

Newly qualified nurses' early experiences of working as unqualified mentors

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Abstract

Although a wealth of research examines varying facets of mentorship within nursing, to date, the voices and perspectives of newly qualified nurses working as mentors without formal preparation have largely been excluded from the literature. This research stems from three exploratory studies undertaken as part-fulfilment for this EdD. These preliminary studies identified the questions that, to date, have not been answered in the literature. This initial work provided impetus for the focus of this dissertation and ultimately led to the conceptual framework laying the foundation for the aims and research questions. The research questions asked were how newly qualified nurses are prepared for mentorship; how they acquire knowledge and skills for mentorship in the reality of practice; how they transition into the mentor role whilst still novice staff nurses; and, finally, how they identify as mentors.

This study presents a qualitative, constructivist interpretation of newly qualified nurses' early experiences of working as unqualified mentors. Using the principles of Smith et al.'s (2013) Interpretive Phenomenological Analysis (IPA) framework, a qualitative hermeneutic approach guided the research process and the analysis of transcribed interview-texts. Four superordinate themes emerged from the data. These were: 1) *Proactive Strategies in Becoming Prepared*, where participants took a pragmatic, hands-on approach to mentoring, took an active personal involvement with reflection on past experiences of being mentored, and sought ways to find emotional support; 2) *Experiential Learning*, where participants engaged in active learning and learnt from their peers and through trial and error and the use of intuition; 3) *Development of Resilience in Transition*, where participants learnt to cope with transitional shock, but experienced being in a liminal phase during their transition; and 4) *Attaining Professional Identity*, where participants sought the approval of others as professional mentors to attain professional identity. Having a sense of belongingness to a professional group provided participants with the professional identity they strived for to be valued as part of the mentorship team.

This study challenges and contributes to the existing body of knowledge and professional practice in four ways. Firstly, the findings narrow an existing gap in the mentorship literature and advances understanding of the experiences of newly qualified nurses who support students in everyday practice. Secondly, the findings contribute to the existing concepts of preparedness, professional identity, transition, and ways of learning in the context of mentorship. Thirdly, although there is a plethora of studies around mentorship, this is the first study to explore newly qualified nurses' experiences of working as unqualified mentors before undergoing formal preparation. Finally, this study will help inform educators and policy makers and enable them to enhance further the preparation of nurses for the new role of practice supervisor.

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Finally, I would like to thank the University of Hertfordshire for believing in my ability to do this doctorate and providing me with the direction, opportunity, time, and finance to carry out this work. Thank you.

Dedication

I dedicate this work to Dr Jo Cahill. You are truly a wonderful friend, and you will always be an inspiration to me. You are the reason I am where I am today. This is for you.

Thank you.

Presentation and Terminology

The first-person pronoun has been used in this dissertation to signal the voice of the researcher. It is the intention that using the first person will allow the reader to understand that this dissertation is a social construction of knowledge with a personal style of narrative. Italics are used in this dissertation to denote points of emphasis or to draw attention to comments made by the participants. The name of each participant has been replaced with a pseudonym in order to protect their identity. For this study, the term 'participant/s' refers to newly qualified nurses who volunteered for this study. It should be noted that the term 'unqualified mentor' is used interchangeably with that of stage 1 mentor. Both terms are used to depict the newly qualified nurse who had not yet completed the Preparation for Mentorship module.

Clinical Placement – The clinical placement is where pre-registration learning for nurses takes place in practice settings. These practice settings could be hospital wards and departments, the community, private hospitals, or schools. The concept of clinical practice refers to a learning environment in which student nurses practise clinical skills under the guidance of a mentor (Jokelainen et al., 2011).

Co-mentor/Associate Mentor – Co-mentor or associate mentor are informal terms for a registrant who supports student learning under the guidance and supervision of a stage 2 mentor. These terms were used for those nurses who were informally allocated to supervise and support a learner, and where co-mentors collaborated with stage 2 mentors to make decisions about student progress (Nursing and Midwifery Council (NMC), 2006). Although used by some of the participants, the terms 'co-mentor' and 'associate mentor' were replaced with the term 'stage 1 mentor' since the NMC published the Standards to Support Learning and Assessment in Practice (SLAiP) in 2008.

English National Board for Nursing, Midwifery and Health Visitors (ENB) – Established in 1979 under the aegis of the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC), reflecting its responsibilities for registration and the maintenance of standards in the nursing professions in England, the ENB was later replaced by a more strategic and streamlined Nursing and Midwifery Council (NMC) in 2002.

Interpretive Phenomenological Analysis (IPA) – Interpretive phenomenological analysis is an approach to psychological qualitative research with an idiographic focus, which means that it aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon.

Registered/Graduate Nurse – A registered nurse/graduate nurse/qualified nurse (terms used interchangeably in nursing literature) is a nurse who has successfully met the learning outcomes of an approved pre-registration programme in an approved Higher Education Institution and who has subsequently registered with the Nursing and Midwifery Council.

Mentorship – Mentorship refers to the guidance provided by a mentor, especially an experienced person in a company or educational institution such as a university who in this context prepares students for the nurse or midwifery role.

Mentor – General definitions of a mentor in the wider literature may be associated with terms such as supervisor, preceptor, teacher, guide, friend or advisor. For the purpose of this study, a ‘mentor’ refers to a nurse who, one year post-qualification, has completed an NMC-approved mentorship preparation course to become a qualified stage 2 mentor (see **Stage 2 Mentor** definition, below).

Mentee – The mentee is advised by the mentor, working in partnership in a two-way working relationship between the mentee and mentor. For the purpose of this study, the mentee is the nursing student.

Module Leader – A module leader is a member of academic staff ultimately responsible for the academic leadership, management and assessment of modules that they have been designated to lead on.

National Health Service (NHS) – The NHS is the publicly funded healthcare system in England and is free at the point of use. The NHS provides opportunities for students of healthcare to work in placements where teaching, learning and assessment can take place.

Newly Qualified Nurse – For the purpose of this study, a newly qualified nurse refers to a participant who volunteered for this research and who has been registered with the Nursing and Midwifery Council for less than two years.

Nursing and Midwifery Council (NMC) – The Nursing and Midwifery Council is the professional regulator for nurses, midwives and nursing associates working in England and Wales. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK. Its role is to protect the health and wellbeing of the public, and set standards of education, training, conduct and performance so that nurses and midwives can deliver high-quality healthcare consistently throughout their careers.

The NMC Developmental Framework – The SLAiP (NMC, 2008) had outcomes for mentors, practice teachers and teachers and were outlined in a single four-stage developmental

framework for nurses and midwives (Figure 2 refers). The NMC defined this as ‘a framework that defines and describes the knowledge and skills nurses and midwives need to apply in practice where they support and assess students undertaking NMC approved programmes that lead to registration’ (p. 3). The framework provided four stages: those of nurses and midwives (stage 1), qualified mentors (stage 2), practice teachers (stage 3) and teachers (stage 4). These four stages had been designed to allow nurses and midwives to map against the outcomes within the stages, evidence of development in knowledge, skills and competence related to supporting learning and assessment in practice. Not all of the stages applied to mentors in practice. Stages 3 and 4, which related to practice teachers and teachers, are not addressed in this study.

Practice Supervisor – According to the new Standards for Student Supervision and Assessment (SSSA) (NMC, 2018c), a practice supervisor can be any registered healthcare professional who is capable of supervision, serving as a role model for safe and effective practice. The NMC particularly states that whilst a practice supervisor may need to be ‘prepared’ in some way before supervising students, this does not necessarily mean they must undergo a formal preparatory course. ‘*Practice supervisors support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills*’ (NMC, 2018c, 3.3). Roles and responsibilities of the practice supervisor can be found in Appendix 2.

Practice Assessor – According to the Standards for Student Supervision and Assessment (NMC, 2018c), the practice assessor role is to conduct assessments to confirm student achievement of proficiencies and programme outcomes for practice learning. The practice assessor is responsible for the evaluation of student performance in the practice placement.

Preceptor – A preceptor refers to a registered practitioner who, after one year post-registration, has been given a formal responsibility to support a newly qualified practitioner through a preceptorship programme (Department of Health, 2010).

Preceptorship – This is a period of structured transition for the newly qualified nurse during which he or she will be supported by a preceptor to develop their confidence as an autonomous professional, to refine skills, values and behaviours, and to continue on their journey of life-long learning (Department of Health, 2010, p. 11). This period is usually from six months to one year post-registration.

Preceptee – Whilst engaged in preceptorship, the newly qualified nurse is sometimes referred to as a ‘preceptee’.

The Pre-Registration Student – This is an individual who is typically enrolled on an approved programme of undergraduate study, which has registration with a health or social care professional regulatory body as its endpoint. In this study, when the term ‘the student’ is used, it refers to a pre-registration nursing student.

Programme Leader – Each programme within the university has a designated programme leader who works closely with module leaders and has overall responsibility for delivering the programme. Programme leaders are responsible for the day-to-day management and leadership of the programme.

Sign-Off Mentor – This is a qualified nurse or midwife who has met the additional criteria specified by the NMC in order to be able to sign off a student’s practice proficiency at the end of an NMC-approved programme. A sign-off mentor is nominated for the role by their manager/ employer and has successfully completed preparation for the role of sign-off mentor:

- In midwifery, a sign-off mentor conducts all summative assessments.
- In nursing, a sign-off mentor conducts the final summative assessment for a third-year, final placement student nurse.

Standards for Student Supervision and Assessment (SSSA) – The Standards for Student Supervision and Assessment (SSSA) (NMC, 2018c) replaced the SLAiP (NMC, 2008) and have been in effect since January 2019. These standards set out the NMC’s expectations for the learning, support, supervision and assessment of students in practice and were implemented across all approved education institutions and practice-learning partners by 2020.

Stage 1 Mentor or Unqualified Mentor – A stage 1 mentor was a registered nurse or midwife who had not yet completed the stage 2 mentorship programme. A stage 1 mentor facilitated learning and contributed information to stage 2 mentors to enable assessment decisions. The domains associated with the roles and responsibilities of this stage can be found in Appendix 1.

Stage 2 Mentor – A stage 2 mentor, according to the Nursing and Midwifery Council Development Framework (NMC, 2008), was a registered practitioner who had undertaken an approved mentorship programme of study and supervised and assessed students. Nurses and midwives became stage 2 mentors when they successfully achieved all the outcomes of this stage. This qualification was then recorded on the local register of mentors. To become a stage 2 mentor, the nurse had to study a Preparation for Mentorship module at an approved Higher Education Institution (HEI). The module was studied over one semester and could be

for academic credit or without. A stage 2 mentor was responsible and accountable for student assessment and progression throughout and at the end of their placements. It was this responsibility that was the main difference between stage 1 and stage 2. A stage 2 mentor in nursing formally evaluated the performance of the mentee to ensure placement-learning outcomes had been met. Stage 2 mentors had to work for a minimum of 40% of their time with students.

The United Kingdom Central Council (UKCC) – The UKCC used to be the regulatory body for nursing, midwifery and health visiting. Its duty was to establish and improve standards of nursing, midwifery and health visiting care in order to serve and protect the public. The UKCC was replaced by its successor body, the NMC, which came into being in April 2002.

Chapter 1: Introduction and Setting the Scene

1.0 Introduction to Chapter

This introductory chapter provides an overview of how the current study was conceived and positioned from exploratory work undertaken prior to the main study. The positioning of this research was influenced partially by the three small-scale studies undertaken in the first year of the Doctorate in Education (EdD) programme and provides the impetus for its focus. Positioning myself in this research is made explicit and identifies me as a person, a nurse, a mentor, a teacher and a researcher. Mentorship is defined and detail is provided as to how mentorship has evolved in nursing education. The research aims and research questions for the study are then presented, followed by an outline of how the dissertation is organised in the seven chapters.

1.1 Positioning the Current Study

At the time that the data was collected for this study, mentorship in the UK was provided for pre-registration nursing students by nurses who had undergone an approved mentorship programme of study (NMC, 2008) and was fundamental to practice-based learning. Mentorship was a progression obligation of nurses (Meier, 2013) and a key construct of nursing education and practice.

This submission describes the early experiences of eight newly qualified nurses who had not yet completed the approved mentorship programme, but mentored students as novice nurses. My interest stems from my own experiences as a nurse, a mentor and a module leader for nurses preparing to be mentors. At the very beginning of my Doctoral journey, small-scale studies were encouraged to develop skills in data collection and analysis. The findings from these were then used to illuminate my emerging conceptual framework (Figure 1 refers) and enabled me to draw together my preliminary ideas and questions, thus establishing the 'golden thread' for the main study. This 'golden thread', as James and Slater (2014) explain, is how the central argument pulls together the dissertation and creates coherence across the submission. Although developing a sufficiently strong 'golden thread' was a process that took time, strengthening the conceptual framework provided a sound basis.

Miles and Huberman (1984) defined a conceptual framework as a visual or written representation of key concepts that need to be explained or studied. Hence, when key concepts are combined together, an integrated conceptual framework emerges that informs the research design and allows for a rich interpretation of data. The framework illustrated in Figure 1, shows the key concepts from the small-scale studies, namely, preparation for

mentorship, mentorship identity, ways of learning mentorship, and transitioning into mentorship. These emergent key concepts from the small-scale studies needed to be explained and studied further. This conceptual framework thus informed the development of the aims and research questions for this study and enabled me to establish the methodological direction of this study. Understanding how these different concepts frame this study is integral to this study.

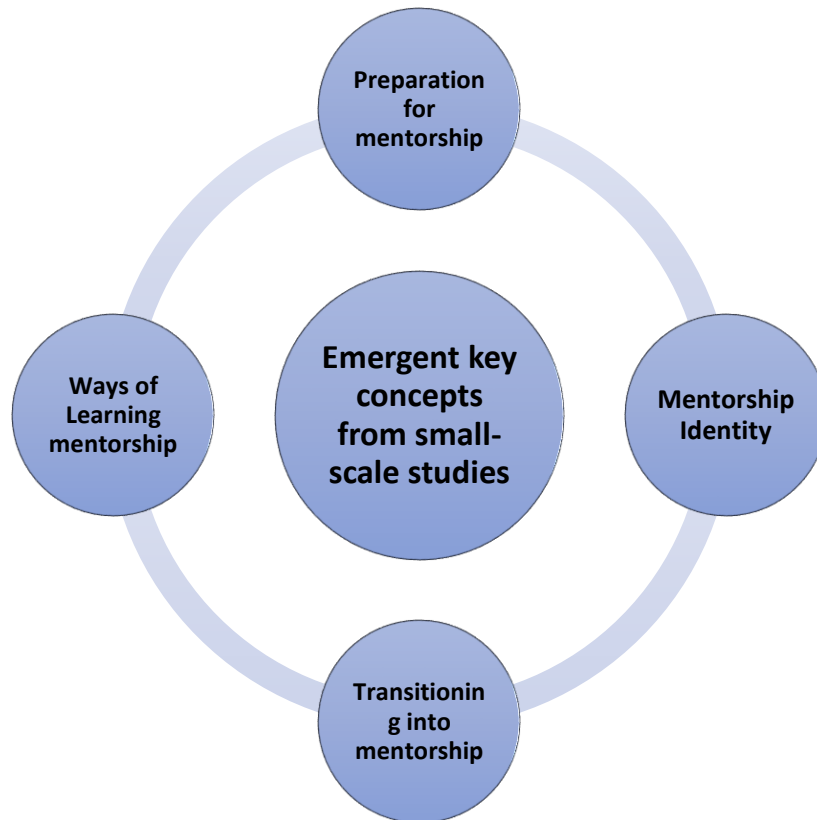


Figure 1: Conceptual framework

This process of developing the conceptual framework had several stages. Firstly, I set out to explore, through focus group enquiry, what third-year student nurses understood by mentorship and whether they felt ready to carry out this role expected of them as stage 1 mentors. The pre-registration nursing programme is designed to equip nurses with the practical skills and knowledge so that they are prepared and ready to carry out their role effectively. However, concerns were raised in the focus groups where student nurses perceived that they were not prepared nor ready for mentorship and did not know what was expected from them. I wondered then, if final-year students had little awareness of the stage 1 mentor role, how could they be prepared for mentorship? Preparedness for mentorship is conceptualised as being ready, willing and able to work as an unqualified mentor. Thus, it seemed pertinent to find out how a newly qualified nurse prepares for mentorship and that this was worthy of further exploration.

Following the focus groups, I interviewed via telephone nursing lecturers from five Higher Education Institutions (HEIs) to explore how each prepared their nursing students for the stage 1 mentor role. Concerns were raised around the challenges that nurses face when transitioning into becoming a nurse. I again wondered, if student nurses were facing challenges becoming a nurse, then when they became a nurse, did they face the same challenges transitioning into the stage 1 mentor role? Transition into the mentorship role, therefore, provides a basis for considering the transitional process that stage 1 mentors experience when introduced to the mentorship role. Transition into mentorship is conceptualised as a fundamental process of progression from newly qualified nurse to becoming and being a stage 1 mentor. Thus, transitioning into the mentorship role was also worthy of further exploration.

Later, through World Café enquiry (Slocum, 2005; Balata, 2018), I sought from a group of fifty stage 1 mentors who were on the Preparation for Mentorship programme, their experiences of mentorship up to the point of their attendance. They spoke of the need to fit in as professionals working as part of the mentorship team. Conversations suggested that there was dissatisfaction with how they were perceived and how they felt unrecognised for their contribution to student learning. Exploring how stage 1 mentors construct their identity is fundamental to finding out how they internalise their sense of belonging. This led me to consider the concept of mentorship identity as worthy of deeper exploration.

They also spoke of how they executed the mentorship role up to attending the programme but could not articulate how they acquired mentorship skills at the same time as learning to be a nurse. This led me to wonder how stage 1 mentors acquire mentorship knowledge and skills for mentorship in practice and how they came to know what to do, which is central to understanding further how educational strategies could be developed to support the newly qualified nurse. It was after this World Café enquiry that I realised that ways of learning the stage 1 mentor role was far more complex than I had ever imagined and was worthy of further exploration.

The emergent issues that stemmed from this exploratory work became a driving force for this study. Carrying out this work at the beginning of my EdD journey helped me to move from a scoping mind-set into a more focused approach to carrying out this study. Furthermore, the exploratory studies helped determine the research design and data collection method, and ultimately led me to investigate a topic on which little or no research had been done. As a novice researcher, carrying out this exploratory work not only gave me the opportunity to practise collecting data but enabled me to develop interviewing skills and competence, and, at the same time, learn from my experiences. These studies, therefore, were not included in their entirety; instead, the conceptual framework that emerged helped lay the foundation for

the aims and research questions for this present study and form the basis of more conclusive research.

1.2 Positioning Myself in this Study

By providing insight into my professional background as a nurse, academic and researcher, my aim is to enable the reader to see who I am in each of these roles. Throughout my own pre-registration nursing programme, I was supported on my placements by a variety of different levels of healthcare professionals, both qualified and unqualified. These healthcare professionals informally mentored me, but the statutory concept of mentorship in the context of nursing did not yet exist. Their role was simply to support and guide me as a student and provide me with clinical experiences in order to be successful in the placement. The clinical nurse tutors from the School of Nursing housed within the hospital site would then come and assess competence in the clinical placement.

Once I became a qualified nurse in 1983, it was expected that supporting students would become part of my staff nurse duties. I felt neither ready nor prepared to take on the responsibility of supporting students, so I experienced similar challenges to the nurses interviewed within this study. Transitioning into practice was a challenging time where nursing skills needed to be acquired on top of taking responsibility for students. Although I recognised that teaching and supporting students was part of being a qualified nurse, my understanding of being ready or prepared was influenced by the expectation that professional practice involved passing on knowledge to the younger workforce. There was no choice; this was an expectation of being a nurse and was a requirement of the Code of Professional Conduct at that time (UKCC, 1984).

I began working at the university in 2002, and later became a Module Leader for the Preparation for Mentorship module, which at the time had over 300 qualified nurses attending every year. This module was for both nurses and midwives who wished to formalise their role as mentors. The nurses undertaking the mentorship programme, over the years, have always informally shared with me their stories of mentoring students from the point of registration. What was apparent from their narratives was that they worked with and supported students from a very early stage in their careers. I could not find any research that explores the phenomenon of nurses working as stage 1 mentors. Realising there was a gap in the literature, I felt encouraged to delve deeper into the world of mentorship, but from the perspective and experiences of newly qualified nurses in the role of mentor without preparation.

During my Doctoral journey, my position changed from Module Leader to Programme Leader for a pre- and postgraduate degree programme. Being the Programme Leader meant I was no longer the Module Leader, but still had responsibility for the mentorship module. My joint role as academic and researcher made it necessary to interrogate and reflect my own feelings, assumptions and beliefs about mentorship by starting a reflective journal. This ability to reflect and question my own biases and assumptions enabled me to document in my research journal the influences of my prior knowledge and experiences and consider my ontological perspective. Willig (2012) asserts that, when aiming to produce new knowledge through research, the researcher must consider the assumptions they hold about the nature of the world (ontological perspective) and how they know these things (epistemological stance). Ontology and epistemology are discussed further in Chapter 3, Section 3.3.

1.3 Defining Mentorship

Mentorship in nursing is often misunderstood, with many different definitions and terms found in the literature. Crisp and Cruz (2009) discovered 50 definitions of mentoring in social sciences, concluding that there needed to be a clearer definition of mentoring. The word 'mentor' relates to '*mens*' in Latin, which means 'to think' and has always had connotations of advice and support from someone who is older and more experienced, in a 'trusted friend' capacity rather than as a teacher (Campbell and Campbell, 1997; Asbee et al., 2000; Good et al., 2000; Garvey et al., 2009). Good et al. (2000) asserted that the practice of mentoring in healthcare has been popular for over three decades, and over that time has become an approach used to provide role models for pre-registration student nurses undertaking professional degree studies. Gray and Smith (2000) selected the term 'mentor' to describe staff nurses who assisted students throughout their course whilst on practice placement. Further, Kilcullen (2007, p. 97) described the term 'mentor' as an experienced first-level nurse who would facilitate learning for student nurses and was identified for teaching and assessing student nurses in clinical practice. However, Kilcullen's definition does not reflect the complexity of what mentorship involves in contemporary nursing.

Later, Lord et al. (2008) defined 'mentoring' as being concerned with 'growing an individual' both professionally and personally and as linked to career development characterised by an expert–novice relationship. Mentorship and supporting people in the workplace enhance the employee's motivation and professional development (Gopee, 2015), not only in nursing but in other professions such as medicine (see Healy et al., 2012), pharmacy (Katajavuori et al., 2005), teaching (Fagan and Walter, 1982) and the police force (Dick and Metcalfe, 2007; Carson, 2009). Though the mentor role in these other professions is undeniably important,

mentorship in these contexts has been linked to career development and growth rather than for teaching and assessment, as is the case in nursing.

There have been so many definitions of mentors, mentoring and mentorship over the years and general definitions of a mentor in the wider literature may be associated with terms such as supervisor, preceptor, teacher, guide, friend or advisor. At the time, the NMC definition of a mentor (NMC, 2008, p. 45) was '*A registrant who has met the outcomes of stage 2 and who facilitates learning and supervises and assesses students in practice settings*' and this has been adopted for this study. However, there still needs to be a clearer role definition so that nurses working in the new practice supervisor role (NMC, 2018c) can be recognised as crucial in providing support and facilitating practice learning. The term 'mentor', if used without the prefix of stage 1, denotes the nurse who has completed an approved mentorship programme and who supervises and assesses students in practice.

1.4 How Mentorship Has Evolved in Nursing

To provide a context for the reader, it is important to understand how mentorship has evolved in nursing. The term 'mentor' largely derived from American education and curricula, quickly becoming part of the educational language in nursing of the eighties and nineties (Burnard, 1990). Historically, the development of nurse education is linked with Florence Nightingale who structured her educational model on students working with nurses who were 'trained to train' (Udlis, 2008). Florence Nightingale was mentored herself by Sir Sidney Herbert during the Crimean War, rooting mentoring in her nursing practice (Fee and Garofalo, 2010). Yoder (1990) took the first step in analysing mentorship across disciplines of business, education and nursing, defining mentorship as occurring when a senior person in terms of age or experience provides information, advice and emotional support to a junior person. Over the years, the concept of mentorship has gained momentum with many, but similar definitions of a mentor in the nursing literature (see, for example, Selwa, 2003; Myall et al., 2008; Burns, 2009; Hodgson and Scanlan, 2013; McCallum et al., 2016). How mentorship is conceptualised is discussed further in Section 2.2.

1.4.1 Standards for Nursing Education and Mentorship

To provide a context for the reader, it is important to understand the changes that nursing education has undergone from the days of Florence Nightingale to what is now a university-based degree education for nurses. Clinical learning was customarily associated with the apprenticeship model of learning where students worked and learnt 'on the job' and were paid a salary by the NHS. Students were employed by hospitals, and the theoretical component

was provided through the integral School of Nursing with clinical instructors facilitating practice-based teaching, learning and assessment.

In 1972 a committee of inquiry, set up by the Department of Health and Social Security and chaired by Asa Briggs, reviewed the role of nurses and the training and education necessary for that role, in order that best use could be made of the available manpower at that time. The resulting report was comprehensive and made seventy-five recommendations (Briggs, 1972). The body of the report was, in part, radical and proposed that the structure of nurse education be fundamentally changed and that nursing research units be established in collaboration with Higher Education (HE). There was an emphasis on the unique role of the nurse, the knowledge necessary to underpin practice, and the separation of the service and education aspects of pre-registration nursing programmes. This was the beginning of the establishment of evidence-based nursing and a wider recognition, within the UK, of nursing as an academic discipline.

Later, in 1986, the UKCC published a report *Project 2000: A New Preparation for Practice* (UKCC, 1986), with recommendations calling for radical changes in the way student nurses were educated, advocating the separation of service and education and a move into Higher Education (HE). After the adoption of Project 2000 in 1986, nurse education moved into universities while continuing to have a close relationship with nursing practice, mainly in the NHS. The most significant change was the introduction of a one-year competency-based common foundation programme, followed by a two-year branch programme. The idea was that nursing education would become more academic than the apprentice style of learning originally adopted from the training school approach.

Project 2000 aimed to change nurse education from a system that responded to the workforce requirements of the NHS to one that would expose its students to the effects of mainstream higher education, but many nurses could not see the relevance of this. Lord (2002) reported that their rejection of the academic content of nurse education became a fundamental problem in the implementation of Project 2000. Students received a bursary which was non-means tested. The students would be awarded a Diploma in Nursing Studies. However, Project 2000 was not the success the government had hoped for. Project 2000 was criticised mainly because nurses, on qualification, were not seen as confident or competent in practice (Lord, 2002).

Later, the Department of Health (DH, 1999) published a document called *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*, in an attempt to modernise the health service. The document evaluated the Project 2000 model of nursing education by suggesting that students were completing their

programme of study without the required knowledge and skills to fulfil the role of nurse within their specialist area. The DH recommended that nursing education become more focused on gaining specialist practical skills, advocating a competency-based approach. These recommendations became intrinsic to the new courses and curricula.

Support for students on placement was further strengthened by the document *Placements in Focus* (ENB, 2001), recognising that mentors would assume responsibility for student learning in the practice setting. This document provided a framework to ensure that students were supported and assessed in practice by an assigned mentor and links were re-established with clinical practice by universities. Clinical assessors who would be responsible for observing, guiding and advising on students' performance in practice were identified by the ENB. The ENB and DH recommended that they would not be involved in formal supervision or assessment of the student but would be there simply to advise and support within the clinical placement. This recommendation meant that the facilitation of learning and supervision for students moved away from an advisory to a functional role where the mentor made decisions as to whether a student should pass or fail in practice. The UKCC (later replaced by the NMC) then published *Fitness for Practice and Purpose* (UKCC, 2001), followed by the *Standards of Proficiency for Pre-Registration Nursing Education* (NMC, 2004a). Students were required to spend 50% of their time in practice and 50% in university, learning the theory that underpinned their practice. Students were assigned a mentor whilst on their placements and supported by a link lecturer from the university, with an emphasis on evidence-based practice. Later, the NMC issued new *Standards for Pre-Registration Nursing Education* (NMC, 2010), which at the time of carrying out this research were the current standards for pre-nursing education. These standards recommended that pre-registration nursing become an all-graduate profession and the last diploma course was offered in 2013.

Although there had been some confusion over the many different titles of clinical assessor, mentor, supervisor and preceptor (Neary, 1997), the framework (ENB and DH, 2001) changed the role of mentor and specifically included that of assessor. Becoming a mentor became a mandatory requirement in 2006, when the NMC published the *Standards to Support Learning and Assessment in Practice: Standards for Mentors, Practice Teachers and Teachers* (NMC, 2006). These standards replaced the previously published *Standards for the Preparation of Teachers of Nurses, Midwives and Specialist Community Public Health Nurses* (NMC, 2004b).

The aforementioned document was updated in 2008 as a second edition, namely the *Standards to Support Learning and Assessment in Practice* (SLAiP) (NMC, 2008). This document stipulated that any student on an NMC-approved pre-registration nursing programme must be supported and assessed by individuals who met the criteria laid out in the document. These revised standards had outcomes for mentors, practice teachers and

teachers, and took the form of a single developmental framework, which defined and described the knowledge and skills nurses and midwives needed when they supported and assessed students. The framework was designed to facilitate mentors' personal and professional development through four stages. The NMC set out clearly what was expected at each of the four stages of mentoring. Figure 2 illustrates the NMC (2008) developmental framework, showing the four stages that are underpinned by five principles and eight domains.

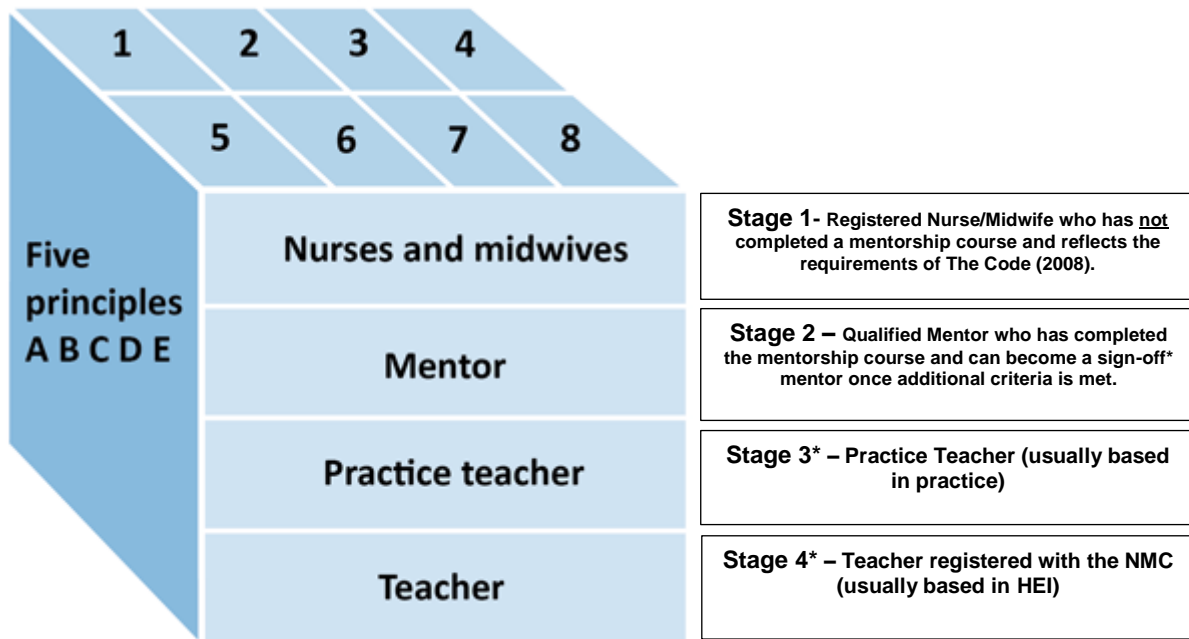


Figure 2: NMC (2008) developmental framework

The developmental framework took account of the NHS Knowledge and Skills Framework (DH, 2004) for supporting learning and assessment in practice. The four stages set out the supervision, teaching and ongoing requirements of mentors, practice teachers or teachers, with an option to enter and exit the framework at any stage. *(N.B. For the purpose of this research, sign-off mentors, stages 3 and 4, will not be discussed in this dissertation.)*

A stage 1 mentor was a registered nurse or midwife on the NMC register who supported learners, facilitated learning and contributed information to stage 2 mentors to enable assessment decisions. A stage 1 mentor could also teach and assess clinical skills, but this was under the supervision of a stage 2 mentor who was accountable for that student's assessment. Kinnell and Hughes (2010) described the stage 1 mentor as an introduction to the roles and responsibilities of being a mentor. An alternative view was conveyed in Lawson (2012b), who defined a stage 1 mentor as a newly qualified nurse who was expected to

support, supervise and teach students, often on a day-to-day basis, but without any preparation for this role. However, Lawson (2012b) asserted that the term 'stage 1 mentor' was not well recognised, nor were the requirements of the role understood within the nursing profession. Furthermore, Duffy et al. (2016) argued that provisions made within the development framework in relation to the stage 1 mentor role in supporting students in practice were yet to be realised. For the purpose of this study, a stage 1 mentor refers to a newly qualified nurse, usually within their preceptorship period, who has not yet completed the mentorship preparation programme and is without the stage 2 mentorship qualification.

Appendix 1 provides further details of the eight domains associated with stage 1 and stage 2 standards of practice and shows the similarities and differences in standards between the two stages. It was envisaged by the NMC that stage 1 mentors would view development and progression to stage 2 as part of their continuing professional development, thus meeting the requirements within the NHS Knowledge and Skills Framework (DH, 2004). This framework is a career development tool for all NHS staff and lies at the heart of pay and career progression.

A stage 2 mentor was a registrant who, one year post-qualification, completed the mentorship preparation programme and, on successful achievement of the outcomes of this stage, became a qualified mentor. A stage 2 mentor could then become a sign-off mentor if they met the additional criteria specified by the NMC in order to be able to sign off a student's practice proficiency at the end of an NMC-approved programme. The stage 2 mentor qualification was recorded on the local register of mentors held by placement providers. This register was monitored by the NMC to ensure that these stage 2 mentors maintained the required skills and competence, completing a yearly update and triennial review. Under the SLAiP standards, a stage 2 mentor would be required to spend 40% of their time facilitating and assessing the student to achieve the NMC requirements. The stage 2 mentor had overall responsibility for pre-registration student nurses whilst they were in clinical placement. The fundamental difference between the two stages is that stage 1 mentors did not 'sign off' nurses' summative learning outcomes for the placement, though this was not made explicit in these standards. However, there seem to be other differences, such as the stage 1 mentor having more proactive responsibilities in creating a learning environment, selecting learning opportunities for students and acting as a role model to others.

1.4.2 Changes in Mentorship Statute

After data had been collected for this study, the NMC published the new *Code – Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* (NMC, 2018e). The NMC also reviewed the way students were supervised and assessed in practice

and published *Future Nurse: Standards of Proficiency for Registered Nurses* (NMC, 2018a), which represent the skills, knowledge and attributes all nurses must demonstrate, replacing the *Standards for Pre-Registration Nursing Education* (NMC, 2014). Alongside these standards, the NMC also published three further parts within the *Realising Professionalism: Standards for Education and Training*, namely, Part 1: *Standards Framework for Nursing and Midwifery Education* (NMC, 2018b), Part 2: *Standards for Student Supervision and Assessment (SSSA)* (NMC, 2018c) and Part 3: *Standards for Pre-Registration Nursing Programmes* (NMC, 2018d). According to Lidster and Wakefield (2018), the reason for these changes was that concerns had been raised over the years about the quality of mentorship and practice-based assessment, on the basis that the process for summative assessment might not be rigorous.

The three parts to the education and training standards are detailed below:

- **Part 1: Standards Framework for Nursing and Midwifery Education**
 - This standards framework focuses on learning culture; educational governance and quality; student empowerment; educators and assessors; and curricula and assessment (NMC, 2018b).
- **Part 2: Standards for Student Supervision and Assessment (SSSA)**
 - These standards replace the existing *Standards to Support Learning and Assessment in Practice* (NMC, 2008) and focus on the student journey around effective practice learning; supervision of students; and assessment of students and confirmation of proficiency (NMC, 2018c).
- **Part 3: Standards for Pre-Registration Nursing Programmes**
 - These standards focus on the student journey around selection, admission and progression; curriculum; practice learning; supervision and assessment; and qualification to be awarded (NMC, 2018d).

Essentially, the key change within Part 2 of the new standards (SSSA) (NMC, 2018c) is that mentors and sign-off mentors be replaced by practice supervisors, practice assessors and academic assessors (*for the purpose of this study, the practice assessor and academic assessor will not be discussed*). The NMC thus declared the end of 'mentorship', stating that all registered nurses and midwives are capable of role modelling and supervising students. All nurses who have completed an approved mentorship module and have remained 'active' on the mentor register are eligible to become practice supervisors and practice assessors. They do, however, have to attend an update session before they can be a practice supervisor and practice assessor, which includes information on how these roles can be realised.

Other changes include the removal of the four-stage developmental framework (Figure 2 refers); the removal of the sign-off mentor; no further requirement for a mentorship programme of study; no requirement for a student to spend 40% of their time with a mentor, nor for a mentor database, triennial review or annual mentor updates. Additionally, the practice teacher award is no longer a requirement to be recorded on the NMC Register. After September 2020, only programmes approved against these new standards could accept new students and meet the NMC requirements for award and registration. Although students remain supernumerary, the NMC proposed that decreasing levels of supervision would be permissible in direct correlation with individual students' increasing proficiency and confidence. Once the student is deemed proficient, the student is encouraged to practise without direct supervision.

The SSSA standards (NMC, 2018c) set out the roles and responsibilities of practice supervisors and assessors, to ensure that students receive high-quality learning, support and supervision during their practice placements. They set out the NMC's expectations for the learning, support and supervision of students in the practice environment, and how students are assessed for theory and practice learning. Nurses are required to play a broader, more supervisory role in student nurse education in practice, and nursing and midwifery students are to be supervised on placement by practice supervisors. Leigh and Roberts (2017) report that these standards allow for the strengthening and legitimisation of the contributions of members of other professions as well as non-registered healthcare workers to the education of pre-registration nursing students. This change in statute gives Approved Education Institutions (AEIs), in collaboration with practice partners, flexibility to develop innovative approaches to education.

A practice supervisor can be any healthcare professional working in any environment, and must be registered with a professional regulator – for example, the NMC, General Medical Council (GMC) or Health and Care Professions Council (HCPC). Practice supervisors are responsible for supporting students on placement and acting as role models in line with the NMC Code (NMC, 2018a) and support learning in accordance with students' scope of practice. (A summary of the roles and responsibilities of a practice supervisor is presented in Appendix 2.) All registered nurses, midwives and nursing associates can be practice supervisors and are no longer required to complete an approved programme of study to become a mentor. However, it is a requirement that they receive appropriate preparation and support to ensure that they have up-to-date knowledge and experience that is relevant to the student whom they are supervising (NMC, 2018c). Notably, there is no definition of 'prepared'.

The SSSA (NMC, 2018c) also state that the practice supervisor must have current knowledge and experience of the area in which they are providing supervision and feedback but do not stipulate to the extent of this knowledge and experience, nor how much experience is

adequate. Like stage 1 mentors, it would seem therefore that newly qualified nurses working as practice supervisors will be expected to coach, teach, supervise, and provide constructive feedback to student nurses. These standards recommend that student nurses will be prepared for supervisory roles during their pre-registration programme, so at the point of registration, they will be ready and prepared to take on the role of practice supervisor. This recommendation aligns with The Code (NMC, 2018e) which states that there is a requirement to support student and colleagues' learning, which is integral to clinical practice, and partnership working. (Further discussion of the implications of the practice supervisor role is discussed in the conclusions of the literature review found in Chapter 2, Section 2.10.)

Leigh and Roberts (2018) suggest that this new supervisory role is a welcome departure from the current profession-centric approach to mentorship. They emphasise the importance of interprofessional teaching and learning opportunities and state that this new supervisory role will give students the opportunity to work alongside key staff working in different healthcare roles. According to Hoy and George (2018), their role will be to support learning and empower students to become independent learners. The NMC require approved HEIs and practice learning partners to ensure that practice supervisors 'receive ongoing support to prepare, reflect and develop for effective supervision and contribution to student learning and assessment, and have an understanding of the proficiencies and programme outcomes they are supporting students to achieve' (NMC, 2018b).

As this research was carried out prior to the new standards (NMC, 2018), the terms 'stage 1' and 'stage 2 mentor' used in this research are based on the SLAiP (NMC, 2008) and will be used throughout this dissertation. Further, the term 'unqualified mentor' will be used interchangeably with that of 'stage 1 mentor' and 'newly qualified nurse'. Recommendations are made for future nurses who will be carrying out the practice supervisor role in Chapter 7, Section 7.2.

Up until the SSSA (NMC, 2018c) were introduced, a nurse became qualified with the knowledge, skills and attributes to mentor students by successfully completing an assessed mentorship programme in an approved university, one year post-qualification, as governed by the Nursing and Midwifery Council (NMC, 2008). The onus is now on the NHS Trust in which the individual registrant is working to provide preparation for the nurses who support students in practice. Recommendations for this preparation will be discussed further in Chapter 7.

Mentorship research to date has focused primarily on the challenges of being and practising as a stage 2 qualified mentor. Whilst research has sought to provide important insights into the practice of mentorship within the context of nursing, the voices and perspectives of those expected to mentor before having successfully completed a preparation programme have so

far been largely excluded from the literature. Further, carrying out this research is important as the NMC move away from prescribed preparation. Furthermore, the research is timely, as the 2018 standards no longer require nurses to undertake specific NMC-accredited preparation. Thus, the experiences of eight nurses within this study will/may become closely aligned to the norm.

1.5 Research Aim and Purpose

In order to better understand the value and purpose of stage 1 mentorship, the principal aim of this study is to explore how eight newly qualified nurses experience working as unqualified mentors. The purpose of this study is to advance understanding of how stage 1 mentorship is viewed in nursing and give value to the extended role of the nurse.

1.6 Research Questions

Drawing on the concepts outlined in the conceptual framework (Figure 1 refers) that stemmed from the three exploratory studies, there is a need to find out further how newly qualified nurses working as stage 1 mentors are prepared for the mentorship role (*concept – preparedness*), how they acquire knowledge and skills for mentorship ‘on the job’ without having attended a formal programme of study (*concept – ways of learning*), how they perceive their transition into the mentorship role (*concept – transition*) and how they identify as an unqualified mentor when working with students (*concept – professional identity*). The research questions for this study are therefore:

1. How do newly qualified nurses prepare for mentorship?
2. How do newly qualified nurses acquire mentorship knowledge and skills in the reality of practice?
3. How do newly qualified nurses experience transition into the mentorship role?
4. How do newly qualified nurses identify as stage 1 mentors?

1.7 Organisation of the Dissertation

This dissertation is organised into seven related chapters. The content of the following chapters is outlined below:

Chapter 2: A Review of Mentorship Literature. Chapter 2 seeks to examine critically the knowledge base around mentorship and answers the question: ‘*What is already known about mentorship in nursing?*’ The chapter begins by detailing the literature review strategy and provides an explanation of how literature was searched systematically. The timeline

associated with the search and review is made explicit. The review is presented using eight key themes, common in the published literature, which represent the features of mentorship in nursing. This review culminates with my conclusions that reveal where limited understanding exists, which subsequently informed this research.

Chapter 3: Research Design and Data Collection. Chapter 3 provides an account of the design of the study. Firstly, it considers the reasons for adopting a qualitative stance and then the specific research design selected is described, detailing the differences between Husserlian and Heideggerian philosophies. My own ontological and epistemological position is made explicit, as is how the role of reflexivity in countering bias was dealt with in this study. Extracts from my research journal are presented throughout, to address the '*researcher's self*' in this study and show insight into how challenges were dealt with. How rigour and, specifically, trustworthiness were established throughout the study is detailed. The research setting and participant demographics are described alongside the process of recruitment and selection of the nurses who volunteered to participate in the study. Proceedings associated with ethical approval, permission to access participants, informed consent and confidentiality are described. The chosen method of data collection is examined critically and an account of how the interview guide was formulated from the conceptual framework and how the semi-structured interviews were conducted is provided. As the analysis of data was complex, a separate chapter (Chapter 4) then details the process of analysis in depth, using the principles of Interpretive Phenomenological Analysis (IPA) and how this inductive approach was operationalised.

Chapter 4: Data Analysis. Chapter 4 describes how interpretive phenomenological analysis (IPA) was utilised as an analytical process in this study. The theoretical foundations of IPA are discussed, and a rationale is provided for its use in this study, including a critical appraisal of methodological critiques of IPA. Justification is provided as to why IPA was adapted into a four-step framework for analysis and how the operationalisation of this framework resulted in the emergence of four colour-coded superordinate themes that were representative of the stage 1 mentors' experiences.

Chapter 5: Participants' Experiences of Being a Stage 1 Mentor. Chapter 5 presents the eight individual participants' experiences of mentorship and the meanings that they give to being a stage 1 mentor. This chapter illustrates how all of the themes – namely, the individual case-specific themes (ICST), the cross-case subordinate themes (CCSubT), and the cross-case superordinate themes (CCSupT), as detailed in Chapter 4 – are derived from the participants' idiographic experiences of mentorship. Each participant's story is précised to provide insight into the world of each of the eight stage 1 mentors. The demographic profile of

each participant is outlined. In keeping with IPA (Smith et al., 2013), within each of the eight stories verbatim quotations from the interviews are used to illuminate the essential points of each participant's experience of mentorship. Quotations are also used to make explicit the transparency of the analytic process and convey how each of the themes was created.

Chapter 6: Discussion: Making Sense of the Findings. Chapter 6 discusses and makes sense of the findings from the cross-case analysis of the eight cases (Chapter 5). The four cross-case superordinate and eleven subordinate themes are used to structure and organise this chapter. This final set of themes was central to the participants' early experiences of working as unqualified mentors and has plausibility as descriptors of important aspects of participants' experiences, grounded in a systematic examination of their own accounts. Scholarly and empirical literature supports how the themes and experiences compare to the existing body of knowledge.

Chapter 7: Conclusions and Recommendations. In this final Chapter 7, the original contributions to knowledge and professional practice are given and the conclusions of the dissertation are considered in relation to the four research questions and how the findings contribute to the study's overall aims. Recommendations for the development of knowledge and professional practice arising from the doctoral study are given, including recommendations for pre-registration nurse education and recommendations for practice supervisors. An evaluation of and reflection on the study is given to conclude this final chapter.

1.8 Summary of Chapter

This first chapter has provided an overview of how the current study was positioned from exploratory work prior to the main study and has justified why this research is needed. My personal context to this study was given to show the reader my position as a nurse, a mentor, a teacher and a researcher. Mentorship has been defined in the context of nursing and how mentorship has evolved over time. A brief description of the changes in mentorship statute is detailed but is discussed in more depth in Chapter 7. The research aims and research questions for the study were presented followed by an outline of how the dissertation is organised in the seven chapters of this dissertation. The next chapter presents a critical appraisal of the literature to address the key review question, '*What is already known about mentorship in nursing?*' and provides a backdrop for this study.

Chapter 2: A Review of Mentorship Literature

2.0 Introduction to Chapter

This chapter seeks to examine critically the knowledge base around mentorship in nursing and answers the question: '*What is already known about mentorship in nursing?*' The chapter provides the literature searching technique and the timeline of my doctoral journey taking into account the changes in statute in 2018. A critical debate will explore the studies that have a focus on mentorship in nursing, analysing the methodologies used, and identifying any gaps in knowledge. The review is organised using eight key themes as headings with a specific focus on mentorship and were common in the published literature. These eight key themes were identified from connections and relationships between the sources read, and represent the features of mentorship in nursing. These themes provide clarity around:

1. The conceptual clarification of mentorship
2. Effectiveness of mentorship
3. Peer mentoring
4. Negative effects of poor mentorship
5. The preparation and support for mentorship
6. Nurses' experiences of mentorship
7. Students' experiences of mentorship
8. Challenges of mentorship.

This review culminates with my conclusions that reveal the gap where limited understanding exists, which subsequently informed this research. Additional literature is introduced in Chapter 6 where the findings of this research are discussed and interpreted.

2.1 Search Strategy and Timeline

A systematic search strategy was employed throughout my doctoral journey to identify literature and empirical studies relating to mentorship. An initial search of the literature was undertaken in 2012 following the three exploratory studies (see Section 1.1) and constituted the planning phase where the aims and research questions were determined. This search was carried out at a point in time when the mentorship of nursing students was governed by the Standards to Support Learning and Assessment in Practice (SLAiP) (NMC, 2008). Further searches were undertaken at regular intervals until 2019 to ensure that relevant and up-to-date research was included in the review. Literature searching throughout my doctoral journey enabled the results of this research to be put into the contemporary context and is referred to

in this chapter and in Chapter 6 to highlight the enduring issues for newly qualified nurses working as unqualified mentors.

Following the publication of the new NMC Standards of Proficiency for Registered Nurses and Standards for Education and Training (NMC, 2018b) and Standards for Student Supervision and Assessment (NMC, 2018c), the literature was searched and reviewed again to identify any new scholarly and empirical research relating to the new standards. The timing of this search was critical within my doctoral journey as the impact of the standards was significant and new terminology was introduced. Because of this, a broader range of search terms was used. A final search and review of the literature was undertaken between November 2019 and March 2020. A flowchart summarising the timeline for the literature search within my doctoral journey is presented in Figure 3. The first two boxes depict the time when the 2008 standards (NMC, 2008) were active. The third box on the tip of the arrow shows further review of the literature between 2018 and 2019 as the new standards were introduced. The last box depicts a final review of the literature where new papers were added once the new standards were operationalised.

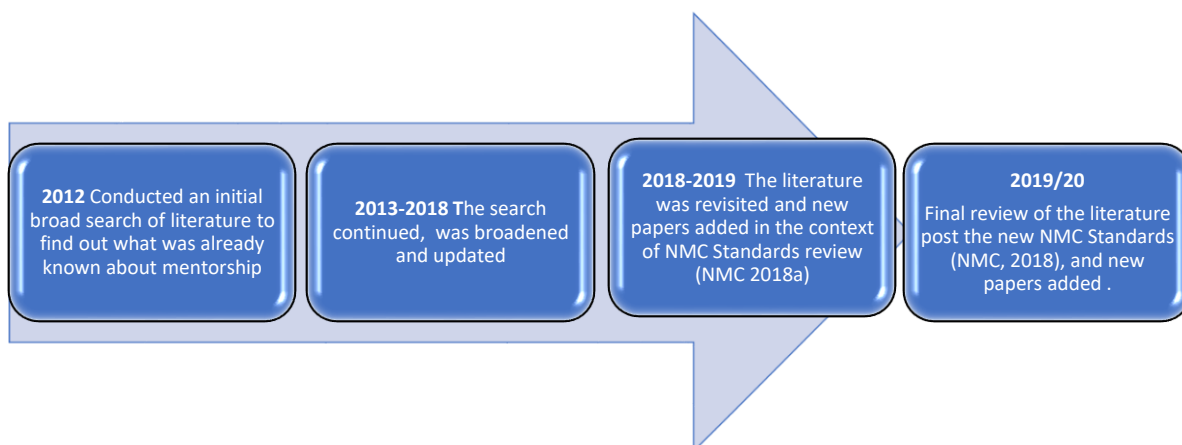


Figure 3: Search timeline within my doctoral journey

2.1.1 Electronic Search

Since a literature review cannot be dependent on a single database, nor on bibliographic databases, multiple databases were initially used to explore the scope of the topic under study. In all phases, electronic databases (for example, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, Medline, PubMed Health databases, Google Scholar and Scopus, as shown in Appendix 3) were searched as they provide the majority of nursing journals. Reference lists in published works were also scrutinised manually to identify any relevant articles that may have been missed, a strategy known as snowballing (Cronin et al., 2008). Many useful secondary sources such as systematic reviews, concept analyses and discussion papers were also identified. The Royal College of Nursing (RCN), the Nursing and

Midwifery Council (NMC) and Department of Health (DH) databases were also accessed for grey literature pertinent to mentorship and nursing. PhD databases and Thesis UK were also searched. As part of my quest to explore the world of mentorship, I also networked at conferences with like-minded academics who were happy to share their unpublished research with me. These sources were valuable in that they provided background and historical context.

Initially, key terms relating to mentorship such as mentor, mentorship, mentoring, protégé, mentee and preceptor were used in the search, which resulted in several hundred papers, although the results were not all related to nursing. Boolean operator terms such as AND, OR and NOT (Ely and Scott, 2007) were used to combine or exclude words and phrases in order to help retrieve specific results and reduce the number of hits – for example, mentorship AND nursing. Other combined keyword searches were undertaken to try and ensure relevant articles relating to mentorship within nursing were found. The term ‘newly qualified nurse’ is also referred to in the literature as ‘newly graduate nurse’, ‘newly registered nurse’, ‘novice nurse’ or ‘neophyte nurse’. Combinations of words from the initial search and post the new NMC Standards were used and include the following:

- Graduate OR registered AND nurse AND mentor
- Mentor* AND nurse
- Mentor* AND nursing AND pre-registration
- Mentors* and pre-registration or pre-qualifying
- Mentor* AND support AND peer AND learn*
- Mentor* AND prepar*
- Graduate nurse AND mentor
- Registered nurse OR newly qualified nurse
- Novice nurse AND mentor
- Practice supervisor NOT mentor

Truncation was used to identify words that shared the same root and ensure that alternatives on the ‘stem’ of the search term were located along with plural terms. For example, nurs* would retrieve nurse, nurses, nursing and ment* would retrieve mentor, mentoring, mentorship. The outcome of the initial search using the words ‘mentorship, mentor, mentorship’ resulted in several thousand hits, so inclusion and exclusion criteria were applied to reduce and refine the hits on the basis of relevance and appropriateness. Only studies published in English were included. Systematic literature reviews were retrieved on the basis that these papers would enable a greater depth of understanding of mentorship and would provide me with another source of literature.

Table 1 details the full list of eligibility criteria for inclusion used in this search.

Table 1: Eligibility criteria for inclusion

Inclusion Criteria
Peer-reviewed primary studies, qualitative, quantitative or mixed methods, concept analysis, narrative or systematic literature reviews, non-experimental cross-sectional surveys or longitudinal studies.
Publications available in English language and full-text availability.
Publications from all countries.
Publications that provide insight into the experiences of qualified nurses carrying out the role of mentor.
Publications that provide insight into the experiences of students who are mentored in the context of nursing.
Publications published in 1980s and after, to include seminal literature around mentorship.
Publications providing broad definitions of mentorship and its uses in other health professions outside nursing, such as midwifery, social work, pharmacy and medicine.
Grey literature such as professional standards or government literature relating to mentorship.

Although a limit of the past five to ten years is often applied to an evaluative literature search (Parahoo, 2014), to allow the most recent literature to be reviewed, I soon realised that, with changes to nursing education, and there was a need to include both up-to-date and seminal papers written when mentorship in nursing was first introduced. The concept of mentorship in nursing only appeared in the literature around the early 1980s with the earliest paper relating to mentorship being by Darling (1984). Darling's seminal work focussed on the characteristics of a mentor. She was the first nurse to give value to the mentor role within the nursing profession. Though Darling's work continues to be cited as seminal, it is widely accepted that there has been a significant shift in terms of what the characteristics of a mentor are and what mentorship now entails.

Mentorship is a term used universally but one that is interpreted in different ways in different countries. Initially, literature relating to mentorship in nursing was searched only from the UK because of the different mentorship systems adopted in other countries. However, studies

from other countries were deemed relevant as they highlighted the similarities and differences in mentorship around the world and enabled the development of a broader conceptualisation of mentorship – for example, Canada: Ferguson (2011), Hodgson and Scanlan (2013); USA: Eller et al. (2013); Nigeria: Olaolorunpo (2019); Norway: Bachmann et al. (2019). These studies demonstrated a global perspective, which enabled me to tap into a national and international knowledge base on how and to what extent nurses might be prepared for mentorship, and nurses' and students' experiences of mentorship in nursing. Although terminology and mentorship systems in nursing vary across the world, the effects and outcomes of mentorship in nursing, the experiences and challenges of mentorship in nursing and conceptualisations of the term have similarities; thus literature relating to practice in other countries was deemed relevant and was included in this review.

