UNIVERSITY OF KWAZULU-NATAL

STUDENT NURSES' PERCEPTIONS OF PEER MENTORSHIP IN CLINICAL SETTINGS

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STUDENT NURSES' PERCEPTIONS OF PEER MENTORSHIP IN CLINICAL SETTINGS

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DECLARATION

I, Zanele Penelope Mlaba declare that the dissertation with the title: "Student Nurses' Perceptions of Peer Mentorship in Clinical Settings" is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted previously at any other university.

Signed

Student..Date................................

Supervisor... Date …………………

DEDICATION

This dissertation is dedicated to several people who have played a pivotal role in my life:

To my beloved sons, Xolile, Mxolisi and Akhona, my daughter-in-law Nokubonga and my grandchildren Olwethu, Lufefe and Amukelisiwe. You are everything to me. You are a blessing from God and I thank Him for blessing me with you. This thesis is the legacy that I have created for generations to come, please follow the footsteps and make sure that your children and grandchildren do the same.

To my husband Erick Bheka for being understanding, and supportive and for words of encouragement.

To my brothers and sisters, cousins, nephews and nieces and all the people closest to me.

This study is dedicated to the memory of my grandmother Agnes Thokozile Dlamini, my mothers, Rose Muhanuwa, Roseline Makalang and Ruth Mamo Matsidiso, my uncles Tsekiso, Sipho and David Thotho Dlamini, my father Sweetbert Madoda Daniels and father in-law Felcot Muzikawufani Mlaba. Their memory gave an urge to study. King Thothos, this is for you.

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ABSTRACT

Novice student nurses face many challenges when making the transition to clinical learning because of the complex and unpredictable nature of the clinical settings. Adequate support of students in clinical placements and positive clinical experiences can increase students' enthusiasm and retention in the profession. Nursing schools use peer mentoring to provide a supportive and non-threatening learning environment for students thus facilitating professional growth and development of student nurses in clinical settings. The KZNCN has a student peer-motoring programme whereby the third year student nurses are assigned to be peer mentor for the first year students thereby facilitating transition through provision of orientation, guidance, support, accompaniment and teaching basic clinical skills. The aim of the study was to explore and describe the perceptions of student nurses on peer mentorship in order to enhance the quality of the peer mentorship programme in the clinical setting.

A quantitative, non-experimental descriptive design was used to achieve the research objectives. All 210 student nurses doing the four year diploma course were invited to participate in the study. A sample size of 170 (66 mentors and 104 mentees) eligible and willing students was conveniently obtained. Fifty six participated as mentors and ninety-four as mentees in the main study. Ten students from each cohort were utilized for pilot study and did not form part of the main study. Data was collected using self - administered questionnaires that were developed from reviewed literature. Descriptive and inferential statistics were used to analyse data.

Study findings revealed that mentees should be actively involved in clinical practice and should engage in personal relationships with experienced individuals in order to learn about the profession and promote professional socialisation. The development of leadership and teaching skills, self-confidence, independence and increased ability to perform clinical skills emerged as benefits of engaging in the programme. Despite notable gains from peer mentoring, this study highlighted that the students experienced a number of challenges that impacted negatively on peer mentoring in clinical settings. These barriers include, inter alia, insufficient practice opportunities for the students because of the short duration of the placement, time and resource constraints and mentoring too many students at the same time.

The questionnaires had three open-ended questions, the common responses that emerged were grouped and quantitatively analysed into percentages. A total of 15.9 percent (n = 15)

mentees expressed gratitude and appreciation for having worked with senior and experienced nurses on their first days. They appreciated the support and assistance they got from mentors.

Based on the findings, it is suggested that the peer mentoring programme should be embedded in the nursing college retention strategy with an intention to improve formalization and structuring of the programme.

Key concepts: Student nurses, perceptions, peer mentorship, clinical setting, peer, peer mentor, peer mentee.

Acronyms

KZN: KwaZulu-Natal

KZN DoH: KwaZulu-Natal Department of health.

KZNCN: KwaZulu-Natal College of Nursing

NMC: Nursing and Midwifery Council

UK: United Kingdom

UKZN: University of KwaZulu-Natal

SA: South Africa

SANC: South African Nursing Council

SPSS: Statistical software package

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CHAPTER ONE

BACKGROUND OF STUDY

1.1   Introduction

The tertiary education institutions are characterised by poor student progression and high attrition and dropout rates. This is associated with opening access to students from diverse backgrounds (Loots, 2009). As a result, innovative ways of additional support to students are devised. In South Africa, the Council of Higher Education (CHE) reported a dropout rate of more than 50% in 2013. This is also observed in Nursing Education Institutions, with the attrition rate among first year students estimated at 25% (Masango, 2014). This high student turnover costs South Africa R1.3 billion in subsidies (Loots, 2009) and has a devastating effect on providing the much needed diversely educated workforce to sustain the financial wellbeing of South Africa (Ross, 2014). The nursing campus selected in this study therefore recommended a structured student support programme that uses innovative interventions to address this challenge. It was believed that a peer mentoring programme could play a vital role in retaining students whilst meeting learning outcomes successfully. Strengthening both theory and clinical learning support is crucial to nursing students as they are expected to pass both components separately to progress.

1.2   Background of the study

The South African Nursing Council (SANC) Education and Training Standards stipulate that clinical practice for the comprehensive diploma in nursing (General, Community and Psychiatry) and Midwifery (R425) commences from the first year of training and should be preceded by the provision of suitable theory. The South African Nursing Council (SANC, 1992) minimum requirements and guidelines relating to clinical learning state that student nurses should spend a minimum of a thousand hours a year in clinical practice, as part of their professional and clinical development. The overall objective of clinical practice as stated by

the SANC is to provide student nurses with meaningful learning opportunities in every area of clinical placement according to the level of training. Successful completion of the programme qualifies students to render comprehensive nursing care as registered nurses equipped with skills and knowledge to nurse efficiently, solve problems effectively and apply a scientific approach to nursing from the initial assessment to the rehabilitation of the patient or client.

It is imperative that the clinical practice area be conducive and supportive to learning and adequate placement support systems should be provided, such as supervision, "mentorship", preceptorship including creating mutually beneficial relationships between the faculty, student nurses and clinical staff (Mabuda, Potgieter & Alberts, 2008). The SANC Education and Training Standards stipulate that supervision models should be utilised for achievement of clinical learning outcomes. Mentoring has been identified as one of the strategies that facilitates professional growth and development of student nurses in clinical practice. This is an attempt to socialise student nurses into the nursing profession with the assistance of experienced professional nurses (Tshabalala, 2011).

 Botma, Hurter and Kotze (2013) advocate that peer mentoring occurs within the same educational programme where the senior student nurse as a more experienced peer, shows the ropes to a less experienced colleague. Different terms are used interchangeably for peer mentoring and include cooperative learning, peer review learning, mentoring, peer coaching, team learning, learning, and problem-based learning (Stone, Cooper and Cant, 2013); collaborative learning, peer learning partnership and peer-assisted learning (Christiansen and Bell, 2010).

However defined, peer mentoring is one of the innovative teaching strategies currently used in nursing education. According to Stone et al., (2013) peer mentoring is a student-centred learning approach which stimulates active student participation, where student nurses take responsibility for their own learning. It fosters critical thinking, psychomotor skills, cognitive development, clinical skills and academic gains (Stone et al., 2013), all of which are characteristics essential in meeting health challenges of the present and in the future. Botma et al., (2013) applauds peer mentoring as an effective method of promoting positive interaction between learners of different cultural backgrounds and for improving achievement, interpersonal relationships and attitudes towards the clinical environment. Dennison (2010) asserts that peer mentorship encompasses a supportive relationship, formed

between equals and helps to prevent problems in busy, stressful practice settings. Being equals with regard to age, status and interests, gives peers a sense of autonomy which motivates them to take more responsibility and actively participate in their education (Stone et al., 2013). This is argued by Christiansen, Bjørk, Havnes & Hessevaagbakke (2011) who mention that peers provide a safe and secure environment in which they are free to unburden themselves without being judged. Peers are important in self - or group assessments as they provide student nurses with a useful perspective on their performance. This feedback occurs more informally and is perceived as less threatening than when teachers provide assessment and feedback (Stone et al., 2013). Purfeerst (2011) affirms that nursing schools use peer mentoring to provide a supportive and non-threatening learning environment for students. Joubert and de Villiers (2015) add that learning is enhanced through maximising the opportunities for student nurses to discuss their work with others. Thus learning with peers is not always about skills but also includes the provision of emotional support and an assurance that things are going to be alright and get better (Christiansen and Bell, 2010). Peers talk openly, honestly and confidentially about their own or others learning challenges and this allows them to reach a point of self-awareness (Kaphagawani and Useh, 2013).

However, Stone et al., (2013) highlight that some senior student nurses decline to take part in peer mentoring because they feel that being a mentor is linked to taking responsibility for someone else's education. They also feel that they are underprepared and they are concerned that their own grades may be negatively affected by mentoring. These researchers further stress that enforcing the educational role of a peer may lead to resentment, especially if the student nurse feels unprepared and unwilling to undertake the role.

Mentors sometimes encounter challenges in the clinical practice area. In a study by Joubert and de Villiers (2015), the unit managers were not aware of the mentoring programme and as a result did not allocate the mentors and mentees together. Mentors sometimes find that striking a balance between overloading the mentees with work and underexposing them to important nursing issues is a challenge. The mentors find it overwhelming if they have to look after two student nurses on a busy day. The time that the mentees are exposed to the mentors may be too short for the amount of information that needs to be disseminated (Joubert and de Villiers 2015). Mentors experience conflict between patient-care demands and fulfilling their mentoring roles (Mhlaba, 2011).

There is evidence in the literature (Mabuda et al., 2008 & Kaphagawani and Useh, 2013) that learning in clinical settings requires an environment which is conducive to learning, and which provides the appropriate support from skilled practitioners and educators. A clinical setting rich in learning experiences, but lacking a supportive environment, discourages the learners from seeking experience and results in the loss of learning and growth opportunities. On the other hand, a setting with limited experiences but rich in support, may provide opportunities for student nurses to examine new health needs and ways of addressing them (Mogale, 2011). In support of this, Jokalainen, Turunen, Tossovainen, Jamoonkeeah and Coco (2011), state that adequate support of students in clinical placements and positive clinical experiences can increase students' enthusiasm and retention in the profession. Stone et al., (2013) confirm that the need for student supervision remains important to ensure that the accurate and correct information and appropriate skills are exchanged by students. Experienced and knowledgeable clinical staff promote clinical learning of students by creating an effective learning environment (Joubert and de Villiers, 2015).

In South Africa, shortage of staff and equipment affects the conduciveness of the clinical learning environment (Mabuda et al., 2008). According to Mhlaba (2011), in South Africa mentoring in the clinical settings for nursing students is not formalised, there are no guidelines from the regulatory body to serve as a guide for mentors in clinical settings. Student nurses are mentored by registered nurses as part of their supervisory and teaching functions. Due to the shortage of nurses, the task of student nurse supervision is shifted onto new graduates and inexperienced nurses (Tshabalala, 2011). This was confirmed by Cassimjee and Bhengu (2006) in their study which reveals that there is a progressive decline in clinical teaching by professional nurses. In addition, nursing education is confronted by many challenges including increasing class sizes, rising student numbers, rising competency requirements, decreasing numbers of lecturers and limited clinical placement areas (Dennison, 2010; Mhlaba, 2011 & Kaphagawani and Useh, 2013). This compromises clinical supervision and teaching of student nurses and therefore peer mentoring is used as additional support to students in clinical settings. Researchers, Stone et al., (2013) posit that senior student nurses could effectively teach and supervise the junior student nurses thus decreasing the demand on lecturers.

Literature (Moscaritolo, 2009; Purfeerst, 2011 & Payton, Howe, Timmons and Richardson, 2013) indicates that the initial clinical experience can be stressful and intimidating and may cause significant fear, anxiety, uncertainty and a feeling of abandonment for the novice student nurses. This is mainly due to the unpredictable and complex nature of the clinical environment and is exacerbated in student nurses who have no prior clinical experience. Many student nurses initially experience a cultural shock during their first weeks of clinical placement especially when they have to deal with the very sick and dying patients (Joubert and De Villiers, 2015). High levels of anxiety can affect student's clinical performance and may pose a threat to success due to poor coping skills (Moscaritolo, 2009; Li, Wang, Lin and Lee (2011); & Purfeerst, 2011). About 26% of all nursing students in the UK dropped out of their studies before graduating and this involves about £99 million (2.25 billion rands) in costs a year (Jokalainen et al., 2011) due to maladjustment problems such as feeling of social isolation , alienation and lack of support.

In South Africa, the Health Care System currently faces challenges such as inadequate staffing levels, heavy workloads, high bed occupancy, increased patients acuity, lack of equipment and other resources for training, inexperience and overcrowded placements which all contribute to poor clinical supervision of student nurses (Mabuda et al., 2008 & Mhlaba, 2011). There is overwhelming documentation in literature (Mntambo, 2009, Mogale, 2011 Botma et al., 2013 & Rosenau, Lisella, Clancy and Nowell, 2015) of problems related to insufficient clinical supervision and mentorship, including the reality that the nursing students are then left under the supervision of inexperienced practitioners or unwilling mentors or left alone to find their own way. According to these researchers, this results in a negative learning environment where student nurses learn by trial and error, with lack of evidence-based practice and a widened theory-practice gap. As a result, the student nurses become demoralised, humiliated and feel hurt for not receiving adequate and good supervision (Botma et al., 2013 & Kaphagawani and Useh, 2013).

Taking up the helm, the nursing campus selected for this study designed a peer mentoring programme to link the support that is provided to first year students with the module requirements of the third year students which covers clinical teaching and ward unit management. The peer mentorship is conducted during the first month of the novice student nurses' placement in clinical settings, where they are allocated to medical, surgical or paediatric nursing units. At the end of first six-week block which covers the fundamentals of

nursing science, a professional day event is organised by the campus where both mentors and mentees are called together and are given information on mentoring, its history, purpose and process. Mentees are also given a brief orientation in the form of a role play by the mentors (third year student nurses) of the clinical set up, organisational culture and the expectations of junior nurses in clinical settings. Mentees also receive motivation from guest speakers and ex-students on the nursing profession, expected social, academic and clinical practice conduct and behaviour.

Third year student nurses are assigned to be peer mentors of the first year students. They are given time to meet and greet and to exchange contact numbers. The allocation of senior and junior students is done ad hoc. The programme was communicated to unit managers in the clinical area and was well received. The mentoring responsibilities include facilitation of junior student nurses' transition through provision of orientation, guidance, support and accompaniment, teaching basic clinical skills as well as to be role models and to socialize them into the clinical environment. The programme was also meant to provide support for novice students so that they will not feel alienated and abandoned. Social learning theory by Bandura maintains that students benefit when working cooperatively in pairs or small groups as they can construct understandings and help each other to master skills. However great the design of a programme, its effectiveness in meeting the planned goals must be evaluated, hence the study aims to address this.

1.3 Problem statement

The college of nursing in KwaZulu-Natal has a student peer-motoring programme which addresses the academic, psychosocial and clinical support of novice student nurses. Peer mentoring was initiated following the research findings by Mhlaba (2011) which indicated that student nurses were not adequately mentored in clinical settings because the professional nurses are challenged by heavy workload, time and resource constraints, staff shortage and patient-care demands. This researcher recommended improvements to clinical mentoring for basic nursing education students in clinical settings.

Joubert and de Villiers (2015) highlight that success and effectiveness of support programmes of student nurses in clinical settings should be determined by feedback from mentors and mentees. In the same vein, Robinson and Neimer (2010) assert that despite research

indicating notable advantages of peer mentorship programmes in the clinical area, the lack of programme evaluation and mentor/mentee feedback impacts on the success of these programmes. The limitation in determining the effects of peer mentoring include the limited use of quantitative measures to prove that the undergraduates' grades improve as a direct result of working with their peer mentors as well as the lack of understanding and data regarding the implementation problems and strategies for improving delivery of a peer mentoring programme in an undergraduate environment (Bonin, 2013).

The programme has been in place for three years and student nurses' perceptions have not yet been determined. This study aimed to address this limitation.

1.4   Purpose of the study

The purpose of the study was to explore and describe the perceptions of student nurses on peer mentorship in order to enhance the quality of the peer mentorship programme in the clinical setting.

1.5   Research Objectives

The objectives of the study were to:

- Explore the perceptions of student nurses on peer mentorship;
- Explore the perceptions of student nurses regarding the role of peer mentor;
- Explore the student nurses' perceptions of the role of the mentee;
- Explore the student nurses' perception of the barriers to peer mentoring in clinical settings;
- Explore the student nurses' perceived benefits of peer mentoring in clinical settings; and
- Describe the suggestions made by mentors and mentees on strengthening the mentoring programme in clinical settings.

1.6   Research Questions

- What are the students nurse's perceptions of peer mentoring?
- What are the student mentors' and mentees' perceptions regarding peer mentoring?

- What are the student nurses' perceptions regarding the role of the mentees?
- What are the student nurses' perceived barriers in peer mentoring in clinical settings?
- What are the student nurses' perceived benefits of peer mentoring in clinical settings?
- How can peer mentoring in clinical settings be strengthened?

1.7   The Significance of the study

The results of the research can be utilised in the unit management curriculum that focuses on facilitation of students' learning experiences in the clinical area. The findings can also highlight areas of the mentorship programme that can be strengthened. If proven to be successful the existing peer mentorship programme can be adopted at various other nursing campuses to facilitate learning outcomes of nursing students. Further to this, other disciplines in education can also adopt the programme for their students. It is hoped that this study will act as a catalyst for further studies on peer mentoring in KwaZulu Natal, and in South Africa.

1.8   Operational definitions

1.8.1   Student nurse

A student nurse is an individual who is registered with the South African Nursing Council (SANC) as a student, undergoing full-time training towards attainment of the Diploma in Nursing (General, Community and Psychiatry) and Midwifery (R425). For the purpose of this study, a student refers to all individuals fulfilling the above mentioned criteria of SANC and who participated in the mentoring programme as mentors and mentees at the selected nursing campus.

1.8.2   Perceptions

According to the Oxford English Dictionary (2010), perception is a particular way of looking at and understanding something. It is the process by which individuals detect and interpret information from an external environment by means of sensory receptors. In this study,

perceptions referred to the observations, views and experiences of student nurses of peer mentorship in clinical settings.

1.8.3   Peer mentorship

Peer mentorship is the process whereby the more experienced person serves as a role model, a guide and a supervisor to the less-experienced person. For the purpose of this study, peer mentorship referred to the process where senior student nurses (mentors) provide support, guidance, orientation, role-modelling, and supervision to the novice student nurses (mentees).

1.8.4   Clinical setting

Clinical setting refers to the hospitals and clinics where students are placed in order to gain exposure to learning opportunities so that they can practice nursing and develop into professionally mature and competent practitioners (SANC, 1992). For the purpose of this study, clinical settings encompassed medical, surgical and paediatric nursing units at the hospital where first and third year student's nurses work together and engage in peer mentoring.

1.8.5   Peer

Peers are people who are equal in social standing, rank, age, experience and status. In the current study, a peer implied a student nurse who was undergoing the same educational programme in the same nursing education institution.

1.8.6   Peer mentor

For the purpose of this study a peer mentor was a third year senior student nurse who participated in a mentorship programme and offered guidance, support, teaching, assessment of learning, counselling and acted as a role model to junior student nurses (mentees).

1.8.7 Peer mentee

In the study, a peer mentee referred to a first year student nurse who participated in a mentoring programme and received guidance, support, teaching, assessment of learning and counselling from a third year student nurse (mentor).

1.9 Conceptual Framework

The conceptual framework underpinning this research was adapted from Jokelainen's (2013) study on the dimensions of effective student mentoring in clinical learning environment in nursing (SMiLE-iN). The dimensions that were selected and incorporated in this study were health organisations and mangers, nursing educators and colleagues, mentors, mentees, student nurses, healthcare placement, student nurses' personal and professional growth and development. These dimensions served as concepts of interest in this study and contributed to the personal and professional development of student nurses. The other dimensions were not utilized because they did not have relevance to this study.

1.9.1 Health organisations, managers, nurse educators and colleagues

The quality of clinical learning environments can directly impact on the students' ability to perform effectively in practice upon graduation (Baglin and Rugg, 2010). It is the responsibility of the nursing unit manager to ensure that the nursing unit provides a rich clinical learning environment for student nurses by being supportive of all student supervision models including mentoring. Institutional recognition and support of unit managers and nurse educators to mentoring are important mechanisms for encouraging senior student nurses to serve as mentors and for ensuring that they dedicate the requisite amount of time and energy to the tasks involved (Keyser, Joan, Lakoski, Lara-Cinisomo, Schultz, Williams, Zellers and Pincus, 2008). These researchers also highlight that documenting and monitoring existing policies, programmes, and structures can optimise a peer mentoring programme. In this study the researcher intended to establish the unit managers' and nurse educators' commitment to peer mentoring. The nurse educators at college should establish formal mentorship training programmes for student nurses. The senior student nurses by virtue of their knowledge and level of training are also expected to serve as mentors. Effective peer mentoring relies on nurse educators and unit managers and staff working

together to ensure that student nurses gain expertise and competency (McKenna & French, 2011). To motivate students to take part in the mentoring programmes, the departments can give incentives such as awards for excellence in mentoring or designate time as well as financial resources for mentoring. This study aims to elicit whether the collaboration of the health organisation, nursing unit managers, nurse educators and nursing unit staff members existed and that these structures were supportive of the mentorship programme.

1.9.2   Clinical Settings

The clinical settings serve as the clinical learning environment, therefore, they should be positive and receptive with a collegial working atmosphere (Jokalainen, 2013). The clinical setting should provide an environment where students are treated with dignity and their contributions are valued. They should be supported in their endeavours to acquire clinical skills, attitudes and values. Such an environment makes the students to feel at ease and become motivated to actively participate in clinical experiences (Mogale, 2011). The senior student nurses should be encouraged to explore a variety of teaching strategies aimed at creating a learning environment that is trusting, supportive, dynamic, respectful, fun, and non-judgmental for mentees (Rosenau et al., 2015).

Good interpersonal relationships, communication and support between staff and students create a conducive environment which is essential for student learning in the clinical setting (Kaphagawani & Useh, 2013). Putting the student nurse in an environment where they feel comfortable asking questions and have an increased sense of worth, sets up the ideal situation in which a positive hands-on experience in applying theory to practice is developed (Sims-Giddens, Helton and Hope, 2010).

Research by Mogale (2011) indicates that workload and shortage of personnel impede clinical learning and that shortage of equipment and supplies negatively affect student competency in skill acquisition. Data collected by Kaphagawani & Useh (2013) highlight the importance of a collaborative process in providing student nurses with an understanding of the process of peer mentoring. Time is also an important resource in the development of students in clinical settings, however, students are allocated for shorter periods which may be an impediment in clinical teaching and learning (Dlamini, 2011). Feedback is essential as it gives students confidence, motivation and encouragement and makes them see that what they

are doing is worthwhile. In this study the focus in the clinical settings was on its conduciveness to clinical teaching and learning, staff attitudes and availability of resources.

1.9.3 Mentor Role

The mentors are encumbered with the responsibility of supporting the personal and professional development of mentees. In the early stages of exposure to clinical practice, the mentees are relatively dependent and the mentors need to be supportive, helpful, friendly and encouraging in order to nurture the mentee in such a way that they learn and grow with exposure to empowering learning activities. As time goes on the mentee will gain confidence and become independent and autonomous. During this time the mentor should challenge, stimulate and encourage reflection and critical thinking in order to sustain and deepen learning. Throughout the whole process, both the mentor and mentee should contribute freely and operate as equal partners (Gisi, 2011).

The literature on mentoring has produced useful insights that through peer mentoring, mentors use various strategies to socialize the mentees to the culture, norms, standards, procedures, values, attitudes, knowledge, skills, and behaviours to develop into successful independent nurses (Keyser et al., 2008).

