Sharing learning resources: workplace learning, mentoring & assessment

Chris Morgan  
Southern Cross University

Meg O'Reilly  
Southern Cross University

J Stewart

Publication details
Sharing Learning Resources: Workplace learning, mentoring and assessment

Julia Stewart  
Health/University Liaison Officer  
Southern Cross University

Chris Morgan  
Instructional Designer  
Centre for Professional Development in Health Sciences  
Southern Cross University

Meg O’Reilly  
Instructional Designer  
Centre for Professional Development in Health Sciences  
Southern Cross University

Abstract

This paper is a report of an example of two organisations sharing resources to provide a workplace based learning and assessment model for registered nurses. The issue of mentorship has been explored in the context of a nurse education program offered in distance mode. The role of the Clinical Teaching Associate (CTA), a workplace mentor and assessor is the focus of the paper which explains the model's evolution over the past seven years.

Whilst there is still much to learn about facilitating workplace mentorship, this paper throws considerable light on the issues associated with partnerships between industry and higher education in the provision of relevant, rewarding workbased learning.

Introduction

This paper examines a model of tertiary accredited workplace learning which has spanned some seven years. The Clinical Teaching Associate initiative (hereafter referred to as the model) was established as part of a joint venture arrangement between the NSW North Coast Health Region (now defunct) and Southern Cross University Faculty of Health Sciences. It was premised on the belief held by both Health Services staff and Faculty that experienced nurse clinicians are the most appropriate people to foster the advancement of clinical skills in formal education. Andrew Restas, a leading Australian nurse (1991) captured this sentiment by stating:

'(p)рактический опыт работы требуется становится равным партнером в обучении и преподавании о том, что составляет суть работы. Бремя необопдимой ответственности, которое несет на себя учителя или очевидцы, может стать общей и в процессе, оба могут научиться новым способам самообразования, которые не связаны с актами самой себя, территориального строительства и расстройства от нас самих и других.' (page 3)

The model presented in this paper is premised on the notions that:

- the current nurses' industrial award identifies specialist and consultant clinicians who have a designed role in clinical skill support and monitoring
- the best people to teach advanced skills are workplace specialists
- skilled nurse clinicians often feel undervalued
- job enrichment opportunities are necessary in a static workforce
- clinical standards can be enhanced through structuring a clinical assessment process that integrates the judgement of a nurse specialist in the context of the workplace
- workplace based clinical skills development and assessment brings considerable credibility to formal education.
For the purposes of administrative convenience, the model came under the auspices of The Centre for Professional Development in Health Sciences, Southern Cross University, which offers opportunities for registered nurses to upgrade their clinical skills in a tertiary level course in an open learning environment. In 1990 when the model was first mooted there were no known operating models of its kind. An experimental approach was therefore taken in planning, implementation and ongoing evaluation. This paper critically reviews the model’s progress through these first seven years. The target group of learners were experienced nurses primarily with two requirements: seeking a mechanism to upgrade their professional qualifications in a clinically relevant manner. Parts of the industrial award within which nurses work, accommodate clinical teaching positions. All workplaces therefore had access to clinical nurse specialists and consultants who, as part of their award role, were required to provide clinical staff education. However, one of the commonly reported problems in implementing these award positions was that there were few formally recognised frameworks within which these specialist staff could effect their role in any structured way as clinical teachers. This was then seen by the course developers as a golden opportunity to link the clinical education needs of the tertiary course with structures already in place in the workplace and so enhance the intent of the industrial award.

The model

Work based learning
The workbased learning and mentorship model is grafted upon the Bachelor of Health Science in Nursing, a program for registered nurses to upgrade their qualifications via distance education. The degree is so structured that nurse learners integrate workplace based clinical skill building as part of their coursework. This can take several forms, from the simple; completion of prescribed advanced nursing skills through to the more complex; development of an independent clinical learning contract. Because experienced clinicians work alongside the nurse learner they are ideally situated to act as a mentor and guide. These roles are of particular value when assisting learners to develop a clinically appropriate contract to advance their clinical practice in a nursing speciality.

