The importance of continuity of mentorship in pre-registration midwifery education

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The author would like to thank all the students and mentors who participated in this study and is sorry not all of the voices of those involved are represented in this paper.

Abstract

Background. Grading pre-registration student midwives’ clinical practice was new to the local BSc (hons) midwifery curriculum following its introduction by the NMC. Student midwives must work with a sign-off mentor at least 40% of the time in clinical practice and the mentor assesses the student’s competence and grades their practice.

Objectives. The aim of this study was to explore the importance of continuity of mentorship in pre-registration midwifery education.

Design. A qualitative case study approach.

Methods. Mentor interviews (n=15) and student focus groups (11 groups with 51 student participants from each year group from 2009 to 2013). Ethical approval was obtained from two higher education institutes and a local research ethics committee and then the research and development department of each of the three trusts.

Findings. Continuity of mentorship is essential for students and mentors when practice is graded. For students, a lack of continuity affects their skill development, confidence and sense of connection in midwifery. For mentors, working with the student for long enough periods is essential to be able to grade their practice. For some mentors, especially in the hospital setting, working solely with first-year students was intensive. Community placements seem better able to offer continuity of mentorship.

Conclusions. One or two mentors (co-mentoring) seems ideal to balance the needs of students and mentors. Continuity of mentorship is essential for all practice assessments, but especially the grading process, if it is to be considered fair and robust.

Key words: Student midwives, sign-off mentors, mentorship, continuity, grading practice, evidence-based midwifery

Introduction

The regulatory body for nursing and midwifery in the UK, the NMC, sets the standards to support learning and assessment in clinical practice (NMC, 2008) and the education of pre-registration midwives and nurses (NMC, 2010; 2009). Student midwives are required to spend at least 50% of their time in clinical practice (NMC, 2009), working with a sign-off mentor for at least 40% of this time (NMC, 2008). Clinical practice is where students learn the hands-on care of women and their families under the direct or, later in training, indirect supervision of their sign-off mentor.

In 2009, the NMC introduced mandatory grading of clinical practice within the midwifery curricula, in addition to the assessment of competency, divided into four domains and five essential skill clusters (ESC) (NMC, 2009). Student midwives’ hands-on clinical care is assessed to ensure they meet the ESC and their performance in practice graded by their sign-off mentor.

Aim

This study’s aim was to explore the importance of continuity of mentorship in pre-registration midwifery education.

Literature review

There is a plethora of literature on mentorship in midwifery and nursing showing that positive student-mentor relationships influence students’ self esteem, their sense of belonging, confidence, and the quality of the placement learning (Frazer et al, 2014; Longworth, 2013; Hughes and Fraser, 2011; Webb and Shakespeare, 2008; Levett-Jones et al, 2007; Begley, 2001). Conversely, unhelpful or poor mentoring, such as not enabling the student to practise, negatively affects the student experience (Henderson and Eaton, 2013; Levett-Jones et al, 2009; Licquirish and Seibold, 2008).

The complex clinical environment, with increasing time pressures on staff and lack of time for student feedback, negatively affects the learning environment and there is sometimes a lack of opportunity for students to work frequently enough with their mentors (Bradshaw et al, 2013).

A concept analysis of grading pre-registration practice states a relationship between the student and mentor is required; the mentor shows the required practice performance and the student learns and practises (Passmore and Chenery-Morris, 2012). At the end of the placement, a judgement is made about the student’s performance, often against a rubric or assessment criteria. There are problems with all practice assessments, such as time for mentors to complete the assessment and consistency between assessors; however, specific to grading is the lack of validated tools with which to grade practice (Gray and Donaldson, 2009), in addition to mentor knowledge of how to accurately grade practice (Gray and Donaldson, 2009).

Research design

A qualitative case study design was used, as is common in educational, health and social sciences due to its flexible approach (Swanborn, 2010; Stake, 1995). Stake (1995:
x1) considered ‘case study the study of the particularity and complexity’ of a context-dependent phenomenon that cannot be controlled. Therefore, this approach was fit for purpose in this study setting.