2.1.2 Search Results

Overall, the literature search retrieved a total of 353 papers relating to mentorship, which was reduced to a final set of 30 papers (see Appendix 4 for table of literature review papers). This reduction was achieved by reading abstracts, which allowed me to eliminate publications that were not relevant to my research questions. Owing to the large volume of publications about mentorship, the results needed to be reduced significantly. Studies not relating to nursing were therefore excluded, such as mentorship in midwifery, social work, pharmacy and medicine. Duplicates from different databases were also removed, but seminal papers were retained as these provided a historical background to the research topic and earlier definitions of the term 'mentor'. Qualitative, quantitative, mixed-method studies, secondary reviews and discussion papers were found, although qualitative studies, literature reviews and discussion papers were dominant. The review reported in the remainder of this chapter is based on a final set of 30 publications. Figure 4 illustrates the search strategy employed that culminated in the selection of the definitive papers used for this review.

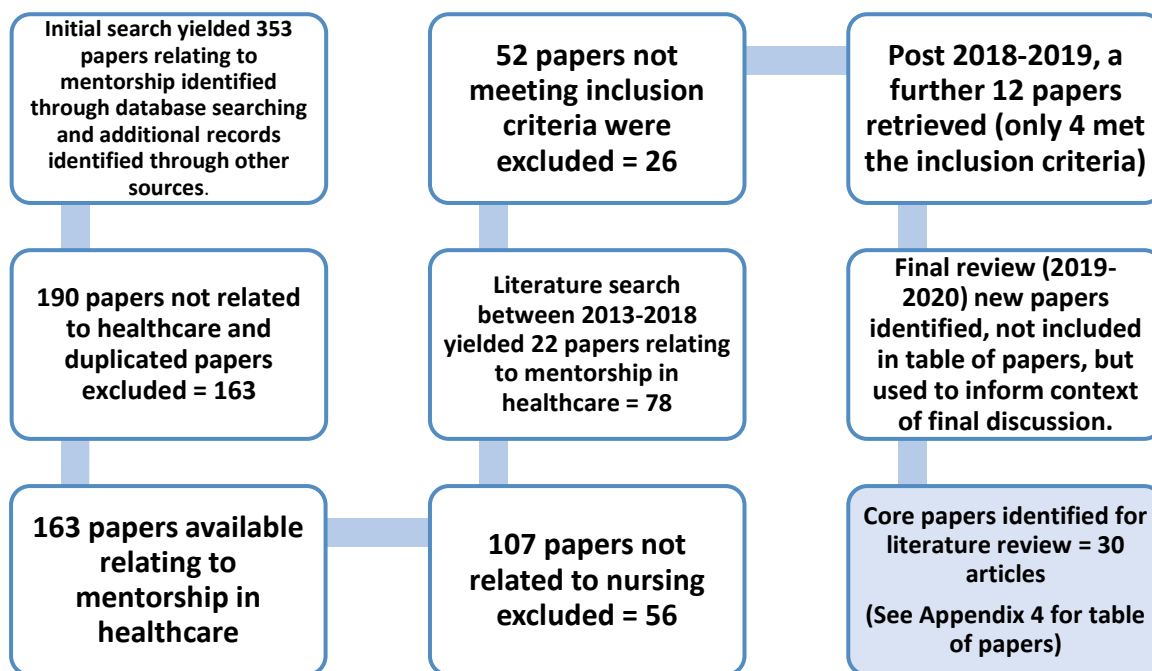


Figure 4: Search strategy

2.1.3 Appraisal and Interrogation of Literature

A literature review needs to possess credibility, integrity and applicability (Cronin et al., 2008). Two critical appraisal tools were utilised to guide the evaluation of the literature and make a judgement about the rigour of the research found. The Critical Appraisal Skills Programme Checklist (qualitative) (CASP, 2016), which focuses on the rigour of the research methods, credibility and relevance in qualitative studies, was used. Whilst this tool was of value in that it provided a good measure of transparency, it was limited in that it could not be applied to the most frequently found non-experimental quantitative studies, for example, non-experimental surveys. Because of this limitation, Coughlan et al.'s (2017) guide was also utilised to critique the quantitative research and so further guide my critical appraisal of the literature. These two frameworks enabled me to critique the robustness and limitations of the studies and appraise the literature for rigorous and viable evidence. It is indeed evident that no gold-standard critical appraisal tool exists for all study designs, and this therefore justifies using a combination of tools. This view is supported by Katrak et al. (2004) who assert that critical appraisal tools should be selected carefully based on need. They suggest that a combination of tools be utilised to appraise research of different designs. Appraisal and review of the studies were carried out once the final studies were selected in the earlier review in 2013/2014, and then repeated in later searches. Following the full text appraisal of the retrieved articles, eight common themes emerged which are utilised as headings within this review.

2.2 Conceptual Clarification of Mentorship

Within nursing, mentorship is described as a valued relationship and is considered by Ali and Panther (2008, p. 35) as 'an important role that every nurse has to assume'. Although other diverse definitions exist, there is a shared understanding that the practice of mentorship in nursing has an influence on the preparation of future nurses for practice (Olaolorunpo, 2019). Despite the many attempts to conceptualise mentorship within the social sciences (Stewart and Krueger, 1996; Andrews and Chilton, 2000; Whitehead, 2001; Myall et al., 2008; NMC, 2008; Hodgson and Scanlan, 2013; RCN, 2015; Joubert and Villiers, 2015; Olaolorunpo, 2019), there appears to be a lack of conceptual clarity around mentorship in nursing. Definitions and terminology vary, creating an air of confusion about what 'mentorship' is. A number of related terms such as 'mentor', 'supervisor', 'preceptor', 'facilitator of learning', 'coach' and 'assessor' are often used interchangeably, with the terms 'mentorship' and 'mentoring' used in most literature (Spouse, 2001). The lack of consensus about definition and the inconsistent use of terminology and its meaning have inspired many researchers to try and establish a commonly accepted conceptualisation of mentorship and what constitutes a good mentor.

Stewart and Krueger's (1996) concept analysis set out to clarify the meaning of mentorship in nursing. Using a random sample of 82 research abstracts and journal articles, they identified six essential attributes of the term 'mentorship'. These were: a teaching–learning process, a reciprocal role, a career development relationship, a knowledge or competence differential between participants, a duration of years and a resonating phenomenon. These defining attributes align with those of Yoder's earlier (1990) concept analysis, which claimed that mentorship was often confused with other concepts of mentoring, such as role modelling, precepting and peer strategising. Yoder, and Stewart and Krueger brought to light mentoring consequences such as the dynamic nature of professional socialisation, and concluded that mentorship should be recognised as an important teaching–learning process for the socialisation of students. Caution must be exercised however, when interpreting findings of the concept analysis of Yoder, and of Stewart and Krueger, as they do not consider that the attributes of mentorship may be affected by the passage of time or the variations in nursing contexts. However, a number of questions that Stewart and Krueger asked remain unanswered. For example, they asked whether multiple mentors over a period of several years were more effective than one mentor over the same year. Empirical research into this question would provide perhaps further conceptual clarity necessary to acknowledge the different approaches to mentorship and the importance of the mentee–mentor relationship in nursing.

Hodgson and Scanlan (2013) carried out a concept analysis of mentoring in Canada, and its relevance to nursing leadership. They reported that mentorship was associated with increased job satisfaction and staff nurse retention, which benefit the mentor, the mentee and the organisation. Therefore, the responsibility of supporting and guiding students in nursing is enormous and concomitant with personal and professional development. Though their concept analysis did not focus specifically on mentoring nursing students, the antecedents and consequences of mentorship could be applied to newly qualified nurses in the UK who are working in a leadership position and would need to be prepared to take on a mentor role.

The conclusions of these concept analyses resulted in a proliferation of literature around professional socialisation (Melia, 1987; Dinmohammadi et al., 2013; Zarshenas et al., 2014; Norman, 2015). They concluded that relationships, professional or otherwise, are essential to nurse education and that mentors need to be cultivated and developed to be able to adopt different approaches to mentorship, whatever the situation. Later, Olaolorunpo (2019) attempted to clarify the conceptual meaning of mentorship in nursing in Nigeria. Using Walker and Avant's (2005) concept analysis approach, she concluded that the defining attributes of a mentor in nursing, such as being a role model, friend and experienced nurse, have a positive influence on the production of nurses and that successful mentoring relationships are characterised by shared values, mutual respect and personal connection. However, the definitions of mentorship given in this paper were mainly drawn from dictionaries, with little reference to published definitions of mentorship in the nursing literature.

Different concepts of mentorship could account for some of the variations in the way mentors facilitate learning, leading to either surface or deep learning. Wittman-Price and Godshall (2009) suggested that deep learning is both a learning approach and a learning strategy that promotes conceptual learning. Nielsen (2016) described the significance of deep learning in nursing as a connection of theory with practice and clinical judgment. To this end, mentors often focus on the development of psychomotor skills, but must at the same time consider the underlying theoretical principles to enable deep learning and develop cognitive skills. For example, when teaching the real-life experience of inserting a naso-gastric tube (a psychomotor skill), associated anatomy and physiology enable the student to understand the consequences of their actions and the risks to the patient. This raises their learning from a surface to a deep level of learning by bridging the gap between theory and practice.

According to Alsayed et al. (2020), deeper learning approaches are necessary for high-quality learning, and a surface approach can lead to poor-quality learning in nursing practice. An alternative conceptualisation of mentorship, therefore, could be that of a 'deep learning' partnership between mentee and mentor, where moving from a surface approach to learning is the goal, with increased understanding and application to patient care. Being mentored

should allow the learner to apply actual experiences with the attainment of skills and/or knowledge. In doing this, learners potentially become more acutely in tune with the inherent complexities of 'real' experiences, and begin to experience deeper learning and understand situations with heightened awareness. Therefore, there needs to be a conceptualisation of mentorship that incorporates deep learning in order for nurses working in the new practice supervisor role to be recognised as crucial in the facilitation of deep learning in the practice setting. It could be argued that contemporary complexity in healthcare demands a more sophisticated conceptualisation of mentorship than that offered when mentorship was primarily about skill acquisition. As nursing practice has evolved, there is a gap in the literature aligning changes in nursing and nurse education to mentorship. The potential of students being intrinsically motivated would be wasted without this reconceptualisation. A failure to reconceptualise could result in mentorship being confined to a supportive role that focuses only on the development and assessment of practice.

2.3 Effectiveness of Mentorship

The effectiveness of mentorship is an important and fundamental notion in pre-registration nurse education and the foundation for being a good mentor is in building positive working relationships between mentor and mentee. Many authors have looked at alternative strategies to mentorship in the need to make recommendations for effective mentorship and what makes an effective mentor. Effective mentorship is considered by Ferguson (2011) as critical to the development of student nurses and ultimately contributes to a knowledgeable and efficient nursing workforce. Ferguson (2011) reports that effective mentors are knowledgeable and supportive nurses who support decision-making and assist others in their decision-making. This definition does not necessarily refer to the quality of the learning experience nor the effectiveness of the mentee–mentor relationship. Other authors have made recommendations for effective mentorship; for example, recommendations for mentors to hold a teaching qualification (Andrews and Chilton, 2000); mentor buddies, higher visibility of link lecturers (Willis, 2015); peer mentoring, peer-assisted learning and peer teaching (Gray, 1997; Gray and Smith, 2000; Spouse, 2001; McGowan, 2006; Price and Price, 2009; Brannagan et al., 2013; James et al., 2014; Smith et al., 2015; Carey et al., 2018a; Carey et al., 2018b); peer role modelling (Donaldson and Carter, 2005; Bartz, 2007; Eller et al., 2013); role modelling (Price and Price, 2009; Felstead and Springett, 2016); and supervision for mentors (MacLaren, 2018) all contribute to a better understanding of effective mentorship.

Andrews and Chilton (2000) carried out a small pilot study conducted over a 3-month period to ascertain the views and experiences of both staff nurses and students about mentorship, and whether having a teaching qualification had any effect on mentorship. Views of 22 mentors

and 11 mentees were purposefully selected to complete similar questionnaires. The questionnaires were developed from the major themes emanating from the literature and incorporated the Measuring Mentorship Potential (MMP) scale as devised by Darling (1984). This MMP scale enables nurses to evaluate their own or others' mentorship potential. Mentors completed the questionnaire at the beginning of the mentorship period with the student. Mentees completed their questionnaire at the end of their ward placement and were asked to take a retrospective view of their recent experiences of being mentored. It should be noted here that students were asked to complete the questionnaire one week prior to their placement ending and prior to receiving the results of their placement assessment. This timing could potentially misrepresent participants' answers if students were awaiting final assessment signatures from their mentors, and were worried that being honest could lead to placement failure.

Andrews and Chilton found that nurses with the stage 2 mentorship qualification did not see themselves as teachers but rated themselves more effective as mentors than those without. They found that mentors felt inadequate in their role because their nursing programme did not equip them with the skills to teach others. Andrews and Chilton raised concerns around the inconsistencies in the effectiveness of mentorship and suggested that there should be further examination of mentorship in equipping nurses with the knowledge and skills to become mentors. They noted that mentors felt unsupported and unprepared for the mentor role, implying that mentorship skills need to be developed much earlier as students. Concerns were also raised by the Council of Deans for Health (2016, Section 4.2.3, p. 11) around the many unknowns about the knowledge and skills required for future nurses to carry out a mentorship role, emphasising that newly qualified practitioners need to be equipped to be ready not only for lifelong learning, but with skills to be able to teach others, not just for formal mentorship, but being able to facilitate learning informally as mentors in a clinical environment. Nurses need skills to enable learning and how to teach others, which are emphasised in the literature as being fundamental in pre-registration education.

Andrews and Chilton's study contributes to an understanding of the effectiveness of mentorship with or without the mentorship qualification. What is relevant to this present study is that it seems that a qualified mentor does not have to be the only person to support and guide students. It is clear that nurses with the stage 2 mentorship qualification do not necessarily influence the effectiveness of student learning, and that students do not just learn within the mentee–mentor relationship. Andrews and Chilton also acknowledged that it was not solely the mentor who was responsible for the student's learning and that students learnt from all those they interacted with. Although the survey contributes to an understanding of the effectiveness of how mentors are selected or prepared for their role, the study is limited. The

questions drawn from the MMP scale developed in 1984 may not have been valid in what was then contemporary nurse education. Although Darling's MMP has been widely adopted in the UK as a framework for mentorship programmes, the list of characteristics thought useful in mentorship have been criticised as inexhaustible and thus unachievable by individual mentors (Colley et al., 2003). Also, the study was confined to two wards in a district hospital in North Wales. Therefore, it is hard to gauge whether the findings can be generalised to mentorship in nurse education across the UK.

Concerns about the effectiveness of mentorship in nurse education were highlighted in the Shape of Caring report (Willis, 2015) which recommended that the current mentorship model and standards be amended. From this report, the RCN carried out a Mentorship Project (RCN, 2015) to provide recommendations for future work that supports nurse education in the practice setting. The question of whether all nurses should become mentors was debated by the National Nursing Research Unit (NNRU) Kings College London Policy Plus (2013), based on a mentorship project (Robinson et al., 2012) that explored the views of Higher Education Institutes (HEI) and service personnel. This study was one of four that were commissioned and funded by NHS London to investigate how students are prepared for practice, focusing on mentorship capacity. The study was carried out by the NNRU in collaboration with Chelsea and Westminster NHS Foundation, and was part of NHS London's 'Readiness for Work' programme. Semi-structured interviews were held with 37 purposively selected personnel from HEIs and NHS Trusts who represented key roles in the provision of mentorship. Interviews were transcribed verbatim, and data analysed using a framework for thematic analysis.

The study acknowledged that becoming a mentor has long been regarded as an important step in a nurse's career and often an essential criterion for promotion. It questioned the extent to which newly qualified nurses are adequately prepared to take on responsibilities in their first post as staff nurse and whether all nurses, once qualified, should become mentors. One of the key findings was on eligibility to become a mentor. Participants held differing views about the length of time nurses should practise post-qualification before becoming a mentor. Some agreed that the recommended one year was too soon whilst others thought six months was sufficient. It was also found that, in the reality of practice, pressures within the NHS led to newly qualified nurses taking on the role of mentor as soon as they had qualified. They recommended that nurses be prepared fully to take on the mentor role, which in turn would result in more effective mentorship. More research therefore is required, not just to evaluate the effectiveness of mentorship, but to explore the synergy between effective mentorship and how and to what extent mentors are prepared.

Another key finding from this Policy Plus study was that the effectiveness of mentorship suffers if carried out by nurses without a genuine interest in student education. They recommended that additional support was needed, such as mentor buddies and study leave to attend the standard five days for the Preparation for Mentorship programme. The study further recommended that high visibility of link lecturers and practice education facilitators was considered fundamental in providing support for mentors. However, some concern was raised as to the extent to which mentors did not challenge other mentors when faced with poor mentoring scenarios. This Policy Plus study identified the challenges that mentors face in practice and the effectiveness of mentorship. They recommended that their project stimulate debate in light of the Willis Commission Report (2012) so that mentorship provision could be examined to provide the support and preparation that mentors require to fulfil this crucial role. Whilst this work provides valuable insight into mentorship as the cornerstone of student education, the findings open up the debate for further questions around whether the education of student nurses would be best serviced by any nurse, role model or peer, or should only be allocated to an experienced nurse with dedicated time to mentor.

Price and Price (2009) used a well-established definition of a role model as someone with whom students identify, those who have qualities they would like to have and are in positions they would like to reach. Bartz (2007), however, considered a role model as someone who serves as a catalyst to transform as they instruct, counsel, guide and facilitate the development of others. The use of the word 'transform' is perhaps a much stronger characteristic of an effective role model and goes beyond the traditional definition of a role model as used by Price and Price (2009), implying a more active role, rather than that of 'doing their job well'.

Felstead and Springett (2016) set out to explore the concept of role modelling in mentorship and the positive influence mentors have in understanding the effects and outcomes on student development as future qualified nurses. Using a phenomenological interpretive approach, 12 face-to-face, individual, unstructured interviews were carried out where the participants were prompted to facilitate reflection on their lived experiences. Students reported that their experience of being mentored taught them how not to behave in practice and cited that a mentor should lead by example. The authors concluded that an effective role model was a mentor who influences behaviour by exemplifying the practical, professional and/or personal traits expected for nursing and therefore emulated by others. These findings concur with those of Baldwin et al. (2014), whose literature review found that nursing students view their mentors as influential role models for their practice. Participants were students in the first, second and third years of a pre-registration nursing programme. Felstead and Springett (2016) made several recommendations. These included firstly the need for students to work with a number of clinical staff to ensure exposure to a variety of practice behaviours, enabling them to identify

poor role modelling traits they wish to avoid in their future practice. Secondly, they recommended that all qualified nurses should advocate the need for lifelong learning with regard to the development of professional practice.

Although the work of Felstead and Springett is of value in that mentors can be excellent role models for student nurses, it is not without limitations. Female students represented the majority of the student group and only white British students volunteered for the study. The apparent bias towards female nurses was not intentional but just reflected the predominance of females in nursing at the time of recruitment. Moreover, the experiences of nursing students from other programmes, BAME groups or from different geographic locations were not represented in this study so results should possibly be treated with caution when considering these groups, as, arguably, the recommendations do not seem to be culturally specific. Indeed, a wider range of participants from diverse backgrounds would have provided a wider diversity in this study. Further, it would be desirable to repeat the study using participants from a variety of ethnic backgrounds to ascertain if the results can be transferable to subcultures in nursing.

In a grounded theory study, Donaldson and Carter (2005) sought to explore the positive effects and value of role modelling within the clinical area. The views of 22 adult nursing students were sought using individual and focus group interviews. Volunteers were sampled using theoretical sampling technique and participants were both undergraduate and diploma pre-registration students. Focus groups were carried out within the first two months and then followed by individual interviews at the mid-point of their programme. Participants were interviewed again two months prior to becoming a nurse to explore their perceived preparedness for the nurse role. Those participants who volunteered were then randomly selected for the study, to give each participant an equal chance of being selected and therefore reducing researcher bias. Data analysis was carried out using constant comparative analysis where data coding and collection took place simultaneously. Data was coded and analysed using substantive and theoretical coding. It is interesting to note that 22 participants were 'drawn' randomly, yet reference is made to grounded theory. Given that a grounded theory study should continue until saturation is reached, the sample size makes unqualified acceptance of the findings difficult. A wider range of students from other fields of nursing such as Mental Health or Child would have helped to increase diversity as much as possible in the responses.

Role models play an important part in shaping student nurses' behaviours and attitudes, but equally reinforce the need to be guarded about poor mentor attitudes and behaviours that can also be emulated by students. Interestingly, the RCN (2013) suggested that it is often staff

who have worked in the NHS for a long time, who should be seen as good role models, who exhibit poor attitudes and behaviours. It would seem therefore that the quality of good mentors should depend on the quality of good role modelling and vice versa. This strengthens the need to prepare mentors to be good role models, and Donaldson and Carter (2005) recommend that mentor preparation courses should include the value of role modelling.

The findings in Donaldson and Carter's (2005) study suggest that students' confidence and competence improve if they are supervised appropriately by a good role model. However, it was not made clear whom the role model was that they referred to, nor did they examine the nature of the behaviours or qualities that were modelled. The findings suggest perhaps that there is no clear consensus as to whom a 'good' role model is, or should be, and makes an assumption that all mentors are good role models. Further research that examines the nature of the role might be of some benefit. Bandura (1997) argued that role modelling is much more than imitative behaviour – that role modelling is where new ideas are formed as to how to behave, which later serve as a guide for future action. Student nurses will emulate other nurses and their mentors as their role models for future practice, but good role modelling does not always constitute good mentorship. For example, a mentor might think they are a good role model, but lack expertise and experience in mentorship, break promises and have poor teaching skills (Gray and Smith, 2000). Conversely, Vinales (2015) reports that often mentors are unaware that students and even other members of staff regard them as role models, so might be unaware of the influence that their behaviour might have on student learning. Indeed, it could be argued that acting as a good role model is just one means of enabling students to know what to do, but essentially, it is the mentor–mentee working relationship that promotes positive outcomes for student learning.

The importance of an effective and reciprocal working relationship between mentor and mentee is considered fundamental for successful mentoring (Eller et al., 2013). Eller et al.'s (2013) study set out to identify key components of an effective mentorship relationship identified by mentor–mentee dyads in the USA. Using a purposive sample of 117 mentor–mentee dyads from twelve different universities, twelve workshops using the Technology of Participation method were used to collect data. Data was analysed using conventional content analysis. Eller et al. found eight key components of an effective mentorship relationship, which included positive role modelling, a caring and personal relationship, and exchange of knowledge. The authors recommended that nurse educators can evaluate and modify their mentoring behaviours as needed, thereby strengthening the mentor–mentee relationship, thus ensuring positive outcomes of the learning process. Though these findings can be used to inform a dialogue between students and nurses who are considering becoming mentors, Eller

et al.'s conception of an effective mentoring relationship may be skewed because of the differences between nurse mentoring systems in the USA and the UK.

Using a qualitative approach, MacLaren (2018) explored the positive effects and outcomes of a dyadic relationship between trainee mentees and experienced mentors supporting their colleagues undertaking mentorship preparation. MacLaren used semi-structured interviews with three recently qualified mentors and experienced mentors who supported them in practice. Findings suggested that a dyadic form of supervisory mentorship might not offer the range of knowledge, skills and attributes required for the mentorship role. MacLaren reported that having a one-to-one relationship between mentee and mentor may encounter problems when one mentor attempts to fulfil all mentorship roles. These findings, however, contrast with those of Eller et al. (2013) who argued that an effective relationship between mentor and mentee enables, for example, a caring personal relationship, role modelling, and mutual respect and trust. MacLaren's (2018) study's limitations are recognised by the author as the three mentees and their supporting mentor were selected from two NHS Trusts and were interviewed at the same time limiting freedom of expression. Future research therefore where mentee and mentor are interviewed individually about both positive and negative aspects of the relationship would be of benefit. Further, replication of the research with mentees/mentors in different care settings might identify different findings if carried out in the UK, providing transferability to nursing and mentorship in the UK.

2.4 Peer Mentoring

The term peer mentoring in the context of nursing practice is often used interchangeably with other terms, such as peer assisted learning, peer learning, peer role modelling, peer teaching and peer tutoring, but essentially involves students helping each other to learn (Loke and Chow, 2007). Whilst each term shares similar underlying principles, where the mentee and peer grow and learn from each other, there is little consistency in usage of a common definition, leading to potential ambiguity in practice. Mentorship in nursing can often be between peers, either a more experienced student and a novice student or an experienced nurse and a new nurse working together in the same practice (Yonge et al., 2007). Mentorship within nurse education has traditionally been carried out by an experienced nurse who has undergone formal preparation in an approved Higher Education Institution. However, peer mentoring has been identified by several authors (Aston and Molassiotis, 2003; Gilmore et al., 2007; Palsson et al., 2017) as an alternative approach to mentorship, and was later shown by Seshabela et al. (2020) to be superior to traditional mentoring by reducing students' stress levels and anxiety. For the purpose of this study, peer mentoring, which can be synonymous in the literature with peer learning, is where a more senior student might support and guide a

less experienced student, but without the immediate intervention of a stage 2 mentor. This peer mentoring relationship can be formally organised or can occur informally when students naturally gravitate towards each other because they are friends or have similar interests. According to Palsson et al. (2017), peer mentoring involves individuals in a similar situation learning from and with each other through interaction and is considered as an important contribution to the mentorship of students. It is important, therefore, to examine peer mentoring as an alternative approach to effective mentorship.

Gray's (1997) qualitative exploration of nursing students found that effective mentoring took place through peer mentoring between students rather than with their mentors. Fellow students were found to have more time to support learners and were able to pass on hints and tips, though this form of knowledge could be recognised as surface learning. Indeed, it was evident in the data that effective mentoring took place through peer-to-peer support and did not necessarily need to come from a qualified mentor, or a qualified nurse. Later, Gray and Smith (2000) explored the qualities of an effective mentor from the student nurse's perspective. This study reinforced and extended the findings of Gray's earlier study (Gray, 1997), but concluded that having a qualified mentor is not necessarily crucial to learning and developing student nurses' professional abilities. In this longitudinal grounded theory study, ten students were interviewed on five occasions during the three years of their programme. Students were also asked to maintain a diary to record their thoughts and experiences. In addition, a further seven students agreed to keep a diary journal only. Data was analysed using constant comparative analysis. Findings suggested that students quickly lost their idealistic view of their mentor and, over time, developed insight into the positive effects and outcomes of having an effective role model to look up to, who was not necessarily their mentor.

Students quickly learnt the importance of connecting with good role models and felt that knowing their likes and dislikes impinged on the positive outcomes of their learning. Gray and Smith's study did, however, reveal that students realised that their relationship with their mentor influenced the effectiveness of the mentee-mentor relationship. As students progressed through their programme, they made more use of their peers, where they learnt from their fellow students, thus becoming less reliant on their mentor. This reduced reliance on their mentor coincided with the development of their confidence, skills and care of patients. The findings concluded that students recognised the value of effective role models and the use of peer mentoring, but also recognised that it was the mentor who influenced their learning the most. The same findings have been found in other studies, for example, Darling (1984); Baillie (1993); Earnshaw (1995); Cahill (1996); Andrews and Wallis (1999); and Wilkes (2006).

It is difficult to draw definitive conclusions from Gray and Smith's study. No attempt was made to examine the parameters of different placements that the students had encountered. Other potential variables were not discussed, such as the speciality of the clinical environment, or how the age and gender of the student could have influenced the student experience. In addition, Gray and Smith's study provided little information about the way the interviews were conducted, where they were carried out or any student variables that may have been significant. Furthermore, there was little discussion as to the negative effects and outcomes of role modelling, such as inappropriate teaching and poor nursing care, which can undermine the goals of effective mentorship.

Carey et al. (2018a) used an alternative term to peer mentoring: peer-assisted learning, relating to the acquisition of knowledge and skills through shared learning of matched equals. The Council of Deans for Health (2016, Section 4.2.4, p.11) also refer to the term peer-assisted learning that found second- and third-year students increasingly turned to peers whom they considered more experienced, to help them gain confidence and develop skills and readiness to take on learning support roles in the future. Carey et al. (2018a) reported a positive outcome for undergraduate paediatric nursing students who engaged with peer-assisted learning. Non-participant observation in a range of paediatric wards was used to examine 17 participants engaging in peer-assisted learning. A total of 67 hours of raw data was analysed using framework analysis to identify themes.

Carey et al. (2018a) concluded from the findings that peer-assisted learning positively stimulates students to become engaged in their learning experiences and enhances collaborative support with the working environment. They recommended that, in light of recommendations for the education of future nurses, mentors and educators should be aware of the benefits of peer-assisted learning and that it contributes towards future strategies and models of learning. They further recommended that more research be carried out to explore other fields of nursing to determine similarities to their study. Though Carey et al.'s findings contribute to the body of knowledge around practice-based learning, the periods of observation in this study were limited to when the students were on placement and there was no mention of the 'Hawthorne effect' (Oswald et al., 2014) on the data collected. Although the study provided a valuable emic perspective from the student nurses in this study, the study included mainly female participants with only one male participant and only included paediatric nurses. Therefore, further research to determine similarities and further influences and include other fields of nursing and to identify any gender differences when engaging in peer-assisted learning would be valuable.

Through the Joanna Briggs Institute, Carey et al. (2018b) carried out a qualitative systematic review to identify and synthesise the best available evidence related to the effects and outcomes of peer-assisted learning among student nurses in clinical practice. The review considered studies that included male and female nursing students aged between 18 and 50 years. The review considered eight qualitative studies, including designs such as phenomenology, grounded theory, action research and feminist research. Quantitative studies were excluded. The authors concluded that peer-assisted learning exists both formally and informally in clinical practice, and friendship and community are often expressed as occurring when peers work together. In light of their findings from the review, Carey et al. made recommendations to consider further how peer-assisted learning enhances the learning of undergraduate nursing students in clinical practice. These recommendations were based on their conclusions from the review that peer-assisted learning was shown to reduce stress and anxiety and supported the transition from university to nursing practice by preparing students to be mentored in clinical settings. However, they noted from the evidence that students have experienced dominating personalities from peer-assisted learning, which is of concern. Notwithstanding this evidence, Carey et al. (2018b) asserted that the perceived benefits of peer-assisted learning outweighed the challenges, so should be advocated in clinical practice.

Brannagan et al. (2013) carried out a mixed-method study with 179 first-year nursing students and 51 third-year nursing students to examine self-efficacy beliefs of those who received peer teaching and learning in the context of a clinical lab setting, compared with those who received faculty instruction. It is important to note that this study was carried out in the United States of America, and used different terminology to the UK, referring to nursing students as tutees and other more experienced students as peer tutors. Brannagan et al. adopted Topping's (2005, p. 631) definition of 'peer tutoring', but then referred to the term 'peer learning' as 'the acquisition of knowledge and skill through active helping and supporting among status equals or matched companions'. Brannagan et al.'s findings differed from previous research in that the use of experienced students serving as peer tutors did not decrease anxiety in first-year students, but they found that the presence of an instructor-tutor-tutee triad appeared to positively alleviate levels of anxiety. Brannagan et al.'s findings indicated a need to better prepare students as peer tutors and affirm the positive effects of peer mentoring, and recommended that peer-mentoring experiences should be provided for students to prepare them for the reality of becoming a qualified nurse. Though Brannagan et al.'s findings add value to the importance of peer mentoring as an alternative form of mentorship; this study sample was only from one nursing group being taught clinical skills in a lab. The inclusion of multiple and more complex skills would have provided a more accurate idea of the effects of peer mentoring. Further, the students serving as peer tutors in this study were only trained to

teach a student how to carry out a specific skill in a lab setting, rather than how to teach other clinical skills using a variety of teaching strategies.

Although the traditional form of mentorship has been shown to be an effective strategy to support practice-based learning and student success (Bray and Nettledon, 2007), this hierarchical mentor–mentee form of mentorship has its weaknesses, such as being one-sided in terms of knowledge transfer and being non-reciprocal (Jacobs, 2018). Further, classic mentorship models can sometimes lead to bullying, especially if the mentor is domineering (Scandura, 1998). It is important, therefore, to challenge the contemporary hierarchical, positional formal mentorship approach between mentor and mentee, and look more closely at the power in this mentoring relationship. A possible alternative to this hierarchical mentorship, or a strategy to be used alongside, could be a shift to a more collaborative use of peer mentorship, through a triad relationship between more experienced peers, the student and the more experienced mentor.

The use of peer mentoring has been shown to have many benefits in comparison to the more traditional form of mentorship, including shared experiences and having more in common with each other than with their allocated mentors (Gray, 1997; Aston and Molassiotis, 2003; Loke and Chow, 2007; Yonge et al., 2007; Gilmore et al., 2007; Palsson et al., 2017; Seshabela et al., 2020). The potential feasibility of peer mentoring between students is important to consider as they socialise together, share experiences together, support and learn from each other. It has been accepted in nursing that traditional mentorship for undergraduate nursing students involves a formal mentoring relationship between student and mentor, and plays a vital part in the support and preparation of future nurses. Sword et al. (2002), however, suggest that mentorship in nursing could have a much broader educational strategy through the use of nursing alumni as student mentors. Peer mentoring could represent a low-cost alternative, or perhaps an accompaniment to traditional mentorship, and demonstrates mutual benefits for both the student and mentors. However, it should be noted that studies relating to alternative forms of traditional mentorship, such as peer mentoring as discussed, are limited, particularly in the context of post-registration nursing. Future enquiry exploring the value of peer mentoring in both pre- and post-registration nursing, as an alternative to the more transitional approach to mentorship, would be beneficial.

2.5 Negative Effects of Poor Mentorship

Most of the literature discussed so far has reported mentorship in a positive light. However, the negative effects of poor mentorship can have a range of adverse effects on the student and student success in placement. Poor mentorship, like poor role modelling, has been

associated with ineffective interpersonal skills, unfriendliness, a lack of respect and lack of time and energy on behalf of the mentor (Andrews and Wallis, 1999). Gray and Smith (2000) gave examples of a poor mentor as being someone who breaks promises, lacks knowledge and expertise, or throws the student in the deep end. Exposure to poor mentorship can have a damaging and negative effect on students with several consequences to student learning, self-esteem and confidence (Darling, 1985; Gray and Smith, 2000; Pearcey and Elliott, 2004; Eby et al., 2010; Hunter and Warren, 2014). It impacts on not only learning but also self-esteem, confidence and the personal and professional development of the student. It has also been reported to lead to increased stress, job dissatisfaction and student attrition (Santos, 2015). In an attempt to understand poor mentoring and the effect this may have on students, Darling (1985) coined the term 'toxic mentor', describing them as dumpers, avoiders, blockers and destroyers. These toxic mentors, according to Darling, make themselves scarce when faced with students, throw students in the deep end and abdicate all responsibility for student learning.

In a frequently cited mixed-method study using both a survey and interviews Jack et al. (2017) explored degree students' perceptions and experiences of clinical placement education whilst undertaking a pre-registration nursing programme. 1425 student nurses were surveyed across 9 institutions in the North-West of England and 22 unstructured telephone interviews were undertaken with Adult and Mental Health nursing students. Jack et al.'s study provides valuable insight into what is meant by effective mentoring, highlighting factors such as the natural enthusiasm of the mentee as being critical to effective mentorship. The findings indicated that student nurses valued their experiences of positive role models, viewing their mentors as being beneficial to their learning. However, the study also draws attention to the negative effects of poor mentorship in the clinical setting. Students reported feeling undervalued, ignored, unsupported, unwanted and not being able to meet their placement learning outcomes. Where students experienced exposure to poor role modelling, this then led to an adverse effect on their learning, leading to negative feelings about becoming a nurse. Other negative experiences included exposure to unhelpful and rude mentors. Jack et al. concluded that, although students' experiences show being mentored by positive role models is indeed an effective way to support learning and is critical to student success, exposure to the negative effects of poor mentorship provides mentees opportunity to consider the type of nurse they aspire to become. However, Kyrkjebo and Hage (2005) argued that exposure and effects of poor mentorship make it more likely that those poor behaviours will be adopted by the student as they themselves become mentors.

Jack et al.'s (2017) findings are similar to those of Joubert and Villiers (2015) who found that mentors did not show enough interest, were unprepared and did not always meet the expectations of the mentee. Whilst Jack et al.'s study provides further understanding into the impact of mentorship in clinical placements and reiterates that effective mentorship is central to student success; the sample recruited was limited to Adult and Mental Health students who had left their programme of study in the previous 12 months. The findings therefore need to be treated with caution as they relate to only two fields of nursing, and it could be that the experiences described by students were adversely affected by their reason for leaving the profession. No reference is made to the context in which the study took place. Given the significance of the negative effect of poor mentoring on the student and on student success, it is interesting that, whilst this research examined the negative effect of poor mentoring on the student and their learning, little attention has been placed on the effects that poor mentoring might have on the students when they assume a mentoring role themselves as newly qualified nurses.

In a study that explored the concept of negative mentoring Eby et al. (2010) developed a taxonomy of fifteen types of negative mentoring experiences. Through in-depth qualitative accounts of proteges' perspectives of negative mentoring experiences, a taxonomy of negative experiences was developed based on descriptive accounts of those relationships. Quantitative data were used to test the initial hypothesis in which negative mentoring experiences might occur. Whilst Eby et al.'s study provides a framework for the concept of negative mentoring and the effects of poor role modelling, further empirical research is needed to uncover how the negative effects of poor mentoring might impact how students on registration mentor students themselves.

It is clear from these studies that mentorship can have a significant negative influence on students, especially as they prepare to transition into becoming a nurse. Students perceive mentors to have a strong influence on their clinical experiences, and the practice of good and effective mentors reflects the nature of nurse professionalism. Whilst some students have reported negative experiences, in the main there is evidence to suggest that mentorship continues to be important to student nurses' personal and professional development, providing those mentors are willing and able to mentor. There is pressure for newly qualified nurses to take on a mentorship role due to high service demands and expectation from the NMC. Therefore, it is necessary to close the gap in the knowledge and to explore the experiences of those newly qualified nurses as they take on the stage 1 mentor role.

2.6 The Preparation and Support for Mentorship

There is much evidence to suggest that nurses continue to feel unprepared and unsupported to face the challenges of mentorship (Duffy et al., 2000; Whitehead, 2001; Myall et al., 2008; Middleton and Duffy, 2009; Whitehead and Holmes, 2011; Lawson, 2012a; Lawson, 2012b; Wilson, 2014b; McGuinness et al., 2016), leading to a lack of knowledge as to how nurses should be prepared and supported for the mentor role. Lawson (2012a) expressed concern that mentors often feel unsupported, struggle to appreciate the requirements of the role and are expected to be able to support, supervise and teach students almost at the point of registration, yet without any preparation or support for this role. Duffy et al. (2000) reported on the results of a survey that was carried out in 1999. This survey investigated the effectiveness of current arrangements for mentor preparation and the ongoing support provided with placements in Glasgow. One hundred and fifty mentors were selected through convenience sampling and sent questionnaires that included both closed questions and open space for qualitative comments. With a response rate of 47% (n=71), their results indicated that, although mentors are generally satisfied with mentorship preparation, there was concern about the issue of support from their managers and academic staff, which was reported to be problematic due to lack of time and resources.

Respondents indicated that they would like to see lecturers from the university visiting them in practice more often, in particular in relation to student assessment, with 97% of mentors considering assessment to be a critical element of mentorship. Of those, 44% of the respondents felt that support for mentorship was adequate whilst 51% felt support was inadequate. However, despite the offer of study days designed to provide initial preparation and support to mentors, 68% of mentors did not attend these for various reasons relating to staff shortages and lack of information, which highlighted a lack of clear communication between lecturers and practitioners relating to the purpose of the study days. They concluded that mentors require support for their role in supporting students on pre-registration nursing programmes and that mentors required support from managers to attend study days for mentor preparation. Due to the poor response rate and the non-randomisation of the sampling strategy for this study, the authors acknowledged that generalisation of results could be limited. Additionally, mentors in this study were not equally representative from each area in and around Glasgow, so results should be treated with caution. Duffy et al.'s (2000) findings were later supported by Finnerty and Pope (2004), who used focus groups to identify whether the preparation and support for mentorship could be more streamlined by better preparation and structured support to fulfil a diverse and demanding role as supervisors and assessors. Their findings, like those of Duffy et al., indicated that mentors find it difficult to fulfil the entirety of their role due to lack of time and resources and identified that mentors found that the current

mentor system did not offer direct support to the mentor when having to manage challenging situations.

Further strengthening the case for mentorship are findings from a qualitative study carried out by Wilson (2014b). Wilson's objective in her study was to search for insights into how mentors can be better prepared and supported to carry out the role effectively, which has been explored by the writings of many other authors who affirm that the preparedness of nurses carrying out the mentor role is crucial. Wilson used a hermeneutic phenomenological approach to explore 12 mentors' 'being' rather than 'knowing', taking the view that a mentor's reality is constituted through being in the world and in shared practices (Heidegger, 1962; Van Manen, 2002). The purposefully selected sample was of mentors working in a range of clinical settings in the UK and each participant was interviewed one to three times. Participants also supplied diary accounts of mentorship-related events for analysis. Wilson analysed data through thematic analysis. Wilson's findings added a new point to the literature by highlighting that the educational use of 'self' offers insight into the professional identity of mentors. Wilson also exposed potential hidden elements of mentorship, such as the personal and meaning-laden nature of being a mentor, with ways of being an educational agent contributing to their sense of belonging and professional identity.

The concept of belongingness and professional identity in nursing has also been explored by Fagermoen (1997); Levett-Jones et al. (2007); Levett-Jones and Lathlean (2008); Levett-Jones et al. (2009); Levett-Jones and Lathlean (2009); Johnson et al. (2012); Walker et al. (2014); and Liljedahl et al. (2016). These researchers suggest that belongingness and professional identity are important elements of becoming a nurse. With the understanding that mentorship can be enhanced by the extension of concepts such as belongingness and professional identity that are identified as being important in the process of becoming a nurse, further exploration into these concepts in relation to mentorship, and how they can be aligned to the preparation of nurses carrying out the mentor role is of importance.

Although Wilson's study (2014b) contributes to the body of knowledge in that it deepens understanding of the effectiveness of mentorship and workplace learning, Wilson focuses on the qualified mentor with no mention of how newly qualified nurses identify with 'being' a mentor and how they can be better prepared and supported. Indeed, Wilson emphasises that mentors are the tools in the business of educating student nurses, but fails to mention how newly qualified nurses might construct their professional identity when working as stage 1 mentors. Wilson's findings offer a possible interpretation of lived experiences of 12 willing mentors who had invested in the role of mentor, so the subsequent recommendations are made in acknowledgement of these limitations. The author does little to explore the choice of

methodology and explains that the potential of dealing with bias must be dealt with. In order to reduce bias, the author explains that trustworthiness was fostered using critical reflection. However, there is no further discussion of how bias was reduced, which reduces the auditability and therefore the rigour of the research. Wilson's objective in her study was to search for insights into how mentors can be better prepared and supported, which has been explored by the writings of many other authors who affirm that the preparedness of nurses carrying out the mentor role is crucial.

McGuinness et al. (2016) employ the chicken or egg conundrum to debate the preparation of registrants for mentor roles. They highlight the need for support when newly qualified nurses are preparing to become mentors in the future. The challenge they consider is not just how to prepare mentors, but who prepares and supports the mentors in practice settings, particularly in the absence of experienced mentors. McGuinness et al. offer an inverted pyramid developmental framework illustrating the complexity of skills, attributes and knowledge development required as registrants progress towards practice and teacher status. They recommend that the term 'experienced mentor' be replaced with 'practitioner' at stages 2, 3 or 4 within the developmental framework (NMC, 2008), which follows the RCN (2015) recommendation that the use of role classification in mentorship be further explored. McGuinness et al. further recommend that the terminology associated with mentorship and mentorship support be reviewed to reflect more accurately the transitional nature of engagement within the developmental framework.

Despite the recommendations given, changes made to the NMC 2008 mentorship model did not take place until 2018, when terminology was reviewed and a new model of student supervision and assessment was advocated (NMC, 2018b,c,d). McGuinness et al.'s discussion paper offers valuable insight into the preparation of future registrants for the mentor role. McGuinness et al. strengthen the argument for university nursing teachers or link lecturers to be involved in the preparation and support of mentors in practice. However, they argue that most nursing teachers may not be on the mentor register, so are not recognised as able to undertake the preparation and support of mentors. Thus, nursing teachers should be supported in adopting the role of supervising mentor and supporting newly qualified nurses in their professional development.

Becoming a nurse has proved to be a stressful experience; with the literature indicating that nurses adopt coping strategies as a result of not feeling adequately prepared (Whitehead and Holmes, 2011). The literature suggests that newly qualified nurses do not feel adequately prepared for the staff nurse role, but there is little research that questions whether novice

nurses are prepared adequately for the stage 1 mentor role. The challenge, therefore, would be to establish how these nurses can be better prepared both practically and emotionally for mentorship as a newly qualified nurse, as identified by Ebrahimi et al. (2016a) and Ebrahimi et al. (2016b). The assumption and acceptance that newly qualified nurses are prepared and ready to mentor students at the point of qualification therefore have been challenged. This questions the rationale as to why student nurses are not provided with knowledge and skills throughout their programme of study and strengthens the argument that nurses should be ready to 'hit the ground running' as they become qualified nurses. Given that they are expected to learn mentorship on the job, finding out how mentors can be prepared and supported in practice is crucial so that recommendations can be made. It could be argued, however, that on becoming a nurse, they need time to consolidate what they have learnt as students before they are expected to facilitate learning without the knowledge and skills to do so. This is further emphasised when considering the content of preceptorship programmes that focus on the advancement of clinical skills, but could be used as an opportunity to prepare newly qualified nurses with mentorship skills for the future.

There is a lack of empirical evidence around the nature of preparation and support for mentorship, specifically around the stage 1 mentor role. Although the role of stage 1 mentor is no longer current in nurse education, nurses are still required to facilitate student learning in practice, and this remains a requirement of The Code (NMC, 2018e). The Code section 9.4 (NMC, 2018e) stipulates that all nurses should 'support students' and colleagues' learning to help them develop their professional competence and confidence'. It would seem therefore that additional clarity of roles and responsibilities is needed not only for those who support students, but for the support of mentors, and that mentors needed more preparation and structured support to fulfil a diverse and demanding role as supervisors and assessors. Furthermore, the new Standards for Student Supervision and Assessment (NMC, 2018c) also require all nurses to play a broader, more supervisory role in student nurse education in practice.

2.7 Nurses' Experiences of Mentorship

In order to strengthen the findings of Brown et al. (2012), a survey of mentorship practice carried out by Douglas et al. (2016) reported nurses' perceptions and experiences of mentorship from the qualitative findings that had not previously been reported by Brown et al. (2012). The original survey carried out by Brown et al. (2012) was devised to gather both quantitative and qualitative data with questions that linked to themes from Duffy's (2003) study. The results from the quantitative data were published by Brown et al. in 2012 from a sample of NMC-approved mentors (n=4,341). Of the mentors, who were from the West of Scotland,

41% responded to closed questions and 7% responded to the open-ended questions within the survey. Brown et al. (2012) acknowledged the low response rate may have been because mentors thought the quantitative section of the questions had addressed their views, and over-reliance on narrative data derived from questionnaires was a limitation of this study, as no interviews or focus groups were carried out. From the thematic analysis of the qualitative narrative accounts given in the questionnaire, Douglas et al. (2016) identified one overarching theme, support, highlighting the nature and quality of support that mentors receive from the university. The findings suggested that mentors experienced confidence through the support of link lecturers and practice education facilitators who provided them with advice and guidance, particularly when they had concerns about students. These findings support those of Duffy (2003) and Veeramah (2012) who also found that regular support from link lecturers and practice education facilitators helped mentors perform their role more effectively and confidently.

Mentorship in contemporary practice, according to Myall et al. (2008) is integral to students' clinical placement experiences and highlights the importance of providing mentors with adequate preparation and support. Myall et al. (2008) also used a two-phase quantitative design to explore the experiences of students and their mentors, with data on mentorship being the focus for the second phase. Phase 1 included semi-structured interviews with academics and clinical staff, and then a survey of pre-qualifying students via self-administered questionnaires. In this phase, data was collected from 161 pre-qualifying students using a 27-item online questionnaire with a 10% response rate. In phase 2, a 31-item postal questionnaire using open and closed questions was then given to 156 randomly selected mentors with a response rate of 21%. The paper reported findings from phase 2. Quantitative data was statistically analysed using SPSS, and qualitative data that derived from open-ended questions was analysed inductively to identify main themes from the findings. Myall et al. found that 85% (n=108) of mentors experienced a positive and rewarding sense of job satisfaction and felt proud to see their students develop. On the other hand, 68% (n=86) of mentors reported experiencing constraints on their role, including increased workload and lack of preparation to carry out the role.

Providing support for mentors to carry out their role was identified, with 38% (n=48) of mentors experiencing adequate support from university link lecturers. However, caution should be exercised when interpreting these results in the context of differing expectations mentors have of the link lecturer role. The low response rate to both questionnaires was noted by the authors as a limitation for their study, but they stated that the low response rates were acceptable as the numbers were representative of the student population. No follow-up procedure was employed. There was no mention of screening questions for objective neutrality which could

have contributed to honest and unbiased answers from those completing the questionnaire. Response bias might have resulted from general questions as opposed to personal wording of item statements, which might have had an impact on the validity of the questionnaire. These response rates were disappointing, but whilst these findings complement previous research and draw similar conclusions to earlier studies, the implications of the findings are only applied to the qualified mentor in contemporary nursing, rather than all nurses who support students in practice.

Bray and Nettledon (2007) conducted a multi-professional study involving qualified nurses, doctors and midwives and their mentees, which investigated both mentee and mentor perceptions and experiences of the mentorship role. This mixed-method study consisted of both questionnaires and semi-structured interviews with the aim of exploring factors that influenced the mentee–mentor relationship and how mentoring was conceptualised in the health setting. Interesting to note was that, when mentors were asked why they became a mentor to student nurses, they responded that it was ‘expected of them’ and that it was seen as part of the staff nurse role. The role was allocated to them routinely due to the high volume of students on placement and one participant commented that she felt ‘*railroaded*’ into becoming a mentor, like it or not (p. 209). Even though participants reported that they were happy to undertake mentorship responsibilities, they all confirmed that they struggled with their dual identity as mentor and nurse. Findings reflected those from other studies that there needs to be a clearer role definition, and that nurses should be allowed to choose to become a mentor because they want to, not because they are told to.

Middleton and Duffy (2009) used a qualitative approach to explore the experiences of twelve purposefully selected community nurses who had mentored pre-registration students prior to registration. A series of three focus groups were used to interview mentors. Data was analysed using a modified version of Burnard’s (1991) framework using constant comparative analysis, but no further discussion was included as to what extent this framework had been modified. Findings suggested that mentors working in the community felt pressurised to pass students by giving them the benefit of the doubt. Middleton and Duffy (2009) concluded that mentors experienced a lack of support and development opportunities, especially in relation to the assessment of final placement student nurses. Though this study offers some clarity around the experiences of mentors and the challenges that they face, bias, which is a common criticism of qualitative research, was considered by the authors as a limitation of the study, as participants self-selected to participate in the study after receiving written information. However, in order to reduce researcher bias, a systematic analytical framework was used alongside independent researcher analysis. The researchers made no claim that the findings

could be generalised to the wider population of community nurses. It would appear that the findings from this study are similar to those of Duffy et al.'s (2000) findings from their 1999 survey where 51% of mentors felt support was inadequate.

It would seem from the literature that nurses experience mentorship as demanding and stressful, struggle with the complexities of their role, and do not feel adequately prepared for their role as mentor. The studies discussed in this section focused on how nurses experience mentorship from the perspectives of qualified mentors but failed to address how stage 1 mentors might transition into the mentorship role without the necessary qualification, and how they might identify as unqualified mentors in the reality of practice. Therefore, it is necessary to explore further how nurses without the mentorship qualification experience how they feel supported and prepared for the stage 1 mentor role. Despite the plethora of studies that explore mentors' experiences of mentorship, there appears to be a lack of empirical literature pertaining to how newly qualified nurses' experience working as stage 1 mentors.

2.8 Students' Experiences of Mentorship

In the main, many of the problematic experiences that pre-registration students have in practice are mitigated by the support of exemplary mentors who practise mentorship at its very best. Foster et al.'s (2015) research explored nursing students' expectations and experiences of mentorship using a sequential mixed-methods design. Semi-structured focus groups were carried out with 12 students, and then 53 out of 129 students completed a questionnaire giving them a response rate of 45%. The findings highlighted that students expected their mentors to be exemplary role models and act in a professional manner with an overall positive experience of mentorship. However, Foster et al. also found that students were able to recognise mentors who did not have the desire or willingness for the role and felt that the university should support mentors better. The need for support from universities is also supported by Jokelainen et al. (2011) who reported the need for HEIs to provide adequate resources and systematic preparation for mentors. It would seem, therefore, that it is essential to ensure that newly qualified nurses are supported for the mentoring role and that universities strengthen the link lecturer involvement in mentorship and support newly qualified nurses as well as students.

Foster et al.'s study found that mentors should be good role models and that poor mentorship is clearly one of the influencing factors of stress and anxiety. The low response rate, however, makes it difficult to make a judgement about how representative the obtained sample was relative to the projected study sample. However, while the study offers some clarity about the value of student nurses' experiences, this study had several limitations, so generalisations

need to be made with caution. The study was confined to one pre-registration nursing student group from one university in London, making it hard to gauge whether the findings can be generalised to other education and practice settings in the UK. Current evidence clearly confirms the value of mentorship when done well. Indeed, knowledge gleaned from Foster et al.'s study provides a greater understanding of students' expectations and experiences of mentorship, and identifies the positive contribution that mentors, link lecturers and universities give to student learning. Yet there is no research into the extent to which stage 1 mentors make a positive contribution to the experience and education of students.

Lascelles (2010) explored the experiences of students and their mentors, and how their relationship in practice impacts on student learning. Using a qualitative longitudinal case study approach, six graduate students undertaking a postgraduate pre-registration programme were interviewed with their mentors. Following Ritchie and Spencer's (1994) framework for thematic analysis, Lascelles found that these students experienced increased motivation, assertiveness and better utilisation of their initiative, using self-directed learning strategies to analyse and synthesise knowledge and apply it to their practice. Significantly, Lascelles reported that positive student–mentor relationships facilitated a better learning experience and were central to developing students' confidence. These key findings emphasise the process of mentorship in terms of its impact on its key purpose, being student learning and ability to apply this to practice, and not being just a good role model. These findings could therefore provide a clearer conceptualisation of how students experience mentorship in nursing and could add to the notion of what represents good mentoring. However, Lascelles acknowledged that her case study did not explore the experiences of the students throughout their whole programme, so was unable to report on their experiences as they transitioned from being students to becoming nurses. Further, the study was carried out in one institution, which may have impacted on the findings; however, this limitation could be diminished by the variety of clinical areas participants were selected from.

The findings from this study, and that of Foster et al. (2015), support the notion that, if they are mentored well, students can use their own initiative to seek out and engage in learning opportunities without the direct observation of their mentor. Where there is an effective working relationship between student and mentor, students' experiences of being mentored can provide an important foundation to becoming good role models as they become mentors themselves. Mentorship in nursing can be complex, as students can be mentored by a variety of mentors, both good and bad. These studies highlight the importance of how student nurses experience being mentored, but also raise issues about some of the challenges faced by the mentors in the reality of practice.

2.9 Challenges of Mentorship

Mentors are responsible for the assessment of nursing students' practical competence, attitudes and behaviours (NMC, 2008) and for preventing failing students from registering with the NMC. However, nurses have been found to struggle with the complexities of being a mentor, such as juggling day-to-day nursing activities with carrying out summative assessment in practice (Bray and Nettledon, 2007; Nettledon and Bray, 2008) and facilitating deep learning (Wittman-Price and Godshall, 2009; Nielsen, 2016). It is not surprising that, given the complexity of mentorship in nursing, there are a number of other challenges that mentors need to overcome. The RCN (RCN, 2015, p. 16) reported challenges that mentors felt they experienced, such as lacking protected time to support students and lacking ongoing training and development for them to fulfil the role effectively. These challenges, alongside competing clinical demands, transitioning and becoming a nurse, have been seen as contributing to high levels of stress and anxiety in nursing (Kramer, 1974; Whitehead, 2001; Ferguson, 2011). There have been several studies carried out that have explored the many challenges of mentorship: for example, the challenges of failing students (Duffy, 2003; Gainsbury, 2010a; Gainsbury, 2010b; Mead et al., 2011; Black, 2011; Brown et al., 2012; Black et al., 2014; Hughes et al., 2016), lack of protected time (Myall et al., 2008) and tensions between obligations to students and patients (McIntosh et al., 2014).