Mentoring
The workplace mentor is an expert nurse clinician with training in clinical teaching. It is a multi-faceted role, involving:
• teaching, fostering and practising clinical skills with learners
• helping learners to devise learning contracts
• acting as resource advisor
• facilitating learning, particularly helping learners to bridge theory with practice
• modelling best practice.

Through example and discussion the mentor may foster improvements in nursing education and nursing care within the defined clinical area. Both learners and clinicians are served by this model which reflects current trends in education, including reflective practice (Schön, 1987), building on existing knowledge and the achievement of identified nursing competencies.

Mentors were trained into the role with a 150-hour learning program covering clinical teaching and learning, mentorship and assessment. They were nominated for the role by nurse managers, mostly on the basis of their existing status as clinical experts and trained by university staff. Questions of time allocation for the role and recognition of mentors by partners were not envisaged in the construction of the model.

Assessment
Clinical assessment – the assessment of clinical skills plus reflection on learning, are also undertaken by the mentor. In order to match the theoretical component of study with frequent changes of nursing practice, the mentorship model was set up as a self-supporting network to be active while all participated in the processes of change. This serves the education provider, the University, by assuring up to the minute clinically
qualified supervision of practice skills. It was also intended to have practitioner input to sustain the clinical relevance of study materials. Once the learner feels sufficiently confident to be assessed, they negotiate a mutually convenient time for their clinical skills assessment. Again, this is done in the familiar surrounds of the workplace with an assessor who has previously had a nurturing role in the learner's skill development. The assessment process is integrated as part of their work role rather than an 'exam' type setting so that reflection on practice and demonstration of the learner's application of their knowledge development becomes the focus. In-house clinical skills assessment also allows the clinical teaching associate to foster agreed upon clinical standards established in the workplace, rather than imposed externally from an educational institution. Alternative models in UK described by Maggs (1994) allows the mentorship role and assessor role to be fulfilled by the one person, but not for the same learner.

Accreditation
Academic staff are an important stakeholder in the model. They negotiate learning contracts (or set skills), develop assessment criteria, maintain standards, and award grades. This serves the industry, providing accredited staff with a career pathway through undergraduate and postgraduate clinical education. The strategy was intended to foster ongoing workplace recognition of the advanced clinical expertise of mentors. Clear criteria and standards for clinical assessment are necessarily set by the university in collaboration with Health Department specialist clinical and administrative staff (Dockrell et al, 1987). Thus for example, academics have a role in establishing what constitutes advanced nursing practice through their role in the approval of clinical learning contracts.

Problems
The model represented in this paper has been in place for nearly seven years. When interviewed, clinicians, faculty, administrators and learners were all well able to enunciate the value of workplace-based clinical skills assessment, yet the nuances of the role as originally conceived seem to have either been lost or ignored. This section provides a summary of problems identified in the model.

In the early conceptualisation of the model, an assumption was made that the clinical specialist and consultant role, by being linked to an industrial award, was sufficiently rigorous to withstand being linked in a dependent relationship to an external entity, the University learner.

Ownership of the Model
A major problem with the model can be traced back to the differing perceptions held by those considered primary stakeholders – health service administrators and Faculty. Although considerable time was spent in the initial set-up period discussing how the model could best operate, five years down the track, their perceptions proved to be quite divergent. The interpretation of Nurse Administrators now is that the clinical assessors were 'recruited' to support tertiary education programs, (and should therefore be appropriately rewarded by that sector). On the other hand, University staff believe that the skills support offered by clinical staff is not separate from their existing work role and their mentorship and assessment activities are a natural extension and 'add value' to their role. The mentors themselves are thus left confused. They best understand the impact their contribution makes within both organisations, but over time have developed a growing resentment about the lack of importance either organisation places on their right for formal recognition.