**Setting**

The research was undertaken in one university offering midwifery education in the East of England and its three partnership trusts where students practise. This is usual in case studies.

**Ethical considerations**

Ethical approval was obtained from two higher education institutes and a local research ethics committee and then the research and development department of each of the three trusts. The head of the school and heads of midwifery were written to, requesting permission to recruit students and staff for the study. Confidentiality was respected at all times and names were removed from the data, which was stored on a password-protected computer.

**Recruitment of study participants**

All three-year midwifery students, in their second or third year who started their education in 2009-13 were invited to participate. The shortened midwifery course students from 2012 and 2013 were also invited after their first progression point, where their practice had been graded. Posters asking for sign-off midwifery mentor volunteers who had graded a student’s practice were displayed in the maternity departments and community offices of the three NHS trusts. Mentors were also requested to participate at annual mandatory mentor updates. An information leaflet and consent form was provided for each participant.

**Data collection**

As is usual in case studies, multiple methods of data collection were utilised. Focus groups or group interviews were used to collect data from the student midwives to counteract the potential power imbalance between the researcher, as one of their lecturers, and the students (Anderson, 2011; Morgan, 1996).

The students were in their second or third year of training, so had experience of several clinical placements and had their practice graded summatively at the end of their first and/or second year. The students formed small groups (n=2-6) to ensure they felt safe to discuss their views in front of each other.

There were 11 students in three focus groups in the pilot study in 2011 (Chenery-Morris, 2014) and a further 40 students in eight more focus groups undertaken in 2012 and 2013. In total, 11 focus groups were undertaken as every volunteer was included. A total of nine of these were with direct-entry students and two with 78-week students. All focus groups were undertaken in the university buildings. The pilot study groups were shortest (around 25 minutes), the core phase groups lasted from 44 to 67 minutes.

Mentors were invited to participate in one-to-one interviews as their individual experiences were sought (DiCicco-Bloom and Crabtree, 2006). The mentors were all sign off mentors who had worked at least 40% of the time with the student and had graded their practice. Four volunteered to participate in the pilot study and a further 11 in the core group.

However, one mentor could not meet physically due to differing work patterns so responded to the questions via email and three requested to be interviewed collectively. Some of the midwives were interviewed at work during their break; others came in early or stayed after their shift. The pilot interviews lasted 10 to 18 minutes, the core phase was 18 to 58 minutes, this was usually dependent on whether the midwives were working or not.

A semi-structured schedule of questions was used with students and mentors, based on how practice was taught and evaluated. The interviews were recorded and transcribed by a paid graduate due to the volume of material recorded and the amount of time required for the transcriptions. The researcher was known to all the participants and so the dual role of the status of a colleague or teacher was considered reflexively to help minimise potential bias (McConnell-Henry et al, 2010).

Other forms of data were also collected. These included a group discussion with all five full-time midwifery lecturers working at the study university in 2013, the students’ practice grades and documents such as the curriculum and NMC standards (2009; 2008) were also examined, although these materials are not presented here.

**Data analysis**

The text from the transcribed interviews and focus groups were uploaded to Nvivo 10 to help the qualitative data analysis. As theoretical frameworks for analysing qualitative data can enhance the rigour of small scale research (Anfara and Mertz, 2006), Bernstein’s pedagogic discourse (Bernstein, 2003) was used deductively to help analyse the data. Bernstein’s theory considers the relationship between teachers and students in any educational setting, so the data were read looking for features of the relationship, such as explicit or implicit hierarchy between the mentor and student and who was leading the learning encounters. These were assigned codes in Nvivo 10.

An inductive approach was also used with coding and qualitative description, looking for themes and concepts outside Bernstein’s theory by using nodes created by the researcher on Nvivo 10 (Johnston, 2006). These themes were then looked for across the different focus groups and interviews, as a way of triangulating the data and increasing the confirmability of the themes (Tobin and Begley, 2004).