Green and Hawley (2009) assert that during the mentoring and socialisation process, the mentee will have feelings of being an integral part of the team, thereby increasing feelings of satisfaction of working within the unit. Some key skills required when mentoring others include listening and the ability to give positive as well as negative feedback. It is important that the mentors are prepared for their roles. This study aimed to elicit the perceptions of the mentors and mentees on the roles of mentors in the mentorship roles

1.9.4 Role of the mentee.

The mentees have a role to play in the mentoring process. They should commit to the mentoring relationship and should share responsibility with the institution and the mentor for the quality of the relationship. They should clearly communicate their needs and expectations thus making peer mentoring effective (Dennison, 2010). The mentees should also receive preparation for their roles and responsibilities as well as expectations (Giordana and Wedin, 2010). Mentees should work cooperatively with mentors in order to get the best out of the mentoring process. They should be motivated to challenge themselves appropriately (Gisi, 2011) and to act professionally with regard to: time-keeping; adherence to dress code;

attitude and confidentiality; the practice of good communication; a willingness to work with the team; and to identify, communicate and take responsibility for their learning needs (Gopee, 2011). They should also: be honest about their abilities and level of competence; actively participate and seek out learning opportunities; act upon constructive feedback; evaluate the peer mentoring programme; and give feedback (Gopee, 2011). In this study, the perceptions of the mentors and mentees regarding the role of the mentees were elicited.

HEALTH ORGANIZATIONS, MANAGERS, NURSE EDUCATORS AND COLLEAGUES.

- Optimization of resources, supportive and appreciative of mentorship culture.
- Compatible policy and guidelines
- Professional support through feedback system, pedagogical support of mentor education and updates.
- Collaboration of nurse educators, nurse managers, clinical teachers

Personal and Professional Development of Mentor

MENTORS

- Support personal and professional development of mentee.
- Exposes mentee to empowering learning activities.
- Stimulates mentee's reflective and critical thinking

MENTEES

- Preparation for mentee role
- Motivation
- Committed to mentorship
- Cooperative attitude
- Communicate needs
- Feedback provision

Personal and Professional Development of Mentee

CLINICAL SETTINGS

- Positive, receptive, supportive and collegial atmosphere
- Learning opportunities
- Availability of resources for learning

Figure 1.1. Conceptual Framework of Student Mentoring in Clinical Learning Environment in Nursing (SMILE-iN). Adapted from Jokelainen (2013), adjusted by the researcher (2015).

Jokalainen (2013) indicates that the elements in the SMiLE-iN framework (indicated above) are on the content of mentorship and should be used as guidelines to assist student nurses in the journey towards becoming qualified nurses. Mentoring is symbiotic and benefits both the mentors and mentees. The outcome of participating in a mentoring process is the personal and professional development of both the mentor and mentee.

This framework was adopted and adjusted to suit the purpose of the study. The elements of the conceptual framework will be used as a guide in the construction of data collection tools and to strengthen the peer mentorship programme in a selected nursing Campus as explained in each area outlined.

1.10   Conclusion to Chapter one

This chapter covered a background and problem statement of peer mentoring as well as the study significance, purpose, objective, questions and operational definitions. A conceptual framework was laid out and explained. The next chapter will present a literature review of experiences of student nurses with peer mentoring in clinical practice.

CHAPTER TWO

LITERATURE REVIEW

2.1   Introduction

A literature review according to Polit and Beck (2012) is an objective, critical summary of published research literature relevant to a topic under consideration for research, conducted to put the research problem in context. Its purpose is to create familiarity with current thinking and research on a particular topic, and may justify future research into a previously overlooked or understudied area (Brink, van der Walt and van Rensburg, 2012). The literature review generates a picture of what is known about the perceptions of student nurses on peer mentoring in clinical practice and the knowledge gaps that exist in it. The literature search that was undertaken for the study used search engines including: Google Scholar, Pub med, Ebsco Host, Eric, Medline and Academic Search Complete.

The literature review revealed that most studies on the perceptions of student nurses on peer mentoring in clinical practice have been conducted internationally and only a few were conducted in South Africa. The limited research information available with regard to the situation in South Africa stimulated this research.

The content of this chapter is centred around the perceptions of student nurses on peer mentoring in clinical practice which revealed that there are both positive and negative experiences but the positive experiences predominate. According to Stone, Cooper and Cant (2013) peer mentoring facilitates cooperative learning and provides opportunities for students to discover their inadequacies and to correct misunderstanding and it encourages openness to the ideas of others.

Mentoring relationships serve two functions: a career development function and a psychosocial support function (Yob and Crawford, 2012). Career functions involve teaching, coaching, sponsoring, protecting, and challenging work assignments. Psychosocial functions involve role modelling, acceptance, counselling, and friendship. The career functions provide guidance to the mentees and facilitate success. The psychosocial functions provide emotional

support to the protégé, and help to build self-confidence and feelings of self-worth (Anderson and Shore, 2008).

In order to understand peer mentoring process and its development fully, a discussion on the history and definitions of mentoring is necessary.

2.2   Definitions of mentoring

The review of literature on mentoring revealed that there is no consensus on the definition of 'mentoring'. Kilgallon (2012) highlighted that mentoring has its roots in Greece where an old man called Mentor educated and nurtured Telemachus. From their relationship, a first definition of mentoring evolved as being an older, experienced person (mentor) working with a younger and inexperienced person (mentee/ protégé) with an intention of helping to shape his growth and development (Li et al., 2011). The hierarchical nature of mentoring is also discussed by Andrews and Clark (2011) who argue that mentoring represents an interpersonal exchange between a senior experienced colleague (mentor) and a less experienced junior colleague (protégé) in which the mentor provides support, direction, and feedback regarding career plans and personal development. The helping nature of mentoring is acknowledged by authors such as Andrew and Clark (2011) who define a mentor as a person who helps another individual to address the major transitions or thresholds that the individual is facing and to deal with them in a developmental way. Colvin and Ashman (2010) add that mentoring is a close relationship between two people with the primary goal of helping the mentee to address career challenges and take advantage of opportunities to grow on the job. Kilgallon (2012) explained that mentoring is a complex, purposeful relationship underpinned by knowledge, experience and opportunities for reflection which is aimed at helping the protégé to identify learning needs.

Kilgallon (2012) acknowledges the value of support given to the mentee and therefore defines mentoring as a protected relationship which provides support and knowledge, helping to remove fear of failure by building confidence. It enables learning and experimentation to occur, skills to develop, and results to be measured. Colvin and Ashman (2010) argue that mentoring is a dynamic, reciprocal relationship in a work environment between an advanced career incumbent (mentor) and a beginner (mentee) aimed at promoting the career development of both.

Casey and Clark (2011) acknowledge that mentoring is a concept and practice that is related to facilitating professional learning in healthcare that has evolved consistently since the 1970s and was formally implemented in pre-registration nursing and midwifery education in the 1980s. Casey and Clark (2011) also mention that the term 'mentoring' has gradually evolved to refer to the activity of designated persons who dedicate some of their time to helping individuals to learn during their developmental years, to progress towards and achieve maturity and to establish their identity. It has been implemented as a formal role in nurse education to direct focus on enabling student nurses to gain safe and effective clinical practice skills during practice placements.

Kilgallon (2012) describes mentoring in nursing as a process of teaching and learning that occurs within a reciprocal relationship between two nurses of different ages, personalities and credentials. In a related manner, Casey and Clark (2011) pointed out that mentoring is a process that provides teaching, sponsoring, guidance, socialisation into a profession and provision of counsel and moral support that allows the mentor to aid the mentee in the realisation of dreams.

The defining attributes of mentoring that are used across several health and non-health as well as social care professions include "being a role model, being a facilitator, having good communication skills, being knowledgeable about the field of expertise, and understanding the principles of adult education" (Gopee, 2011). This researcher further highlights that the definitions of a mentor should encompass:

- nurturing;
- enacting the role of a teacher, sponsor, encourager, counsellor and friend;
- focusing on the professional development of the mentee; and
- sustaining a caring relationship over time (Gopee, 2011).

2. 3   The Nature of Peer Mentoring

Slightly different titles and terminologies are used interchangeably by different healthcare professional groups for peer mentoring, including cooperative learning, peer review learning, mentoring, peer coaching, team learning, peer learning, and problem-based learning (Stone et

al., 2013); collaborative learning, peer learning partnership and peer assisted learning (Christiansen and Bell, 2010) peer tutoring (Colvin and Ashman, 2010).

Joubert and de Villiers (2013) remind us that peers are individuals who share some common characteristics, attributes or circumstances which may relate to age, ability and interests. Peer mentors have more experience within the common area along with additional training on how to assist others in acquiring skills, knowledge and attitudes to be more successful.

Peer mentoring according to Purfeerst (2011) is a mentoring relationship where the mentor and the mentee are similar with regard to age and or status. To Colvin and Ashman (2010), peer mentoring involves the teaching, supervision and guidance of one student by another. However, Botma et al., (2013) state that peer mentoring occurs within the same educational programme where the senior student nurse, as a more experienced peer, shows the ropes to a less experienced colleague. Similarly, Christiansen, Bjork and Hessevaagbakke (2011) refer to peer tutoring as a system which involves students helping each other to learn and learning themselves by teaching. It places commitment and responsibility for the teaching and learning experience on students. Colvin and Ashman (2010) maintain that peer mentoring is conducted between people of equal status. These definitions move away from the traditional view of an hierarchical nature of mentoring in that they suggest that peer mentoring involves a relationship between equals and often younger individuals, rather than between a senior, more experienced person and a less experienced person. In the same vein, Andrew and Clark (2011), support the importance of equality within the peer mentoring relationship when they stress that in order for mentors and mentees to view themselves as peers, the mentors should demonstrate an interactive and collaborative approach. Likewise, Lopez (2013) stresses that in a peer mentoring model, mentoring is provided by individuals who are essentially equal in age, experience and rank. Due to the inherent equality among these student nurses, relationships are more mutual and each participant has something of value to contribute and gain. They further mention that these relationships are more likely to offer personal feedback and friendship than the traditional mentoring. The absence of power inequality, and the reciprocity of the relationship allows for mutual feedback in the mentoring relationship and in career planning (Lopez, 2013).

Andrew and Clark (2011) further mention that there are three types of peer relationships: Information Peers - for information sharing; Collegial Peers - for career support; and Special Peers - for confirmation, emotional support, personal feedback and friendship.

Peer mentoring may form part of the senior students' practical requirements to develop teaching skills as part of the training programme. In South Africa, peer teaching is a module requirement for Ethos and Professional Practice which is done in the third year of the four-year course diploma in the general nursing programme. Kaphagawani and Useh (2013) add that peer supervision and guidance provides students with a useful perspective on their performance, which they can gain in ways that are more informal and less threatening than that which can be provided by registered nurses.

Earlier researchers such as Zilembo and Monterosso (2008) revealed that peer learning enables student nurses to achieve a deeper understanding of the subject matter by reorganising the existing knowledge, clarifying and exemplifying the knowledge and applying the knowledge in practice. Peer mentoring facilitates cooperative learning which provides student nurses with opportunities to discover their inadequacies, to correct misunderstandings, and it encourages openness to other student nurses' ideas. Christiansen et al., (2011) also stress that peer mentoring is an active learning process which enables student nurses to develop critical thinking skills and to analyse, synthesise and communicate information while solving clinical problems. This is in line with Jokelainen et al., (2011) who stress that peer mentoring deepens the development of critical and reflective thinking which is achieved by the creation of opportunities such as facilitating students to learn from experiences using active listening, discussions and sharing of nursing experiences. Mentoring also involves encouraging student nurses to reflect consciously on nursing procedures and their own learning. These researchers further highlight that critical reflection is developed by encouraging student nurses (peer mentees) to ask questions, to present arguments about nursing practice and to debate the key issues. Mentoring also facilitates the development of problem-solving and decision-making skills by helping to clear up difficult nursing situations (Jokelainen et al., 2011). Dennison (2010) & Joubert and de Villiers (2015) support this by stating that in their study both mentors and mentees sought answers to problems from various sources of information and shared clinical experiences.

Dennison (2010) & Rosenau et al., (2015), state that peer-to-peer learning provides learning opportunities for junior student nurses and it increases leadership and teaching skills of senior nursing students. Rosenau et al., (2015) further stated that peer mentoring with nursing students can be applied in a variety of contexts including to academic study, socialisation and personal growth as well as to laboratory or practice skills. Senior student nurses provide a link that closes the gap between the nursing laboratory and the ever-changing health care

policies, procedures, supplies and equipment. According to Christiansen et al., (2011), the quality of mentoring and peer support available in the clinical practice area has an impact on the learning experiences of student nurses.

According to Andrew and Clark (2011), peer mentoring in higher education serves three main functions: (a) emotional and psychological support (b) direct assistance with career and professional development and (c) in role modelling. They also indicate that mentors are required for various reasons including the opportunity to make friends; assistance with acclimatising to tertiary education life; helping to come to terms with the new identity of being a tertiary student; helping to deal with personal problems; providing the opportunity to discuss difficulties or concerns over academic work; providing assistance with understanding vocational or professional demands; helping with non-study related matters including personal problems and difficulties with culture or language (Andrew and Clark, 2011).

Several researchers (Giordana and Wedin, 2010; Stone et al., 2013 and Rosenau et al., 2015) argue that peer mentoring programmes have been shown to: reduce student nurse anxiety; provide a positive learning environment; boost self-esteem and confidence; lessen confusion; increase student interaction at various levels; and improve retention rates among first year student nurses. These findings are consistent with Christiansen et al., (2011) who state that peer tutoring strategies can improve student nurses' motivation, participation, communication, responsibility for learning and confidence.

Jokelainen et al., (2011) highlight that mentoring is a process, where student nurses interact as professional partners in co-operative relationships in patient care situations. Working together means that novice student nurses are introduced to different kinds of nursing activities, which are appropriate for their level of training, in every shift where they should work side-by-side with peer mentors. A close interactive relationship includes acting as equal pairs in cooperation, having mutual, trusted communication and interaction and working together as collegial friends. This is congruent with the studies of Christiansen et al., (2011) who state that a peer mentoring project provides a vehicle for encouraging collegial interaction and learning amongst student nurses.

Jokelainen et al., (2011) also mention that peer mentoring facilitates student nurses' emotional development by helping them to understand their own feelings and emotions and those of the patients they care for and they learn to deal with different emotional nursing situations. This is consistent with Stone et al., (2013) who argue that peer learning can be

utilised in multiple situations from teaching ethics and critical thinking to helping student nurses deal with emotional situations with patients.

In a study by Yob and Crawford (2012) on establishing and maintaining mentoring relationships, it transpired that creating an effective mentor-mentee relationship requires the competence to create increasingly trust-worthy settings whereby the mentors perform appropriate care-giving functions which allow mentees to experience themselves as valued and supported. The mentees need to make themselves increasingly visible and disclose what they are thinking, feeling and perceiving in the course of seeking support and guidance.

Additionally, Yob and Crawford (2012) found that the most powerful learning is often provided by the mentor-mentee relationship which provides both task learning and socio-emotional learning. To build rapport, the mentee should capture the mentor's interest and commitment while the mentor must be able to help the learner sort out what he or she wants to achieve and to set and adhere to a schedule of meetings.

Hughes and Becky (2009) highlight that mentors and new students are encouraged to communicate on their own terms. Mentors answer questions and talk about the best ways to navigate through courses. Mentors, as veteran students, are good problem-solvers and sounding boards for the varied frustrations that new students may encounter. These researchers further mention that new students often feel more comfortable asking other students about course requirements and other facets of the programme than seeking this information from a faculty member.

2.4   Types of Peer Mentoring.

2.4.1. Formal Peer Mentoring

Keyser, Joan, Lakoski, Lara-Cinisomo, Schultz, Williams, Zellers and Pincus (2008) indicate that formal mentoring relationships are prescribed and established by organisations and the mentors and mentees are matched based on some criteria such as similarity of interests and experiences, complementary values, skill sets, and styles of interaction. In clinical practice, a formal peer mentoring programme occurs where senior student nurses either doing third year of training, are allocated to oversee junior first year student nurses as mentees. However,

Akanni (n.d) argues that formal or planned mentoring focuses on the needs and goals of the organisation such as increasing productivity, eliminating turnover and reducing absenteeism.

The programme is facilitated by a qualified person who could be the nursing unit's professional nurse or the college faculty member (lecturer) forming a tripartite group (Christiansen et al., 2011 & Joubert and de Villiers, 2015). The role of the programme coordinator is to provide support to both senior and junior students but particular attention should be given to the mentors because some mentors reported initial apprehension and the need for ongoing support during the programme. The coordinator also provides oversight and ensures that confidentiality is maintained by all parties. The coordinator provides constructive feedback that will enhance the student nurses' development, encourage reflection time for both groups and this ensures that the senior student nurses' learning needs are not neglected. The coordinator oversees the operations and evaluates progress (Stone et al., 2013). Colvin and Ashman (2010) suggest that academic involvement and interaction with faculty and fellow students increases the time and physical and psychological energy that students devote to the academic experience.

In Norway, mentors' participation in the programme is voluntary. All students who are at the level of performing mentoring duties undergo preparation which may be embedded in their curriculum (Christiansen et al., 2011). Keyser et al., (2008) indicate that a training seminar is arranged to introduce the concept of peer mentoring, ground rules, role and responsibilities of mentors as well as basic teaching and learning principles. Written guidelines explaining what each party can expect from the mentoring relationship, including an outline of respective duties and responsibilities are issued (Pillay and Mtshali, 2008) to improve the mentoring relationship. Mentors and mentees are required to report on the progress of the relationship and their satisfaction with specific institutional components intended to support it. Hughes and Becky (2009) maintain that assertiveness skills, available support services for student nurses, when and how to refer junior student nurses to support services, common problems encountered by new student nurses as part of peer programme development, clinical learning strategies and strategies for managing peer mentor sessions form part of the preparation of mentors. Joubert and de Villiers (2015) highlight that the mentors are provided with the set of course materials which include the syllabus, objectives and content to be covered.

According to Akanni (n.d), regular scheduled meetings or discussions as well as informal interactions are held to encourage and support the mentoring progress. All members are

expected to attend meetings and give feedback to each other on individual teaching and clinical endeavours. Both mentors and mentees are encouraged to keep a reflective journal about their experiences with the programme (Payton, Howe, Timmons and Richardson, 2013).

The duration of the mentoring relationship is determined by the organisation. In Nigeria, the duration is usually six to eight months or when the organizational goals are reached (Akanni, n.d).

2.4.2. Informal Mentoring

Mhlaba (2011) identified that with informal mentoring, the relationship between the mentor and mentee develops spontaneously or when the need arises. Mhlaba (2011) further clarifies that informal mentoring is characterised by unspecified goals, long-term relationships, unknown outcomes, self-selection of mentors and mentees and no expert training or support. She also mentions that informal mentoring gives little attention to the learning needs of students in practice settings as it prioritises getting work done and the provision of service. It mainly assists in the transfer of knowledge, departmental communication and organisational learning and is less effective in students' education. In a related manner, Akanni (n.d) maintains that the mentor or the protégé seeks the other one out or they both initiate the relationship as they are paired together by their own internal forces such as liking or respect for each other, which forms the ingredient that creates the relationship. He further mentions that it is friendship rather than a job requirement that keeps the two parties together. This researcher also found that informal mentoring evolved spontaneously without a formal mandate and was based on a need and on an interpersonal attraction.

In their study of formal and informal mentoring, Desimone, Hochberg, Porter, Polikoff, Schwartz, and Johnson (2014) discovered that informal mentors focus more on social and emotional issues than formal mentors. Emotional support can boost confidence of novice student nurses, increase their morale and job satisfaction, and reduce their feelings of isolation. Formal mentor assignments are rarely able to consider personality and temperament, which can play a critical role in the effectiveness of a mentoring relationship. Novice student nurses may choose informal mentors based on their perceptions of similar or complementary social or emotional characteristics, which may allow different types of connections, trust, and interactions. Desimone et al., (2014) further reiterated that novice student nurses seek the help of informal mentors to compensate for what they are not

receiving from their formal mentors; whether that is emphasis on emotional support or some other aspect of support. They also state that informal mentoring results in more benefits such as social support, due to closer bonds that are formed in the relationship.

2.5 The need for mentoring in nursing programmes

Novice student nurses face a multitude of challenges when they are inducted into the nursing profession. They struggle with inevitable problems such as isolation; role conflict and reality shock (Li et al., 2011). Other challenges include: lack of academic preparation for tertiary education; lack of commitment; lack of good study habits; loneliness; alienation; lack of peer understanding and knowledge of cultural differences (Payton et al., 2013).

Moscaritolo (2009) and Li et al., (2011) reported that high levels of stress and anxiety in the clinical learning environment interferes with the student nurses' academic performance impeding concentration, memory, and problem-solving ability and leading to the development of poor coping skills and inability to participate in clinical learning. It is this heightened sense of anxiety that deserves attention and intervention so that the student nurses can apply their knowledge skilfully in an environment that is supportive and conducive to learning, which will facilitate success and increase retention (Payton et al., 2013). Jokelainen et al., (2011) claim that it is possible to achieve collegiality and friendship in a mentoring relationship, but these rarely occur in clinical practice.

Jokelainen et al., (2011) also maintain that the culture of working is crucial in determining success of the learning experience. However, novice student nurses have little experience with the culture of the clinical learning environment as well as limited understanding of how to negotiate and work within that culture to maximise their opportunities for learning. Peer mentoring is a strategy that seems useful in reducing stress and anxiety, improving confidence and in helping student nurses to understand and to negotiate the culture of the clinical environment.

Winterman, Sharp, McNamara, Hughes and Brown (2014) suggest that the novice nursing students should be taken under the wing of an experienced mentor rather than leaving them to flounder in response to the numerous challenges. The mentor eases the induction process of a mentee by providing information and guidance to the workplace. They further mention that

through positive role modelling and leadership skills, the mentors are expected to provide student nurses with expert teaching, personal support and a robust assessment to ensure they gain competence in nursing practice. This is concurred by Kilgallon (2012) as he states that the novice student nurses need mentors for guidance and support. Mentors also structure the working environment for the student so that the novice student nurses becomes familiar with the ways of working on those clinical areas. Mentors are role models and they provide an appropriate knowledge base for the mentees. They give them encouragement and support and thus help them to build confidence. The mentor gives constructive feedback and debriefing after a bad experience (Kilgallon, 2012).

Murphy (2012) reminds us that in a busy clinical environment, mentoring and supervising pre-registration student nurses can be challenging for registered nurses. Senior nurses assist as mentors to identify and address pre-registration nursing students' learning needs and ensure competent and safe practice. Colvin and Ashman (2010) further add that peer mentoring enables students to act as facilitators for each other in clinical situations, to provide encouragement to each other which contributes to the development of independence, and preparation for their future caring and teaching roles as nurses. These researchers reiterate that responsibility, initiative and independence which are the basis for peer mentoring, increase student nurses' self-confidence and contribute to deeper contact with patients and opportunities for problem-solving and decision-making.

According to Christiansen et al., (2011) organising learning would not only enhance practical skill learning in 1st year student nurses, but it will also provide an arena for 3rd year student nurses to develop competence in supervision and to develop the capacity to be assessors of learning. Competence in supervision is regarded as crucial for professional nurses in interaction with unskilled staff, students and patients, and is therefore part of the curriculum for 3rd year nursing students.

2.6 Characteristics and Roles of the Mentor

The literature on mentoring has produced useful insight regarding personal characteristics of a good mentor and personality traits that can enhance the mentoring relationship. These characteristics according to Gopee (2008) include patience, open-mindedness and approachability. The mentors should have a good knowledge base and be up to date in their

knowledge and practical skills. He further mentioned the ability to communicate verbally and the ability to listen, to encourage mentees and to demonstrate concern, compassion and empathy. In discussing this, Winterman et al., (2014) added that in the beginning the mentor will need to develop a safe and protected environment and be a supporter, protector and guide, but as the mentee develops confidence and becomes less dependent and more autonomous, the mentor will need to develop a more analytical, reflective, critical, and challenging role. The mentor should provide empathy, candour, openness and honesty. He/she should also be willing to share his/her expertise, and should not feel threatened by the mentee's potential for equalling or surpassing him/her, nor by the mentee detecting weaknesses and shortcomings (Winterman et al., 2014). This view is supported by Keyser et al., (2008) as they regard trust, respect, understanding, flexibility, patience, integrity, support, vision, approachability, accessibility, and ability to communicate as the ideal characteristics of a mentor.

