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Clinical Supervision And Mentorship In Nursing: The Gambia Experience

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Abstract: ***Clinical training which is part of nursing education and professional development takes place under the direction and supervision of a trained supervisor or mentor with higher qualification in the nursing profession. However, it seems from the literature that the boundaries between mentoring and clinical supervision are not clear-cut. Nonetheless, it is broadly accepted that extensive experiences and supervision from mentors, and clinical supervisors are necessary for nurses and student nurses to achieve a considerable nursing skill performance competency, self-confidence and patient safety. Despite this, clinical supervision and mentorship in nursing remains low in the Gambia. There is no formal mentorship program, coupled with high attrition rates of experience nurses creating a huge gap in clinical supervision for quality nursing care in this country.***

Keywords: mentorship, clinical supervision, nursing

I. INTRODUCTION

Nursing work can be a very rewarding profession, but also incredibly demanding and stressful. Nurses respond to the needs of those they work with on a daily basis, and yet they may be less aware or direct less attention to their own professional needs (Research in Practice, 2013). Nurses are often required to work with individuals who are resistant to receiving help. Nurses may even experience violence or aggression in the course of their day to day work (Chiller & Crisp, 2012). This combination of occupational stressors has been linked to the high rates of burnout in Nurses (Guy, Newman & Mastracci, 2008) and high turnover (Russ, Lonne & Darlington, 2009). Therefore, supportive relationships are the key to establishing supportive work settings, where nurses want to stay and improve professionally and socially. In order to achieve this, health care settings should create a conducive environment for clinical training.

Clinical training which is part of nursing education and professional development takes place under the direction and supervision of a trained supervisor or mentor with higher qualification in the nursing profession. Clinical training prepares nurses with the ability of doing as well as knowing the clinical principles in nursing practice. The clinical experience which is a vital part of nursing education and competency building by the newly graduate nurse, stimulates critical thinking skills for problem solving. It provides the opportunity for active self-learning, self-development and ability to apply knowledge from theoretical context situation to emergency and general public health care. In line with this therefore, clinical education must be able to help nurses to acquire the necessary nursing skills and the ability to perform in order to establish their capacity to handle changing realities and situations in nursing practice, (Melone, 2010). This indicates that extensive experiences and supervision from mentors, preceptors and supervisors are necessary to achieve a considerable nursing skill performance competency, self-confidence and patient safety. However, it seems from the literature that the boundaries between mentoring and clinical supervision are not clear-cut, and that there are no distinctive characteristics that conclusively define a relation as either one or the other. Nonetheless, Fowler (1996) defined clinical

supervision as a process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues. During clinical supervision nurses employ the processes of reflection in order to identify and meet their need for professional development. The purpose of clinical supervision is to improve nursing practice and therefore needs to be focused on nurse-patient interaction (Van Ooijen 2000).

On the other hand, mentoring is generally conceptualized as a learning process in which helpful, personal, and reciprocal relationships are built and mentees learn and develop through conversations with more experienced mentors. The key purposes of mentoring include career advancement, professional socialization, and development of social capital and transfer of tacit knowledge. Most definitions of mentorship suggest a hierarchical relationship in which the mentor is more experienced than the mentee, or that the mentor has or can provide knowledge and skills that the mentee wants or needs (McCormack & West, 2006; Aladejana, Aladejana & Ehindero, 2006; Fowler & O'Gorman, 2005; Billett, 2003; Price & Chen, 2003; Hayes, 2001). Galbraith (2001) defined mentoring as a process by which persons of superior rank, special achievements, and prestige, instruct, counsel, guide and facilitate the intellectual and/or career development of persons identified as mentee. Mentoring can be described as an intense interpersonal relationship (Kram, 1985) and Smith (2007) notes that mentoring is a process which develops the whole person, rather than parts.

Despite having been prominent in nursing for well over a decade, clinical supervision and mentorship in nursing remains low in the Gambia. There is no formal mentorship program in the Gambia, coupled with high attrition rates of experience nurses (MOSHW, 2015) creating a huge gap in clinical supervision. Moreover, the continuing lack of understanding of the concept of clinical supervision by supervisors who often use it as a tool for punishment, combined with underlying mistrust by nurses has resulted into obstacles for those attempting to provide supervision to those who need it.

