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staff development

mentorship

Developing trainee advanced nurse practitioners in clinical environments

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None declared

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Abstract

Teaching and mentorship are fundamental parts of registered nurses' roles, and learning should be managed and promoted in clinical practice to ensure excellence. This article reflects on, and critically analyses, the developing relationship between the author, an advanced nurse practitioner (ANP)/practice educator and an experienced nurse undertaking an ANP level 7 programme of study. The article describes the supervision and mentorship of the student ANP in an emergency department, in the context of the 'facilitation of learning' and 'evaluation of learning' domains of the Nursing and Midwifery Council Standards to Support Learning and Assessment in Practice (2008).

advanced nurse practitioner, evaluation of learning, reflection, supporting learning

The Nursing and Midwifery Council (NMC) (2008) emphasised that teaching and mentorship are fundamental parts of registered nurses' roles, while Warne (2011) described how learning should be managed and promoted in the profession to ensure excellence in clinical practice. The NMC's (2008) standards and competencies for practice teachers, and the UK Professional Standards Framework for Teaching and Supporting Learning in Higher Education

(The Higher Education Academy 2011), provide a structure for developing individuals' learning in the workplace. This article focuses on the NMC facilitation of learning and evaluation of learning domains (2008) in its reflection on the relationship between an advanced nurse practitioner (ANP), the author, and an experienced nurse undertaking a postgraduate module in advanced practice.

At the time, I was practising as an ANP in a city centre emergency department (ED). I worked mainly in the majors' stream, rather than in minor injuries where traditionally emergency nurse practitioners (ENPs) practise, although there was some overlap in my role because of the nature of ED work. I practised autonomously and was an independent prescriber – within my sphere of competence.

The ANP role in my workplace had been developed because of a national shortage of ED trainee doctors. Many staff had already undertaken level 7 training in advanced practice at a local university, and were therefore supported to develop in the role. The ANPs are now a crucial resource in the department, and work alongside the middle-grade tier of the medical rota.

As one of the most experienced ED ANPs, and a trainee practice teacher, I was responsible for supporting staff to develop the skills and competences required to undertake a level 7 module in advanced practice. Mark (not his real name), an experienced emergency nurse, had worked in the department for six years and was embarking on this qualification with the aim of becoming an ANP. The module required students to participate in supervised clinical practice to develop their clinical assessment and diagnostic skills, alongside a formal university-based course.

In Wales, nurses training beyond initial registration, who aspire to become advanced practitioners, must complete level 7 (National Leadership and Innovation Agency for Health Care 2010). The Royal College of Emergency Medicine (2015) suggests the same level for advanced clinical practitioners, who are non-nursing practitioners such as paramedics, who work in EDs. Postgraduate students must have mentors in their clinical environments to supervise their development, and I was undertaking this role. The NMC (2008) requires practice teachers to provide the support required for learners to develop new skills, and to transfer existing knowledge to new areas of practice.

Reflection

Reflection is an essential part of nurses' toolkits to help them bridge the theory-practice gap by critically analysing and evaluating scenarios (White et al 2013). Driscoll's (1994) reflective model enables nurses to link theory to practice using the following structure:

- What? – what happened?
- So what? – what were you feeling, what was good/bad about the experience?
- Now what? – if it happens again what you would do differently?

The rest of the article is structured using this framework.

What?

Mark asked me to act as his practice teacher while he was completing an MSc in advanced practice. He was required to do 70 hours of supervised practice along with objective structured clinical examinations (OSCEs). OSCEs are described as practical examinations used to assess candidates' competence in clinical situations in a structured way, and are recognised as a valid method of assessment (Traynor and Galanouli 2015).

As Mark's practice teacher, it was important to develop an effective relationship with him before beginning mentorship. This relationship would then enable me to assess Mark's learning style, and my ability to support his learning and professional growth. The VARK learning preference tool (Flemming and Mills 1992) suggests that learners fall into one of four categories: visual learners, aural learners – who thrive on traditional didactic learning styles, read/writing learners, or kinesthetic learners – who prefer hands-on demonstrations of practice. It was

important to determine Mark's and my own 'learner type' to support meaningful learning, develop Mark's learning contract and help me develop an appropriate learning environment.

