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REVIEW ARTICLE

Mentoring, clinical supervision and preceptoring: clarifying the conceptual definitions for Australian rural nurses. A review of the literature

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ABSTRACT

In Australia, mentoring is beginning to emerge on the rural and remote nursing landscape as a strategy to improve the recruitment and retention of nurses. However, the terminology used to discuss this and other supportive relationships in nursing is often unclear and can be confusing. The main aim of this article is to locate mentoring, clinical supervision and preceptoring in the nursing literature, and thus provide a guide for Australian rural nurse clinicians, managers and policy-makers in general. It is through better understanding of the possibilities of each type of relationship that they can be factored into the development of supportive work settings, and that will encourage the retention of existing staff and possibly the recruitment of new staff. Each type of supportive relationship discussed in the literature has a different focus. Mentoring is broadly based and concentrates on developing areas such as career progression, scholarly achievements and personal development. Clinical supervision focuses on progressing clinical practice through reflection and the provision of professional guidance and support. Preceptorship focuses on clinical skill acquisition and socialisation. Each support relationship also differs in context and intensity. Mentoring relationships are based around developing reciprocity and accountability between each partner. They are normally conducted outside the work environment and in the participants' own time. Clinical supervisory relationships are similar to mentoring in that they are reliant on developing a strong sense of reciprocity and accountability, and take place over a long period of time. They differ, though, in that they are conducted during working hours, although preferably away from the work setting. They are also commonly facilitated through the use of small

groups. Preceptoring relationships are short term, exist in the clinical context and concentrate on clinical skill acquisition and assessment.

Key words: clinical supervision, mentor, nursing, preceptor, remote

Introduction

Supportive relationships are the key to establishing supportive work settings, work places where people want to stay. Mentoring is gaining popularity among Australian rural nurses as a strategy to increase the recruitment of new staff and the retention of current staff. In the workplace, though, there are often different understandings about what mentoring is and how it might play out in practice. There are also other support strategies that need to be considered in the same context.

This article will define the three main supportive relationships identified in the nursing literature: mentoring, clinical supervision and preceptoring. Highlighting the similarities and differences among them will illuminate the range of possible supportive relationships that could be fostered by those who strategically plan for rural health care facilities.

Background

Australian rural nurses: emerging trends

Australian rural nurses work in diverse settings and across a range of practice roles[1]. The most recent labour force data accounts for 59 301 rural nurses who make up 26.4% of Australia's nursing work force[1, p.15]. These are nurses who work in a rural town or area with a population centre of fewer than 99 999 and greater than 5000[2, p.5].

Undoubtedly the most significant issue in rural nursing is a shortage of clinicians. This is being compounded by an ageing work force, poor rates of pay, and the difficulties and conditions of work[3]. The importance of improving or finding new work-force support strategies for rural nurses was highlighted in the recommendations of recent reviews of nursing carried out by the Australian government: *Our Duty of Care*[4] and *The Patient Profession: Time for Action*[5].

In October 2002, the National Rural Health Alliance (NRHA) convened a stakeholder forum, *Action on Nursing in Rural and Remote Areas*, in response to a recommendation from the 6th National Rural Health Conference, held in March 2001[6]. The provision of mentoring to support rural nurses was considered to be a high priority due to a number of factors impacting on Australian rural nurses (Table 1).

The forum concluded with the preparation of a set of recommendations that would set the rural nursing agenda for NRHA organisations for the next five years. The rural and remote nurses who participated in the forum made their first priority the establishment of mentoring programs.

Supportive relationships in nursing

Mentoring

There is a paucity of literature explicitly dealing with rural nurse mentors. Only one study involving rural nurses and mentoring has been located[8]. This study examined the outcomes of mentoring partnerships arranged between academic mentors and beginning rural nurse practitioners in the USA.

