Mentor, Coach, Teacher, Role Model: What's in a name?

Abstract

In its new standards for education and training, the Nursing and Midwifery Council (NMC) states students should be 'empowered and provided with the learning opportunities they need to achieve the desired proficiencies and programme outcomes' (2018a:5). This concept of empowerment, with students as active, rather than passive learners, will be supported by the introduction of Practice Assessors and Supervisors, providing individualised support according to the student's proficiency and confidence. The Mentor, traditionally perceived as a 'teacher' being replaced by the Practice Assessor and Supervisor as 'role models' and 'coaches'.

A previous article in this series (Power and Jewell, 2018) looked at the introduction of a coaching model of student support in practice. This article will discuss third year student midwife Alice Wilson's experiences of her final labour ward placement and her reflections on her mentor's approach to student support using the coaching model.

Keywords: coach; mentor; Practice Assessor; student midwife; Practice Supervisor; Standards

Introduction

The NMC are currently redefining the standards of proficiency for the future midwife, to ensure that at the point of registration, student midwives can deliver evidence-based, compassionate and safe care. A 12-week consultation period on the draft standards commenced in February 2019 for publication in January 2020 with their introduction to follow in September 2020 (NMC, 2019).

Realising professionalism: standards for education and training

Recently published outcome-focused NMC Standards for education and training (2018a; 2018b) offer approved education institutions (AEIs) and their practice learning partners greater flexibility and autonomy in the development and delivery of innovative pre-registration midwifery programmes. In terms of practice learning, new titles such as 'Practice Assessor' and 'Practice Supervisor' have been introduced into this new flexible model of student supervision and assessment, with the emphasis on students being proactive learners, being 'supported to learn' rather than passive recipients of knowledge.

The title 'Mentor' is conspicuous in its absence from the Standards (NMC, 2018b); AEIs and practice learning partners must ensure 'there is a nominated person for each practice setting to actively support students and address student concerns' whilst providing students with opportunities 'to learn from a range of relevant

people in practice learning environments, including service users, registered and non-registered individuals and other students as appropriate' (NMC, 2018b:5).

Roles and Responsibilities for supporting students in practice

Academic Assessors	• collate and confirm student achievement of proficiencies and programme outcomes in the academic environment for each part of the programme • make and record objective, evidence-based decisions on conduct, proficiency and achievement, and recommendations for progression, drawing on student records and other resources • maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing and confirming • the nominated academic assessor works in partnership with a nominated practice assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards and local and national policies • have an understanding of the student's learning and achievement in practice • communication and collaboration between academic and practice assessors is scheduled for relevant points in programme structure and student progression • are not simultaneously the practice supervisor and practice assessor for the same student
Practice Assessors	• conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning • assessment decisions by practice assessors are informed by feedback sought and received from practice supervisors • make and record objective, evidenced-based assessments on conduct, proficiency and achievement, drawing on student records, direct observations, student self-reflection, and other resources • maintain current knowledge and expertise relevant for the proficiencies and programme outcomes they are assessing • a nominated practice assessor works in partnership with the nominated academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with

	programme standards and local and national policies • there are sufficient opportunities for the practice assessor to periodically observe the student across environments in order to inform decisions for assessment and progression • there are sufficient opportunities for the practice assessor to gather and coordinate feedback from practice supervisors, any other practice assessors, and relevant people, in order to be assured about their decisions for assessment and progression • have an understanding of the student's learning and achievement in theory • communication and collaboration between practice and academic assessors is scheduled for relevant points in programme structure and student progression • are not simultaneously the practice supervisor and academic assessor for the same student
Practice Supervisors	• serve as role models for safe and effective practice in line with their code of conduct • support learning in line with their scope of practice to enable the student to meet their proficiencies and programme outcomes • support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills • have current knowledge and experience of the area in which they are providing support, supervision and feedback • receive ongoing support to participate in the practice learning of students

Box 1 (NMC, 2018b:6)

Mentoring v Coaching

In line with the new Standards, midwives will act as role models and coaches for student midwives, with the level of supervision being dictated by the individual student's needs, confidence and competence. A previous article in this series (Power and Jewell, 2018) discussed the role of the Student Support Midwife and how one Trust is preparing for the introduction of the new standards by adopting a coaching model of student support based on aspects of the CLiP (Collaborative Learning in Practice) model, based on the Amsterdam Model developed in 2011 at the VU Medical Centre in Amsterdam (Ashton *et al.*, 2016; Arthur, 2015; University of East Anglia, 2014). Box 2 shows the contrast in approaches between mentoring and coaching.