This paper focuses on one of the inductive aspects of the larger case study: the importance of continuity of mentorship for the student and mentor when assessing clinical practice. The following formula will be used for the words of the participants: student or mentor (S or M) and which trust they worked at (T1, 2 or 3), for students their focus group is stated (FG), and for mentors whether they are hospital or community based (H or C) is noted.
Findings
Participant details are in the tables below. Students and mentors were aware of the importance of continuity of mentorship to enable student and mentor relationships to develop, however, for mentors, the student’s year of practice affected their workload. The relationship between the student and mentor was pivotal, however, there was caution noted regarding the boundary between effective mentorship and developing a friendship and how this affected the grading process. A discourse on the benefit of having more than one mentor was heard from students and mentors alike and some areas of practice afforded greater opportunity for continuity of working together. All of these findings affected the ability of the mentor to grade a student’s practice and the perceived reliability of the grade awarded.

Continuity of mentorship for relationship development
Continuity of mentorship was seen as essential to success on the midwifery course from both three-year and shortened course students’ point of view for a relationship to develop with their mentor:

“T1hink when you’re in practice and you’re with a mentor for 40 or whatever percent you are with your mentor, it is personal because you build up a mentor/student relationship” (S48/T2/FG11).

“If you’ve got a bit more of a relationship when you’re talking to each other they’re (the mentors are) more willing to say, ‘oh come and do this’, or ‘help me do that’, or ‘I’ll show you how to do this’” (S42/T3/FG9).

“And I think it depends on your experience of practice, particularly on whether you’ve got one or two mentors which you work with regularly and you’ve built up a good relationship with, or whether you’ve been passed from pillar to post to a new person every couple of days who doesn’t know what you’re capable of, isn’t comfortable necessarily letting you develop your practice as smoothly as you would if you’ve got that continuity” (S19/T3/FG5).

As students and mentors get to know each other they ‘build up a good relationship’, which is one of the domains mentors are required to demonstrate (NMC, 2008: 25). The relationship is not just about supporting learning; the need to work a minimum of 40% of the time with the student is a regulatory requirement, as S48 noted. The students above (S19, 42 and 48), all from different focus groups, have demonstrated how important building a relationship is: it is personal, enables practice to develop and learning opportunities to be offered. Lack of continuity of mentorship is detrimental to the students’ learning as they feel ‘passed from pillar to post’, and the student has to convince the new mentor to let them practise skills.

Not having continuity or building a relationship with a mentor had a detrimental effect on this student:

“Like I hadn’t connected with anybody because I didn’t have a mentor at all, so I felt like and I still feel I’m sort of six months behind all the time because of that experience” (S33/T1/FG8).

This student was assigned a named sign-off mentor but, for one reason or another, she did not work with her and this left the student feeling like she did not have a connection to midwifery. This had a detrimental effect on her learning and a major effect on her confidence.

Some mentors valued continuity so they could try to meet students’ needs and nurture them:

“I think it is about having that relationship with student(s). Some students come here (obstetric unit) and they looked terrified and it is a scary place, you know. So it’s about sort of just easing them into it over the three years” (M7/T2/H).

“I think when you get someone in their first placement you sort of do (build up a relationship with them) and you’re with them every single day, you quickly build up a little bit of a bond, as they are reliant on you and you feel that you are nurturing them and a major effect on her confidence.

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The students discussed the nature of the relationship with their mentors and acknowledged there was the chance of this becoming too close and impacting upon the grade:

“Yes, because of course you’ve got to have a good relationship but where do you stop at a good relationship and you know socialising with your mentor?” (S5/T1/FG2).

“But it’s human nature to get on better with some people than others and if you get a mentor you get on really well with and it’s the sort of person in a normal life you would choose as a good friend, it is very difficult to then be objective, isn’t it?” (S33/T1/FG2).