Resourcing and funding of the model
Recognition comes in various forms and is clearly essential if people go beyond the 'normal call of duty' – which became the case in this model. Because of the consistent failure by either organisation to recognise the contribution being made, clinical mentors began agitating for a more traditional forms of compensation – payment for services rendered. Their argument is that the model is one of exploitation by the University, as markers of written/theoretical assignments receive payment, why is clinical assessment treated differently? This issue was subsequently raised by some of their managers. The conflict of perceptions as to who 'owns' the model thus became significant because of the resource implications even if this argument
was accepted. The Health Service and the University, both in situations of increasing limited fiscal resources, were unwilling or unable to 'pick up the tab'.

Changing environments

Over the period of time since the model's inception the implementation environment has changed. The industrial award legitimates clinical nurse specialists and clinicians as having a role outside that of direct patient care. However with the increase in hospital activity, sicker patients hospitalised for shorter periods of time, clinical specialists and consultants are being increasingly deployed in direct patient care situations. This significantly reduces their ability to offer clinical skill support requiring adherence to a specific time frame as needed by University learners. This, combined with the general lack of interest in the assessor/mentor role, means support for nurse learners and assessments are frequently being done out of rostered hours. The model thus currently hinges upon the considerable goodwill of the assessors, hardly the ground for the development of an equitable partnership.

Both organisations have undergone re-structuring since the inception of the model. Boundaries have been re drawn and delegations changed. The result is that many new staff are generally unaware of the philosophy of the model and how it operates. Secondly, the model does not necessarily have the same 'fit' administratively. Along with organisational re-structuring, the course has also undergone review. The result has meant a much more generic approach to skills development with the emphasis on developing the independence of the learner by having them focus on skills in reflection and review. There is also less specific mention of the need to use the model for the formal integration of workplace based assessment.

Communication problems

The model attempted to build upon, but was clearly separate from, an already functional role within the workplace. There were well established communication networks within each organisation however, there were no natural communication flows between organisations. It was assumed by all at the time that once the model was established, a symbiotic working relationship would develop between the Health Services staff and Faculty. But because this did not happen, the sharing of information about the model, initially considered of minor importance, became a significant impediment to the model's successful operation and more particularly recognition of the specific contribution being made by the assessors. The staff involved at the coal face at the health services had neither easy access to communication structures nor the position power to implement inter-organisational communication on anything but a person-to-person level. There was never any recognition by health service managers or the Faculty that the model required stewardship. At no time beyond the initial establishment and training were any staff allocated specifically to facilitate the model. Neither their employer nor the University monitor their assessor/mentoring role so no-one has direct evidence about how the role is being implemented. In fact its survival was dependent upon the dedication of the clinicians within the health services and the maintenance of course requirements which stipulated workplace based clinical skills assessment.

Academic Concerns

One of the incentives for establishing the model was to bridge the theory/practice gap often identified as a cause for concern by nurse clinicians. Traditionally academic programs rarely have the structure to access best industry practice and recent innovations. This model provided such a facility. However, there was always concern about the need for rigour in the assessment process by all stakeholders. Thus there was much effort by course designers in establishing assessment standards and accreditation procedures for mentors. As required by the educational institution, academics retain responsibility for assessment standards, so all documents related to clinical assessments are ratified by the academic responsible for each clinical subject. Much to the aggravation of many clinical mentors/assessors this is primarily done through exchange of paper rather than the expected peer exchange and discussion. In many ways the lack of personal academic contact is interpreted by nurse clinicians as insulting and a rejection of workplace knowledge and skills in the assessment process. Yet it is this strong workplace clinical link that confers the credibility that is sought by the learners and their managers.
Responses to problems: further evolution of the model

The mentors, university and health representatives were brought together several times once the model appeared to be under extreme threat. Once, for a Search Conference where many of their problems were specifically identified and actions plans developed, and a second occasion subsequent to that conference to provide feedback on those action plans. Obtaining sufficient financial and organisational support for this group to meet on these occasions was very difficult. There have been no further meetings. A data base has been maintained of active accredited assessors. But as the course structure has changed there is no mechanism to link nurse learners with named mentors (instead, learners nominate their own mentors). This was the major connecting point, now severed. Thus there is no way the University can maintain accreditation procedures and Health Service managers have no record of who is doing what in terms of assessment as there are no formal communication links to provide this information.