Evidence suggests that one of the challenges for mentors is when to fail and when not to fail a student's clinical competence. Using a grounded theory approach, Duffy's (2003) study, funded by the NMC, set out to identify factors that influence the decisions regarding assessment of students' competence in practice. Using a sample of 14 lecturers and 26 mentors from three Scottish universities, semi-structured interviews were carried out to uncover the challenges that mentors and lecturers face when assessing students, and to explore their individual perceptions as to why some student nurses are being allowed to pass clinical assessments without having demonstrated clinical competence. Of concern were findings that revealed students were passing clinical assessment despite the mentor having doubts of their capabilities. Mentors identified that failing a student was not only difficult from a practical perspective, but personal and emotional feelings played a part in their decision-making requiring support. Duffy (2003) reported that failing to tell students that they have not met the required standards does not protect the interests of the public and puts patients at risk. She concluded that failing a student in practice requires confidence, experience and adequate preparation and that preparing mentors for their role and responsibility was vital.

Duffy's study criticised nurse mentors who were willing to pass students inappropriately, and for not failing students who demonstrated a lack of clinical competence in placement. She also highlighted the many challenges that mentors face every day, such as reluctance to commit anxieties to paper, the emotional cost of failing students; also identified by Ebrahimi et al. (2016a&b), and inadequate documentation for student problems. Duffy reported that mentors were willing, in certain circumstances, to fail students inappropriately and recommended that a national survey be conducted to establish the number of students who fail programmes based on their clinical competence. However, it is important to note that Duffy's study was carried out in Scotland, so applicability to England could be questioned because of the variations of mentorship between the four UK countries. Nonetheless, there have been further studies since, investigating continued concerns about 'failing to fail' (Duffy and Hardicre, 2007; Rutkowski, 2007; Nettledon and Bray, 2008; Gainsbury, 2010a; Gainsbury, 2010b; Black, 2011; Mead et al., 2011; Brown et al., 2012).

Gainsbury's frequently cited online survey, conducted at a mentor conference, found that 37% (n=1945) of mentors passed under-achieving students where the student should have failed, despite having concerns about the student's competence and attitude. One major drawback of her approach to recruitment is the selection bias, as the sample were mentors attending a conference, so were considered by the author as a captive audience. Further, there was no demographic information given of participating mentors, and information was unclear as to the nature of their workplace, making it impossible to make an accurate judgement of the generalisability of these findings. There was also insufficient data about the composition of the survey sample to make an accurate judgement in terms of the generalisability of the findings. The same applies to the findings from Gainsbury's second study in 2010 (Gainsbury, 2010b), as this failed to offer any demographic information about the participants or any information of methodological aspects of her study.

Later, Mead et al. (2011) utilised a mixed-methods approach with two phases, including group interviews with 50 mentors and a survey of 94 self-selected mentors who were delegates at another mentorship conference in South Glamorgan. For comparison purposes, questions in the questionnaire were taken directly from Gainsbury's online survey carried out in 2010 (Gainsbury, 2010a). Data from Mead et al.'s survey revealed significant differences to those of Gainsbury. In Mead et al.'s study, only 10% of mentors agreed they could not fail students compared to 40% of mentors who took part in Gainsbury's survey. Mead et al. (2011) further found that 80% of mentors disagreed that they would not fail a failing student because their decision might be overturned by the university, leaving 20% who admitted to passing a failing student. This compared to 69% of mentors admitting to failing a student from Gainsbury's

survey. The survey in Mead et al.'s study was then followed by a series of group interviews with 50 mentors to obtain qualitative data, but there was no further discussion about this data found in this article. The significant difference in Mead et al.'s and Gainsbury's findings can be seen as indicating more research is needed in relation to mentors' willingness to fail students. After the publication of Gainsbury's results, the NMC wrote to all UK Directors of Nursing to find out how they intended to address the problems highlighted from that study. The NMC assumed that Gainsbury's data could be extrapolated to all mentors throughout the UK. However, further research in this area has led nurse mentors and those responsible for nurse education to question the validity of these findings to their practice (Mead et al., 2011; Brown et al., 2012; Duffy and Hardicre, 2007; Hughes et al., 2016).

Hughes et al. (2016) conducted a systematic integrative literature review to investigate whether the term '*failure to fail*' was a catchphrase or a real issue in nurse education. From a selection of 24 studies, Hughes et al. confirmed that '*failure to fail*' is a real issue in nursing with many complex facets to consider, such as the emotions and confidence of mentors, student characteristics and the emotional support provided by the university in a fail situation. Emotional support for nurses was also raised by (Ebrahimi et al., 2016a) who identified barriers to support new graduated nurses included a lack of support-seeking behaviours, management weaknesses, ineffective communication, personal characteristics, and cultural barriers. Similarly, in a cross-sectional survey design study, Bachmann et al. (2019) also set out to confirm internal consistency and reliability of the subject-specific '*failing to fail*' from a sample of 561 Norwegian nurse mentors. Using Likert scale questions, the 30 items related to reasons why they passed a student when they should have failed. The internal reliability coefficient was confirmed for the items in the pilot study as Cronbach = 0.89. Questionnaires were distributed online via email to 2,380 nurse mentors, with a low 23.6% response rate, though follow-up strategies were employed. The five-point Likert-style statements about their decision-making can be criticised in terms of response style bias.

Response styles are response biases that respondents display independent of the content of the questions (Dolnicar et al., 2011), which might have resulted from the general as opposed to personal wording of statements. Furthermore, such a crude five-point scaling method might not enable the researchers to determine and examine the complex interrelationships between variables such as age, gender and context of the workplace. Since the mentorship of nursing students is dependent on a whole variety of interacting variables, the use of scaling approaches to examine the subjectivity of failing to fail is not without problems. However, factor analysis confirmed a five-factor structure of the '*failing to fail*' scale with adequate model fit and it proved feasible to test whether mentors are failing to fail nursing students.

Similar to much of the previous research mentioned into the challenges of the mentor role, compounded by the complexity of healthcare in the 21st century and the diversity of students' learning needs, nurses working as mentors continue to face many challenges. Challenges found include managing workload and time commitment, the lack of protected time to support students, the lack of ongoing training and development, and the challenges around rigorous assessment of practice. Black et al. (2014) used a qualitative hermeneutic approach to explore the many factors that prevent nurses from failing students. Employing a purposive sampling strategy, a sample of 19 mentors from 7 different healthcare organisations were interviewed using reflective cue questions to facilitate openness and allow the participants to express their true experiences. Following data analysis, a new horizon of understanding emerged in the form of three key themes. These were: experiencing moral stress, demonstrating moral integrity and ensuing moral residue. The findings highlighted that mentors felt guilty as they believed they had not been good enough as mentors to turn the failing student around, but they also felt a sense of moral integrity and professional accountability around fitness for practice decisions.

Being faced with a decision to fail a student in the final placement resulted in physical and psychological feelings and emotions, which challenged their values and beliefs about mentorship. Black et al. questioned whether mentors in the UK who fail to fail incompetent students are in fact negating their duty of care. Though this study illuminates a new horizon in moral courage in mentorship and adds value to mentors' experiences of failing to fail students in their final year, the study sample is limited to the South-East of England. However, findings from other similar studies reinforce the value of this study and strengthen the need to explore further the challenges that mentors face during clinical assessment. Black et al. recommended that discussions on courage, moral integrity, moral stress and decision-making be considered in mentorship programmes, and that mentors should be offered coaching sessions to help them work through difficult assessment decisions. They also recommended early support for new mentors and that leaders in nursing should develop a culture that promotes courage and integrity in mentorship.

McIntosh et al. (2014) reported on a funded project examining the many challenges associated with the mentorship role. The study employed a mixed-methods approach using both focus groups and questionnaires with mentors working in an Acute Trust and a Community Trust. 130 mentors were convenience sampled to complete questionnaires with a response rate of 46.9% and two focus groups were held with six mentors from the Acute Trust and seven mentors from the Community Trust. Descriptive statistics resulted from the questionnaire and focus group data was transcribed and analysed in line with the process of data reduction.

Participants reported encountering a range of challenges, including time management and competing demands of the role, the completion of practice documents and an overarching emphasis on competence and assessment. Assessment of practice outcomes was seen as a major challenge, with documentation being arduous and overly competence based. The mentors pointed out the complexity of the assessment process and the need to ensure that students were competent at the point of registration. The questionnaire data highlighted that 33% of mentors saw their practice education facilitators as their main source of support. 23% found their peers to be the main source of support, with only 5% finding support from university lecturers.

Although the size and local composition of the samples in this study confine its generalisability, it offers a worthwhile hypothesis to test through research in other settings. In keeping with other studies, mentors in this study reported several challenges associated with being a mentor, which were compounded by the increasing complexity of managing their own learning as a novice nurse and that of students' learning. Webb and Shakespeare (2008) also found that mentor–mentee relationships were key in determining outcomes of assessment. Mentors play a fundamental role in the assessment of students and have a responsibility to the NMC, particularly when 'signing off' to become registered nurses. The literature suggests that mentors' experiences are varied, but there continues to be many issues and challenges faced by them every day, particularly around assessment (Duffy, 2003; Gainsbury, 2010a,b; Mead et al., 2011; Brown et al., 2012; Black et al., 2014; Hughes et al., 2016). Challenges that nurses face as mentors in today's healthcare environments have highlighted the fact that mentors must be equipped for mentorship, so that they can manage certain situations in practice.

The literature provides additional evidence that mentors find the mentorship role challenging and that balancing conflicting demands as a nurse adds to the complexity of the mentorship role. Future research into how to prepare nurses for the challenges of the mentor role could further highlight the importance of preparedness. It is particularly pertinent given the introduction of the practice supervisor role which, to be fulfilled well, requires preparation, support and guidance. The questions to be asked, however are, who will provide the preparation and how will this be facilitated? At the time of writing this review, the preparation of practice supervisors has yet to be established.

2.10 Conclusion of Literature Review

There is a need to build on existing literature and explore the value of newly qualified nurses working as unqualified mentors so that findings can be applied to the preparedness and support for the practice supervisor role. Therefore, highlighting the gap that this research can

fill, by finding out to what extent newly qualified nurses feel prepared for mentorship is vital so that they can be prepared for the competing demands and challenges of this role. This literature review was first carried out at a point in history where there were clear mentorship standards which had to be followed within the profession (NMC, 2008). If a nurse wanted to be a mentor, they attended an approved programme of study at a university to 'train' as a mentor and gain the formal qualification of stage 2 mentor. This stage 2 mentor was considered 'prepared' to take on the role in an effective and competent manner. Since the introduction of the new SSSA (NMC, 2018c), the requirement to be formally prepared for mentorship has been removed and the requirement for nurses, who are often just newly qualified, to become practice supervisors has been introduced. This role requires all registered nurses (and other registered health and social care professionals) to support and supervise students in the practice learning environment but stipulates that they should be 'capable of supervising students, serving as role models for safe and effective practice' (NMC, 2018c, p. 6).

The SSSA herald a new era in nurse education, equipping the profession for an increasingly demanding and complex healthcare environment (Hoy and George, 2018). With the new standards for pre-registration nursing and the increasing need to support and prepare newly qualified nurses for their future role, this research is important and timely. The issues and gaps highlighted from the literature review enable me to examine how eight newly qualified nurses, who had not yet been formally prepared to mentor, experience carrying out the mentorship role. Understanding these challenges can inform the way that the supervision of students who require the knowledge and skills to take on a learning support role in the future will be better understood. Against this backdrop, this present study focuses on an area of mentorship that has previously been overlooked. This review has highlighted the role of the newly qualified nurse working in a mentorship role for which they have not been prepared or trained, has not been adequately articulated or clarified, and remains one of the least understood practices in contemporary nurse education.

Although the literature shows considerable work has been done to conceptualise mentorship in the context of nurse education, it could be argued that the studies have failed to address the concept of mentorship from the perspective of the newly qualified nurse who has not been prepared for the mentorship role. Whilst the studies reviewed have played a significant role in further understanding the value of mentorship in the context of nursing, they also raise concerns as to the negative effects of poor mentoring in practice on mentees. There is a need, therefore, to challenge the traditional approach to mentorship in order to reflect 21st-century nursing and the education of students. For example, perhaps the more formalised and traditional way students are currently mentored discourages mentors from being innovative

and creative in the way they teach students in practice. Therefore, the benefits of peer mentoring, peer learning, peer-assisted learning and good role modelling to run alongside the more traditional approach to mentorship could be significant. Hence, a move away from dyadic forms of mentorship is recommended by the new standards (NMC, 2018c), which propose that prescriptive models of mentorship be discarded in favour of more innovative approaches to student support. It is these standards that suggest that all nurses play a broader, more supervisory role in student nurse education in practice. The present study, therefore, is timely.

2.11 Summary of Chapter

This chapter has critically examined the knowledge base around mentorship and answered the question: '*What is already known about mentorship in nursing?*' This chapter has provided an explanation of how literature was searched systematically, and the timeline associated with the search and review has been made explicit. The evidence in this chapter has highlighted the importance of mentorship in nurse education and provides an insight into mentorship in the context of nursing. Attention has been given to literature under eight pertinent themes that relate to: the conceptual meaning of mentorship, the effectiveness of mentorship, peer mentoring, negative effects of mentorship, the preparation and support for mentorship, nurses' experiences of mentorship, and students' experiences of mentorship and the challenges of mentorship. Although this literature review provides a framework for other researchers to build on, it also raises further questions for consideration, such as how newly qualified nurses prepare for mentorship, how they acquire knowledge and skills for the mentor role, how they might transition into mentorship and how they might identify as stage 1 mentors.

The following chapter presents the research methodology that was used for the present study. The method of inquiry is explained, alongside the sampling strategy and method of data collection employed. The chapter also provides a detailed view of self-reflexivity and personal reflections throughout my research journey.

Chapter 3: Research Design and Data Collection

3.0 Introduction to Chapter

This chapter provides an account of the design of the study. Firstly, it considers the reasons for adopting a qualitative stance and then the specific research design selected is described, detailing the differences between Husserlian and Heideggerian philosophies. My own ontological and epistemological position is made explicit, as is how the role of reflexivity in countering bias was dealt with in this study. Extracts from my research journal are presented throughout, to address the '*researcher's self*' and show insight into how challenges were dealt with. How rigour and, specifically, trustworthiness were established throughout the study is detailed. The research setting and participant demographics are described alongside the process of recruitment and selection of the nurses who volunteered to participate in the study. Proceedings associated with ethical approval, permission to access participants, informed consent and confidentiality are catalogued. The chosen method of data collection is examined critically and an account of how the interview guide was formulated from the conceptual framework and how the semi-structured interviews were conducted is provided. As the analysis of data was complex, a separate chapter (Chapter 4) then details the process of analysis in depth, using the principles of Interpretive Phenomenological Analysis (IPA), and how this inductive approach was operationalised.

3.1 Research Paradigm

A research paradigm is considered both to be a fundamental set of beliefs and assumptions of how the world is seen, and to act as a framework to guide the design of the study (Jonker and Pennink, 2009). Each paradigm has different underpinning epistemological and ontological assumptions. Epistemology is about 'how we know what we know' (Crotty, 1998, p. 8). In epistemological terms, my stance is social constructivist, which aligns with my ontological perspective in that the nature of knowledge is co-created and can only be drawn from those that know. I acknowledge the importance of double hermeneutics, where the researcher is 'trying to make sense of the participant trying to make sense of their world' (Smith and Osborn, 2015, p. 26), and that knowledge of the world is constructed through social communications. As such, I ask the participants in this study to share with me their subjective perspectives of their experiences of mentorship, which I then interpret. This means developing a description of each individual, analysing data for themes, and finally making an interpretation and drawing conclusions about its meaning. It also means that data is filtered through a personal lens that is situated through the subjective world of stage 1 mentorship.

This epistemology underlies my entire research process and is not only consistent with the aim and interpretive design of this study, but provides a philosophical grounding for deciding the methodological procedures for this study. Knowledge is socially constructed through the meanings acquired about the phenomena studied; researchers interact with the subjects of study to obtain data (Coll and Chapman, 2000), rather than it being objectively determined. Thus, what is explored about being a stage 1 mentor can be negotiated within their cultures and social settings and their relationships with other people. As advocated by Clough and Nutbrown (2002), researchers with this epistemological stance tend to carry out qualitative studies that seek to explore and interpret specifics about a phenomenon that is taken for granted. Thus, the way that knowledge is generated in this study is to hear the voices of eight newly qualified nurses from their point of view, as they are the ones who have experienced this phenomenon for themselves.

In seeking to expose the social reality of this topic, my ontological position is that of a social constructivist. I inherently bring my own beliefs and assumptions about the nature of mentorship that may influence my approach throughout this research. It is therefore important that these beliefs and assumptions be acknowledged from the outset, as they could impact on the choice of research method as well as how data is viewed. As a researcher, I acknowledged my individual attributes and insight into mentorship and felt that my theoretical position, interests and perspective could have some impact on my research questions and the process of data collection and analysis. However, I carefully recorded my viewpoints and biases in a research journal to avoid contamination of the data and make my biases explicit. The main focus of Heidegger's (1962) interpretive method was to develop an ontological understanding of 'how we live in the world'. My position is firmly rooted in interpretivism where I aim to make sense of and understand participants' personal experiences and is closely linked with constructivist epistemology (Guba and Lincoln, 2005; Hefferon and Gil-Rodriguez, 2011). The interpretivist paradigm seeks to understand how individuals construct reality in their natural settings focusing on their experiences (Guba and Lincoln, 1985).

3.2 Adopting a Qualitative Stance

Since the aim of this study was to gain an in-depth understanding of the experience of stage 1 mentors working in an unqualified capacity and appreciate fully *their* world from *their* perspective, a qualitative research design was deemed most appropriate. Qualitative enquiry was selected for several reasons. Firstly, there was little published evidence on the subject. No empirical literature that examines the experiences of newly qualified nurses working as unqualified mentors was found. Bowling (2014) explains that qualitative research can be particularly useful when there is little pre-existing knowledge, as it allows maximum opportunity to explore complex issues. Also highlighted in this paradigm is the opportunity for the

researcher to get closer to the research material and to gather in-depth information (Bowling, 2014). Petty et al. (2012) explain that qualitative research allows us to understand and interpret human experiences so we can engage with issues that are central to the participant. Being able to engage with the participants was particularly important in this exploratory study, as it allows them to explain and explore their feelings and experiences. As qualitative research seeks to explore the world by gaining an understanding of the experiences and feelings of those within it (Petty et al., 2012), choosing a qualitative approach for this study is appropriate to discover the experiences of stage 1 mentors in their world.

As an alternative approach, quantitative research explains phenomena by collecting numerical data, quantifying behaviours, actions and other variables. Quantitative research in this area may have been suitable to measure, for example, the factors that affect the preparedness of newly qualified nurses for mentorship. It would not, however, have met the research aims of this study. Whilst it would enable the gathering of objective data, and possibly list the challenges that these nurses face, this approach would not enable the gaining of a rich and deep understanding of the lived experiences of the unqualified mentor. It may have resulted in a much narrower and superficial dataset. Hence adopting a quantitative approach might have resulted in a rather limited understanding of the research problem. By using a qualitative approach, a gap in the literature is addressed and in-depth understanding of stage 1 mentorship is enhanced. Indeed, being able to capture the multi-faceted nature of this phenomenon through qualitative research enables the voices and experiences of stage 1 mentors to be heard, which is the substantive feature of this study.

3.3 Research Design

There are several possible research designs within the qualitative paradigm that could be used to explore the experiences described within this study. Phenomenology appealed, as I wanted to understand what it is like to be in the world of stage 1 mentors. Phenomenology is essentially both a philosophy and a method of studying and describing human experiences (Holloway and Wheeler, 2002; Speziale and Carpenter, 2007). It is an interpretive approach that provides a methodological structure suitable for nursing research studies (Crotty, 1996). Reiners (2012) asserts that phenomenologists assume that knowledge is achieved through interactions between the researcher and participant and is considered subjective, inductive and dynamic. Phenomenology aims for fresh, complex and rich descriptions of a phenomenon as it is concretely lived (Finlay, 2009). It is responsive to both the phenomenon and the subjective interconnection between the researcher and the researched.

3.4 Theoretical Foundations of Interpretive Phenomenological Analysis (IPA)

IPA is essentially an integrative interpretive phenomenology (Finlay, 2009). Many researchers have been inspired to use this approach as it has a commitment to explore, describe, interpret and situate the participants' sense-making of their experiences. Conceptualised by Smith (1996), Smith (2007) and Smith et al. (2013), IPA has been developed as an interpretive phenomenological approach to analysing qualitative data. It offers a theoretical foundation and a detailed procedural guide for the analysis of qualitative data. IPA draws on an inductive method of data analysis. That is, the analysis is led by the data, and requires an in-depth qualitative analytical approach which enables detailed examination of personal lived experience (Smith and Osborn, 2015). IPA is intended to produce an interpretive account of lived experience in its own terms rather than one prescribed by pre-existing theoretical conceptions. As both a philosophical framework and method of analysis, the theoretical foundations of IPA are underpinned by Heidegger's interpretive phenomenology (Heidegger, 1962), and the central notion behind this approach is to learn about the lived experiences of the participants, in this case, stage 1 mentors. IPA brings together three branches of philosophy, namely idiography, hermeneutics and phenomenology (Figure 5 refers) and is committed to the examination of how people make sense of their major life experiences (Smith et al., 2013).

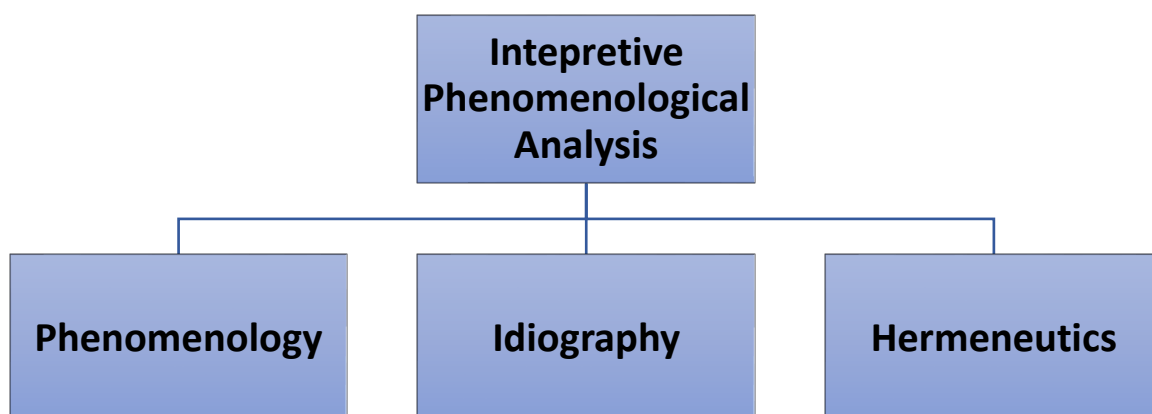


Figure 5: The three philosophical branches of IPA

The word '**phenomenology**' is derived from the Greek word 'phenomenon', meaning 'to show itself', and simply defined by Polit and Hungler (2001) as a 'research tradition with roots in philosophy and psychology that focuses on the lived experiences of human beings' (p. 64). Phenomenology is a philosophical approach to the study of experience, is embedded in psychological research and is often applied to research within the health and social sciences (Reid et al., 2005; Smith et al., 2013; Eatough and Smith, 2017). Essentially, IPA is phenomenological in that it is concerned with capturing lived experiences and involves the detailed consideration of participants' 'life worlds' (Husserl, 1964). Therefore, a phenomenological approach allows me to explore newly qualified nurses' experiences of working as unqualified mentors, focusing on meaning and interpretation rather than causality.

Idiography has had a major influence on IPA and attempts to provide a detailed analysis of the subjective experience of the social world. Idiography is concerned with the *particular*, and with understanding comes meaning for the individual, rather than an attempt to establish universal and causal laws. There is a commitment to a sense of detail and therefore in-depth analysis is required. Idiography is important as it makes a commitment to the single case and moves to the general by detailed analysis of other cases (Smith et al., 2013). The interpretative component of analysis results in meaning that is contextualised and, in this study, the context is each participant's place of work. An idiographic approach assumes a viewpoint where the participant is an active interpreter of their subjective world, rather than a passive recipient (Eatough and Smith, 2017). This means that, in this study, there is no objective truth or reality, but more, it enables the researcher to question what the experience means to this individual, and what sense the individual makes of what is happening to them. Idiography therefore enables the researcher to gain an in-depth understanding of the stage 1 mentors' individual perspective of experiences and the role they assumed. IPA provides the opportunity to develop an idiographic understanding of the experiences of the stage 1 mentor and what it means to them within their social reality.

Hermeneutics is a method of interpretation (Smith et al., 2013). IPA is connected to the core principles of hermeneutics, through paying respectful attention to a person's experience and by encouraging participants to tell their own story in their own words (Smith et al., 2013). IPA employs a 'double hermeneutic' where the researcher tries to make sense of the participant making sense of their experiences in their world (Smith and Osborn, 2015). This double process of interpretation enables the researcher to generate data on the critical reflection and memory of the participants and how they make sense of their experiences. Engaging in double hermeneutics is an attempt to comprehend and make sense of stage 1 mentors trying to make sense of what is happening to them within the context of their mentorship role, as illustrated in Figure 6.

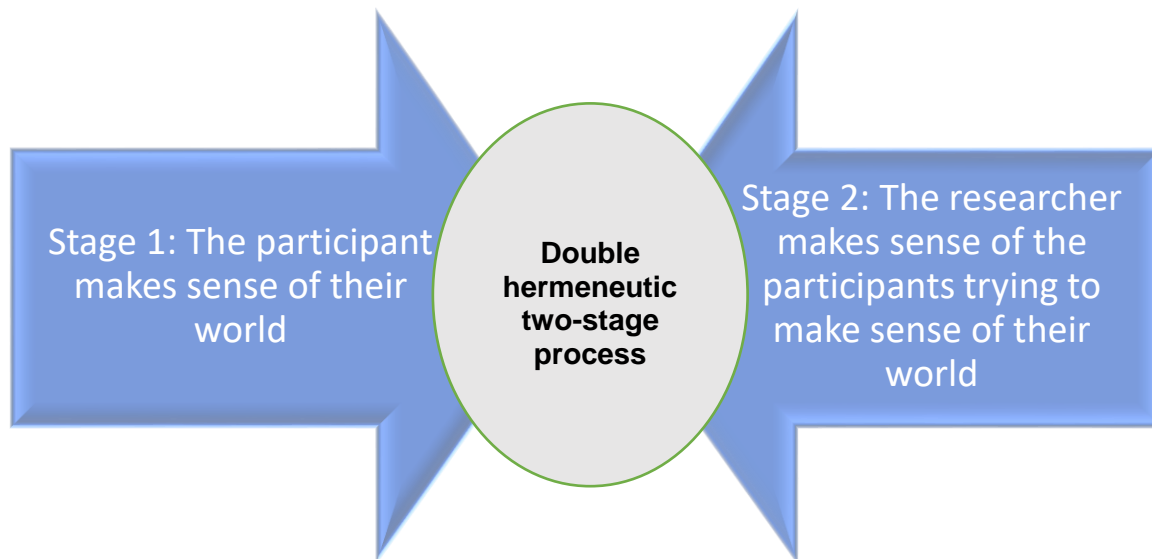


Figure 6: The double hermeneutic two-stage interpretation process, adapted from Smith and Osborn (2015)

The founding philosophers of phenomenology were Edmund Husserl and Martin Heidegger, whose views were very different, and much has been written about their theoretical assumptions of phenomenology (Sartre, 1956; Heidegger, 1962; Merleau-Ponty, 1962; Husserl, 1964; Gadamer, 1975). These philosophers raised the question of how we come to know what we know and how being within this world allows us a temporal and relational perspective on our lives (Smith et al., 2013). According to Moustakas (1994), Husserl's philosophy was transcendental or descriptive, and grounded in setting aside all preconceived ideas to see phenomena through unclouded glasses, whilst Heidegger's philosophy was hermeneutic or interpretive. Heidegger (1962) wanted to go beyond the world of pure description to develop an understanding of '*being in the world*' or '*Dasein*'. He conceptualised *Being* as '*being in the world*' which requires the researcher to approach the understanding of *Being* in a certain way. He rejected the notion of the person (subject) as a viewer of objects, separated from the world, and considered the object and subject to be inseparable. Both philosophies are explored below.

3.4.1 Husserlian Philosophy

Husserl believed that we are always already in the world and that our only certainty is our experience of our world. Examples of Husserlian purists are Colaizzi (1978) and Giorgi (1985), who adopted the Husserlian philosophy that considers the position of 'conscious recognition'. Husserl subscribed to *intentionality* – that is, having a clear intention to observe a phenomenon with as pure a mind as possible with the desire to *bracket out* or remove one's own

preconceived ideas (Fitzgerald, 1995; Mackey, 2005). Husserl believed that the researcher could suspend the *natural attitude* and open consciousness to a naïve or innocent mind state. Thus, transcendental phenomenology was created, using a three-step approach containing *Anschauung* – looking at the phenomenon, *Intentionality* – being conscious of the phenomenon, and most notably *Bracketing* – which involves separating the phenomenon from one’s own beliefs and experiences (Fitzgerald, 1995). Husserl’s position could provide a philosophical foundation for this study with the researcher as a detached observer, where the phenomenon could be observed with ‘wide open eyes’ clear of any preconceived ideas (Colaizzi, 1978). However, I was unable to separate myself from the participants’ experiences. I did not want to simply describe my participants’ stories or just present raw data; I wanted to be able to interpret what they said so that I could co-construct meaning about the ‘*being in the world*’ of stage 1 mentors. Therefore, Husserlian philosophy was not deemed appropriate for this study, and also not congruent with my own philosophical position.

3.4.2 Heideggerian Philosophy

Whilst Husserl strived for a phenomenology that was clear of preconceptions, Heidegger’s philosophy was hermeneutic (Holloway and Wheeler, 2002; Mackey, 2005; Polit and Beck, 2012). Heideggerian phenomenology does not promote putting to one-side preconceptions of the researcher (Dowling, 2007; Parahoo, 2014). Heidegger originally built on the work of Husserl as his student and fellow philosopher. Heidegger disagreed with transcendental (descriptive) phenomenology and was sceptical about Husserl’s idea of phenomenological reduction. Heidegger argued that researchers cannot separate or distance themselves from the world and its object. He believed that the researcher is indivisible from thoughts and feelings, and that participants’ experiences are entwined with these feelings and impossible to separate (Van Manen, 2002; Giorgi, 2011). His central interest was to raise the issue of *being*, which he specifically referred to as the human being, or loosely translated as ‘*Dasein*’ or ‘*being there*’ (Heidegger, 1962, p. 62).

Heidegger’s idiographic notion of one ‘*being in the world*’ was therefore deemed most appropriate, as the intention for this study was to explore the ‘particular’ of the experiences of what it was like ‘*being in the world*’ of the participant – the stage 1 mentor. According to Van Manen (2002), Heidegger’s interpretive phenomenology eliminated bracketing, asserting that impartiality was impossible because researchers are often embroiled with the experiences of the people they are exploring. Johnston et al. (2017) declare it would be inattentive not to utilise the researcher’s own lived experiences of the phenomena under investigation.

3.5 Criticisms of Phenomenological Research

There appears to be much debate in the nursing literature (Crotty, 1996; Mackey, 2005; Finlay, 2009; Reiners, 2012; Wilson, 2014a) when it comes to the use of phenomenological research. Crotty (1996) reported there was often confusion between the two philosophical assumptions of Husserlian and Heideggerian phenomenology and criticised many nurse researchers' interpretation of phenomenology as a method for undertaking qualitative research. Crotty proposed that research conducted by nurses is not phenomenology according to the European tradition but uses a North American hybrid. Subsequently, there has been much debate about the use of phenomenology as a methodology in nursing research and what the implications are for the conduct of research. Barkway (2001), for example, examines this debate and the implications of Crotty's work and finds Michael Crotty's book *Phenomenology and Nursing Research* (Crotty, 1996) to be judgemental and fault-finding in its criticism of nurses using phenomenology for their research. However, despite her criticisms, Barkway (2001) concludes that Crotty presents a well-argued critique of phenomenological research in nursing and cannot be ignored. She goes on to suggest that the challenge is for nurses to lay aside their preconceived attitudes to the book and engage with the critique that Crotty articulates. Similarly, Finlay (2009) believes that researchers should be clear about which philosophical tradition they are following. Terminology in nursing research is confusing, with epistemologies, theoretical perspectives, methodologies and methods '*thrown together in grab-bag style as if they were all comparable terms*' (Crotty, 1998, p. 3).

Although IPA is acknowledged as a well-established modern qualitative research design, this phenomenological approach has also been critiqued for being unsystematic and subjective, having conceptual and practical limitations, and lacking methodological rigour (Hall, 2006; Larkin et al., 2006; De Witt and Ploeg, 2006; Hefferon and Gil-Rodriguez, 2011; Willig, 2012; Tuffour, 2017; Dennison, 2019). Further, Giorgi (2011, p. 212) argued that IPA fails to satisfy recognised scientific criteria as it lacks structure and is riddled with ambiguities. He reported that it lacks standardisation and is descriptive in nature and not sufficiently interpretive. Similar concerns have been articulated by Sousa (2014), who claimed that IPA lacks coherent theoretical and methodological foundations, causing rigour and trustworthiness to diminish. Further, Tuffour (2017) raised the question as to whether IPA can accurately capture the meanings of experiences rather than opinions of it. Tuffour questioned whether both participants and researchers have the requisite communication skills to successfully communicate the nuances of experiences. The communication skills of the researcher were also questioned by Willig (2012), who asserted that phenomenology is only suitable for eloquent individuals. This criticism could be seen as slightly elitist, suggesting that only people

who are able to articulate in a satisfactory manner should participate in research or be a researcher.

Any possible implications of these criticisms for the conduct of IPA research need to be considered. De Witt and Ploeg (2006), for example, carried out a critical appraisal of published nursing research for expressions of rigour and criteria used to judge rigour in interpretive phenomenology. They argued that Sandelowski's (1986) use of generic qualitative criteria for interpretive phenomenological studies was problematic because it is philosophically inconsistent with the methodology and creates obstacles to full expression of rigour. Furthermore, De Witt and Ploeg (2006) contended that rigour, in terms of conveying methodological rigidity, is inadequate and inappropriate, with philosophical inconsistencies between interpretive phenomenology and the criteria of credibility and confirmability. They revealed several obstacles that interfere with rigour specific to interpretive phenomenology. However, in response to De Witt and Ploeg's (2006) critical appraisal, Sandelowski (2006) objected to the way they used her work as an example of an inadequate criterion. She felt that they had committed the cardinal error of failing to contextualise her original paper from 1986 to the present day. She argued that the language they had used masked and obscured the unique characteristics of her discussion around interpretive phenomenology. Despite her disapproval, Sandelowski (2015) later wrote that she agreed that no consensus exists. She then pointed out that to evaluate the quality of qualitative research; a researcher should not be confined to a single set of criteria.

3.6 Justification for Choosing IPA

Despite the methodological concerns noted above, the interpretive approach used in this study brings a higher level of standardisation and coherent theoretical and methodological foundations by acknowledging the relationship between the researcher and the participant in interpreting the data. The concern of methodological rigour (as highlighted by Hall, 2006; Larkin et al., 2006; De Witt and Ploeg, 2006; Hefferon and Gil-Rodriguez, 2011; Willig, 2012; Tuffour, 2017; and Dennison, 2019) has been addressed in this study by my commitment to engage with the phenomena in an attempt to delve beyond descriptive accounts into a more detailed in-depth analysis of stage 1 mentoring. The resulting narrative of the findings discussed in Chapter 6 thus presents a carefully constructed account of the experiences of stage 1 mentors that are grounded in details of their own words.

IPA as an interpretive phenomenology was chosen for this study, as it acknowledges the researcher's role in interpreting the data. I acknowledge that my interpretations are affected by me being a nurse and a mentor and the way I belong in my own world. Thus, my experience of being a mentor is of value as it contributes to the depth and breadth of analysis. IPA thus

embraces my impact on the data and acknowledges that the interpretation is a result of me being in my world and my resultant interpretations of participants' lived experiences. Adopting an interpretive phenomenological approach for this study was deemed appropriate as my research aims and questions were centred on the desire to understand and give meaning to the early experiences of newly qualified nurses working as unqualified mentors.

As a nurse and a mentor exploring the world of stage 1 mentorship, it was important I selected a method and philosophy of data analysis that discovers lived experiences using a process of analysis in which the researcher enters the participants' world (Reid et al., 2005). Choosing IPA as a framework for analysis enabled me to give a sense of understanding and sense-making of the stage 1 mentors' reality, allowing meaning to be ascribed to mentors' experiences. The primary rationale for using IPA, therefore, was to allow analysis of the complex multi-faceted working lives of newly qualified nurses, to better understand how they experience mentorship and what it means to them. The use of IPA links well with the aims of this study, allowing for a rich and detailed understanding of the stage 1 mentors' experiences. The rationale of adopting IPA as an analytical framework (as discussed in Section 4.1) for this study enabled an in-depth analysis of a group of newly qualified nurses who do not typically have a strong representation. However, critics of IPA question its methodological rigour and to what extent the meanings could be captured by inexperienced researchers, and argue it is only suitable for the most eloquent individuals (Shinebourne and Smith, 2010; Tuffour, 2017). However, strength is given to this research because of the systematic and critical way that this study has been undertaken, and because it faithfully conveys important aspects of the participants' experiences. The attention given to this study makes it as trustworthy as possible so that the data has a strong degree of credibility.

3.7 Considering Epistemology and Ontology

IPA's epistemological and ontological stance aligns with a constructivist paradigm and resonates strongly with the understanding and reconstruction that the stage 1 mentors in this study hold. Epistemology is about 'how we know what we know' (Crotty, 1998, p. 8). As such, I ask the participants in this study to share with me their subjective perspectives of their experiences of mentorship, which I then interpret. The theoretical foundations of IPA are underpinned by Heideggerian interpretive phenomenology and the central notion behind this approach is to learn about the lived experiences of the participants, in this case, the stage 1 mentors. The use of IPA means that generalisations cannot be made from this study, as I recognise that any interpretations of my data are shaped by my own understandings and experiences as a nurse and mentor. In other words, I do not accept a positivist notion of objectivity.

3.8 The Role of Reflexivity in This Research

The role of reflexivity is examined consciously to acknowledge any assumptions and presuppositions brought to the research process and to this study. In order to make my experiences, opinions, thoughts, actions and feelings visible, I acknowledged that I am part of the research process and through showing how I engaged with my research journal demonstrated the notion of transparency in the research process. I acknowledged, in my research journal, my thoughts and preconceptions throughout the process of inquiry, and re-read it often at this point to remind myself what I was actually asking the literature. Through a process of reflexivity, I sought to reveal assumptions and premises I developed from the literature, so I was able to recognise evidence of any literature contamination. Indeed, it was through this reflexive process that I was able to remain self-aware and explore and understand the world of mentorship in the context of contemporary nursing. My epistemological and ontological positions place great emphasis on reflexivity in that, as a researcher, one cannot escape the personal interpretations brought to qualitative research.

Reflexivity is an intrinsic feature of qualitative research and refers to the constant and critical reflection of the researcher's decision-making process (Etherington, 2004; Jootun et al., 2009). Northway (2000) emphasised the importance of reflexivity in making research accessible and unambiguous. Reflexivity, however, is not without challenge and is seen by some as being fraught with danger. Pillow (2003) cautioned against excessive reflexivity, and argued that reflexivity is not a way to solve the 'problem' of subjectivity. Despite its critics, reflexivity is generally cited as an important tool for enhancing the rigour and trustworthiness of a qualitative study (Jootun et al., 2009; Gilgun, 2008; Gringeri et al., 2013).

In the present study, being reflexive involved the acknowledgement of my pre-existing background and interest in mentorship within nurse education, and the continuous examination of my own beliefs and judgements during every step of the research process. To demonstrate my reflexivity, I have provided in the chapters of this dissertation excerpts of my journal entries. These excerpts present pre-existing assumptions and preconceptions that had the potential to shape decisions. The entries also made visible the power dynamics that existed in my relationship with the participants in this study. The excerpts also include self-reflections, reflections post-meetings with supervisors and summaries of discussions I had with my peers.

These journal entries or personal narratives were invaluable as they enabled me to examine and consciously acknowledge how I might have shaped my study and influenced research decisions. Importantly, they enabled me to mitigate against influencing all steps of the research process. This is important in research, especially when the area under investigation

and participants are known to the researcher. Jootun et al. (2009) stated reflexivity enhances the quality of research through its ability to extend our understanding of how our positions and interests as researchers affect all stages of the research process. The constant awareness of the need to be reflexive throughout the entirety of my study was critical, as it enabled me to undertake a more effective and impartial analysis and not be misled by my own experience and interpretations. Maintaining a research journal was a means by which I attempted to bring my own consciousness and predetermined beliefs to the forefront of my research. As Jootun et al. (2009) asserted, such reflection adds credibility to any research. Indeed, reflexivity was essential as it enabled me to understand newly qualified nurses' early experiences of working as unqualified mentors, and in itself is seen as an intrinsic part of good quality IPA.

I did not use a research journal in the first year of my doctorate programme (EdD), as I was unclear as to its value. However, having explored why using a journal throughout data collection and analysis is central to the rigour of any qualitative enquiry (Primeau, 2003), I soon realised that it would be an invaluable means by which I could ensure rigour in my study. Any issues and challenges arising from being an insider, including disparities in power, coercion or assumptions made by myself or the participant, were also recorded in my journal. These issues and challenges were managed primarily through reflexivity. In my journal, I was able to demonstrate my collegial relationship with my participants, and my position as an insider-researcher. Innes (2009) defines an insider-researcher as someone who conducts research about home communities, such as one's own profession, and who shares experiences with the research participants.

McDermid et al. (2014) assert that being an insider allows for familiarity, respect and rapport with participants, and is likely to increase participation and richness of research data. Although working as an insider allowed me to access in-depth information from my participants, my insider status meant I had many commonalities with my participants, and thus perhaps what some would argue is an over-familiarity with the research context. Sharing these commonalities can present challenges during the process of data collection. For example, being seen by the participants as a nurse with mentorship experience might have been a barrier to them sharing their experiences. In addition, the inherent risk of being seen as a lecturer as opposed to a researcher was considered. I did indeed become aware at the beginning of the early interviews that participants were initially somewhat reserved, probably because I was a member of academic staff. For example, when I asked specific questions about some of their activities as a mentor, one participant responded by saying '*why are you asking me, you know what we do*'. I was concerned that participants might not provide details of their experiences because of our shared common knowledge. In order to address this, I reiterated at every interview that I was there as a researcher, and not as a nurse, mentor or

academic. On the contrary, my insider knowledge was also of value as it enabled me to speak in their own language as a nurse and a mentor during the initial few questions, and thus I could put them at ease.

Costley et al. (2010) assert that being able to draw on the shared understanding and trust of participants as an insider is a useful means of creating an informal atmosphere and rapport, so interactions and conversation become more valid and meaningful. Indeed, being an insider stimulated an increased desire to address my own feelings and beliefs, which led me to openly acknowledge in my journal the influence of working as a mentor. Being reflexive throughout this study enabled me to be mindful of my own personal feelings and biases stimulated by the eight interviews; the exploratory studies carried out at the beginning of my doctoral journey and published literature.

In summary, the process of reflexivity throughout this study enabled me to identify, acknowledge and mitigate against influencing the research process and the participants' experience. Being reflexive meant maximising the extent of being honest within research practice. To fail to acknowledge my interests in this research, or to assume a value-free position of neutrality, would be to assume what Shacklock and Smyth (1998, p. 67) call 'an obscene and dishonest position'. My reflections as a researcher were important to elucidate the subjectiveness within the interpretive paradigm.

3.9 Establishing Trustworthiness

According to Guba and Lincoln (1985), interpretivist studies must satisfy the criteria for trustworthiness. They describe these criteria as credibility, transferability, dependability and confirmability and provide evolving methodological guidelines for the evaluation of qualitative research. Table 2 illuminates how the criteria associated with trustworthiness and advocated by Guba and Lincoln (1985) were applied in the current study.

Table 2: Strategies used for establishing trustworthiness in this study according to Guba and Lincoln (1985)

Criteria Associated with Trustworthiness	Strategies Applied
Credibility	Interview guide tested with two stage 1 mentors using two pilot interviews.
	Interviewing process and techniques training in London.
	Peer debriefing at different stages through the data collection and analytical process.
	Thick description of the study process from exploratory work, literature review to data analysis.
	Flexibility during interviews.
	Familiarity with phenomenon and research context.
Dependability	Audio recording during interviews.

	Transparent transcription process keeping data secure. Critical friend peer-reviewed first two transcripts against audio files for accuracy.
	Establishing an audit trail by developing a detailed track record of my data collection process and accuracy of interview documents and recordings.
	All steps in identifying key concepts discussed with critical friend and supervisors.
	Systematic data analysis process. To maintain consistency, I documented each step of the process in research journal and kept a trackable record of when and how decisions were made.
	Sceptical peer and supervisor review of analysis process and coding to assess if my findings, interpretations and conclusions are supported.
Confirmability	Engagement with reflexivity to monitor my own biases, beliefs and personal experiences – I maintained my reflexive journal and shared entries with supervisors and critical friend. I recorded any issues that were sensitive to the participant and any ethical issues that arose from the interviews. These were discussed with critical friend and supervisors.
	Participants' experiences interpreted and analysed through my own knowledge and experience (Heideggerian).
	Inclusion of raw data to demonstrate themes.
Transferability	Purposeful sampling techniques used to make sure selected participants were representative of the variety of experiences across different clinical settings. Small sample size so each experience examined in depth.
	Descriptions given in Chapter 3 present information about the participants' context, allowing the reader to identify with applicable settings and determine the appropriateness of my findings.
	Contextual/demographic information about study participants provided.
	Sufficient detail of context provided to enable reader to decide if prevailing environment is similar to another situation and whether findings can be applied to another setting.

To further demonstrate the trustworthiness of this study, criteria proposed by Yardley (2011) were also considered alongside those of Guba and Lincoln (1985) as they were specific to IPA. Smith et al. (2013) favour the 'four principles' approach of Yardley (2011), who provides a framework to evaluate the trustworthiness of research. Yardley's four principles are sensitivity to context; commitment and rigour; transparency and coherence; impact and importance.

Table 3 illuminates how the criteria associated with trustworthiness as proposed by Yardley were applied in the current study.

Table 3: Strategies used for establishing trustworthiness in this study according to Yardley (2011)

Criteria Associated with Trustworthiness	Strategies Applied
Sensitivity to context	Interactional nature of data collection with stage 1 mentors at the interviews.
	Putting the stage 1 mentors at ease throughout the interview process, recognising any interactional difficulties such as shyness and negotiating power play where research expert meets experiential expert.
	Throughout the interview process, participants seemed comfortable, and I paid close attention to what they were saying at all times.
	During the analysis, immersive and disciplined attention to each of their unfolding stories, thereby demonstrating sensitivity to the raw material that I worked with.
	Sensitivity to context refers to sensitivity to participants' perspectives, such as showing empathy, helping the participants feel at ease and recognising the power dynamics between participant and researcher during the interview.

Commitment and rigour	Commitment and rigour are demonstrated through in-depth engagement with the topic, and my methodological competence and skill through data collection and depth/breadth of analysis.
	The process and completion of analysis were carried out to a sufficient interpretive level showing an in-depth window into the lives of eight stage 1 mentors.
	The final set of major themes and elements of these themes are presented with sufficient extracts of verbatim data to support each theme that represents a thorough analysis.
	Rigour was ensured by discussing coding structures, my process of analysis and themes with a colleague experienced in the use of IPA, to ensure that my final set of themes was grounded in the data. Willig (2012) suggested that initial themes should be grounded in the data and marginal to the phenomenon.
Transparency and coherence	Highlighting clearly the stages of this research process and detailing an audit trail of my judgements in journal.
	I reflected carefully how stage 1 mentors were recruited and selected, how the interview guide was constructed from the conceptual framework, and adjusted following the pilot interviews, and what steps took place for the analytical process. Maintaining my research journal enabled me to demonstrate coherence and a clear audit trail.
	Decisions made regarding presentation of raw data, analysed data, data collection tool utilised and activities in the present study have been shared with critical friend and supervisors.
	Tables and figures have been presented to illustrate features of the study or to offer a summary of details discussed for easy reading.
	Transcripts were also read alongside listening to the audio to ensure transparency in relation to how the themes were developed through the analytical process that I have been through.
	After each interview, I reflected on my role and my behaviour so that I could critically examine my practice, so the effects could be laid open.
Impact and importance	I reflected on the impact and importance not only to add to any existing knowledge and understanding of mentorship, but to gain new insights into the importance of the stage 1 mentors' practice from which new assumptions can be made.
	The findings from this study contribute to an understanding of how newly qualified nurses should receive the preparation that they need to fulfil the role, but also will fill some of the gaps identified in the literature review.
	My expectation is that the importance and impact of this study inform the development of practice supervisors.
	The use of a 'critical friend' throughout the analysis process enabled me to maintain the credibility of this study.

3.10 The Research Setting

The setting for this research was a Higher Education Institution (HEI) in the South-East of England. Approximately 200 nurses, midwives, social workers and allied healthcare professionals come to attend the university to attend the Preparation for Mentorship module which is delivered all year round. The participants recruited for this study were newly qualified nurses working as stage 1 mentors and were students studying for stage 2 mentorship qualification.

3.11 Recruitment of Participants and Sampling Strategy

The goal at this stage of the research process was to persuade potential participants to participate in my research and share their personal experiences of working as unqualified mentors. The aim was to try and find a group of stage 1 mentors to whom the research questions were relevant and personally significant. Although the participants all needed to have worked as stage 1 mentors, I realised that volunteers would be working in a variety of

clinical settings and might possess a wide range of personal characteristics, for example, age, gender and ethnic orientation. However, in keeping with the tenets of purposeful sampling, the sample was not selected based on personal characteristics, but rather on the basis that they had experience of working as unqualified mentors and could contribute to an in-depth understanding of the world of the stage 1 mentor.

Whilst there is not an absolute agreed sample size within IPA, the sample should be small enough to enable an idiographic analysis (Smith et al., 2013), but big enough to provide a sufficient perspective on the phenomenon. The use of a small sample of participants in a phenomenological study is not problematic as generalising to the wider population is not the intention. Rather, the aim is to discover information about the lives of newly qualified nurses working as stage 1 mentors through the analysis of their experiences. In contrast to random sampling strategies used in quantitative research, IPA research focuses on the detailed in-depth analysis of small samples that are suited to the research question (Smith and Osborn 2015). Hefferon and Gil-Rodriguez (2011) and Smith and Osborn (2015) recommended having no more than three to six participants for an IPA study. Smith et al. (2013) later advocated no more than eight participants as an adequate sample size for a doctoral study using interpretive phenomenology, provided that the interviews yielded adequate data to allow in-depth analysis of the study topic. Following Smith et al.'s guidance, I judged that this sample size was acceptable for this study. Although this low number of participants could be considered a limitation of this study, the number was adequate in generating rich data that contributed to the understanding of newly qualified nurses' experiences of working as unqualified mentors.

In keeping with IPA requirements, Smith and Osborn (2008) recommended a small and fairly homogenous sample for a research study. Patton (2002) suggested that homogenous sampling is in direct contrast to maximum variation sampling, allowing the researcher to select a particular subgroup (in this case, mentors). However, as expected, volunteers came from a variety of clinical areas and from different local NHS Trusts. Participants came from a variety of ethnic backgrounds and varied in age, nationality, gender and nursing experience since graduation. However, all participants came from an Adult nursing background and did not include nurses from the other three fields of nursing (Children, Mental Health and Learning Disability). Therefore, it could be argued that this was a homogeneous sample, because all participants were from one field of nursing, although their clinical areas did differ. This wide range of clinical areas was to be expected and represents a spectrum of adult nurses working within this geographical location. Therefore, the ultimate homogeneous sample with all participants the same was not possible. However, Shenton (2004) recognises that one way of triangulation may involve a wide range of variants in participants, allowing viewpoints and

experiences to be verified against others. Hence, the variations around workplace, age, gender and nursing experiences ultimately create a rich picture of stage 1 mentorship and promote confidence in establishing trustworthiness in this study. (The demographics of the final participants group are captured in Table 4, p. 71 refers.)

To access stage 1 mentors studying at the university, a message was placed on the university Managed Learning Environment (MLE) inviting them to take part in the study. As students at the university, they had access to the MLE at any time, so were free to read the information sheet (Appendix 5 refers) before deciding to participate. The information sheet contained contact details of the researcher and invited the recipient to make contact if they wished to take part in the study. The introductory message stated that when attending an interview, they would be required to sign a consent form (Appendix 6 refers). Initially, there were many volunteers who made contact, but most had been qualified nurses for many years. I realised on reflection that the information sheet was unclear exactly who could volunteer for the study, as I had assumed that all stage 1 mentors on the module had only been qualified for one year. At this point, I reflected in my journal my assumptions, as below.

"I obviously made an assumption that all nurses who came on the course had been qualified for only one year as per NMC recommendations. I didn't realise loads of them had been qualified for years as I had never actually asked them" (Journal entry LL).

In order to address this, an amended message was placed on the module site asking for volunteers who had been qualified for no more than two years. As the numbers were so high for the mentorship module, students were split into three groups with classes held on different days for each group, with one lecturer per group. The message was intentionally posted for volunteers in a different group to the one I looked after, so they would have had no interaction with me at all. It was critical for me to keep in mind that there is no correct or optimal relationship with participants, and that the power relationship varied during each stage of the research process, namely recruitment, data collection and analysis of data. From the beginning of the research process, I was honest with myself and the participants about the nature of the partnership at each of these steps. However, some anxieties on this were documented in my journal:

"I'm feeling nervous about asking my own students to participate in my study even though they didn't know who I was. I worry that they might feel that they have to participate because I am the module leader, and they might think I have influence on their grades. I've found a paper on power relations in qualitative research by Karnieli-Miller (2009) which I must read on how to reduce the power relationship between me and the students" (Journal entry LL).

Finally, ten stage 1 mentors volunteered for the study, who all met the eligibility criteria detailed in Table 4 and represented a perspective rather than a population of all nurses.

Table 4: Eligibility criteria used for participant selection

Eligibility Criteria
Be a qualified nurse and stage 1 mentor for no more than 2 years.
Have had exposure to mentoring students.
Willingness to participate in this study.
Informed consent given and signed.

At this point, a decision was made to stop recruiting. Having fewer participants for an in-depth study is preferable to a broader, shallower and simple descriptive analysis of many individuals (Smith and Osborn, 2015). There was no intention to achieve a representative sample in terms of population from a large group of stage 1 mentors' experience; rather, the study aimed to present an in-depth examination of the phenomenon. A large data set may result in the loss of 'potentially subtle inflection of meaning' (Collins and Nicolson, 2002, p. 626). Thus, the emphasis here was on depth rather than breadth, and so gave me an opportunity to examine in detail each case in its entirety, and then identify similarities and differences between individuals. It was considered whether the original number of ten volunteers might be too large for this sort of study. However, two of the volunteers later decided to withdraw from the study for personal reasons. Fortunately, they agreed to give me the opportunity to practise interviewing with them, so I could try out my interviewing skills and for the purpose of piloting the interview guide (Appendix 7 refers). A summary of the final group of eight participants is detailed in the next section.

3.12 Final Participant Group

A final sample of eight stage 1 mentors was recruited for the study. Table 5 provides a summary of the participant profile with demographic and contextual information about the participants. To protect their identity, each participant has been provided with a pseudonym.

Table 5: Demographic profile of participants

Pseudonym	Length of Time as Stage 1 mentor	Gender	Age	Workplace Speciality
Tom	15 months	Male	27	Orthopaedics Ward
Vaiya	2 years	Female	23	Intensive Care
Gabby	2 years	Female	24	Theatres
Rizza	2 years 3 months	Female	29	ENT Ward
Regita	18 months	Female	38	Accident and Emergency
Emily	22 months	Female	29	Elderly Care
Martha	2 years	Female	23	Surgical Ward
Abbas	2 years	Male	24	Medical Ward

Though Rizza had been qualified for over two years as per inclusion criteria, she only worked part-time, so I felt could be included in the sample group. The participants' ages ranged between 23 and 38, though only one participant was over 30 years old. The eldest participant (Regita) had come into nursing later in life after achieving a first degree in psychology and was studying nursing as her second degree. The sample included six females and two males who were from diverse personal, ethnic and clinical backgrounds and of various ages. The proportion of female nurses reflects the nursing population, which is predominantly female (Yar et al., 2006). It could be argued that this under-representation of male nurses could be a limitation within the study, though the sample was not intended to be representative of all nurses. As such, it is likely that the experiences of other nurses from other backgrounds, workplaces, gender or ethnicity could be very different. It is also likely that the experiences of the males might have been different to those of the females based on their responses to some of the questions. Smith et al. (2013), however, suggest that gender-related differences are clear in the way that men and women respond to interviews. Therefore, it was probable that a sample from one particular gender or cultural background could face other issues, thus giving a different set of results. However, the rich data collected from them all was detailed and had the benefit of their experiences working as a stage 1 mentor.