Some of the mentors considered their role within the relationship and thought boundaries were necessary:

“I think you’ve got to keep a certain distance (in

Table 1. Student participants

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Number of students and number of focus groups</th>
<th>Cohort size</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 (3 year)</td>
<td>11 students (3 groups)</td>
<td>11/16 = 68%</td>
</tr>
<tr>
<td>2010 (3 year)</td>
<td>2 students (1 group)</td>
<td>2/11 = 18%</td>
</tr>
<tr>
<td>2011 (3 year)</td>
<td>11 students (2 groups)</td>
<td>11/17 = 62%</td>
</tr>
<tr>
<td>2012 (3 year)</td>
<td>16 students (3 groups)</td>
<td>16/21 = 76%</td>
</tr>
<tr>
<td>2012 (shortened)</td>
<td>5 students (1 group)</td>
<td>5/6 = 83%</td>
</tr>
<tr>
<td>2013 (shortened)</td>
<td>6 students (1 group)</td>
<td>6/6 = 100%</td>
</tr>
<tr>
<td>51 students in total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Mentor participants

<table>
<thead>
<tr>
<th>Trust 1</th>
<th>Trust 2</th>
<th>Trust 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 midwives</td>
<td>5 midwives</td>
<td>6 midwives</td>
</tr>
<tr>
<td>2 community</td>
<td>2 community</td>
<td>3 community (1 in pilot)</td>
</tr>
<tr>
<td>2 hospital</td>
<td>3 hospital</td>
<td>3 hospital (3 in pilot)</td>
</tr>
<tr>
<td>1 hospital midwife answered questions by email, 3 asked to be interviewed together</td>
<td>All interviewed individually</td>
<td>All interviewed individually</td>
</tr>
</tbody>
</table>
relationship, anyway, I don’t do Facebook with students… I won’t say we’ve never socialised with students as sometimes we have… you’ve got to keep a sort of boundary” (M6/T2/C).

“Not that I’ve made deep friendships with any of the students and gone out with them or anything like that because from my point of view that doesn’t feel right as they are still students. I kind of keep work and private lives quite separate” (M8/T3/C).

Working with students from different years

However, some of the mentors found the relationship between the student and mentor intense, especially in the first year of direct-entry training:

“The more along in their training, the easier it is to be a mentor, obviously, I do find sometimes the first years are quite challenging especially when you have to prompt them… when you’ve got a first year it’s like for six or seven weeks every shift with you and it is a lot” (M3/T3/H).

“If you’ve got a third-year, very competent student, it makes your life a little easier in some ways because you can share the workload a bit. If you’ve got a brand new first year, that’s really difficult, but you just have to get on with it, don’t you?” (M11/T1/H).

“It is quite time-consuming because you want to show them (the student). With a third year, they are helping you with the paperwork, with a first year, you’re having (to) talk through the whole way” (M10/T1/H).

All three of these mentors (M3, 10 and 11) work in a busy hospital environment, which might have proved a barrier to their mentoring first-year students. Initially, there is such a lot to teach the first-year student midwives and, in an environment where the mentor is already busy, this is more work. However, as they note, later in the student’s training they can share the workload.

The benefits of working with more than one midwife

A discourse in practice about the benefits of working with more than one midwife was heard from several sources; perhaps this combats the intensity of mentoring and prevents dependent relationships developing:

“I think they (students) could work with different mentors in different areas clinically because I do think it’s important to work with other people as well because otherwise you just end up with clones” (M1/T3/H).

“If you’re only ever working with one mentor… you don’t want to morph into her. I’m not saying that’s a bad thing if she’s good, but I think you kind of get quite comfortable, you get too comfortable with one” (S24/T1/FG6).

“There are benefits to working with different midwives cause now I can see a range of different ways… whereas I know that’s not the one way that you can do it, I know that there are several ways to do it and then I can formulate my own decision about how I want to practise, so there are benefits to working with different people but when it comes to grading, you need to, I think you need to have continuity, definitely” (S26/T1/FG6).

“I think it’s nice to work with different people, but there’s working with different people and having continuity if you like. Two different midwives in a four-week placement, your mentor and your sign-off mentor and then there’s Lydia’s (pseudonym) experience, which I witnessed on several occasions, ‘oh you go with her’, and you had nine different midwives” (S36/T2/FG8).