Potential mentees must be enthusiastic, willing to be challenged and guided, willing to relate and share, and they should be clear about what they want in a mentor.

2.7   Advantages of Mentoring

2. 7.1   Advantages for the Mentor

Dennison (2010) remarks that through peer mentoring, students as mentors have the opportunity to start developing the qualities and skills required for mentoring roles in clinical settings such as effective communication, confidence, organisational skills, approachability, understanding and enthusiasm. This is congruent with the studies done by Christiansen and Bell (2010) who claim that the mentor benefits from mentoring as reorganising and communicating information to the mentee promotes deeper understanding of the subject matter. The study by Christian and Bell (2010) went on to reveal further findings where the mentors highlighted that much more tangible learning occurred when they facilitated the development of a junior nurse's clinical skill and ensured that students were emotionally prepared for practice. They stated that the process of organising, simplifying and clarifying an explanation or skill while helping the mentee to understand, facilitated the mentors' own reflective learning. The sharing of responsibility for developing a junior nurse and facilitating his or her learning brings affective and cognitive gains and the internal positive feedback

builds confidence. Senior student nurses also obtain recognition and positive feedback from junior student nurses (Christianson and Bell, 2010).

Engagement of senior student nurses in peer mentoring where they provide support and encouragement enhances personal and professional growth and self-worth. This increases self-esteem which enables them to fulfil their role compassionately and with care (Christiansen et al., 2011). Mentoring provides them with an early exposure to being role models and promotes their attitudes towards the teaching function with future generations. Dennison (2010) states that peer mentoring increases leadership and teaching skills of senior student nurses.

Gopee (2011) concurs that the mentors develop personal gratification from aiding and abetting the development and learning of another student nurse, self-development through reflective practice and all this contributes to the improvement in self-confidence. Hodgson and Scanlan (2013) add that the psychosocial support that the mentor provides to the protégé makes the mentor feel important, respected and valued. In the same vein, Botma et al., (2013) say that acting the role of being a confidant and counsellor makes the mentor feel helpful and enhances his or her feeling of accomplishment. The mentor's satisfaction may also increase due to helping a less experienced colleague (Botma et al., 2013).

Dennison (2010) notes that in his study the mentors reported that participating in a peer mentoring programme enabled them to measure their own learning in terms of how much they know and how much they still have to learn. Mentors also reported an improvement in their clinical skills and that they had developed more effective learning strategies as a result of participating in a mentoring programme. Likewise, Joubert and de Villiers (2015) maintain that mentors develop the ability to reflect on their own knowledge and skills and that this encouraged them to go back to their books and read again. In both studies (Dennison, 2010 & Joubert and de Villiers, 2015), mentors felt the pressure to keep abreast of current practice as the mentor-mentee relationship is perceived as a partnership that leads to professional development of both parties.

Giordana and Wedin (2010) in their study of peer mentoring for multiple levels of nursing students, found that when mentors reflected on their mentoring activity, they noted that they had improved on their leadership skills. Similarly Jokelainen (2013) identified that mentors benefits included notable improvement in leadership skills and self-confidence.

Yob and Crawford (2012) contend that mentors' communication skills and clarifying skills are enhanced and that this facilitates effective discussions. The mentors learned the importance of asking less complicated questions at the beginning and then to build up to more complex questions and that to be approachable and sensitive to the needs of the mentees were useful tactics to effective mentoring.

2.7.2. Advantages for the Mentee

The aim of mentoring for the junior students is to reduce initial anxiety which they usually experience in their clinical placement area, to assist them to develop essential care skills, to aid them in the integration of theoretical knowledge into practice and to encourage them to reflect on their own practice (Stone et al., 2013).

Giordana and Wedin (2010) in their study of peer mentoring for multiple levels of nursing students, found that mentees reported being less anxious by the second day in the clinical practice area. They perceived that to be corrected by a mentor was less intimidating than being corrected by the instructor. They also felt a heightened sense of confidence after working with mentors and felt comfortable with performance of tasks. They were also reported to be better able to take care of patients than the junior student nurses who had not been mentored. This is consistent with the findings of Stone et al., (2013) whose study discovered that, as a result of the orientation, help and support that the novice student nurses got from their senior counterparts, the mentees reported reduced anxiety in making the transition to the clinical setting.

In their study on a systematic review of nursing students in clinical placement, Jokelainen et al., (2011) highlight that through mentoring, the novice nurses are made familiar with the clinical placement areas as the working environment and are taught the culture of care and equal participation in teamwork. In this way the mentees become committed to their duties. Mentees learn to cooperate with other stakeholders in placement who are participants in their clinical training. These researchers also mention that mentees grow from being observers to being independent workers, step by step and they develop skills in coping with nursing actions independently. They also maintain that mentoring deepens the development of critical and reflective thinking because opportunities for development of these skills are created whereby student nurses are encouraged to consciously reflect on nursing procedures and their

own learning. Development of decision-making and problem-solving skills is also facilitated by engaging students in clinical discourse and sharing of ideas and experiences (Jokelainen et al., 2011).

Christiansen et al., (2011) conducted a study on student nurses as peer mentors and found that mentees reported increased learning and development of new learning as a result of accessibility of their mentors in terms of information provision; emotional support and availability of mentors as resource persons. This is argued by Kaphagawani and Useh (2013) who conducted a study in the North West Province, South Africa, on an analysis of nursing students' learning experiences in clinical practice and found that student nurses perform better both clinically and academically if they have support from peers and significant others. They further mention that lack of peer support in the clinical environment is manifested by conflicts, tensions and competitions for opportunities for practice, and this is detrimental for learning. When student nurses support each other, they discuss their practice, share knowledge, skills and experience and thus become socialised into the profession (Kaphagawani and Useh, 2013).

In a study that was conducted by Joubert and de Villiers (2015) in the Free State Province of SA, addressing the social, academic and clinical needs of undergraduate students, the mentees reported positive experiences including the ability to integrate theory with practice and improved clinical performance due to clarification of ideas and the rehearsal of skills under supervision and guidance from mentors. They reported that their mentors provided them with support which created a relaxed and non-threatening clinical environment in which they felt safe, secure and free to unburden themselves without being judged. They also reported that the emotional bond that they had with the mentors enhanced better understanding, communication and interpersonal relationship which resulted in better practical achievements. They also adapted easily to the hospital surroundings which boosted their self-confidence. It is the increased self-confidence that enabled them to gain greater personal control of the learning environment and this motivated them to learn. This is echoed by Stone et al., (2013) as they state that the increase in confidence levels promotes interactive learning and active participation which encourages students to take responsibility and ownership for their own learning.

Various studies (Dennison, 2010; Christiansen and Bell, 2010; & Christiansen et al., 2011) explain that through peer mentoring, students have the opportunity to start developing the

qualities and skills required for mentoring roles in clinical settings such as effective communication, confidence, organisational skills, approachability, understanding and enthusiasm.

2.7.3. Advantages of peer mentorship programmes for the organisation

Jokelainen et al., (2011) indicate that formal mentoring programmes ensure that protégés are better socialised into the corporate culture because mentors spend time teaching them the ropes. This means that protégés learn about the organisation's values and performance metrics more quickly. In addition, mentoring is also related to lower protégé turnover rate. This higher retention can save considerable money and time that would have been spent recruiting new students. Kaphagawani and Useh (2013) highlights that when junior student nurses are assisted by their peers through cooperation and emotional support, they eventually become independent of their clinical supervisors. This will enable the registered nurse to engage in patient care and management duties, knowing that senior students are supervising juniors. Casey and Clark (2011) concur that peer mentoring is beneficial in terms of promoting best practice in that the presence of students in the healthcare setting leads to a culture that values reflection and interrogation of practice thus promoting evidence-based approaches to care and a spirit of creativity in overcoming barriers to improving practice. Jokelainen et al., (2011) mention that nursing values, standards and culture are shared through mentoring of new nurses, thus nurses become empowered to do and be more for themselves and for the profession.

Within nursing education, the benefits derived from a peer mentorship as pointed out by Rosenau, Lisella, Clancy and Nowell (2015), included the fact that nurses who had positive peer-mentoring experiences as students may later on in their career be more willing to take on a leadership role and serve as mentors to those entering the profession. These researchers also posit that incorporating students as supplementary teaching support mechanisms in clinical practice has been established and recognised worldwide as a valuable strategy to positively influence cognition and to positively affect both the peer leaders (mentors) and the student nurses taught. They also acknowledge that the academic gains associated with formalised peer leadership are equal to or greater than some of the conventional procedures involving lecture and student discussions. Peer mentoring also prepares students for complex job responsibilities and leadership roles (Rosenau et al., 2015). Meanwhile Dennison (2010)

maintains that the implementation of peer mentoring programmes are a resourceful way to increase student productivity and skill acquisition while lightening the workload of an already strained nursing faculty population. A study conducted by McKenna and French (2011) yielded results that indicated that senior-led peer mentoring review groups produced evaluation results which were equivalent to evaluation results from instructor-led review groups. Such findings may signify an opportunity to allow peer mentors to adopt some educational tasks in which direct instructor supervision is not needed, allowing nurse educators more time with other educational matters.

2.8   Disadvantages of Mentorship

2. 8.1.   Disadvantages for the Mentor

In their study on roles, risks and benefits of peer mentoring relationships, Colvin and Ashman (2010) identified the following risks or challenges: getting very emotionally attached to the mentee and then having to let go at the end of the mentoring programme, students being too dependent on the mentor and using the mentor as a crutch forgetting that the mentor is only there to help and not to do everything for the mentee. Conversely, the mentor may not be accepted by the mentee, creating challenges because the mentor is supposed to be helping and working with the mentee.

In a study by Li et al., (2011) on the effects of a peer-mentoring strategy on student nurse stress reduction in clinical practice, a mentor voiced concern that he felt stressed because he needed to spend time with his patients and did not have time for his mentee. This holds true because in clinical practice a case assignment method of work allocation is sometimes used and student nurses as mentors have to attend to their patients while they are also assigned to mentor novice student nurses.   Another mentor mentioned that it is difficult to mentor students when there are big gaps in abilities among student nurses. Some students are naturally slow graspers and it is really difficult for the mentor who is still a student himself to handle a mentee with learning difficulties. Other mentors in the same study by Li et al., (2011) complained about an increased load and stress because of having to help their mentees who had different learning behaviours and characteristics than what they expect in an academic class. Some mentioned that some mentees displayed a lack of initiative and motivation to find answers on their own and were totally depend on mentors.

An additional challenge for the mentors that is highlighted by Halcomb, Peters, and Mcinnes (2012) is skill deficits on the mentees' side, where the skill levels are below the standard expected of the students' academic level. These researchers found that some mentors felt challenged because they have to ensure that the students become competent with the skills yet they are still students themselves.

2.8.2. Disadvantages for the Mentee

Researchers, (Kaphagawani and Useh, 2013) reported that students feel anxious and confused if a discrepancy is found between what is taught in class or in simulation and what is actually implemented in the clinical practice. Students become nervous and anxious if the mentor appears to be uncertain about his or her knowledge and actions. In support of this discussion, Colvin and Ashman (2010) mentions that mentees get concerned when mentors fail to fulfil their role, are not dedicated or are not friendly. Colvin and Ashman (2010) go on to state that due to the hierarchical nature of the relationship between mentor and mentee, help, power, and resources tend to flow in one direction, creating the possibility for misunderstanding or misuse of such power and resources, leading to challenges and resistance.

2.9 Challenges of Peer Mentoring

One of the main challenges associated with both peer mentoring and peer tutoring in academia reflects unsuitable pairings. This is particularly the case where weak students are paired with other weak students as this can result in little or negative pedagogical impact (Andrew and Clark, 2011). Halcomb et al., (2012) drew attention to issues around trust and confidence, pointing out that difficulties arise when students lack confidence in the quality of their partners. Across all higher education mentoring programmes the main challenges reflect academic, social and personal boundaries between mentor and mentee. In discussing this, Anderson and Shore (2008) argue that despite the fact that the boundaries may be indistinguishable at times, it is the mentors' responsibility to maintain clear academic and personal boundaries between themselves and the mentee. In the same vein, Lascelles (2010) states that a quality mentoring relationship requires trust and effort from both members, which comes about when the mentor and protégé welcome

the opportunity to learn about their differences. They further mention that mentoring partners with similar backgrounds may easily perceive each other as trustworthy and predictable since they share many commonalities. In a cross-gender or cross-cultural mentoring relationship, there could be a lack of comfort due to the uncertainty of the other person's culture, experiences, values, and behaviour.

Mhlaba's (2011) study on views of nursing students and clinical mentors on clinical mentoring identified a number of challenges which may render mentoring unfruitful and ineffective such as staff shortages, time constraints, students being used as workforce, competing commitment and lack of resources and infrastructure. Likewise Stone et al., (2013) stress that observation and supervision of students by a professional nurse or lecturer is required in all peer learning to ensure that the correct and current information is being exchanged because if peers are not knowledgeable or do not have the appropriate skill, they cannot accurately pass information onto other students. On the other hand, Mntambo, (2009) points out that shortage of staff, particularly with senior nurses may be a limitation to effective mentoring in the clinical arena. Lack of supervision may lead to students becoming incompetent, and losing interest in the nursing profession, as they feel frustrated in their work due to incompetence. This is supported by Joubert and de Villiers (2015) who found that mentors find it difficult to mentor two or more students at the same time.

Another challenge in peer mentoring is time constraints. Mhlaba (2011) pointed out that if students are allocated to a clinical area for a short period of time such as two weeks and then sent back to college, this causes an interruption in their clinical practice and can affect learning opportunities and clinical experience. Clinical teaching is less effective when continuous interruptions occur during the sessions or when there is insufficient time to assimilate information. Some students take longer to achieve competency in certain procedures and need more time to practice the skill. Students need enough time to assimilate content, expand their thinking about patient care and to improve decision-making and problem-solving (Mhlaba, 2011).

The nature or type of nursing unit such as intensive care units may not be conducive to peer mentoring because of patient acuity levels and duration of students' stay in those areas. Joubert and de Villiers (2015) in a study on peer mentoring in critical care units revealed that mentors experience difficulty in performing mentor roles in a critical care unit. This is due to challenges such as the inability to strike a balance between overloading and underexposing

the mentee with work, the critical care units being overwhelmingly busy and the duration of allocation of student nurses in an intensive care unit is too short when there is lot of information to be disseminated to them as mentees. Similarly the study findings of Mhlaba (2011) highlighted that mentoring in intensive care units is challenged by the fact that the intensive care units are very busy and different from other nursing units because the condition of patients is complex and unstable and there is too much to be learned. She further mentioned that students experience reality shock during the first weeks of placement in intensive care unit and they do not learn much.

Researchers, Joubert and de Villiers (2015) identified that the incompatibility of mentor-mentee personalities and learning styles may result in the occurrence of poor learning. Some mentors are reluctance to mentor students and as a result, they spend very little time working with their mentees. Some could not be on duty at the same time with them and when a mentor is absent or sick, no one else readily takes over this role. Lascelles (2010) highlights that the mentoring relationship may face many dilemmas and challenges such as mismatch of expectations; a reluctant mentor/mentee; over-zealous mentees ; the fact that the relationship may not be valued in the organisation; cultural mismatch; gender and race mismatch as well as emotional involvement.

Similarly, Akanni (n.d) mentions that there could be deviant interpersonal behaviour such as sexual harassment, aggressive acts and verbal abuse. To counteract the perceived risk of sexual involvement and concerns about public image which may inhibit a mentoring relationship, Anderson and Shore (2008) recommend that the peer mentoring relationship be maintained at a professional level and boundaries should be discussed, established and respected.

According to Stone et al., (2013) some mentors reported anxiety, apprehension and a feeling of responsibility for another student nurse's education. They reported to be under-prepared and concerned that their own grades would be negatively affected by group work or dynamics. Forcing the nurse to take part in a mentoring programme after he or she has expressed unwillingness to adopt the role may lead to resentment. Stone et al., (2013) also highlight that even if student nurses have a responsibility to teach others, many are reluctant to do so.

 Winterman et al., (2014) point to the lack of time, workload, lack of staff and patient dependency that can hinder the mentorship role. According to these researchers, the daily

challenges and demands of current nursing situations and contexts make it difficult for the mentors to fulfil this role effectively.

2.10   Types of Organisational structures that can facilitate Peer Mentoring

According to Jokelainen et al., (2011), leadership and management enacted by the ward manager or head nurse are essential baselines in organising, coordinating and developing student mentoring in placements. It is also essential for management to provide opportunities for student mentoring with enough resources and education. Kaphagawani and Useh (2013) mention that a clinical environment that positively influences learning is manifested by friendly and happy staff with good morale, positive attitudes, and with cooperation and willingness to teach and guide student nurses. A supportive learning environment must be created. A positive ward atmosphere creates a feeling of security and this enhances the quality of clinical placement and learning opportunities.

2. 11   Organisational structures that inhibit Peer Mentoring

Mabuda et al., (2008) found that a shortage of equipment and staff were identified as obstacles to the facilitation of student nurses' learning in clinical areas. They further reiterate that the gap between theory and practice is accelerated by the lack of equipment in clinical practice, making it difficult for the registered nurses to teach student nurses. Due to a shortage of staff and high bed occupancy, it is difficult for the experienced professional nurses to guide and supervise the new student nurses sufficiently (Mabuda et al., 2008).

Mntambo (2009) mentions that relational problems, including unfriendly staff and staff with hostile attitudes, may inhibit mentoring. Earlier researchers, Cassimjee and Bhengu (2006) revealed that a poor relationship between the students and supervisors resulted in inadequate supervision and lack of feedback, thus affecting acquisition of competencies by student nurses.

2.12   Conclusion to Chapter two

Peer mentoring is a professional behaviour that contributes to career success and to the development of professional leaders since both mentors and mentees benefit from the relationship in terms of increased satisfaction and sharing of knowledge and wisdom. Peer mentoring contributes to a sense of intra-professional support that reflects the nursing ethos of caring and sharing. Mentoring programmes are most successful when both parties are willing and able to devote time, energy, and resources to the success of the relationship, when the programme is voluntary and when the organisation provides encouragement, support, and tangible resources. Active participation of innovative thinkers and the dedication and commitment of both mentors and mentees are required for a successful peer mentorship programme. Peer mentoring should be considered as a viable supplement to the traditional mentoring paradigm that is provided by registered nurses (Purfeerst, 2011).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1   Introduction

This chapter describes the research approach as well as the details of the methods and the overall plan to obtain answers to the research questions relating to the perceptions of student nurses on peer mentoring in clinical settings. Research methodology refers to a scientific method that includes steps, procedures and strategies for obtaining and analysing data (Polit and Beck, 2012). This chapter includes a presentation of how data was collected, managed and analysed as well as ethical issues that were considered during the study.

3.2   Research Paradigm

For the purpose of this study, a positivist paradigm which holds the position that there is a fixed, orderly reality that can be studied objectively (Polit and Beck, 2012) was used. Positivism is linked to a quantitative research approach which incorporates logistic, deductive reasoning and the use of orderly, disciplined procedures with tight control measures to limit the effects of extraneous variables that are not being studied (Polit and Beck, 2012). The deductive method implies that events are ordered and inter-connected, and therefore reality is ordered and deducible. The axiological assumption of positivism adheres to the view that only factual knowledge gained through observation (the senses), including measurement, is trustworthy. To find the truth, the researcher was completely objective and kept the values, feelings and personal perceptions. In keeping to the epistemological assumption of the paradigm, that the researcher is independent from what is being researched and does not influence the findings (Polit and Beck, 2012) the researcher collected data through using structured data collection tools (Burns and Grove, 2009).

3.3   Research Approach

This study adopted a quantitative approach to allow the researcher greater objectivity in research situations so that she had no power to influence the research situations (Shuttleworth, 2008). In line with the adopted research paradigm, the quantitative approach is

a formal, objective, rigorous, systematic process for generating information about the world. It is conducted to describe new situations, events or concepts in the world (Burns and Grove, 2009). Quantitative research attempts to filter out all external factors so that results are unbiased (Daniel, 2011). The perspective of quantitative research is concise and reductionist (Burns and Grove, 2009) thus it was appropriate for this study which aimed to explore and describe the perceptions of student nurses on peer mentoring in clinical practice in a selected nursing campus in eThekwini, KwaZulu-Natal province, South Africa.

3.4. Research Design

A research design is "a blue print for conducting the study as it maximises control" over factors that could affect the validity of the findings and increases the possibility that the study results are true reflections of reality (Burns and Grove, 2009). It serves as the backbone of the research study and determines the structure for the research methodology as well as the design decisions enabling the researcher to achieve the intended goal (Botma, Greeff, Mulaudzi and Wright, 2010). It is a set of logical steps taken by the researcher to address the research questions (Polit and Beck, 2012).

In this study, a non-experimental, explorative descriptive study design was adopted. It was considered as the most appropriate because the purpose of descriptive studies is to explore and describe the phenomenon in real life situations, in order to provide a picture of the situation as it naturally occurs (Botma et al., 2010 & Burns and Grove, 2009). Descriptive designs permit the researcher to identify problem areas within a particular field of the nursing practice, to warrant current clinical practice, or might be used to develop theories or to establish what others are doing in similar situations (Botma et al., 2010 & Burns and Grove, 2009). Through descriptive designs information is generated from a representative sample of the population and structured observation, questionnaires and interviews or survey studies are used during the data collection phase (Burns and Grove, 2009). The researcher did not attempt to determine the cause or the effect, and did not try to manipulate any variables in order to get answers to the research problem. For this reason the explorative descriptive design was deemed the most suitable research design for the study at hand.

3.5   Research Setting

The study was conducted at a specifically selected nursing campus in the eThekwini District which is affiliated with a district hospital where students are placed for clinical practice. The hospital has all major units of care i.e. medical; surgical; paediatric; gynaecology; maternity; psychiatric units; operating room theatres; intensive and critical care units; trauma and emergency care departments and out-patients clinics. A natural setting, which is real life and an uncontrolled environment was used for data collection as the explorative descriptive design requires that the participants be at ease and comfortable during data collection. Therefore the nursing campus was used as a research setting. The researcher did not control the environment. The selected nursing campus is one of the campuses of the KwaZulu-Natal College of Nursing and offers the following nursing programmes: the four- year comprehensive diploma leading to registration as a nurse (general, community and psychiatric) and midwife; a two-year bridging course for enrolled nurses leading to registration as general nurses; a one-year diploma in midwifery; a one year diploma in primary health care, the two-year certificate course for enrolment as a nurse and a one-year certificate course for enrolment as enrolled nursing assistants. A peer mentoring programme was piloted and implemented in this setting, with the four-year diploma course students, who were the focus of the study.

3.6   Study Population

A population is the entire set of individuals in which the researcher is interested. In this study the research population was all student nurses registered for the four-year comprehensive diploma in general nursing, leading to registration as a nurse (general, community and psychiatric) and midwife, at the selected nursing campus in eThekwini (210 students). This four-year comprehensive diploma is also known as the R425 course because it is run under the auspices of the Regulation Number 425 (R425) of 22 February 1985 of the South African Nursing Council (SANC). Two groups of 25 student nurses are enrolled yearly into the four-year comprehensive diploma course. An additional ten students joined the first and second year groups because they had been demoted from previous groups due to failure to obtain Due Performance (DP) mark, failure of examinations, illness or maternity leave. The total population for the study was 210 students.

The target population is the aggregate or entire set of persons or any other single unit of the study, also referred as elements or sampling units that meet the sampling criteria (Botma et al., 2010 & Burns and Grove, 2009). For this study the target population was all students who registered for the four-year comprehensive diploma in general nursing between January 2012 and July 2015 and participated in the peer mentoring programme at the selected nursing campus in eThekwini. The first and second year students made the "mentees" population because they had been mentored in their first year of training by the senior third and fourth year student nurses. On the other hand, the third and fourth year students made the "mentors" population because they mentored the first year students as a requirement for the Ethos and Professional Practice module during their third year of training.

Eligibility or Inclusion Criteria

These are the criteria that specify the population characteristics and that define who should be included in the population (Botma et al., 2010). The inclusion criterion for this study was student nurses who had participated in the mentoring programme, as mentors and protégés or mentees and who were willing to participate in the programme. All participants were above 18years of age.