Mentoring/Teaching	Coaching
Answers questions	Asks questions
Steps in and provides care	Steps back and allows the student to learn by providing care
Is watched by the student	Watches the student
Directs the student's learning	The student demonstrates what they've learnt (usually self-directed) to the coach
Shows the student how	Is shown how by the student
Allocates work to the student	Is allocated work by the student
Talks	Listens
Does the same work as before, but with a student	Works differently, while coaching the student
Identifies individual learning opportunities in the ward environment	Uses the whole ward as a complete learning environment

Box 2 University of East Anglia (2014:4)

Case Study: Alice's reflections on practice

Before starting my third-year labour ward placement I was terrified: expectations were high, not just from mentors (Power, 2016) and colleagues but from myself, and no placement can put the pressure on the way labour ward does! When my mentor sat me down to talk about my goals for the five weeks, my main aim was to develop my confidence, take the lead and plan care. I essentially wanted to end the placement feeling that the transition from student to qualified midwife wouldn't be a huge step, rather a natural transition.

On my first shift working with my sign-off mentor, she immediately stepped back. 'You're taking the lead - just tell me what you want me to do'. Instead of telling me the plan of care she asked me what my plan was and encouraged me to justify my approach. She listened to my rationale, helping me to trust my instincts, and prompted me to see the bigger picture in cases that were more complex. She

encouraged me in my passion for promoting normality and her positivity was infectious. The first time I performed a successful artificial rupture of membranes (ARM) I think she was as excited as I was. She empowered me to take the lead role and I never doubted that if I needed her I only had to ask. I was even given the chance to mentor a first-year student on a Taster Week (observational week). My confidence soared with every labour, every delivery and at the end of every shift when she thanked me sincerely for my work.

By the end of the five weeks I was ready to give my last shift everything I had. We were assigned a low-risk woman to triage and it was up to me to decide if she was in established labour and could be admitted. On examination, she was in established labour and we settled down for what I hoped would be a lovely shift. My mentor sat outside, popping in occasionally, and reassured me that if I needed her she would be there right away. It was a student's dream: a low-risk woman labouring in the pool, music in the background, lights low and everything calm. When the time came for the next vaginal examination to assess progress my mentor came back into the delivery room and when I relayed my findings to her and confirmed that I intended to continue with my current plan of care as labour was progressing, she seemed unsure. As I updated the handover board she spoke to the midwife in charge, before coming to me and saying that they felt it would be best to perform an ARM to augment labour; the rationale being the woman was getting tired, her progress wasn't what they would expect, and it seemed the best course of action.

I knew that the woman had had an upsetting experience whilst having her last baby ten years previously and that she was keen for minimal intervention this time around. I was also confident that her progress was within the guideline and that there was no indication for an ARM at this point. So that was what I said - as her lead carer that was not what I felt would be the most appropriate plan. My mentor and I discussed our justifications for our differing viewpoints and agreed to discuss both options with the woman so that she could make an informed choice. She opted for my plan to continue as she was, with a dose of pethidine to help her rest. Two hours later she birthed her baby and was overjoyed that her experience had been so much better this time.

At the end of the shift my mentor and I sat down to go through my final interview. When it came time to grade me, she said that my performance that day had truly impressed her. She said that she had reviewed the guideline following our discussion and that I had been correct in my assessment of the woman's progress. She said I had demonstrated knowledge of the guideline and of normal physiology and I had been a strong advocate for the woman in my care as I ensured she had the birth experience she wanted. I told her that I was only able to do this as she had boosted my confidence throughout the placement by giving me the space to practice without undue interference or monitoring. Above all, I trusted that she would listen to and value my input as an individual and equal.

On reflection, my mentor practises mentorship in a different way to what I have experienced before and to me it seems more in line with the CLiP model (Arthur, 2015). The dynamic of our professional relationship felt that we were partners in care and instead of standing back and observing, which can be daunting, my mentor encouraged me to delegate tasks to her and liaise with the labour ward team as the lead. By asking questions and allowing me space to think when complications arose, my problem-solving skills also developed. This also gave me the opportunity to take responsibility for care in a way that I otherwise may not have done (Lobo *et al*., 2014). Based on my experience, I believe that coaching will prepare students for the responsibility of qualification and ensure that they are confident and self-aware as practitioners going into the workforce.

Moving forwards

Alice's experiences demonstrate the value and impact of students receiving high-quality support in clinical practice. A successful and productive relationship between the midwife as expert practitioner and the student midwife as novice should be based on trust, mutual respect and professionalism. The semantics of titles for this important role shouldn't detract from the main objective: women and their families receiving high quality, safe care from a well-trained, compassionate workforce.

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