There is clearly a balance between working with too few and too many mentors. At certain points in their midwifery education, students and mentors feel it is beneficial to work with a range of midwifery mentors. The students think their learning develops and it takes them out of their comfort zone so they can develop their own style by seeing a range of midwifery practices. One of the articulated risks of working too closely with one mentor is becoming too like them, as demonstrated in the words ‘clone’ or ‘morph into’. However, students work in all areas of midwifery practice with several mentors over their course, so it is unlikely they will actually become too similar.

Different areas of practice

Working in the community was often described as affording better continuity. Most of the students had good continuity of mentorship in these placements. The nature of the work in the community means the student and the mentor are physically together for most of the day, whether travelling between visits, in a woman’s home or in a clinic setting:

“I think they do build up a very different relationship in community to what you do in hospital” (S23/T2/FG6).

“I think mentors in the community as well, they see more of your practice and your communication, everything like that because they are with you all the time, whereas in the hospital the midwives tend to leave you with the women on your own for periods of time to see if you build your confidence up on your own but they don’t actually see what you’re doing” (S24/T1/FG6).

“In community doing the booking interview your mentor is there and I’ve got like a really good relationship with my mentor and it’s like she’s not there” (S39/T2/FG9).

For these students, the mentor’s presence in the community is reassuring. S24 is more critical of the hospital midwives’ ability to assess her performance as the midwife is not omnipresent. The space mentors gave students in the hospital to communicate with women, undertake observations and provide care, was sold as confidence building, yet S39 feels confident with her mentor being present as it is like she is ‘not there’. This is reiterated by a community mentor who enables the student to feel relaxed and develop her own style of undertaking a booking interview:

“In a booking interview, the student talks constantly for 45 minutes if she’s doing the whole thing, and if you feel that somebody is watching you the whole time, if you’ve got a good relationship with them then you think well, you know if I say something wrong I know she’s not going to humiliate me in front of the woman or whatever. I think you feel like then that you can develop more of your individuality like that” (M9/T3/C).

Working together means both the midwife’s actions and communications with others and the student’s performance are directly visible for each other. Not only does the student...
learn midwifery, but they also get to know the midwife and relax in their presence as their skills develop. Then when the midwife assesses the student’s performance, the student generally feels this is a fair assessment.

Need for continuity of mentorship to grade students’ practice
The study university introduced grading in 2009, so it was new for all involved. Mentor workshops were undertaken to prepare midwives prior to introduction. The local validated grading process involves a student and mentor independently awarding a grade aligned to the performance criteria and their grades are discussed and sometimes negotiated in the presence of the lecturer at a tripartite meeting.

One mentor discusses her first experience of grading a student’s practice:
“I didn’t feel prepared but because it’s easy to do. I was prepared in the sense that I’d worked with the student enough... I had to sit and obviously read through it (the grading criteria) so it took quite a long time, but I don’t think that’s a difficult thing to do if you, the most important thing is that you work with the student enough... I don’t think you can make the distinction between the grades if you don’t know them (the student)” (M1/T3/H).

Here, the mentor is describing her experience and for her, working with, and coming to know, the student is essential to assess their performance level. Students also considered continuity to be essential for the grading process:
“I had good continuity with mentors, (it) made a huge difference, and actually I get on really well with my mentors. Every mentor that has graded me, we’ve been on the same sheet so, (interrupted by another student)” (S40/T2/FG9).

When this student says they were on the same sheet, she may have mixed two metaphors ‘on the same page’ or ‘singing from the same song sheet’. The respective metaphors mean agreement with one another or presenting a united front in public. This student is also talking about the tripartite meeting where she and the mentor discussed the performance grade in front of a lecturer. She is saying there was no need to negotiate the grade, as they both agreed and said the same thing in front of the lecturer. This was due to the continuity and development of the relationship between the two of them.