3.7   Sample and Sampling Procedure

A sample is a subset of the population elements that are the basic units from which data is collected. **Sampling i**s the process of selecting a portion of the population to represent the accessible population so that inferences about the population can be made (Botma et al., 2010). The sample selection is based on the characteristics important to membership of the target population (Burns and Grove, 2009), that is, the eligibility criteria. The sample for mentors was all student nurses who participated as mentors in the peer mentoring programme between the years 2012 to 2015. This group had been exposed to clinical practice for three years and were doing the Ethos and Professional practice module at the time of participating in the mentoring programme. The sample for mentees was all student nurses who participated as mentees in the peer mentoring programme. Their mentoring occurred when they were in clinical practice areas for the first month of training following the initial theoretical block at college.

Sampling designs

Sampling design is the method or approach chosen to select the sample from the overall population. There are two basic sampling designs, the probability and the non-probability designs. A probability sample gives each member of the population an equal chance (greater than zero) of being included in the sample. The probability sample may be drawn from a population by simple random sampling, systematic sampling, stratified sampling and cluster sampling (Brink, van der Walt & van Ransburg, 2012). With non-probability sampling methods, the elements in the target population have an unknown chance of being selected into the sample. The non-probability sampling is more convenient, economical and suitable in situations where the researcher cannot locate the entire population. The techniques of non-probability samples include purposive, convenience, quota samples and snowballing or networking (Brink et al., 2012).

For this study a non-probability convenience sampling design was used. In convenience sampling the elements are selected from the target population on the basis of their accessibility or convenience to the researcher. They are drawn into the sample simply because they happened to be situated, spatially or administratively, near to where the researcher is conducting the data collection (Ross, 2005). The researcher approached all student nurses who were on block at college and had participated in the mentoring programme, as mentors and mentees or protégés and were willing to participate in the programme. The main assumption associated with convenience sampling is that the members of the target population are homogeneous and that there would be no difference in the research results obtained from a sample gathered in some inaccessible part of the population (Ross, 2005).

Sample size

The sample size refers to the number of participants who are selected from the population and become respondents in the process of collecting data. There is no simple formula to guide the researcher to determine the sample size (Botma et al., 2010 & Polit and Beck 2012). For quantitative research, the largest possible sample is used because the larger the sample, the more representative of the population it is likely to be (Botma et al., 2010 & Polit and Beck, 2012). The selected nursing campus had 210 student nurses who were registered for the four year diploma in general nursing from January 2012 to December 2015. Of these students, 110 were in first and second year of training and 100 were doing third and fourth year. The total

number of students was 210. No formula was used to calculate the sample size because all the students were invited to participate in the study as they had all participated in the mentoring programme as mentors and mentees. At the time of data collection, a group of 25 fourth year students were in clinical psychiatric settings that are outside the hospital and were therefore not accessible for data collection. The mentor cohort was then left with 75 students. An accessible population comprised of respondents that were available on the dates when data was collected and formed the sample size. A sample size of 170 (66 mentors and 104 mentees) eligible and willing students was conveniently obtained. Fifty-six students participated as mentors and ninety-four as mentees in the main study. Ten students from each cohort were utilized for pilot study and did not form part of the main study.

3.8 Data Collection Instrument

Data was collected with the use of self-administered questionnaires that were constructed using information that was obtained from an extensive literature search with regards to the perceptions of student nurses of peer mentoring. The questionnaires were reviewed by the supervisor and two other lecturers with specialization in nursing education. For the purpose of this study a 4 point Likert scale was used to rate the students' perceptions where 1 = Strongly Disagree, 2 = Disagree , 3 = Agree, and 4= Strongly Agree. Respondents indicated the degree to which they agreed or disagreed with the opinion expressed by the statement (Polit and Beck, 20012).

Two self-administered questionnaires were used, one for the mentors and the other for the mentees (Appendix A & B). Section A of the questionnaire requested the demographic data of the respondents and consisted of 5 items which included level of training, involvement in peer mentoring as either a peer mentor or mentee or both, gender, age and ethnicity. Section B was designed to acquire data on the perceptions of the participants of the mentorship programme in clinical practice area and this consisted of 65 items which included the respondents' perceptions of the roles of the mentor, qualities of the mentor, roles of the mentee, barriers to peer mentoring, mentorship programme benefits, experiences of participants with peer mentoring in the clinical placement areas and whether the programme met their expectations. There were three open-ended questions in Section C where the participants were asked to indicate the other aspects of the peer mentoring programme that

they found useful, the suggestions they had for improving and strengthening the peer mentoring program in the future and to state other comments they would like to make.

3.9   Data Collection Process

After ethical clearance had been obtained from the University of KwaZulu-Natal ethics committee, the researcher sought permission to collect data from authorities of the KwaZulu-Natal Department of Health, KwaZulu-Natal College of Nursing as well as the Principal at the Selected Nursing Campus. The researcher made an appointment to meet with the campus principal and explained the purpose and the significance of the study and asked for a period slot in the timetable of 45 minutes. During that time, each group was addressed separately. After the cooperation of prospective participants had been sought, the groups were given information sheets (Appendix C), containing the comprehensive and precise information regarding their participation in the research, which included the purpose of the research, what type of information was required from them, how they, as participants, were selected, potential benefits and risks, assurance of confidentiality, voluntary consent, the right to withdraw from the study at any stage and it also provided the researcher's name and contact information as well as the estimated time required to complete the questionnaires (Burns and Grove, 2009 & Polit and Beck, 2012). When the participants had fully understood and comprehended what their participation involved, the researcher documented the informed consent process by having participants sign the consent forms. A convenient time and venue that promoted privacy was chosen for completion of the questionnaires. The researcher personally distributed the questionnaires to the respondents. The estimated time for completion of the questionnaire was approximately 30 minutes. After the respondents had completed the questionnaires, the researcher collected these and checked for completeness and these were placed in a box which was then sealed.

3.10   Validity and Reliability

3.10.1 Validity

Validity of the measuring instrument influences the degree to which it reflects the construct being examined (Burns and Grove, 2009). Validity means that the research instrument measures exactly what it is intended to measure; it is the measure of truth or accuracy or

reflection of reality (Polit and Beck, 2012). Validity is classified into face validity, criterion validity, as well as content validity and construct validity. Content validity is defined as an assessment of how well the instrument represents all the components of the variable to be measured (Polit and Beck, 2012). The content and construct validity were ensured by checking the items in the data collection instruments against the research objectives and questions to ascertain whether or not they measure all the elements to be investigated. The instruments were then examined by the supervisor and specialist lecturers in education to confirm compliance with content validity**.**

Table 3.1 Content Validity

Research Objective	Research Questions	Mentor Research question number	Mentee Research question number	Research Study
Describe the perceptions of student nurses on peer mentorship	What are the student nurses' perceptions of peer mentoring?	46-59	40-53	Conceptual framework Jokalainen (2013).
Describe the perceptions of peer mentors and mentees of the role of the peer mentor.	What are the student mentees' and mentors' perceptions regarding peer mentors?	1-12	1-12	Gibbs, Brigden and Hellenberg (2005); Bray and Nettleton (2007); Colvin and Ashman (2010) & Andrew and Clark (2011).
Describe the student nurses' perceptions of the role of the mentee.	What are the student nurses' perceptions regarding the role of mentees?	13-20	13-20	Colvin and Ashman (2010); Dennison (2010) & Gopee (2011).
Describe the perceived barriers of peer mentoring in clinical settings.	What are the barriers of peer mentoring in clinical settings?	21-34	21-28	Carlisle, Calman & Ibbotson (2009); Li et al., (2010); Mogale (2011); Halcomb, Peters and McInnes (2012); Veeramah (2012) & Joubert & de Villiers (2015).
Describe the benefits of peer mentoring in clinical settings.	What are the benefits of peer mentoring in clinical settings?	35-45	29-39	McKenna and French (2011) & El-Sayed, Metwally and Abdeen (2013).
Describe the suggestions made by mentors and mentees on strengthening the mentoring programme in clinical settings.	How can peer mentoring in clinical settings be strengthened?	60-63	54 & 56.	

3.10.2　　　　Reliability

Reliability is the degree of consistency with which an instrument measures the aspects it is designed to measure (Polit and Beck, 2012). It refers to the extent to which the particular instrument can produce equivalent results if used frequently over time on the same person, or if used by more than one researcher (Burns and Grove, 2009). Reliability was obtained by constructing simple questions to prevent misinterpretation and to construct different sections of the questionnaire in the same manner.

Internal consistency describes the extent to which all the items in a test measure the same concept or construct. Cronbach's alpha test is used for objective measure of reliability. It provides a measure of the internal consistency of a test or scale and is expressed as a number between 0 and 1. If alpha is too high it may suggest that some items are redundant as they are testing the same question (Tavakol and Dennick, 2011). The internal consistency of the questionnaires was measured using Cronbach's alpha coefficient and alpha was found to be ranging between .721 and .880 which is considered satisfactory.

3.10.3　Pilot study

The pilot study is another measure of ensuring content validity and reliability of the instrument (Polit and Beck, 2012). For this study a pilot study was conducted, on a sample of 20 students (10 mentors and 10 mentees) representing 10% of the study sample. The purpose was to ascertain the feasibility of the study and the clarity and applicability of the tools. It also helped to estimate the time needed for filling out the questionnaire. Based on the results of the pilot study, no modifications were needed. The pilot served to assess the reliability of the instruments through assessing their internal consistency. The instruments proved to have a good reliability with Cronbach's alpha coefficients .721 and .880 respectively.

3.11　　　Data Analysis

Data analysis means that the collected data is categorised, ordered, manipulated and summarised thus assisting with data interpretation (Burns and Grove, 2009). Descriptive statistics were used to describe and summarise the data and measures such as frequency and

percentage distributions were obtained. The latest version of computerised statistical software package (SPSS 22) was used to organise and analyse data with the assistance of a statistician.

The questionnaires had three open-ended questions, the common responses that emerged were grouped and quantitatively analysed into percentages.

3.12   Ethical Considerations

Research ethics, as a system of moral values, is concerned with the degree to which research procedures adhere to the professional, legal and social responsibilities of the respondents (Botma et al., 2010).

Permission for the Study. When humans are used as study participants, care must be taken to ensure that the rights of those humans are protected (Burns and Grove, 2009). The research proposal was presented to the University of KwaZulu-Natal (UKZN) College of Health Sciences Research Ethics Committee in order to obtain approval to conduct this research study. Permission to conduct the study in a selected nursing campus was requested from the KwaZulu-Natal (KZN) Provincial Department of Health (DoH), KwaZulu-Natal College of Nursing (KZNCN) and from the Campus Principal at the selected nursing campus in eThekwini.

Informed Consent: The respondents were provided with adequate information about the research and they were informed that they had the right to give consent to or decline participation voluntarily (Emanuel, Wendler, Killen and Grady, 2004). They were provided with an information sheet that spells out the type of data that will be collected, how they were selected for the study as well as the potential risks and benefits, confidentiality, right to withdraw from the study at any time and the contact details of the researcher (Emanuel et al., 2004; Burns and Grove, 2009 & Polit and Beck, 2012). The information sheet and the consent form were attached to the questionnaires (Appendix A & B). All respondents of the study were above 18years of age, which is the legal age in South Africa to provide consent.

Confidentiality: Confidentiality was maintained by ensuring that only the researcher and supervisor involved in the study had access to information that the participants provided and did not willingly or intentionally share it with others (Botma et al., 2010 & Burns and Grove,

2009). During dissemination of the study findings, there was no mentioning of names of individuals or the institution involved in the study.

Anonymity: The researcher ensured that the participants were not linked to the collected data and therefore they were told not to write their names on the questionnaires (Burns and Grove, 2009 & Polit and Beck, 2012). Questionnaires that had been filled in by the participants were kept in a sealed box. The collected data was not attached to the identity of any participating individual or institution therefore the researcher could not attribute any information to a specific participant. During dissemination of the study findings, again there was no mentioning of names of individuals or the institution involved in the study.

Favourable Risk – Benefit ratio: The participants were assured that the study carried no potential physical, psychological, social or legal risks (Emanuel et al., 2004). They were informed that participation in the study would not affect their grades. Participants were informed that there would be no monetary benefits for participation in the study.   However, the information they contributed to was to be utilised for the improvement of the mentoring programme. Each respondent was given a questionnaire to complete and was not allowed to discuss their answers with anyone in order to avoid any discomfort in case they revealed sensitive information.

Respect for recruited participants and study communities: Procedures to protect the confidentiality of recruited and enrolled participants were in place and this was explained to the participants before data was collected. Participates were informed that their participation in the study was voluntary and they had the right to refuse to participate or to withdraw from the study at any time. They were informed that the findings of the study would be shared with them (Emanuel et al., 2004).

Data management: Collected data was used solely for the purpose of this investigation. Raw data was securely locked away during analysis and the processing of the report. The data on the computer was password protected, the password known only to the researcher. The data (soft and hard copies) will be stored safely for five years and then destroyed. To avoid loss and mixing of data collected, four files were purchased for handing information collected from the respondents. The first one was labelled 'completed consent forms', the second 'completed questionnaires', the third 'uncompleted questionnaires' and the last one was for results from questionnaires that had been entered into the computer. These will be stored safely under lock and key during and after use for future use. The completed data was coded and entered into the computer within 48 hours with backup on external storage devices (pen drive, external hard drive and CD-ROM) to prevent data loss. Soft copies of data were stored using a password. Additionally, copies of the data and research report will be made available to the university's library and to my supervisor. Hard copies of data and CD-ROMS will be destroyed and soft copies of data stored and other forms will be completely deleted five years after the completion of the study.

3.13   Dissemination of Findings

 Findings of this study will be disseminated as a hard copy dissertation submitted to the UKZN, KZN DoH and through the KZNCN to the selected Campuses in Durban that served as a study setting. The study findings will also be published in academic journals and presented at scholarly conferences and seminars. An oral presentation will also be conducted at the nursing campus where participants will be part of the audience. During dissemination of the study findings, there will be no mentioning of names of individuals or the institution involved in the study.

3.14 Timeline and Budget for execution of the proposal

Table 3.2 Study Timeline

Time	Activity
June - July 2015	Literature Review
August - September 2015	Presentation of proposal
October 2015	Submission of Proposal and Application to Ethics
November 2015	Application for Gatekeepers permission
December 2015	Data Collection
January - February 2016	Data Analysis
March - April 2016	Report writing and Submission of final report

Table 3.3 Study Budget

Phase	Activities	Needs	Unit Price (ZAR)	Total	Total (ZAR)
1	Data Collection	Ream of paper	70	5	350
		Printing Cartridges	450	4	1800
		Ball point pens	3	10	30
		Transport			1500
2	Data Analysis	SPSS	1300		1300
3	Report Writing	Synthesizing quantitative findings	18	40	720
4	Printing, editing And binding	Ream of paper	70	5	350
		Printing cartridges	450	3	1,350
		Editing costs	20	100	2500
		Binding costs	200	5	1500
Contingency 15%					
Grand Total					12500

3.15 Conclusion to Chapter Three

To conclude this chapter, a detailed description of the research design, method, trustworthiness and ethical considerations, data analysis and management as well as the dissemination plans were presented.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

In the previous chapter, attention was given to various aspects of the design of the study and the methodology that was used to obtain sources of information was declared. The data collection method was discussed, together with how this data was analysed and, finally, how this analysis was interpreted. The focus of this chapter is on presentation of the collected quantitative data that will be organised, and interpreted to obtain meaning. Two sets of self-administered questionnaires were used to collect data; one set from the mentors and the other for the mentees. Both questionnaires contained similar questions except for the sections on benefits and barriers to peer mentoring. The data were quantitatively analysed using the SPSS version 22 computer programme and Excel spreadsheets to elicit descriptive statistics. Frequency distribution tables, pie charts, graphics and discussions were used in order to present the content and to enhance interpretation (Botma, Greeff, Mulaudzi and Wright, 2010).

4.2 Sample Realisation

A pilot study was carried out with a sample of 10 percent (n = 20) of students (10 mentors and 10 mentees) who were not involved in the main study and its findings indicated that the data would be valid. For the main study, all students were invited to participate and they were provided with information regarding the questionnaire. A total of 56 out of 75 (74.6 percent) third year and fourth year students completed the self-administered questionnaires as mentors and 94 out of 110 (85 percent) first to second year students completed the self-administered questionnaires as mentees. The degree of participation was a result of the voluntary nature of the research as students were not coerced into participating in the study.

The list of discussion points on mentoring are presented accordingly:

- Socio-demographic data of mentors and mentees;
- The role of the mentor;

- The qualities of the mentor;
- The role of the mentee;
- Barriers to peer mentoring in clinical settings;
- Benefits of peer mentoring in clinical settings; and
- Evaluation of peer mentoring programme by both mentors and mentees.

4.3 Socio-Demographic data of mentors and mentees

The socio-demographic data sought in both questionnaires consisted of five questions and five variables, namely level of training, involvement in peer mentoring, gender, age and ethnicity.

4.3.1 Level of Training of respondents

As indicated in Table 4.1 (level of training of respondents), the majority of mentors, 50 percent (n = 28) were in year four while 48.2 percent (n =27) were in year three and only 1.8 percent (n=1) were beyond year 4. The highest percentage of mentees 51.1 percent (n = 48) were in the first year of training, while 39.4 percent (n = 37) were in year two and only 9.6 percent (9) were in year three.

Table 4.1: Level of training of respondents.

MENTORS				MENTEES		
Variable	Frequency (n)	Percentage (%)		Variable	Frequency (n)	Percentage (%)
Level of Training				*Level of Training*		
Year 3	27	48.2		Year 1	48	51.1
Year 4	28	50		Year 2	37	39.4
Floating	1	1.8		Year 3	9	9.6
TOTAL	56	100		TOTAL	94	100

4.3.2 Involvement of respondents in peer mentoring.

Respondents were asked to indicate what their involvement was in the peer mentoring programme. Table 4.2 (involvement of respondents in the peer mentorship programme)

indicates that 53.6 percent (n = 30) of the mentor cohort had only been involved as mentors and 46.4 percent (n = 26) had been involved as both mentors and mentors. In the mentee cohort all mentees 100 percent (n = 94) had been involved in the mentorship programme only as mentees.

Table 4.2: Involvement of respondents in the peer mentorship programme

MENTORS				MENTEES		
Variable	Frequency(n)	Percentage (%)		Variable	Frequency (n)	Percentage (%)
Involvement in peer mentoring				*Involvement in peer mentoring*		
Mentor	30	53.6		Mentee	94	100
Both	26	46.6				
TOTAL	56	100		TOTAL	94	100

4.3.3 Gender distribution of respondents

The results depicted in Table 4.3 (gender categories of respondents) indicate that the mentor cohort was predominantly female (71.4 percent; n = 40) and only (28.6 percent; n=16) were males. On the other hand, the mentee cohort had (78.7 percent; n = 74) females and (21.3 percent; n = 20) males.

Table 4.3: Gender of categories of respondents

MENTORS				MENTEES		
Variable	Frequency (n)	Percentage (%)		Variable	Frequency (n)	Percentage (%)
Gender				Gender		
Male	16	28.6		Male	20	21.3
Female	40	71.4		Female	74	78.7
TOTAL	56	100		TOTAL	94	100

4.3.4 Age range of respondents

Findings displayed in Table 4.4 (age range of respondents) show that the majority of mentors (51.8 percent; n = 29) were in the age range of 20-24, while (28.6 percent; n = 16) were between 25 and 29. The 30-35 age range added up to 10.7 percent (n = 6) and only 8.9 percent (n = 5) exceeded age 35. Thus the majority of the respondents (80.4 percent; n = 45) were younger than 30 years of age. Concerning the mentee cohort, the highest number (68.1 percent; n = 64) were in the age range of 20-24, followed by (14.9 percent; n =14) who were in the range of 25-29. The age group of between 15 and 19 totalled 7.4 percent; (n = 7) while (6.4 percent; n= 6) were above age 35 and the smallest group (3.2 percent; n =3) were those in the 30-35 age group. The respondents who were younger than 30 years of age in the mentees cohort made a total of (90.4 percent; n = 85).

Table 4.4: Age range of respondents.

MENTORS				MENTEES		
Variable	Frequency (n)	Percentage (%)		Variable	Frequency (n)	Percentage (%)
Age in Years						
15-19	0	0		15-19	7	7.4
20-24	29	51.8		20-24	64	68.1
25-29	16	28.6		25-29	14	14.9
30- 35	6	10.7		30- 35	3	3.2
≥ 35	5	8.9		≥ 35	6	6.4
TOTAL	56	100		TOTAL	94	100

4.3.5 Ethnic distribution of respondents.

Frequencies and percentages in Table 4.5 (ethnic distribution of the respondents) revealed that the vast majority (80.4 percent; n = 45) of the mentor cohort were Black respondents, followed by Indian (17.9 percent; n= 10) and only 1.8 percent (n = 1) were Coloured. Regarding the mentee cohort, the highest number (84 percent; n = 79) of respondents were Black, followed by 11.7 percent (n = 11) Indian, while 3.2 percent (n = 3) were coloured and only 1.1 percent (n = 1) was White.

Table 4.5: Ethnic Distribution of Respondents

MENTORS				MENTEES		
Variable	Frequency (n)	Percentage (%)		Variable	Frequency (n)	Percentage (%)
Ethnicity				*Ethnicity*		
Black	45	80.4		Black	79	84
Indian	10	17.9		White	1	1.1
Coloured	1	1.8		Indian	11	11.7
				Coloured	3	3.2
TOTAL	56	100		TOTAL	94	100

4.4. The role of the mentor

In this section respondents were given a list of roles enacted by the mentors and were asked firstly to indicate which roles they viewed as the most important and secondly to select five roles of the mentor ranking them in order of importance.

4.4.1 The important role of the mentor

Findings in Figure 4.1 (mentors' perceptions of the most important roles enacted by the mentor) conclude that all respondents (100 percent; n =56) in the mentor-cohort perceived that the most important role filled by a mentor is that of a guide. This was followed by the role of advisor (84.4 percent; n = 47) and supporter (80.4 percent; n=45). The role of teacher was selected by 62.5 percent (n = 35) of respondents and the role of being a friend was chosen by 53.6 percent (n = 30) students. Other roles that were considered less important, included the role model being chosen by less than half (48.2 percent; n = 27) of the mentor-cohort, the role of colleague followed with 46.4 percent (n = 26) and the role of supervisor was selected by 39.3 percent (n = 22) students. The role of being a counsellor was selected by 35.7 percent (n = 20) of the students. A minimum of 30.4 percent (n= 17) respondents chose the role of facilitator, followed by evaluator with 21.4 percent (n= 12) and the role of being a coach was chosen by 19.6 percent (n = 11) of the cohort. The role that was chosen by the least number (17.9 percent; n = 17) of respondents was that of a trainer.