3.13 Ethical Considerations and Permission for Access

Ethical approval was granted (Protocol no: 11-12.1) (Appendix 8 refers) by the Social Sciences, Arts and Humanities Ethics Committee at the University of Hertfordshire in 2012, with an investigation end date of 1 September 2014. Following ethical approval, I obtained verbal permission from the Programme Leader and Dean of School to access stage 1 mentors who were about to commence the Preparation for Stage 2 Mentorship course. No attempt was made to conceal the nature and purpose of the research, and a clear statement was made via the MLE concerning the confidential nature of any information collected.

Stage 1 mentors had the right to freely decide to participate in the present study without fear of coercion and with a full knowledge of what was being explored. The right of non-maleficence was addressed by ensuring that the need of the study was not placed above the wellbeing of the stage 1 mentors. Therefore, interviews would have been terminated if participants showed signs of stress or upset in the interviews. All participants were treated as equals and no one stage 1 mentor received preferential treatment. It was made clear that participants had the right to withdraw at any point.

3.13.1 Informed Consent

Stage 1 mentors were emailed the information sheet and consent form in order to allow them to read the information sheet away from the research environment, to consider whether they consented to participate in the study. The issue of consent was raised at the start of each interview and confirmation gained that the participant agreed to participate in the study. Consent forms were collected on the day of the interview and assurance was given that a decision to withdraw from the study at any time would not jeopardise their teaching, learning and assessment journey in any way.

The right of self-determination as stated by Parahoo (2014) means that all participants were informed that they had the right to withdraw from the process at any time, even after signing the consent form. Stage 1 mentors were reminded that any participation in the study would be entirely voluntary and were reassured that they had the right to withdraw at any time. Assurance was also given that my role was as a research student and not as an academic. All questions raised by participants were answered before consenting to participate in the study. At the outset of each interview, the plan for each interview was explained and it was indicated that I would be referring to my interview guide throughout the interview. Gerrish and Lacey (2010) assert that to respect the right of privacy, anonymity and confidentiality, the interview location should be chosen appropriately so that the risk of interruption or being overheard is minimised. Therefore, all participants were given the choice of where they would like to be interviewed. Indeed, this allowed them to give informed consent about their

participation in the study, which is another important ethical consideration in the research process.

3.13.2 Confidentiality

In accordance with the University of Hertfordshire's Good Practice in Research Guidelines (University of Hertfordshire, 2013), ethical permissions granted, audio recordings and transcripts from interviews were stored on a secure encrypted computer and only accessible to myself as the researcher of this study. Hard copies of consent forms were locked in a filing cabinet in my locked office to comply with General Data Protection Regulations (GDPR, 2018) for data protection of participants. Participants were informed that the interviews would be recorded on an iPad, and that recordings would be transcribed after the interview. Pseudonyms were allocated to each participant to protect their identity, but also to make their stories personal to the reader of this dissertation. Participants were advised that I would have a duty of care in accordance with The Code (NMC, 2018e), which provides professional standards for nurses and midwives, and that in the event of a disclosure of poor practice, I would be obligated as a nurse to report as appropriate any practice that contravened The Code or anything that might be harmful to patients, students or nursing staff. However, having to say this led me to encounter feelings of role ambiguity in my research journey. According to Moore (2007), role ambiguity is associated with role duality (being both the researcher and the lecturer) and role conflicts which are often claimed to be part of an insider-researcher's journey. Therefore, although role ambiguity was a benefit in terms of having insider knowledge and research skills, it also made data collection challenging at times. An example is noted in my journal:

"One of the stage 1 mentors told me about an episode of care with a student that had not gone well and had caused unnecessary pain to the patient. This put me in an awkward position as I was interviewing her as a researcher and not in a position of authority such as her mentor or lecturer. We had a lengthy discussion about this after the interview and I was reassured that she had spoken to her ward manager about the situation" (Journal entry LL).

3.14 Data Collection

In order to address credibility in this study, the adoption of a well-established research method was utilised. The selection of semi-structured interviews as a method of data collection for this study was guided by the ontological and epistemological positions of IPA. My ontological position stemmed from multiple influences such as my own experiences as a nurse and a mentor over the years. Through semi-structured interviews, I found meaning and understood the multiple realities of newly qualified nurses' early experiences of working as unqualified

mentors. This research was not merely asking stage 1 mentors for their views, but also providing them with an opportunity to construct a view and share their process of construction with me as the researcher. Thus, this constructivist approach to the enquiry arose from my interest in understanding stage 1 mentors' experiences.

At the same time, I recognised that the participants in this study did not hold the answers I was seeking; rather, they were part of the process of discovery. My intention was to further understand stage 1 mentorship through talking to participants and drawing together the information to form new understandings and concepts. Thus, the questions posed in the eight interviews were flexible and broad so that participants could construct their stories without the constraints of closed questioning techniques. This personal and open questioning (as suggested by Creswell, 2013, p. 25) is consistent with my ontological view that, for this study, the personal experiences of newly qualified nurses cannot be measured nor described numerically. However, the value of measuring the number of students a stage 1 mentor interacted with over a defined period could be of value, or the number of nurses whom they perceived as giving them advice could be worthy of further study in the future. By remaining open to new knowledge throughout the study, I was able to understand how the participants gave meaning to their early experiences of working as unqualified mentors.

The semi-structured interview procedure followed that of Smith et al. (2013) involving the formulation of an interview guide that was guided by the conceptual framework, piloting the interview guide and then carrying out the interviews. I wanted to give the participants the opportunity to share with me their stories and what their experiences meant to them. According to Smith et al. (2013), semi-structured interviews are the favoured means of data collection for a phenomenological study. In essence, IPA requires rich data that allows participants to freely express their experiences and stories with the researcher, who strategically introduces questions and responses (Hefferon and Gil-Rodriguez, 2011; Smith et al., 2013). Palmer et al. (2010) assert that most researchers who employ IPA for their studies have primarily made use of one-to-one semi-structured interviews.

Some studies using IPA use focus group interviews as a basis for their studies, such as Flowers et al. (2001), Macleod et al. (2002) and De Visser and Smith (2007). However, Lane et al. (2001) argue that focus groups will not always allow individual exploration of experiences or specific views, as one or more participants may dominate the discussion and could be difficult to control if participants wish to express their experiences at length. This form of data collection would have been a disadvantage for this study as it would more likely produce a consensus, rather than reveal individual accounts. Hence, focus groups were not considered suitable for answering the research questions for this study.

3.14.1 Formulating the Interview Guide

A short interview guide with prompts was formulated from the conceptual framework, my own prior experience of mentorship, and reading of relevant literature. The questions in the guide were developed from the conceptual framework to generate responses that were likely to enable me to address the research objectives. The interview guide was designed to enable the research questions to be addressed and allow the participants to tell their stories, to speak freely and reflectively and to develop their ideas and thoughts at some length.

Due to the exploratory nature of the research, the interview guide as advised by Smith et al. (2013) was kept short to enable probing of any areas of interest to emerge. The guide was designed to be flexible and short, starting with broad, general questions around the concepts that would allow the participants to lead the discussion, not the other way around. Being able to maintain a balance between guiding and being led was a challenge for me as a novice interviewer, as I did not want to impose my understanding and views about stage 1 mentors on the participant's narrative. Questions were developed in an open-ended and non-directive manner. Specific probing such as, 'can you tell me a bit more about this?', was used to develop a more in-depth understanding of their multiple realities and experiences of mentorship.

At the beginning of the interview stage, the interview guide was developed to enable focus on relevant questions. However, as a novice interviewer, I needed to be able to practise interviewing. Two volunteers were happy to trial the interview guide to test my interviewing techniques. Initially, the five-page interview guide turned out to be more of a questionnaire and the first interview therefore became a question-and-answer session. I found that, in my eagerness and anxiety to get the interview over and done with, the participant was unable to share her true experiences with me due to the speed of my questioning. Biggerstaff and Thompson (2008) assert that the interview guide should merely be the basis for a conversation. Throughout this learning process for me, my interview guide went from five pages to half a page, as I reflected in my journal:

"I realise that having such a long interview guide made the interview sound like a question-and-answer session. This is a skill that I need to develop" (Journal entry LL).

3.14.2 Learning to Interview

The first pilot interview took place early in 2013 in order to practise conducting a semi-structured interview and to test the wording used. Being new to qualitative research and IPA, I attended a two-day IPA workshop in London where we were given an opportunity to practise interviewing in a safe environment using journalistic techniques through role-play to promote in-depth discussion. The workshop also covered the development of interview schedules and

analysing qualitative data. Indeed, issues raised at this workshop on in-depth interviewing skills made me realise that I was a complete novice when it came to interviewing people for research, as my journal details:

"I soon came to realise that I was in a steep learning curve when it came to getting depth from interviewees which presents a number of challenges for me. I think I have made a naïve assumption that interviewing someone for research is that I ask a question and they simply answer. I now realise that I need to prepare myself and my interview guide if I am to get the depth I am looking for" (Journal entry LL).

My attendance at this workshop no doubt enabled me to understand the challenges of in-depth interviewing, but also led me to realise the dilemmas I could face. By the time I came to carry out my first 'real' interview for this study, I felt much more confident in the process by inviting them to simply talk about their experiences rather than me doing all the talking. Over the course of the second and third interviews, my technique in interviewing improved considerably. Whilst the rigour of this study might have been affected by my status as a novice qualitative researcher, I felt that this training enhanced my commitment and engagement with this method of data collection. Smith and Osborn (2015) assert that novice researchers find interviewing demanding and that training and supervision are important to ensure the commitment and rigour of the study. A consideration was the setting in which the pilot interviews took place. One of the interviews had to be carried out in the workplace canteen of the participant whilst she was on duty. This may have influenced her account due to worrying about being called back to work, or other people overhearing our conversation. The other participant was interviewed in one of the classrooms at the university on the day that they attended lectures. This again might have influenced their accounts due to thinking about the lectures on the day. According to Yardley (2011), ensuring that the quality of the interviews and the analysis of data are thorough demonstrates a degree of commitment and rigour.

The interview recordings were listened to on many occasions, specifically in the peaceful environment of my car on the way to work. This one-to-one engagement with their accounts allowed me the opportunity to think about and absorb what they were saying, and the deeper meanings that they ascribed to their experiences. I was able to question my own interpretations and for-understandings of mentoring, as recommended by Dahlberg et al. (2008). However, it was a struggle at times to understand my position as a researcher because of the difficulty in separating my past experiences as a nurse and mentor, as documented in my journal:

"I realise that as an insider, I am in a unique position to be able to study newly qualified nurses' experiences of working as unqualified mentors in depth as I know I have knowledge about this issue as a module leader, but also as a nurse and a mentor. However, I realise that being an insider-researcher is not without its challenges" (Journal entry LL).

Maintaining my research journal was important so that I could ensure that the stage 1 mentors' accounts remained true to them and did not unconsciously become my story. Listening to the audio in the first pilot interview made me realise that I often used leading questions. I also realised that I tended to interrupt the flow of conversation through my own enthusiasm to contribute to the conversation. Indeed, my use of leading questions and interrupting, though done subconsciously, meant that I put words into the mouths of my participants and made assumptions that the participants understood my meanings – for example, 'So how did you support the students?', assuming that they were supporting students. I realised that had I posed the more open question, 'What did you feel your role with the students was?', this would have facilitated a more open response and left the participant to answer in their own way. Therefore, post-attendance at the interview workshop, the second pilot interview was far more successful, and I was able to apply my new-found knowledge and skills in interviewing. Though these interviews were not for inclusion in the study, being able to reflect on my interviewing technique and get used to using the iPad recording application gave me an insight into what was to come next time. In addition, recording my reflections in my research journal allowed me to secure a level of rigour by reflecting on my skills as a researcher, as below:

"I felt that the pilot interviews enabled me to develop my confidence and skill in interviewing techniques, but also enabled me to reduce the number of questions I had developed from the original draft. I realised that doing these was a valuable self-evaluation tool that enabled me as a researcher to develop skills in interviewing technique which I believe is crucial to the rigour of my study. Talking to my critical friend about the pilot process helped me to make an informed judgement about how the next interviews would take place. I think I need to make sure next time that I use the interview guide as an aide-memoire rather than relying on it for the next question because I now know that I should use it in a more flexible manner to facilitate a comfortable interaction with the participant" (Journal entry LL).

The eight interviews were carried out between November 2013 and January 2014 using the revised interview guide.

3.14.3 Conducting the Semi-Structured Interviews

“I had felt quite anxious before beginning my interviews. I wondered in the beginning as a novice interviewer, whether I would be able to make the participants feel comfortable to be able to share their experiences with me” (Journal entry LL).

Putting the participant at ease, empathising and recognising any difficulties in interacting with me were key to adhering to the principles of sensitivity to context (Yardley, 2011). Also, having the ability to reduce the intricate power-play between myself and the participants was fundamental. I was aware of the challenges I might be presented with, for example, if a participant shared with me an issue in practice that might be considered as poor or unsafe practice. I documented in the information sheet and again at the start of the interview, that in the event of a disclosure of poor practice, I was obligated as a nurse to report as appropriate any practice that contravenes The Code that provides professional standards for nurses and midwives (NMC, 2018e), or anything else that might be harmful to patients, students or nursing staff. Thus, in order to acknowledge sensitivity to context and issues of power between myself and the participants, I endeavoured to demonstrate this by considering my role in the interaction throughout interviews, giving particular attention to any ethical issues that arose in the interviews. Though reflective in nature, recounting their stories in a dialogic in-depth discussion with me, I hoped would provide an accurate understanding of each participant's authentic self, and their true early experiences of working as unqualified mentors. IPA aims to explore an insider's perspective of a phenomenon, whilst acknowledging the co-constructed nature of meaning and sense-making inherent in the researcher-participant relationship (Smith et al., 2013; Eatough and Smith, 2017). A mutually convenient date, time and venue for each interview was arranged and refreshments were provided for the duration of the interview. The research setting is described in Section 3.10.

Prior to the interviews, the participants were asked if they had read the information sheet provided for them on the MLE and had signed the consent form and completed the demographic details. To maintain confidentiality and anonymity, participants were informed that the interview would be digitally recorded using my own password-protected iPad. Audio recording helps to ensure that, when the data is transcribed, the results will be as accurate and reliable as possible (Gerrish and Lacey, 2010). I was aware that the very presence of an audio machine might inhibit participants and make them feel shy and self-conscious, so I made sure the recorder was close to the participant to enable them to end recording at any time for whatever reason. Participants were informed that they could press stop at any time and were shown how to do this on the iPad. The interview guide played a part in the interview, but I

found that, once the ice-breaker questions had been asked and conversation flowed, this then became redundant in many of the interviews. Notes were kept to a minimum to pay full attention to each participant and maintain eye contact throughout the interview. The interview guide served to ensure that all participants were asked the same questions.

Though Rubin and Rubin (2012) and Kvale and Brinkman (2009) argue that interviewing should be a series of logical steps in a sequence of stages, every effort was made to ensure that the interview process was flexible but semi-structured. I aimed to ensure that if a participant introduced anything that did not relate to the question, they would have the opportunity to discuss this freely, rather than just answering the question posed. DiCiggo-Bloom and Crabtree (2006) suggest that the researcher should be prepared to depart from the planned itinerary during the interview because digressions can be productive as they follow the interviewee's interest and knowledge. They advocate that the person interviewed is more a participant in meaning-making rather than a conduit through which information is retrieved. Hence, the interviews set out to foster learning about each individual stage 1 mentor and their perspectives on their early experiences of working as unqualified mentors. Questions were initially conveyed in an open-ended and expansive manner using the funnelling technique (Hennink et al., 2011). An example of this technique can be found in Appendix 9.

I began with an introduction to warm up the discussion, then broad opening questions to provide rapport. However, I was aware that this rapport was short-lived, lasting only the duration of the interview. The process of establishing rapport is an essential component of the interview and is described in the classic works of Douglas (1985). I was aware that in a one-off interview it would be difficult to establish a rapport, and that being unable to build a rapport with participants could be viewed as a limitation. This limitation could have been avoided if I had taken the time to meet with the participants on a few occasions prior to interviews to help develop this rapport. However, practically, this might not have been possible due to the nature of my role as lecturer and the fact that participants only attended university lectures sporadically as part-time students.

Participants were encouraged to give examples of their experiences with further clarification through prompts. Specific questions and prompts were used in order to stimulate conversation and provide rich data. There were several negative or adverse experiences raised during the interviews. An explanation of this could be that being interviewed gave participants an opportunity to 'sound off', or that they tended to remember negative events more vividly than positive ones. This could have been indicative of the challenges that participants faced during

this period working as stage 1 mentors. I then finished with closing questions when I realised that the participant had nothing further to add and conversation had slowed.

3.15 Summary of Chapter

This chapter has provided an account of the design for this study. The reasons for adopting a qualitative stance and the research design were considered, detailing the differences between Husserlian and Heideggerian philosophies. The decision to employ IPA allows the reader to be taken beyond the participants' interpretations of their experiences in Chapter 5, to my interpretive analysis of the early experiences of newly qualified nurses working as unqualified mentors discussed in Chapter 6. My ontological and epistemological perspectives and the role that reflexivity played in this research were presented. Examples of strategies used to establish trustworthiness in this study are detailed according to Guba and Lincoln (1985) and Yardley (2011). The research setting and participant demographics were described, alongside the process of recruitment and selection of the nurses who volunteered to participate in the study. Proceedings associated with ethical approval, permission to access participants, informed consent and confidentiality were described. The chosen method of data collection was examined critically, and an account given of how the interview guide was formulated and how the semi-structured interviews were conducted. Extracts from my research journal have been presented throughout to address the '*researcher's self*' in this study. In order to make my experiences, opinions, thoughts and feelings visible, I have acknowledged that I have been part of the research process through keeping my research journal and using it in the writing-up process. Chapter 4 discusses the process of data analysis in more detail before findings are presented in Chapters 5 and 6.

Chapter 4: Data Analysis

4.0 Introduction to Chapter

This chapter describes how data was analysed and how IPA was operationalised in the present study. This framework for analysis shows my idiographic commitment to an understanding of the participant's particular point of view with a focus on personal meaning-making according to the analytical task. How the framework for analysis was chosen is discussed, and how my four-step framework was developed from Smith et al.'s (2013) six-step framework. My four-step framework for analysis is described in detail to make explicit my audit trail and how the initial emergent themes (IETs), the individual case-specific themes (ICSTs), the cross-case subordinate themes (CCSubTs) and cross-case superordinate themes (CCSupTs) emerged.

4.1 Choosing a Framework for Analysis

Once data had been collected, in order to familiarise myself and learn about analytical frameworks, a variety of thematic analysis frameworks were reviewed to provide me with some guidance and insight into how I could look at the data through an interpretive lens. Frameworks considered included Colaizzi's (1978) seven-step framework, which is mainly used in Husserlian phenomenology. Ritchie and Spencer's (1994) five-step thematic analysis framework was also considered but is more suited to applied policy research with the potential to generate theory. Wengraf's (2001) was also considered as it provides a comprehensive methodology for exploring lived experiences through biographic narrative interviews of an individual, namely 'The Biographic-Narrative Interpretive Method' (BNIM). This relatively new methodology provides a dynamic hermeneutic analytical framework with an emphasis on action and latent meaning, which distinguishes it within the broad and rich range of narrative approaches (Chamberlayne and King, 2000).

According to Miller (2000), the BNIM offers a practical step-by-step framework for analysing and understanding narrative life stories from semi-structured interviews. Microanalysis of the reconstructed life follows the interview stage using a reflective team approach to data analysis. The '*told story*' or thematic ordering of the narration is analysed using thematic field analysis and objectivity is maintained by keeping each stage of the analysis discrete, as well as by involving teams of researchers (Wengraf, 2001). I realised that Wengraf's approach to data analysis is based in part on grounded theory where the researcher aims to discover theory. Discovering theory did not align with the aim of my study, which was to explore how stage 1 mentors made meaning of their life experiences. Although these frameworks share some

affinity with phenomenology, Wengraf, Colaizzi and Ritchie and Spencer's frameworks were not deemed appropriate to employ as a framework of analysis for this study.

On the other hand, Smith et al.'s (2013) six-step framework is more specific to IPA. This framework for thematic analysis provides a methodological approach to analysis that allows researchers to engage in an interpretive relationship with the data (Pietkiewicz and Smith, 2014). Further, they provide a procedural guide for a phenomenological researcher, aiming to be flexible and iterative, but which could be adapted by the individual researcher according to their research objectives. Smith et al.'s (2013) six-step framework provides a guide for one possible way of analysing data in a study using IPA, advocating that the researchers need not use all six steps in the framework, or read it as a prescriptive recipe. Rather, Smith et al. (2013) suggest that researchers should be creative in their thinking, and that attachment to a prescribed set of steps does not necessarily lead to the production of high-quality rigorous research. Taking this view into account, I created my own simplified four-step framework that, for the purpose of this present study, allowed me to use the number of steps that I needed while remaining closely aligned to those suggested by Smith et al. (2013). My simplified four-step framework for analysis is explained in the next section. As I read more into this framework, I realised that it gave me clear insight into a flexible but logical process that could be adapted for my study.

4.2 Moving from Smith et al.'s Six Steps to Lawson's Four-Step Framework

Smith et al.'s (2013) six steps are: 1) *reading and re-reading*; 2) *initial noting*; 3) *developing emergent themes*; 4) *searching for connections across emergent themes*; 5) *moving to the next case*; and 6) *looking for patterns and connections across cases*. Smith et al.'s Steps 1–5 were amalgamated into my Steps 1 and 2, which were the transcription and interrogation of the data, followed by the identification of initial emergent themes (IET) within each individual case. Step 2 became the organisation and grouping of the IETs with the generation of individual case-specific themes (ICST). These first two steps were the individual case analysis across each of the eight participants.

Smith et al.'s Step 6 became my Steps 3 and 4. Step 3 involved the grouping of individual case-specific themes (ICST) to generate a number of cross-case subordinate themes (CCSubT), and then Step 4 involved the grouping of the cross-case subordinate themes, and the development of cross-case superordinate themes* (CCSupT). In IPA, the terms superordinate and subordinate are used to indicate a higher and lower ranking of importance respectively. Steps 3 and 4 were the cross-case analysis of the eight participants. The four-

step framework for analysis is presented below in Figure 7, showing the operation of each step.

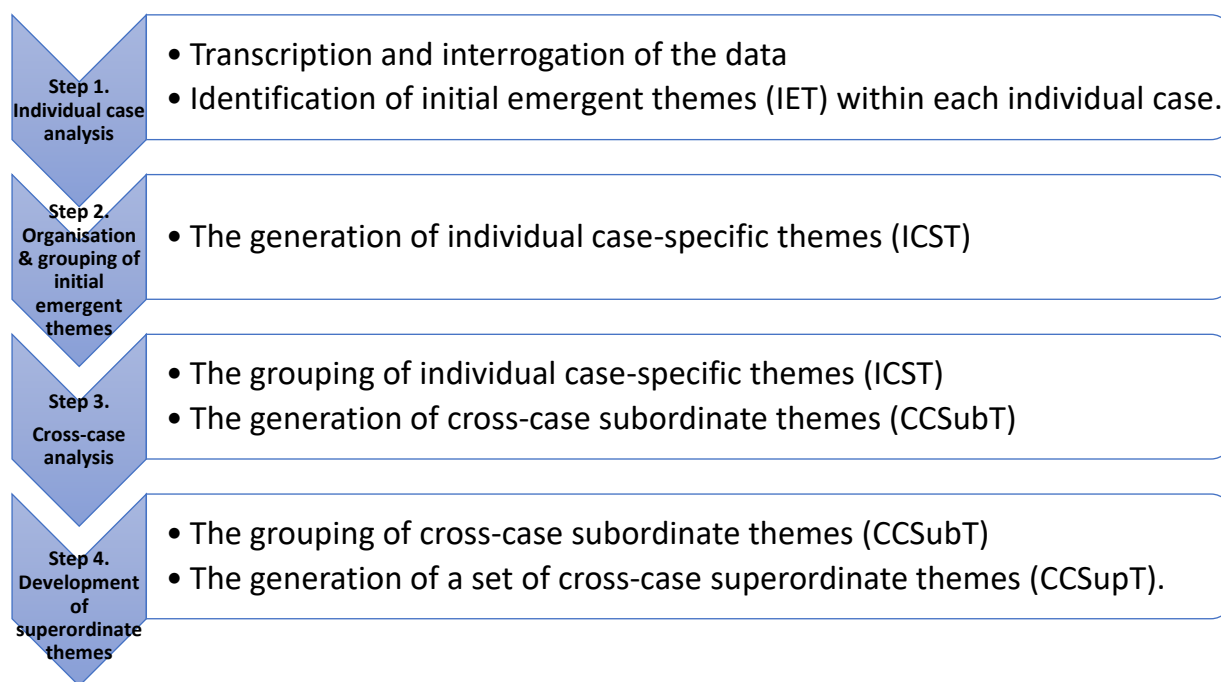


Figure 7: Lawson's Four-Step Framework for Analysis

My four-step framework enabled me to look at the particular (the individual cases in Steps 1 and 2) and then move to a deeper level of interpretation through the cross-case analysis (Steps 3 and 4) across all eight cases. The four steps within my framework brought trustworthiness to the process by illuminating a transparent data analysis process to make the audit trail clear. These steps are now discussed in depth to describe how they were operationalised.

4.3 Step 1: Individual Case Analysis

In line with Smith et al.'s (2013) idiography of the particular, each individual case was central to this enquiry where I sought to understand as much as possible about one case before moving on to the next. The first step in understanding the particular was to immerse myself in the data through repeated reading to gain a general sense of understanding about each individual account. By examining the findings from each individual case, assertions were made about what it is like to be in the world of stage 1 mentors without preparation.

4.3.1 Transcription and Interrogation of Data

This first step involved active engagement with the audiotapes, which was vital to gain an in-depth understanding of the participants' experiences. As recommended by Smith et al. (2013), an attempt was made to listen to each interview within 24 hours to gain familiarity with the

content. Actual transcription within 24 hours proved a challenge as I had to try and juggle full-time employment with this activity. However, every attempt was made to transcribe the audiotapes within this time period as Graneheim and Lundman (2004) asserted that transcription not done close to the time of interviews may not support the reliability, dependability and trustworthiness of a study. The listening to and typing of interview notes at the same time facilitated in-depth thinking and enabled me to gain insight into the participants' experiences. Indeed, I soon became immersed in the world of the stage 1 mentors.

In order for analysis to be properly inductive, the transcripts when completed were read 'suspiciously' as recommended by Ricoeur (1981) in an attempt to expose the concealed meanings of what participants were saying. This type of interrogation enabled an in-depth analysis of the data and allowed themes to emerge on different levels. Interrogation of the data occupied significant time but was an important component of the analytical process as transcripts needed to be examined word for word and line by line. Below is an example of reflexivity, where I lay bare my feelings in an attempt to increase the quality of the analysis and acknowledge my pre-existing assumptions that may have shaped the framework chosen for use.

"Having reflected on my own interpretations in order to make sense of what the stage 1 mentors were saying, I feel that I need to visit my own values, experiences, preconceptions and assumptions. The trouble is, I know what it's like to be a mentor and have experienced many of the challenges that my participants are sharing with me. However, listening to their stories makes me more aware of the prevailing discourse around mentorship and the associate pressures that nurses face. At this time, I am feeling a bit overwhelmed and frustrated that I can't help them in their specific challenges that they share. As a researcher, I find it hard to remain 'outside of the subject matter'" (Journal entry LL).

Though transcribing was a time-consuming exercise which took many months, I was committed to conducting this process thoroughly to enhance the trustworthiness of my findings. To ensure accuracy, transcription quality and resonance with their experiences, I considered whether I should return the transcripts to participants. Guba and Lincoln (1985) considered member-checking as the single most important provision that can be made to bolster a study's credibility and trustworthiness. However, IPA cautions strongly against member-checking and the use of inter-reliability (Smith et al., 2013). Sandelowski (2015) argued that if reality is assumed to be multiple and constructed, then repeatability is not essential. Yardley (2011) suggested that asking peers to check the researcher's understanding as a method of establishing credibility is contentious, as understandings are subjective and can be misinterpreted, leading to confusion. Whilst it could be argued that the most reliable method for improving the adequacy of the transcript is to return it to the

participant (Fleming et al., 2003; Bradbury-Jones et al., 2010), I made a conscious decision not to employ this strategy, as asking them to give up more of their free time to look at the transcripts was a great imposition. Sandelowski (2000) asserted that stories are remembrances about the past and asking participants to relive those moments might have unknown consequences. Similarly, Angen (2000) contended that participants may change their minds about an issue discussed and may feel uncomfortable with the interpretations of the researcher. Every effort however was made to be rigorous and transparent, so the use of a 'critical friend' throughout the analysis process enabled me to maintain the credibility of this study. To be mindful of this, extra attention to rigour and trustworthiness was given during the interviews (Section 3.9, Tables 2 and 3), to give voice to the experiences of the stage 1 mentors, so that rich and exhaustive data could be collected, followed by a rigorous process of analysis and interpretation of their stories. I realised that any efforts to pursue replicability would overlook the epistemological commitment to producing interpretive accounts of stage 1 mentors' experiences and needed to remain consistent with the aims of this study.

Yardley (2011) suggested that asking participants to check the researcher's understanding as a method of establishing credibility is contentious as understandings are subjective and can be misinterpreted, leading to confusion and disarray. Similarly, Angen (2000) contended that participants may have changed their minds about an issue discussed and may feel uncomfortable with the interpretations of the researcher. It was therefore decided that to return the transcripts to participants for verification would not be appropriate. It was also felt that asking the participants to give up more of their time to look at the transcripts was unreasonable. However, sharing my coding procedures and subsequent themes with participants' quotes with my critical friend provided me with insight and motivation to ensure my interpretations were logical and transparent to the reader. Further, in order to address the issue of trustworthiness, the first two transcriptions were shared with my critical friend who worked in the same department and understood the context of this study. My critical friend was asked to check the accuracy of the transcript against the audio recording. Cutcliffe (2003) recommended the use of a critical friend and reported that implementing such checks and balances is needed to maintain a reflexive stance and is critical to enhancing the trustworthiness of research findings. My journal entry below shows my thoughts in relation to my transcribing and any inferences or assumptions I had, and the subsequent conversation with my critical friend which led me to double-check my transcripts.

"A very interesting discussion with my critical friend. She had noted a couple of errors in the transcription to what the participant has said which made me realise that this inadvertent error could have completely changed the meaning of what she actually meant!" (*Journal entry LL*).

Every effort was thus made to ensure that the transcripts represented what was said in the recordings. I did this by reading the transcripts whilst playing the audiotape to check for accuracy of content. I was nervous that parts of the transcription may have been misheard or incorrectly transcribed, which could influence the analysis and conclusions of this research. This was rarely the case but following one small error, I repeatedly checked transcripts at least twice to ensure further errors were not made. To further strengthen the trustworthiness and credibility of my study, my critical friend was also asked to comment on the appropriateness of the emergent themes. She was asked to comment critically on the extent to which the themes emerged from the transcripts to ensure they were not a product of my over-interpretation. I was, however, mindful that Cassidy (2009) had reported it unlikely that an independent person would identify exactly the same themes as the emphasis may differ on the basis of the researcher's personal context and experiences. This 'checking' did nevertheless provide me with confidence that the themes emerged from the data.

4.3.2 Identification of Initial Emergent Themes (IET)

In order to be able to demonstrate how the initial themes emerged and trace the themes back to the raw data, a data management system was developed. This activity was deemed crucial in making my decision making and audit trail clear. For each transcript, a document was developed that comprised three columns. The left-hand column was where, following line-by-line reading, rereading and questioning of the data, I recorded all the initial themes that emerged. The IETs captured the main elements of the participant's experiences and many were identified from the interview transcripts of each case. The number of these IETs generated ranged from 20 to 40 for each case. All the IETs aligned to the actual words of the participant.

In the middle column, I inserted the participant's words and interpretations of their experiences. Sections of the transcriptions that were significant were pasted into this column. Phrases, explanations, analogies, examples of experiences, assumptions, sound bites, acronyms, idiosyncratic figures of speech and emotional responses deemed to be significant were underlined. Keywords were also identified to describe salient points that mattered to the participants. I underlined passages in the text that contained something that appeared especially meaningful to the participant by the length and depth of commentary in the interview.

The right-hand column contained my interpretations and gave me space to write brief notes to myself, make exploratory comments and record any metaphors or analogies that the participant used. These exploratory comments directly related back to the participant's words. My notes aided my interpretations to develop ideas and thoughts as they emerged and

enabled me to create theme titles. I also, in this column, reorganised or merged together themes when appropriate. At the same time, writing notes enabled me to check my own interpretation of what the participant was saying. My notes in the right-hand column enabled me to summarise the content of the interview, and note anything that seemed interesting or significant, including laughing and interjections.

According to Smith et al. (2013), writing notes in this right-hand column is a useful and important part of analysing qualitative data. This was where I began to examine the semantic content and language on an exploratory level, case by case, by looking for keywords, phrases or explanations, metaphors, analogies, examples of experiences, assumptions, acronyms, idioms and emotional responses. Interpretive note-making, where I tried to make sense of the data, also helped me to understand how and why the participants had these experiences. Making such notes was of extreme value as I was able to see emergent associations and was thus able to document IETs in the left-hand column. These related directly back to participants' words and the underlying feelings behind them. For example, Emily remembered feelings of anxiety by talking about her lack of confidence and the admission that she was terrified. Her emotions led to the initial emergent themes of *feelings of anxiety* and *lack of confidence in self* which were pertinent to her experiences. This discourse demonstrated feelings of uncertainty in her attitude towards working with students. Further accounts of Emily's experiences are presented in Chapter 5, Section 5.6.

Table 6 below provides a segment of a document that was created from Emily's transcript. It shows how the data was interrogated and provides an example of my interpretive thinking. The table format also shows how the initial emergent themes (IET) were identified and link with Emily's interview data.

Table 6: Identification of IETs – Extracts from Emily's interview

Initial Emergent Themes (IET)	Extracts of raw data from Emily	Brief notes and my interpretations
Feelings of anxiety/feeling scared/lack of confidence in self Just getting on with it Having to deal with students when not ready	<p>Researcher: You mentioned earlier that you work with students on the ward. Can you tell me a bit more about these experiences?</p> <p>Emily: <i>“Yes, I remember being introduced into the world of mentorship. I didn't know what to do of course and it felt strange at first. I found it quite stressful because we're such a small team, and they just sort of expected me to chip in and just get on with it” (lines 72–74)</i></p>	She admits feeling stressed. Emotion maybe. Is she trying to say she wasn't ready? Maybe being chucked in the deep end here. Admits not knowing

<p>Questioning preparedness</p> <p>Adapting to the role of S1M</p> <p>Reflecting back</p> <p>Needing praise/trying to fit in</p> <p>Turning to friends</p> <p>Fear of making mistakes</p> <p>Using gut feelings</p>	<p>Researcher: So how did that make you feel?</p> <p>Emily: “Oh my God, I had butterflies in my stomach when they asked me to work with students, I just didn’t know what to do, but I guess maybe none of us were really ready, were we? We all felt like that, I know. We just had to sink or swim. We just hoped we didn’t get it wrong” (lines 156–158).</p> <p>“I felt that if I didn’t get it right, they wouldn’t ask me to do it again” (line 159).</p> <p>“Thank God I had my mates to turn to” (line 164).</p> <p>“I was constantly looking for praise” (line 182).</p>	<p>Uses metaphors. Emily feels compelled to justify her feelings. She believes everyone feels the same as her. She’s learning to adapt to her new role. Is sink or swim a strategy for coping?</p> <p>She doesn’t seem to know what to do. Is Emily relying on her intuition to get by?</p> <p>Is this about acceptance?</p>
<p>Developing confidence</p> <p>Getting used to students and mentoring</p> <p>Learning from experience</p> <p>Seeking help and advice</p> <p>Doing what feels right</p> <p>Fear of making mistakes</p>	<p>Researcher: You mentioned earlier about not feeling confident in what you were doing. Can you explain to me a bit more about this, please?</p> <p>Emily: “I mean, I just remember thinking, what am I supposed to be doing and what if I make a mistake? I tried to stay positive, work it out for myself, and if I got it wrong, I just did it differently the next time. I did feel sometimes that students might feel, you know ... how to explain it, that they sensed my lack of experience in what I was doing, but all new nurses feel like that right?” (laughs nervously) (lines 198–201).</p>	<p>I sense that Emily laughing at this point was due to her nervousness about what she was sharing. Bravado maybe? She is saying she felt ill-equipped to mentor students, but questions whether she felt ready. Becoming resilient.</p>
<p>Not really knowing</p> <p>Taking an active role in mentorship</p> <p>Growing resilience</p> <p>Problem solving/Trial and error</p> <p>Making mistakes</p> <p>Using gut feelings</p> <p>Learning to cope</p> <p>Using her own initiative</p> <p>Proactively reflecting</p>	<p>Researcher: So how did you know what to do?</p> <p>Emily: In order to know what to do, I had to work with other mentors and ask for their help, but I was worried I would get it wrong sometimes” (lines 250–257).</p> <p>“I came to realise that trying to work it out for myself helped me to learn mentoring, but I didn’t always get it right, I have to say” (lines 143–155).</p> <p>“Yeah, I made loads of mistakes with students (laughs), but it worried me to death in case they sussed me out ... I tried to learn by my mistakes, but I just remember thinking, I won’t do it like that again, you know” (lines 289–291).</p> <p>“I went out of my way to find the support I needed ... well if I didn’t go looking, it wasn’t exactly forthcoming you know” (lines 220-221).</p> <p>“I would use any opportunity to reflect back on how much I had been prepared to take on the mentor role.... I realised that I felt totally unprepared and that in order to get prepared, I would have to be a bit more dynamic or I would get left behind” (lines 355-359).</p>	<p>She is admitting to asking for help. Shows concern about making mistakes. This seems to be a realisation here that the more she worked with mentors the more she learnt their way.</p> <p>Is she saying that this was self-directed learning? Making mistakes along the way maybe?</p> <p>She is admitting that she didn’t always get it right. Admitting that she is worried. Scared of being found out. Has learning happened here?</p> <p>Is she being proactive here?</p> <p>I feel she might be pre-empting what might be.</p>

Fitting in Using intuition to get by Watching & learning Problem-solving techniques Growing confidence	<p>Researcher: Can you give me some examples of how you might have learnt mentoring?</p> <p>Emily: <i>“Deep down I just had a gut feeling when it came to mentoring students, I felt like that once I started working with the students, I felt a bit more confident and began to feel like I fitted in a bit more like a proper mentor, you know. I wanted them to appreciate me, you know” (lines 234–236).</i></p> <p><i>“Over time, I started to get it” (line 382).</i></p>	<p>Is she saying that over time and doing mentoring, she was developing confidence in her role? Does she need to feel accepted?</p> <p>Is her confidence growing as she learns more?</p>
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4.3.3 Step 2: Organisation and Grouping of IETs

This second step involved organising and grouping the IETs (from the left-hand column) to become individual case-specific themes (ICST). Some of the IETs were put to one side based on the limited amount of verbatim text from the transcript. According to Smith et al. (2013), putting them to one side rather than discarding them, even if they were significantly weak, was essential in case they became important later. Some of the IETs seemed open to being straightforwardly merged together, as they shared a common issue. For example, *looking for empathy and understanding*, *turning to those who listen* and *holding back the tears* were grouped into a case-specific theme, ‘*Emotional support*’. I tried to make sure at this point that these words represented the experience of the participant, rather than just a convenient heading. This grouping of IETs into ICSTs was repeated for all cases.

4.3.4 Generation of ICSTs

Figure 8 shows an example of how some of Emily’s IETs, from the outer columns, were grouped according to similarity and commonality of meaning to become her ICSTs in the middle columns. This process was repeated for each participant, ensuring that there were clear connections between verbatim quotes and themes. Moving through this process enabled my understanding of each participant’s experience to evolve.

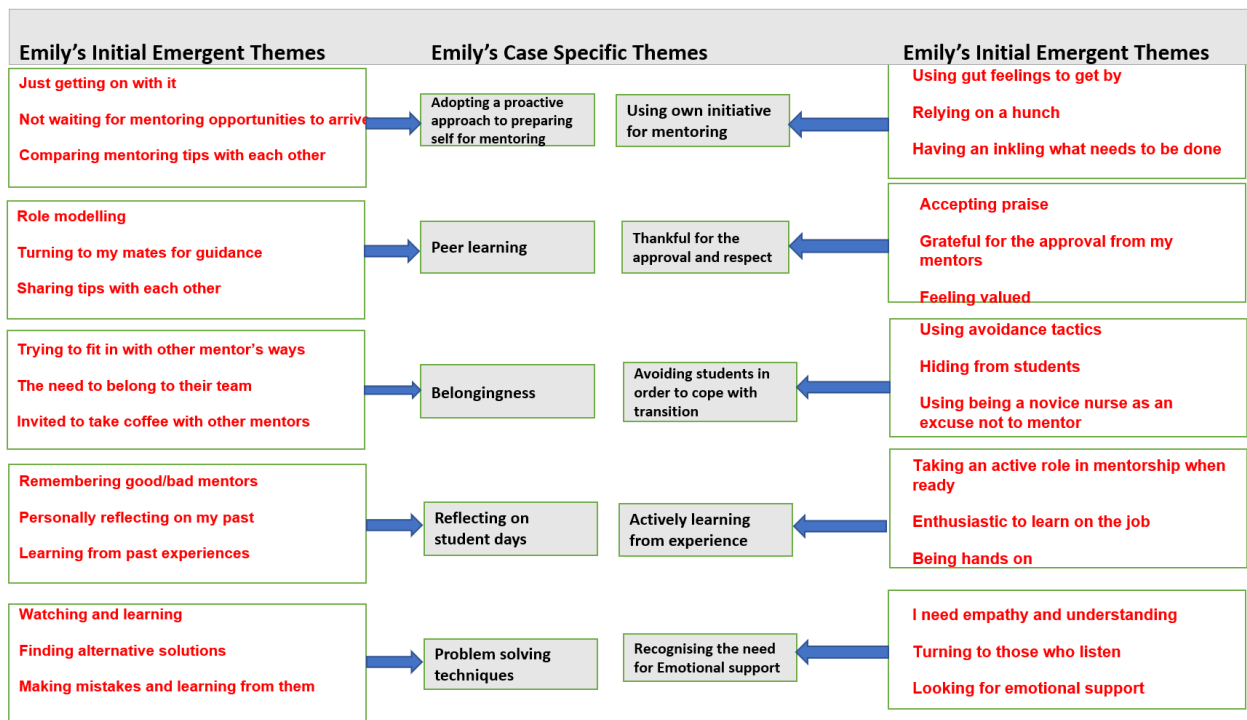


Figure 8: ICSTs generated from Emily's IETs

Table 7 provides a list of the final set of ICSTs generated from the groupings of all the IETs for each of the eight cases.

Table 7: Final set of ICSTs for each case

Tom's ICST	Vaiya's ICST	Gabby's ICST	Rizza's ICST	Regita's ICST	Emily's ICST	Martha's ICST	Abbas's ICST
<p>1. Being hands-on when mentoring opportunities arise</p> <p>2. Learning decision making through self-directed learning</p> <p>3. Finding ways to develop endurance and stamina for transition</p> <p>4. Earn respect from peers</p> <p>5. Reflecting on past experiences</p> <p>6. Taking responsibility to work with peers</p> <p>7. Feeling of in-betweenness</p> <p>8. The need to feel important & respected</p> <p>9. Looking for a shoulder to cry on from experienced colleagues</p> <p>10. Basing mentoring on hunches</p> <p>11. Not always getting it right</p>	<p>12. The need to be self-directed to help prepare</p> <p>13. Developing hardiness for transition shock</p> <p>14. Taking full advantage of mentoring activities</p> <p>15. Managing and dealing with confusing dual role</p> <p>16. Sharing knowledge with peers</p> <p>17. Looking for appreciation</p> <p>18. Reflection on action</p> <p>19. Trying out a different way next time till we get it right</p> <p>20. Using instinct for mentorship</p> <p>21. Feeling disconnected</p>	<p>22. Participating in mentoring jobs</p> <p>23. Trying to find emotional support</p> <p>24. Connecting learning to real-life scenarios</p> <p>25. Acquiring approval from others</p> <p>26. Reflecting on being mentored</p> <p>27. Finding alternate solutions</p> <p>28. Having to deal with being in limbo</p> <p>29. Feeling part of the team</p> <p>30. Looking for encouragement from peers</p> <p>31. Knowing intuitively what to do</p>	<p>32. Taking responsibility for my own preparation</p> <p>33. Learning from my peers</p> <p>34. Adjusting to feelings of uncertainty and confusion</p> <p>35. Finding inner resilience</p> <p>36. Not getting it right first time</p> <p>37. Enjoying higher status as mentor</p> <p>38. Looking for someone to hand hold</p> <p>39. Unconsciously mentoring</p> <p>40. Being part of the team</p>	<p>41. Taking a hands-on attitude to being coached for mentor role</p> <p>42. Not wanting to be self-directed</p> <p>43. Just getting on with it</p> <p>44. Being involved in decision making</p> <p>45. Making sense of past experiences</p> <p>46. Trying to avoid picking up others' bad habits</p> <p>47. Resilience to wear two hats</p> <p>48. Learning from my work mates</p>	<p>49. Peer learning</p> <p>50. Adopting a proactive approach to preparing self for mentoring</p> <p>51. Actively learning from experience</p> <p>52. Belongingness</p> <p>53. Using own intuition for mentorship</p> <p>54. Taking responsibility to learn problem-solving techniques</p> <p>55. Reflecting on past student days</p> <p>56. Avoiding students in order to cope with transition</p> <p>57. Recognising the need for praise and reassurance</p> <p>58. Seeking approval and respect</p>	<p>59. Doing hands-on mentoring</p> <p>60. Disbelief and shock of becoming a stage 1 mentor</p> <p>61. Positive influence of peers</p> <p>62. Belonging to the mentoring team</p> <p>63. Taking responsibility for mistakes made</p> <p>64. Crossing the threshold into mentorship</p> <p>65. Turning to experienced colleagues for emotional support</p> <p>66. Decreasing peer support</p> <p>67. Securing recognition from other mentors</p>	<p>68. Actively learning mentorship on the job</p> <p>69. Modifying behaviours through transition</p> <p>70. Craving and gaining professional recognition</p> <p>71. Renouncing poor mentoring behaviours from past mentors</p> <p>72. Discarding failed attempts and moving on</p> <p>73. The importance of belonging in a team</p> <p>74. Making practical and emotional support work together</p> <p>75. Reduced peer support</p>

At this point, a rich blending of description and interpretation of individuals' experiences had emerged. These first two steps of analysis showed my idiographic commitment to an understanding of the participant's particular point of view with a focus on personal meaning-making according to the analytical task. Once the analysis of each of the eight individual cases was completed, and each case had its own set of ICSTs, the next step was to carry out cross-case analysis.

4.4 Step 3: Cross-Case Analysis

The next step is the cross-case analysis of all cases, involving the grouping of individual case-specific themes (ICSTs) and the generation of cross-case subordinate themes (CCSubTs).

According to Merriam (2009), cross-case analysis differs from analysis of data in a single qualitative case and suggested that reinforcement can be found across cases to new themes or concepts. Smith and Osborn (2015) also suggested that the ICSTs from all cases should be used to inform the subsequent analysis across cases, which would then begin to produce a picture built up of the general as well as the particular experiences of the individuals. Stake (2005, p. 44) asserted that, while emphasising the uniqueness of each case, cross-case analysis retains 'the most important experiential knowledge'. Carrying out this cross-case analysis allowed for diversity of the eight cases and allowed for reconsideration of the ICSTs and opportunity for renewed insight into the lived experiences of newly qualified nurses working as unqualified mentors. Obtaining these insights thus allows a deeper account of individual experience to emerge (Willig, 2012).

4.4.1 The Grouping of ICSTs

In order to group the ICSTs to generate the CCSubTs, I continued to revisit the transcripts to check that they related to the original claims made by the participants. Smith and Osborn (2015) asserted that in IPA, the researcher going back and forth through the transcripts is fundamental to ensure that the ongoing analysis is driven by the data, rather than by the researcher's preconceptions and ideas about individual cases. Though extremely time consuming to return to each transcript to examine the extracts, this process was an important part of the analysis. As recommended by Collins and Nicolson (2002), care was taken to minimise research bias by re-reading the original transcripts to ensure that interpretations were grounded in participants' accounts. This third step also allowed me to identify recurrent connections that were consistent across participants. In an attempt to ensure that the CCSubTs were not forced, the data was constantly questioned to reveal subtleties of the relationships and commonalities across the themes. At this point, persistence was required to arrange and rearrange the ICSTs and continue asking questions until all were connected.

4.4.2 The Generation of CCSubTs

Most importantly at this step, active continuing questioning enabled me to organise and blend the data into a coherent entity and a framework of CCSubTs that represent the experiences of the stage 1 mentor. For the purpose of presentation, the following figure (Figure 9 refers) illustrates an example of how ICSTs (within the brackets) from each of the eight cases were grouped, to generate the CCSubTs.

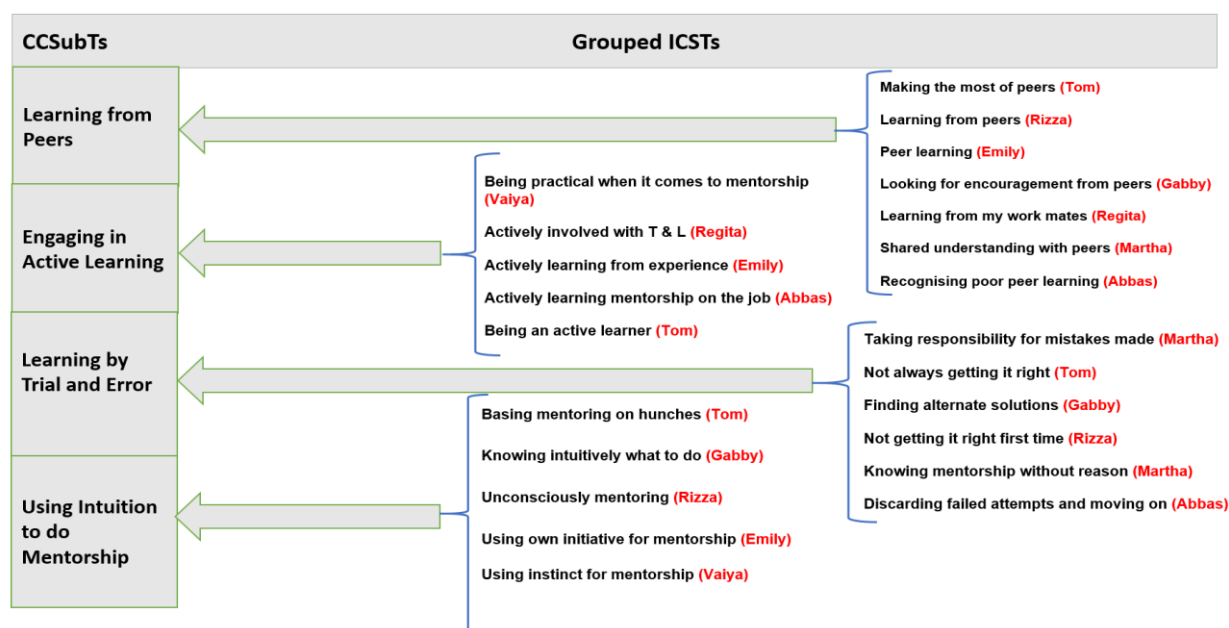


Figure 9: Grouped ICSTs becoming CCSubTs

I could already see at this point how the CCSubTs were beginning to connect which led me to the final step 4 where the final set of cross-case superordinate themes became apparent.

4.4.3 Step 4: The Development of Cross-Case Superordinate Themes

The final step of the cross-case analysis involved the grouping of cross-case subordinate themes (CCSubTs) and the generation of a set of cross-case superordinate themes (CCSupTs). During this step, the CCSubTs shown on the left side of Figure 9 were grouped according to patterns and connections into a final set of four cross-case superordinate themes (CCSupTs). To make explicit my audit trail, at this point, a colour-coding system was introduced for each of the four cross-case superordinate themes: *proactive strategies in becoming prepared* in blue, *experiential learning* in orange, *developing resilience for transition* in green and *attaining professional identity* in purple.

Figure 10 shows how the CCSubTs *active participation in mentorship activities*, *active reflection on past experiences* and *seeking ways to find emotional support* were grouped to become the CCSupT *proactive strategies in becoming prepared*. This CCSupT helped in

addressing how and to what extent stage 1 mentors prepared for mentorship (Research Question 1).

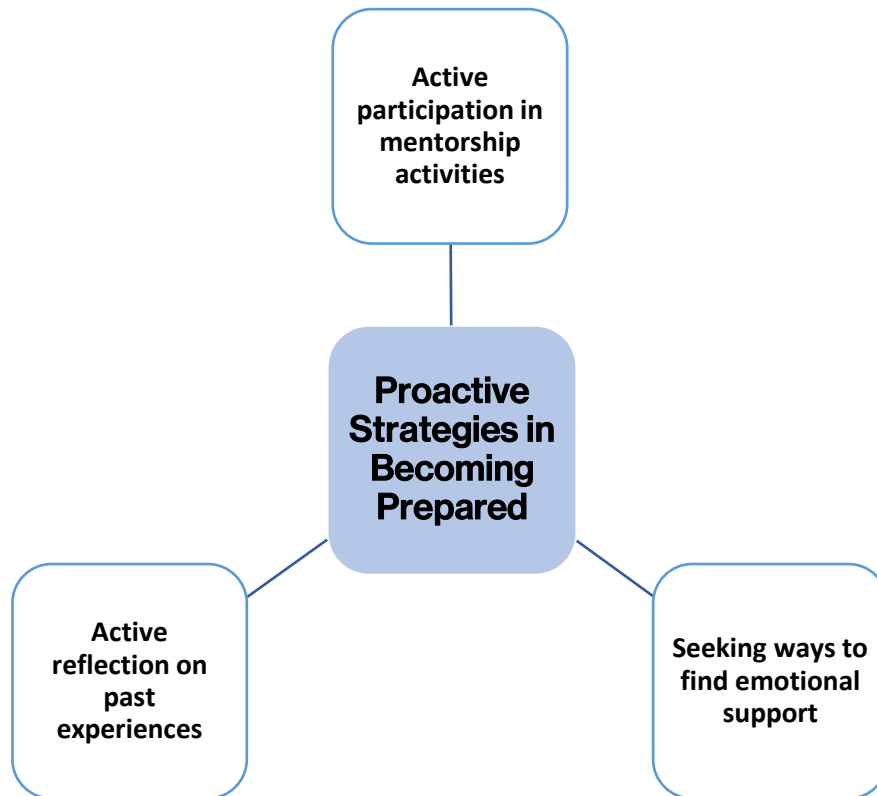


Figure 10: Proactive strategies in becoming prepared

Figure 11 below shows how the CCSubTs *engaging in active self-directed learning, using intuition to do mentorship, learning by trial and error and learning from peers* were grouped to become the CCSupT *experiential learning*. This CCSupT was allied to how stage 1 mentors acquired knowledge and skills for mentorship (Research Question 2).