Table 1: Factors impacting on Australian rural nurses[7]

An increased shortage and rapid turnover of appropriately skilled rural nurses The nursing work force in rural areas appears to be older on average than the nursing work force overall. Growing general shortage of nurses in Australia means greater competition for a dwindling supply Paucity of leadership and management skills	Limited attention to work force planning; limited incentives to attract and retain new rural nurses Poor image of rural nursing Isolated practice Increasing demand for advanced practice skills Limited opportunities to upskill and maintain practice skills

In Australia, there are formal mentoring programs for undergraduate rural and remote nurses, aged care nurses and re-entry to practice nurses who hold Australian government scholarships. The purported benefit of these scholarships is that they will encourage students from rural and remote Australia to gain nursing qualifications that they will then use on their return home.

The Association for Australian Rural Nurses (AARN) initiated its Mentor Development and Support Project in 2003 to provide training and support for rural nurse mentors involved in the Royal College of Nursing, Australia (RCNA), Undergraduate Mentor Program. This was a direct response by AARN to the recommendations of the *Action on Nursing in Rural and Remote Areas* forum. A comprehensive evaluation of this project has highlighted the influence of continuing education on rural nurse mentors and the relationships that they form with their mentees (J Mills, pers. data, 2005)[9].

Elsewhere in the literature, the Institute of Nursing Executives in New South Wales has been identified as providing mentoring for new nurse managers working in isolated areas. This mentoring program involved both continuing professional development and access to a support network[10].

The general literature on mentoring in nursing is vast and, as would be expected, there are many definitions of mentoring from which to draw[11-13]. However, two important concept analyses of mentoring in nursing, Yoder[14] and Stewart and Krueger[15], are useful in reaching a consensus on the definition. Concept analysis in nursing is a relatively recent research method that has emerged over the past 20 years. Rodgers' theory of evolutionary concept development[16] is often used as a method for undertaking concept analysis. Each of the concept analyses of mentoring drew upon Rodgers' work, which uses a literature-based method[14,15,17].

Stewart and Krueger's study[15] is described in its title as 'evolutionary', in that it builds on the work of Yoder and follows Rodgers' belief that significant concepts develop and change over time. It is this definition that most adequately reflects the concept of mentoring in nursing today:

> *Mentoring in nursing is a teaching-learning process acquired through personal experience within a one-to one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The nurse dyad relies on the relationship in large measure for a period of several years for professional outcomes, such as research and scholarship; an expanded knowledge and practice base; affirmative action; and/or career progression. Mentoring nurses tend to repeat the process with other nurses for the socialization as scholars and scientists into the professional community and for the proliferation of a body of nursing knowledge*[15, p.315].

A comparison of the outcomes of Yoder's and Stewart and Krueger's concept analyses of mentoring in nursing shows that there has been a shift over time, from mentoring being solely a way to promote career advancement, to it being a broader-based concept that includes the development of the body of nursing knowledge[14,15].

This conceptual shift is illustrated in Stewart and Krueger's six key attributes of mentoring: that there should be a teaching-learning process; a reciprocal role; a career development relationship; a knowledge or competence differential between participants; and a duration of several years; and that it should be a resonating phenomenon[15].

Because of the evolving nature of mentoring, there is a greater emphasis on some attributes of the concept as opposed to others, depending on the context to which it is being adapted. This is important to remember, because scholars trace the ongoing development of mentoring as a strategy in more diverse clinical and academic practice areas such as research, minority student retention, creative thinking, writing and scholarly productivity[18-28].

Clinical supervision

As with mentoring, there are many definitions of clinical supervision in nursing[29-31]. Using Rodgers' method of concept analysis, Lyth examined the literature about clinical supervision in order to clarify the concept and the term that represents it. This definition appears to include the commonly held attributes of clinical supervision and has been adopted for this paper:

> *Clinical supervision is a support mechanism for practising professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice*[17, p.728].

Clinical supervision is a term not often used in Australian nursing outside of the practice area of mental health[29,32]. Traditionally, clinical supervision developed in many health disciplines, although primarily in psychotherapy and social work[29,30,33]. In the UK, clinical supervision for nurses was introduced in the late 1980s, and since then it has become an integral part of clinical governance and quality assurance in the public health system.