MENTORS' PERCEPTIONS OF THE THE MOST IMPORTANT ROLES ENACTED BY A MENTOR
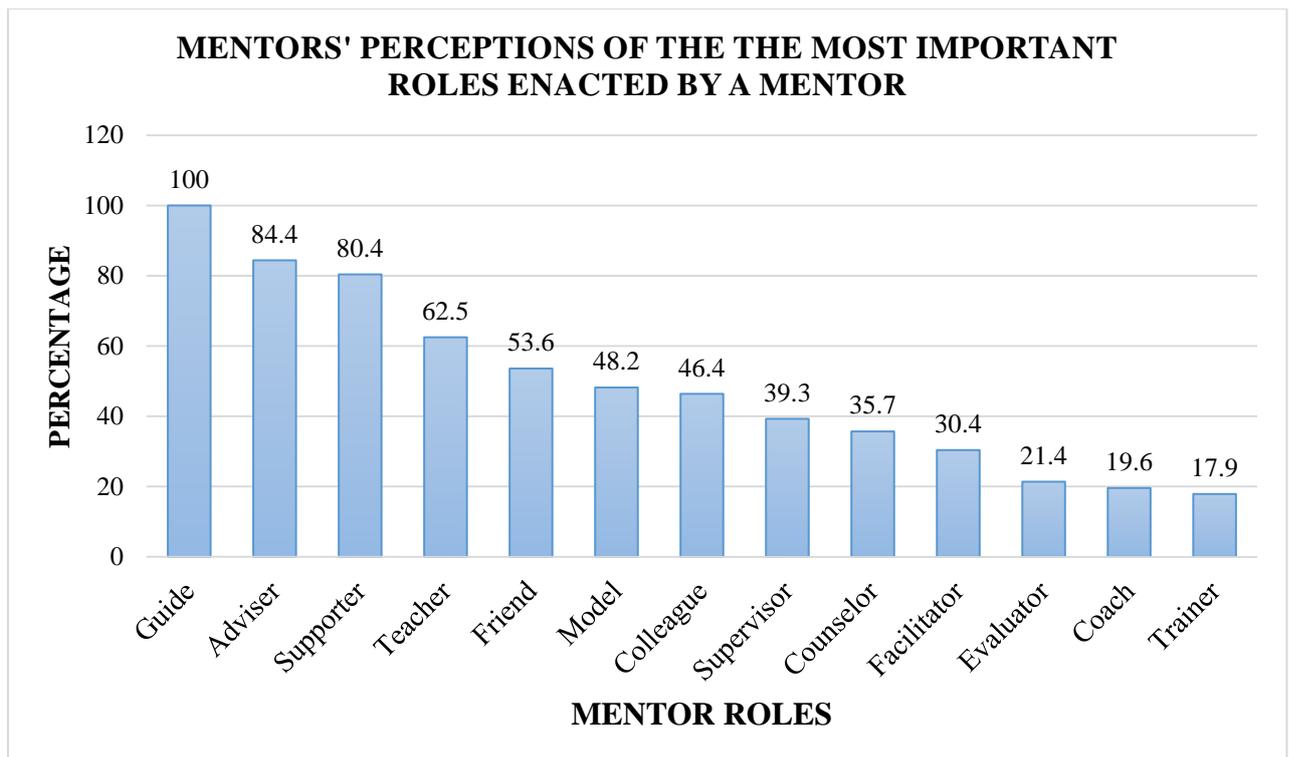
Figure 4.1 Mentors' perceptions on the most important role enacted by a peer mentor

The results shown in Figure 4.2 (mentees' perceptions of the most important roles enacted by the mentor) indicated that the mentees saw the role of the mentor from a different perspective from that of mentor respondents. The majority (78.7percent; n = 74) chose advisor as the important role of the mentor, followed by 77.7 percent (n = 73) who chose the role of a supporter. A total number of 72.3 percent (n = 68) respondents chose the role of being a teacher, followed by 63.8 percent; (n = 60) who chose the role guide. Half of the mentee cohort (50 percent; n= 47) chose the role of model as an important role of the mentor. Other roles that were selected included that of supervisor selected by 43.6 percent (n = 41) and the role facilitator followed with 40.4 percent (n = 38). The role of trainer was chosen by 39.4 percent (n = 37) of the respondents, followed by the role of friend which obtained 36.2 percent (n = 34) and the role of colleague was chosen by 35.1 percent (n = 33). A minimum (26.6 percent; n = 25) of students chose the role of coach followed by 25.5 percent (n = 24) who chose evaluator. There was poor recognition of the role counsellor as it was only chosen by 14.9 percent (n = 14) of mentee respondents.

THE MENTEES' PERCEPTIONS OF THE MOST IMPORTANT ROLES ENACTED BY A MENTOR
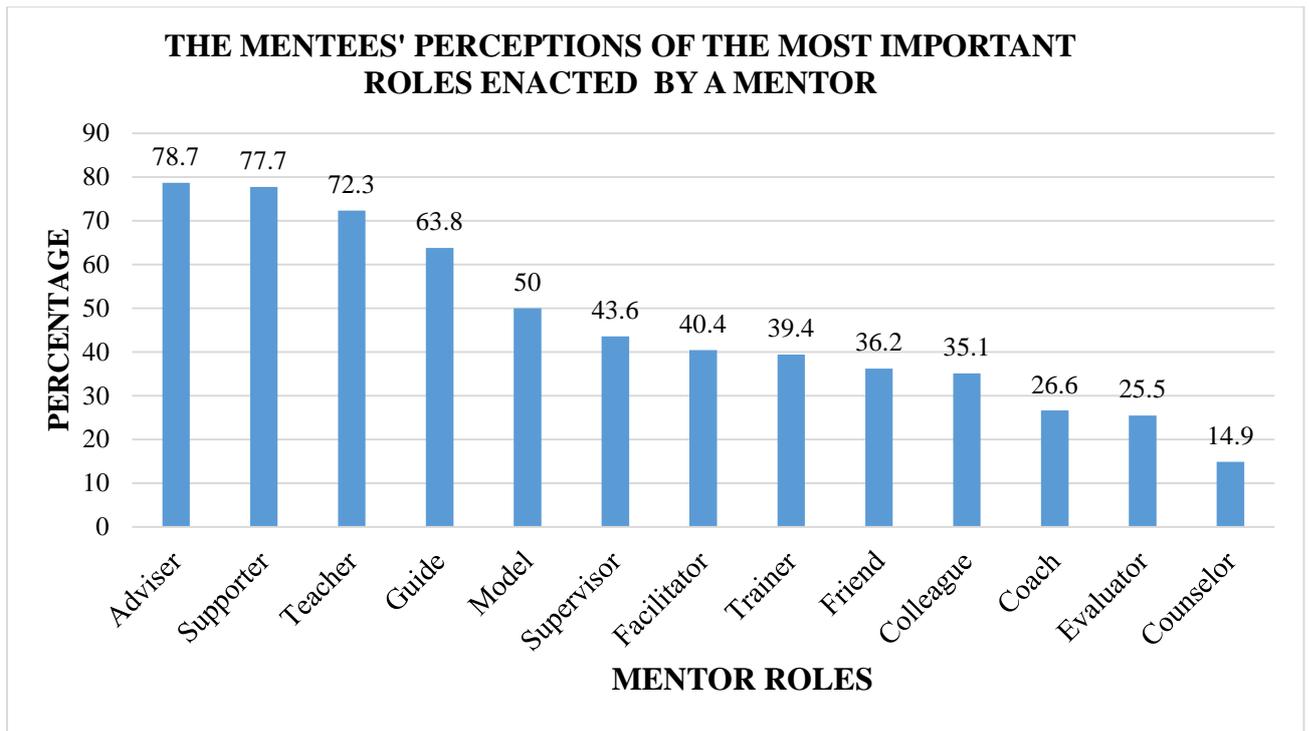
Figure 4.2 Mentees' perceptions of the most important role enacted by a peer mentor

4.4.2 The five roles of the mentor ranked in order of importance

4.4.2.1 Mentors' selection

Students were asked to select five roles of the mentor that they perceived to be most important and rank them in order of importance. The study results in Figure 4.3 (five selected role of the mentor in order of importance: mentors' selection) revealed that in the mentor cohort, the role of guide emerged as a key role selected by the majority (26.5 percent; n = 15) of the respondents followed by the role advisor selected by 25 percent (n = 14). The role of teacher came up as the third important role of the mentors having been selected by 19.6 percent (n = 11) respondents while the role of being a model was selected by 12.5 percent (n = 14) respondents as the fourth important role of the mentor. The roles of being a supporter, colleague and supervisor were selected by 10.7 percent (n = 6) respectively as the fifth important role.

FIVE ROLES OF A MENTOR IN ORDER OF IMPORTANCE: MENTORS' SELECTION

(Chart: PERCENTAGE vs ROLE OF A MENTOR IN ORDER OF IMPORTANCE)

- Guide: 26.5
- Advisor: 25
- Teacher: 19.6
- Model: 12.3
- Colleague, Supporter & Supervisor: 10.7
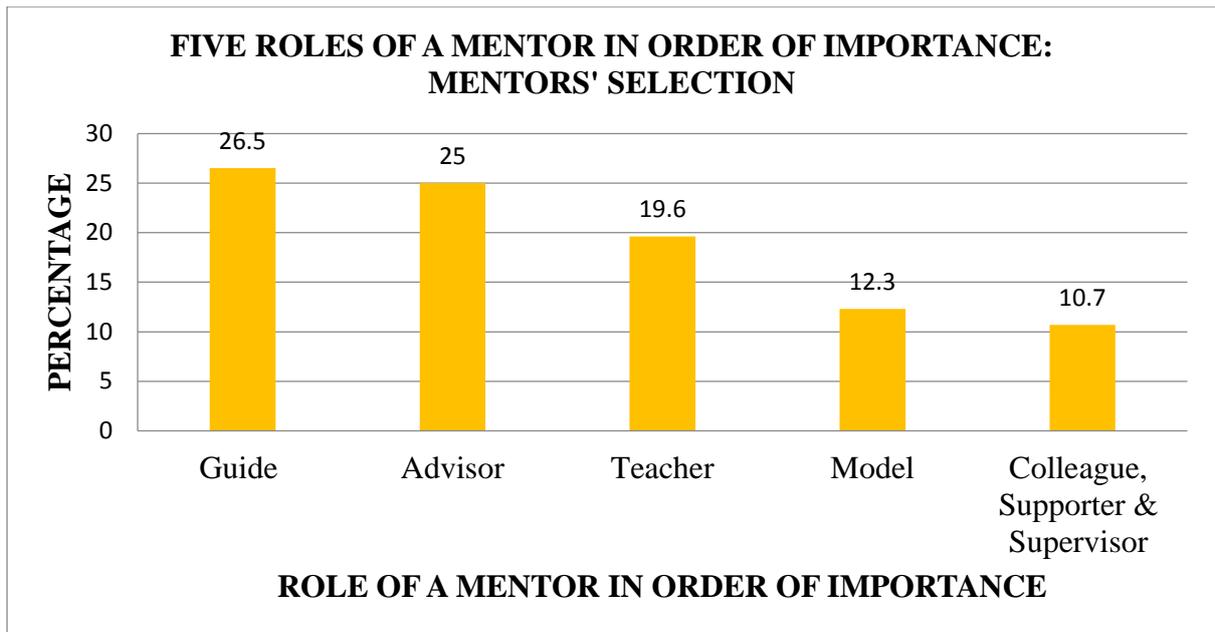
Figure 4.3 Five role of a mentor in order of importance: mentors' selection

4.4.2.2. Mentees' selection

As indicated in figure 4.4 (five roles of the mentor in order of importance: mentees' selection) the responses of the mentee cohort differed to that of the mentor cohort, as a total of 35.1 percent (n = 33) selected teacher as the most important role of the mentor, followed by 14.9 percent (n = 14) who selected advisor and supporter roles respectively. The role of advisor was also selected by 13.8 percent (n = 13) respondents as the third important role. The role of guide came fourth as it was selected by 10.6 percent (n = 10) respondents while the roles of model and friend were selected by 9.6 percent (n = 9) respondents as the fifth important role of the mentor.
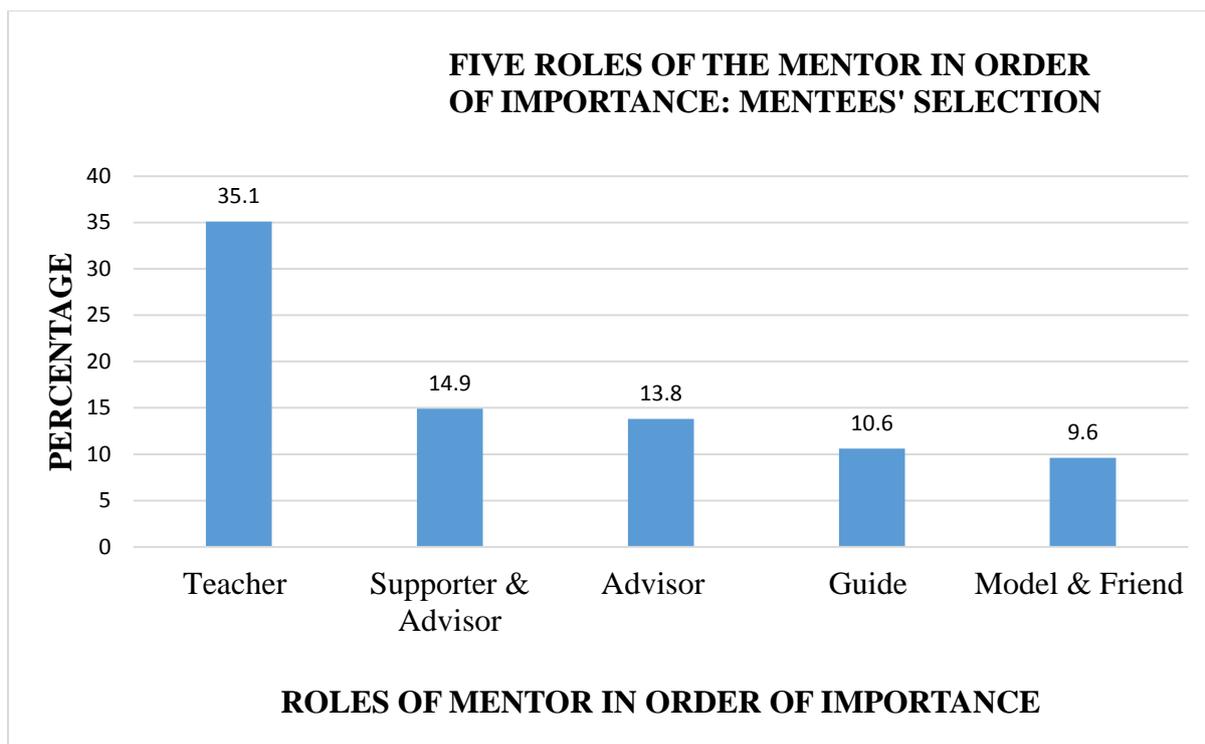
Figure 4.4 Five roles of the mentor in the order of importance: Mentees' selection.

4.5   The qualities of the peer mentor

In this section, the respondents were provided with a list of eleven qualities of the peer mentor and were asked to rate these qualities based on their experiences with the peer mentoring programme. A four point Likert scale that range from 1 = strongly disagree, 2= disagree, 3 = agree and 4 = strongly agree was used.

Findings in Table 4.6 (The qualities of peer mentors as perceived by mentors and mentees) reveal that the majority of the mentor cohort (44.6 percent; n= 25) agreed with the statement that mentors appear to command respect for what they talk about, while 3.6 percent (n = 2) strongly agreed with the statement. Of the remainder, 33.9 percent (n = 19) mentors disagreed and 17.9 percent (n = 10) strongly disagreed with the statement. On the other hand 55.3 percent (n = 52) from the mentee cohort agreed with the statement that mentors appear to command respect for what they talk about and 6.4 percent (n = 6) strongly agreed. A minimum of (28.7 percent; n = 27) mentees refuted and 9.6 percent (n = 9) strongly refuted this statement.

When the statement, mentors are competent in their job was posed, statistical evidence indicates that an overwhelming majority (71.4 percent; n = 40) of the mentor cohort agreed and 14.3 percent (n = 8) strongly agreed while 10.7 percent (n = 6) disagreed and only 3.6 percent (n = 2) strongly disagreed. From the mentee cohort, the largest number (70.2 percent; n= 66) agreed with the statement while 23.4 percent (n = 22) strongly agreed. A total of only 6.4 percent (n = 6) disagreed with the statement.

Regarding mentors being easy to approach, the vast majority (58.9 percent; n= 33) of mentors agreed with the statement and 39.3 percent (n = 22) strongly agreed while only 1.8 percent (n= 1) disagreed with this statement. Interestingly, the mentees had a different viewpoint as 50 percent (n = 47) of the cohort agreed with the statement, 31.9 percent (n = 30) strongly agreed while 13.8 percent (n = 13) disagreed that mentors are easy to approach and only 4.3 percent (n = 4) of the mentees took a 'strongly disagree' stance.

Results further revealed that half (50 percent; n = 28) of the mentor cohort agreed and 28.6 percent (n = 16) strongly agreed with the statement that mentors are interested in mentees personally and show genuine concern for the mentees' learning while 19.6 percent (n = 11) disagreed and only 1.8 percent (n = 1) strongly disagreed with the statement. Findings in the mentee cohort revealed that 48. 9 percent (n = 46) agreed and 24.5 percent (n = 23) strongly agreed with this statement while 20.2 percent (n = 19) disagreed and a small number 6.4 percent (n = 6) strongly disagreed that mentors are interested in mentees personally and show concern for the mentees' learning.

Students were asked whether they felt that providing subtle guidance but ensuring that mentees make their own decisions is a quality of a mentor and about 53.6 percent (n= 30) responded affirmatively and were supported by a further 41.1 percent (n =23) who strongly agreed. The remainder, 5.4 percent (n = 3) disagreed with the statement. Similar findings were revealed in the mentee cohort with the majority (59.6 percent; n = 56) of them in agreement with the statement and 17 percent (n = 16) in strong agreement with this statement. A total of 21.3 percent (n = 20) of the mentees refuted and only 2.1 percent (n = 2) strongly refuted the contents of this statement.

From the mentor's respondents on the statement that mentors question in a non-threatening but purposeful manner, the majority (57.1 percent; n = 32) were affirmative, followed by 37.5 percent (n = 21) who strongly agreed, whilst only 5.4 percent (n = 3) disagreed with this. Mentees were in overwhelming agreement with this statement, as the majority (74.5 percent;

n = 70) agreed and 20.2 percent (n = 19) strongly agreed to this statement while 3.2 percent (n = 3) disagreed and only 1 percent (n =2) strongly disagreed.

It was enquired as to whether mentors are willing to debate, argue and discuss in a constructive way and statistics showed that 58.9 percent (n = 33) of the mentors were in agreed and 26.8 percent (n = 15) agreed strongly while 12.5 percent (n = 7) denied and 1.8 percent (n = 1) strongly denied. Concerning the mentees, the majority (59.6 percent; n = 56) agreed and 17.0 percent (n = 16) strongly agreed while a total of 20.2 percent (n = 19) disagreed and 3.2 percent (n = 3) strongly disagreed with this notion.

The vast majority (53.6 percent; n = 30) of the mentor cohort agreed with the statement that mentors provide honest answers to the best of their ability, or guide if they do not have the answer and were followed by 41.1 percent (n = 23) who strongly agreed. A total of 3.6 percent (n = 2) of this cohort disagreed and only 1.8 percent (n = 1) strongly disagreed with the statement. On the contrary, 58.5 percent (n = 55) of the mentees agreed and 37.2 percent (n = 35) strongly agreed with the content of the statement while 3.2 percent (n = 3) disagreed and only 1.1 percent (n = 1) strongly disagreed.

Respondents from the mentor cohort who attested that mentors do not afford blame but they stay neutral and compassionate comprised 62.5 percent (n = 35) , followed by 16.1 percent (n = 9) who strongly attested. The remaining 14.3 percent (n= 8) of this cohort disagreed and 7.1 percent (n= 4) strongly disagreed with the statement. However, the mentees had a different perception since the majority (57.4 percent; n = 54) agreed and 13.8 percent (n = 13) strongly agreed with this statement while 26.6 percent (n = 25) disagreed and 2.1 percent (n = 2) strongly disagreed.

On the point of examining whether mentors are empowering, enabling, caring, open and facilitative, students also had varied responses. The highest number of mentors (64.3 percent; n = 36) agreed and 28.6 percent (n = 16) strongly agreed with the statement while those who disagreed made a total of (7.1 percent; n = 4). From the mentees' viewpoint, the majority (61.7 percent; n = 58) agreed and 33 percent (n = 31) strongly agreed with this statement while only a few that only made 3.2 percent (n = 3) disagreed and 2.1 percent (n = 2) strongly disagreed.

Respondents were also asked to rate the statement that mentors provide critically constructive and positive feedback. Results indicate that the majority (57.1 percent; n = 32) of mentors

affirmed and 30.4 percent (n = 17) strongly affirmed with the statement while only 12.5 percent (n = 7) disagreed. From the mentees' perspective, the majority (53.2 percent; n = 50) agreed and 36.2 percent (n = 34) strongly agreed with the statement while only 10.6 percent (n = 10) negated this notion.

Perceptions of mentors and mentees regarding the qualities of a mentor were further compared using a Mann Whitney test and the findings revealed that there were higher rankings from the first year respondents who agreed and strongly agreed that the mentors possess the listed qualities compared to respondents who were in 2nd, 3rd and 4th year level of training.

Table 4.6   The qualities of peer mentors as perceived by mentors and mentees

	MENTORS									MENTEES							
	SD		D		A		SA			SD		D		A		SA	
	n	%	n	%	n	%	n	%		n	%	n	%	n	%	n	%
They appear to command respect for what they talk about.	10	17.9	19	33.9	2	3.6	25	44.6		9	9.6	27	28.7	52	55.3	6	6.4
They are competent at their own job.	2	3.6	6	10.7	40	71.4	8	14.3		-	-	6	6.4	66	70.2	22	23.4
They are easy to approach.	-	-	1	1.8	33	58.9	22	39.3		4	4.3	13	13.8	47	50.0	30	31.9
They are interested in mentees- personally, showing genuine concern for the mentees learning.	1	1.8	11	19.6	28	50.0	16	28.6		6	6.4	19	20.2	46	48.9	23	24.5
They provide subtle guidance, but ensure that mentees make my own decisions.	-	-	3	5.4	30	53.6	23	41.1		2	2.1	20	21.3	56	59.6	16	17
They question in a non-threatening but purposeful manner.	-	-	3	5.4	32	57.1	21	37.5		2	1	3	3.2	70	74.5	19	20.2
They are willing to debate, argue, and discuss in a constructive way.	1	1.8	7	12.5	33	58.9	15	26.8		3	3.2	19	20.2	56	59.6	16	17
They provide honest answers to the best of their ability, or guide if they do not have the answer	1	1.8	2	3.6	30	53.6	23	41.1		1	1.1	3	3.2	55	58.5	35	37.2
They do not afford blame, staying neutral, but compassionate.	4	7.1	8	14.3	35	62.5	9	16.1		2	2.1	25	26.6	54	57.4	13	13.8
They are empowering, enabling, caring, open and facilitative.	-	-	4	7.1	36	64.3	16	28.6		2	2.1	3	3.2	58	61.7	31	33.0
They provide critically constructive and positive feedback.	-	-	7	12.5	32	57.1	17	30.4		-	-	10	10.6	50	53.2	34	36.2

Crosstabulation on agreements of mentors and mentees regarding the qualities of a mentor

A Chi square statistical test (Table 4.7) was performed on both questionnaires to elicit whether there were relationships and associations between the responses of mentors and mentees. The areas that were found to be statically significant with *p* values below 0.005 were on the following qualities of a mentor: they are not intimidating but easy to approach and they provide subtle guide but ensure that mentees make their own decision.

Table 4.7 Cross-tabulation of agreements on the qualities of a mentor

Variables	MENTORS		MENTEES		
	Disagree	Agree	Disagree	Agree	p-value
The qualities of a mentor They are easy to approach	(n =1) 1.85%	(n =55) 98.2%	(n =17) 18.1%	(n =77) 81.9%	.003
They provide subtle guidance, but ensure that mentees make their own decisions	(n =3) 5.4%	(n =53) 94.6%	(n =22) 23.4%	(n =72) 76.6%	.004

4.6   The Role of Mentees

4.6.1   Mentors' Perceptions of the role of mentees

Findings in Figure 4.5 (Mentors' perceptions of the role of the mentee) illustrate that the majority of the mentors (51.8 percent; n = 29) believe that mentees should act professionally in relation to time keeping, dress, attitude and confidentiality, while a further 41.1 percent (n = 23) supported this strongly. The remaining few respondents (5.4 percent; n = 3) disagree and 1.8 percent (n = 1) strongly disagreed.

Regarding the role of practicing good communication and a willingness to work with the team, the vast majority of the mentors (60.7 percent; n = 34) agreed with this and 37.5 percent; (n = 21) strongly agreed, followed by 1.8 percent (n = 1) who disagreed.

Student nurses were also asked to rate their responses on the statement that mentees should identify and communicate their own learning needs. The largest number (58.9 percent; n = 33) agreed with this statement and 35.7 percent (n = 20) strongly agreed. Only 3.6 percent (n = 2) disagreed and 1.8 percent (n = 1) strongly disagreed with this statement.

All students who participated in the study as mentors agreed that the mentees have the role of taking responsibility for their own learning needs. Statistics indicate that 51.8 percent (n = 29) agreed and 48.2 percent (n = 27) strongly agreed with this statement.

