? (ie: how do we know we have achieved our goals?)
- Then there is reality ...



Text for Website:

The school of nursing provides students with a variety of placements where students have opportunity to engage clients in new learning opportunities.

Click on the respective links to ensure that you can connect with the appropriate information.

Click [here](#) for mentee and mentorship workshops, evaluations and handbook.

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