Australia has been slow to recognise the place of clinical supervision for nurses. The Australian Health Ministers' Advisory Council recommended that access to formal and informal clinical supervision be available for mental health nurses only[29].

The literature about clinical supervision in nursing therefore originates predominantly in the UK, with the landmark work of Brigid Proctor commonly cited as underpinning the implementation of a variety of practice models. Proctor's model of clinical supervision incorporated three key elements: normative (managerial); formative (educative); and restorative (pastoral support)[29,30,32,34-40].

There are three main forms of clinical supervision: one-on-one; triad; and group[37]. Research about the outcomes of clinical supervision has found that group clinical supervision is particularly effective, especially if conducted off-site. Group sessions are also more effective if held frequently (at least monthly) and if they are able to last longer than 60 min[29].

Individual or one-on-one clinical supervision is also deemed to be effective, but there is considerable discussion in the literature about potential role conflicts should supervisors also be supervisee's line managers[31,41]. Conversely, however, there is also an argument that the clinical supervisory relationship can create greater understanding and mutual respect between managers and practitioners[42].

Two accounts in the literature discussed the outcomes of clinical supervision for rural nurses in the UK[42,43]. One in particular explored the use of videoconferencing to facilitate such relationships over a wide geographical area (although

their idea of long distances – a 35 mile round trip – and ours would be quite different!). The three rural nurses who wrote their accounts were involved in one-on-one and group clinical supervision. The rural nurses felt that their clinical supervision experiences were valuable in improving their understanding about their practice, as well as increasing their self-awareness and ability to critically reflect[43].

Preceptoring

Unlike mentoring and clinical supervision, preceptoring in nursing has not been subjected to a concept analysis. Preceptorship is a method of preparation for practice, utilising clinical staff, as opposed to faculty staff, who provide supervision and clinical instruction to new practitioners: undergraduate or newly registered, or new to a specific clinical environment[44,45].

Usually preceptoring relationships are one-on-one. However, another model of preceptorship discussed in the literature is that of the clinical teaching associate, in which healthcare facilities are funded by universities that are seeking clinical placements for undergraduates so that a clinician, the clinical teaching associate, is able to assume responsibility for supervising and teaching a small group of students[46].

A preceptor, therefore, can be defined as 'an experienced practitioner who teaches, instructs, supervises and serves as a role model for a student or graduate nurse, for a set period of time, in a formalised programme'[47, p.507]. Experienced nurses usually assume this role over a short period, in addition to their existing clinical responsibilities. The authors would also argue that another key action of the preceptor is to provide formal feedback on the preceptee's performance to his or her supervisor or lecturer. As a part of their responsibilities, Australian rural nurses often fulfil the role of preceptor to undergraduate nursing students undertaking clinical placements, as well as preceptoring new staff[48].

Discussion

In Australia, New Zealand, Canada, the USA and Sweden[30,45,49-55] the concepts of mentoring and preceptoring, as defined in this paper, are used consistently in the vast majority of cases. In the Australian literature, there are two exceptions where they become confused. Lo and Brown discuss an undergraduate mentoring program that involves short-term clinical placements and student assessment by mentors[56]. Similarly, this model of clinical mentoring was reported by Wright[57]. Morton-Cooper and Palmer refer to this as 'pseudo-mentoring'[30, p.46] although it could be argued that this type of supportive relationship really constitutes a model of preceptoring.

The remaining Australian publications about mentoring demonstrate an agreement about the role[10,13,44,58-68] that is congruent with the adopted theoretical definition of Stewart and Krueger[15]. Mixed messages about the definitions of mentor and preceptor are prevalent, however, in the literature from the UK, and it is this writing that has caused authors from other countries to note a continuing thread of confusion in the literature about the terms mentor and preceptor[14,59,60,62,65].