With regard to the statement that the mentees should be honest about their own abilities and level of competence, results indicate that 57.1 percent (n = 32) mentors agreed and 42.9 percent (n=24) strongly agreed and nobody negated this statement.

Many students in the mentor cohort were of the view that the mentees should actively participate and seek out learning opportunities, with an overwhelming result of (55.4 percent; n = 31) who agreed and 41.1 percent (n = 23) who strongly agreed with this statement while only a minimum of (3.6 percent; n = 2) denied.

In examining the statement that mentees should act upon constructive feedback, 57.1 percent (n = 32) agreed and 35.7 percent (n = 20) strongly agreed. Some respondents did not share the similar view as 5.4 percent (n = 3) disagreed and only 1.8 percent (n = 1) strongly disagreed.

Nursing students reported mixed perspectives on the statement that mentees should evaluate the peer mentoring programme and give feedback. The majority (66.1 percent; n = 37) of the mentor respondents were in agreement with the statement while 25 percent (n = 14) strongly agreed. On the other hand a minimum of 7.1 percent (n = 4) were in disagreement and 1, 8 percent (n =1) strongly disagreed with this.

MENTORS' PERCEPTIONS OF THE ROLE OF A MENTEE
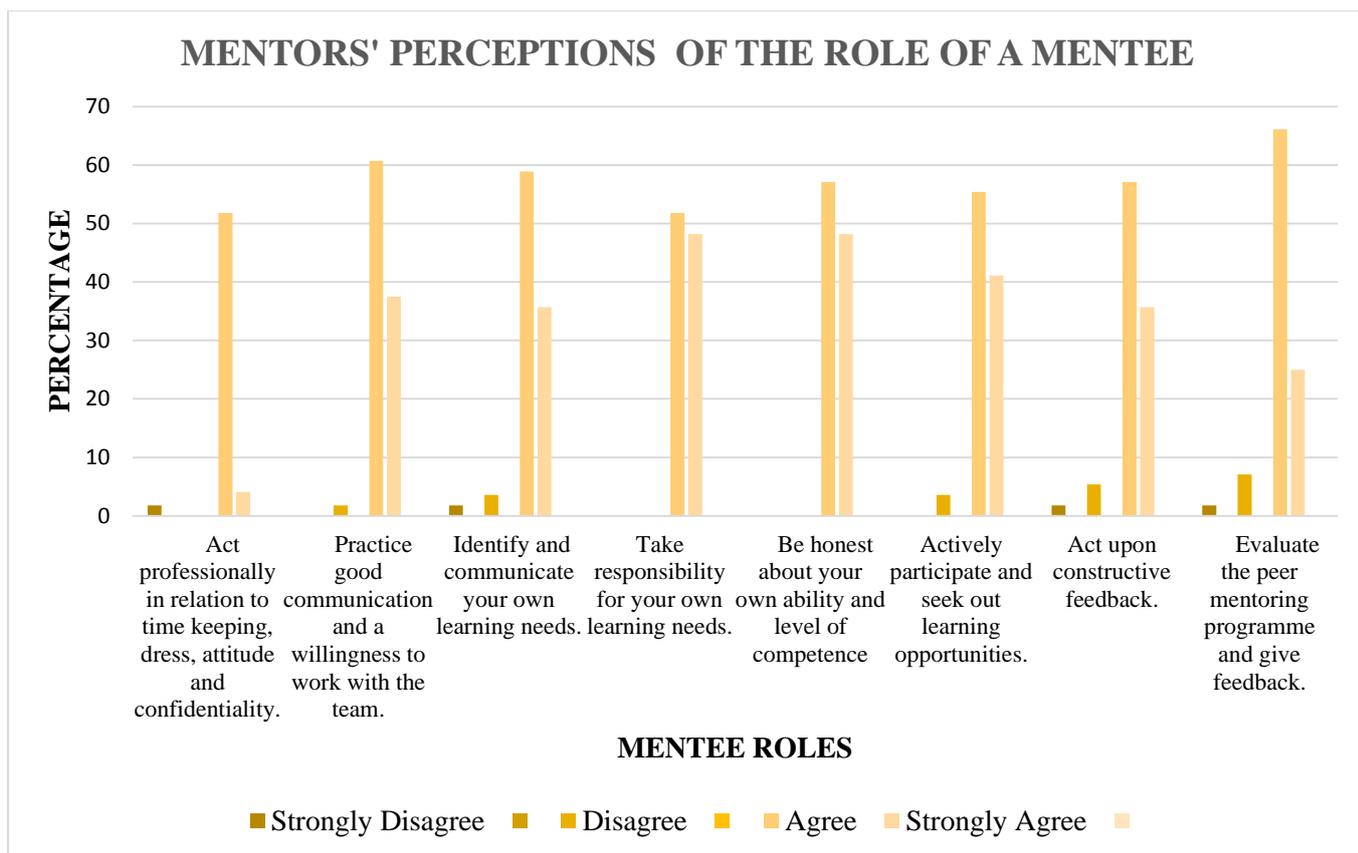
Figure 4.5 Mentors' perceptions of the role of a mentee.

4.6.2 Mentees Perceptions of the role of mentees

Mentees were also given eight roles of the mentees and asked to rate how they disagree or agree with each of these roles based on their experiences in clinical settings.

Results shown in Figure 4.6 (mentees' perceptions of the role of the mentee) depict that 51.1 percent (n = 48) of mentee respondents strongly agreed that mentees should act professionally in relation to time keeping, dress, attitude and confidentiality and 43.6 percent (n = 41) agreed. However, this was negated by 3.2 percent (n = 3) and the other 1.1 percent (n = 1) of the mentees strongly disagreed.

Mentees were also asked to give their views on the statement that mentees should practice good communication and a willingness to work with the team. Study results show that the vast majority (41.5 percent; n = 39) agreed and 57.4 percent (n = 54) strongly agreed with this statement while only 1.1 percent (n = 1) disagreed.

When asked to rate the statement that mentees should identify and communicate their own learning needs, 52.1 percent (n = 49) agreed and 40.2 percent (n = 38) strongly agreed with the contents of this statement. Other mentees differed in this perspective as 6.1 percent (n = 6) disagreed and 1.1 percent (n = 1) strongly disagreed.

Significantly 48.9 percent (n = 46) of the respondents in the mentee cohort agreed with the statement that mentees should take responsibility for their own learning and 41.5 percent (n = 39) strongly agreed with this statement. However, a small percentage (7.4 percent; n = 7) disagreed and 2.1 percent (n = 2) strongly disagreed with bearing this responsibility.

Concerning the rating of the statement that mentees should be honest about their own abilities and level of competence, an average of 47.9 percent (n = 45) strongly agreed and 46 percent (n = 44) agreed with the statement while 4.3 percent (n = 4) disagreed and only 1.1 percent (n = 1) strongly disagreed.

In terms of mentees actively participating and seeking out learning opportunities, more than half (53.2 percent; n =50) of the mentee cohort strongly agreed with this statement and a further 42.6 percent (n = 40) agreed. Those who did not share the same view point made 2.1 percent (n = 2) who disagreed and the same percentage strongly disagreed.

Mentees who agreed that mentees should act upon constructive feedback comprised 58.5 percent (n = 55), followed by 36.2 percent (n = 34) who strongly agreed. However, other students took a different stance as 5.3 percent (n = 5) of mentees disagreed with this perception.

On the issue of mentees evaluating the peer mentoring programme and giving feedback, the highest percentage (60.6 percent; n = 57) of mentees agreed that this should be done whilst 26.6 per cent (n = 25) strongly agreed. A minority, 8.5 percent (n = 8) disagreed and 5.3 percent (n=3) strongly disagreed.

Using the Mann Whitney test to determine associations between the mentees' age and how they perceived their roles, the *p* values were above 0.005 indicating no statistical significance. However, it was interesting to note that responds who are in the 15-19 age group were in agreement with almost all the questions that were asked in this section.

MENTEES' PERCEPTIONS OF THE ROLE OF THE MENTEE
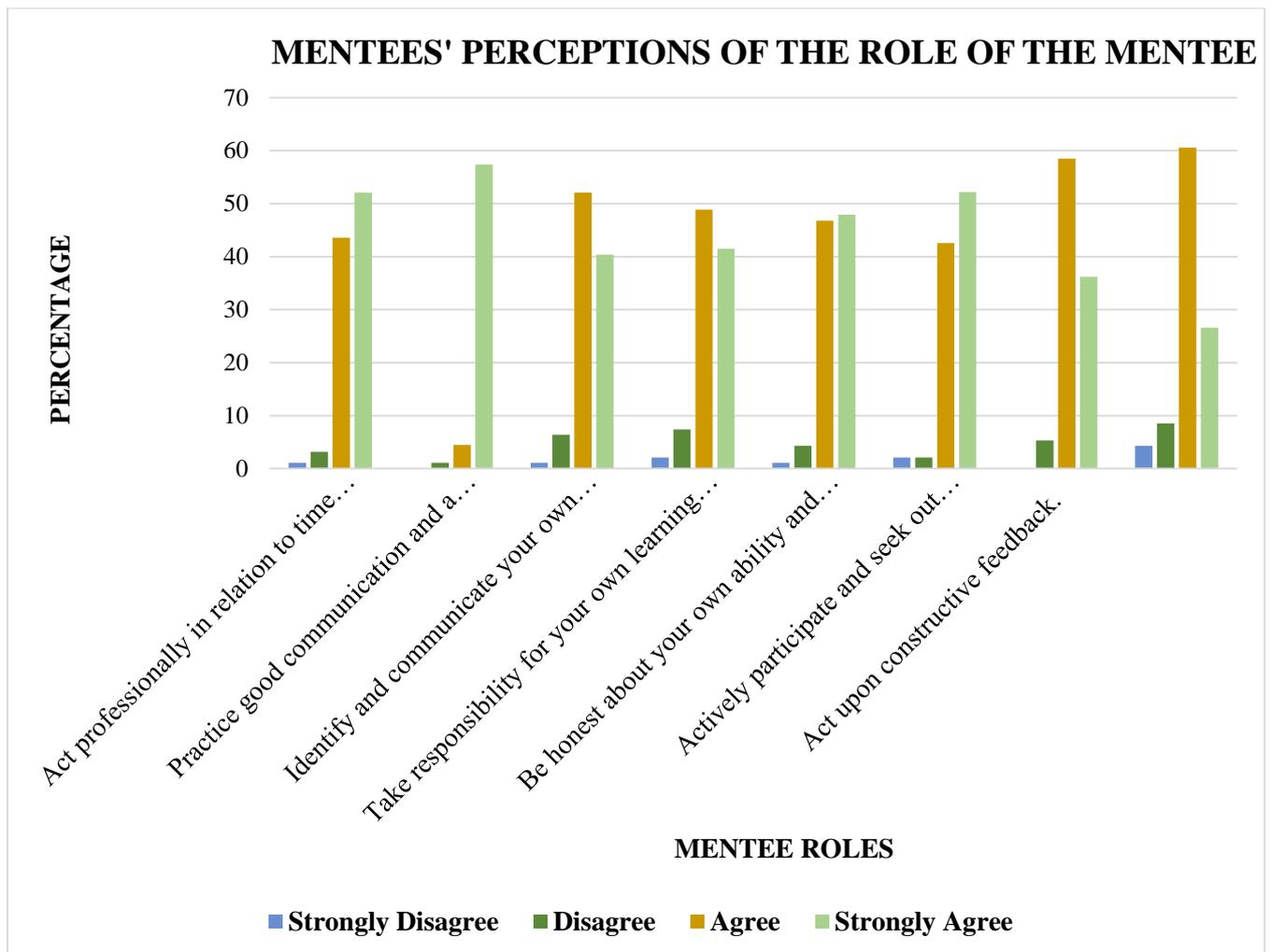
Figure 4.6 Mentees' perceptions of the role of the mentee.

4.7 Barriers to peer mentoring in the clinical settings

In understanding the students' perceptions of the barriers that impede peer mentoring in clinical settings, mentors were given a total of 14 closed-ended questions and mentees were asked to respond to 8 closed-ended questions.

4.7.1 Mentors' perceptions of barriers to peer mentoring in clinical settings

Findings in Figure 4.7 (mentors' perceptions of the barriers of peer mentoring in clinical settings) reveal that the majority of mentor respondents (66.1 percent; n = 37) agreed that conflict of interest due to the demands of both the nursing programme and the peer mentoring programme is a challenge and were supported by 23.1 percent (n = 13) respondents who strongly agreed with this statement. A few respondents (7.1 percent; n = 4) disagreed and 3.6 percent (n = 2) strongly disagreed that these were barriers.

With regards to the lack of recognition of the demands of the role of peer mentoring by nurse educators as a stumbling block to peer mentoring, mentors had mixed feelings because 44.6 percent (n = 25) agreed and 30.4 percent (n = 17) strongly agreed. About 23.2 percent (n = 13) disagreed and only 1.8 percent (n = 1) of the mentors strongly disagreed.

The majority of the mentors (57.1 percent; n= 32) agreed that limited equipment and other resources is a barrier to peer mentoring, and were strongly supported by 33.9 percent (n = 19) respondents. However, 5.4 percent (n = 3) disagreed and 3.6 percent disagreed strongly to these as barriers.

When responding to the statement that the lack of understanding of the programme requirements is a hindrance to peer mentoring, the majority (58.9 percent; n = 33) of the mentors agreed and another 21.4 percent (n = 12) strongly agreed with the statement. On the contrary, 17.9 percent (n =10) disagreed and were supported by 1.8 percent (n = 1) who strongly disagreed.

Peer mentors were asked whether they perceived the lack of support from clinical staff members as an obstacle to peer mentoring and the highest number of 53.6 percent (n = 30) agreed and a further 37.5 percent (n = 21) strongly agreed. Only 8.9 percent (n = 5) saw this from a different perspective and therefore disagreed and nobody from this cohort strongly disagreed.

Results further revealed that the majority of respondents 58.9 percent (n = 33) agreed that poor preparation to carry out the role of peer mentoring in clinical settings constitutes a barrier to per mentoring and were supported by 17.9 percent (n = 10) who strongly agreed.

Other respondents held a contrary view about this statement, indicated by 17.9 percent (n = 10) who disagreed and 5.4 percent (n = 3) strongly disagreed.

Interestingly, 39 percent (n = 22) of the mentor cohort disagreed that mentoring too many students at the same time poses a hindrance to peer mentoring and were followed by 25 percent (n = 14) who strongly disagreed. The remainder that totalled 26.8 percent (n = 15) agreed and the other 8.9 percent (n = 5) strongly agreed that this is a barrier.

Concerning the mentors' perceptions of whether performing mentoring duties in a very busy clinical setting with very sick patients hinders peer mentoring, findings indicated that 50 percent (n = 28) of the cohort agreed and 42.9 percent (n = 24) concurred strongly with this notion. A few mentors viewed this differently as 3.6 percent (n = 2) strongly disagreed and the same number disagreed.

There were mixed feelings among mentors as to whether assisting a learner whose skills levels are below the expected standard is a barrier to peer mentoring, as a total of 48.2 percent (n = 27) mentors agreed and a further 12.5 percent (n = 7) strongly agreed to this while an average of 33.9 percent (n=19) refuted this statement and only 5.4 percent (n = 3) strongly disagreed.

It is significant to note that a total of 25 percent (n = 14) of mentors strongly disagreed and 35.7 percent (n = 20) disagreed that cross-cultural and cross-gender mentoring create discomfort. About 28.6 percent (n = 16) of respondents saw this from a different perspective and attested to this notion and were supported by 10.7 percent (n = 6) strongly agreed.

It was enquired as to whether a too wide age gap between peer mentor and peer mentee creates a barrier to peer mentoring, and 39.3 percent (n = 22) respondents disagreed with this and 19.6 percent (n = 11) strongly disagreed. A further 32.1 percent (n = 18) agreed and 8.9 percent (n = 5) strongly identified this as a barrier.

Half of the peer mentor cohort 50 percent (n = 28) confirmed that peer mentoring was challenged by insufficient practice opportunities for the students because of the short duration of the placement, and were supported by 41.1 percent (n = 23) who were in strong agreement. A few respondents held a contrary view because 5. 4 percent (n = 3) disagreed and 3.6 percent (n = 2) strongly disagreed that this was a challenge.

In responding to the statement that there was inadequate time available to attend to the mentees and patients, 44.6 percent (n= 25) mentor respondents confirmed this and were supported by 35.7 percent (n = 20) who strongly agreed. A small minority 12.5 percent (n = 7) indicated disagreement and the other 7.1 percent (n = 4) strongly disagreed.

MENTORS' PERCEPTIONS OF BARRIERS OF PEER MENTORING

Legend: ☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

BARRIERS OF PEER MENTORING (y-axis)

- Insufficient practice opportunities for the students because of the short duration of the…: 41.1, 50, 5.4, 3.6
- Too wide- age gap between peer mentor and peer mentee.: 8.9, 32.1, 39.3, 19.6
- Cross-cultural and cross-gender mentoring create discomfort: 10.7, 28.6, 35.7, 25
- Assisting learners who display a lack of initiative and motivation: 28.6, 62.5, 5.4, 3.6
- Assisting a learner whose skills levels are below the expected standard.: 12.5, 48.2, 33.9, 5.4
- Performing mentoring duties in a very busy clinical setting with very sick patients.: 42.9, 50, 3.6, 3.6
- Inadequate time available to attend to both the mentees and patients: 35.7, 44.6, 12.5, 7.1
- Mentoring too many students at the same time: 8.9, 26.8, 39, 25
- Poor preparation to carry out the role of peer mentoring in clinical settings: 17.9, 58.9, 17.9, 5.4
- Lack of support from clinical staff members: 37.5, 53.6, 8.9, 0
- Lack of understanding of the programme requirements: 21.4, 58.9, 17.9, 1.8
- Working with limited equipment and other resources: 33.9, 57.1, 5.4, 3.6
- Lack of recognition of the demand of the role of peer mentoring by nurse educators: 30.4, 44.6, 23.2, 1.8
- (unlabelled): 23.6, 65.5, 7.3, 3.6

PERCENTAGE (x-axis: 0, 20, 40, 60, 80)

Figure 4.7 Mentors' perceptions of the barriers of peer mentoring in clinical settings

4.7.2 Mentees' perceptions of barriers to peer mentoring in clinical settings.

Study findings in Figure 4.8 (mentees' perceptions of barriers of peer mentoring) indicate that when responding to the statement on whether a discrepancy between what is taught in class or in simulation and what is actually implemented in the clinical setting causes anxiety and confusion, a total of 44.7 percent (n = 42) mentees attested to this and 39.4 percent (n = 37) strongly agreed. This was refuted by some respondents and consequently, 11.7 percent (n = 11) disagreed and 4.3 percent (n = 4) strongly disagreed.

With regard to the statement that working with limited equipment and other resources is a barrier to peer mentoring, the study results revealed that the highest number of respondents (54.3 percent; n = 51) affirmed this and 35.1 percent (n = 33) strongly agreed. Other students felt differently and as a result 8.5 percent (n = 8) refuted and were supported by 2.1 percent (n = 2) who strongly refuted with this notion.

The majority of mentees (44.7 percent; n= 42) attested that mentors that appear to be uncertain about their knowledge and actions make students nervous and anxious and were strongly supported by 33 percent (n = 31). Other respondents held a contrary view with 14.9 percent (n = 14) refuting and 7.4 percent (n = 7) refuting strongly.

Mentee respondents who confirmed that the reluctance of mentors to fulfil their roles as well as mentors who are not dedicated and unfriendly is an obstacle to peer mentoring comprised 46.8 percent (n = 44) of those who agreed and 30.9 percent (n = 29) who strongly agreed. On the contrary, 19.1 percent (n = 18) viewed this from a different stance and disagreed while 3.2 percent (n =3) strongly denied that this was an obstacle to peer mentoring.

Responses concerning lack of support from clinical staff members as an impediment to peer mentoring in clinical settings varied widely among mentees as 44.7 percent (n = 24) were in agreement with the statement and 24.5 percent (n = 23) were in strong agreement. However, a small number 23.4 percent (n = 22) denied and 7.4 percent (n = 7) strongly denied the contents of this statement.

Furthermore, mentees revealed varied perceptions when examining the statement that poor preparation to carry out the role of peer mentoring in clinical settings was an impediment to peer mentoring. The greatest number of respondents (45.7 percent; n = 43)

agreed and 21. 3 percent (n = 20) strongly agreed. Other respondents refuted this, with 28.7 percent (n = 27) disagreeing and only 4.3 percent (n = 4) strongly disagreeing.

Concerning the statement that cross-cultural and cross-gender mentoring create discomfort, the highest number of respondents refuted this as an obstacle with 44.7 percent (n = 32) disagreeing, followed by 23.4 percent (n = 22) strongly disagreeing. However, there were students who responded affirmatively to this and as a result 22.3 percent (n = 21) agreed and only 9.6 (n = 9) strongly agreed that this was a barrier.

Responses regarding the statement that a too wide age gap between peer mentor and peer mentee creates a challenge to peer mentoring varied widely among respondents. Findings indicate that 37.2 percent (n= 35) of the respondents disagreed and 22.3 percent (n – 21) strongly disagreed with this statement. Other students had different experiences and consequently 26.6 percent (n = 25) agreed and 13.8 percent (n = 13) strongly agreed.

Cross-tabulations were also done on the demographics (age groups and level of training) of respondents from both cohorts and the barriers of peer mentoring and the results were of no statistical significance because the p values were above .005.

MENTEES' PERCEPTIONS OF BARRIERS OF PEER MENTORING

□ Strongly Agree □ Agree □ Disagree □ Strongly Disagree

Too wide- age gap between peer mentor and peer mentee.
- 13.8
- 26.6
- 37.2
- 22.3

Cross-cultural and cross-gender mentoring create discomfort
- 9.6
- 22.3
- 44.7
- 23.4

Poor preparation to carry out the role of peer mentoring in clinical settings
- 21.3
- 45.7
- 28.7
- 4.3

Lack of support from clinical staff members
- 24.5
- 44.7
- 23.4
- 7.4

Reluctance of mentor to fulfil their roles, mentors who are not dedicated and unfriendly.
- 30.9
- 46.8
- 19.1
- 3.2

Working with limited equipment and other resources
- 35.1
- 54.3
- 8.5
- 2.1

Mentors that appear to be uncertain about their knowledge and actions makes students nervous and anxious.
- 33
- 44.7
- 14.9
- 7.4

Discrepancy between what is taught in class/in simulation and what is actually implemented in the clinical setting causes anxiety and confusion.
- 39.4
- 44.7
- 11.7
- 4.3

BARRIERS

PERCENTAGES

0   10   20   30   40   50   60

Figure 4.8 Mentees' perceptions of barriers of peer mentoring

4.8 Benefits to peer mentoring in the clinical settings.

4.8.1 Mentors' Benefits

The study results in Figure 4.9 (mentors' perceptions of the benefits of peer mentoring) conclude that the vast majority of 69.6 percent (n = 39) mentors agreed and 23.2 percent (n = 13) strongly agreed that peer mentoring experience was time and effort well spent and only a few that totalled 3.6 percent (n = 2) strongly disagreed and the same number disagreed.

Mentors who felt strongly that peer mentoring enabled the application of principles of teaching and learning comprised of 60.7 percent (n = 34) and were supported by 33.9 percent (n = 19) who agreed. Meanwhile 3.6 percent (n = 2) were in disagreement together with 1.8 percent (n = 1) who strongly disagreed that this was a benefit.

Interestingly, a total of 57.1 percent (n = 32) mentors agreed with the benefit that acting the role of peer mentor enabled the development of teaching and leadership skills and were supported by another 37.5 percent (n = 21) who strongly agreed. On the contrary, 3.6 percent (n = 2) disagreed that this benefited them, followed by 1.8 percent (n=1) who strongly disagreed.

While 64.3 percent (n = 36) of the mentor cohort agreed that engaging in peer mentoring helped them to gain an opportunity to review knowledge and to stay current with skills, followed by 32.1 percent (n = 18) who strongly agreed, 3.6 percent (n 2) of the respondents disagreed.

It was inquired as to whether providing support and encouragement to a junior nurse promoted personal and professional development and a total of 55.4 percent (n = 31) mentor respondents were in agreement and 42.9 percent (n = 24) fell into a category of those who strongly agreed. Only 1.8 percent (n = 1) fell into a category of those who refuted the statement.