II. MENTORSHIP AND CLINICAL SUPERVISION IN NURSING: CLARIFYING THE CONCEPTUAL DEFINITIONS

Mentorship is beginning to emerge in nursing landscape as a strategy to improve the recruitment and retention of nurses (Mills, Francis & Bonner, 2005). However, the terminology used to discuss this and other supportive relationships in nursing such as clinical supervision is often unclear and can be confusing. Mentorship and clinical supervision differ in focus, context and intensity. Therefore, the main aim of this section of the article is to differentiate the terms mentoring and clinical supervision in nursing so as to provide guide for nurse clinicians, managers and policy makers in general. It is through better understanding of the differences in these two types of relationship that they can be factored into the development of supportive work settings that will encourage professional growth in nursing and improve quality of patient care. This section defines mentorship and clinical supervision, highlighting their similarities and differences as follow:

MENTORSHIP

A universally agreed definition of mentorship has yet to materialize in nursing. Indeed Mitchell & Feldman (2013) indicated that the term mentoring is used acontextually and inconsistently. However, there are commonalities which tend to cut across all approaches to mentoring. Specifically, mentoring is seen to involve two parties (a mentor and a mentee or protégé), a relationship (formal or informal), and the transfer of skills, knowledge and attitude with the objective of development and growth of the mentee (and invariably the mentor) (Fuller, 2001).

Mentorship is particularly useful for supporting the professional development of nurses from the early professional socialization through to role transitions at management level. According to Fuller (2001) mentorship is an offline help by one person to another in making significant transitions in knowledge, work or thinking. It is a process in which high-ranking, influential Nurse who has advanced experience and knowledge and who is committed to providing upward mobility and support is provided with the opportunity to interact with a less experience Nurse (Huybrecht, Loeckx, Quaeyhaegens, De Tobel & Mistiaen, 2011)). That is, mentoring is process in which a trusted and experienced individual who by mutual consent takes an active interest in the development and education of a less experienced individual. Mentoring is a voluntary, intense, committed, extended, dynamic, interactive, supportive, trusting relationship between two people in which one is experienced and the other a newcomer, which is characterized by mutuality.

However, in Nursing there has been a shift on the conceptualization of mentoring as being solely a way to promote career advancement to being a broad-based concept that includes the development of the body of knowledge of nursing (Yoder, 1990; Gray & Smith, 2000). This is featured in Gray & Smith (2000) definition that mentoring in nursing as a teaching-learning process which occurs during personal experience within one-to-one contact between a mentee and a mentor leading to reciprocal career development relationship between these two individuals diverse in age, personality, life cycle, professional status and/or professional achievements. The Nurse Mentee relies on these relationship in large measure for a period of several years. The Nursing profession gains from such relations through professional development such as research and scholarship and expanded knowledge and practice base.

CLINICAL SUPERVISION

The implicit meaning of supervision is to oversee others and their work, and is an integral part of nursing practice. Recently clinical supervision has been described as having four key elements: reviewing the effectiveness of decision making and interventions; ensuring management and patient

care accountability; caseload and workload management; and identifying personal or career development opportunities (Gray & Smith, 2000). Clinical supervision is both a collaborative and a supportive process between two or more nurses to encourage the development of professional skills, promote quality standards in practice and enhance quality and safety of patient care. Clinical supervision is defined by Fowler (2011) as the process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues. This involves the indirect and direct observation of a clinical supervisor who is an appropriately qualified and recognized professional who guides students' education and training during clinical placements. Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations (UKCC, 2006). Clinical supervision has been described in the literature as `time for me' (Salvage 1998 p. 24). However, Chiller & Crisp, (2012) argued that clinical supervision involves three people, supervisor, supervisee and the patient, and that all issues covered in clinical supervision sessions should relate directly to patient care. Nonetheless, there is agreement that clinical supervision should not to be seen or used as a managerial tool for discipline or control although there is evidence to suggest that this is how it is viewed by some practitioners (Bray & Nettleton, 2007).