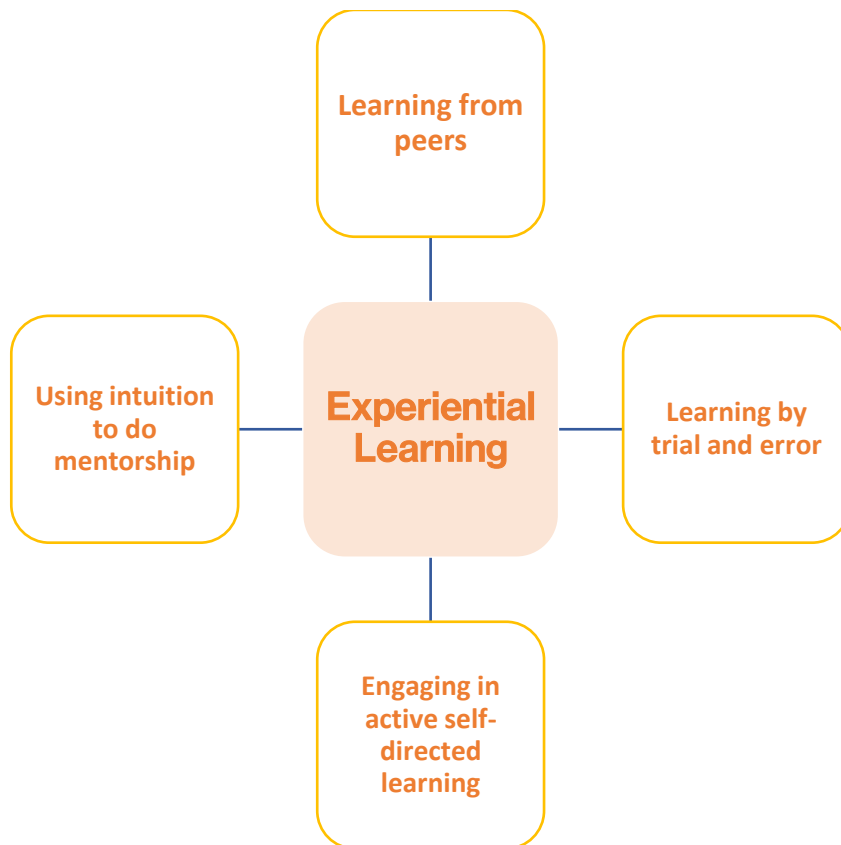


Figure 11: Experiential learning

Figure 12 below shows how the CCSuT's *coping with transitional shock* and *managing transition through the liminal phases* were grouped to become the CCSuT *development of resilience for transition*. This CCSuT was allied to how stage 1 mentors experience transition into the mentor role (Research Question 3).



Figure 12: Development of resilience for transition

Figure 13 below shows how the CCSubTs *belongingness to the mentorship team* and *securing the esteem of others* were grouped to become the CCSupT *attaining professional identity*. This CCSupT was allied to how newly qualified nurses construct their professional identity as stage 1 mentors (Research Question 4).



Figure 13: Attaining professional identity

In summary, Figure 14 below presents an overview of the four-step process of analysis, depicting the centrality of the participants' experiences of stage 1 mentoring. The figure shows: against Step 1, the number of IETs in each case; against Step 2, the number of ICSTs per each case; against Step 3, the eleven CCSubTs that emerged from the cross-case analysis, colour coded according to the CCSupT they were grouped into; against Step 4, the four CCSupTs illustrated in Step 4.

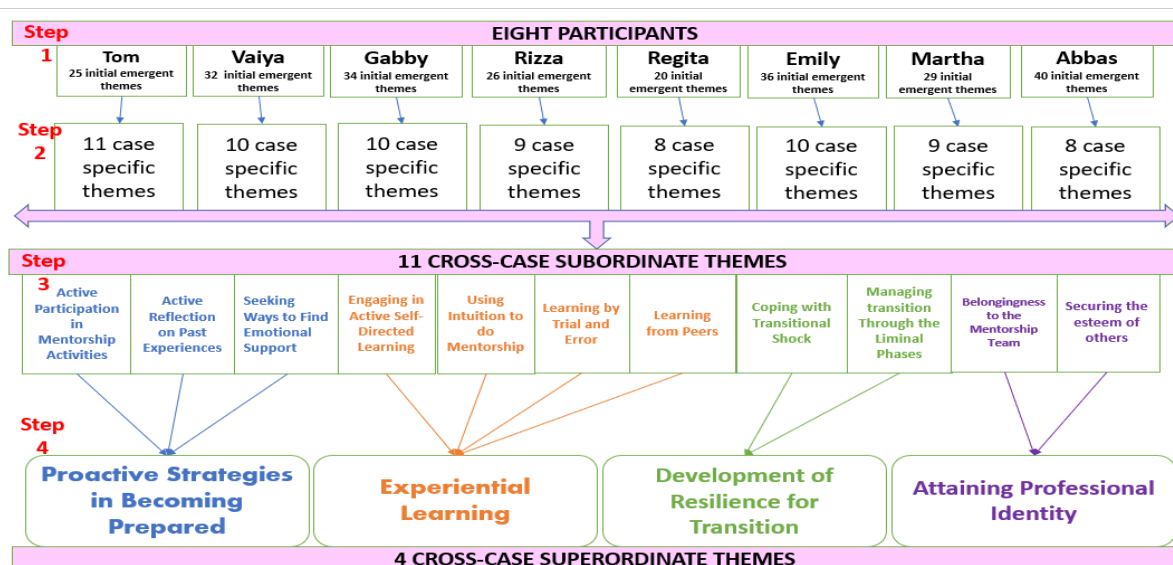


Figure 14: An overview of the four steps of analysis

It is important to note that the CCSupTs capture the complexity of the data and the inter-connections that exist between them and the CCSubTs. Each of the CCSupTs and their CCSubTs will be explored in detail in Chapter 6.

4.5 Summary of Chapter

This chapter has described how data was analysed and how IPA was operationalised in the present study. This framework for analysis has shown my idiographic commitment to an understanding of the participant's particular point of view with a focus on personal meaning-making according to the analytical task. The four-step framework for analysis has been described to make explicit my audit trail and how the IETs, the ICSTs, the CCSubTs and CCSupTs emerged.

The following Chapter 5 presents the individual case experiences of the eight participants and the meanings that they give to being a stage 1 mentor. It also illustrates how the themes, as detailed in Chapter 4, are derived from the participants' idiographic experiences of mentorship. Chapter 6 then explores in more detail the four CCSupTs and their associated CCSubTs and draws on relevant literature to further develop the meaning and value of these themes for understanding newly qualified nurses' early experiences of mentoring.

Chapter 5: Participants' Experiences of Being a Stage 1 Mentor

5.0 Introduction to Chapter

This chapter illustrates how all the themes – namely, the individual case-specific themes (ICSTs), the cross-case subordinate themes (CCSubTs) and the cross-case superordinate themes (CCSupTs), as detailed in Chapter 4 – are derived from the participants' idiographic experiences of mentorship. The findings are presented through the individual case experiences of the eight individual participants' experiences of mentorship (Tom, Vaiya, Gabby, Rizza, Regita, Emily, Martha and Abbas), and the meanings that they give to being a stage 1 mentor. This chapter illustrates the first stage of the double hermeneutics, as shown in Figure 6 (page 58 refers), as the participants give meaning to their experiences of working as stage 1 mentors.

Each participant's story is précised to provide insight into the world of each of the eight stage 1 mentors. The demographic profile of each participant is outlined. In keeping with IPA (Smith et al., 2013), within each of the eight stories verbatim quotations from the interviews are used to illuminate the essential points of each participant's experience of mentorship. Quotations are also used to make explicit the transparency of the analytic process and convey how each of the themes was created. They have been selected carefully as they are the most descriptive or explanatory of the researcher's conceptual interpretation of the data.

To bring transparency to the analytic process and illustrate how the ICSTs, CCSubTs and CCSupTs connect with each other, a colour coding system has been developed. Four colours were selected: blue, orange, green and purple. The assignment of the same colour to each type of theme illuminates a connection between those themes and more specifically how the ICSTs (n=75), the CCSubTs (n=11) and the CCSupTs (n=4) connect with each other and were created during the analytic process (see Table 8). One of the four colours has also been assigned to each extract of raw data to enable the reader to see connections between the raw data and the specific ICST, CCSubT and CCSupT. The assignment of colour also helps to convey the researcher's thinking during data analysis and how that thinking steered the development of each type of theme.

Participants' words that could result in a breach of confidentiality have been deleted and names have been changed to protect the identity of people or workplaces. Some minor changes to the verbatim quotes have been made to improve readability, and the 'erms' have been removed. However, spoken grammatical errors and colloquialisms are included, but care was taken not to misrepresent individuals' experiences. Missing text is indicated by dotted lines within brackets (...) and explanations of the researcher's interpretations of what the

participant meant, if not clear, are presented within brackets. Repeated words have been removed unless pertinent to the point being made. No reference is made to literature in this chapter as the aim is to enable the reader to get 'as close to the participants as possible' (Larkin et al., 2006, p. 104). Each interview quote is followed by an indication of the themes it links to, for example, the first quote presented is followed by the information 'Links to ICST 9, CCSubT 1.3, CCSupT 1 [Table 8]'.

Table 8: An overview of all themes with colour coding

Cross-Case Superordinate Themes (CCSupT)	CCSupT 1). Proactive Strategies in Becoming Prepared		CCSupT 2). Experiential Learning		CCSupT 3). Development of Resilience in Transition		CCSupT 4). Attaining Professional Identity	
Cross-Case Subordinate Themes (CCSubT)	1.1) Active participation in mentorship activities 1.2) Active reflection on past experiences 1.3) Seeking ways to find emotional support		2.1) Engaging in active self-directed learning 2.2) Learning by trial and error 2.3) Using intuition to do mentorship 2.4) Learning from peers		3.1) Coping with transitional shock 3.2) Managing transition through the liminal phases		4.1) Securing the esteem of others 4.2) Belongingness to the mentorship team	
Tom's ICST	Vaiya's ICST	Gabby's ICST	Rizza's ICST	Regita's ICST	Emily's ICST	Martha's ICST	Abbas's ICST	
1. Being hands-on when mentoring opportunities arise 2. Learning decision making through self-directed learning 3. Finding ways to develop endurance and stamina for transition 4. Earn respect from peers 5. Reflecting on past experiences 6. Taking responsibility to work with peers 7. Feeling of in-betweenness 8. The need to feel important & respected 9. Looking for a shoulder to cry on from experienced colleagues 10. Basing mentoring on hunches 11. Not always getting it right	12. The need to be self-directed to help prepare 13. Developing hardiness for transition shock 14. Taking full advantage of mentoring activities 15. Managing and dealing with confusing dual role 16. Sharing knowledge with peers 17. Looking for appreciation 18. Reflection on action 19. Trying out a different way next time till we get it right 20. Using instinct for mentorship 21. Feeling disconnected	22. Participating in mentoring jobs 23. Trying to find emotional support 24. Connecting learning to real-life mentorship scenarios 25. Acquiring approval from others 26. Reflecting on being mentored 27. Finding alternate solutions 28. Having to deal with being in limbo 29. Feeling part of the team 30. Looking for encouragement from peers 31. Knowing intuitively what to do	32. Taking responsibility for my own preparation 33. Learning from my peers 34. Adjusting to feelings of uncertainty and confusion 35. Finding inner resilience 36. Not getting it right first time 37. Enjoying higher status as mentor 38. Looking for someone to hand hold 39. Unconsciously mentoring 40. Being part of the team	41. Taking a hands-on attitude to being coached for mentor role 42. Not wanting to be self-directed 43. Just getting on with it 44. Being involved in decision making 45. Making sense of past experiences 46. Trying to avoid picking up others' bad habits 47. Resilience to wear two hats 48. Learning from my work mates	49. Peer learning 50. Adopting a proactive approach to preparing self for mentoring 51. Actively learning from experience 52. Belongingness 53. Using own intuition for mentorship 54. Taking responsibility to learn problem-solving techniques 55. Reflecting on past student days 56. Avoiding students in order to cope with transition 57. Recognising the need for praise and reassurance 58. Seeking approval and respect	59. Doing hands-on mentoring 60. Disbelief and shock of becoming a stage 1 mentor 61. Positive influence of peers. 62. Belonging to the mentoring team 63. Taking responsibility for mistakes made 64. Crossing the threshold into mentorship 65. Turning to experienced colleagues for emotional support 66. Decreasing peer support 67. Securing recognition from other mentors	68. Actively learning mentorship on the job 69. Modifying behaviours through transition 70. Craving and gaining professional recognition 71. Renouncing poor mentoring behaviours from past mentors 72. Discarding failed attempts and moving on 73. The importance of belonging in a team 74. Making practical and emotional support work together 75. Reduced peer support	

5.1 Case 1: Tom

Tom was a 27-year-old Irish male nurse working as a staff nurse on an Orthopaedic ward. Tom had completed his studies 15 months earlier and was in his first post since qualifying as a nurse. He began mentoring students 3 months into this first post. His preceptorship period lasted for 6 months and included achieving advanced skills, but his preceptor reported to him that she intended to expose him to students as soon as possible. His role as a stage 1 mentor ranged from showing students around the ward to changing wound dressings with students. Tom shared that he initially felt very anxious about his early experiences of mentorship and felt uncertain about the nature of his role. Tom had worked as a healthcare assistant prior to training to become a nurse, so had worked with students in the past but on an incidental basis.

Tom initially had felt anxious and unready to mentor. Tom realised that he needed to look for reassurance, compliments and positive praise, giving him a feeling of being valued and emotionally supported. He explained that he had often wondered why his less experienced colleagues were keen to offer him practical support for mentorship but seemed reluctant to offer the emotional support that he felt he needed at the time. Tom reported finding a shoulder to cry on from his more senior colleagues who were able to empathise with him:

“It was definitely the more senior colleagues who were able to give me that shoulder to cry on. Those less experienced seemed to steer well away from that stuff (laughs)”.
(Links to ICST 9, CCSubT 1.3, CCSupT 1 [Table 8])

He reported that he knew he needed to take responsibility for his own preparation and devised a ‘plan of action’ where he could work towards becoming ready for mentorship. Tom spoke of preparing himself for the mentor role, such as finding opportunities to give feedback to students and facilitate learning opportunities for students.

“I felt that by taking a hands-on approach for mentorship was the way forward in preparing myself to give feedback, otherwise, how else was I supposed to be ready?”. (Links to ICST 1, CCSubT 1.1, CCSupT 1 [Table 8])

Tom divulged how reflecting on his own past experiences (both positive and negative) as a student had contributed to his preparation for mentorship. He recalled how he had tried to make sense of his experiences as a mentee to enable him to manage being a stage 1 mentor so he could feel ready to work with students. When asked about his readiness for mentoring, Tom reported that being mentored as a student had given him the basics of what mentorship was about. He reflected on the right values and behaviours from some of the mentors he had come across as a student, such a good role modelling and being friendly. Tom realised that he had picked up most of the right values and behaviours from good mentors, but more importantly had avoided the poor values and behaviours displayed by other mentors.

"I took steps to reflect with my preceptor who helped me to reflect on some of my experiences of being mentored, but also how I could use those experiences in my mentor role. Those opportunities to reflect helped me to realise what good mentoring was and what bad mentoring I needed to avoid". (Links to ICST 5, CCSuT 1.2, CCSuT 1 [Table 8])

Whilst remembering his student days, Tom talked about his transition from being a student to becoming a nurse to becoming a mentor. Tom spoke of a feeling of in-betweenness, where he felt he was neither one thing nor another. He remembered questioning his priorities, stating that he did not know whether to prioritise settling in and learning to be a staff nurse, or learning to be a mentor. Tom's experiences of being in the liminal phase refer to where he felt a period of uncertainty as he developed a sense of resilience. Tom used the word 'in-betweenness' in his interview. He described being in the middle of something or somewhere, but then went on to say that this feeling had been short-lived with his ability to stay focused on the mentor role. He explained:

"I felt that in order to survive at work, I need to face up this weird feeling of being in no man's land, you know, trying to be a staff nurse and trying to be a stage 1 mentor at the same time.... I often wondered what camp I was supposed to be in". (Links to ICST 7, CCSuT 3.2, CCSuT 3 [Table 8])

He shared that, on occasion, he and other new nurses had to deal with not knowing what to do, leading them to often feeling demotivated and disengaged with mentorship generally. This initial lack of engagement he had experienced may, he believed, have contributed to his own initially poor performance as a stage 1 mentor and the realisation that he needed to be more resilient if he was going to manage to carry on. Tom explained that initially, he had been in denial about his role, suggesting that avoidance of students had been a way to protect himself should he fail as a mentor. However, he also had a strong motivation to want to do the job well, enabling him to move beyond denying his mentorship role and find ways to draw on his personal strength. The following excerpt illustrates how Tom believed he developed resilience to manage his transition into mentorship:

"I realised that I was able to manage my own stresses in order to adapt to the challenges of being a mentor. I know I was in denial to start off with, and if I could find a way to avoid students, I would. Saying that though, it was those early days that gave me the resilience to get through to the other side, you know". (Links to ICST 56, CCSuT 3.1, CCSuT 3 [Table 8])

He reported how, by being able to just 'pick himself up and focus on getting on with the job in hand', he had learnt to build on his resilience so that he could manage his transition into mentorship. He spoke of managing his stress by buffering the negative effects of transitioning into the mentor role, which had contributed to him finding an inner resilience that he had not felt before. He spoke of the increasing positivism he felt in order to make it through tough times. When discussing how he developed mentorship skills, Tom felt that he would have to

be more active in learning the practicalities of the role so that not only could he work more autonomously, but work on building his own confidence to carry out the mentorship role effectively. Tom believed that someone would at least formally advise him of his roles and responsibilities as a stage 1 mentor, especially in relation to student supervision, or that he would be provided with useful reading or learning resources. He declared that this formal advice never came. He reported staying focused and being determined to just get on and do the job in hand, preferring to take a more hands-on approach when it came to students. When asked to elaborate, he explained that he felt he had to take a self-directed approach to his learning, as he preferred to learn independently rather than someone just telling him what to do. Tom stated that over time, he had been able to build on his decision-making skills by *'getting his hands dirty'* and favoured a practical way of learning over a lecture in a classroom.

"I preferred to take on a more active approach to learning, you know, like more hands-on which I really like. Taking responsibility for my own learning enabled me to be more autonomous when I made decisions about students". (Links to ICST 2, CCSuT 2.1 CCSuT 2 [Table 8])

During the process of acquiring mentorship skills, Tom admitted that he had *'often made mistakes'* and then had regretted not asking for help beforehand. Tom felt embarrassed to admit to his colleagues that he had not known what to do and saw it as a weakness. He gave examples of trying to problem solve and where it had gone wrong, referring to trial and error. He recognised that his learning to mentor had been somewhat haphazard and acknowledged the trial and error element of learning. However, he reported that learning from his mistakes had enabled him to give meaning to those experiences and make sense of what he had learnt.

"I know I didn't always get it right, I mean, let's face it, I didn't really know what I was doing, did I, so I just got on with it. Saying that, though, making mistakes and learning from them is definitely the way forward when trying to do it again next time". (Links to ICST 11, CCSuT 2.2, CCSuT 2 [Table 8])

Despite his admittance of *'getting it wrong'*, Tom admitted that *'learning by trial and error'* had been a good thing and enabled him to problem solve on his own. Making mistakes and learning from them had been crucial to his learning mentorship skills. However, he confessed to having a fear of getting it wrong if he solely relied on using intuition to get by, explaining that he had felt foolish having to admit he did not always know what he was doing. He admitted that, at times, he has based his mentoring on hunches and an intuition that he could not articulate. Tom explained:

"Yeah, in the beginning, I guess I used to have a sort of sixth sense when it came to student learning, you know, like a hunch, but it's sort of difficult to explain, sorry". (Links to ICST 10, CCSuT 2.3, CCSuT 2 [Table 8])

Tom also reported that he had naturally gravitated to other newly qualified nurses during his early days, seeking help and advice from anyone who was prepared to help him. Tom described covertly watching and learning mentorship whilst on the job as he perceived his peers were too busy to teach him. However, on other occasions, he was able to shadow his peers when they worked with students, enabling him to observe and learn on the job. Tom commented that learning the language of mentoring through observing his peers at work not only helped him to learn but contributed to him learning how to be a mentor.

“I soon came to realise that if I spoke their language (referring to his peers), then they sort of included me in their conversations, which in turn helped me to learn mentorship by being involved”. (Links to ICST 6, CCSuT 2.4, CCSuT 2 [Table 8])

Tom described his colleagues at work as being ungrateful for what he did for students which had resulted in him lacking motivation. He said that their lack of gratitude had overshadowed his early experiences of working with students and thus his sense of belonging to the team. He explained that the apparent lack of acceptance from his peers had acted as a barrier to his learning to mentor. Reflecting on his current experience, Tom reported being significantly more confident in the mentorship role now he had been doing it for a while and felt part of the team. Later in the interview, he went on to say how he began to feel accepted into the mentorship team.

“At first, I didn’t feel part of the mentorship team, but over time, I felt that they (stage 2 mentors) began to trust me with students and I sort of felt like I was one of them ... I started learning the lingo if you know what I mean, you know, starting to sound like them (laughs)”. (Links to ICST 4, CCSuT 4.2, CCSuT 4 [Table 8])

Tom believed that seeking their approval was important to him being accepted as a competent and professional stage 1 mentor. He explained that he thought that he was simply acting out the role at first, but soon came to realise that taking more responsibility with students contributed to his identity as a professional mentor. He confessed that he often sought clarity of his role and questioned being labelled as a stage 1 mentor. Tom realised that he was not necessarily defined by his job title but felt that the lack of clarity in his title and role influenced how others treated him, admitting that he needed to feel important and valued.

“You know, I define myself through my identity as a nurse, but not having a proper title of stage 1 mentor or something like that makes me feel that I’m not recognised as a professional mentor. It was important to me that my peers valued me for what I did with students (laughs)”. (Links to ICST 8, CCSuT 4.1, CCSuT 4 [Table 8])

5.2 Case 2: Vaiya

Vaiya was a 23-year-old Asian female nurse working in an Intensive Care Unit. She had completed her studies 18 months earlier and was in her first staff nurse post. She began

mentoring students 2 months into this first post where she was allocated students to 'show them the ropes'. Her duties included orientating students to the workplace and showing them how to do basic clinical skills. Vaiya had been excited to work with students and was keen to share her knowledge with them. Vaiya described her early experiences of working as an unqualified mentor as extremely rewarding and saw this role as integral to her development as a newly qualified nurse. However, Vaiya also confessed that she felt scared, and hated the fact that she did not know what to do for students. When questioned about taking responsibility for her own learning and looking for mentoring opportunities, Vaiya spoke of finding mentorship opportunities that were of interest to her and activities that she knew would be of benefit to her. Vaiya mentioned in her interview that, despite feeling anxious about taking students and unprepared for the role, she realised she needed to take a practical approach to preparing herself, such as finding someone to help unlock the potential in her. She spoke of looking for someone who would personally coach her and take an interest in her development as a stage 1 mentor.

"I found this really nice mentor who seemed to recognise my potential to be a good mentor. She really invested in me and helped me to feel a bit more prepared, yes". (Links to ICST 12, CCSubT 1.1, CCSupT 1 [Table 8])

She later went on to reveal in her interview that, despite her anxieties, she took time out to reflect on what she had learnt from observing others, but also to reflect on how she had been mentored as a student.

"As a qualified nurse, I know that being reflective is important and learning from past experiences. Being actively involved in reflection really helped to prepare me for the mentorship role as I was able to use my past and present experiences to prepare me for being a mentor right". (Links to ICST 18, CCSubT 1.2, CCSupT 1 [Table 8])

Participating in reflection seemed to be important to Vaiya in her preparation for the mentor role. When asked about her move into the mentor role, Vaiya talked about having to make some personal and professional adjustments so that she could adapt to the added pressure of mentoring students. She spoke of having her confidence knocked and being told off by other mentors when things had not always gone to plan. She gave an example where her colleague told her not to bother teaching the student as it was quicker if she just did it herself. These experiences, she reported, knocked her confidence. However, she believed that she had the ability to bounce back and not let moments like that affect her. Vaiya recounted that once she had become accustomed to the routine of the job, she felt herself toughening up which led to her not needing the support of stage 2 mentors. She continued by saying that her ability to develop resilience had progressed over time by coping with the many challenges she faced in the last couple of years. Vaiya also spoke of how building resilience had stemmed from increased exposure to students. She had not only learnt to deal with and manage their needs, problems and challenges, but also how to manage her own needs as a novice mentor. Vaiya

gave an example of staying focused and having endurance and stamina when working with students:

“I was determined to get through this, and knew I had the stamina to get it right, even though I got it wrong loads of times (laughs). I knew that if I persevered and kept working with students, then I would be ok”. (Links to ICST 13, CCSubT 3.1, CCSupT 3 [Table 8])

She spoke at length about a transitional process that she felt she had been through in becoming a stage 1 mentor. She explained that she had experienced role confusion and unfamiliarity that she had not felt before, stating that she had needed to develop an inner strength to cope with her transition into the mentor role:

“I did experience some role confusion at times, you know, am I supposed to be a nurse or a mentor or both? After a while, I sort of realised that I should be both nurse and mentor which was what was expected of me, but I didn’t know who I was half the time. It was like wearing two hats”. (Links to ICST 15, CCSubT 3.2, CCSupT 3 [Table 8])

When questioned about acquiring knowledge and skills for mentorship, Vaiya spoke of turning to her peers for support and information. She explained that initially, she saw herself as a passive recipient of knowledge where mentors just told her what to do and how to focus on learning the job in hand. Vaiya talked about the significance of her relationship with her peers on the ward. She spoke of her peers as other Band 5 nurses who were in the same position as her and working as stage 1 mentors. Vaiya found that having peers to turn to not only provided her with a source for emotional support, but also gave her more confidence and lessened her anxieties. She explained that all the newly qualified nurses tended to gravitate towards each other as they had that mutual understanding of what was important when it came to student learning. Vaiya told of realising that using her peers to share information enabled a reciprocal learning relationship where they learnt from each other:

“We were, like, all learning from each other whenever we could. I know for a fact that we preferred to ask each other than have to go to a stage 2 mentor and confess we didn’t know what to do. Saying that, sometimes it was like the blind leading the blind”. (Links to ICST 14, CCSubT 2.4, CCSupT 2 [Table 8])

When probed about how she knew what to do with students when first introduced to mentorship duties, Vaiya spoke of using her intuition when mentoring students. When asked to explain what she meant, Vaiya spoke of a gut feeling that she felt stemmed from being mentored as a student and her own motherly instincts. She explained:

“I don’t know, I sort of just knew how to mentor the students, probably from being mentored myself. I don’t know why, it’s like a gut feeling, isn’t it, like a mother nurturing a child, sort of”. (Links to ICST 20, CCSubT 2.3, CCSupT 2 [Table 8])

Vaiya felt the need to say that this initial use of intuition was short-lived, as, over time, she began to acquire knowledge for mentorship through learning on the job and picking up practical skills as she went along. Vaiya also spoke of the need to belong to the mentorship team and how often she felt left out when they were discussing a student's progress. The following extract illustrates the point:

“Because I work in intensive care, everyone is always so busy with no time to spend with me. All I wanted to do was fit in, but because of the nature of my ward, they didn't always make time for me which made me feel like I was not part of their team”. (Links to ICST 21, CCSubT 4.2, CCSupT 4 [Table 8])

She alluded to just wanting to feel accepted and part of the team, but in the reality of practice, this was just how they worked on her ward. Although she accepted that the expectation to mentor students was part of her role as a qualified nurse, she just needed to feel like she belonged to the mentorship team. She told of not wanting to reveal her concerns to the senior nurses in case she was seen as the awkward one. Vaiya spoke of the need to feel appreciated by her colleagues and gave examples of when she had felt she was taken for granted. Her need for appreciation is captured in the quote below:

“I just felt that the need to be appreciated for what I do for students. Sometimes, I just want them to say thank you and well done, you know, just to show a bit of gratitude for all my hard work”. (Links to ICST 17, CCSubT 4.1, CCSupT 4 [Table 8])

5.3 Case 3: Gabby

Gabby was a 24-year-old white female nurse working as a Band 5 nurse in theatres. She had been a newly qualified nurse for two years. Gabby told of her early experiences of working as an unqualified mentor as being expected from very early on to spend time showing students how to do basic clinical procedures, explaining anaesthetics and recovery duties. Preceptorship support was given for her first six months but no preparation for mentoring was provided. Gabby had not been keen to be introduced into mentorship initially, as she felt that there was an expectation that if she 'took' students regularly as part of her staff nurse role, then she would always have to do it. Despite stating that she lacked mentorship knowledge and skills, such as effective communication and building relationships with students, she understood from her colleagues that she would have to be proactive and find her own opportunities to mentor students and practise on the students whenever she could, Gabby explained how she took practical steps to be proactive and prepare herself for the mentor role:

“I didn't mind finding my own way, I mean, the other mentors were always busy, so it was just a matter of getting on with it. I think there was an expectation that you were a bit more hands-on to what I was used to being as a student (laughs)”. (Links to ICST 22, CCSubT 1.1, CCSupT 1 [Table 8])

Gabby spoke of looking for more experienced colleagues who were reassuring, patient and supportive, rather than those who she found to be standoffish and unwilling to share their knowledge. She said she felt unhappy that her colleagues were not always interested in supporting her, especially when they knew that she felt unprepared. While the lack of preparation had made her feel anxious, she knew that looking for both practical and emotional support when working with students would provide her with the reassurance she needed and give her the confidence boost that she was looking for. What upset Gabby the most, however, was that the reassurance and support that she needed to help her feel prepared had not been forthcoming:

“What got me was that I felt I had to go looking for the emotional support which was not always forthcoming. Everyone is keen to give practical support, but not so much when it comes to my mental health, if you know what I mean”. (Links to ICST 23, CCSubT 1.3, CCSupT 1 [Table 8])

Gabby also spoke of uncertainty and confusion as to what her role was meant to be. When probed, Gabby explained that she felt a sense of bewilderment about her roles and responsibilities as a stage 1 mentor, and how she needed to both manage and deal with her lack of experience. Gabby made clear that she needed to have a period where she could settle and adjust to her workplace but spoke of being in an indeterminate state of transition. She admitted that having the resilience to overcome feeling uncomfortable in the space she was in and not knowing what to do gave her the ability to stay focused and remain determined to do well. Later in her interview, Gabby used the term ‘being in limbo’ and explained what she meant by this metaphor and how she overcame adversity at this time:

“Being in limbo was like a feeling of uncertainty that just made me feel a bit vague as to what I was supposed to do and who I was supposed to be. That was a period of time when I was just expected to get on with it. It was a sink or swim situation really”. (Links to ICST 28, CCSubT 3.2, CCSupT 3 [Table 8])

When the conversation turned to how she thought she had learnt mentoring, she spoke to learning on the job. Despite not knowing how to mentor students and feeling unprepared for the role, she spoke of having an implicit awareness for mentorship that she tried to explain. She remembered making decisions about students and wondering what factors had brought her to make that decision, but not knowing the answer. Gabby spoke of knowing what to do, but not knowing what to do, and talked at length of having some sort of intuition for mentorship that she could not justify:

“I don’t know, I can’t explain it, I just sort of had a feel for it, so there was me thinking that I didn’t know what to do, but when it came to reality, I just sort of knew. Weird, eh?” (laughs). (Links to ICST 31, CCSubT 2.3, CCSupT 2 [Table 8])

However, she admitted in her interview that she did not always get mentoring right and had to find alternative solutions when she had made the wrong decision. The following excerpt describes how through finding alternate solutions, she managed to find a way to problem solve and pick up mentorship skills. She reported that the only reason she had to learn mentorship through trial and error was because of her lack of knowledge for mentorship and inadequate supervision to carry out the role. She explained:

“I didn’t always get it right in the beginning, I know that, but I soon came to realise that if I persevered and found different ways to do stuff, then I would get there in the end. Mind you, I did usually find a better way of doing it, but it was a bit hit and miss, I guess”. (Links to ICST 27, CCSubT 2.2, CCSupT 2 [Table 8])

Gabby also reported that she had taken responsibility for her own learning by engaging with her more experienced peers who had been mentoring for longer than herself. She gave examples of active learning strategies, such as real-life role-play with peers and students, problem-solving activities, or working and reflecting on practice in pairs with another stage 1 mentor. She spoke of one of her peers who encouraged her to think more deeply about mentorship, but also gave her the freedom to use reflection to make sense of her own experiences with students, and then connect these experiences with real-life scenarios and examples of how she could do it better the next time. This self-directed and participatory learning with her peer, Gabby felt, had enabled her to acquire deeper learning for mentorship, which in turn led to increased confidence to carry out the mentor role:

“I felt that having the time with my peers to engage with active learning really brought home to me how much I didn’t know. I guess using scenarios and reflecting on my experiences helped me to feel more confident in connecting with the reality of what mentorship is meant to be about, right”. (Links to ICST 24, CCSubT 2.1, CCSupT 2 [Table 8])

Gabby reported that over time, the more she worked with students, the more she began to feel part of the mentorship team and really enjoyed taking responsibility for student learning. Gabby also spoke of being able to accept the norms of her ward and ultimately behave like other mentors, enabling her to feel that she fitted in and be part of the mentorship team. However, in order to fit in, she needed to put aside her own values and expectations of others and accept some of the bad habits of other mentors. Being accepted as part of the mentor team was important for Gabby, even though she admitted to adopting poor mentoring habits of others just to be one of them. Notably, her propensity to fit in and learn mentorship meant she gave up her true values learnt as a student just to feel a sense of belonging. She reported developing over time a sense of integration into her place of work and becoming one of them. She referred to ‘them’ as qualified mentors who enabled her to engage with the mentorship role and motivated her to want to learn. She remembered a sense of importance from feeling like she belonged to the mentorship team, as depicted below:

“Yes, it was important for me to feel like I belonged to the mentor team, even though I wasn’t a proper mentor, I still needed to feel like I was worthy of being a stage 1 mentor I just wanted them to like me”. (Links to ICST 29, CCSuT 4.2, CCSuT 4 [Table 8])

Gabby confessed that it was important to her that she felt valued and sought approval from other mentors. She admitted that this approval had not come easy; she believed it had taken many months to secure any form of appreciation, and also to feel part of the team. Gabby stated that at some point (when probed at what point this might be, she stated at least six months into her job as a staff nurse), she began to feel respected and accepted by stage 2 mentors and enjoyed being called a mentor. When probed as to what it was that made her feel she had their approval, she stated:

“I guess it was them (referring to stage 2 mentors) confiding in me, you know, talking to me about the students, including me in their conversations. It felt good to know that there was some value in being a stage 1 mentor, even if that acceptance and value was only from a few of them”. (Links to ICST 25, CCSuT 4.1, CCSuT 4 [Table 8])

5.4 Case 4: Rizza

Rizza was a 29-year-old female originally from the Philippines, working on an Ear, Nose and Throat ward. She had trained as a nurse in the Philippines eight years earlier and had been registered with the NMC for just over two years. She had only worked with students in the previous five months on a part-time basis. She had a formal preceptorship period, but this did not include any exposure to students or exposure to mentorship. There were four stage 2 mentors working on the ward and one sign-off mentor. Rizza openly admitted that she had avoided working with students as much as she could get away with. Her early experiences of mentorship started when she was asked to mentor a student and teach catheter care. In her previous role as staff nurse in the Philippines, there had been no requirement to mentor students, as student learning and assessment had been carried out by academics from the college. She felt that mentoring students was a role for qualified mentors only. Rizza said that she had realised that her adjustment to the mentorship role had stemmed from an ongoing exposure to students and reflecting on her own practice. Rizza spoke again of nursing in the Philippines and how, in her own country, there was no expectation for newly qualified nurses to mentor students. Rizza explained that when she had been a student herself, someone from the college would come to the ward and work with her and then assess her. Rizza felt that she had not had much exposure to student education in her home country.

Rizza perceived herself to be a professional and knowledgeable nurse in her own right, which she believed gave her professional identity. Rizza spoke of her growing independence and autonomy, the more she felt she belonged to the mentorship team. Rizza spoke of needing to

believe that she was a valued member of the mentorship team which she felt played an important role in developing self-confidence. The following extract from Rizza's interview places further emphasis on her growing professional identity in her work as a stage 1 mentor. She explained:

“What was important to me was that once I was doing it all the time, they saw me as a good mentor even though I wasn't qualified. It meant a lot to me to feel like I was one of them if you know what I mean... I don't know, I sort of needed approval from them so that my status as a stage 1 mentor was earned, if you know what I mean. It took a while, but we got there in the end”. (Links to ICST 37, CCSuT 4.1, CCSuT 4 [Table 8])

When probed about how she felt about how she identified with being a stage 1 mentor, she was keen to share that being recognised for what she did made her feel stronger and gave her the feeling of being part of the mentorship team. However, what she found when she first qualified as a nurse was that she had to secure the esteem of her colleagues in order to feel accepted as part of the mentorship team. She emphasised the importance of being and feeling part of the team and linked this to how she identified as a stage 1 mentor.

“I hadn't realised how important it was to me to feel and be part of the mentorship team. Feeling like I was one of them and feeling like I had been accepted was important to me when they included me in decision-making stuff. Being included made me feel like a proper mentor”. (Links to ICST 40, CCSuT 4.2, CCSuT 4 [Table 8])

When asked about learning mentoring at work, Rizza explained that despite feeling ill-prepared for mentorship, she had set out to try and find ways to learn as she went along. Rizza spoke of mentoring students without the necessary knowledge and skills to know what she was doing, but found herself doing what she perceived as quite well. When probed further about using her own intuition, Rizza spoke of having an instinct for teaching students as she had come from a large family. Like the other participants, Rizza could not exactly explain how she had mentored students without having had any formal preparation but felt that having looked after her own younger siblings had unconsciously given her the practical wisdom to mentor students. She explained:

“I'm not really sure how to put it, but I just sort of unconsciously knew what to do, let's face it, it's not difficult is it, I used to teach my siblings stuff when they were young”. (Links to ICST 39, CCSuT 2.3, CCSuT 2 [Table 8])

She admitted that over time, she had picked up the practicalities of mentorship such as being able to teach basic clinical skills from her peers. When asked to explain who she was referring to, Rizza spoke of other newly qualified nurses who all worked with students. Rizza equated learning from her peers as helping each other to learn on the job, which she perceived as helping her to gain confidence in mentoring and improve her communication skills when

working with students. Though Rizza spoke at length about learning from her peers, she also recognised the negative side of working closely with other novice mentors. She explained:

“I found that working with other newly qualified nurses really helped me gain confidence in myself as we did loads of stuff like taking students to theatre and recovery and going through it all together. However, I soon realised that it was like the blind leading the blind sometimes ... Whenever clinical workload permitted, me and the other Band 5s always worked together for support. To be honest, I learn more from them in my first year than any course would, I reckon. I don't know, I think that stage 1 mentors do most of the work with students anyway, so maybe they know best, yeah” (laughs). (Links to ICST 33, CCSubT 2.4, CCSupT 2 [Table 8])

Although Rizza recognised the downside of working with other novice mentors, she felt that the positives had outweighed the negatives. Rizza accepted that that was how she was supposed to learn mentoring at work, and that was from each other. She believed that working with and learning from her peers had provided her with transferable skills such as interpersonal skills, good communication and effective time management. She also identified that learning from her peers had given her the foundations of effective mentoring that she felt she could not have learnt from a book or in a lecture.

When asked to give other examples of how she prepared herself for mentorship, Rizza explained that, though she found mentoring students to be highly stressful at the beginning, she had been realistic about taking a hands-on approach to mentorship, as she believed that was expected from her as a qualified nurse. In order to manage her feelings of unpreparedness, Rizza remembered that when she first started working on the ward, she had tried to work out what was expected from her in relation to students. She spoke at length about how her friends had helped her to prepare for the mentor role, where they had forewarned her that she would have to mentor students. She stated that those conversations had helped her to be realistic about mentoring and nursing in the UK, and had contributed towards becoming prepared. She explained:

“I think that having so many friends from the Philippines who work here in the UK helped to prepare me for the reality of the role. They warned me what it was like here and tried to explain the differences between the UK and home.” (Links to ICST 32, CCSubT 1.1, CCSupT 1 [Table 8])

Rizza spoke of the emotional demands of the role and how initially she looked to more experienced mentors to help her to overcome her anxieties about the stage 1 mentor role. She remembered experiencing many stressful circumstances during her early days as stage 1 mentor, describing how she had managed challenging situations that had led to her feeling anxious. She explained that, though she felt she had the basic skills for mentoring, she lacked knowledge about the nursing curriculum in the UK that had not been fully explained to her:

“Sometimes, I just felt emotionally exhausted with the demands of learning to be a nurse, learn about nursing curriculum in the UK, and learn how to be a mentor all at the same time. Having someone to hold my hand and show me compassion to help me cope with those demands really got me through those early days, I have to admit”. (Links to ICST 38, CCSubT 1.3, CCSupT 1 [Table 8])

Rizza confessed that due to her lack of knowledge of nursing and mentoring in the UK, she had felt inadequate as a stage 1 mentor. She spoke of having to make many personal and professional adjustments in order to address her feelings of uncertainty, such as modifying her behaviour and attitudes towards students. She confessed that in order to adjust to feeling uncertain and confused as to what she was doing, she made the effort not to avoid students, and accept that she could not control the situation. Rizza also spoke of managing her anxieties in order to develop her own resilience, so she could adjust to the situation at her own pace as she transitioned into the mentor role:

“I felt that if I own the situation I found myself in, then I would be able to adjust more to being a mentor without being too anxious. Owning the situation enabled me to develop my resilience so I could become a mentor at my own pace and not theirs.” (Links to ICST 34, CCSubT 3.1, CCSupT 3 [Table 8])

Although she confessed to struggling with her transition into mentorship, she stated that she had developed over time enough resilience to face the uncertainty of not knowing where she stood in the team, or what was coming next. She spoke of how her developing resilience had been an important feature of managing the confusion and uncertainty she felt as she crossed the threshold into mentorship. During this uncertain time when she questioned her abilities as a nurse and mentor, Rizza felt that the resilience that had grown in her had stemmed from finding an inner strength and ability to adjust to help her move beyond the uncertainty of working in a different way to what she had been used to in the past.

“I believe that finding that inner strength in myself influenced the way I was able to handle my transition into the mentor role. I mean, the first few months of being a nurse and a mentor in the UK was probably the most difficult time of my life”. (Links to ICST 35, CCSubT 3.2, CCSupT 3 [Table 8])

5.5 Case 5: Regita

Regita was a 38-year-old Spanish nurse working as a Band 5 nurse on an Accident and Emergency ward. Regita was the eldest of all the participants and had come into nursing later in life after achieving a first degree in psychology in Spain. She studied nursing in the UK as her second degree. Regita had been a nurse for eighteen months and had been introduced to mentorship since she became a nurse. Despite feeling unprepared for the stage 1 mentor role, she admitted to embracing the mentorship role, and believed it to be an essential, but extended role as a nurse. Even though she experienced some initial anxiety about taking some responsibility with students, her experiences of initial transition into the mentor role had been

more stressful. She managed to overcome these stressful times by turning to her colleagues for support. Regita claimed that this support from her colleagues enabled a sense of resilience with her ever-increasing confidence, and reduced stress and anxiety.

When probed as to how her experiences of mentorship had been so far, she felt that the way she prepared herself was to have a positive attitude towards mentoring and use those around her for support. Regita spoke of being proactive right from the start, and a willingness to invest in becoming a mentor. She told of finding students to work with and asking them if they would like to observe her when carrying out specific clinical skills. She also spoke of taking a hands-on approach to preparing herself for the mentor role, asking an experienced mentor to coach her, which she valued and which gave her the encouragement to grow as a mentor. She explained:

“I figured if I asked one of the more experienced mentors to coach me, she would help me to improve my performance and help me to grow as a mentor. I wish we could have had more of that, you know”. (Links to ICST 41, CCSubT 1.1, CCSupT 1 [Table 8])

She also commented that there had been an element of personal reflection involved, where she was able to draw on her past experiences of being mentored and the knowledge gleaned from those experiences. Regita used reflection to learn from her many encounters when being mentored as a student nurse, and how being able to reflect helped her to prepare for mentorship as a qualified nurse. When asked how taking time to reflect on her past experiences of being mentored had prepared her for the mentor role, she responded:

“I felt then, and still do, that taking time out to personally reflect on what I have learnt in the past played an important role in reducing my anxiety that I felt when I first qualified. We are constantly being reminded to be reflective practitioners, so I was able to link my past experiences of being mentored to now as a stage 1 mentor which ultimately prepared me, to a point, for mentorship”. (Links to ICST 45, CCSubT 1.2, CCSupT 1 [Table 8])

When asked what she meant by ‘to a point’, Regita elaborated by saying that it was her ability to be proactive and have a positive attitude that helped to prepare her for mentorship. However, when probed, she perceived that her preparedness had been psychological rather than practical. Regita was asked to recall some of her experiences of how she felt she had acquired knowledge and skills for mentorship. She initially hesitated and said that the reason she had come onto the course was to gain knowledge and skills for mentorship. However, when probed, she reported feeling obliged to take responsibility for her own learning and found the whole experience of mentoring students without the appropriate knowledge and skills caused her much stress and anxiety. She explained:

“I didn’t realise that I would have to take responsibility for my own learning. After all, isn’t it up to them (referring to other mentors) to guide me and tell me what to do? I didn’t realise how much stress that caused me”. (Links to ICST 42, CCSuT 2.1, CCSuT 2 [Table 8])

Regita laughed as we spoke, saying that she had been naïve in thinking she would be taught mentoring skills by other mentors. However, talking about it in her interview had made her admit that she had acquired a deeper level of learning for mentorship than she thought. Regita also admitted that having to take responsibility for her own learning had in fact moved her from a surface level of gaining practical skills to a deeper understanding of the realities of the role. She reported managing her lack of competence by building a network of peer support who supported her as she learnt. Regita emphasised that learning mentorship together had been beneficial to her:

“There was a few of us newly qualified nurses who all started our preceptorship together. What we realised though was that we need to learn about mentoring as well, so we all sort of clubbed together and found out what and how we could learn mentorship as well as all the other stuff we had to learn. I don’t know what I would have done without them being there”. (Links to ICST 48, CCSuT 2.4, CCSuT 2 [Table 8])

Like Gabby, Regita spoke of picking up bad habits from both experienced mentors and her less experienced peers. She spoke at length about cutting corners but admitted that she did it because everyone else did. When probed, she gave examples of some of the bad habits that she had picked up. For example, she admitted to, at times, not taking students with her when carrying out a complex dressing, knowing that if she took a student with her, that would slow her down. Regita spoke of how she consciously tried to avoid picking up bad habits, but tried to rationalise them by stating that they were not bad habits, but simply juggling being a busy nurse with mentoring students. She added:

“I knew I had picked up some of my colleagues’ bad habits, and funnily enough, I recognise the same bad habits from when I was a student. I really did try not to be like some of the mentors on the ward, but you just sort of slip into it without realising”. (Links to ICST 46, CCSuT 2.4, CCSuT 2 [Table 8])

Regita spoke of how she actively participated in mentorship duties, her transition into mentorship and the shock she had experienced when faced with the reality of the role. Regita had admitted that she knew mentoring students was part of being a nurse, but felt that it was more an extended role of the nurse, rather than an expectation that they mentor from the point of qualification. She spoke of how she felt she had been ‘*thrown in the deep end*’, and how she had coped with a shift in her responsibilities for students.

“I was trying to get my head around nursing, and then they added the responsibility of taking students pretty much every day. I just felt that in order to have the stamina to be thrown in the deep end a bit, I just had to bite the bullet and get on with the job”. (Links to ICST 43, CCSuB T 1.1, CCSuP T 1 [Table 8])

Regita spoke of feeling out of her depth, but reinforced that any feelings of shock were short-lived, as once she threw herself into mentorship duties. The more she actively participated in mentorship, the more positive she felt as she learnt to cope better with the challenge of student learning. She made explicit in her interview that she coped with pressure and anxiety by just focusing on learning on the job. Staying focused enabled her to accept her professional responsibilities and adapt to the stage 1 mentor role. However, later Regita reported that despite developing a degree of resilience over time, she felt she still needed more time to sustain her strength so she could continue managing the stage 1 mentor role effectively. When asked how she learnt to cope better, she reported how both practical and emotional support she had been given during preceptorship had been fundamental in developing resilience to manage both roles as a nurse and as a stage 1 mentor. She spoke at length about having two roles, one being a nurse and the other a mentor. She admitted that both roles were part of being a nurse, but it required very different skill sets to be effective at both. She explained:

“I was sort of in this period of transition where I was being preceptored as a novice nurse, but then given the responsibility to mentor students. I felt I knew what to do for nursing, but didn’t know what to do when it came to mentoring. I mean, sometimes I didn’t really know who I was supposed to be, a nurse or stage 1 mentor or both at the same time. I had to stay positive otherwise I wouldn’t have been able to cope”. (Links to ICST 47, CCSuB T 3.2, CCSuP T 3 [Table 8])

Whilst discussing her two hats, this led the conversation to how she identified as a mentor. She confessed to being baffled at first as to what or to whom her priorities should be, stating that wearing two hats had caused her confusion over where her loyalties lay. Regita reported how important she felt it was to fit in, in order to be seen as part of the mentorship team. She added that she often felt isolated when staff left her out of decision making when discussing students, emphasising the need to fit in and feel included. Regita told that despite gaining a professional identity over time, she felt that to this day, she was still waiting for some sort of professional recognition from her colleagues, which she believed she did not feel or get. In particular, Regita felt strongly that she needed to be recognised for her value and worth as a stage 1 mentor. Regita admitted that being involved in decision making was confirmation that she was good enough and she was worthy. She confirmed how over time, feeling valued as part of the mentorship team contributed to her sense of professional identity:

“If they included me when they were making decisions about student progression and stuff, then that made me feel like they valued me. I just wanted them to acknowledge me as a professional and all that, so I could at least feel that I was making a contribution, you know”. (Links to ICST 44, CCSuB T 4.2, CCSuP T 4 [Table 8])

5.6 Case 6: Emily

Emily was a 29-year-old white British female nurse working in elderly care. She had qualified 22 months earlier and experienced mentorship from when she qualified as a nurse. This was her second Band 5 role and she had worked in elderly care in her previous role. Emily's first experiences of working as an unqualified mentor started early on in her career, where she worked with students in her first post, and had continued supporting students ever since.

In her first staff nurse post, Emily had felt unqualified to look after students and would have preferred to wait until she had completed the mentorship preparation course. Emily spoke of her early transition into mentorship as being a time when she knew she developed a sense of resilience in order to cope with her transition into the mentor role. She described having a fear of the unknown at first, which she had expected to ease over time. She explained that, in order to deal with her lack of expertise for mentorship, she found ways to manage her transition into mentorship. Emily gave an example of avoiding students as often as she could and found herself making excuses whenever she had been asked to 'take' a student.

"I had to learn to adjust to the way this ward ran, and I did that by using avoidance tactics at first. When that didn't work, I always used to try and look busy. I found every excuse in the book not to take students, but saying that, I didn't avoid the students for too long as my confidence grew, the more I was happy to mentor them". (Links to ICST 56, CCSubT 3.1, CCSupT 3 [Table 8])

Emily did however reiterate that this avoidance tactic was short-lived as she progressed through her transition into the mentor role. She spoke of her developing resilience that gave her the strength to get through this time and how, eventually, she enjoyed mentoring students. Emily spoke at length about her feelings of unpreparedness both as a nurse and as a stage 1 mentor. When probed about how she prepared herself for mentoring, Emily spoke of mentally preparing herself by acceptance of what was required from her and being as adaptable as possible by being curious and committed to student learning. She told that once she had accepted that she had to mentor students, she found a way to actively prepare herself to mentor, such as shadowing other mentors and offering to teach a student a clinical skill. She stated that being adaptable was the best tool in preparing herself and the best possible outcome.

"I had to adapt to this new situation that I faced as a newly qualified nurse. No one really prepared me to take students, so I had to face up to the uncertainties and adapt. Finding ways to prepare myself, like shadowing other mentors, really worked for me". (Links to ICST 50, CCSubT 1.1, CCSupT 1 [Table 8])

Emily spoke of her initial anxieties and how she had to find someone who could give her the emotional support that she needed at the time. She spoke of how important having that emotional support had been to her and explained that she had just tried to find someone who

had nice qualities about them, such as someone who was friendly and willing to offer her a shoulder to cry on if she needed it. Emily spoke of these personal qualities in the people who supported her when she first became a nurse. When probed as to the type of support she was given, and who these people were, Emily said that it was everyone she had worked with:

“It wasn’t just other mentors who gave me that emotional support, it was other newly qualified nurses, the ward sister and even student nurses. I found that being reassured and praised for what I had been doing really meant a lot to me and is what kept me going”. (Links to ICST 57, CCSubT 1.3, CCSupT 1 [Table 8])

When questioned how she learnt mentoring, she stated that she had relied on her own intuition as she lacked any formal teaching or qualification for mentorship. She reported that her learning had probably been intuitively based on being mentored as a student. When probed about her intuition as a stage 1 mentor, Emily described her ability to execute this role as being based mainly on gut feeling and her personal disposition as someone to nurture people. She stated that she had not relied entirely on her gut instinct, and that was only an initial tactic to get by until she felt she had learnt more over time.

“Oh my God, I totally relied on instinct in the beginning, I mean, well, who wouldn’t? We didn’t know what we were supposed to do, and no one really went out of their way to show us, like, so we just sort of got on with it. There was an expectation that as a qualified nurse, we would work with students and show them the ropes. I just sort of knew what to do, but in reality, I just went with my gut feelings, that’s what everyone does, right?”. (Links to ICST 53, CCSubT 2.3, CCSupT 2 [Table 8])

Emily spoke at length of working and learning from her peers and was keen to talk about the importance she had placed on having other newly qualified nurses to learn with. She spoke of how learning from them had played a significant part in learning mentorship and how working and learning together had provided her with the confidence and assurance when mentoring students.