Once the problem of ownership was identified at the Search Conference, approaches were made to both the University and Health Service managers to negotiate a meeting point. This has never been satisfactorily achieved. On a formal level organisational structures within the health services are increasingly subject to rapid change and so have less and less facility to sustain commitments linked to outdated structures. The legal implications related to workplaces being used for private income of assessors also precludes the payment of assessment fees even if that notion was supported by managers. They have also consistently denied, presumably because of the lack of confirming evidence, any cross-institutional benefits associated with University accredited mentors. Health services personnel increased their pressure for the University to accept more responsibility because the major focus of the assessors activity was constantly interpreted as being of primary benefit.

The University as an institution continues to adopt a 'not our problem' approach to recognition of workplace based assessors as a group. There are several reasons for this: there is no precedence for this to be done and the costs would be passed on to students, and this option is avoided if at all possible. Negotiating for access to clinical skills assessment is left to the prerogative of the learner. Academic involvement is limited to retaining the right to ratify what learners propose as an appropriate learning contract to suit individual need and rigour of degree study. This is in line with their responsibility to maintain assessment standards.

In order to track how much time is spent on mentorship and assessment, voluntary audits have been done with both learners and their workplace support staff. This information has been made available to managers. This in turn has been used to argue the case that health services staff are being exploited rather than resolve issues related to appropriate recognition.

As a means of acknowledging the work of mentors, the university has issued Certificates of Appreciation to Health Services managers for each staff member contributing to the model. Each Certificate lists the contribution each accredited assessor has made in the previous year. No feedback has ever been received by the University as to what happens to these Certificates. There are no mechanisms for University staff to receive information or comment about the work of accredited assessors.

The model today

Despite the organisational disarray of the model, at the implementation level nurse clinicians still act as assessors and mentors and remain actively involved in day-to-day clinical skills development and assessment in spite of the ever increasing demands upon their time. Attempts have been made to reduce the pressure exerted by learners seeking University assessment by expanding the number of mentors. Again this is problematic given the organisational issues discussed above.

The original integrity of the model has now been permanently lost. In spite of this in 1996 many specialist clinicians still fulfil a significant role in mentorship and skills assessment. It could therefore be argued that the appropriateness of the model has stood the test of time. However, much of their effort remains unrecognised. Individual mentors still practise the role and dutifully provide records of their in-house
activity that relates to clinical skills assessment for those staff completing the University course. In spite of all the organisational and managerial impediments, the value of a workplace based clinical skills support for staff completing formal education is still perceived by these nurses as very high and certainly worth the effort.

Conclusions

With the focus in this paper upon ‘sharing resources’ between industry and academe, we have not touched upon the critical issue of learners and learning within this model. To do justice to this area, we would need to write a further paper, based upon the data we have at hand. Suffice to say here that this model was valued highly by learners.

Despite the administrative difficulties of the model, specialist health services staff surprisingly still apply to the university seeking endorsement as accredited mentors/assessors. This is an indication of how the role is still valued and how the model addresses an ongoing professional need.

While we have no doubts regarding the value of this model of tertiary accredited workbased learning, some very valuable lessons have been learned here which may be of use to others contemplating such a model:

• establish formal lines of communication at administrative, practitioner and academic levels, capable of withstanding challenges created through restructuring and rapid change within organisations. Dialogue develops a sense of trust and shared purpose which was never achieved in this model.

• contributing organisations need to contribute towards decision making about the model, creating a sense of shared endeavour. When the sense of ownership is high, and the direct benefits are clear, there is a large reservoir of good will to be tapped. In this model, the people who enjoyed the practical benefits were too removed from the decision making, both in terms of power, authority and physical location.

• innovative programs challenge cultural norms. While many individuals within organisations are innovative and are keen to foster change, this model was bureaucratised within traditional organisational structures, which led to traditional and questionably inappropriate responses to problems as they arose.

References


Schön, D 1987 Educating the Reflective Practitioner San Francisco: Jossey Bass

Toop, L, Gibb, J & Worsnop, P 1994, Assessment system design Canberra: AGPS