QUALITIES OF A GOOD SUPERVISOR AND MENTOR

Fowler (1995) argues that there are qualities in a supervisor that are generally valued by all students and nurses such as an interest in the one being supervised and approachability, a knowledge of wider professional issues, and a willingness to negotiate with supervisee regarding learning experiences. Fowler (1995) also noted that some qualities, notably having a supervisor who is knowledgeable regarding the practice area, are dependent on the experience and knowledge of the supervisee. Sloan (1998), in a study of staff nurses, identified 10 characteristics of a good supervisor. These varied from an ability to form supportive relationships and having knowledge and clinical skills, to the need for the supervisor to be actively supportive, able to acknowledge their own limits and be committed to providing supervision. In order to provide good supervision, Morton-Cooper & Palmer (1993) argue that a supervisor has responsibilities to the supervisee (education and standard setting), the patient (should be assured of good treatment), the profession (to maintain satisfactory standards among nurses) and also to themselves (to remain up to date not only in knowledge but also in maintaining an awareness of their own strengths and weaknesses).

Similar qualities for a good mentor was describe by Eller, Lev, & Feurer (2013) in a study titled key components of an effective mentoring relationship which indicated that eight qualities are required from a good mentor. These include ability to create open communication and accessibility; develop goals and challenges; be passionate and inspirational; caring and good interpersonal relationship; mutual respect and trustworthy; ability to exchange knowledge; encourages independence and collaboration; and skillful in role modeling. Mitchell & Feldman (2013) uncovered some commonly agreed-upon personal qualities of successful mentors. Good communication skills, including active listening and reflection are primary in effective mentorship. According to Mitchell & Feldman, (2013), one natural and understandable mistake that some mentors make is seeing their primary role as giving advice and guidance – and so they advise too much and listen too little, he noted. Expertise is another trait shared by successful mentors. Therefore, mentors need to know their stuff – both in terms of content and methodologically and if they are doing career mentoring, they need the right institutional experience and savvy in order to provide good guidance.

Successful mentors also advocate for their mentees within the institution, helping with networking and putting their mentees up for awards and honors. They also act as protectors, providing a safe place to discuss sensitive career issues and even when appropriate, speaking on behalf of their mentee with a supervisor or department chair. Successful mentors empathize with their mentees.

III. MENTORING TECHNIQUES

Mentors in nursing practice have to adapt their mentorship style to the needs of different mentees. It is important that they understand processes of skill acquisition and theories of learning. Mentoring techniques include teaching and learning styles, skill development techniques, reflection and feedback analysis. Firstly, mentors and mentees should discuss learning styles to find out which method works best for them while bearing in mind that a combination of styles is more likely to maintain mentees' interest. For example, Honey and Mumford (2006) identifies four types of learning styles, namely, reflector, theorist, pragmatist and activist. These are intended to help mentees reflect on their experiences, discuss the theory behind their work, adapt it, and put it into practice. Where appropriate, these can be combined with other styles such as those described by Filipczak (1995), namely auditory, kinaesthetic and tactile, and visual. The GROW model can also form the basis for supervision, mentoring and action learning.

- ✓ Goal - Defining what needs to be achieved;
- ✓ Reality - Understanding the situation;
- ✓ Options - Discussion of the options available;
- ✓ Wrap up - Agreement of the course of action.

Secondly, skill development can be mentored with the help of the Dreyfus model of mentorship (Benner, 1984) which suggests that mentees pass through five levels of proficiency during their acquisition and development of skills, namely novice, advanced beginner, competent, proficient and expert mentee. If mentors ensure that they are aware of these levels, they can develop a greater understanding of mentees' development processes. As novices for example, mentees simply want to know what they have to do before they carry it out. Mentors can help ensure that mentees are on the right track by using reciprocal teaching in which they no longer

simply ask questions but also introduce discourses, for example by asking a mentee: What would you expect to find when a patient complains of a sore throat? When mentees are able to cope with particular tasks without necessarily being able to recognize the overall picture, mentors can regard them as competent; when they understand both the overall picture and the theory behind the tasks they perform, they should be regarded as proficient. As mentees assimilate their new knowledge, their teaching may then follow Bennett (2003) Initiation, Response and Follow up (IRF) pattern, which is a process of checking and clarifying.