“Thank God we were all in it together. In the beginning, we just sort of hung out together for moral support, but actually, we found that we were all learning from each other as we all had different levels of knowledge when it came to mentorship”. (Links to ICST 49, CCSubT 2.4, CCSupT 2 [Table 8])

Emily spoke at length of the value of reflection at work and how being able to learn from her experiences of mentoring students had contributed to acquiring knowledge and skills for mentorship. Emily gave examples of actively reflecting on mistakes she had initially made, and how reflecting helped her with problem solving so she could work things out for herself. Emily admitted that, as she was able to work out what was right and wrong, her problem-solving skills developed over time. She gave some examples of acquiring problem-solving skills in the context of her own ward:

“Yes, taking responsibility to learn problem-solving techniques such as asking questions, trying to work stuff out on my own, you know, like trying to piece together a jigsaw helped me to learn it for myself. Thinking for myself actually did help me to learn rather than just doing as I’m told”. (Links to ICST 54, CCSuT 2.1, CCSuT 2 [Table 8])

Emily spoke of trying to fit in in order to be part of the mentorship team, and how it had been important to her that she was seen to be an integral part of the team. She spoke at length of not feeling appreciated nor recognised for her worth and believed that nurses without the mentorship qualification were undervalued. She added that having developed an understanding of the mentor role and feeling part of the mentor team were important to her feeling a sense of professional identity that she had not felt before. Emily put much value on feeling accepted into the mentorship team and admitted to trying to be seen by other mentors to participate in mentoring and being seen to adopt the necessary values of mentors for participation and acceptance into the team. She explained:

“I wanted them to see that I was making the effort to be part of the team, so I made sure that they knew I was making the effort to take students and get on with mentoring and that ... I sort of had to learn the culture and customs of mentorship and start acting like them, you know, like learning the skills and behaviours necessary to be like them. Once I was seen to be acting like them, that’s when I felt accepted into the team” (Links to ICST 52, CCSuT 4.2, CCSuT 4 [Table 8])

Emily went on to say that she had not felt the qualified mentors on her ward had consciously not accepted her into the mentorship team, admitting that she had probably been paranoid at the time. She questioned her professional identity as a stage 1 mentor and how initially, she had to internalise her belongingness by earning the respect and appreciation of her colleagues. She added:

“You know, it was hard for me at first. I just felt that I needed to earn their (stage 2 mentors) approval and respect for the amount of work that I did with students. Stage 1 mentors are the ones who students turn to mainly and we are the ones that do most of the work with students. We just wanted to feel appreciated”. (Links to ICST 58, CCSuT 4.1, CCSuT 4 [Table 8])

5.7 Case 7: Martha

Martha was a 23-year-old white British female working on a surgical ward. She had qualified as a nurse eighteen months earlier and was in her first Band 5 post. Her early experiences of working as an unqualified mentor involved early exposure to students and she was keen to develop her role as stage 1 mentor. Martha planned to move into nursing education in the future, so embraced being a stage 1 mentor. Martha reflected on her own experiences of mentoring students as a stage 1 mentor and spoke at length of how much she had needed emotional support. She told of how mentors had been willing to provide her with practical support for mentoring whenever she had asked for it, but how praise and reassurance had not

been forthcoming. When probed as to how she gained the emotional support she needed, she stated that she had found that support from older and more experienced mentors, rather than younger mentors who expected her to just get on with the job. When asked to explain, Martha went to say that it was often the 'older' mentors who provided her with emotional support, believing that it had been down to their motherly instincts: The following quotation illustrates this:

"I don't know, I just naturally gravitated to the older mentors for emotional support as they were the ones who I felt had more of a motherly instinct. I often used them as a shoulder to cry on believe me". (Links to ICST 65, CCSubT 1.3, CCSupT 1 [Table 8])

Martha explained that despite feeling unprepared for the mentorship role, she felt it was critical to be proactive and find opportunities to engage in mentorship duties. She stated that being hands-on not only gave her a sense of empowerment and a feeling of self-discovery that had contributed towards her preparedness for the mentor role, but an increased confidence in herself and how she worked as a mentor. Martha gave examples of how she prepared herself for mentorship, saying that she had been encouraged to practise mentorship so she could use these hands-on experiences to reflect and reframe her ability to mentor so she could give meaning to those experiences. The sense of preparedness that Martha felt had stemmed from being hands-on, subsequently enabled her to retain what she had learnt and grasp the concept of mentorship. Active learning through hands-on mentorship gave her the freedom to have real lasting experiences with students, rather than simply being told by someone how to do mentoring. She explained:

"Looking back on it, being hands-on with students helped me to prepare for more responsibility. When you do something tangible that you can take pride in, and use those experiences for later, then it just motivates you to want to do it again. Doing it for real helped me make it more meaningful and helped me to understand the next steps to take, so I could overcome the challenges I faced later. Now that was good preparation, right?" (Links to ICST 59, CCSubT 1.1, CCSupT 1 [Table 8])

When asked about how she acquired knowledge and skills for mentorship, Martha had wondered at the different ways she believed she learnt mentorship at work from her peers. Like the other participants, Martha remembered how initially, she had turned for support to her peers, who she felt had been essential to her gaining confidence. She confessed that she had been needy at times, and felt embarrassed at having to keep asking for help. However, like Abbas, the support from her peers decreased over time, which she had not noticed. She gave an example of working with a failing student, and noticing that she had not asked any of her peers for help:

"I was always turning to my peers for support, then one day, I realised that I was making my own decisions without having to ask for help. I suppose by then they trusted me to get on with it". (Links to ICST 66, CCSubT 2.3, CCSupT 2 [Table 8])

Martha explained how important it was for her that her peers had good values and behaviours, and were positive role models at work. When asked what she meant by good values and behaviours, she gave examples of compassion, approachability and being passionate about student learning. Martha stressed that having a network of peers with these characteristics had given her, she felt, a shared understanding of what it was like to mentor students, and a sense of responsibility for students. She reflected that mentoring students alongside those peers inspired her to learn more about mentorship and mirror their good values and behaviours. Martha felt that the positive influence of her peers was pivotal in strengthening relationships with each other and driving her to greater independence as a stage 1 mentor:

“The positive influence of my peers really helped me to forge better relationships with everyone on my team. We all had a shared goal at the end of the day, and that was to provide the best experience for students”. (Links to ICST 61, CCSuB 2.4, CCSuB 2 [Table 8])

Martha also confessed that making mistakes had caused her much stress, knowing that she was relying heavily on trial and error to get by. Martha felt that the most common cause of her making mistakes was her lack of knowledge and information on what she considered to be good practice. She spoke of managing her stress by remaining positive and accepting responsibility for making mistakes. Martha believed that taking responsibility for her own mistakes led to making positive changes in how she felt and, subsequently, how she worked with students. When asked to give examples of the positive changes that had occurred, she explained:

“Well, making mistakes and learning through trial and error gave me the opportunity to reflect on where I went wrong, and then talk it through with one of the mentors. I think this way of learning helped me to feel more confident when making decisions about students”. (Links to ICST 63, CCSuB 2.2, CCSuB 2 [Table 8])

Despite her making mistakes with students, Martha spoke about her developing resilience over time, from when she first qualified to speaking at this interview. Her transition into the mentorship role, like other participants', had been a shock to her when faced with the reality of being responsible for student learning. When probed as to signs of shock she had experienced, she gave examples of feeling anxious, worried about failing herself and students and, often, a fear of isolation. She went on to explain some of the coping strategies she found she drew on to cope, such as reflecting and debriefing with her peers, and actively seeking support when needed. Martha explained how she felt at this time:

“I just couldn't believe what I was expected from me. It felt like I had collided with the reality and the demands of this additional role that I was unprepared for and often asked myself what I had let myself into. I tried to see my transition into mentoring as a challenge rather than something to be scared of, you know, turn something negative into a positive”. (Links to ICST 60, CCSuB 3.1, CCSuB 3 [Table 8])

Martha told of her developing resilience, which she needed to help her overcome her transition into mentorship, and how she felt that being resilient would enable her to confront the challenges that faced her as a stage 1 mentor. Martha also revealed how she sometimes felt abandoned by more experienced mentors who were always just too busy to help her transition into mentorship. She explained that she had needed that resilience to overcome feelings of uncertainty and vulnerability on many accounts and described how she had employed different strategies to cope with her ever-increasing feeling of defeatism. Martha used the analogy of 'crossing the threshold' in terms of coping and adjusting to the role over time. When asked what she meant by this, she explained:

"It was like a feeling of transience, you know, where you feel so unsettled in a place that you don't recognise. But then you sort of come out the other side and you feel like you've made it". (Links to ICST 64, CCSubT 3.2, CCSupT 3 [Table 8])

Martha admitted that by 'crossing the threshold' she meant that she felt less uncertain and had more confidence to get on with the job in hand without having to ask. She also spoke of the need to feel part of the mentorship team and reflected that her sense of value gained from feeling that she belonged had been important to her. Martha spoke of acquiring a sense of professional identity that she associated with her sense of belonging, which she felt developed over time. Martha confessed that acquiring an identity as a stage 1 mentor had not been important to her when she first became a nurse and stage 1 mentor, explaining that initially, she just focused on trying to learn what to do. However, she explained that after a while, she realised that she felt like an outsider and was not included in conversations about students. The more she felt excluded, the more she felt the need to feel and be seen to be part of the mentoring team.

"When they used to discuss students that I have looked after and make decisions without me, that just made me feel even more that I should be included as part of the team So when I eventually felt included, well that's when I started to feel I belonged to the mentorship team". (Links to ICST 62, CCSubT 4.2, CCSupT 4 [Table 8])

Martha explained that integrating the expected knowledge, behaviours, skills and attitudes of the mentorship team aided her socialisation into the mentorship role and contributed to gaining her identity as a professional mentor. She told of an expectation that she would become comfortable with mentoring over time and would begin to see herself as a competent mentor who could be relied upon. However, in the reality of practice, when Martha noticed a dissonance between what she had expected to feel and the reality of being accepted into the mentorship team, she resorted to seeking the esteem of her colleagues so that she could be not just noticed, but respected for her value as a stage 1 mentor. Martha spoke of a defining moment when she had been asked for her advice about a particular student. Being approached for advice gave her a sense of respect where she was recognised for her value and worth.

Having that respect for Martha, she felt had been the making of her professional identity, which she had not felt she needed or had. She realised, however, that the respect she now felt had been earned over time and had not been given lightly. Martha reiterated this in the quote below:

“I just felt that I had this human need to be appreciated for all my efforts with students. You know, it didn’t matter to me at first what the other mentors thought of me, I just cared what the students thought about me But the more experienced I became, the more it became important to me that my colleagues recognised me as a good mentor”. (Links to ICST 67, CCSubT 4.1, CCSupT 4 [Table 8])

5.8 Case 8: Abbas

Abbas was a 24-year-old male nurse originally from Nigeria, working on an adult medical ward. He had been a nurse for two years. His experiences of working as an unqualified mentor started early, as he states, “*from day one*”. His expectations of being a stage 1 mentor were that he would work with students regularly to gain experience to become a qualified mentor. He was very keen to share his knowledge with students and was excited to be doing the Preparation for Mentorship course. Despite Abbas not feeling ready to become a stage 1 mentor, he felt he had embraced the challenge and had looked forward to working with students. Abbas reported how he had offered to work with students regularly to gain enough experience so that his manager would send him on the mentorship course. He admitted to realising very quickly that to be put forward for the mentorship course meant he had to prove to his manager that he had the ability and willingness to work with students. Abbas had every intention of becoming a stage 2 mentor early on in his career as he planned to move up the ranks as quickly as possible.

Abbas’s interview captured his early experiences of working as an unqualified mentor and how he was proactive in identifying learning opportunities that he felt would prepare him for the mentor role. He described how he set out to be independent and not reliant on others to provide him with opportunities for mentorship, but accepted that he needed guidance at times. Abbas confessed that initially he felt anxiety and a lack of confidence, but over time his anxiety decreased and confidence increased as he took responsibility for his own learning. For Abbas, being actively self-directed in his own learning gave him a sense of fulfilment that he had not felt before, and a feeling that he was able to apply what he had learnt himself to mentorship practice.

“I felt that by making an effort to get involved with mentorship off my own back, helped me to gain the necessary skills that I needed to mentor. Learning that way certainly helped me to understand more how I made the decisions I was making and why”. (Links to ICST 68, CCSubT 2.1, CCSupT 2 [Table 8])

Abbas deemed that some of his mentorship skills had been developed through trial and error and learning from his mistakes. He described how learning through trial and error enabled him to identify problems with students and consider alternative solutions that would help them learn. Abbas believed that making mistakes in the past had been a good thing. He told of putting mistakes in the past and being able to move on from them. He added that he used the mistakes to reflect on his practice and then move on and do better next time. Abbas had adopted a motto that nobody is perfect, just in case he got it wrong, which Abbas confessed to doing on many occasions. Abbas explained how he felt about getting it wrong:

“I didn’t mind really getting it wrong sometimes as long as I discussed it with someone after and tried to reflect on my learning. It was fine, yes, I made some bad decisions in the past with students, and yes, I did reflect on perhaps how I could do it better next time. But you know, it’s ok to make mistakes and errors in judgement sometimes as that’s how we learn, isn’t it?” (Links to ICST 72, CCSuT 2.2, CCSuT 2 [Table 8])

Abbas spoke of the nature of his speciality and the climate of the ward on which he worked. He reported how busy the ward was, with patients being admitted every day and the high turnover of sick patients. Despite the busyness of the ward, he spoke kindly of most of his peers who had helped him to develop knowledge and skills for mentorship by working with him and showing him the ropes. Abbas also spoke of some of his peers whom he had been asked to buddy up with as newly qualified nurses. He confessed that, as a novice nurse and mentor, he had just accepted what he had been told to do by peers who had been on the ward longer than him. As he gained more experience in mentoring, he noticed that peer support decreased over time, and he found he turned to them less as he gained confidence. He explained:

“I really had to rely on my peers at first, and bless them, they were really patient with me in the beginning. I was always asking questions and asking them to help me, probably too much, but over time, that support was less needed, and they sort of let me get on with it. I didn’t notice it at the time though”. (Links to ICST 75, CCSuT 2.4, CCSuT 2 [Table 8])

Abbas compared his past mentors from his student days to his role as a stage 1 mentor, and reflected on how some of them had not been kind or friendly. Among some of the positive characteristics that Abbas described of his mentors were friendliness and a desire to share knowledge with others. He told of avoiding unfriendly people, and reflected on some of the negative characteristics of past mentors, such as being intimidating and hostile. Abbas believed that the positive mentors had prepared him to be a mentor in the future, but he had not realised it at the time. He remembered occasions of good mentoring, such as being encouraged to teach his fellow students, and how these opportunities prepared him for the mentor role. Abbas reflected on how he was encouraged, as a third-year student, to work with first-year students, which he believed gave him a good grounding for what was to come as he

became a nurse. He admitted he utilised his past experiences as a student as a tool for reflection to prepare him for the reality of mentoring students. By actively reflecting on past experiences of being mentored, Abbas felt he was able to become the best mentor that he wanted to be. Abbas stated that he was able to recognise his own values and beliefs and obtain a clearer picture of how he should not behave as a stage 1 mentor. He explained:

“I know that the values and beliefs that I have as a stage 1 mentor are not the ones that some of my mentors had when I was a student. Being able to recognise that through actively reflecting on my practice really prepared me for mentorship”. (Links to ICST 71, CCSubT 1.2, CCSupT 1 [Table 8])

Abbas told of having mixed feelings when it came to mentoring students. Though he admitted he had been excited at the prospect of mentoring students, he admitted to feelings of stress and anxiety in the early days as a staff nurse, as he transitioned into the mentor role. The mixed feelings that Abbas experienced were also clear when he talked about the support of his colleagues who helped him through those early days. Abbas reported using his network of peers who would take him under their wing and support him in managing his anxieties. He knew that he had a professional responsibility to teach students and described himself as a natural teacher, but he admitted that, on some days, it was nice to have someone to give him the emotional support that he needed then. Like other participants, Abbas told that his colleagues were all willing to offer him practical support, and provide hints and tips to prepare him for mentorship, but he had been worried about picking up the bad habits which he felt some of them had. Abbas made an attempt to combine practical support with emotional support by finding a mentor who was emotionally intelligent and aware that both types of support were required. When probed about what he meant by this, he explained:

“I found that I would look for someone who could offer genuine encouragement and reassurance and compassion, as well as giving me the practical advice that I needed to mentor students.” (Links to ICST 74, CCSubT 1.3, CCSupT 1 [Table 8])

Abbas spoke of his transition into mentorship as a period of time where he had experienced shock at the reality of being a stage 1 mentor. When asked to explain, he spoke of a role confusion and the need to adapt his behaviours, beliefs and attitudes to those around him in order to cope. Abbas spoke of managing his transition into mentorship and regarded this period as a crucial time in his life where he acknowledged how far he had developed over the last year. He described how he had adapted and modified his behaviour, giving an example about being naturally shy but using humour in specific situations to manage his anxieties. Abbas' use of humour facilitated the development of resilience so he could see the lighter side of the situation he found himself in. Abbas believed that he had the power to strengthen his resilience by positivity and use of humour in awkward situations, and that making light of situations kept his problems in perspective. He explained:

“I think by changing the way I was from a shy bloke to a humorous one helped me during stressful situations. I don’t know, I just found that being funny enabled me to deal with mentoring better and rebound from negative emotional experiences that I was faced with. Staying positive is what gave me the resilience to cope with mentoring in the beginning”. (Links to ICST 69, CCSubT 3.1, CCSupT 3 [Table 8])

Abbas spoke at length of the term ‘stage 1 mentor’ and what that meant to him. He spoke of a lack of professional recognition felt by him and many of his peers. When asked to explain what he meant, Abbas spoke of being taken for granted and feeling undervalued. Abbas revealed that he had struggled with his professional identity as a mentor, but remained committed to mentorship and its ethos around student learning. He spoke of trying to enact core values of the mentorship team to help him sustain membership within the team. He told of initially craving professional recognition as a mentor for his contribution to student learning. He spoke of recognising at some point that he had become an accepted member of the mentorship team over time without realising. When probed as to what made him feel he had gained professional recognition and was part of the mentorship team, he explained:

“By gaining the professional recognition by everyone else in the mentorship team did like make me feel accepted, but also made me feel like I had earned my badge of honour. It was things like them consulting me about a student, or them asking my advice that made me feel I had earned my stripes”. (Links to ICST 70, CCSubT 4.1, CCSupT 4 [Table 8])

5.9 Summary of Chapter

The findings have been presented in this chapter as a synopsis of the eight individual participants’ idiographic descriptions of their early experiences of working as unqualified mentors. The stories presented in this chapter are in response to the research questions set out in Chapter 1 and are the perspectives and experiences of each participant. It is important to note, however, that although the presentation of verbatim quotes in this chapter has been useful in identifying, analysing and reporting patterns and connections in the stage 1 mentors’ stories, it may have left a fragmented image of their narratives which might not necessarily be a true reflection of their experiences. Extracts of colour-coded raw data have allowed the reader to appreciate and understand how the themes emerged in this study and contribute to the faithfulness and trustworthiness of the findings. The verbatim quotes have been supported by my interpretive commentary to enhance their voices and provide a context to their lived experiences. The intensity and complexity of the lived experiences of all eight nurses have shown human insight and a dimension to their experiences that provides a deeper understanding of their world.

The next Chapter 6 critically discusses and makes sense of the findings from the cross-case analysis of the eight cases. The four cross-case superordinate themes (CCSupTs) and eleven cross-case subordinate themes (CCSubTs) are used to structure and organise the chapter. This final set of themes represents issues that are central to the participants' early experiences of mentoring.

Chapter 6: Discussion: Making Sense of the Findings

6.0 Introduction to Chapter

This Chapter 6 provides a critical discussion of the four cross-case superordinate themes (CCSupTs) and eleven cross-case subordinate themes (CCSubTs) as detailed in *Table 8* (page 100 refers). The themes in this final set were central to the participants' early experiences of working as unqualified mentors and have plausibility as descriptors of important aspects of participants' experiences, grounded in a systematic examination of their own accounts. This chapter illustrates the second stage of the double hermeneutics, as shown in Figure 6 (page 58 refers), with the researcher's attempt to make sense of the findings.

6.1 Cross-Case Superordinate Theme 1: Proactive Strategies in Becoming Prepared

The cross-case superordinate theme 1 labelled Proactive Strategies in Becoming Prepared describes how the participants took a pragmatic, hands-on approach to mentoring, took an active personal involvement with reflection on past experiences of being mentored, and sought ways to find emotional support. The cross-case superordinate theme 1 (Table 8, Chapter 5) encompassed three subordinate themes that represented how the participants in this study prepared for mentorship. Despite participants feeling unprepared and unready, they were all proactive in preparing themselves for mentorship by (1.1) *active participation in mentorship activities*, (1.2) *active reflection on past experiences* and (1.3) *seeking ways to find emotional support*. For the purpose of this study, the term 'preparedness' refers to the possession of practical skills and attributes required for newly qualified nurses to fulfil the stage 1 mentor role.

6.1.1 Cross-Case Subordinate Theme (1.1): Active Participation in Mentorship Activities

Participants actively participated in mentorship activities by being hands-on and getting involved to prepare themselves for the mentorship role. Participating in hands-on mentoring meant for them many things. In order to feel and be prepared, participants got involved as early as possible. For example, they partnered with other mentors to help with teaching students at the bedside, took time to give students feedback on their performance and then reflect on what they had learnt, and interacted with students on the ward. Actively participating in mentorship activities was crucial in their grounding, and inextricably linked to preparing themselves for mentorship practice.

In Whitehead and Holmes' (2011) review of the literature, newly qualified nurses used the term '*thrown in the deep end*' (p. 22) to describe how they felt about the realities of nursing, adding that they did not feel adequately prepared for their roles in practice. Similarly, participants in this present study spoke of feeling inadequately prepared for the realities of the mentor role. Regita used the same term used by participants in Whitehead's study '*being thrown in the deep end*' (Chapter 5, Section 5.5) to explain how she felt about the realities of mentorship practice. Though Regita felt she had been thrown in the deep end and was out of her depth, having to get on with mentorship enabled her to overcome her anxieties and boost her confidence. The more she actively participated, the more she was able to cope with the realities of the mentor role. Being able to cope with the realities of the mentor role subsequently boosted her confidence, enabling her to manage the anxieties and feel more prepared. This finding adds to the body of knowledge around the preparation of newly qualified nurses and the need for them to be prepared for practice (Duffy et al., 2000; Whitehead, 2001; Myall et al., 2008; Middleton and Duffy, 2009; Whitehead and Holmes, 2011; Lawson, 2012a; Lawson, 2012b; Wilson, 2014b; McGuinness et al., 2016). If newly qualified nurses are provided with coping strategies by more experienced nurses and mentors, then perhaps being able to cope would ultimately lead to increased confidence and preparedness for mentorship and supervisory practice.

Being hands-on and collaborating with others had been a positive move in becoming ready for the role. Preparedness for clinical practice is a critical issue for new nurses (Hart and Bowen, 2016), with the path from novice to competence being challenging and difficult. Despite participants in this study feeling overwhelmed and often inadequate, the very nature of being involved with students enabled participants to feel motivated to mentor students. This participatory, discovery-based and hands-on approach to their preparation was identified as crucial for them to feel ready for the mentorship role, as evidenced by some of the case-specific themes in Chapters 4 and 5. For example, as seen in the data, participants such as Tom (Section 5.1), Gabby (Section 5.3), Regita (Section 5.5), Martha (Section 5.7) and Abbas (Section 5.8) all recognised that in order to prepare for mentorship, they needed to be proactive and hands-on. The more proactive and hands-on they were, the more they felt motivated to take more responsibility to mentor students. This finding differs from those of Clinton et al. (2018), who reported that nurses and students need encouragement to take responsibility for their own learning, which is considered by educationalists as essential for them to develop knowledge and skills for nursing. However, Bruner (1996) believes that when students discover something for themselves, it increases feelings of responsibility to learn on their own and motivation to learn more. This is consistent with the work of Knowles et al. (2011) who assert that when individuals actively participate, with or without help from others in diagnosing their learning needs, they are capable of building on opportunities to use rich

experiences to learn. Earlier, Knowles (1975) described these individuals as andragogic learners who prefer to take responsibility for setting their own learning goals.

Whilst the preparation to become a stage 2 mentor was undertaken at one year post-qualification under the NMC mentorship standards (NMC, 2008), Christiansen and Bell (2010) suggested that mentorship principles be introduced into pre-registration programmes early, to foster understanding of mentorship prior to registration. The participants in this study all felt that to be given practical mentorship opportunities as student nurses would have provided a grounding for what was to become a significant part of their role once registered with the NMC. Abbas (Chapter 5, Section 5.8) had experienced the opportunity to do some mentorship as a third-year student, where he had been encouraged to teach first-year students. He believed that these practical opportunities gave him the grounding that he needed on becoming a stage 1 mentor.

It is well known that newly qualified nurses experience a period of feeling unsettled and anxious as they learn to adapt to their new nursing role (Gerrish, 2000; Kelly and Ahern, Myall et al., 2008; Mooney, 2007; Whitehead, 2001; Whitehead & Holmes, 2011; Whitehead et al., 2013, 2016). Yet there is strong evidence in this study that having the opportunity to actively participate in mentorship activities and be hands-on enables nurses to overcome feelings of anxiety and stress and cope with the mentor role. This study found that nurses at an early stage of their nursing career, and without formal preparation for mentorship, use proactive strategies to participate in hands-on mentoring which subsequently prepares them for the mentor role. Hence, there is little doubt that early active participation in mentorship duties is an important strategy to support the preparation of newly qualified nurses for mentorship. However, there is little evidence in this study to suggest that through active participation, participants would have acquired the necessary theoretical knowledge and understanding of mentorship that underpinned their mentorship practice.

6.1.2 Cross-Case Subordinate Theme (1.2): Active Reflection on Past Experiences

Johnson (2013) asserts that active reflection is necessary to determine how students learn and think, how they make sense of information and how they view problems from varying perspectives. Since the participants in this present study had little experience with real-life mentoring situations, another strategy to become prepared was active reflection on past experiences, specifically relating to when they were mentored themselves as students. For the participants in this study, active reflection involved conscious consideration of their past experiences of being mentored to gain insight into how these experiences might prepare them for future mentorship practice. In short, active reflection on past experiences helped participants to cultivate self-reflection as a skill through their application and practice as

mentors. Somerville and Keeling (2004) reported that reflective practice was a valuable tool to help nurses manage their own strengths and weaknesses and could benefit them on both a personal and professional level. Somerville and Keeling recommended practical tools for critical reflection, such as viewing experiences objectively. However, none of the participants in this present study spoke specifically on the practicalities of reflection or any specific approaches and techniques for reflection.

Donald Schön was an influential thinker in developing the theory and practice of reflective learning and defined reflective learning as 'the capacity to reflect on action so as to engage in a process of continuous learning' (Schön, 1983, p.102). He later introduced the concept of reflection-in-action and reflection-on-action. Participants in this study regularly used reflection-on-action, where they tried to retain and understand their past experiences by acting on what they had learnt from past mentors and using those experiences to mentor students themselves. Active self-reflection-on-action enabled participants to integrate their past experiences into a better understanding of how they mentor students. For example, Regita (Chapter 5, Section 5.5) used active reflection to draw on her past experiences of being mentored and apply what she had learnt from those encounters that ultimately prepared her to mentor. Regita believed that taking time to actively reflect on her practice through discussion and application to practice not only prepared her for mentorship practice, but also reduced her initial anxieties.

Lee (2007) asserted that andragogy as a theory of learning can be a model of discovery learning, and gives attention to experience as a resource for learning. This was evident in Tom's experiences. Tom (Chapter 5, Section 5.1) was motivated to learn from his past experiences by actively reflecting with his preceptor who had helped him to put those past experiences into action as he mentored students. Through reflection and discussion, his preceptor enabled him to realise good and bad behaviours from his past mentors and replicate those positive experiences in his own practice. Therefore, the opportunity to actively reflect through critical discussion on the behaviours of previous mentors was described by Tom to be a positive contribution to his preparedness. It is important to note, however, that Tom's positive experiences might be dependent on the nature of the relationship with his preceptor. Tom was able to apply his experiences of being mentored and model his mentorship practice as a stage 1 mentor to what good role modelling looked like. This finding is consistent with Donaldson and Carter's (2005) study about role modelling, but also raised in studies by Illingworth (2006); Felstead and Springett (2016); Jack et al., (2017); and Carey et al., (2018a), who found that students model their practice on those to whom they closely relate, both positively and negatively.

As well as actively reflecting on positive past experiences, participants used active reflection through a process of examining and linking past mentors' behaviours to learning from negative experiences. All participants had experienced negative role modelling at some point in their three-year programme, which corresponds with other research findings (Donaldson and Carter, 2005; Parker et al., 2014; Baldwin et al., 2014; Felstead and Springett, 2016). For example, Abbas (Chapter 5, Section 5.8) used reflection to gain some meaning from the influence poor mentoring had on him. However, it could be worthy to note that poor mentoring, as discussed by the participants in this study, could have been a reaction against a mentor who was considered too strict but was, in fact, a thorough and competent mentor. Through active reflection, Abbas was able to consciously consider how his own values and beliefs were important to mentoring and how poor mentoring should be avoided, which in turn enabled him to learn from his bad experiences of poor mentoring. This finding is consistent with those of Papp et al. (2003, p. 233), who reported that '*one can learn from bad experiences*' and that students can be very forgiving.

With all eight participants, their experiences of being reflective practitioners were triggered by questioning of their actions, values and beliefs. Indeed, it seemed that reflection had led to potential learning situations. Using reflection to revisit and learn from their experiences as students was a strategy to feel ready and significantly shaped their preparedness and development for the mentor role. This finding, however, does not resonate with those of Mooney (2007), who found that time spent as students did not prepare them for the realities of practice. Yet this study confirms that participants were actively involved in reflection to focus on both positive and negative mentors encountered on pre-registration nursing placements and used those experiences to prepare themselves for the mentor role. Thus, the value placed on reflection of experiences of being mentored was a positive feature and significant in terms of a contribution to the literature and mentorship practice.

The importance of active reflection in nursing is seen as essential to knowledge development and is depicted as a continuous cycle in which experience and reflection on experiences are inter-related (Chong, 2009). Chong found that active reflection enabled student nurses to develop a greater sense of responsibility and accountability in their practice but made no reference to a greater sense of responsibility and accountability for qualified nurses. Caldwell and Grobbel (2013) also highlighted that nurses who take time to reflect on their daily experiences provide enhanced nursing care, and have a better understanding of their actions, which in turn develops their professional skills. Like the nurses in Caldwell and Grobbel's study, being able to be actively involved in personal reflection on past experiences of being mentored significantly shaped participants' preparedness and development for the mentor role. As stage 1 mentors, they encountered what was new and unknown to them, and drew

on their understandings of what was known to them from their past experiences of being mentored. Whilst reflective practice is recognised in the nursing literature (Bulman et al, 2012; Bulman and Schutz, 2013), active reflection has not been recognised with regard to nurse mentoring as a proactive strategy in preparing for the mentor role.

The concept of active reflection on past experiences contributes to the development of coping strategies, making sense of personal and emotional challenges in practice, and the ability to bridge the gap between what happened to them as students and the reality of practice now as mentors. Therefore, the outcome of being able to make sense and the ability to bridge the gap in their mentorship knowledge can help newly qualified nurses to deepen their understanding of mentorship practice and, at the same time, engage in reflective practice.

6.1.3 Cross-Case Subordinate Theme (1.3): Seeking Ways to Find Emotional Support

Though it has already been established in other research that nurses require emotional support for nursing (Duchscher, 2009; Whitehead & Holmes, 2011; Ebrahimi et al., 2016a; Ebrahimi et al. (2016b), participants in this study initially sought emotional support not just as nurses, but to fulfil the mentor role with confidence and preparedness. A finding not elucidated previously by any other researchers in the field of mentorship was that emotional support was not often available to newly qualified nurses at first but developed over time through encouragement and reassurance.

Participants reported that, initially, they experienced high levels of stress and anxiety when they began mentoring, so had to seek ways to find the emotional support that they needed at the time. It was clear in the data that there were feelings of unpreparedness associated with taking on the mentor role without the knowledge and skills to do so, which initially overshadowed their excitement at becoming a nurse. All participants recounted that practical support was always on offer, but emotional support had not initially been offered. Tom (Chapter 5, Section 5.1), Martha (Chapter 5, Section 5.7) and Gabby (Chapter 5, Section 5.3) specifically mentioned that emotional support had not always been forthcoming, which could suggest that nurses might not be equipped with the necessary qualities such as sensitivity and responsiveness to provide emotional support to newly qualified nurses. However, Ebrahimi et al. (2016) argued that providing emotional support to newly qualified nurses should not require special expertise, and all that is required is goodwill, openness, kindness of heart and altruism.

The concept of emotional support has been reflected in nursing literature (Gerrish, 2000; Higgins et al., 2010; Duchscher, 2009; Dyess and Sherman, 2009; Ebrahimi et al., 2016), acknowledging the fundamental need for newly qualified nurses to be emotionally supported. However, the literature has given limited attention to this issue specific to the mentoring role.

This study found that having emotional support by more experienced nurses enabled participants to feel they were on the right track, and was considered as fundamental to them feeling more motivated, confident and prepared for the mentor role. This findings is similar to those of Ebrahimi et al. (2016b) who found that the provision of emotional support from more experienced nurses can ameliorate such work-related tension. However, it was apparent in the data that any emotional support that was given came from more experienced nurses and mentors. Both Tom (Chapter 5, Section 5.1) and Martha (Chapter 5, Section 5.7) found that, when support had been given, it was from older, more senior colleagues who helped reduce anxiety, rather than the younger, less experienced ones who were not forthcoming in offering praise and reassurance. These findings are consistent with those of Ebrahimi et al. (2016), who concluded that emotional support from more experienced nurses can ameliorate any tensions in the workplace and reduce stress and anxiety. This Iranian study contributes to the evidence base for the need for emotional support in nursing. However, the different cultural norms can be borne in mind when considering how this might relate to mentorship practice in England.

This study found that emotional support given during the first year as stage 1 mentors featured strongly in their quest for preparedness. Emotional support was initially hard to come by as newly qualified nurses but was eventually found through means of encouragement to mentor, praise, reassurance and compliments. These means of emotional support, when given, were an important influential factor in reducing their anxiety and feelings of unpreparedness. Emotional support, however, was in the main, only given by older, more senior nurses. This would perhaps suggest perhaps that with age and experience, the skills to be able to provide emotional support is developed over time. In contrast to Ebrahimi et al.'s (2016) argument that nurses should not require special expertise to provide emotional support, this study argues that all newly qualified, or less experienced nurses should be enabled with skills to provide emotional support for those taking on a mentorship role. However, it could be argued that personal skills such as the encouragement, praise and reassurance of others should be central to the role of the nurse. However, it was clear that emotional support was not initially forthcoming, and had to be found, suggesting that it did not necessarily come naturally to some nurses. Thus, this finding draws attention to the assumption that all newly qualified nurses are equipped with the skills to provide emotional support, but fails to recognise that providing emotional care might require additional training. This finding will help to establish that emotional support is key to the development and preparation of future nurses working in the mentorship role.

6.1.4 Cross-Case Superordinate Theme 1 Summary

In summary, the findings from this study highlight that in order to become prepared for the mentor role, newly qualified nurses in this study were proactive rather than passive in becoming prepared. Strategies to become prepared included actively participating in mentorship activities, actively reflecting on past experiences of being mentored, and seeking ways to find emotional support. These findings support studies referred to in Chapter 2 and in this Chapter 6, in that the need for preparedness and readiness for mentorship practice continues to be an issue. This cross-case superordinate theme *Proactive Strategies in Becoming Prepared* has conveyed the multiple views of how newly qualified nurses prepared for the stage 1 mentor role. Table 9 provides the highlights of the study conclusions relating to CCSupT1 and its associated CCSubTs. Table 9: Proactive Strategies in Becoming Prepared highlights

Cross-Case Superordinate Theme 1: Proactive Strategies in Becoming Prepared Highlights	
CCSubT (1.1) Active participation in mentorship activities	<ul style="list-style-type: none"> • Participants prepared themselves for mentorship by becoming involved in meaningful practical activities that felt relevant to them in the context of their own workplace. • Being hands-on included joining in with other mentors to help with teaching students at the bedside, taking part in giving students feedback on their performance, and carrying out orientation activities for new students. • Actively contributing towards mentoring opportunities was crucial in their grounding, and inextricably linked to preparing themselves for mentorship practice and being a stage 1 mentor. • The level of preparedness and readiness and how much responsibility each participant in this study took for participating in mentoring opportunities were varied and individual to each participant. • Though participants acknowledged that they prepared for the mentorship role through active participation, there was little evidence to suggest that participants would have acquired the necessary theoretical knowledge and understanding of mentorship that underpinned their practice. • Participatory, discovery-based and hands-on approaches to their preparation were identified as crucial for them to feel ready for the mentorship role.
CCSubT (1.2) Active reflection on past experiences	<ul style="list-style-type: none"> • Active reflection involved conscious consideration of their past experiences of being mentored to gain insight into how these experiences might prepare them for future mentorship practice. • Active reflection on past experiences helped participants to cultivate self-reflection as a skill through their application and practice as mentors. • None of the participants in this present study spoke specifically on the practicalities of reflection or any specific approaches and techniques for reflection. • Active self-reflection on action enabled participants to integrate their past experiences into a better understanding of how they mentor students. • Participants used active reflection through a process of examining and linking past mentors' behaviours to learning from negative experiences. • Participants' insights into negative experiences were gained through active reflection, which was distinct from ordinary reflection, and that learning and reflection was not a passive activity.

	<ul style="list-style-type: none"> • Being able to be actively involved in personal reflection on past experiences of being mentored significantly shaped participants' preparedness and development for the mentor role. • Whilst reflective practice is recognised in the nursing literature, active reflection has not been recognised with regard to nurse mentoring as a proactive strategy in preparing for the mentor role.
<p>CCSubT (1.3)</p> <p>Seeking ways to find emotional support</p>	<ul style="list-style-type: none"> • Practical support flowed freely, but emotional support was hard to find. • Emotional support included being encouraged, shown that they were important and listened to, and feeling cared for. • Participants also looked for reassurance and praise for how they were doing, being told they were doing well and a shoulder to lean on. • Participants acknowledged that having emotional support not only reduced their anxieties and stress but gave them the reassurance that they needed to fulfil the mentor role. • Finding emotional support from colleagues helped participants to be in the right frame of mind to prepare for mentorship and was considered as fundamental to feeling confident and reassured.

6.2 Cross-Case Superordinate Theme 2: Experiential Learning

The cross-case superordinate theme 2 labelled Experiential Learning explains how participants engaged in active learning and learnt from their peers and through trial and error and the use of intuition. The cross-case superordinate theme 2 (Table 8, Chapter 5) encompassed four subordinate themes: 2.1) *engaging in active, self-directed learning*, 2.2) *learning by trial and error*, 2.3) *using initiative to do mentorship* and 2.4) *learning from peers*.

6.2.1 Cross-Case Subordinate Theme (2.1): Engaging in Active, Self-Directed Learning

According to Knowles (1975, p. 18), self-directed learning is 'a process in which individuals take the initiative, with or without the help of others'. Later, Knowles et al. (2011) defined self-directed learning as undertaking responsibility to identify individual learning needs, devise individual learning objectives and seek learning resources in order to self-evaluate learning. Fisher et al. (2001) defined self-directed learning in terms of the amount of responsibility the learner accepts for his or her own learning, but recognised that making the most of self-directed learning opportunities was dependent on individual attitudes, abilities and personality.

Atkinson (1997) argued that people may already be equipped with common sense and intelligence, and therefore higher order thinking skills need not be taught. Like Atkinson, this study found that they used their common sense and intelligence to engage in active, self-directed learning. Participants in this study reported taking control of their learning in order to learn, which in turn led to aspects of deeper learning through problem solving and critical thinking. Examples of active, self-directed learning included using the freedom to engage in real-life scenarios with poorly performing students, reflecting and analysing what was learnt, evaluating previous mentoring scenarios and negotiating with other mentors' ways to do mentorship better next time. The ability to be proactive in finding opportunities to develop core mentoring skills in practice, such as decision making, problem solving, active listening skills

and analysing mentorship practice, was a defining feature of deeper learning. This present study found that, despite the various clinical environments and characteristics of the study's participants, the cognitive processing that participants gained through active, self-directed learning enabled them to make critical connections between what they learnt through active learning and draw insightful conclusions as to how to mentor students effectively. Whilst nurse education continues to respond to the dichotomy between theoretical input taught in class and what is learnt in practice (Landers, 2000), Dale (1994) postulated that making critical connections with theory provides the basis for understanding the realities of nursing. Ultimately, this study highlighted that the ability to make critical connections through active self-directed learning enabled participants to bridge knowledge learnt from mentorship skills with practice, which is fundamental to nursing and mentorship practice. On the other hand, there was no evidence to suggest whether the participants in this study had an intrinsic academic capability to bridge theory with practice that could be moulded by their educational background.

Active and self-directed learning in nurse education are not new concepts and centre on non-passive pedagogical strategies devised by students as they engage in the learning process (Murray, 2018). Participants in this study were proactive and self-directed. Rather, by engaging with active learning, they were able to move beyond earlier experiences of participation in mentoring opportunities, to a deeper learning where they were able to analyse and make sense of what they had learnt. For example, Gabby (Chapter 5, Section 5.3) was typical of other participants in that she reflected critically on how she facilitated role-play with students, and problem-solving activities that connected those learning opportunities to the reality of practice. By thinking and critically reflecting on how she organised role-play scenarios and pair working, Gabby felt that she was able to process what she had learnt, leading to a deeper learning of the mentorship role. She was then able to move beyond a surface learning approach, where she simply carried out a mentorship task, to being able to analyse a situation and apply what she had learnt to mentorship. Regita (Chapter 5, Section 5.5) reported feeling naïve in thinking that she would be taught mentorship skills by other mentors, but admitted that taking responsibility for her own learning enabled her to critically evaluate how she worked as a mentor, which in turn gave her a deeper level of learning than she had realised at the time.

Research that has explored surface to deeper learning approaches has led to contradictory results. For example, Baeten et al. (2010) reported too many variables that could influence a student moving from surface to deeper learning, such as how students were taught, the learning environment and student characteristics. The ability to engage in active, self-directed learning largely supports previous studies that draw attention to the experiential way nurses

take on the responsibility to learn at work (Higginson, 2004; Armbruster et al., 2009; Knowles et al., 2011; Kinsella and Pitman, 2012; Murray, 2018; Chakkaravarthy et al., 2018). Despite not having any initial knowledge and skills for mentorship, participants took the opportunity to learn experientially by taking responsibility for their own learning at work. For example, despite Tom feeling unprepared (Chapter 5, Section 5.1), he chose to take a self-directed approach to his learning, as he preferred to learn independently rather than being told what to do. It would seem, therefore, that being put in a new situation without preparation pushed Tom to take responsibility for his own learning and process what had been learnt to acquire critical thinking skills that he might not have had otherwise. Tom may not have had formal training to become a mentor, but his ability to take responsibility for his own learning through active learning strategies enabled him to cope within the confines of not knowing what to do. Being able to engage in active self-directed learning found in most cases in this study, diminishes the argument that a conventional mentorship course would be the best way of preparing nurses for the mentorship role and provides an important distinction between what stems from viable knowledge built from active, self-directed learning and theoretical preparation through academic study. According to Karstadt (2019), viable knowledge is a concept that addresses the use of such information or knowledge as a unique and personal way of thinking that supports individual experiences. The opportunistic yet essential engagement with active learning facilitated viable knowledge that participants were able to build on over time, either individually or through interaction with others. Knowledge was therefore constructed by each of the participants, yet each relied on their own individual experiences to understand and give meaning to their learning as stage 1 mentors.

This study found that participants engaged in active self-directed learning, and in most cases, led to a deeper level of mentorship knowledge, criticality and problem-solving skills. Participants in the main were able to take control of their learning in order to develop higher order problem-solving skills, leading to increased confidence (Tom Section 5.1; Gabby Section 5.3; Martha Section 5.7; Abbas Section 5.8). Clearly, findings suggest that participants' ability to engage with active, self-directed learning that led to increased and deeper learning appears to be consistent with existent literature (Higginson, 2004; Armbruster et al., 2009; Kinsella and Pitman, 2012). However, there appears to be little empirical evidence supporting active, self-directed learning in relation to mentorship, although some studies relate active and self-directed learning to increased learning in the workplace (Hoke and Robbins, 2005; Armbruster et al., 2009). Thus, these findings complement the wider literature and could be viewed as a valid contribution to mentorship practice, and highlight the importance of experiential active learning strategies in the workplace.

6.2.2 Cross-Case Subordinate Theme (2.2): Learning by Trial and Error

Young (2008) stressed that people learn by trial and error if they try out new strategies and reject choices that are 'erroneous' in the sense that they do not lead to higher payoffs. Learning by trial and error was found to be essentially important to learning mentorship and depicts how participants were able to address a problem and find ways to change their practice in order to '*do it better next time*'. Participants used a situation that had not gone well to identify and analyse a situation so that they could generate possible solutions or the right answer. To solve a problem, Emily (Chapter 5, Section 5.6) felt that working things out for herself by trial and error, over and over, enabled her to develop problem-solving skills. This signified that she interpreted the process as a form of practice-based learning that was useful to her and which she felt was required for the mentorship role.

Another important finding was that the extent of learning through trial and error and problem solving varied across participants and was dependent on each individual's previous experience. Newly qualified nurses needed to use problem-solving techniques through trial and error to learn mentorship skills. Participants learnt not to fear mistakes, but rather to view them as part of the process of learning mentorship. This practice to a large extent was learning by '*trial and error*' and '*making mistakes*'. In essence, what was common across all eight participants was a sense that their development in mentoring was often accidental in nature. These findings are consistent with many studies that acknowledge that being able to use problem-solving skills in nursing enriches critical thinking and clinical reasoning (Choi et al., 2014; Geitz et al., 2016; Wosinski et al., 2018; Shahbazi et al., 2018). However, what this study's findings add to the body of knowledge is that nurses use problem-solving techniques through trial and error to learn mentorship skills becoming more iterative as they take more responsibility and manage situations that occur on a day-to-day basis. Over time, they feel they make fewer mistakes as their new-found knowledge and skills give them increased awareness of their cognitive processes.

Being able to reflect and problem solve in nursing is considered by Mann et al. (2009) as an integral part of practice-based learning. Five participants reported that learning mentorship skills through trial and error had enhanced their problem-solving abilities and had been an important element of engaging with their own learning. Martha (Chapter 5, Section 5.7), for example, reported that learning through trial and error gave her the opportunity to reflect on where she had gone wrong. Talking through her mistakes with colleagues enabled her to respond to students' needs and feel more self-confident when making decisions. However, it is important to note that Hagbaghery et al. (2004) proposed that self-confidence could be rooted in personal characteristics, suggesting that knowledge, social and work-related interactions could have had effects on feelings of their self-confidence.

Many participants recognised that learning through trial and error enabled them to give meaning to their experiences, which then guided future action. For example, Tom (Chapter 5, Section 5.1) felt that applying what he had learnt to practice enabled him to give meaning to those experiences and contributed to him being able to think at a higher level. The meaning that Tom gave to those experiences meant that Tom was able to learn how to think at a higher level and apply what he had learnt to the reality of practice. However, it could be argued that more time spent working with students could result in a concomitant increase in the opportunities participants had to develop mentorship skills and higher order thinking. Some, like Taylor (1997) consider trial and error to be a basic low-level form of learning, a method rather than a skill of problem-solving. However, the findings from this study show learning through trial and error to involve a high level of learning. Acquiring knowledge and skills for mentorship through trial and error therefore was shown not to be a basic, low-level form of learning, but instead enabled deeper learning through problem solving, characterised by repeated, varied attempts which are continued till successful.

Mentors play a vital role in supporting and assessing learning, with considerable emphasis on ensuring adequate support and a professional relationship that facilitates learning (Pellatt, 2006; Ness et al., 2010; McIntosh et al., 2014). However, it could be argued that being a mentor is far more complex than simply being a support person, and that the mentee is more than just a receiver of support for practice. Therefore, in order to understand how learning occurs, the nature of the learner also needs to be considered. More recently, for example, students enter nursing with first degrees, life experiences, transferable skills, personal qualities and motivation that they bring to the mentor–mentee relationship. These students are usually intrinsically motivated, striving to understand and seek meaning from their new experiences and what they have read (Pritchard and Gidman, 2012). Entwistle (2000) describes this type of learner as a deep learner, a person who is motivated to achieve as highly as possible, diving deeply into their learning rather than taking a superficial approach. It could be argued, therefore, that the nature of the learner has changed.

The perspective of the newly qualified nurse as a learner is under-represented in the literature, particularly how they learn mentorship in practice. The intrinsically motivated learner as a student nurse, for example (Pritchard and Gidman, 2012), embraces a facilitative relationship with their mentor, enabling the development of critical problem-solving skills, stemming from deeper discussions that allow the mentee to interrogate their experiences, resulting in deep learning. Arguably, a less committed student lacks intrinsic motivation, and has a desire to simply satisfy the demands of the curriculum, resulting in a more surface approach to their learning. This type of student would require a different approach in the mentee–mentor relationship, with the mentor working harder with the student who ultimately may never

achieve deep learning. As well as motivation levels amongst some learners which may lead them to be satisfied with surface learning, there appear to be three other challenges in supporting deep learning found in the literature. Firstly, mentorship is not explicitly conceptualised as being about deep learning, Secondly, toxic mentoring (Darling, 1985) may also lead to a more surface approach to learning, due to an unsatisfactory relationship with a learner who often feels intimidated. Thirdly, other barriers to deep learning identified in the literature (Myall et al., 2008; Neary, 2000; Andrews et al., 2010) include increased workload of the mentor or mentee, leading to a perceived lack of time to establish a satisfactory relationship.

Despite the challenges in supporting and encouraging deep learning in practice, whether it be for a student or newly qualified nurse, it is important that learning mentorship embraces trial and error as a learning tool to promote deep learning. How deep learning is facilitated will depend on local circumstances and the needs and outlook of the learner. If learning mentorship focuses on the development of problem-solving skills and critical thinking skills, deep learning can lead to a more probing interrogation of experience which can then lead to more profound learning. Nurse educators and practising nurses agree that the complexity of healthcare demands critical thinking skills (Fowler, 1998). Critical thinking skills would therefore be better developed through an active learning approach in which the learner achieves deep learning through critical thinking and effective communication (Loke and Chow, 2007). Loke and Chow also advocated an approach to mentorship that involved critical thinking and reflective learning. Similarly, Joubert and Villiers's (2015) qualitative study of third-year students reported that an active approach to mentorship enabled critical thinking skills and helped them to apply their knowledge and integrate theory into practice.

It is evident therefore that learning mentorship through trial and error requires critical thinking and deep learning, facilitating the newly qualified nurse to gain a deeper understanding of mentorship in practice. The findings from this study therefore challenge the premise that learning through trial and error is a basic form of experiential learning. Thus, it would seem that learning through trial and error is a simple and intuitive heuristic for learning mentorship and moves beyond intentional preparation for mentorship. The ability of participants to explore the nature of information learnt through trial and error led to incisive learning using higher order cognitive skills. This finding adds to the body of knowledge confirming that, despite inadequate preparation, learning mentorship through trial and error has become a valid way of learning. This finding is consistent with the work of Race (2005), whose experiential learning model is based on the premise that learning by doing, such as practice and trial and error, constitutes successful learning.

6.2.3 Cross-Case Subordinate Theme (2.3): Using Intuition to Do Mentorship

Using intuition to do mentorship was found in this study to be a pragmatic source of both practical knowledge ('knowing how'), giving participants the ability to carry out the mentor role effectively. Research evidence (Carper, 1978; Benner and Wrubel, 1989; King and Appleton, 1997) suggests that intuition occurs in response to knowledge. Participants struggled to articulate how they used their intuition to do mentorship, but spoke of an immediate knowing, like a gut feeling or reaction without logical thought. This is consistent with Billay et al.'s (2007) view that intuition is understanding without rationale, and intuition is the instant understanding of knowledge but without evidence of thought. Both Vaiya and Emily (Chapter 5, Sections 5.2, 5.6) recognised their use of intuition when mentoring students, using the term '*gut feelings*', but found it difficult to verbalise and rationalise during their interviews. There have been many attempts to make sense of intuitive learning in nursing (Blum, 2010; Pearson, 2013; Hassani et al., 2016; Rosciano et al., 2016), with many highlighting the importance of intuitive practice. McCutcheon and Pincombe (2001) considered gut feelings as the intuitive component of experiential learning and identified the importance of clinical experience in the development of gut feelings, suggesting that intuition was an integral element of nursing care.

The findings from this present study are similar to the work of Spouse (2001), who spoke of nurses using craft knowledge instinctively without cognitive and conscious thought. The gut feelings experienced by Vaiya and Emily stemmed from a way of knowing but was experienced as a tacit knowing in a way they did not understand. Eraut (2000) ascribes intuition to tacit understanding, where coming together with professional performance is based on a tacit understanding of the situation. Further, Parissopoulos and Rovithis (2005) referred to intuitive practice and the '*eyes of the heart*' where perception is without rules. They suggested that intuitive practice evolves from the merger of knowledge, skill and practice and that intuitive practice stems from recognition of previously experienced behaviours and patterns from which they had learnt. Many of the initial emergent themes, such as '*Knowing intuitively from pre-reg days*' and '*being instinctive*', confirmed that, although participants had been thrown in the deep end and often had acted on impulse, they had all, through a diverse range of past experiences, mentored students using their intuition and instinct.

There have been many attempts to introduce an awareness of the nature and role of intuition in nursing practice but, despite the effectiveness of intuitive learning found in other studies (Herbig et al., 2001; Hassani et al., 2016), it has generally been ignored as a valid way of knowing. Intuition in this study was used as a pragmatic way of 'doing' mentorship so they could carry out the role effectively. Whilst the participants in this study did not necessarily know how they had learnt to mentor, they had used their instinct and intuition to mentor. Many of the emergent initial themes relating to learning intuitively and transition confirmed that,

though they had been thrown in the deep end and often had acted on impulse when it came to student learning, they had all, by means of a diverse range of experiences, learnt intuitively through watching and learning subconsciously. Though Herbig et al. (2001) referred to *acquiring* intuitive knowledge, the nurses in this study *applied* their intuition to mentor students. Although some would say that intuition is not yet accepted as a plausible way of knowing in nursing education and practice (Hassani et al., 2016), other researchers consider intuition as an effective way of knowing and a type of legitimate knowledge in nursing (Smith and Glaser, 2008; Smith, 2009). This study confirms that participants in this study used their intuition without analytical thought as a way of thinking and knowing to guide their mentorship practice.

Benner (1984) proposed a model of five stages of proficiency that nurses navigate, from novice, advanced beginner, competent and proficient to expert, and reported that intuitive knowing is associated entirely with the expert nurse. The premise of her model is that a novice beginner is a graduate nurse who has little experience of situations in which they are being asked to perform, whereas the expert nurse, qualified for more than five years, operates from a deep understanding and has an intuitive grasp of the situation. Gobet and Chassy (2008) also proposed that a defining characteristic of intuition is expertise, and recognised the importance of learning to nurse intuitively. They proposed a new theory of nursing expertise and intuition, asserting that one of the defining characteristics of intuition is expertise. However, the premise that intuitive practice is associated with the expert nurse is challenged by the findings of this study, in that it is not only expert nurses who use intuition, and that intuition should not be considered exclusively a phenomenon of expert nurses. Gobet and Chassy emphasised how perception and problem solving are closely linked, and how intuitive, perceptual decision making could be linked to problem solving. It would seem, therefore, that developing an ability to have an intuitive grasp of situations is important, but the difference between intuitive learning and practising nursing intuitively is not explicit.

Gobet and Chassy made a normative argument, that only expert nurses have sufficiently advanced knowledge and experience to justify using intuition. A criticism of this argument would be that it overlooks the value of less advanced, less expert levels of knowledge and experience. Researchers have argued that using intuition in nursing is not a valid way of knowing (Rew and Barrow, 2007; Pearson, 2013; Ruth-Sahd, 2014). Yet the participants in this study believed that they could draw upon useful experience and tacit knowledge which then became valid intuition. Participants who were within the first two years post-registration, considered by Benner to be novice beginners with little mentorship experience, all made use of their intuitive gut feelings and sixth sense to mentor students, giving them a deeper grasp of how to mentor. Therefore, the conclusion I draw from the findings of my research is that intuition is not limited to those with advanced expertise. Intuition should not be viewed as

something that can only be used by expert nurses and the role that it can play towards preparing newly qualified nurses for mentorship should be recognised. The deficient conceptualisation that intuition only exists in an expert nurse should be questioned and is not consistent with the findings in this study.

6.2.4 Cross-Case Subordinate Theme (2.4): Learning from Peers

Participants valued the support and being able to learn from their peers, but all reported how their learning decreased over time as they became more confident in mentoring, allowing them to develop their own autonomy. Their autonomy was achieved gradually by establishing the required links between what they had learnt, what they saw and what they did, thus reducing their need for direction and support. Initially, participants were able to learn collaboratively with peers who had a wider range of knowledge and skills in mentorship than themselves, rather than learning alone. According to Gilmour et al. (2006), peer-mentoring relationships are where a mentor and mentee are similar in terms of age and status. However, the participants in this study referred to as their peers, not just other students, but any other novice nurse or healthcare professional who inspired them, whatever their age or status. This finding is in accordance with the findings of others (Loke and Chow, 2007; Christiansen and Bell, 2010; Ravanipour et al., 2015; Palsson et al., 2017; Carey et al., 2018a; Carey et al., 2018b), whose participants in their studies referred to a peer as not just someone to learn from, but someone who inspired them to learn and grow in confidence. Martha (Chapter 5, Section 5.7) felt that the positive learning influence of her peers was pivotal in strengthening relationships with each other and drove her to further independence as a stage 1 mentor. Having the positive influence of a peer relationship enabled opportunities to discover what learning was relevant to them. Peer learning mentoring activities included giving student feedback together, orientating new students, working with practice documents and participating in practice-based teaching, learning and assessment activities.

Both Martha (Chapter 5, Section 5.7) and Abbas (Chapter 5, Section 5.8) specifically mentioned decreasing peer learning over time, which they felt happened without them noticing as they gained confidence. McGowan's (2006) view was that peers who worked and acted as effective leaders significantly influenced student experiences of placement. Comments such as '*I suppose by then they trusted me*' (Martha, Chapter 5, Section 5.7) or '*they just let me get on with it*' (Abbas, Chapter 5, Section 5.8) could be interpreted to mean instructional scaffolding (Applebee and Langer, 1983; Sanders and Sugg, 2005), where the expert deliberately reduces support over time. These findings suggest that with increasing confidence, they were given more responsibility and less support from their peers, a finding consistent with the literature (Applebee and Langer, 1983; Spouse, 1998; Cope et al., 2000; Sanders and Sugg, 2005).

Whilst the concept of peer mentoring has important pedagogical implications, the literature tends to focus on peer learning partnerships between pre-registration nursing students and their peers in clinical practice (McGowan, 2006; Gilmour et al., 2006; Loke and Chow, 2007; Christiansen and Bell, 2010; Ravanipour et al., 2015; Carey et al., 2018a; Carey et al., 2018b). Although peer relationships are an essential element of learning in pre-registration nursing, peer mentoring, where novice nurses learn from peers such as other newly qualified nurses or healthcare professionals, has received minimal attention in previous studies. This study revealed that participants tended to veer towards peers with whom they developed friendships, and who were willing to offer assistance, support and guidance, rather than those who were unfriendly or unkind. Interestingly, the RCN (2013) reported that clinical staff's kindness and compassion have been worn down and it is often nurses who have worked in the NHS for longer who are disillusioned and exhibit poor attitudes and behaviours. Abbas specifically spoke of looking for friendly peers to whom he could turn and avoided people who were unfriendly and demonstrated poor mentoring practice. Marsick and Watkins (2001) agreed that using friends and peers for information is what modern networking and peer learning are about. Similarly, Whitehead et al. (2016) acknowledged that it is necessary to provide a period of friendly support for nurses to help them settle in and carry out their role as graduate nurses. An interesting point here is that this could indicate that it is personal qualities that are more significant to peer learning rather than expertise.