As a practice teacher, I was responsible for helping Mark gain the advanced nursing skills required to practise as an ANP, and to support him to develop his critical thinking, and my role changed during the time we spent together. Initially I took on a nurturing role while Mark spent time shadowing me. This allowed me to create an environment for Mark's development, through the context of building our student/teacher relationship. I talked with Mark about the rationale for patients' examinations, after which we discussed differential diagnoses and developed treatment plans. As Mark became more confident in his role, I observed him in clinical examinations, and supported him to develop his own learning. At the end of each examination we debriefed and reflected on the experience.

As part of the university's formal assessment of competence, Mark was required to undertake three OSCEs in clinical practice, supervised by me. This was a useful way of assessing Mark's learning and the effectiveness of my teaching, and enabled me to evaluate Mark's practice and academic experience at a level beyond registration, while working in clinical practice. It also enabled Mark to reflect critically on his performance, and relate theory to practice, which is a requirement of the NMC 'facilitation of learning' domain (2008).

So what?

Experiential learning, as an approach to adult learning, has become embedded in nurse education in recent years (Hughes and Quinn 2013). In its simplest form, experiential learning is learning by doing rather than listening to lectures or reading. Kolb (1984) described how development results from learners' experiences and their subsequent reflections. It is a cyclical process initiated by an experience which learners observe and from which they gather information. This experience is then reflected on by learners, who analyse events until concepts are created and observations are integrated into theories.

The final stage of Kolb's (1984) model involves modifying nursing practice based on the concepts created earlier in the cycle. Kolb (1984) also described how understanding their own learning styles can help learners get the most out of experiences. This theory fitted well with the type of adult learning undertaken by Mark, in which he could observe practical skills supported by me as the practice teacher.

Bastable et al (2014) describe how learning contracts are increasingly popular methods of focusing students' learning. During our first meeting Mark and I talked about the learning requirements for completion of the course, and designed a learning contract which would help focus us on Mark's developing clinical needs and form part of the assessment. The contract was drawn up with mutual agreement, and aimed to close the gaps in Mark's knowledge, and expose him to ANPs' varied workload to enable him to develop his assessment and diagnostic skills.

Learning contracts allow students to acquire and plan their own learning, within the course objectives, rather than being restricted by content plans (Kreider and Barry 1993). They also promote individualised learning and independence by fostering learning through self-discovery and becoming less reliant on teachers/mentors (Chan and Wai-tong 2000). Bearman et al (2013) described learning contracts as students taking responsibility for their own learning and providing clinical mentors with feedback that can be tailored towards clinical assessments. Race (2014) discusses the notion of assessment as learning, rather than assessment for learning, and it could be argued that learning contracts are an example of the latter.

The aim of Mark's learning contract was to identify aspects of the ANP role he needed to develop and how this could be achieved. Donaldson (1992) found these contracts positively affected students' learning, and students valued the control they gave them. However, I believe Mark had included elements that he was capable and competent at undertaking, and he was using the contract as a way of completing the practical requirements of the course with minimal effort.

Chan and Wai-Tong (2000) suggested that effective learning contracts depend on students' attitudes to learning and their motivation. I believe the lack of study leave Mark was allocated negatively affected his attitude towards learning, and he was doing as little as possible to fulfil the course requirements.

To try to overcome this I encouraged Mark to undertake a strengths, weaknesses, opportunities and threats (SWOT) analysis (Makos 2014) of his current level of practice and what he needed to do to become an ANP. The aim was to identify, at an early stage, deficits in Mark's knowledge and skills. Bearman (2013) and Hinchliff (2006) suggested that encouraging individuals to evaluate their own practice helps them appraise their progression, identify their learning needs, and recognise how their current knowledge can be used in practice, and this process enabled Mark to recognise his learning needs and take ownership of the need to learn (Race 2014).

Following this, Mark and I worked together to amend his learning contract, and although I still believed it included some elements of practice in which Mark was already competent, I was also aware of his lack of allocated study time to complete the course. Mark was working his contracted hours and fitting in the course. The amended contract reflected Mark's developmental needs to enable him to gain competence in managing a varied patient caseload.

Bastable (2014) shows that once learning needs are identified, practice teachers can design instructional plans to meet those needs, and decide when and how learning should take place. This is supported by Bearman et al (2013), who suggests using multiple assessment tools to identify deficits in knowledge, develop learning plans, give feedback, reflect on work undertaken and reassess practice competence.