Finally, Schon (1983) talks about reflecting in practice, which both mentors and mentees can undertake. Mentees who feel they require further development should be encouraged to identify these areas openly. They should not perceive their need for development as a weakness and should not assume that they have to improve themselves on their own. Feedback analysis is an essential part of mentoring in nursing, and can be achieved using Pendleton's Rules of Four Steps (Benson, 2005). This involves discussing what has gone right, starting with mentees' opinions of their strengths followed by mentors' views, and then discussion of what needs to be improved, again starting with the mentees' opinions followed by those of the mentors. Feedback is also needed on how well mentees and mentors work together, because mentors also need constructive feedback on their performance.

IV. BENEFITS OF MENTORING AND CLINICAL SUPERVISION

Mentorship provides an enabling relationship to encourage other people's growth and development. In primary care settings, mentorship can benefit three groups of people or organizations. These include the mentors who can gain personal satisfaction from assisting the development of others, the mentees, who can achieve greater job satisfaction and more possibilities of advancement, and the health care institution whose workforce can become more satisfied and motivated, leading to improved outcomes for clients. Mentorship creates an environment that nurtures communication and connectedness, and planned activities as well as collegiality and sharing of wisdom between an experience nurse and a novice one. It enhances professional growth and job satisfaction.

Clinical supervision in the other hand, enables nurses to discuss patient care in a safe and supportive environment (Haggard & Turban, 2012). Through participation in clinical supervision nurses are able to provide feedback and input to their colleagues in an effort to increase understanding about clinical issues. In this sense clinical supervision is designed to serve a peer-educative function. The opportunity to discuss general issues in relation to patient care also opens a window of opportunity to develop consistent approaches to standardized care. In this sense, clinical supervision provides nurses with an opportunity to improve patient care. In addition, clinical supervision provides an avenue for nurses to demonstrate active support for each other as professional colleagues. Through sharing and understanding they come to realize that they are not alone in their feelings and perceptions, thus providing reassurance and validation. This can greatly help to reduce burnout and turnover among nurses.

V. CHALLENGES OF MENTORSHIP AND CLINICAL SUPERVISION

Barriers to the implementation of mentorship and clinical supervision for nurse tend to fall into two categories, personal and organizational (Morton-Cooper & Palmer, 993). This is supported by Bennett (2003), who agree that barriers to the implementation of clinical supervision range from individual factors to wider organizational issues. In order to effectively overcome these barriers they first need to be understood.

Personal barriers relate to the way in which individuals perceive themselves in relation to the process of clinical supervision and mentorship. They are governed largely by primal emotive factors, such as fear of change, lack of confidence, knowledge, skills or understanding, failure to recognize the need for supervision and reluctance to let go of old routines and work habits. To improve understanding and prevent confusion, the principles of clinical supervision and mentorship need to be communicated in clear and accessible language that stresses the benefits to patients and staff as well as to the organization.

Organizational barriers relating to clinical supervision and mentorship are prone to result from political conflicts, lack of understanding, constraints on nurses' time and limited resources. Gilmour (2001) acknowledges that few health organizations include clinical supervision in their corporate agenda or business plans and argues that time needs to be built into practitioners' workload schedules for preparing for and attending meetings. Time for supervision and mentoring is a crucial factor and an area where the financial cost of the process becomes most influential. An appropriate environment for supervision to take place is another requirement, but most critical is the provision of trained supervisors and mentors to choose from, a list of which should be available in every clinical area.

VI. CLINICAL SUPERVISION AND MENTORSHIP IN NURSING; THE GAMBIA EXPERIENCE

Limited data was found in the literature on clinical supervision and mentorship for nurses in the Gambia. However, according to the experience of the author as a Registered Nurse and a Nurse Tutor, there is no formal mentorship program for nurses in the Gambia. *There are no uniform guidelines and protocols to follow during clinical supervision and mentorship in this country.* Rather, principals and tutors of nursing institutions generate their own directives based on experience. Trainings are not usually offered to mentors and clinical supervisors to enable them to fit effectively into their roles. The choice of mentors are those available in the clinical facilities but not by choice and willingness, experience, competencies or personal attributes.