Abbas and other participants' descriptions of poor peer mentoring are similar to the concept of '*sitting next to Nellie*' where learning mentorship on the job was often haphazard and variable, with some of their peers unwilling to pass on knowledge. The literature suggests that 'Nellie' might be personable but has bad habits and might not have the necessary skills to teach in practice (Cope et al., 2000; Caldwell and Carter, 2004). However, for some participants, poor peer learning had been with those who were less friendly, less competent and lacked interest in passing on their expertise, rather than those with less experience such as healthcare workers. Gabby in particular (Chapter 5, Section 5.3) recognised that she might have picked up some bad habits through imitation and observation of some of her peers, but the need to fit in was more important to her. Normally, learning in a practice context is where experts can guide novices through the complexities of practice (Cope et al., 2000; Henderson et al., 2012). Arguably, learning from other experienced nurses is ideal. However, exposure to 'Nellie', who expects the learner to do as she does without question, is unhelpful, and learning can become arbitrary and variable. Therefore, it is important to consider how newly qualified nurses might be prepared for mentorship, and to allow mentors time to facilitate learning without having to juggle responsibilities and competing demands of their day-to-day work. Participants were only too happy to learn on the job from others and glean from their expertise,

but soon came to realise which of those mentors' bad habits were not acceptable to their personal and professional values.

Within this study, the accounts of the participants suggest that learning opportunities with peers provided them with practical support and played a role in their emerging independence and growing confidence. Their accounts highlight how learning and working together with peers enabled participants to deal confidently with some mentoring situations they were exposed to on a day-to-day basis. Becoming independent therefore was typified by the participants as moving away from '*hand holding*' by their peers, but then continuing to share learning opportunities whenever they arose.

This study acknowledges the positive aspects that peer learning had on participants' enhancement of mentorship skills and cognitive gains, but also adds to the literature around the peer who is of the same age and status. The recognition that peer learning occurs within the workplace is not new. However, this study found that, although learning from peers was a mode of experiential learning and central to participants developing mentorship knowledge and skills, participants tended to turn only to peers who were friendly and willing to support them. Working and learning on the job in partnership with friendly peers such as healthcare assistants, student nurses, other stage 1 mentors, stage 2 mentors and sign-off mentors were more important to their learning mentorship than who they learnt from. The findings illuminate the positive influence of peer learning where participants were able to learn and work together and then independently from their peers without noticing the reduction in support.

6.2.5 Cross-Case Superordinate Theme 2 Summary

In summary, the cross-case superordinate theme *Experiential Learning* can be conceptualised according to four broad principles: *engaging in active learning*, *learning by trial and error*, *using intuition to do mentorship* and *learning from peers*. These four principles of experiential learning are seen as central features of how participants acquired knowledge and skills for mentorship in the reality of learning on the job. Table 10 provides the highlights of the study conclusions relating to CCSupT2 and its associated CCSubTs.

Table 10: *Experiential Learning highlights*

Cross-Case Superordinate Theme 2: Experiential Learning Highlights	
<p>CCSubT (2.1)</p> <p>Engaging in active self-directed learning</p>	<ul style="list-style-type: none"> • By engaging in active, self-directed learning, participants in this study reported taking control of their learning in order to learn, which in turn led to aspects of deeper learning through problem solving and critical thinking. • Examples of active, self-directed learning included using the freedom to engage in real-life scenarios with poorly performing students, reflecting and analysing what was learnt, evaluating previous mentoring scenarios and negotiating with other mentors' ways to do mentorship better next time.

	<ul style="list-style-type: none"> • The ability to be proactive in finding opportunities to develop core mentoring skills in practice, such as decision making, problem solving, active listening skills and analysing on mentorship practice was a defining feature of deeper learning. • These findings complement the wider literature and highlight the importance of experiential active learning strategies in the workplace.
<p>CCSubT (2.2)</p> <p>Learning by trial and error</p>	<ul style="list-style-type: none"> • Learning by trial and error was found to be essentially important to learning mentorship and depicts how participants were able to address a problem and find ways to change their practice in order to '<i>do it better next time</i>'. • The extent of learning through trial and error and problem solving varied across participants and was dependent on each individual's previous experience. • What was common across all eight participants was a sense that their development in mentoring was often accidental in nature. • Nurses use problem-solving techniques through trial and error to learn mentorship skills becoming more iterative as they take more responsibility and manage situations that occur on a day-to-day basis. • The findings from this study show learning through trial and error to involve a high level of learning. Acquiring knowledge and skills for mentorship through trial and error therefore is not a basic, low-level form of learning, but instead enables deep learning through problem solving, characterised by repeated, varied attempts which are continued till successful. • Learning through trial and error is a simple and intuitive heuristic for learning mentorship and moves beyond intentional preparation for mentorship.
<p>CCSubT (2.3)</p> <p>Using intuition to do mentorship</p>	<ul style="list-style-type: none"> • Using intuition to do mentorship was found in this study to be a pragmatic source of both practical knowledge ('knowing how'), giving participants the ability to carry out the mentor role effectively. • Whilst the participants in this study did not necessarily know how they had learnt to mentor, they had used their instinct and intuition to mentor. • This study confirms that participants in this study used their intuition without analytical thought as a way of thinking and knowing to guide their mentorship practice. • The premise that intuitive practice is associated with the expert nurse is challenged from the findings of this study, in that it is not only expert nurses who use intuition, and that intuition should not be confined to a phenomenon of expert nurses. • The findings conclude that the conceptualisation of intuition is not limited to expertise. Intuition should not be viewed as something that can only be used by expert nurses and should be recognised for the role that intuition can play towards preparing newly qualified nurses for mentorship. • The deficient conceptualisation that intuition only exists in an expert nurse should be questioned and is at odds with the findings in this study.
<p>CCSubT (2.4)</p> <p>Learning from peers</p>	<ul style="list-style-type: none"> • Participants valued the support and being able to learn from their peers, but all reported how their learning decreased over time as they became more confident in mentoring, allowing them to develop their own autonomy. • Their autonomy was achieved gradually by establishing the required links between what they had learnt, what they saw and what they did, thus reducing their need for direction and support. • Initially, participants were able to learn collaboratively with their peers who had a wider range of knowledge and skills in mentorship than themselves, rather than learning alone. • Participants in this study referred to their peers as not just other students, but any other novice nurse or healthcare professional who inspired them, whatever their hierarchical status, age or status.

	<ul style="list-style-type: none"> • Peer learning mentoring activities included giving student feedback together, orientating new students, working with practice documents and participating in practice-based teaching, learning and assessment activities. • Participants tended to veer towards peers with whom they developed friendships, and who were willing to offer assistance, support and guidance, rather than those who were unfriendly or unkind. Poor peer learning had been those who were less friendly, less competent and lacked interest in passing on their expertise, rather than those with less experience such as healthcare workers. • Participants were only too happy to learn on the job from others and glean from their expertise, but soon came to realise which of those mentors' bad habits were not acceptable to their personal and professional values. • Working and learning on the job in partnership with friendly peers such as healthcare assistants, student nurses, other stage 1 mentors, stage 2 mentors and sign-off mentors was more important to their learning mentorship than who they learnt from.
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6.3 Cross-Case Superordinate Theme 3: Development of Resilience in Transition

The cross-case superordinate theme 3 labelled Development of Resilience in Transition describes how participants learnt to cope with transitional shock, but experienced being in a liminal phase during their transition. The cross-case superordinate theme 3 (Table 8, Chapter 5) encompassed two subordinate themes that represent how the participants in this study developed resilience to meet the challenges for transition by (3.1) *coping with transitional shock* and (3.2) *managing transition through the liminal phases*. This cross-case superordinate theme 3 makes explicit the distinctive ways participants developed resilience as they transitioned into the mentorship role.

There are two key concepts in this cross-case subordinate theme. Resilience, according to Meyer and Shatto (2018), is the ability to recover and cope after a stressful period. Overcoming adverse circumstances reflects the nature of resilience developed in nurses found in other studies (Jackson et al., 2007; McAllister and McKinnon, 2009; Cameron and Brownie, 2010; McCann et al., 2013; Azimian et al., 2014; Hart et al., 2014; Thomas and Revell, 2016). For the purpose of this study, resilience explains the aptitude and fortitude of newly qualified nurses that developed as a consequence of coping with transitional shock and managing transition through the liminal phases. The second concept, transition, is a familiar concept in nursing literature that focuses in the main around the transition from student to newly qualified nurse. Duchscher (2012) described transition as a non-linear journey in which stages of evolution present iteratively, coexisting as interplay between emotion and intellect, relational dynamics, and the impact of unfamiliar or complex situations. For the purpose of this study, transition explains the journey into the world of mentorship, where newly qualified nurses experienced significant shock as they moved into the mentorship role.

6.3.1 Cross-Case Subordinate Theme (3.1): Coping with Transitional Shock

This cross-case subordinate theme refers to coping with the transitional shock as they were confronted with the challenges and reality of mentorship. Transitional shock was felt through unpreparedness, stress and anxiety as they began to accept the significant changes in their roles and responsibilities on moving into the stage 1 mentor role. Kramer's (1974) transition shock theory described the difficulties newly qualified nurses had in preparing for the nursing role. The participants' accounts of shock resonate with elements of Kramer's transition shock theory as they had to cope with and overcome transitional shock as they entered the mentor role. Participants were confronted with a broad scope of physical, intellectual and emotional challenges as they became stage 1 mentors, but developed coping strategies including being in denial, avoidance tactics, drawing on a network of colleagues, drawing on inner strength, adjusting to the situation and remaining positive. Though participants in this study did not necessarily think at the time they were developing resilience, these coping strategies were inherently linked to how their developing resilience enabled them to overcome transitional shock. However, it should be noted that the individual's ability to cope could also have been influenced by other intrinsic and extrinsic factors such as personality, age and experience not reported in this study.

The concept of transition and transition shock is not new and findings in this study largely support previous studies (Duchscher, 2001, 2008, 2009, 2012; Duchscher and Windey, 2018; Kumaran and Carney, 2014; Laschinger et al., 2016; Clinton et al., 2018; Meyer and Shatto, 2018; Murray et al., 2019) that draw attention to the transition to becoming a nurse. According to Duchscher (2008, 2009), transitional shock is the most immediate, acute and dramatic stage in the process of professional role adaptation for the newly qualified nurse who might experience both physical and emotional changes through transition. Duchscher highlighted that the initial three months of newly qualified nurses' transition in practice was consumed by an adjustment to new roles and responsibilities. Duchscher stressed that there was an acceptance of the differences between what they learnt as students and through the practical focus of professional work. The transitional shock identified in this study resonates with the findings from Duchscher's (2009) cumulative research in that newly graduated nurses experience a range of emotions relating to initial role adaptation to nursing. Duchscher's (2009) found that the nurses in his study learnt to cope with being thrown in the deep end, but acknowledged that this is not always the best way of making the transition to becoming a staff nurse. Like Duchscher's study, participants were thrown in the deep end, but also learnt to cope through various coping strategies. Being resilient enough to draw on coping strategies was a significant turning point for participants as they became more confident in mentorship. Nonetheless, having to cope rather than being prepared for mentorship is not ideal, and

consideration needs to be given to how newly qualified nurses are prepared for the mentor role.

Participants were shocked to learn that they were not required to show that they had any specific knowledge or skills to carry out the role effectively. Hence, being able to cope with transitional shock was considered by participants as a necessity to overcome not knowing what to do. Participants frequently referred to '*the shock*' of having to adapt to and accept a new role, but then found they had the resilience to cope as they transitioned into mentorship. Feelings of stress and anxiety conveyed by participants in this study have also been recounted by other authors who report that it is indeed common for new nurses to feel anxious and insecure about their competence and ability to adjust to becoming a nurse (Gerrish 2000; Burns, 2009; Duchscher, 2008, 2009; Whitehead and Holmes, 2011; Whitehead et al., 2013; Kaihlanen et al., 2013; McDermid et al., 2014, 2016; Ebrahimi et al., 2016). These studies reported the stress and anxieties experienced by newly qualified nurses as they began their career in nursing, and reported the different coping strategies used to overcome stress, for example, seeking help from others, reflecting and taking control of the situation.

Participants accepted that during their transition from student to staff nurse, there would be a degree of stress and anxiety, and accepted that over time these emotions would wane as their confidence and knowledge of nursing increased. However, what they had not anticipated was the additional and continued stress and anxiety experienced as they took on the mentor role. Research suggests that nurses have a degree of resilience to manage stress and anxiety as they transition into the staff nurse role (Murray et al., 2019). Yet findings from this study add to the body of knowledge in that nurses require much more resilience to face up to the challenges of a further transition into the mentorship role. This resilience facilitated success in their transition into the mentorship role.

Participants in this study spoke of how their transition into mentorship had been the most difficult and overwhelming. Tom, for example, (Chapter 5, Section 5.1) reported managing his own stress and anxieties so he could overcome feeling overwhelmed and adapt in the face of the challenges of being a mentor. He spoke of being in denial as a way to protect himself and used avoidance tactics to manage his stress and anxieties. Tom believed that being in denial and avoiding students was how he had coped initially, and through coping, he developed resilience to '*get through to the other side*'. Similarly, Regita (Chapter 5, Section 5.5) also spoke of her network of colleagues whom she relied on for support, enabling a sense of resilience as her confidence grew, and her stress and anxiety lessened. Both Rizza (Chapter 5, Section 5.4) and Emily (Chapter 5, Section 5.6) used avoidance tactics as a way of coping and adjusting to the situation they found themselves in. Vaiya (Chapter 5, Section 5.2) also reported having to draw on an inner strength to cope, but experienced role confusion where

she had two roles to contend with. Regita (Chapter 5, Section 5.5) also spoke of role confusion, using the same phrase as Vaiya, '*wearing two hats*'. Both created within themselves a sense of feeling positive as a means to overcome initial feelings of anxiety.

Because of the challenges faced by the participants, the need to remain positive was a significant feature of this study. The concept of positivity and how this contributes to the development of resilience has been examined by several authors (Cameron and Brownie, 2010; Jackson et al., 2007; McAllister and McKinnon, 2009). These authors all agreed that remaining positive as a strategy to enhance resilience enables an individual to progress through transition with ease. Regita (Chapter 5, Section 5.5), for example, spoke of staying positive, otherwise she felt she would not have been able to cope through her transitional period. Similarly, Martha (Chapter 5, Section 5.7) talked of turning a negative into a positive as she transitioned into the mentor role. Regita's and Martha's positivity enabled them to overcome feelings of uncertainty and reduced confidence and is a good example of how positivity can contribute to resilience development. The meaning of positivity, however, was highly individualised. The positivity that Martha and Regita spoke of did not mean flamboyance and joviality, but more of a 'can-do' attitude, with determination to transition successfully into the mentor role, whereas Abbas used humour as a means of remaining positive, which helped him through his transition into the mentor role. Remaining positive as a coping strategy corroborates the research of McDermid et al. (2016), who determined that creating and embracing positivity to ameliorate negative experiences were necessary components of developing resilience.

The difficult time participants experienced as they transitioned into the mentor role also echoes the work of many authors who found that the most difficult time for role transition in new graduate nurses was during preceptorship (Hardyman and Hickey, 2001; Casey et al., 2004; Clark and Holmes, 2007; Wolff et al., 2010; Bjerknes and Bjork, 2012; Edward et al., 2017). However, what is not found in any of these studies is the relationship between developing resilience and coping with mentoring during the preceptorship programme. The Report of the Willis Commission on Nurse Education (Willis, 2012) acknowledged that good preceptorship is essential in preparing and supporting newly qualified nurses for the stressful transition from student to staff nurse, but reported that current provision is variable. Studies about preceptorship (Hardyman and Hickey, 2001; Gleeson, 2008; O'Brien et al., 2014) indicate a disparity between the reality of practice and the aspirations to provide support as communicated in the literature where nurses should be supported and valued, especially within the preceptorship period (Hardyman and Hickey, 2001; Gleeson, 2008; O'Brien et al., 2014). Feelings of uncertainty from being thrown in the deep end, expressed by the participants, were also reported by other authors who affirmed that it is indeed common for

nurses to feel anxious and insecure about their competence and ability in their transition to becoming a nurse (Kaihlanen et al., 2013; Burns, 2009; Gerrish, 2000; Whitehead and Holmes, 2011). Kaihlanen et al. (2013) also suggested that the transition from nursing student to nurse can be challenging and that the role of the preceptor is essential in preparing them for the reality of professional practice.

The findings from this present study also provide support for current theories of preceptorship which propose that supporting newly qualified nurses at the point of registration plays a key role in their adjustment and transition into the mentorship role (Willis, 2012; Whitehead et al., 2013; Whitehead et al., 2016). Although these studies have considered the experiences and transitions of newly qualified nurses, there is little empirical evidence to suggest that they experience these same emotions in their transition to becoming a stage 1 mentor. Willis's (2012) findings showed that the transition from student to staff nurse created a period of uncertainty, with new responsibilities and accountability being a source of stress and pressure. Willis recommended that nurses should be able to develop further management and leadership skills during the preceptorship period and beyond. Nevertheless, what is also required for newly qualified nurses is the development of mentoring skills through supervised practice to prepare them for the practice supervisor role in the future. Thus, the findings of this present study in the context of mentorship are of relevance to newly qualified nurses assuming the role of practice supervisor, who need a degree of resilience to transition into this role effectively if they are not supported or prepared beforehand.

Although previous research has focused on the transition from being a student to becoming a staff nurse, they have not highlighted the need for resilience during transition, nor focused on newly qualified nurses' transition into the mentor role. The findings indicate that, despite participants in this present study being faced with feelings of stress and anxiety as identified in other studies, coping with transitional shock appears to have been a catalyst for developing resilience when transitioning into mentorship. The coping strategies found in this study contributed to their resilience, thus ultimately influencing their preparedness for the mentor role. It is important to note, however, that having the resilience to overcome and manage their transitional shock could have been down to strength of character and inherent resilience rather than the use of various coping strategies discussed in their interviews. These study findings clearly indicate that more needs to be done to identify how newly qualified nurses can be prepared not just for practice, but for their transition into the mentor role.

6.3.2 Cross-Case Subordinate Theme (3.2): Managing Transition through the Liminal Phases

This cross-case subordinate theme examines the individual and collective experiences of participants managing their transition into mentorship as they moved through liminal phases. The lens of liminality is used to describe the experiences of participants as they managed their transition into mentorship, thus building on their resilience to do so. Liminality is an anthropological concept derived from the Latin word *limen*, meaning 'threshold', and refers to occupancy of 'in between' spaces (Turner, 1969). Later, Tierney et al. (2013) described liminality as the social location of those on the threshold of a new social position and status and gave meaning to such change. The concept of liminality stems from the work of the anthropologist Van Gennep (1960), and later Turner (1969) and Barton (2007), who wrote of rituals and rites of passage, and identified liminality as a mid-phase in which an individual passes from one state to another. Van Gennep (1960) described three phases of liminality as being, firstly, the pre-liminal phase, secondly, the liminal phase and, lastly, the post-liminal phase. In congruence with the works of Van Gennep (1960) and Turner (1969), participants also experienced three phases of liminality as they developed resilience throughout their transition into the mentorship role.

The pre-liminal phase found in this study reflected the resilience participants found to manage their feelings of anxiety and uncertainty and lack of confidence as they left behind the familiarity of being a nurse without the additional responsibility of mentorship. Feelings of unfamiliarity felt in the pre-liminal phase continued into the second, liminal phase where participants reported feelings of transiency, in-betweenness, role ambiguity, uncertainty and feelings of disorientation. For the purpose of this study, in-betweenness can be described as the liminal place 'betwixt and between', where participants reported a state of uncertainty and ambiguity, wavering between two worlds, being neither here nor there. The feelings experienced by participants in this liminal phase are similar to those feelings experienced by nurses in the studies of Evans and Kevern (2015), who suggested that nurses occupied a liminal space with its ambiguity, uncertainty and chaos and found this time to be an uncomfortable and unsettling period. The reality of mentoring students in this liminal phase did not meet participants' expectations where they experienced uncertainty and ambiguity, requiring them to build on their resilience whilst transitioning into the mentor role. Van Gennep (1960) reported that during the liminal phase, individuals experience a state of being neither here nor there as they move from one occupation to another. Turner (1964) confirmed his nomenclature for the three phases of passage from one status to another, and expanded on the notion of the liminal phase, naming this phase as '*betwixt and between*' where the status of the individual is ambiguous.

Over time, however, participants were able to build on their resilience through the pre-liminal and liminal phases as they moved into the post-liminal phase. The post-liminal phase was not defined by a particular time, but by a change in feelings and loss of that sense of being in-between, and was characterised by increased confidence within the mentorship role, which was critical to participants as they felt more certain in what they were doing. For example, Martha (Chapter 5, Section 5.7) used the analogy of '*crossing the threshold*', and spoke of a feeling of transience, but then coming out the other side. Crossing the threshold for Martha meant increased confidence and feeling less uncertain. Similarly, Tom (Chapter 5, Section 5.1) spoke of how his resilience was tested as he adapted to the challenges of mentorship, and how he needed resilience to '*get through to the other side*'. It was clear the participants' experiences resonated with the concept of liminality and related to their developing resilience as they adapted to the world of mentorship.

Although liminality is a useful concept for understanding experiences of transition (Blows et al., 2012; Evans and Kevern, 2015; McDermid et al., 2014, 2016, 2018; Barrow et al., 2020), little research has explored the concept of liminality in relation to newly qualified nurses, and how they experience feelings of in-betweenness as they transition into the mentor role. Even though Turner (1964) and Van Genep (1960) did not describe liminality in the context of nursing, findings from this study add to the body of knowledge around liminality, in that newly qualified nurses experienced uncertainty and ambiguity. Despite much literature relating to transition and resilience in nursing, the concept of liminality has received little attention in contemporary nursing literature. In the realm of mentorship and contemporary nursing, understanding the concept of liminality can be a powerful framework for understanding the development of resilience whilst nurses transition into the mentorship role.

6.3.3 Cross-Case Superordinate Theme 3 Summary

There are no known studies that have explored how newly qualified nurses transition into the mentorship role. Participants' descriptions of transitioning into mentorship help unpack the meaning of developing resilience in nursing, specifically how they adopted coping strategies such as self-management of stress and anxieties, using avoidance tactics and remaining positive. Their words and stories not only offer clarity on how they felt during their transition into mentorship, but also add to the body of knowledge on how the coping strategies contribute to developing resilience. Whilst other studies have sought to understand the outcomes of coping and building resilience in the clinical arena, the outcomes of coping strategies used by newly qualified nurses to build resilience when carrying out the mentor role are still poorly understood. Overall, these findings, together with the studies relating to liminality and transition, are gradually mapping shared meanings associated with resilience and transition.

In summary, this cross-case superordinate theme 3 *Developing Resilience for Transition* has conveyed the multiple views of how newly qualified nurses developed resilience for transition by *coping with transitional shock* and *managing transition through the liminal phases*.

Table 11 provides the highlights of the study conclusions relating to CCSupT3 and its associated CCSubTs.

Table 11: Development of Resilience for Transition highlights

Cross-Case Superordinate Theme 3: Development of Resilience for Transition	
Highlights	
<p>CCSubT (3.1)</p> <p>Coping with transitional shock</p>	<ul style="list-style-type: none"> • This cross-case subordinate theme refers to coping with the transitional shock as they were confronted with the challenges and reality of mentorship. • Participants were shocked to learn that they were not required to show that they had any specific knowledge or skills to carry out the role effectively. • Transitional shock was felt through unpreparedness, stress and anxiety as they began to accept the significant changes in their roles and responsibilities on moving into the stage 1 mentor role and resonates with elements of Kramer's transition shock theory. • Coping strategies adopted by participants in this study included: being in denial, avoidance tactics, drawing on a network of colleagues, drawing on inner strength, adjusting to the situation and remaining positive and were inherently linked to how they overcame transitional shock. • Individuals' ability to cope could also have been influenced by other intrinsic and extrinsic factors such as personality, age and experience. • Participants frequently referred to '<i>the shock</i>' of having to adapt to and accept a new role, but then found they had the resilience to cope as they transitioned into mentorship. • The coping strategies found in this study contributed to their resilience, thus ultimately influencing their preparedness for the mentor role.
<p>CCSubT (3.2)</p> <p>Managing transition through the liminal phases</p>	<ul style="list-style-type: none"> • Liminality is used as a lens for understanding the uncertainty and ambiguity experienced by participants at that time. • In congruence with the works of Van Gennep (1960) and Turner (1969), participants also experienced three phases of liminality as they transitioned into the mentorship role. • The pre-liminal phase found in this study reflected the resilience found to manage their feelings of anxiety and uncertainty and lack of confidence by the participants as they left behind the familiarity of being a nurse without the additional responsibility of mentorship. • The liminal phase was where participants reported feelings of transiency, in-betweenness, role ambiguity, uncertainty and feelings of disorientation. Participants were able to build on their resilience to enable them to manage their transition as they moved through this phase into the post-liminal phase. • The post-liminal phase was not defined by a particular time, but by a change in feelings and loss of that sense of being in-between, and was characterised by increased confidence within the mentorship role, which was critical to participants as they felt more certain in what they were doing.

	<ul style="list-style-type: none"> • For the purpose of this study, in-betweenness can be described as the place 'betwixt and between', where participants reported a state of uncertainty and ambiguity, wavering between two worlds, being neither here nor there. • The reality of mentoring students did not meet participants' expectations where they experienced uncertainty and ambiguity, requiring them to build on their resilience whilst transitioning into the mentor role. • In the realm of mentorship and contemporary nursing, understanding the concept of liminality can be a powerful framework for understanding the development of resilience whilst nurses transition into the mentorship role.
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6.4 Cross-Case Superordinate Theme 4: Attaining Professional Identity

The cross-case superordinate theme 4 labelled Attaining Professional Identity details how the participants sought the approval of others as professional mentors to attain professional identity. Having a sense of belongingness to a professional group provided participants with the professional identity they strived for to be valued as part of the mentorship team. The cross-case superordinate theme 4 (Table 8, Chapter 5) *Attaining Professional Identity* encompassed two subordinate themes, (4.1) *securing the esteem of others* and (4.2) *belongingness to the mentorship team*.

Professional identity has been a frequent topic in nursing literature with many meanings and definitions addressed in terms of related concepts such as socialisation (Melia, 1987; Mackintosh, 2006; Feng and Tsai, 2012; and self-concept (Johnson et al., 2012; Hoeve et al., 2014).

Brown et al. (2018) describes professional identity as a person's perception of themselves within a profession or the collective identity of the profession and depicts professional identity as an evolving process shaped by many factors. The definition of identity offered by Flores and Day (2006, p. 220) is as 'an ongoing and dynamic process that entails the making sense and (re)interpretation of one's own values and experiences'. Belongingness related to identity also features in nursing literature as a deeply personal and mediated experience that evolves in response to the individual feeling secure, accepted, included, valued and respected (Levett-Jones et al., 2007; Levett-Jones and Lathlean 2008; Levett-Jones et al., 2009; Levett-Jones and Lathlean 2009; Liljedahl et al., 2016). For the purpose of this study, professional identity stemmed from the esteem of others, and belongingness to the mentorship team, encompassing the feeling of having a place within a professional context.

6.4.1 Cross-Case Subordinate Theme (4.1): Securing the Esteem of Others

This subordinate theme highlighted that participants needed to secure the esteem of others which, in turn, contributed to gaining a professional identity. The need for the esteem of others

was common across all cases. Securing the esteem of others meant for the participants, having approval from others, being praised and complimented, made to feel valued and included, which in turn enabled them to feel cared for, respected, appreciated and valued. However, it could be noted that the resulting esteem may depend on the characteristics of the individual participant and the colleagues they work with which were not explored in this study.

Gabby (Chapter 5, Section 5.3), Tom (Chapter 5, Section 5.1) and Rizza (Chapter 5, Section 5.4) all felt it was important to them to feel valued and sought approval from other mentors. Gabby gave examples of being confided in and being included in conversations that gave her a sense of approval and ultimate acceptance. Rizza felt that approval needed to be earned, so when given, it meant a lot to her.

Participants spoke of their place of work, and to what extent their working environment contributed to the development of their professional identity. Having a welcoming, supportive culture, where self-esteem and confidence were cultivated, contributed to gaining professional identity. Martha (Chapter 5, Section 5.7) resorted to seeking the esteem of her colleagues so she could be noticed and feel respected and valued for her contribution to student learning. According to Baumeister and Leary (1995), esteem is about being cared about, valued and respected by others, and is essential to positive wellbeing. The need to feel cared about, and of value to others, meant different things to the participants. During the interviews, participants often identified defining moments through which they felt cared for and valued, leading to a sense of professional identity. For Martha, her defining moment was when she felt recognised and valued for her worth by her colleagues when someone asked for her advice about a student. On the other hand, Tom (Chapter 5, Section 5.1) wanted his colleagues to give him a formal title of mentor as a form of esteem that he felt he deserved. Tom felt that a formal title of stage 1 mentor would reflect his contribution to student learning and would enable him to be recognised for his contribution to mentorship. For others, there was no obvious defining moment. Securing the esteem of others happened over time, and was only noticeable to them when they felt included and sensed a feeling of professional identity that they had not felt before.

Interestingly, the importance of job titles was also an important finding in Neary's (2014) study, which reported that, if job titles were vague or indistinct, it impacted on how nurses perceived themselves and how they were perceived by others. Having a formal job title was considered by Tom to be a signifier of professional identity. The term 'stage 1 mentor' was considered by other participants as ambiguous and not helpful to students who had never heard of such a title. This was also evident in the first focus group that I carried out at the beginning of my research journey, with third-year student nurses who confessed that they had never heard of the term 'stage 1 mentor'. For some participants, having to explain to students who they were

and what their role was made them feel undervalued and unworthy, hence the need to seek the esteem of others as professional mentors. Whilst there is little research exploring the impact of job titles, the need for the esteem of others through a job title may be a contextual reason why the participants in this study felt defensive over their professional identity in terms of recognition and approval.

These findings expand the knowledge from other studies relating to professional identity and belonging (Spouse, 2001; Levett-Jones et al., 2007; Levett-Jones and Lathlean 2008; Levett-Jones et al., 2009; Levett-Jones and Lathlean, 2009; Newton et al., 2009; Neary, 2014; Williams and Burke, 2015; Liljedahl et al., 2016; Ashktorab et al., 2017). However, the literature suggests that the need for professional identity is still one of nursing's most vague and ill-described concepts (Caza and Creary, 2016). Despite the lack of professional identity that was initially felt by participants in this present study, this finding makes explicit that stage 1 mentors gained professional identity in the sense of the feeling of having a place within the professional context.

Being valued with high regard for their contribution to mentorship played an important role in creating a feeling of being cared for, respected, appreciated and accepted as a stage 1 mentor. Feeling cared for, respected, appreciated and accepted contributed to the development of professional identity, but it is interesting to note that the esteem that they searched for had not been forthcoming in the initial months of taking on the stage 1 mentor role. Professional identity was not found to be formed in a defining moment, but rather through an evolving process shaped by having approval from others, being praised and complimented, and being made to feel valued and included. This study concludes that securing the esteem of others is central to attaining professional identity, and feeling valued and accepted for their contribution to student learning is fundamental to well-being and worth. This finding contributes to mentorship knowledge and also raises awareness of the need to value newly qualified nurses' contribution to student learning. It is important, therefore, that the development of professional identity through recognition and esteem of others is an essential component for newly qualified nurses as they move into the mentorship role. This study found that having the esteem of others enabled a sense of personal importance, and the freedom to work with students without having to explain themselves to every student. It is important, therefore, to consider the relationship between the development of self-esteem and professional identity, especially for newly qualified nurses taking on a mentorship role, and this is worthy of further investigation.

6.4.2 Cross-Case Subordinate Theme (4.2): Belongingness to the Mentorship Team

This cross-case subordinate theme explains the participants' need for belongingness to the mentorship team. Belongingness to the mentorship team reflects the extent to which newly qualified nurses in this study felt personally accepted, respected, valued and included by other mentors in the clinical setting, which to them was fundamental to their professional recognition and personal credibility. The concept of belongingness has featured in many nursing journals, in particular around student nurses' sense of belonging on placement and its relationship with self-efficacy, motivation and confidence (Hagerty et al., 1992; Brown et al., 2012; Levett-Jones et al., 2007; Levett-Jones and Lathlean, 2008; Levett-Jones et al., 2009; Levett-Jones and Lathlean, 2009; Vinales, 2015; Liljedahl et al., 2016). According to Baumeister and Leary (1995), belongingness is related to the attachment individuals feel towards a particular place and the extent to which they perceive themselves as being an integral part of that place. The most comprehensive definition of belongingness given by Baumeister and Leary (1995), and further developed by Somers (1999, p. 16), is 'the perception of being involved with others at differing interpersonal levels, which contributes to one's sense of connectedness, being part of, feeling accepted, and fitting in'. Hence, the need to belong and feel accepted is fundamental and drives much human pursuit, activity and thinking (Levett-Jones et al., 2009).

Belongingness for the participants in this study was signified by fitting in and feeling personally accepted; feeling involved and being included by other mentors in the clinical setting; being involved in the decision-making process; feeling like '*one of them*' (Tom, Gabby, Rizza); collaborative team working; sharing difficult mentoring challenges with mentors; and having to align to workplace traditions. The sense of belonging to the mentorship team allowed participants to feel they had attained a professional identity that they did not have before as stage 1 mentors. Gaining a professional identity seemed to be a key factor for the participants, which linked with feeling a sense of belonging to the team. The relationships that participants had with both peers and students were central to their sense of identity, giving them a feeling of self-worth and motivation to mentor students. More importantly, being known personally and professionally as a good stage 1 mentor was significant. Thus, the need to develop a strong sense of professional identity seemed crucial to the participants as they entered the world of mentorship.

Whilst participants were encouraged to '*take*' students, they were implicitly expected to '*get on with it*' (Gabby, Chapter 5, Section 5.3) and align to the traditions of mentorship on the ward. Gabby, as an example, recognised that she had to align with workplace norms to gain a sense of belongingness to the community of practice, but also recognised that the need to belong was more important than following her own values around mentorship. Gabby felt she had compromised her own basic values with the expected reality of feeling included as part of

the mentorship team. This finding is consistent with those of Lawler (2008) and Liljedahl et al. (2016), who found that nursing students negotiated their belongingness with the community because of strong inherent norms and values in the profession. Both these studies asserted that professional identity can only be earned through membership of a community or group.

On the other hand, for many of the participants, a lack of belongingness was typified by feelings of alienation and lack of connectedness. They reported how the very nature of their workplace had initially inhibited belongingness, saying that everybody was just too busy to work with them, leading to them feeling excluded. Vaiya (Chapter 5, Section 5.2), for example, reported how she had often felt left out when mentors were discussing a student's progress, leaving her feeling disconnected from the mentorship team. Further, Regita (Chapter 5, Section 5.5) reported that she was often left out of decision-making and not included in conversations about students due to inadequate staffing/heavy workloads. However, all recognised that the more they were included in the decision-making process, the more they felt integrated and part of the mentorship team. Rizza (Chapter 5, Section 5.4), for example, felt that being involved in decision making gave her a sense of feeling accepted as part of the mentorship team, which she felt was important to her identity as a mentor.

Consistent with the findings of this study, Duchscher (2009) reported that the acceptance of newly qualified nurses increased their self-confidence and led to greater effort on their part in overcoming their problems. Similarly, being integrated into the mentorship team through collaboration and team working fostered a clear sense of belongingness for Gabby (Chapter 5, Section 5.3). She reported a sense of integration into her place of work and becoming one of them, giving her a sense of professional identity within the team. The need to feel part of the team was advocated by Manninen et al. (2015) who found that, when students experience belongingness to a team, they are able to focus on learning and understanding nursing. Though this study applied to student nurses, the similarities are apparent that decision-making skills were more effective the more they perceived their acceptance into the mentorship team. This finding supports the continuing emphasis on maximising practical opportunities in practice to enable the development of belongingness, specifically for those nurses working in a mentorship role.

In addition, other features found in this study that fostered belongingness were involvement; feeling like '*one of them*'; collaborative team working; sharing difficult mentoring challenges with mentors; and having to align to workplace traditions. Becoming '*one of them*' was mentioned by Tom (Chapter 5, Section 5.1), Gabby (Chapter 5, Section 5.3) and Rizza (Chapter 5, Section 5.4), giving examples of '*learning the lingo*' (Tom) and feeling accepted as independent and credible mentors, even though they were not qualified as such. These findings are consistent with much of the literature relating to belongingness, which recognises

that having a sense of belonging is fundamental to gaining a professional identity. The need to attain a professional identity aligned with participants' sense of belonging to the mentorship team, which resulted not just from the knowledge and skills gained for mentorship, but from feeling accepted within the mentorship team. Hence, the present study has shown the importance to newly qualified nurses of belonging to the wider mentorship team and how this is part of a wider process of attaining professional identity as mentors. In turn, such understanding carries implications for practice supervisors who will become an asset to the mentorship team.

Despite research showing that interaction with others in practice heavily determines the extent to which nurses feel accepted and included (Levett-Jones et al., 2007; Levett-Jones and Lathlean 2008; Levett-Jones et al., 2009; Levett-Jones and Lathlean 2009; Newton et al., 2009), these results imply that, in order to belong, membership, interaction and integration into the mentorship team is required for stage 1 mentors. Findings from this study support conclusions from previous research (Pellatt, 2006; Rekha and Ganesh, 2012; Hodgson and Scanlan, 2013; Vinales, 2015), where the need to feel accepted and included is considered paramount to belonging to a professional group. This study shows that there continues to be a synergy between belongingness and professional identity, and that professional identity as a mentor is shaped by a feeling of belonging. Nevertheless, the need to belong to the mentorship team for the participants was far more than simply the need for social contact, but more a need for acceptance and approval. It is therefore salient to this study to centre not only the importance of belongingness in the workplace, but how professional identity can be manifested in newly qualified nurses taking on a mentorship role. Belonging to a professional group of mentors is critical in gaining professional identity and can be achieved through many factors. The most common features found in this present study that corroborate other studies include feeling accepted, feeling involved and being included by other mentors in the clinical setting.

6.4.3 Cross-Case Subordinate Theme 4 Summary

In summary, this cross-case superordinate theme Attaining Professional Identity has conveyed the multiple views of how newly qualified nurses construct their professional identity by securing the esteem of others and belongingness to the mentorship team. Table 12 provides the highlights of the study's conclusions relating to CCSupT4 and its associated CCSuTs.

Table 12: Attaining Professional Identity highlights

Cross-Case Superordinate Theme 4: Attaining Professional Identity Highlights	
<p>CCSubT (4.1)</p> <p>Securing the esteem of others</p>	<ul style="list-style-type: none"> • Participants needed to secure the esteem of others which, in turn, contributed to gaining a professional identity. • This finding makes explicit that stage 1 mentors gained professional identity in the sense of the feeling of having a place within the professional context. • Being valued with high regard for their contribution to mentorship played an important role in creating a feeling of being cared for, respected, appreciated and accepted as a stage 1 mentor. • Securing the esteem of others meant for the participants, having approval from others, being praised and complimented, made to feel valued and included, which in turn enabled them to feel cared for, respected, appreciated and valued. • Having a welcoming, supportive culture, where self-esteem and confidence were cultivated, contributed to gaining professional identity. • Some participants recognised defining moments when esteem had been secured. For others, the esteem of others happened over time, and was only noticeable to them when they felt included and sensed a feeling of professional identity that they had not felt before. • Having the esteem of others enabled a sense of personal importance, and the freedom to work with students without having to explain themselves to every student.
<p>CCSubT (4.2)</p> <p>Belongingness to the mentorship team</p>	<ul style="list-style-type: none"> • Belongingness to the mentorship team reflects the extent to which newly qualified nurses in this study felt personally accepted, respected, valued and included by other mentors in the clinical setting, which to them, was fundamental to their professional recognition and personal credibility. • This study shows that there continues to be a synergy between belongingness and professional identity, and that professional identity as a mentor is shaped by a feeling of belonging. • The defining features of belongingness for the participants in this study signified fitting in, feeling personally accepted, feeling involved and being included by other mentors in the clinical setting, being involved in the decision-making process; feeling like '<i>one of them</i>'; collaborative team working; sharing difficult mentoring challenges with mentors; and having to align to workplace traditions. • The relationships that participants had with both peers and students were central to their sense of identity, giving them a feeling of self-worth and motivation to mentor students. • The need to develop a strong sense of professional identity seemed crucial to the participants as they entered the world of mentorship. • There was a need to align with workplace norms to gain a sense of belongingness to the community of practice, but also recognised that the need to belong was more important than following own values around mentorship. • A lack of belongingness was typified by feelings of alienation and lack of connectedness. • Participants initially felt disconnected from the mentorship team. • Being included in decision-making enabled participants to feel integrated and part of the mentorship team. <p>Being integrated into the mentorship team through collaboration and team working fostered a clear sense of belongingness.</p>

6.5 Summary of Chapter

This chapter has provided an overview and critical discussion of the final set of themes that emerged from the data in this study. It has drawn on a variety of supporting literature around the centrality of these themes whose work can be characterised as making a contribution to the central issues found in this study. Tables 9–12 represent the highlights of the findings to provide, at a glance, an overview of the lived experiences of eight newly qualified nurses working as unqualified mentors. Whilst the development of themes reflects a synergistic process from description to interpretation, the aim was to capture and portray an understanding of newly qualified nurses' early experiences of working as unqualified mentors. Inevitably, this analysis has resulted in an account of how I think the participants think, described by Smith (2007) as double hermeneutics. Thus the 'truth' claims within this analysis are tentative and subjective, but, at the same time, that subjectivity has been dialogic, systematic and rigorous in its application. IPA is underpinned by subjectivity; the aim is not to verify or generalise findings. Whilst this could be a criticism of interpretive phenomenology, Dahlberg et al. (2008) recommend that qualitative research findings should be transferable so that new knowledge can be applied to nursing education and policy, and that research findings should be practised in order that the knowledge is made clear. Therefore, it is important to consider the transferability of these findings within the context of nursing.

In Chapter 7, the findings discussed in this chapter will be considered in relation to the four research questions. Conclusions and recommendations arising from the doctoral study are discussed and this study's specific contribution to knowledge and practice development is stated. The key messages from this research are summarised, the potential limitations of the study are considered and how the findings contribute to the study's overall aims is indicated. Recommendations for mentorship practice, policy and areas for future research are identified.

Chapter 7: Conclusions and Recommendations

7.0 Introduction to Chapter

In this final chapter, I draw together the findings from my research to establish my contribution to the development of knowledge and professional practice in the context of nursing. The conclusions of the dissertation are considered in relation to the four research questions and the aims of the research. The initial concepts shown in the conceptual framework (Figure 1 refers) that provided impetus for the focus of this dissertation, are reconceptualised based on the findings from this study. Firstly, recommendations are given for knowledge, professional practice and research specific to pre-registration nursing students who will be taking on the practice supervisor role post-registration. Secondly, in light of the SSSA standards (NMC, 2018c), recommendations are then made specifically for practice supervisors. An evaluation of, and reflections on, the study are given to conclude this final chapter.

This dissertation addresses the gap in research where the voice of stage 1 mentors is conspicuously missing from the research literature. This qualitative, phenomenological study offers a unique insight through the individual experiences of eight newly qualified nurses working as unqualified mentors. These findings are not quantifiable, but offer an important and unique contribution to the understanding of how newly qualified nurses experience mentorship, which has the potential to inform policy and practice development for what is now practice supervision. It is the identification of the final set of four cross-case superordinate themes (*proactive strategies in becoming prepared, experiential learning, development of resilience in transition* and *attaining professional identity*) and their associated eleven subordinate themes and the conclusions drawn about the nature of these as important means to understand and develop practice supervision that are my original contribution to the knowledge base. Although the regulatory framework around mentorship in nurse education has changed over the duration of this research, the practice supervision of student nurses and how practice supervisors are prepared for this role remain issues of topical concern for the nursing profession. Nurses can now carry out the practice supervisor role, but no longer need to undergo a formal preparatory course. However, approved HEIs, together with practice learning partners, must ensure that practice supervisors receive ongoing support to prepare, reflect and develop for effective supervision and contribution to student learning and assessment (SSSA, NMC, 2018c, p. 7).

With the introduction of the new Standards for Education Parts 1–3 (NMC, 2018b–d) that replace the former mentorship model (NMC, 2008), practice supervisors need to have appropriate support and resources to support student learning. However, unlike the 2008 model which stipulated that mentors must undergo preparation for mentorship, annual updates

and triennial reviews, the new 2018 standards do not detail any requirement for practice supervisors to undergo preparatory training. What is stipulated, however, is that an approved Higher Education Institution and practice partners should appropriately prepare practice supervisors, and that there should be ongoing support to prepare, reflect and develop for effective supervision and contribution to student learning and assessment (NMC, 2018c). However, this requirement lacks specificity as to how newly qualified nurses will be prepared and supported, so it is inevitable that supervisory practice could be nationally inconsistent. In light of this uncertainty, and given the need to prepare practice supervisors locally, specific recommendations for practice development and enhancement are made concerning how to meaningfully prepare and develop nurses to fulfil the practice supervisor role.

7.1 Conclusions of the Dissertation: Returning to the Research Questions

7.1.1 How Do Newly Qualified Nurses Prepare for Mentorship?

My engagement with, and analysis of, the narratives presented in Chapter 5 led to the conclusion that, in answer to this first research question 1 (RQ1) (*shown in the left-hand blue box in Figure 15*), newly qualified nurses take responsibility for and are proactive in becoming prepared for mentorship (*shown in the middle blue box, Figure 15 refers*) (CCSupT1). This finding is an integral part of understanding how newly qualified nurses become prepared for what is now the practice supervisor role. Proactive strategies included (*shown in the right-hand blue box, Figure 15 refers*) (CCSubT) active participation in mentorship activities, active reflection on past experiences (see Section 6.1.2) and seeking ways to find emotional support (see Section 6.1.3). Figure 15 shows the first research question and the findings from this study that relate to it.

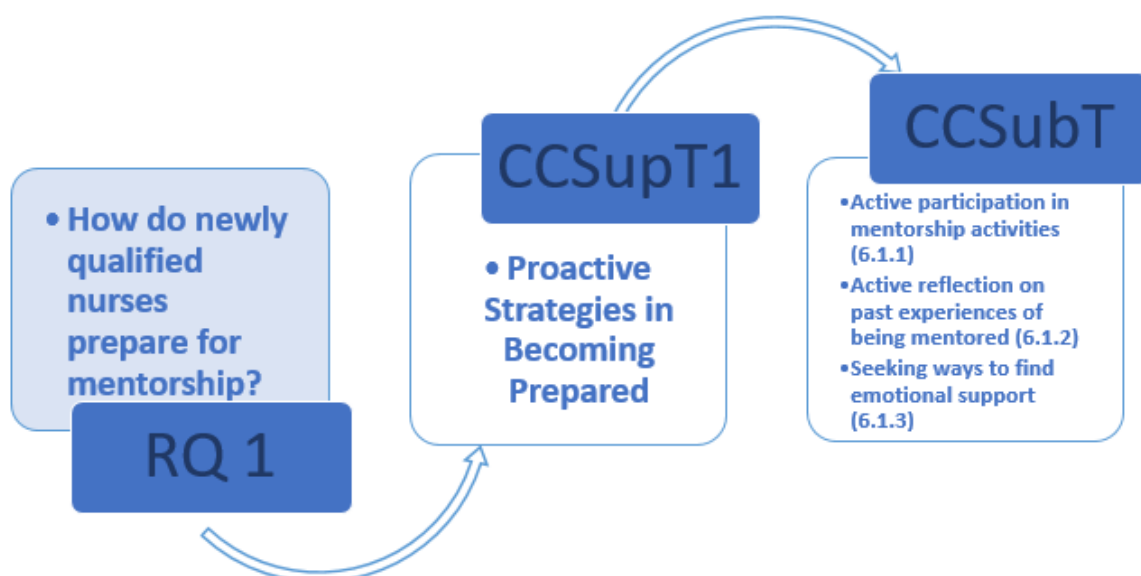


Figure 15: Research Question 1 and Research Findings

This study concludes that learning through the experience of being hands-on enabled participants to feel a sense of preparedness for mentorship that they had not felt before they became newly qualified nurses. Therefore, there is an argument for an earlier engagement with a supervisory role in the workplace, where student nurses could be guided to take a hands-on approach to teaching, learning and assessment. These activities integrated into pre-registration education could be tailored to prepare nurses to meet the ever-changing needs of students' learning.

Adding to our understanding of preparedness for supporting practice supervision, this study shows that both positive and negative past experiences of being mentored had been invaluable in preparing participants for the mentorship role. They used reflection as a tool to overcome feeling unprepared for the mentor role. Being able to draw on those past experiences enabled them to execute the mentorship role in a way that they felt was effective, and with some confidence. This study found that active reflection as a strategy was a positive approach to processing past experiences of being mentored as students, leading to a clearer understanding of how to prepare for the realities of the role. This conscious consideration of being mentored as students enabled them to recognise positive and negative behaviours of their mentors and apply those experiences to their own practice. Furthermore, when emotional support was given by mentors, confidence was increased, and anxieties decreased. These findings draw attention to the important role that emotional support can play in reducing stress and increasing confidence and wellbeing as newly qualified nurses take on the supervisory role. Establishing the importance and nature of these processes and how these experiences might influence future supervisory practice is significant to nurse education and the preparation of future nurses.

This finding contributes to the evidence base for mentorship, and now practice supervision, in that it explains the phenomenon of how newly qualified nurses prepare in a way that is meaningful and relevant to themselves at the point of registration. Planning for the supervisory role would therefore seem central to the readiness and preparedness of newly qualified nurses. Indeed, it is hoped that this finding will guide curriculum and policy decisions when preparing nurses for the new practice supervisor role. If curriculum developers, researchers and policy makers of the future aim to prepare nurses for the new practice supervisor role, then they need to adopt an approach that is congruent with this finding. This finding should prompt practice partners and Higher Education Institutions to explore the educational and practical needs of student nurses in relation to how they prepare them not only for registration, but also for what is now the practice supervisor role. More importantly, this finding should

stimulate discussion around the preparation of newly qualified nurses and consideration of the extent to which they feel prepared to support students in practice so early in their careers.

7.1.2 How Do Newly Qualified Nurses Acquire Knowledge and Skills for Mentorship in the Reality of Practice?

This second research question asked how newly qualified nurses acquired knowledge and skills for mentorship (RQ2) (shown in the left-hand orange box, Figure 16 refers), to discover how in the reality of practice they can be prepared for the stage 1 mentor role. Newly qualified nurses fundamentally learn mentorship experientially in practice (shown in the middle orange box, Figure 16 refers) (CCSupT2). Experiential strategies included (shown in the right-hand orange box, Figure 16 refers) (CCSubT) engaging in active, self-directed learning (see Section 6.2.1), learning by trial and error (see Section 6.2.2), using intuition to do mentorship (see Section 6.2.3) and learning from peers (see Section 6.2.4). Figure 16 shows the second research question and the findings from this study.

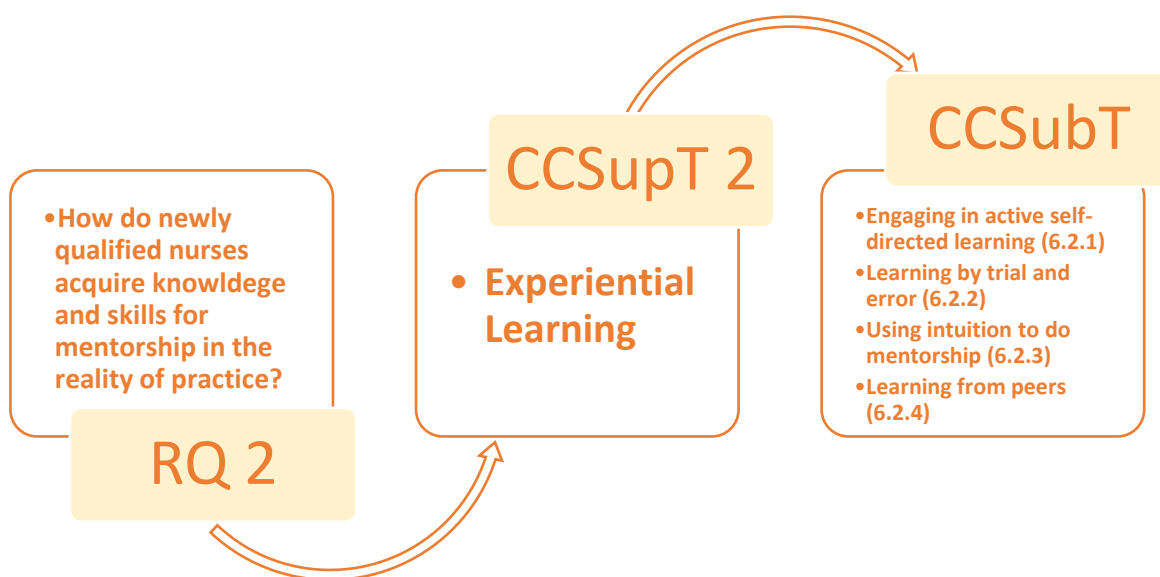


Figure 16: Research Question 2 and Research Findings

The lived experience, as reported by participants in this study, was that newly qualified nurses learnt mentorship on the job through role performance. As established in the previous section, participants did not want to be passive learners; rather, they preferred to take a more hands-on, self-directed approach to their own learning. In the reality of practice, participants in this study acquired mentorship knowledge and skills experientially in several ways, namely, active self-directed learning, learning by trial and error, using intuition to do mentorship, and learning from peers. Participants adjusted their actions to their own contexts by reframing what they

had learnt so they could change the way they practised mentorship. Therefore, in the context of this study, the knowledge and skills gained from experiential learning are significant.

Although Benner (1984) states that the use of intuition is only associated with expert nurses, this study found that, despite being novice nurses and novice stage 1 mentors, participants used their intuitive experiences to learn mentoring and relied on their intuition to judge what was right and what was wrong. It would appear from this study that, despite drawing on their intuition, the participants made explicit their intentions to consciously develop practical skills in mentoring and move away from having that *gut feeling* to consciously knowing how to 'do mentoring'. Despite not knowing initially how to mentor, mentorship skills were learnt through a process of trial and error. Over time, they developed insight into the mentor role by reflecting on their mentorship practice, problem solving and learning from their mistakes. Their attempt to practise mentorship skills until mastered was important to them, but how they attempted to do this was a significant finding in the data.

Learning through a process of trial and error has been shown in this study to be an effective way of learning mentorship through experience. This learning was not deliberate or reactive learning, but an understanding over time of mentoring practice through trial-and-error situations. This experiential approach to learning helped participants to acquire mentorship skills that enabled them to reflect, analyse and evaluate, as well as using problem-solving skills along the way. This study concludes that mentorship skills can be learnt through shared learning and shared interactions with peers. Hence, new practice supervisors can build on their knowledge and skills by working collaboratively with their peers to supervise students together, making use of social synergy in the development of expertise.

Despite the many reported benefits of learning on the job, learning by trial and error, using intuition to learn and practise mentorship and learning from peers, newly qualified nurses run the risk of poor-quality on-the-job learning. This study recognises that learning mentorship experientially from peers who might not have the required knowledge and skills for mentorship should be treated with caution. Learning mentorship these ways could foster poor learning experiences through uninformed and out-of-date nurses and mentors ('Nellie'). Though there is a good argument for nurses to learn mentorship from peers, the newly qualified nurse runs the risk of experiencing poor quality on-the-job preparation to become a mentor. These findings demonstrate that, in this case, the '*sitting with Nellie*' model of training could have a detrimental effect on the newly qualified nurse, personally and professionally, where they may have picked up bad habits from poor on-the-job training. Given that the NMC recommend that nurses are prepared locally for practice supervision (NMC, 2018c), it is important to ensure that peers have sufficient time and resources to support their fellow nurses, and that the support and preparation of newly qualified nurses carrying out the practice supervisor role are

of a high standard. Investing in time and resources for more experienced nurses to prepare newly qualified nurses as a way of formalising this commitment might reduce the likelihood of poor preparation and support due to heavy workloads and additional responsibilities.