Clinical supervision as defined in this article has received little attention in the nursing literature outside of the UK. In Australia, its role in providing a supportive relationship with a clinical focus has not been widely adopted outside the practice area of mental health nursing. A different use of the term clinical supervision can be observed in the nursing literature from Australia, New Zealand and Canada, where it has been written about in relation to the supervision of nursing students on clinical placement[69-71].

The literature contains several key areas that provide points of difference between mentoring, clinical supervision and preceptoring. These areas are level of commitment, time, context, relationship reporting and expected outcomes (Table 2).

Table 2: Key points of difference between mentoring, clinical supervision and preceptoring

Element	Mentoring	Clinical supervision	Preceptoring
Context	Outside the immediate work setting	Within the work setting, but away from the immediate work area	Within the work setting
Time	Long time-frame with a progression of relationship phases	Long time-frame with a progression of relationship phases	Short period, usually 2–12 weeks
Relationship reporting	Confidential discussions; minimal reporting on relationship status in a formal setting	Confidential discussions; minimal reporting on relationship status in a formal setting	Formal reporting on the progress of the preceptee
Level of commitment	High level of commitment; may require a time commitment outside of the work setting	High level of commitment; hopefully conducted within working hours, but away from the work setting; may require a time commitment outside of the work setting	Lower level of commitment; conducted solely in the work setting
Outcomes	Broader outcomes that can encompass improved clinical practice, career progression, scholarly endeavour, personal achievement	Improved clinical practice	Clinical skill development

Mentoring and clinical supervision require a very similar high level of commitment from each participant for the relationship to be established. Both are conducted over long periods; in some cases they can be sustained over years. The main point of difference between these relationships is the focus of discussions between participants. Mentoring allows for a more all-encompassing level of discussion that could range from day to-day clinical issues to the 'bigger picture' of all parts of the mentee's life – should they choose to discuss such issues. Clinical supervision confines itself to the novice's life as a nurse, although this can often encompass their personal lives as they impact on their work lives. This is described as the pastoral aspect of clinical supervision.

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 relationship as either one or the other. In both relationships, participants are accountable to each other with a minimal amount of reporting to the outside world about the discussions that take place within their mutually created space.

Preceptoring, however, is quite different from mentoring and clinical supervision in the levels of time and commitment that characterise relationships, as well as the requirement for formal reporting of the outcomes of the relationship. These outcomes are based on the acquisition of clinical skills that are observable and measurable by the preceptor. Mainly because

of the short time frame of preceptoring, the relationship developed is unlikely to be as intense as those formed during mentoring or clinical supervision.

Implications

Mentoring, clinical supervision and preceptoring are extremely important concepts for the development and support of rural nurses. In Australia the concept of clinical supervision and its potential for supporting rural nurses remains largely unexplored, although indications in the literature from the UK are that rural nurses, especially in small groups, stand to benefit from the use of this concept in their practice lives.

Mentoring, with its broader focus, has the potential to develop a professionally stronger and more rounded work force, with the fostering of scholarship and research, as well as clinical expertise, through the development of relationships between wise and experienced rural nurses and those who are beginning their careers as rural nurses. Positive preceptoring experiences for a student or newly graduated nurse experiencing rural nursing for the first time, can shape future career decisions and are vitally important in succession planning.

Each of these support strategies can contribute to a more sustainable rural nursing work force, improving staff retention through the development of more supportive work settings. For nurses contemplating a shift to a rural environment, offering to establish a supportive relationship for them at the beginning of their employment may provide an enticement to try. For existing rural nurses, establishing supportive relationships within the workplace may demonstrate a pragmatic commitment to supporting staff that entices them to stay. Either way, the provision of access to mentoring, clinical supervision and preceptoring is a key measure that needs to be factored into rural health service planning as a matter of course.

Conclusion

Australian rural nursing is problematic for policy-makers and managers on a range of fronts. Going some way towards addressing the difficulty of recruiting and retaining rural nurses is valuing and planning for supportive relationships within the work setting. Mentoring, clinical supervision and preceptoring are all valuable strategies in meeting this particular challenge and are essential tools to be included in strategic work-force planning for the future.

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