Mentors and Clinical Supervisors for Nurses in the Gambia are usually registered midwives or nurses (with or without bachelor degrees) assigned to clinical facilities and

offering care as part of their day-to-day services. These midwives and nurses are generally not members of the faculty of the training institutions, but are staff that may be requested, by virtue of their presence in the facility, to pass on skills to various categories of students or junior nurses posted to their site. Requests for service may be by a letter submitted by the student on posting to the site, delivered by the director of nursing at the facility, or by personal contact with a tutor of the training institution. Students are assigned to the facilities with specific expectations and may be given log books for mentors or clinical supervisors to endorse objectives achieved for the time period. Clinical supervisors and mentors usually use the apprenticeship method where the students and less experience nurses are assigned to nursing tasks as an apprentice to a more experienced nurse or midwife. Opportunities for one-on-one meetings to assess daily performance and objectives achieved usually do not occur. Opportunities for generating critical thinking tasks are never the focus of the process. Young inexperienced nurses are sometimes posted to rural areas without the support of a senior nurse to build their competencies. This is incongruent to the assertions of the North Carolina Board of Nursing and that of the University of Texas School of Nursing (2011) where, within their definition of mentorship, it must be conducted in the purview of a structured system where mentors agree to function to provide supervision to a student or less experience nurse for a specified period of time using identified learning objectives.

Several challenges militate against effective mentorship and clinical supervision for competency building in nursing in the Gambia. These challenges range from young and inexperienced mentors and clinical supervisors due to inadequate numbers of senior nurses in the clinical sites as a result of high turnover and heavy workload. Other challenges include lack of interest by experience nurses to be mentors and clinical supervisors for nursing students and inexperience nurses due to no remuneration or perceived self-benefit. Therefore, some experienced nurses view mentoring as an added burden.

Furthermore, there are few number of nurse tutors in the training institutions who are unable to make follow up of the large numbers of students posted in different clinical areas across the country. There are small-sized skills laboratories that challenge tutors' abilities to prepare students for skills training before their release to the clinical sites. There are ill-equipped and overpopulated clinical sites due to the fact that students from various institutions and professions are all assigned to these few facilities to demand attention from the few nurse clinicians. Policies and standardized guidelines from the regulatory bodies on mentorship and clinical supervision are largely unavailable. Such challenges affect supervision and contact with mentors and may be one of the underlying causes of the declining quality of nursing care in the Gambia.

VII. CONCLUSION

Mentorship and clinical supervision is a very important approach to training and acquisition of skill for nursing competency. However, the present situation of clinical supervision and mentorship for students and young nurses in the Gambia calls for initiatives that will direct an effective selection of mentors and clinical supervisors that are capable of meeting student needs, especially in the areas of bridging the knowledge gap between theory and practice; role modelling, competency and confidence building through insightful guidance and sharing of experiences.

VIII. RECOMMENDATIONS

Multi-pronged approach is needed in addressing the weakening state of mentorship and clinical supervision of nurses and nursing students in the Gambia. Strong mentoring and clinical supervision systems should be develop which run in synergy within a nationally approved framework or policy guidelines. The competencies of nurse tutors and clinicians who act as clinical supervisors and mentors should be improved and there should be improvement in the clinical sites, equipment and supplies and identify willing role models for leadership training and assignment. Retired nurses and midwives should be given the opportunity to serve as school-based mentors or clinical supervisors so that they can share their experiences with the students and newly graduate nurses. This can also help to bridge the gap created by the high attrition rate of nurses in the Gambia. Nurse tutors can also be supported to take up clinical responsibilities in health facilities to maintain and improve skills and act as buffers to clinical supervisors and mentors. Lastly but not the least, motivational incentives should be provided to the senior nurses in the Gambia in order to reduce their high turnover.

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