Data revealed that a total of 55.4 percent (n = 31) of mentors attested that peer mentoring experience prepared them for their registered nurse's role and 39.3 percent (n = 22) strongly agreed with this, whilst 5.4 percent (n = 3) held a contrary view.

The most perceived benefit of peer mentoring among the mentor cohort was that the role of a peer mentor increased confidence, self- esteem and self-worth, affirmed by all respondents with 57.1 percent (n = 32) agreeing and 42.9 (n = 24) strongly agreeing.

When mentors were asked whether facilitating and aiding learning and development of a less experienced nurse enhances personal gratification, 66.1 percent (n = 37) agreed and 32.1 percent (n =18) strongly agreed. Only 1.8 percent (n = 1) felt differently and disagreed with the statement.

Responses on the statement that mentoring provided an early exposure to being a role model, the overwhelming majority of the respondents were in favour of this statement and as result, 55.4 percent (n = 31) agreed and 42.9 percent (n = 24) strongly agreed. Only 1.8 percent (n = 1) did not share the same view and therefore disagreed.

In responding to the statement that providing psychosocial support to mentees makes the mentors to feel important, respected and valued, the highest number of respondents (60.7 percent; n = 34) agreed with the statement and 28.6 percent (n = 16) strongly agreed. A few respondents had negative perceptions with 8.9 percent (n =5) indicating disagreement and 1.8 percent (n = 1) strongly disagreeing.

It is interesting to note that all student nurses who participated in the study as mentors asserted that nurses have a professional responsibility to teach students and peers. It was found that 51.8 percent (n = 29) responded affirmatively and 48.2 percent (n = 27) strongly agreed to this statement.

MENTORS' PERCEPTIONS OF THE BENEFITS OF PEER MENTORING
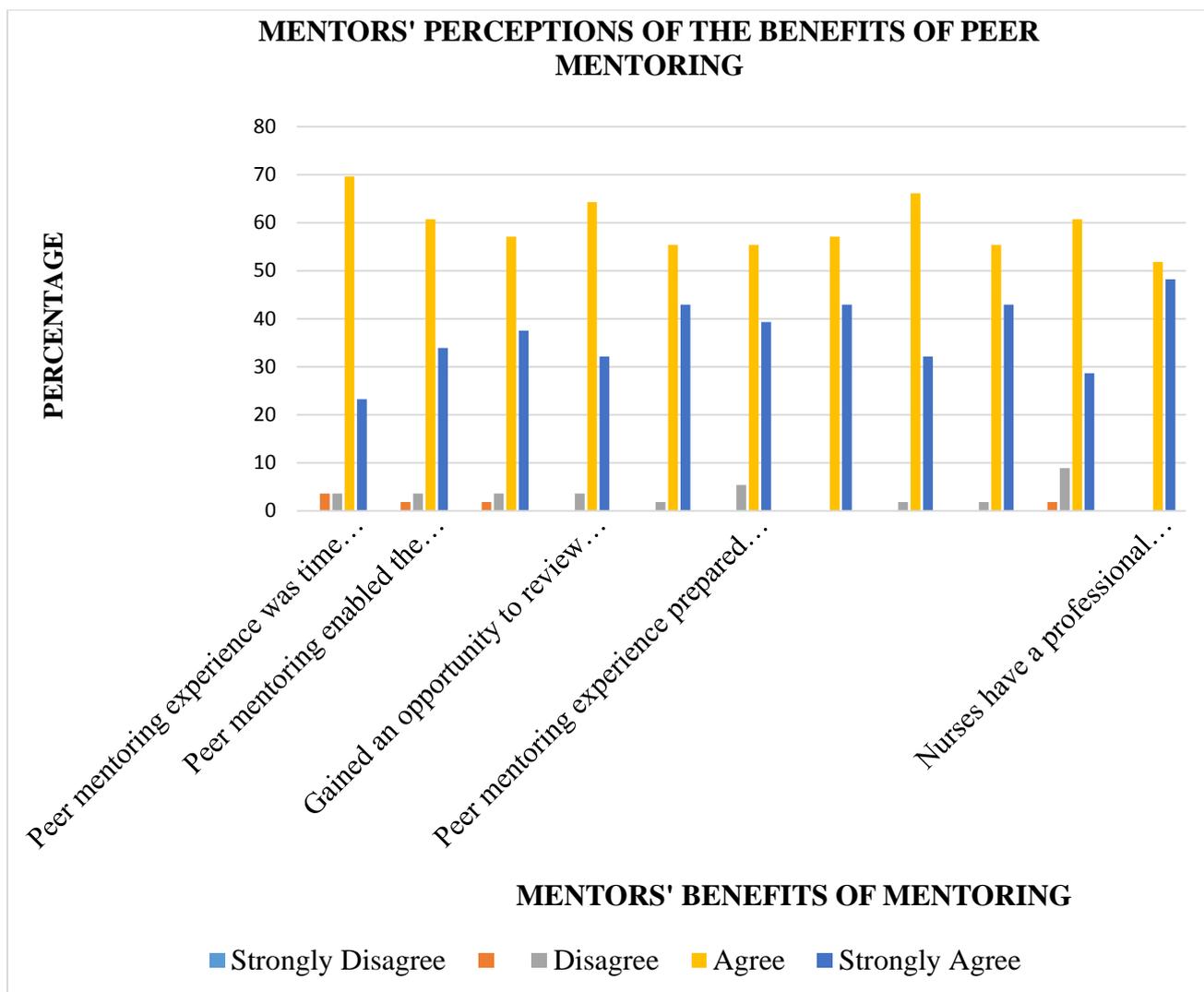
Figure 4.9 Mentors' perceptions of the benefits of peer mentoring.

4.8.2 Mentees' perceptions of benefits of peer mentoring in clinical settings.

From the data that is depicted in Figure 4.10 (mentees' perceptions of the benefits of peer mentoring) it can be concluded that a total of 43.6 percent (n= 41) mentees agreed and 53.2 percent (n = 50) strongly agreed that peer mentoring makes adapting to the clinical environment easy while only 1.1 percent (n = 1) strongly disagreed and 2.1 percent (n = 2) disagreed.

Mentees who felt that peer mentoring makes one to be less intimidated and more comfortable totalled 40.4 percent (n = 38) who agreed with this statement and 54.3 percent (n = 51) who strongly agreed while only 5.3 percent (n = 5) disagreed.

A total of 44.7 percent (n = 42) mentees were in agreement that approaching a peer mentor for assistance is easier than approaching the instructor, followed by 48.9 percent (n = 46) who strongly agreed. However, a very few respondents felt differently as 3.2 percent (n = 3) strongly disagreed and the same number disagreed.

The majority of mentees, 54.3 percent (n = 51) responded affirmatively that when a clinical skill is taught by a peer mentor, interaction and collaboration with other students increases more than when it is taught by my instructor and were strongly supported by 36.2 percent (n = 34). Other students denied this notion and consequently 1.1 percent (n = 1) disagreed and 8.5 percent (n = 8) strongly disagreed.

Respondents (54.3 percent; n = 51) agreed that when a clinical skill is taught by a peer mentor, interaction and collaboration with other students increases more than when it is taught by their clinical instructor. The remaining 36.2 percent (n = 34) strongly agreed whilst only 1.1 percent (n = 1) strongly disagreed and 8.5 percent (n = 8) disagreed.

Peer mentees who agreed that acting the role of a peer mentor increased their confidence, self- esteem and self-worth totalled 57.1 percent (n= 32) followed by 42.9 percent (n = 24) who strongly agreed.

The majority of respondents (45.7 percent; n = 43) agreed that they experienced less anxiety when performing nursing skills in the presence of their peers than in the presence of the instructor and were strongly supported by the same number of respondents. Mentees who did not share the same view added to 7.4 percent (n = 7) of those who disagreed and only 1.1 percent (n =1) strongly disagreed.

The study results revealed that the greatest number of respondents felt that communication with a peer mentor is freer than with the instructor, with 50 percent (n = 47) strongly agreeing and 42.6 percent (n = 40) agreeing. However, refuted this statement with 6.4 percent (n = 6) disagreeing and 1.1 percent (n =1) strongly disagreeing.

Mentees who felt that the peer mentors were more supportive when they were performing nursing skills comprised of (61.7 percent; n = 58) who agreed and 29.8 percent (n = 28) who strongly agreed. Others had different perceptions as 8.5 percent (n=8) disagreed.

Overall, 60.6 percent (n = 57) respondents agreed that peer mentoring helped in integration of theory and practice and were followed by 35.1 percent (n = 33) who strongly agreed. A few respondents refuted this as only 4.3 percent (n 4) disagreed with the statement.

The respondents were also asked to rate the statement that teaching is an important role of the nurse. Responses varied because 57.4 percent (n = 54) strongly agreed and 37.2 percent (n = 35) agreed with the statement. A minimum number of respondents held a contrary view, and 4.3 percent (n = 4) disagreed while 1.1 percent (n = 1) strongly disagreed.
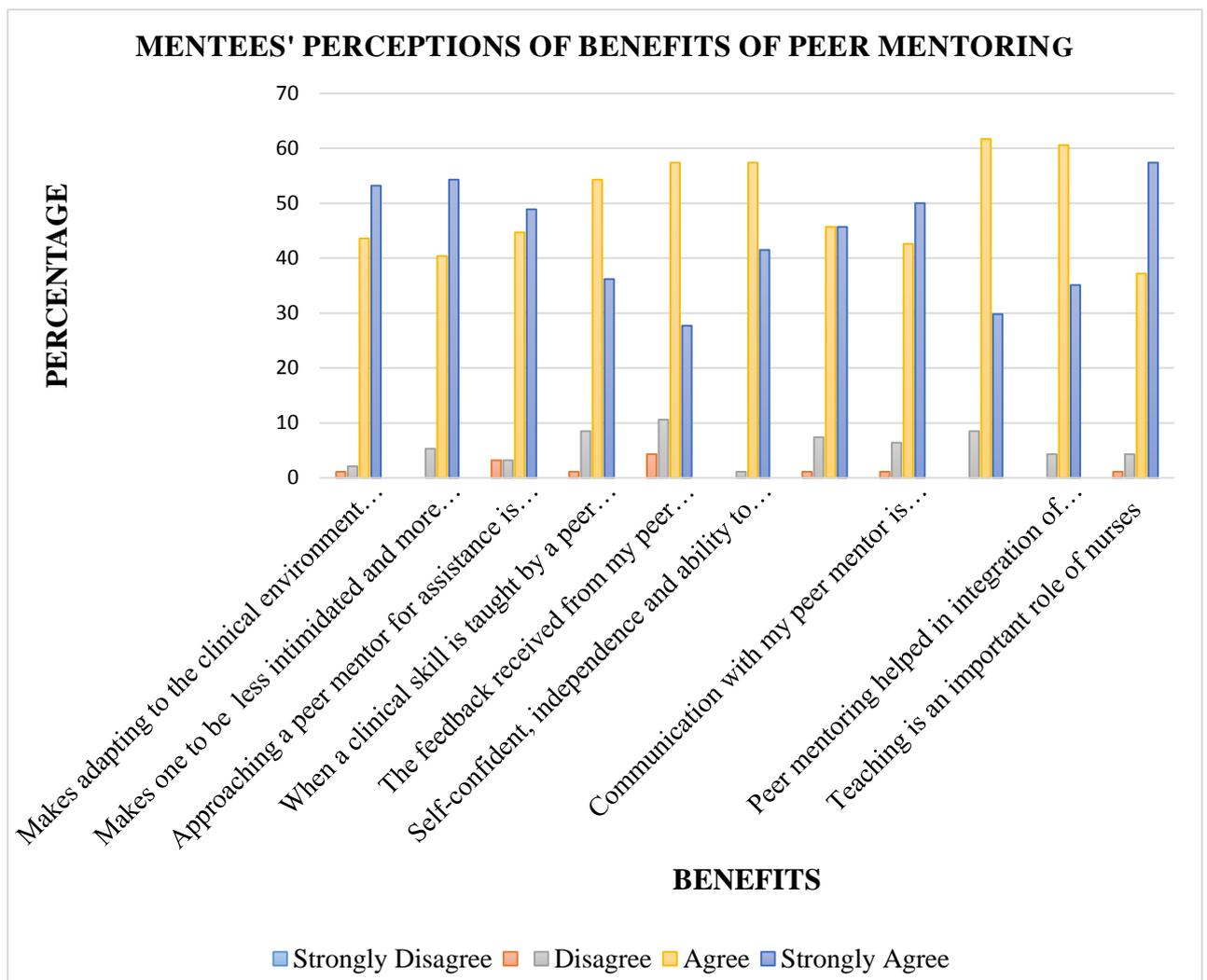
Figure 4.10 Mentees' perceptions of benefits of peer mentoring

Correlations between the level of training of respondents from both cohorts and the benefits of peer mentoring were performed and the results indicated that the majority of first year

mentees agreed with the stated benefits of peer mentoring compared to second year mentees. No associations were found and the Chi square values were above 0.005.

4.9 Evaluation of the mentorship programme

4.9.1 Mentors' Evaluation

Mentors were asked to rate their experiences with peer mentoring in the clinical placement area using a scale of 1-5, where 1 = poor, 2 = fair, 3= satisfactory, 4 = very good and 5 = excellent. These ratings were subsequently collapsed to poor, fair and good.

As depicted in Figure 4.11 (mentors' evaluation of peer mentorship programme) the overwhelming 87.5 percent (n= 49) majority rated that the mentorship programme was good followed by 8.9 percent (n = 5) who rated it as fair while only 3.6 percent (n= 2) rated it as poor.

The respondents were invited to evaluate the support received by peer mentors from programme coordinators and 80. 4 percent (n = 45) mentors ranked it as good while 7.1 percent (n = 4) ranked it poor and 12.5 percent (n = 7) ranked it fair.

In responding to the statement on the unit manager's support of peer-mentoring, research indicates that 58.9 percent (n = 33) rated it as good, 28.6 percent (n = 16) rated it fair and 12.5 percent (n = 7) rated it poor.

A large number (48.3 percent; n = 27) of respondents considered the unit manager's involvement in peer mentoring as good while 32.1 percent (n = 18) rated it fair and 19.6 percent (n = 11) rated it poor.

Regarding the statement on the facilitation of learning by peer mentors in the clinical settings, a total of 87.3 percent (n = 49) participants believed that was good. On the other hand 10.9 percent (n =6) felt it was fair and only 1.8 percent (n = 1) rated it poor.

The overwhelming majority of 83.9 percent (n = 47) mentors felt that the feedback they provided to mentees was good and only a few 16.1 percent (n = 9) felt it was fair.

The feedback provided by peer mentees to mentors was rated as good by 85.7 percent (n = 48) while 10.7 percent (n = 6) felt it was fair and 3.6 percent (n = 2) indicated that it was poor.

When evaluating feedback provided by programme coordinators to peer mentees, statistics indicate that the greatest number (71.4 percent; n = 40) of mentors believed it was good, 14.3 percent (n = 8) believed it was fair and 14.3 percent (n = 8) believed it was poor.

A significant majority of 67.9 percent (n = 38) felt that an environment that was created for peer mentoring in clinical settings was supportive, while 19.6 percent (n= 11) felt it was fair and 12.5 percent (n = 7) felt it was poor.

The majority of respondents felt that the clinical environment allowed for maximum clinical learning by mentees because 75 percent (n = 42) rated this as good while 14.3 percent (n = 8) rated it fair and 10.7 percent (n = 6) rated it as poor.

It is encouraging to note that a total of 94.6 percent (n = 53) of mentors rated that peer mentoring programme facilitated the development of confidence in a new nurse and only 5.4 percent (n = 3) rated it as fair.

The availability of equipment and other resources as enhancing learning through peer mentoring was rated as good by 80.3 percent (n = 45) while 14.3 percent (n = 8) rated it as fair and 5.4 percent (n = 3) rated it poor.

From the mentors' viewpoint, half of the cohort (50 percent; n = 28) felt that the staff in the clinical settings were supportive to peer mentors and mentees while 25 percent (n = 14) felt that the support was fair and the same number felt it was poor.
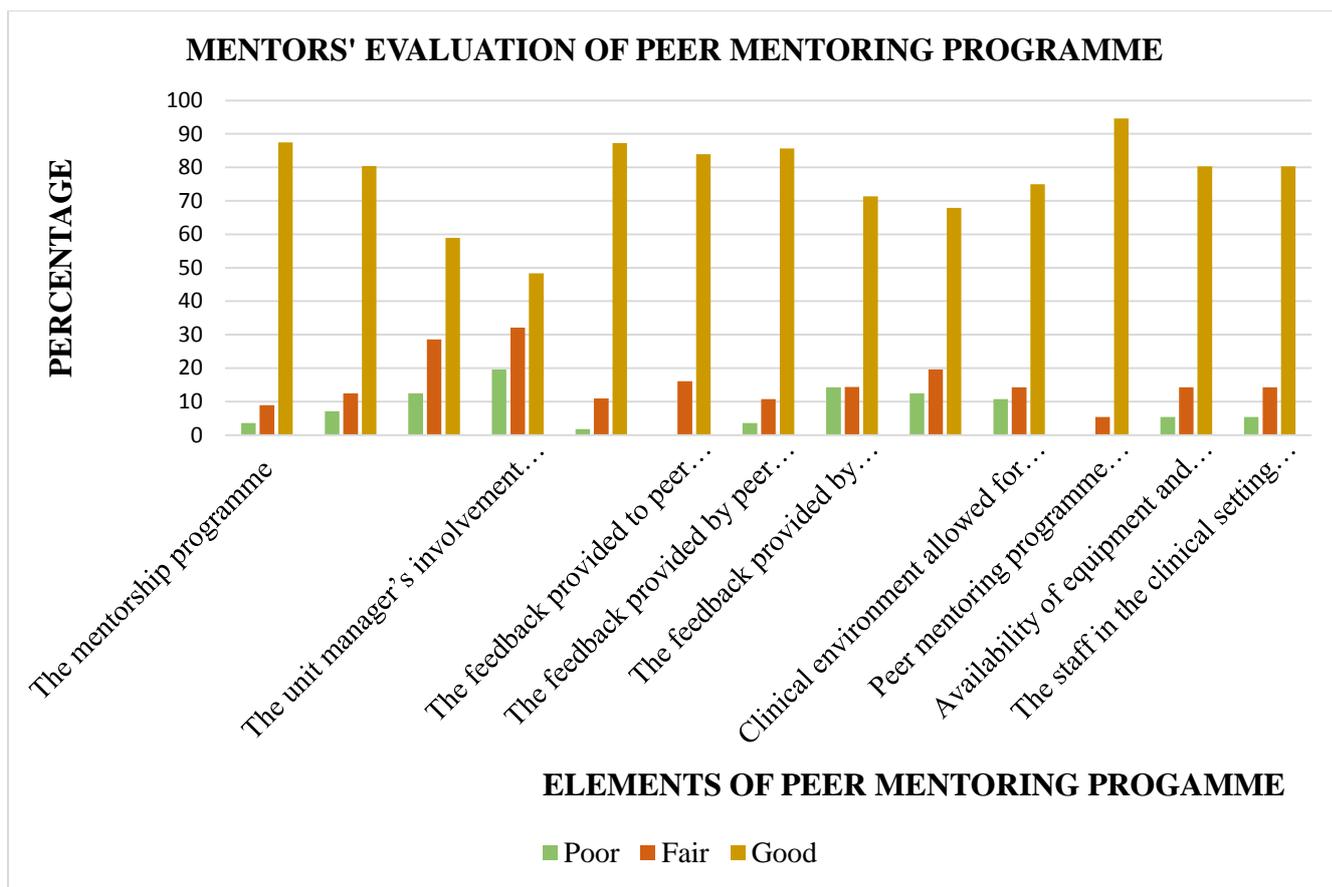
Fig 4.11 Mentors' evaluation of the peer mentoring programme

4.9.2   Mentees' evaluation of the peer mentoring programme.

Data shown in Figure 4.12 (Mentees' evaluation of the peer mentoring programme) reflects that 86.2 percent (n = 81) of mentees felt that the mentorship programme was good, 10.6 percent (n = 10) felt it was fair and 3.2 percent (n = 3) felt it was poor.

With regard to the support received by peer mentors from programme coordinators, 83 percent (n = 78) rated it good, 13.8 percent (n = 13) rated it as fair and 3.2 percent (n = 3) rated it as poor.

Concerning the evaluation of the unit manager's support of peer mentoring in clinical settings, an overwhelming majority (79.9 percent; n = 75) felt it was good, 16.0 percent (n = 15) felt it was fair and 4.3 percent (n = 4) felt it was poor.

About 69.2 percent (n = 65) mentees believed that the unit manager's involvement in peer mentoring was good while 20.2 percent (n = 19) believed it was fair and 10.6 percent (n = 10) believed it was poor.

Respondents were also invited to evaluate the facilitation of learning by peer mentors in clinical settings and an overwhelming majority of 93.6 percent (n = 88) rated it as good and 6.4 percent (n = 6) felt it was fair and nobody rated it as poor.

Respondents from the mentee cohort who felt that the feedback provided by peer mentors to the mentees was good totalled 76.6 percent (n = 72), followed by 12.8 percent (n =12) who responded that it was fair. The remaining 10.6 percent (n = 10) indicated that feedback provided was poor.

Similar findings were obtained with regards to feedback provided by peer mentees to mentors with a large majority (78.7 percent; n = 74) of respondents rating the feedback as good, followed by 11.7 percent (n = 11) indicating a stance of fair and a lastly a small number 9.6 percent (n = 9) perceived the feedback as poor.

The results further revealed varied responses about the feedback provided by programme coordinators to peer mentees regarding their role as 74.4 percent (n = 70) rated it as good while 12.8 percent (n = 12) rated it fair and the same number rated it poor.

With regard to a supportive environment that was created for peer mentoring in clinical settings, a total of 75.6 percent (n = 71) respondents believed it was good, while 17.0 percent (n = 16) felt it was fair and 7.4 percent (n = 7) indicated it was poor.

Furthermore, when respondents were asked to examine the statement that the clinical environment allowed for maximum clinical learning for mentees, the majority of the respondents 81.9 percent (n = 77) indicated positively, 13.8 percent (n = 13) felt this was fair and 4.3 percent (n = 4) felt it was poor.

Interestingly, the peer mentoring programme as facilitating development of confidence in a new nurse was rated good by the vast majority of respondents(94.4 percent; n = 89), followed by a 3.2 percent (n = 3) rating of fair and 2.1 percent (n = 2) rating of poor.

It is significant to note that the availability of equipment and other resources to enhance learning through peer mentoring was rated by 77.6 percent (n = 73) as good while 18.1 percent rated it fair and 4.3 percent rated it poor.

Overall, 77.7 percent (n = 73) respondents rated the evaluation of staff in the clinical setting as being supportive to peer mentors and mentees as good , followed by 13.8 percent (n = 13) who rated it as fair and only 8.5 percent (n = 8) who rated it as poor .