The students felt continuity of mentorship increased the reliability and validity of the grading process:
“I had my community midwife come with me (to the tripartite grading) and she was fantastic and we’d worked together for four weeks and we really got to know each other and I felt my grading was quite fair” (S30/T1/FG7).

Student 30 describes her positive experience, which she attributes to the continuity of her mentorship. The words ‘fantastic’ and ‘really’ demonstrate how positive the experience was. Another student also thought this time together made the assessment of her performance fair:
“I am not sure you have to have a continuous practice with your mentor, because sometimes it is not possible and you spend more time just with different people... I must admit that with my last mentor, who was in the tripartite with me, we spent about 90% of the time so that was really, really positive on the impact that they had, because she remembered different situations and still remembers different experiences and we had the time to sit and chat to her about different events, so that was really positive” (S49/T1/FG11).

During the tripartite meeting, S49 is reassured by the mentor’s reflections of her practice, which contribute to the grade awarded, thus reinforcing her positive experience due to having spent so much time with the mentor. Without continuity of mentorship, students have reduced confidence in their mentor’s ability to grade their performance. The next vignette shows a student who was supposed to have her practice graded by her delivery suite mentor but because of the lack of continuity, after discussion with her personal tutor, she asked the mentor from her previous placement in the community to undertake the assessment:
“I had rubbish continuity on CDS so I chose my community mentor because I was with her every day” (S36/T2/FG8).

This demonstrates again how positively student midwives value continuity of mentorship and its relationship to their graded performance and, in this study, it was more likely to happen in their community placements.

Discussion
The discussions and experiences of the students and midwives in this study are similar to the nursing literature on mentorship. The nursing literature focuses mostly on assessment of competence not grading performance, where the relationship may have a bigger impact upon the grade awarded. Establishing and maintaining a relationship with a mentor is essential for student midwives and mentors alike and perhaps more importantly when a student’s practice is graded. For optimal learning in clinical practice, students need a sense of belonging. In a seminal text on nursing students’ socialisation (Melia, 1987), fitting in or a sense of belonging was a key theme. A sense of belonging was also a prerequisite to learning in clinical practice for 18 nursing students across the UK and Australia in interviews (Levett-Jones and Lathlean, 2008). A midwifery study corroborates these findings (McKenna et al, 2013); mentors can have a positive effect on students’ sense of belonging. These studies resonate with this paper; the positive effects of continuity of mentorship help the students to connect with their mentor and progress in their learning. Not connecting, due to a lack of continuity of mentor, was considered detrimental to a student’s development. The relationship can also affect the grade awarded and has been cited as the cause of grade inflation and failure to fail (Speer et al, 2000).

The burden of establishing and maintaining effective mentoring relationships is documented in nurse education (Webb and Shakespeare, 2008). To get competencies signed off and have productive placements, students need to engage in emotional labour (Webb and Shakespeare, 2008). This was also seen in the current study – with a better relationship, the students were more able to discuss their progress and areas to work on to get a higher grade. Learning their mentor’s preferences (Gray and Smith, 2000) in nurse education was
key to the assessment process; this too was evident in the discussions with the student midwives, with students often wanting a day or two to observe their mentor’s practice. Building relationships was the major theme of a Swedish study of student midwives on labour wards (Brunstad and Hjälmhult, 2014). The students had to be accepted by the midwives before they could begin their learning journeys; they achieved access to the learning through this acceptance. Students also had to tune into their mentors’ ways (Brunstad and Hjälmhult, 2014); a feature identified in this study as well. A positive mentor/student relation was seen as pivotal to student learning (Licquirish and Seibold, 2008).

In this study, having a first-year student was said to be hard on mentors, especially in a busy hospital environment. However, in another study (Fisher and Webb, 2008), it was the community midwives who found some aspects of mentoring challenging. Fisher and Webb (2008) attributed the longer student midwifery placements in the community and some changes to the local service delivery to the mentor difficulties. They postulated community mentors might need an occasional break from students. A resolution might be to co-mentor first-year students with students working exclusively with one of two mentors, perhaps one full-time and the other part time, so the whole workforce shares the responsibility of mentoring students. This would be beneficial for students to have a sense of belonging and for mentors to have a break form the intensity associated, especially in the hospital, with first-year students.