Practice teachers should be aware of their strengths and weaknesses to minimise negative effects on student learning (Hinchliff 2006), and at this stage I recognised that I did not have all the clinical skills required to support Mark's development. Therefore, I arranged for him to spend time with other specialists in the department. This is in line with the 'facilitation of learning' and 'creating an environment for learning' domains (NMC 2008), which advocate the use of multidisciplinary teaching to support learning and highlight the importance of developing an ethos of inter-professional learning and working. Initially Mark worked alongside me and other colleagues to observe our work. As his confidence and skills developed he started to complete individual system assessments and then holistic patient assessments in preparation for his OSCE.

Mark and I agreed to spread the OSCEs throughout the academic year. This would assess his competence and development as he progressed through the course, enable me to provide constructive feedback, identify further learning needs, as well as enhancing performance at strategic points throughout the mentorship process. It would also demonstrate Mark's professional growth and personal development.

This illustrates the second stage of Kolb's (1984) experiential learning theory, allowing learners to reflect on and analyse events, and formulate a change in practice accordingly. I found the feedback during the teaching process an extremely helpful part of the reflective cycle. At the end of each supervised patient examination, Mark and I discussed his findings and diagnosis, and I used this as an opportunity to appraise his clinical skills and advise changes where necessary.

This process supported self-assessment, as I could encourage Mark to look at his practice and consider where he needed to be to become an independent practitioner. I regarded feedback as a two-way process (Bastable 2014), enabling both of us to develop in our roles and adapt our practice as required (Kolb 1984).

Before undertaking the OSCEs, Mark and I discussed which patient presentations would enable him to demonstrate the clinical competences set out in his learning contract. This also allowed for informal one-to-one instruction and capitalised on the 'teachable moment' that occurs unexpectedly in situations, and offers opportunities for educators and students to discuss knowledge, ideas and feelings. To do this effectively requires practice teachers to use interpersonal skills, and develop a rapport with students (Bastable 2014).

Immediately following each OSCE Mark and I reflected on the case, thus allowing for reflection to 'take place in action' (Race 2014). One criticism of OSCEs, when used in educational settings, is that they do not take into account

the demands on students while working in clinical areas, which could affect their critical thinking (Mitchell et al 2009). So, undertaking the assessments in clinical environments means that students are observed in 'real-life' situations.

The OSCE format also enables assessment of students' professional behaviour and communication skills, offering a more holistic assessment of their competencies. Overall, the OSCEs demonstrated Mark's professional growth and personal development, which are vital components of the facilitation of learning domain (NMC 2008). At first I found marking the OSCEs a daunting prospect, but once I had overcome my anxieties I found the process encouraged me to keep my own clinical skills and competence up to date (Baid 2011).

I was supporting Mark's development while working clinically as an ANP. This presented its own challenges because often I did not have a medical colleague supporting me and I was conscious of the waiting times in the unit. Baid (2011), in her examination of OSCEs, discussed how disadvantages of this form of assessment include time restraints in clinical practice, alongside the need for large amounts of equipment and tutors. For example, I often found it difficult to find an appropriate space to see patients when I was working with Mark, due to the demands of the unit. This was even more difficult when finding an appropriate space for assessments, and often these were interrupted by the need to find equipment.

Now what?

Reflecting on my experience as Mark's practice educator, I noted how vital his feedback was, and how important it is to build a relationship with students to identify their learning styles and to adapt teaching methods to suit their needs. It is also sometimes important to help students adjust their learning styles, as not all clinical learning situations can be adapted to fit their requirements.

I found that debriefing after each clinical case was essential, and enabled me to focus on Mark's clinical skills and support his continued development where necessary. Debriefings also included Mark's thought process when diagnosing patients, therefore we could discuss his clinical decision-making skills. Finally, this process gave me the opportunity to identify where Mark lacked experience and adapt my teaching accordingly.

I found managing the learning environment in clinical practice difficult. It was not possible to predict when the unit would be quiet, and therefore when the environment would be suitable for teaching, so it was important to use opportunistic learning points throughout the day.

Conclusion

This experience helped develop my knowledge and understanding of supporting nurses' learning at a level beyond registration, and I was able to support Mark in the context of the NMC (2008) facilitation of learning and evaluation of learning domains. I moved from a nurturing role to one where I could support Mark's own learning through debrief and reflection, while using the learning contract we drew up on our first meeting.

The OSCEs were used to evaluate the learning that had taken place in the clinical setting, and by spreading the assessments throughout the year I could highlight learning needs at strategic points. I supported Mark's learning throughout the process by using the 'teachable moments' and encouraging active reflection, thereby capitalising on learning opportunities. By using reflective practice I hope to become a more skillful practitioner who can meet the demands of teaching while working in the fast-paced environment of emergency medicine.

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