7.1.3 How Do Newly Qualified Nurses Experience Transition into the Mentorship Role?

The third research question asked how newly qualified nurses experience transition into the mentorship role (RQ3) (shown in the left-hand green box, Figure 17 refers), to establish how the concept of transition is understood and experienced by stage 1 mentors. Nurses developed resilience in transition (shown in the middle green box, Figure 17 refers) (CCSupT3). They did this by (shown in the right-hand green box, Figure 17 refers) (CCSubT) coping with transitional shock (see Section 6.3.1) and managing transition through the liminal phases (see Section 6.3.2). Figure 17 illustrates the third research question and the findings from this study.

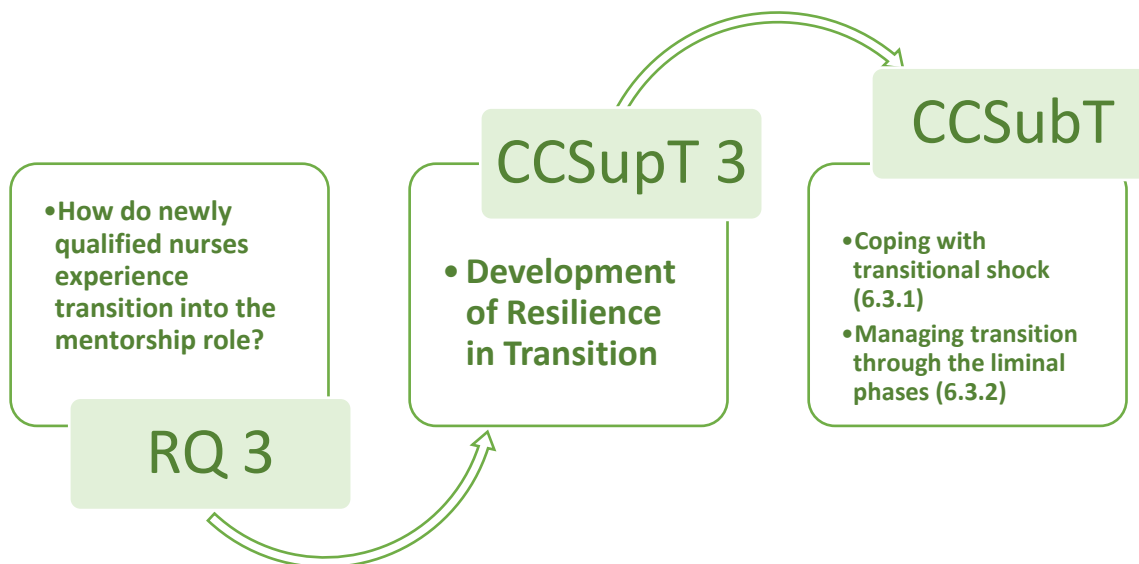


Figure 17: Research Question 3 and Research Findings

This study concludes that transition into the mentorship role involved the development of resilience. Newly qualified nurses characterised resilience as having to toughen up and deal with their transition into the mentor role, as well as the unpredictability of learning to be a nurse. Participants had to face up to the reality that not only was mentoring students a professional requirement of becoming a nurse (NMC, 2018d), but also that their transition was not over as they had transitioned from student to nurse, and now into the mentorship role. However, given the challenges that newly qualified nurses face, the fact that learning to cope was a key factor in developing resilience and impacted on their transition into the mentor role

is not surprising. If resilience is a characteristic that can improve nurses' transition into the practice supervisor role, this then raises the question of how resilience can be developed and built on from student nurse to nurse to practice supervisor.

This finding indicates the importance of resilience in newly qualified nurses. This study concludes that resilience can be developed by learning coping strategies to overcome transitional shock and acknowledges that the feeling of liminality is experienced by newly qualified nurses transitioning into the mentor role. The findings further conclude that remaining positive not only helped participants to develop resilience, but also enhanced their confidence, which in turn reduced feelings of transitional shock. I would contend, therefore, that for the process of transition to be successful, it would be helpful if newly qualified nurses embodied positivity to enable and develop resilience.

The participants' ability to develop resilience through the three liminal phases during their transitional period into mentorship helps us to understand further the process of transition through Van Gennep's (1960) and Turner's (1969) theory of liminality. The three phases of liminality experienced by participants in this study can therefore enable a better understanding of how resilience can be developed, not just for nursing, but for those nurses taking on the practice supervisor role. What is particular to the participants' accounts in this study is their description of 'in-betweenness' as they transitioned through the phases of liminality into the mentorship role. Perhaps because of their experiences of liminality and their emphasis on developing resilience, their accounts in future research could be compared and contrasted to establish the meaning of liminality in the context of newly qualified nurses transitioning into the practice supervisor role. Understanding the experiences of how newly qualified nurses transition into the practice supervisor role through the lens of liminality may not only help towards creating awareness of the challenges they might face, but also provide a supportive framework that enables the development of resilience. The framework could be used for educators and practice partners to successfully guide newly qualified nurses through the liminal phase.

7.1.4 How Do Newly Qualified Nurses Identify as Stage 1 Mentors?

This fourth research question asked how newly qualified nurses identify themselves as stage 1 mentors. (RQ4) (*shown in the left-hand purple box, Figure 18 refers*). In becoming stage 1 mentors, nurses attained professional identity (*shown in the middle purple box, Figure 18 refers*) (CCSupT4). Professional identity was attained in part by (*shown in the right-hand purple box, Figure 18 refers*) (CCSubT) securing the esteem of others (see Section 6.4.1) and developing a sense of belongingness to the mentorship team (see Section 6.4.2). Figure 18 illustrates the fourth research question and the findings from this study.

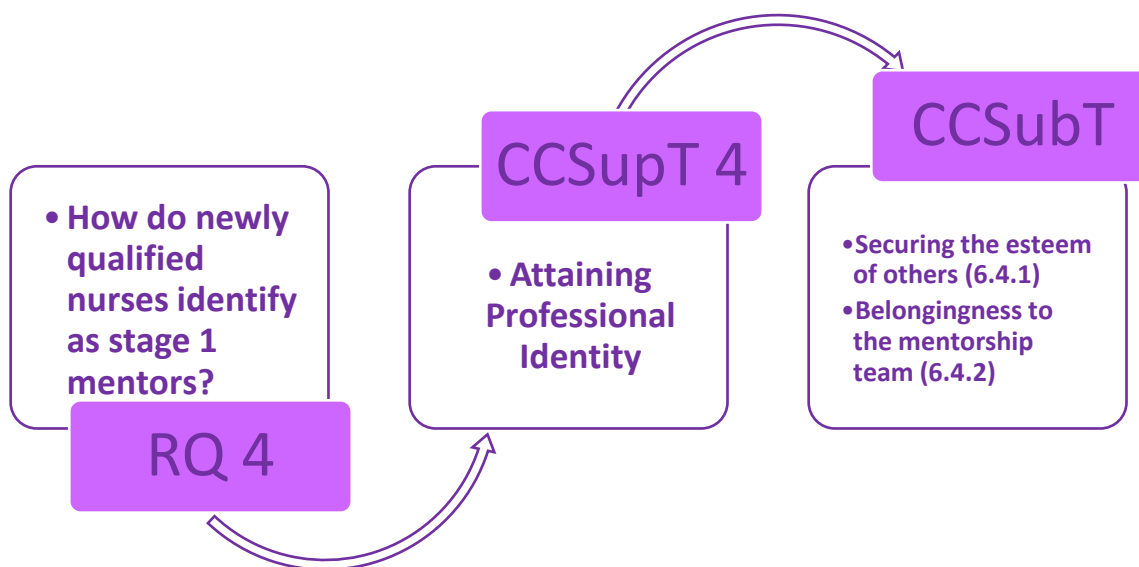


Figure 18: Research Question 4 and Research Findings

Conclusions drawn from this study were that professional identity was sought and achieved through securing esteem from the approval and acceptance of other mentors and colleagues (see Section 6.4.1) and gaining a sense of belongingness to the mentorship team. Securing the esteem of others contributed to participants' growing confidence, leading to feelings of developing a professional identity as a stage 1 mentor. Establishing belongingness within the professional group of mentors was necessary for mentors to attune themselves to each other, specifically the goals, roles and responsibilities that each needed to assume. Newly qualified nurses' need to develop a sense that they belonged to a professional group of mentors was an important finding, in that it highlights that a sense of belongingness is essential to newly qualified nurses as they become socialised into the mentor role. Participants initially struggled with their mentorship identity, but through feeling accepted and valued, and moving into a sense of belongingness over time, they attained professional identity as newly qualified nurses. Indeed, participants believed that the development of their professional identity as newly qualified nurses was key to autonomous practice.

This study concludes that feeling valued as part of the mentorship team laid an important foundation towards establishing a professional identity. From my analysis, there was a process of growing independence that stemmed from their sense of belonging, thus leading to attaining professional identity. All participants made clear that they had felt undervalued as stage 1 mentors, and often were seen as a *'pair of hands'*. Therefore, the need to feel valued for their contribution and important to student learning was significant. These findings illustrate the

importance of practitioners and educators recognising that newly qualified nurses working in the practice supervisor role need to have a sense of belonging and of being and feeling recognised for what they do so that their identity can be shaped early on in their careers.

7.2 Recommendations for the Development of Knowledge, Professional Practice and Research

In light of the fact that the participants in this study did not feel prepared for the mentorship role upon registration, recommendations with pragmatic advice for practitioners are first made for the development of knowledge and professional practice for pre-registration nursing students who will be taking on the practice supervisor role post-registration (see Table 13). Further recommendations with pragmatic advice for practice supervisors themselves are made (see Table 14), especially in the light of the new NMC Standards for Student Supervision and Assessment (SSSA) (NMC, 2018c) in relation to their preparation and support. Hence, the suggested recommendations given are particularly pertinent as newly qualified nurses are expected to play a broader, more supervisory role in student nurse education and take on the practice supervisor role post-registration.

Table 13: Pragmatic recommendations for the development of knowledge and professional practice specific to pre-registration nurse education

- With little preparation to carry out a supervisory role as student nurses qualify, nursing programme providers could strengthen and develop the preparation of these students who will be assuming the role of practice supervisor upon registration. Student nurses could be prepared early in their programme to develop specific supervisory skills, starting from the core nursing skills, which include active listening skills, communication and coaching, in the first year of their pre-registration programme, then working towards more specific mentoring/supervisory skills, such as instruction, teaching, assessment and decision making, with deepening layers of complexity throughout the programme. Each time these skills are revisited, the student will gain deeper knowledge, which has the benefit of reinforcing learning over time, and uses prior knowledge to inform future learning. This spiral approach to learning is advocated by Bruner (1960) where learners construct new ideas or concepts based upon their current/past knowledge. This deeper approach to learning involves information being structured so that complex ideas can be taught at a simplified level first, and then revisited at more complex levels later.
- The process of mentorship learning as shown in the data leads me to recommend a unique pedagogical framework based on Bruner's (1960) spiral curriculum. In pedagogic terms, a traditional didactic, teacher-centred approach in which knowledge is disseminated to the learner rather than constructed (Mascolo, 2009) should be replaced by a more reflective approach that can support new practice supervisors' deeper learning and enable them to place the student at the heart of an active learning process. Hence, the development of knowledge and skills to enable supervision, support and the facilitation of teaching, learning and assessment could be a dynamic process of spiral learning that prepares students from the first year through to becoming a practice supervisor at the point of registration.

- Figure 19 below proposes a pedagogical framework for the development of knowledge and supervisory skills for the pre-registration nursing curriculum. This spiral curriculum interrelates with Bruner's view of learning being an active process in which learners construct their own knowledge.

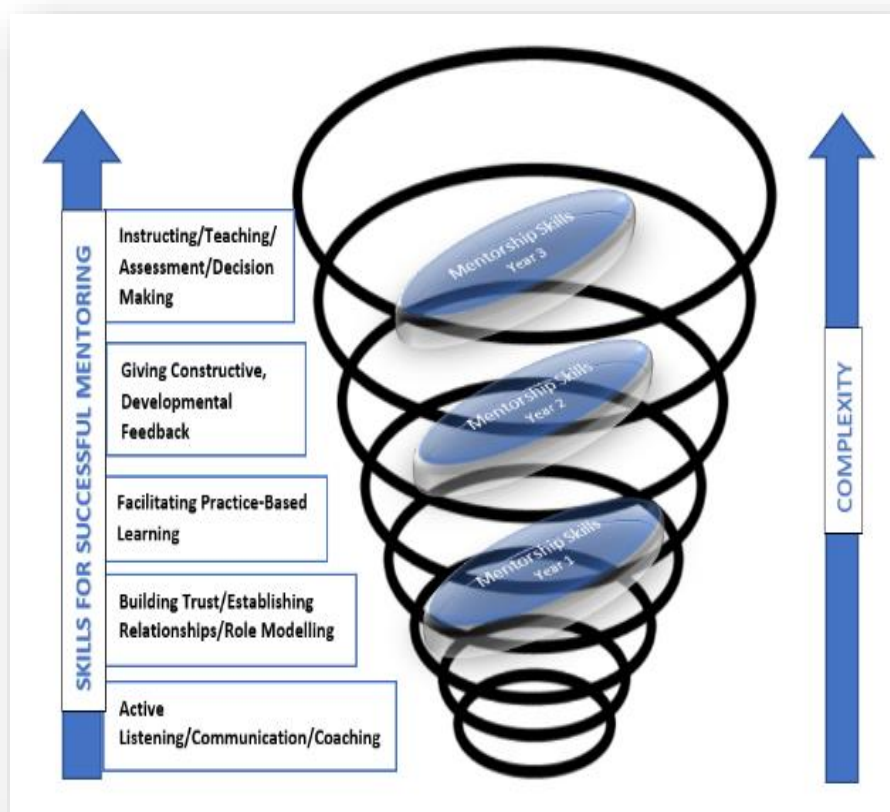


Figure 19: A pedagogical framework based on Bruner's (1960) spiral curriculum

Based on the findings of this study, I now provide pragmatic recommendations for the development of knowledge and professional practice and research specific to practice supervisors. The recommendations are linked to the cross-case superordinate (CCSupT) and subordinate (CCSubT) themes detailed in Chapter 6.

Table 14: Pragmatic recommendations for the development of knowledge, professional practice and research specific to practice supervisors

<ul style="list-style-type: none"> • The need to provide newly qualified nurses with emotional support is complex and requires a high level of ongoing support for those who guide novice mentors. Experienced nurses should not only be encouraged to offer emotional support, but be developed in their role within the preceptorship period to provide support to novice practice supervisors by having peer support available to them, as well as education and training in counselling and coaching skills. Further research is needed to explore the relationship between emotional support given to newly qualified nurses and confidence and wellbeing when taking on the practice supervisor role (relates to findings CCSupT 1 & CCSubT 1.3).
<ul style="list-style-type: none"> • The modern healthcare environment is extremely complex, demanding that nurses take on additional roles such as practice supervisor. In order to challenge existing practice, newly qualified nurses need to be given the time and resources during their preceptorship period to actively partake in supervisory activities to develop problem-solving skills leading to critical thinking and reflection in and on action (relates to findings CCSupT 1 & CCSubT 1.1).
<ul style="list-style-type: none"> • The reliance on intuitive practice and trial and error to learn and develop mentorship knowledge and skills found in this study must be challenged and acted upon. The facilitation of practice-based active self-directed learning enables novice practice supervisors to construct knowledge and understanding, skills and attributes around the supervisory role. The limited literature around readiness for self-directed and hands-on learning in relation to newly qualified nurses indicates a need for further studies to investigate how active self-directed learning correlates with preparedness and readiness for supervisory practice (relates to findings CCSupT 2 & CCSubT 2.1, 2.2 & 2.3).
<ul style="list-style-type: none"> • Ward/practice managers to establish or support the development of peer-learning groups and action learning sets for new practice supervisors, and provide quality time for peer learning partnerships within the preceptorship period, thus reducing poor quality learning experiences from peers (relates to findings CCSupT 2 & CCSubT 2.4).
<ul style="list-style-type: none"> • Considering the benefits of practice supervisors developing resilience, this study recommends that employers invest in developing resilience and enabling resilience-building strategies. This is significant for successful transition into the practice supervisor role and eliminating feelings of transitional shock. This study showed the need for newly qualified nurses to develop coping strategies to manage stress and anxiety through transition. A greater emphasis on developing coping mechanisms therefore is required for practice partners by encouraging positivity, and a greater understanding of the challenges they face in this role. Understanding the transitional experiences of newly qualified nurses may not only be significant in creating awareness of the challenges that they face, but may also provide a supportive framework for educationalists and practice partners to successfully guide them as they transition into the practice supervisor role. These findings therefore lay the groundwork for more qualitative research to explore the various coping strategies used by newly qualified nurses, and focus specifically on the relationship between transition and resilience. Thus, there is a need for further research into the relationship between resilience and liminality in the context of becoming a mentor (relates to findings CCSupT 3 & CCSubT 3.1 & 3.2).

- There are opportunities for practice partners and HEIs to develop a shared responsibility to develop practice supervisors' professional identity. This could be achieved by recognising their contribution to student learning through team-building exercises and reflective supervision that promotes professional identity within the supervisory team, thus reducing the need to secure the esteem of others. This perhaps raises the question and opens issues not covered in this research of how to promote professional identity from the point of registration, without the need for newly qualified nurses to have to search for an identity that they deserve. The challenge, therefore, for employers of newly qualified nurses is to identify and understand the relationship between being valued with high regard for their worth, and its impact on the development of professional identity. Further research that explores the relationship between job titles and professional identity may have an impact on future perceptions of nurses taking on a practice supervisor role. Given that nurses are expected to take on the additional role of practice supervisor, there needs to be a greater understanding through future research of how to make newly qualified nurses feel cared for, esteemed, accepted and valued for this important role (***relates to findings CCSupT 4 & CCSupT 4.1***).

- In recognition of the significance that the participants in this study attributed to the sense of belongingness, leading to a subsequent feeling of professional identity, there is a need for practice partners to consider involving newly qualified nurses in decision making that relates to student progression and assessment. Further, it is important to consider how the early partnership between newly qualified nurses taking on the practice supervisor role and experienced practitioners could not only prepare them but reduce feelings of exclusion and enable a sense of integration and belongingness in the mentorship team. The challenge for practice partners, when employing newly qualified nurses, is to find ways to enable an early sense of belongingness by not expecting them to conform to often ritualistic and established routines. If employers are to fully understand the relationship between the early experiences of newly qualified nurses and belongingness, then further research is required to understand the concept of belonging from the perspectives of those undertaking the mentorship role. Although these findings add to the body of knowledge around the concept of belongingness in nursing, further research is required to explore the relationship between belongingness and professional identity from the perspectives of newly qualified nurses working in the practice supervisor role. This research would be illuminative and go some way to closing the gap in the nursing literature around belongingness and professional identity, but specific to the practice supervisors (***relates to findings CCSupT 4 & CCSupT 4.2***).

The implications of this research are of critical importance in nursing, albeit that a new practice supervisor role has been established. Even though the term 'mentor' does not exist in the new standards (NMC, 2018a,b,c), knowledge, skills and attributes that represented the contribution of mentors to practice-based teaching, learning and assessment are still required to fulfil the practice supervisor role. This study has given voice to a group of newly qualified nurses that has received little attention in the research literature. Many researchers have utilised a phenomenological approach to interview mentors about their practice over the years; however, I have found no other qualitative studies that focus specifically on newly qualified nurses working as stage 1 mentors. Whilst there may be limitations on how generally the findings from a study which used a small sample of newly qualified nurses can be applied, the

findings provide a degree of transferability that potentially lifts the conceptualisation beyond the scope of mentorship in nursing, to the preparation of newly qualified nurses taking on the practice supervisor role. These recommendations therefore contribute to the advancement of professional practice by making explicit how practice supervision could be developed and supported in both pre- and post-registration nursing.

7.3 Evaluation of, and Reflection on the Study

Although this final chapter is perceived as the end of my doctoral journey, in many ways it is a beginning in its own right. At the start of my research journey, the mentor role and preparation for such was a pillar of the way that nurse education was operationalised, and the research questions were contemporary and pertinent. Over the years that this research was carried out, the publication of the NMC standards (NMC, 2018a,b,c,d) changed the landscape of mentorship in nursing. Therefore, this research provides a timely engagement with the importance of preparing and supporting newly qualified nurses taking on a supervisory role. I feel it is reasonable to make meaningful assertions from the findings of this study, with potential to influence the practice of future newly qualified nurses as they take on the practice supervisor role.

It has been interesting to track my own learning over the last few years, and the change of my perspective on mentorship alongside that of my participants. These eight nurses have been on a journey learning to be mentors and, equally, I have been on a journey towards acknowledged status as a researcher in nurse education. This study informs nurse education by reconceptualising the preparation of student nurses for the practice supervisor role as they become nurses. The research findings are not offered as objective truths and claims of generalisability will not be made. Instead, findings are offered as interpretations, and the data analysed from a particular viewpoint that could be transferable to nursing practice and student education.

Ultimately, my commitment to carrying out this study was to explore how stage 1 mentorship is viewed in nursing and to give value to the extended role of the newly qualified nurse. I do not intend this study to become the final declaration of stage 1 mentoring practice. Rather, this study is just the beginning of my own research journey. Carrying out this study has provided me with a foundation for future research into the challenges that newly qualified nurses may face, specifically around preparedness, practice-based learning, transition, professional identity and belongingness, but in the context of practice supervision. This research gave these eight nurses an opportunity to share their stories so that findings from this study can contribute not only to the current evidence base of mentorship practice, but to future research into newly qualified nurses working as practice supervisors. From the findings of this study, the practice

of future practice supervisors could be considered as an unexplored area of nursing research that has potential for further enquiry. A newly qualified nurse should no longer be viewed as someone who simply looks after the students when not with their mentor. The value of a stage 1 mentor has been shown to be a significant and important role to the participants in this study, and should be recognised as such, especially in light of the new practice supervisor role.

This study looked at the experience of stage 1 mentors, i.e. mentors who were newly qualified as nurses and who had not received the statutory preparation required to be fully recognised mentors in the context of pre-registration nurse education. As the new standards are now operationalised, and nurses are carrying out the practice supervisor role, they might find themselves in situations experienced by the research participants in this study, in that they have received no formal preparation. Currently, statutory preparation for practice supervision is no longer available and preparation of new registrants becomes the responsibility of the employing NHS Trust. Therefore, the results of this research can be viewed as a significant contribution to policy and practice in the future, and essential for all those who supervise student nurses in practice.

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Appendices

Appendix 1: The Domains of Practice Associated with the Stage 1 and Stage 2 Mentor (NMC, 2008)

<i>Domain</i>	Stage 1	Stage 2
<i>Establishing effective working relationships</i>	<p>Work as a member of a multi-professional team, contributing effectively to team working. Support those who are new to the team in integrating into the practice learning environment.</p> <p>Act as a role model for safe and effective practice. Develop effective working relationships based on mutual trust and respect.</p>	<p>Demonstrate an understanding of factors that influence how students integrate into practice settings.</p> <p>Providing ongoing and constructive support to facilitate transition from one learning environment to another.</p>
<i>Facilitation of learning</i>	<p>Co-operate with those who have defined support roles contributing towards the provision of effective learning experiences. Share their own knowledge and skills to enable others to learn in practice setting.</p>	<p>Have effective professional and interprofessional working relationships to support learning for entry to the register. Use knowledge of the student's stage of learning to select appropriate learning opportunities to meet individual needs.</p> <p>Facilitate the selection of appropriate learning strategies to integrate learning from practice and academic experience. Support students in critically reflecting upon their learning experiences in order to enhance future learning.</p>
<i>Assessment and accountability</i>	<p>Work to the NMC Code for nurses and midwives in maintaining own knowledge and proficiency for safe and effective practice. Provide feedback to others in learning situations and to those who are supporting them so that learning is effectively assessed.</p>	<p>Foster professional growth, personal development and accountability through support of students in practice Demonstrate a breadth of understanding of assessment strategies and ability to contribute to the total assessment process as part of the teaching team. Provide constructive feedback to students and assist them in identifying future learning needs and actions. Manage failing students so that they may enhance their performance and capabilities for safe and effective practice or be able to understand their failure and the implications of this for their future. Be accountable for confirming that students have met or not met the NMC competencies in practice and as a sign-off mentor confirm that students have met or not met the NMC standards of proficiency and are capable of safe and effective practice.</p>
<i>Evaluation of learning</i>	<p>Contribute information related to those learning in practice, and about the nature of learning experiences, to enable those supporting students to make judgements on the quality of the learning environment.</p>	<p>Contribute to evaluation of student learning and assessment experiences, proposing aspects for change resulting from such evaluation. Participate in self and peer evaluation to facilitate personal development and contribute to the development of others.</p>
<i>Create an environment for learning</i>	<p>Demonstrate a commitment to continuing professional development to enhance own knowledge and proficiency.</p> <p>Provide peer support to others to facilitate their learning.</p>	<p>Support students to identify both learning needs and experiences that are appropriate to their level of learning.</p> <p>Use a range of learning experiences, involving patients, clients, carers and the professional team, to meet defined learning needs.</p> <p>Identify aspects of the learning environment which could be enhanced, negotiating with others to make appropriate changes. Act as a resource to facilitate personal and professional development of others.</p>

Context of practice

Evidence-based practice

Leadership

Whilst enhancing their own practice and proficiency, a registered nurse or midwife must act as a role model to others to enable them to learn their unique professional role.

Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated.

Set and maintain professional boundaries that are sufficiently flexible for providing interprofessional care.

Initiate and respond to practice developments to ensure safe and effective care is achieved and an effective learning environment is maintained.

Further develop their evidence base for practice to support their own personal and professional development and to contribute to the development of others.

Identify and apply research and evidence-based practice to their area of practice.

Contribute to strategies to increase or review the evidence base used to support practice.

Support students in applying an evidence base to their own practice.

Use communication skills effectively to ensure that those in learning experiences understand their contribution and limitations to care delivery.

Plan a series of learning experiences that will meet students' defined learning needs.

Be an advocate for students to support them accessing learning opportunities that meet their individual needs, involving a range of other professionals, patients, clients and carers.

Prioritise work to accommodate support of students within their practice roles.

Provide feedback about the effectiveness of learning and assessment in practice.

Appendix 2: Roles and Responsibilities of the Practice Supervisor

In accordance with the SSSA (NMC, 2018c), a Practice Supervisor is a registered nurse, midwife or registered healthcare professional who will support learning in line with their scope of practice. The PS will have current knowledge and experience of the speciality in which they work and be appropriately prepared to ensure that learning opportunities are facilitated. The PS will be given sufficient opportunities to engage with Practice Assessors (PA) and Academic Assessors (AA). In addition, roles include:

- Serve as role models for safe and effective practice in line with the code of conduct.
- Ensure learning opportunities are facilitated.
- Contribute to the student's record of achievement by periodically recording relevant observations of conduct, proficiency and achievement.
- Contribute to assessment to inform decisions and record regular feedback.
- Support and supervise students, providing feedback on their progress towards, and achievement of, proficiencies and skills.
- Receive ongoing support to reflect and develop in this role.

Appendix 3: Databases Used in the Electronic Search

Databases used in the electronic search

- **CINAHL Plus** (the cumulative index to nursing and allied health literature, indexing more than 4500 journals of nursing and allied health from 1937 to the present day).
- **Cochrane Library** (systematic reviews of literature on medicine, nursing and professions allied to health).
- **Blackwell Synergy** (an online journals service from Blackwell Publishing. It holds the full-text articles of over 850 journals, the majority of which are published by Blackwell on behalf of international scholarly and professional societies).
- **PubMed** (>20million citations for biomedical literature from MEDLINE, life science journals and online books).
- **SCOPUS** (a multidisciplinary indexing and abstracting database, covering citations from journals, the Web, patent databases and other sources in the sciences, social sciences and the arts & humanities publications).
- **Nursing and Midwifery Council** (accessed for grey literature pertaining to mentorship in nursing).
- **Department of Health** (accessed for recent publications related to nursing strategies).

Appendix 4: Table of Literature Review Papers

Key = Qualitative papers in **yellow**, quantitative papers in **green** and mixed methods in **blue**. Other, including discussion papers, literature reviews, concept analyses, in **grey**.

Conceptualisations of Mentorship in Nursing				
Author(s) & year of study	Title	Aim of study	Methodology	Study findings
Stewart, B.M. & Kreuger (1996)	An evolutionary concept analysis of mentoring in nursing	To provide an understanding of the meaning of mentoring in nursing, its current status, and the conceptual clarity necessary for additional systematic and rigorous enquiry to further directives.	The concept of mentoring is analysed using the framework developed by Walker and Avant.	Mentoring relationships, professional or otherwise, are essential to graduate nursing education.
Hodgson, K.A., Scanlan, J.M. (2013)	A concept analysis of mentoring in nursing leadership	To provide a greater understanding of mentoring and its importance in today's healthcare system.	The concept of mentoring is analysed using the framework developed by Walker and Avant.	Mentoring is an invaluable tool for the future of nursing leadership and should be highly regarded as a way to promote and support nursing leaders; it is a mechanism critical to the future of the nursing profession.
National Nursing Research Unit Kings College London Policy Plus (2013) UK	Should all nurses be mentors?	Policy Plus presents a rethink of the role of mentor	Policy from the National Nursing Research Unit	
Ferguson, L.M. (2011) Canada	From the perspective of new nurses: What do effective mentors look like in practice?	To explore nurses' perspectives on what makes a mentor effective, and how they engaged in mentoring relationships with their informal mentors.	Qualitative Grounded theory. 25 participants. Audio recorded ss interviews. All participants interviewed 2-3 times. Constant comparative analysis. Data collection continued until saturation.	New nurses entered practice expecting to learn from their more experienced colleagues but recognised that they wanted to emulate the practice of experienced nurses who practised nursing in the way new nurses idealised.
Preparation and Support for Mentorship in Nursing				
Author(s) & year of study	Title	Aim of study	Methodology	Study findings
Middleton, R., Duffy, K. (2009). UK	Mentoring a student immediately prior to registration: a qualitative study	To explore the experiences of community nurses mentoring a pre-registration student immediately prior to registration.	Qualitative study using three focus groups. Purposive sampling to select 12 community mentors who have mentored at least one diploma student prior to registration.	Analysis suggests the community nurse mentors require support and development opportunities in relation to mentoring and assessing final placement preregistration students.
Wilson, A.M.E. (2014)	Mentoring student nurses and the educational use of self: A hermeneutic	To achieve a deeper understanding of the lived experience of mentoring, searching for insights into	Qualitative hermeneutic phenomenological methodology drawing on Heidegger. Twelve mentors	The educational use of self offers insight into the lived experience of mentors, and exposes the potentially hidden elements of

UK	phenomenological study	how mentors can be better prepared and supported.	were recruited via purposive and snowball sampling. Method: Participants described their experiences of mentoring through in-depth interviews and event diaries which included 'rich pictures'. Analysis involved the application of four lifeworld existentials proposed by van Manen — temporality, spatiality, corporeality and relationality.	mentoring experience, which can inform mentor preparation and support.
McGuinness, C., McCallum, J., Duffy, K. (2016) UK	Preparing registrants for mentor roles: the chicken or egg conundrum	Discussion paper highlighting the need to support registrants when preparing to become mentors.	Discussion paper	Lecturers should be supported in adopting the role of supervising mentor and to support registrants' mentorship professional development.
Duffy, K. Docherty, C., Cardnuff, L., White, M., Winters, G., Greig, J. (2000) UK	The nurse lecturer's role in mentoring the mentors	Investigating the effectiveness of current arrangements for mentor preparation and ongoing mentor support provided within adult placement areas within Greater Glasgow Health Board.	Quantitative non-experimental survey design A sample of 150 mentors was surveyed with a response rate of 47 per cent (n=71).	Results indicate that although mentors are generally satisfied with the current approach to mentorship preparation, the issue of support from both managers and academic staff is problematic. Mentors indicated that they wished to see lecturers visiting the practice placement areas and providing support, particularly in relation to assessment of students.
Myall, M., Levett-Jones, T. and Lathlean (2008) UK	Mentorship in contemporary practice: the experiences of nursing students and practice mentors	This study explores the role of mentor in contemporary nursing practice in the UK.	Quantitative survey of pre-qualifying students and practice mentors. Data were collected using an online survey questionnaire of pre-qualifying students and a postal questionnaire for practice mentors.	The findings highlight the importance of mentorship for prequalifying students and emphasise the need to provide mentors with adequate preparation and support. They confirm previous research, but also highlight improvements in bridging the gap between rhetoric and reality for mentorship.
Douglas, V., Garrity, J., Shepherd, C.K., Brown, L. (2016). UK	Nurses' perceptions and experiences of mentoring	To identify how mentors perceive support from link lecturers and PEFs.	A quantitative survey was devised to gather quantitative and qualitative data with questions linked to themes that arose in other studies. Qualitative data were obtained from three open-ended questions related to student failure and mentor support. Participants were registered nurses and NMC-approved mentors (n=4,341), response rate was 41%.	The findings suggest that mentors value support from link lecturers and practice education facilitators, especially when they experience difficulties with nursing students who do not have the required competencies to pass their placement.

Nurses and Students' Experiences of Mentorship in Nursing				
Author(s) & year of study	Title	Aim of study	Methodology	Study findings
Andrews and Chilton (2000) UK	Student and mentor perceptions of mentoring effectiveness.	To explore the views of staff nurses and students about the mentoring process.	A small pilot study conducted over a 3-month period. Views of 22 mentors and 11 mentees purposefully selected. Questionnaires were used as the main data.	The findings demonstrate that mentors with a teaching and assessing qualification consistently rated themselves higher (total MMP score) than those without (median score of 50 and 41 respectively). Students in the study consistently awarded mentors higher ratings than the mentors awarded themselves.
Foster H, Ooms A, Marks-Maran D, (2015). UK	Nursing students' expectations and experiences of mentorship	This study aimed to gain a greater understanding of students' expectations and experiences of mentorship and to identify the kind of support provided by the mentor that is most valued by the student, the role of the link lecturer in mentorship and how the university might further enhance the mentorship experience of their students.	Mixed-methods exploratory sequential design was used. The research involved two stages: a semi-structured focus group in the first stage and an online questionnaire in the second. 53 students completed the questionnaire (response rate= 45%).	Students' experiences were largely positive. The most valued mentor activities included teaching and explaining, support and supervision, and encouragement.
Cahill, H.A. (1996) UK	A qualitative analysis of student nurses' experiences of mentorship	To explore what student nurses themselves thought about mentorship.	Qualitative. Using group discussion and individual interviews, the views of 16 third-year students on a traditional RGN programme were explored, and the resulting qualitative data organised and presented using a method of thematic analysis.	Examples of supportive, non-supportive and unsupportive relationships were described. Mentorship was described in terms of assessment and appraisal; the student's apparent preoccupation with achieving a satisfactory ward report clearly influenced both their relationships and behaviour with trained staff. Mentorship for these students seemed to be more about control than support.
Effects and Outcomes of Mentorship in Nursing				
Author(s) & year of study	Title	Aim of study	Methodology	Study findings
Gray M.A. & Smith L.N. (2000) UK	The qualities of an effective mentor from the student nurse's perspective: Findings from a longitudinal qualitative study	To discover the effect(s) of mentorship on student nurses following the introduction of the 1992 programme of education leading to a Diploma of Higher Education in Nursing and registration with the (UKCC).	Longitudinal cohort study using grounded theory. Sample of 10 students who kept a diary. Interviews on five occasions over three years.	Diploma students quickly lose their idealistic view of their mentor and over time develop an insight into the qualities they perceive are required of an effective mentor. Students quickly become aware of the importance of choosing good role models and learning their own mentor's likes and dislikes as they realise this impinges on the outcome of their assessment.

Donaldson, J.H., Carter, D. (2005) UK	The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students	To explore the value of role modelling in teaching and learning within the clinical area.	Grounded theory Views of undergraduate ($n = 20$) and diploma ($n = 22$) nursing (adult) students were sought using individual and focus group interviews.	'Good' role models were seen to have a tremendous influence on the clinical learning environment and on the development of students' competence and confidence.
Eller, L. S., Lev, E.I., Feurer, A. (2013) USA	Key components of an effective mentoring relationship: A qualitative study	To identify key components of an effective mentoring relationship identified by protégés–mentor dyads in an academic setting	Qualitative study. Purposive sampling from 12 universities in the USA. Twelve workshops using the Technology of Participation© method were held with 117 mentor–protégé dyads. Conventional content analysis	8 key themes described an effective mentoring relationship-
MacLaren, J.A. (2018) UK	Supporting nurse mentor development: An exploration of developmental constellations in nursing mentorship practice	This paper explores the supportive relationships of nurses undertaking a mentorship qualification, using the novel technique of constellation development to determine the nature of workplace support for this group.	Qualitative. Semi-structured interviews were conducted with three recently qualified nurse mentors. All participants developed a mentorship constellation identifying colleagues significant to their own learning in practice. These significant others were also interviewed alongside practice education and nurse education leads. Constellations were analysed in relation to network size, breadth, strength of relationships, and attributes of individuals.	Findings suggest that dyadic forms of supervisory mentorship may not offer the range of skills and attributes that developing mentors require. Wider nursing teams are well placed to provide the support and supervision required by mentors in training.
Felstead, I.S., Springett, K. (2016) UK	An exploration of role model influence on adult nursing students' professional development: A phenomenological research study	To explore nursing students' choice of role models and their lived experience of role modelling with a particular focus on the development of adult nursing students as professional practitioners.	Qualitative IPA. This study explored twelve adult nursing students' lived experiences of role modelling through an interpretive phenomenological analysis approach	Identifying and educating mentors who are ready, willing and able to role model professional attributes appear crucial to developing professionalism in nursing students.
Jack, K., Hamshire, C., Chambers, A (2017) UK	The influence of role models in undergraduate nurse education	To explore the concept of role modelling in undergraduate nurse education and its effect on the personal and professional development of student nurses.	A qualitative descriptive narrative approach. Unstructured interviews were conducted with 14 nursing students from UK. Data were thematically analysed.	Students valued exposure to positive role models in clinical and university settings and viewed them as beneficial to their learning. Exposure to negative role models occurred, and this provided students with opportunities to consider the type of nurse they aspired to become.
Levett-Jones, T. & Lathlean, J. (2008).	Belongingness: A prerequisite for nursing students' clinical learning	This paper reports on the selected findings from the qualitative phase of mixed-methods study that explored nursing students' experience of	Qualitative phase of mixed-methods study. 18 interviews. Thematic analysis.	The theme of belongingness dominated all of the interviews. Given that the primary purpose of clinical placements is for students to learn to nurse, there needs to be a clear understanding of the

		belongingness while on clinical placements.		relationship between belongingness and learning.
Carey, M.C., Kent, B., Latour, J.M. (2018) UK	Experiences of undergraduate nursing students in peer assisted learning in clinical practice: a qualitative systematic review	To identify and synthesise the best available evidence on experiences of peer assisted learning (PAL) among student nurses in clinical practice so as to understand the value of PAL for this population.	Qualitative systematic review. The systematic review considered qualitative studies that included male and female nursing students aged between 18-50 years. Quantitative studies excluded.	3 main themes synthesised are: 1. Challenges of clinical practice are mitigated by peer support. 2. Support and feedback develop competence and confidence and reduce stress and anxiety. 3. Peers are role models for enhancing clinical knowledge
Carey, M.C., Chick, A., Kent, B., Latour, J.M. (2018) UK (Nurse Ed Today)	An exploration of peer-assisted learning in undergraduate nursing students in paediatric clinical settings: An ethnographic study	To explore peer-assisted learning in undergraduate nursing students, studying children's health, in the clinical practice setting.	A qualitative ethnographic study using non-participant observations. 17 1 st , 2 nd & 3 rd year student nurses. Non-participant observations were used to observe a range of interactions between the participants when engaging in peer-assisted learning within the same clinical area. A total of 67 h of raw data collected across all observations were analysed using framework analysis to draw together key themes.	3 key themes: 1. Peers as facilitators to develop learning when engaging in peer-assisted learning. 2. Working together to develop clinical practice and deliver care. 3. Positive support and interaction from peers to enhance networking and develop working structure.
Huybrecht, S., Loeckx, W., Quaeyhaegens, Y., DeTobel, D., Mistiaen, W. (2011). BELGIUM	Mentoring in nursing education: Perceived characteristics of mentors and the consequences of mentorship	The study investigates 1) how mentors perceive themselves, 2) which problems do they encounter, 3) what do mentors consider the advantages/drawbacks and 4) what is the main source for help in mentoring students.	Mixed methods including questionnaire and semi-structured interviews. Response rate 62%	The ability to give feedback, experience, availability of time and a positive attitude were the elements considered important for mentors. Despite the benefits outweighing the drawbacks, support by mentoring courses, additional study and especially of link lecturers proved to be beneficial.
Challenges of Mentorship in Nursing				
Author(s) & year of study	Title	Aim of study	Methodology	Study findings
Bachmann, L., Groenvik, C.K.U., Hauge, K.W., Julnes, S. (2019) NORWAY	Failing to Fail nursing students among mentors: A confirmatory factor analysis of the Failing to Fail scale	To explore the psychometric properties with respect to the internal consistency reliability of the subject-specific questionnaire "Failing to Fail."	Cross-sectional study, Questionnaire. Exploratory factor analysis with varimax rotation. A confirmatory factor analysis was used to examine the factor structure of the "Failing to Fail" scale. A total of 561 Norwegian nurse mentors responded to the questionnaire, resulting in a response rate of 23.6%.	The confirmatory factor analysis confirmed a five-factor structure of the "Failing to Fail" scale. The scale proved to be feasible to test whether mentors are Failing to Fail nursing students. The confirmatory factor analysis model supported the predictive validity of the "Failing to Fail" scale.

Duffy, K. (2003) UK	Failing Students: A Qualitative Study of Factors that Influence the Decisions Regarding Assessment of Students' Competence in Practice	To uncover mentors' and lecturers' experiences regarding this issue and to explore their individual perceptions about why some student nurses are being allowed to pass clinical assessments without having demonstrated sufficient competence.	Qualitative grounded theory. The sample consisted of 14 lecturers and 26 mentors. One-to-one interview with participants. Data collection commenced using unstructured interviews, moving to semi-structured interviews with ongoing data analysis.	Findings reveal that students are passing clinical assessments even when there are doubts about their clinical performance. Some mentors are unwilling to put pen to paper regarding these concerns, which presents lecturers and subsequent mentors with difficult moral dilemmas. Preparing mentors for their role and responsibility in a fail scenario was vital as was adequate support from both education and practice.
Gainsbury, S (2010)	Mentors passing students despite doubts over ability	To examine the extent to which nurse mentors pass students who should fail.	Quantitative survey. Online questionnaire to 2000 nurse mentors.	37% of mentors who have passed students about competence or attitude thought they should be failed. No response rate mentioned.
Brown, L., Douglas, V., Garrity, J., Shepherd, C.K. (2012)	What influences mentors to pass or fail students	To establish mentorship practice in relation to the University of the West of Scotland pre-registration nursing students.	Non-experimental survey. 29 item questionnaires were sent to 4,341 mentors, with a 41 per cent response rate.	Results show that 18 per cent of participants had passed a failing student. A number of factors influenced mentors' decisions, which to some extent echo findings from previous research.
Black, S., Curzio, J., Terry, L. (2014)	Failing a student nurse: a new horizon of moral courage	To explore the factors that prevent registered nurses from failing students in practice.	Qualitative hermeneutic study. Sample of 19 mentors for 7 different healthcare organisations. Semi-structured interviews.	Three key themes – 'the personal price', 'a sense of professional responsibility and accountability' and 'having the strength' – emerged.
Mead, D., Hopkins, A., Wilson, C. (2011) UK	Views of nurse mentors about their role	To expand the knowledge base around mentorship to explore best practice in nurse mentorship and student education. To explore the views and experiences of mentors about assessing the clinical performance of nursing students at the borders of achieving clinical competency.	Mixed methods. Survey (n=94) and group interviews (n=50 mentors).	Quantitative data revealed differences to those of Gainsbury. 95% revealed that they did not lack confidence if failing student. Qualitative data suggest mentors were confident they had received sufficient training to manage failing students. Findings differ from those of Gainsbury 2010.
McIntosh, A., Gidman, J., Smith, D. (2014) UK	Mentors' perceptions and experiences of supporting student nurses in practice	To explore the perceptions and experiences of mentors regarding student nurse support in practice.	The study employed a mixed-method approach, using questionnaires and focus groups with mentors from one Acute Trust and one Community Trust.	Mentors were aware of their roles and responsibilities in supporting students and recognised the importance of their own personal attributes. However, participants reported a number of challenges, particularly time, competing demands and paperwork, and suggested that a team approach and support groups could help to overcome these

Appendix 5: Information Sheet for Participants

University of Hertfordshire

Information Sheet for Participants

Title of the research: Newly Qualified Nurses' Early Experiences of Working as Unqualified Mentors.

Introduction

You are being invited to take part in a research study being conducted for my Professional Doctorate in Education at the University of Hertfordshire. Before you decide to participate, it is important for you to understand why the research is being done and what your involvement will include. Please take time to read the following information carefully. Ask me if there is anything that is not clear or if you would like more information. Please do take your time to decide whether you wish to take part. Thank you for your time.

The background to the research

Increasingly, newly qualified nurses are being introduced to mentorship despite having no formal training or preparation to take on the role as a stage 1 mentor. The NMC Code Section 9 (2018) states that nurses must share their skills, knowledge and experience for the benefit of people receiving care and your colleagues. Therefore, supporting and developing the skills of newly qualified nurses in the practice area is key to the development of students.

What are the aims and purpose of the research?

The overall aim of the study was to gain a greater understanding of what it is like to experience the phenomenon of newly qualified nurses' early experiences of working as unqualified mentors. Understanding how their experiences will provide insight into how it feels for them and what early exposure to mentorship means to them. It is anticipated that the findings will trigger further interest in this area and be considered for future curriculum development and contribute to establishing the most effective ways of preparing future newly qualified nurses for mentorship.

Why have I been invited to participate?

I would very much like to hear your experiences of mentorship from when you became a newly qualified nurse to now.

Do I have to take part?

No. Participation is completely voluntary. It is entirely up to you to decide whether to take part in the research. If you decide to take part, you are still free to withdraw at any time by e mailing me on l.lawson@herts.ac.uk and without giving a reason.

What are the possible disadvantages, risks or side effects of taking part?

There are no side effects or risks to taking part. We are asking you to share your experiences and ideas. You do not have to answer any questions you are uncomfortable with and can choose to say as much or as little as you want within the discussions.

What are the possible benefits of taking part?

The information that is collected during this study will give me a better understanding of how the university and practice area can better prepare newly qualified nurses for mentorship. There may be no direct benefits to the participants of this study but changes to mentoring practice may be made following the completion of the study.

Would my taking part in this study be kept confidential?

In line with the Data Protection Act (1998) and the University of Hertfordshire ethical guidelines, all information collected about you during the research will be kept strictly confidential. The consent for that you sign will be kept in paper form in a locked cabinet in the office of the researcher. Audio recordings of the interviews will be kept on my password protected iPad. Transcribed data from your interview will be analysed and key themes will be identified. Data will be anonymised and stored in a separate and secure location and destroyed at the end of the study.

What will happen to the findings of the research study?

Outcomes and recommendations of the study will form actions for pre and post qualifying nursing education. Findings will be presented as my dissertation and for publication in nursing journal and in relevant conference presentations.

Will any readers be able to identify individuals?

Data from your interview may be included in these outputs but any information will be anonymised and not attributable to any person. All of the information will be presented in an anonymous form and will be password protected. Any reports or publications relating to the study will be completely anonymous too. The study has been approved by the University of Hertfordshire School of Education Ethics committee. If you have any concerns about the conduct of this research project, you can contact my supervisor.

Contact for further information:

I am very happy to discuss any issues or questions you might have before making any decision. Please feel free to e mail or call me using the details above. I will of course be happy to speak to you to clarify any questions you may have.

Thank you very much for reading this information and considering taking part in my study.

Louise Lawson (Researcher)

l.lawson@herts.ac.uk

07930561975

Appendix 6: Consent Form

I have read the attached information and agree to participate in this research.

(Please circle) Yes or No

I am aware that what I say in any interviews will be anonymised for this research and I agree to the interview being recorded. I understand that the recordings will be stored safely during the research and will be erased on completion of the study. I understand that the information may be published but my name will not be associated with the research.

(Please circle) Yes or No

I understand that I am free to deny any answer to specific questions. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty. I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

(Please circle) Yes or No

I am clear that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without affecting my rights and without affecting my assessment as a student at this university.

(Please circle) Yes or No

Signature:.....

Name:..... *(this will be kept confidential)*

Date:.....

Thank you again.

Louise Lawson (Researcher)

This form will be stored separately from any interview data.

Researcher

Primary Research Supervisor

Louise Lawson, Principal Lecturer

Professor Philip Woods

University of Hertfordshire

Tel: 01707 285642

School of Health & Social Work

E mail: p.a.woods@herts.ac.uk

College Lane. Hatfield Herts. AL10 9AB

Tel: 01707 285939 E mail: l.lawson@herts.ac.uk

Appendix 7: Interview Guide

Opening and Introduction: Introduce myself and the aims of the study. Reiterate that this interview will remain anonymous and what the intended outcomes are. Allow the participant to settle and ask any questions prior to the interview. Remind the participant that the interview will be recorded and that the interview will be terminated at any point should they wish.

Broad opening question: Can you tell me a little bit about yourself as a newly qualified nurse and working as a stage 1 mentor?

Specific questions relating to mentoring students?

- Can you tell me how you felt about some of your first experiences when working with students?
- Can you give me some examples of your experiences of mentoring students?

Specific questions relating to experiences of their readiness and preparedness for mentorship:

- What were your expectations of mentoring students when you first qualified as a nurse?
- How prepared did you feel to carry out the stage 1 mentor role when you first qualified as a nurse?
- Can you tell me about your preceptorship programme and to what extent this might have prepared you for the stage 1 mentor role?
- What does it mean to you when we talk about being prepared for mentorship?

Specific questions relating to their identity as a stage 1 mentor:

- Can you tell me what you perceive your professional position to be within the mentorship team?
- How did you identify with being a stage 1 mentor?
- How do you feel that others saw you as a stage 1 mentor?

Specific questions relating to their experiences of transition into mentorship:

- Can you tell me how you feel you moved into stage 1 mentoring from becoming a staff nurse?
- Can you tell me about the nature of support given to you as a new nurse and stage 1 mentor?
- What factors enabled you through your transition into mentorship?

Specific questions on learning how to do mentorship:

- Can you tell me how you think you learnt to do mentoring at your work?
- Can you say who you turned to for support if any?
- Can you tell me what knowledge and skills you think you needed to be a stage 1 mentor?

On the nature of the workplace when working as a stage 1 mentor:

- Can you tell me a little bit about how you were treated as a newly qualified nurse working as a stage 1 mentor?
- How did you feel about being part of the mentorship team?

Prompts – can you tell me a bit more about that? Go on. How did that make you feel? Is this different now to how you felt at the beginning? End with closing questions. Is there anything else you want to add?

Appendix 8: Approval of Ethics Application Form



FACULTY OF HUMANITIES, LAW & EDUCATION

Approval of Ethics Application Form

(for a study programme involving human informants)

Applicant: Louise Lawson

Supervisors: Philip Woods and Roger Levy

Date: 24 November 2012

Title of study programme: To advance understanding of the knowledge and skills, and the preparation, required for stage 1 mentoring.

Protocol no: 11-12.1

Dear Louise

I am pleased to confirm that your revised application for the above study has been approved by the Chair of the Faculty Ethics Committee with an investigation end date of 1 September 2014.

Obviously, the start date for your research has also been revised to start from 24 November 2012, rather than 1 November 2012, in accordance with the approval date.

If this investigation will not be completed by the 1 September 2014 then please can you resubmit your application with an extension request to the Faculty Ethics Committee for consideration.

I will contact you nearer the time asking you to confirm whether or not you would be interested in applying for an extension to your project or if you intend to meet the agreed deadline.

If you have any other ethics related questions then please do not hesitate to contact me.

May I wish you all the best with your research.

Kind regards

Julia

Julia Ratcliffe

Senior Administrator (Academic Quality)

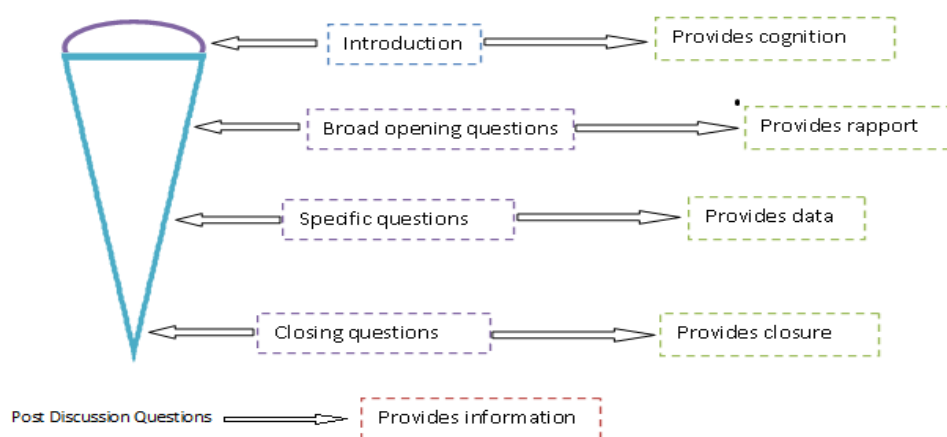
Faculty of Humanities, Law and Education

Room R343, de Havilland Campus. Tel: 2649 Email: J.Ratcliffe@herts.ac.uk

Appendix 9: Interviewing Using the Funnel Technique

I began with an introduction to warm up the discussion, followed by broad opening questions to provide rapport, then moved to more specific questions and prompts in order to stimulate conversation and provide rich data. I then finished with broader closing questions to provide closure as shown below:

Funnel Design for Questioning (Based on Hennink et al., 2011)



Introduction – Consideration was given to how to introduce questions and topics in a conversational manner and to include introductory, linking and key questions. At the start of the interview, first name introductions were made, and permission was gained to use the audio recorder. In order to make participants feel at ease, an overview of the study was repeated providing information on how the interview would be conducted. In order to break the ice, the introductory or opening question posed to the participant was ‘*Can you tell me a little bit about your place of work?*’ Hennink et al. (2011) report that an opening question should be a brief and factual one that encourages open conversation.

Broad Opening Questions – The introductory questions were followed by broad general questions such as ‘*Can you tell me a little bit about yourself as a nurse and stage 1 mentor?*’ Followed by, ‘*What does this mean to you as a nurse?*’ These broad questions were asked to encourage the participants to talk about stage 1 mentorship in their own words in order to contextualise the forthcoming discussion. In general, early questions allowed participants to recount a fairly descriptive experience of their stage 1 mentorship practice – for example, ‘*Can you tell me the sort of things that you do in your role as stage 1 mentor?*’ Once the participant became comfortable talking, questions became more specific as they eased into the interview.

Specific Questions – The participants were prompted to talk about both positive and negative experiences in order to allow in-depth exploration of the nature of stage 1 mentorship practice. The discussion then flowed freely with minimal prompts being needed to elicit natural interactions between myself as the interviewer and the participant. An example of a specific question posed is, *'How do you identify with being a stage 1 mentor?'* An example of a linking, or transition question to move on to another topic is *'Let's now talk about what support/preparation you think newly qualified nurses need in order to fulfil this role'*.

Closed questioning was minimised so that participants could raise and discuss issues relevant to them and allowing them to talk in as much depth as they felt comfortable (Owen, 2001). In fact, one of the most consistent threads in the literature is the vital importance of using non-directive questions to elicit spontaneous expression among participants (Kidd and Parshall, 2000; Hudson, 2003; Rabiee, 2004). Probing was utilised and was a valuable technique in gaining greater detail from the participant to obtain more in-depth information. The aim of probing was to follow up questions that I did not fully understand, that were interesting, when the answer was vague or I wanted to hear more. Probing enabled me to search further into the reality of the stage 1 mentor role and deepen the response to a question, thus increasing the richness of the data. Clearly, probing not only provided a signal to describe and develop views further, but it also encouraged the participant to speak in depth about issues that might not have been mentioned before. Furthermore, I anticipated that snowballing might occur, whereby the participants' responses trigger other responses, adding to the richness of the data, as emphasised by Hudson (2003). During this interview phase, I was able to leave my 'researcher world' and enter into the participants' world. Participants were encouraged to talk at length, and my verbal input was kept to a minimum.

Closing Questions – The discussion concluded with more general questions summarising and clarifying salient points raised, as well as asking participants if this accurately reflected the conversation. Participants were also asked if they had any further comments to make, the session closed and the audio recorder was stopped.