The importance of continuity, especially in the first year of midwifery training, was explicit in Hughes and Fraser’s (2011) study of 58 UK student midwives. In the second year of their training, the students were looking at the mentors as role models for their future qualified practice and the opportunity to work with different mentors was beneficial (Hughes and Fraser, 2011). This study also noted the difference between community and hospital mentorship, with community appearing to be more receptive to students. The demand on staff in the hospital seemed to be a barrier to mentoring. This was definitely reiterated by students and mentors in this paper.

This feature of hospital staff feeling pressurised to get through the workload is reminiscent of Hunter’s emotional labour study of hospital-based midwives (Hunter, 2004). In the community, the midwives tended to have a more woman-centred approach (Hunter, 2004). This might explain the difficulties of hospital midwives in managing the competing needs of the woman and students in their care as the hospital midwives are already working hard at managing their emotions in a busy clinical environment (Hunter, 2004) and having one further competing demand – a student – exacerbates their work- and emotional load. The busyness of the hospital environment is a recurring feature in the literature where students felt less supported in the hospital than the community (Kroll et al, 2009).

Community placements seem to offer greater opportunities for continuity of mentorship. The learning in clinical practice is more visible, as the mentor is able to directly supervise the student. In the hospital, there was talk of indirect supervision being common, which left students feeling their skills were not always seen. In another study, students engineered their off-duty to reduce the time they worked with a poor mentor (Gray and Smith, 2000). In this study, one student chose a different mentor to grade her practice, as she had not had effective continuity of mentor in one of her placements and was not confident the mentor would grade her fairly.

However, depending on the relationship between the mentor and student, this direct observation can seem intense. This correlates with literature on guiding or controlling hands in midwifery and hawks and doves in medical education (Hughes and Fraser, 2011; McManus et al, 2006). The hawks hovered above students and made them nervous while the doves were calm and reassuring (McManus et al, 2006). Mentors who stepped in too soon, or made students feel self conscious were seen as controlling, while being able to practise without feeling overly scrutinised enabled students to learn (Hughes and Fraser, 2011).

Integral to the role of mentoring (Lennox et al, 2008) is confidence building, rather than assessment. This has been called role confusion (Bray and Nettleton, 2007) as the mentor is both the assessor and supporter. The students in the present study felt continuity and achievement with one or two mentors gave them confidence, and lack of continuity caused a lack of confidence. The assimilation of both roles, supporter and assessor, may be undertaken more easily by mentors with greater continuity of working together with one student. The reciprocal nature of knowing each other seems to be needed for students’ to feel happy with their grades and for mentors to grade students’ practice.

Conclusion

This paper has considered continuity of mentorship and its affect on grading student midwives’ practice. Key themes included the relationship development between the student and mentor. Whether the minimum standard of 40% of the time with a mentor is sufficient, especially in the first year, needs to be explored further. An early lack of continuity and associated lack of connecting can have lasting effects on the student’s progress.

There were differences in perceived effort when mentoring first-year students, particularly in the busy hospital environment. Perhaps co-mentoring first- and second-year hospital-based students would help address the competing mentor and student needs of intensity versus a sense of belonging.

Continuity of mentorship is the best way for students to develop, at least initially, in their education. What this paper adds is the relationship between continuity of mentorship and the need to grade students’ clinical practice. Continuity in community placements seems to be easier to achieve and the nature of community student midwife relationships and working practices seem to offer more visible midwifery care and communication.

The mentor and student need time to develop their relationship so the student knows what the expected performance or skill looks like and can demonstrate this.
References

Anderson G. (2011) Students as valuable but vulnerable participants in research: getting the balance right using a feminist approach and focus groups. Evidence Based Midwifery 9(1): 30-4.


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