MENTEES' EVALUATION OF THE PEER MENTORING PROGRAMME

ELEMENTS OF THE PEER MENTORING PROGRAMME

Poor Fair Good
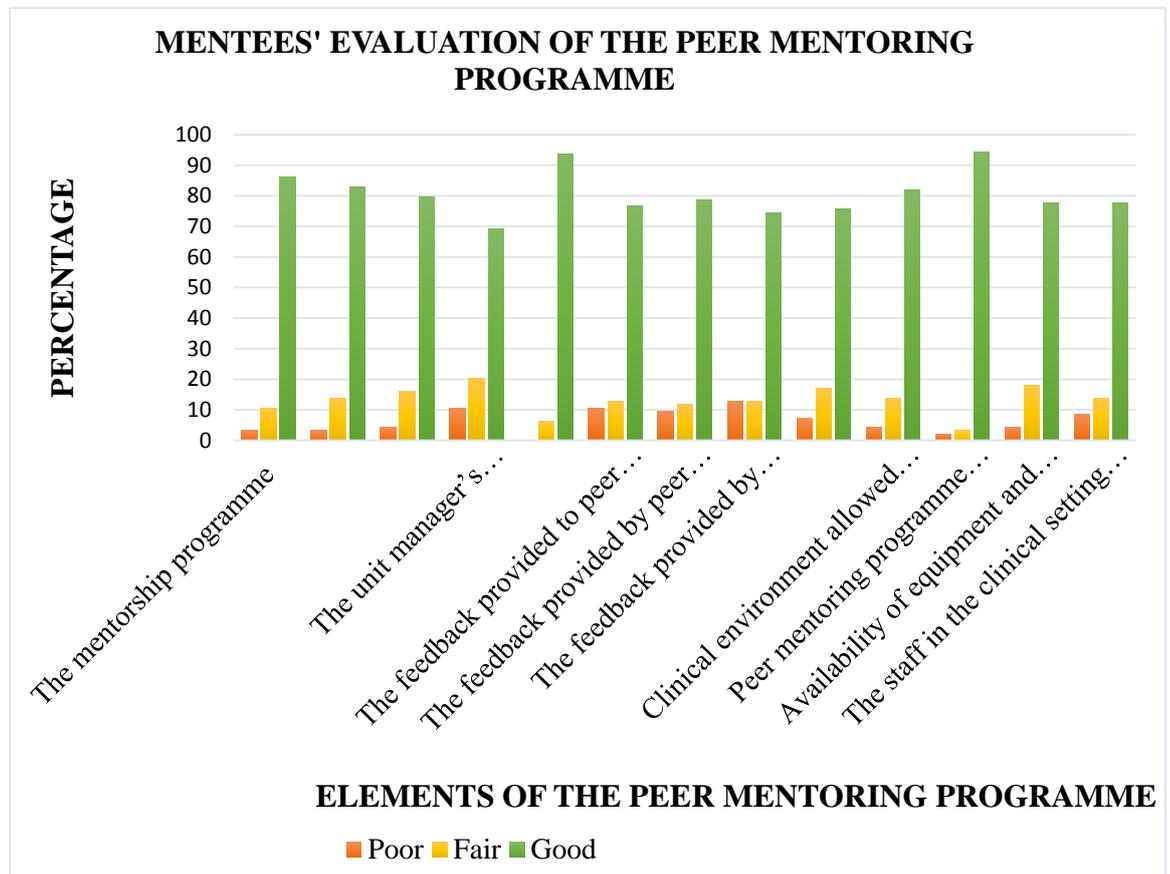
Figure 4. 12 Mentees' evaluation of the peer mentoring programme

Scale reliability testing and Cronbach's alpha coefficients

Separate scale reliability and consistency testing was conducted on combined mentor and mentee questionnaire items by performing the Cronbach's coefficiency test (Table 4.8). It is interesting to note that the results for all variables were above .7. The closer the Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in the scale. An alpha of .8 is probably reasonable, **> .**7 is acceptable, > .6 is questionable, > .5 is poor, and< .5 is unacceptable (George & Malley, 2003). The results indicated that the questionnaire items were interrelated and unidimensional (Tavakol & Dennick, 2011).

Table 4.8   Cronbach's alpha coefficients on combined mentor's and mentee's instrument

Theme on instrument	Cronbach's Alpha results
Qualities of peer mentors	.748
The role of a mentee	.774
Barriers to peer mentoring	.880
Programme benefits	.808
Students' rating of their experiences with peer mentoring in the clinical placement	.721

4.10   Students' View on whether the peer mentoring programme met their expectations

4.10.1 Mentors' views

Data in Figure 4.13 (indication of how the peer mentoring programme met the mentors' expectations) indicates that a total of 60.7 percent (n = 34) mentors felt that the mentoring programme adequately met their expectations, 7.1 percent (n = 4) felt it exceeded their expectations and 26.8 percent (n = 15) felt it partially met their expectations while 5.4 percent (n = 3) felt it did not meet their expectations.

MENTORS' EXPECTATIONS OF THE PEER MENTORIMG PROGRAMME
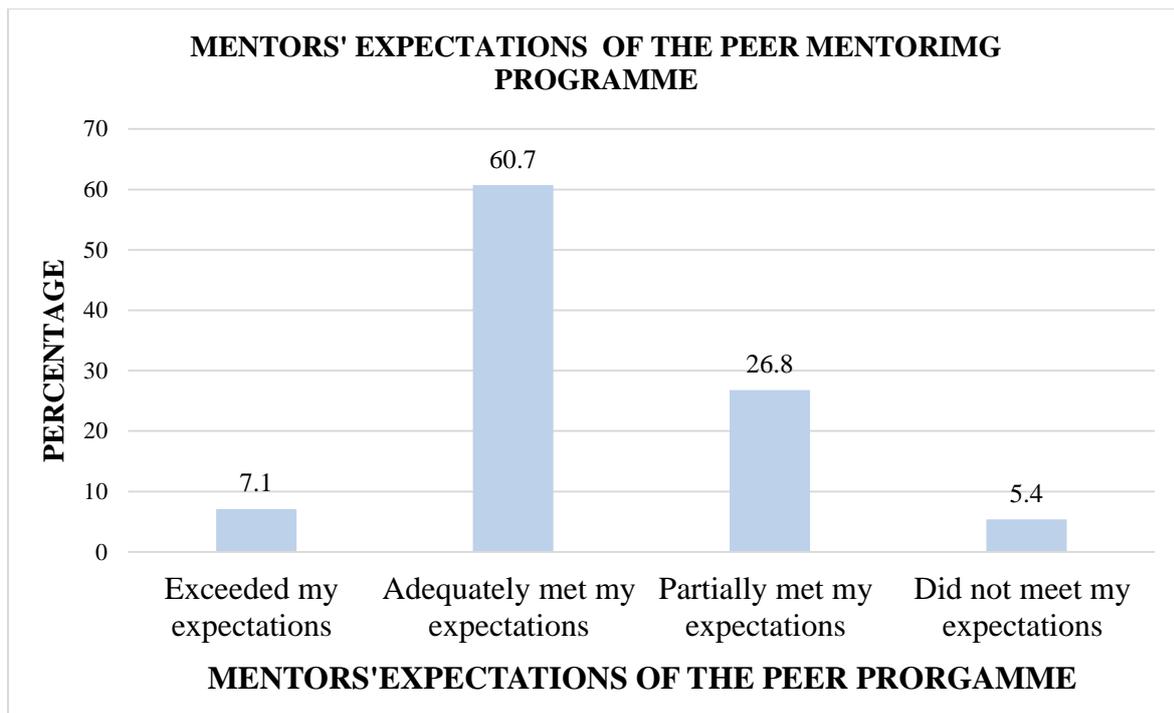
Figure 4.13 Indication of how the peer mentoring programme met the mentors' expectations

4.10.2 Mentees' views

From the findings in figure 4.14 (indication of how the peer mentoring programme met the mentees' expectations), it can be seen that a total of 56.4 percent (n = 53) of mentees stated that the mentoring programme adequately met their expectations, 17 percent (n = 16) reported that it exceeded their expectations while 23.4 percent (n = 22) stated that it partially met their expectations and only 3.2 percent (n = 3) stated that it did not meet their expectations.

MENTEES ' EXPECTATIONS OF THE PEER MENTORSHIP PROGRAMME
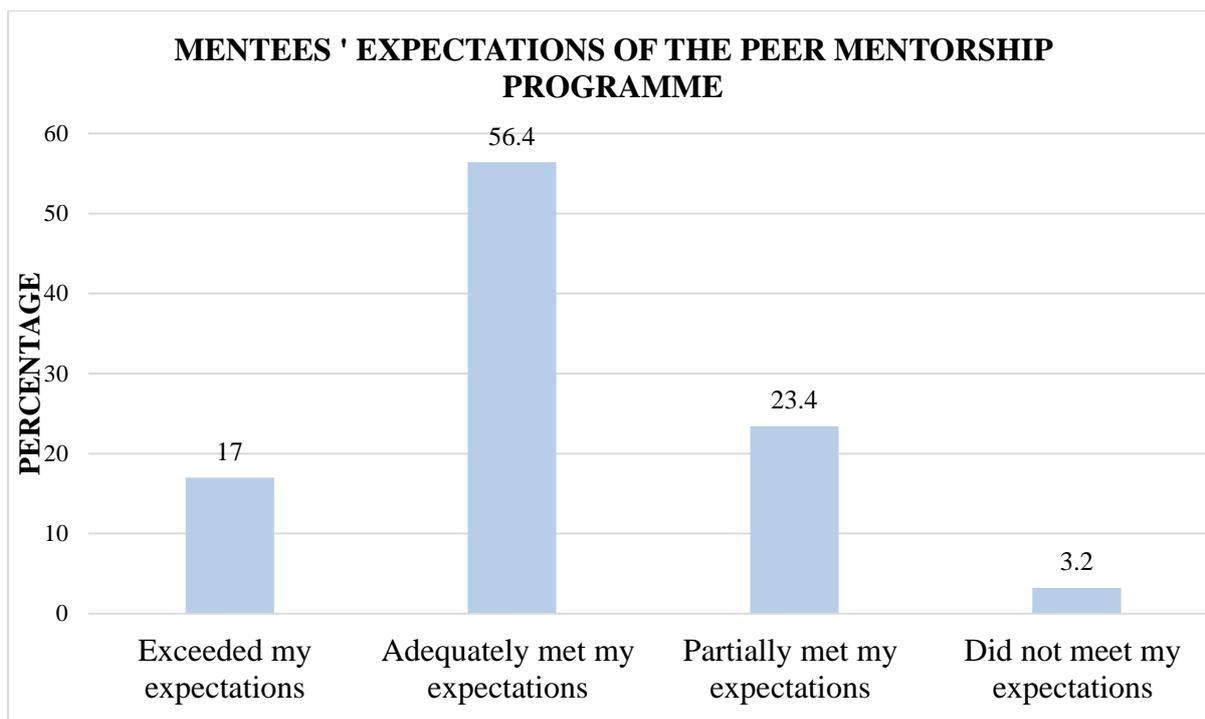
Figure 4.14   Indication of how the peer mentoring programme met the mentees' expectations

4.11   Respondents' views on whether they would recommend the peer mentoring programme to friends and peers.

4.11.1 Mentors' Views

From the findings in Figure 4.15 (mentor's views on whether they would recommend the peer mentoring programme to friends and peers), it can be seen that a total of 85.7 percent (n = 48) mentors stated that they would recommend the mentoring programme to their friends and peers while 5.4 percent (n = 3) said they would not recommend it and 8.9 percent (n = 5) said they were unsure.

RECOMMENDATION OF PEER MENTORS BY MENTORS TO OTHERS
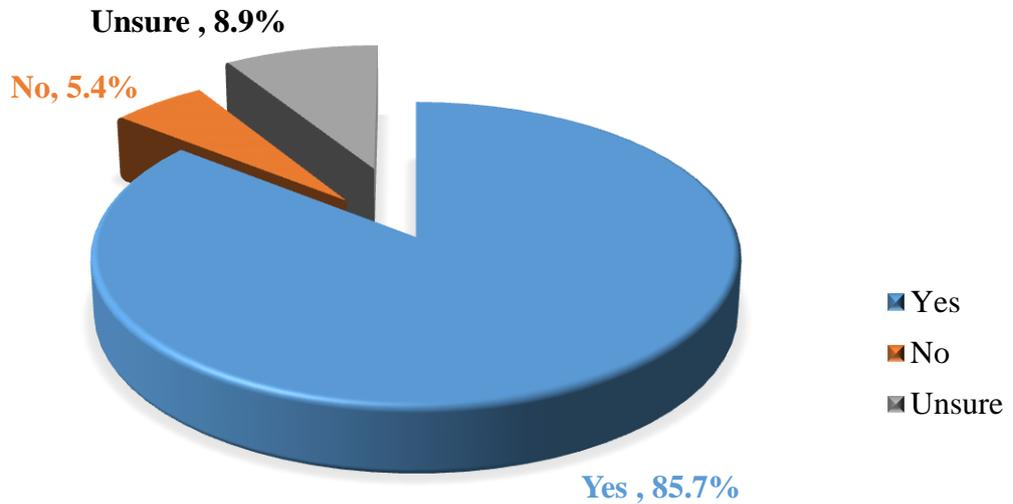
Unsure , 8.9%

No, 5.4%

Yes , 85.7%

- Yes
- No
- Unsure

Figure 4.15   Mentors' views on whether or not they would recommend the peer mentoring programme to friends and peers

4.11.2 Mentees' Views

From the findings depicted in Figure 4.16 (mentees' views on whether they would recommend the peer mentoring programme to friends and peers) it is evident that an overwhelming majority of 90.4 percent (n = 85) mentees said they would recommend the mentoring programme to their friends or peers, while only 2.1 percent (n = 2) said they would not recommend it and 7.4 percent (n = 7) said they were unsure.

RECOMMENDATION OF PEER MENTORING PROGRAMME BY MENTEES TO OTHERS
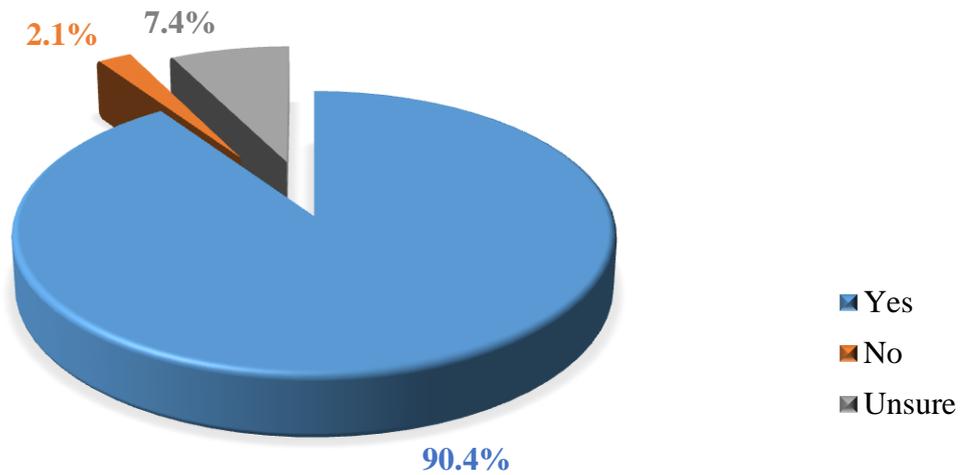
2.1%   7.4%

90.4%

- Yes
- No
- Unsure

Figure 4.16   Mentees' views on whether or not they would recommend the peer mentoring programme to friends and peers

4.12 Responses to open-ended questions

At the end of the questionnaire, the respondents were asked to respond to open-ended questions which included:

- What other aspects of the peer mentoring programme had they found useful?
- What suggestions could they offer for the improving and strengthening of the peer mentoring programme?
- Would they like to volunteer any additional comments?

Responses varied especially among mentors and mentees. The researcher grouped the responses according to common themes that emerged:

4.12.1 Other aspects of the peer mentoring programme that they found useful

Work Ethics: A total of 27 percent (n = 15) mentors stated that the mentees were very respectful towards them and were always punctual at work. One mentor stated: *"my mentees came on duty on time and were punctual even when returning from tea and lunch breaks."* Another one commented: *"I was given a hardworking mentee who helped with basic patient needs and was helpful when I was busy with patients."*

Maintenance of dignity: About 7 percent (n = 4) mentees also indicated that the mentors had a non-judgmental but caring attitude and they treated them with respect and dignity. One mentee reported: *"We were treated like real nurses yet we had just started training."* Another one said: *"Our seniors were very respectful of us, as junior as we were."*

4.12.2 Benefits gained

Mentors' benefits

Updated knowledge base: Mentoring made senior students realise the importance of keeping abreast with new developments. About 1.7 percent (n = 1) *student remarked, "mentoring made me realise that I have to be competent in clinical skills and have up-to-date knowledge."*

Development of assessment skills: About 10.7 percent (n = 6) mentors reported that they practically learned to assess and evaluate junior nurses and to give reports about their progress. *One mentor wrote "my unit mangers told them that I have to write a progress report of my mentee at the end of the month and that made me realize that I have to constantly assess and evaluate my mentee."*

Reciprocal learning: A total of 8.9 percent (n = 5) mentors reported that they also learned a lot from the mentees who had fresh knowledge. *One mentor wrote: "I benefited from the programme because I was not only teaching my mentee but I also learned the latest version of how things are done from her."*

Mentees' benefits

Performing Nursing skill: About 7.4 percent (n = 7) mentees reported that they became actively involved in performing patient care duties under supervision and guidance of their

peer mentors. A few (3.1 percent ; n = 3) mentees said their mentors taught them nursing skills such as checking of glucometer which they had not been taught at college and in that way they became in advance of their peers with skills and knowledge.

Dissatisfaction with mentoring style: A total of (3.1 percent; n = 3) mentees were less satisfied that the mentors challenged and presented them with the unfamiliar duties as *one mentee reported "my mentor asked me lots of question and expected me to know everything even things that I had not heard of before." Another one remarked: "it will be better if the mentors will be told what to teach us because my mentor pushed me to the deep-end of the pool as she was asking me to perform duties that we had not been taught at college."*

Enhancement of communication skills: A total of (3.1 percent; n = 3) highlighted that the mentors helped them to communication with patients and relatives and they began to learn the indigenous language, IsiZulu. *Some mentees reported: "when I first came here I could not utter a single word of IsiZulu. I could not even talk with my patients but my mentor has taught me the language." Another one said "My Zulu language vocabulary has improved, I can now greet the patients and ask them how they feel." Another one said "I can now talk with patients' families and relatives. This is so helpful when I do history taking."*

Orientation to surroundings and residence: About 7.4 percent (n = 7) mentees reported that they got orientated to the hospital surroundings and the nurses' residence.

One mentee remarked: "my mentor took me along to all the places she was visiting and introduced me to her friends and acquaintances, in that way my circle of friends got bigger in a short space of time."

Problem-solving skills: A total of 7.1 percent (n = 4) mentors provided them with answers and assistance to the clinical problems and complicated clinical conditions.

Role-modeling: About 4.2 % (n = 4) mentees reported that the mentors were influential in shaping their views on how they themselves would function as mentors in future.

One student commented: "my mentor was enthusiastic, ambitious and very knowledgeable and she made me realize that this is the type of a nurse I should also be."

4.12.13   Suggestions by mentors and mentees on how to improve and strengthen the peer- mentoring programme

Allocation and pattern of off-duties: A total of 12.5 percent (n = 7) mentors and 4.2 percent (n = 4) mentees suggested that they should be allocated to the same nursing unit so that they will have frequent contact. About 10. 6 percent (n = 10) mentees suggested that they should

have similar off-duties with their mentors especially on the first day at work. About 3.1 % (n = 3) mentees reported that when their mentors were day-off there was no one to help them.

Preparation for mentoring: A few (5.3 percent; n = 5) mentees also suggested that they should also receive preparation for their roles so that they would know what to expect from the programme. It was also suggested by 5.3 percent (n = 3) mentors that the ward staff should also receive preparation on peer mentoring because students are allocated for other duties or are sent to do errands and they miss valuable educational time when they are out from the nursing unit.

Feedback: About 5.3 percent (n = 3) mentors and 6.3 percent (n = 6) mentees suggested that feedback session should be organised at the end of the programme.

An extract from one of the student stated: "It would be better to have a session on our last day in the nursing units, just as we had at the beginning so that we will report on the progress of the mentorship programme."

Extension of duration of mentorship: About 10. 6 percent (n = 10) mentees suggested that the period at which they are mentored be extended to at least the whole month of their initial exposure to the clinical settings.

Reward for mentors: Only 3.1 percent (n = 3) mentees suggested that mentors should be rewarded for the good job that they do.

4.12.14 Other comments made by respondents

Expression of gratitude

A total of 15.9 percent (n = 15) mentees expressed gratitude and appreciation for having worked with senior and experienced nurses on their first days. They appreciated the support and assistance they got from mentors.

Conclusion to Chapter four

In this chapter the collected data was analysed, interpreted and presented in frequency distribution tables and percentages. The researcher is convinced that the aim and objectives of the study were addressed.

CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

Following the statistical analysis of data, this chapter will present a discussion and interpretation of the most significant findings in line with the reviewed literature on the phenomena of this study. Additionally, this chapter will present recommendations, limitations and conclusions. The purpose of the study was to explore and describe the perceptions of student nurses on peer mentorship in order to enhance the quality of the peer mentorship programme in the clinical setting The objectives of the study were to describe the perceptions of student nurses: on peer mentorship; on the role of peer mentors; on the role of the mentees; on benefits of and barriers to peer mentoring in clinical settings. The objective was also to take on board the suggestions made by mentors and mentees on strengthening the mentoring programme in clinical settings.

The findings will be discussed in relation to the research objectives and the conceptual framework used in the study as well as the literature reviewed and previous research done on this topic.

5.2 SUMMARY OF MAJOR FINDINGS

Novice student nurses face many challenges when making the transition to clinical learning because of the complex and unpredictable nature of the clinical settings. Students learn best in a safe, relaxed and non-threatening milieu. It is therefore imperative that the peer mentors be supportive, understanding and provide empathetic assistance. The humanistic mentors make an impact in clinical learning by alleviating social isolation and fears (Mntambo, 2009).

The roles of a mentor are numerous, dynamic, multifaceted and complex. Both mentors and mentees pinpoint similar roles that mentors should undertake in their mentoring duties. Mentors tend to consider their roles in terms of providing support, help, teaching, and feedback. Mentees consider the roles of the mentor as being to support, to teach and to advice. The most perceived benefit of peer mentoring among the mentor cohort was that the

role of a peer mentor increased confidence, self-esteem and self-worth, which was affirmed by all respondents. Findings suggest that peer mentoring mutually benefits both senior students (mentors) as well as junior students (mentees), personally and professionally. All respondents recognised that teaching is an important part of the nurse's role.

5.3. SUMMARY AND DISCUSSION OF FINDINGS

5.3.1 Socio-Demographic Findings

The socio-demography of both the mentor and mentee groups in the study was 61 percent Black, 1.5 percent White, 31.5 percent Indian and 6 percent Coloured. The high number of Black students is due to the fact that the Black ethnic group represents the largest proportion of the population of South Africa (Letseka and Maile, 2008 & Wangenge - Ouma, 2012).

The gender distribution of mentors was 28.6 percent males and 71.4 percent females; while the mentees cohort had 21.3 percent males and 78.7 percent females. The under-representation of males in this study is in line with nursing demography, nationally and internationally, which is due to the fact that nursing is generally regarded as a female-dominated profession. The study findings (the SANC's geographical distribution of manpower, 2011) indicate that the total number of females employed was 26 071 721 and males 24 515 036.

With regard to age distribution, the mentor cohort starts from the age range of 20-24 while among the mentees cohort, 7.4 percent (n = 7) were younger, being in the 15-19 age range. The youngest respondent in the study was 18 years old. The mentor cohort had a lower percentage of respondents who were in the 20-24 age range compared to the mentee cohort (51.8 percent; n=29 mentors and 68.1 percent; n=64 mentees). Both cohorts had almost the same number of respondents who were in the 30 – 35 age range and those whose age exceeded 35 years. The students in the mentee cohort were younger because recruitment of prospective students starts from 18 years of age to ensure that nurses remain in the profession for longer. These findings are in line with the SANC Annual Statistics (2015), age distribution report of four-year course students, which indicates that the average age for students is 24 years. The minimum age is 17 years and the maximum is 56 years. This increases the chances of mentor-mentee mismatch regarding age. According to current SANC

registers only 39% of active nurses are under the age of 30. This may indicate that only a small number of young nurses is entering the profession.

About 46.6 percent (n = 26) of mentors had been involved in the mentoring programme as both mentors and mentees, this ensured that these respondents had two different experiences of mentorship from which to draw their responses. Al- Hamdan, Fowlers, Bawadi, Norrie, Summer and Debbie (2014) highlight that previous experience as a mentee is considered beneficial to the mentoring relationship.

Specific demographic factors that impact significantly on peer mentoring include age and gender. Studies (Pitt, Powis, Levett-Jones & Hunter, 2012 and Ross, 2014) have found that older students perform better academically than do younger students. A possible explanation is that an older student is often more motivated and committed to succeed due to previous experiences or failures. Klopper and Uys (2013) also report that gender is a strong indicator for attrition and males students tend to leave the nursing programmes twice more often than females. Males may therefore benefit from peer mentoring.

5.3.2 ROLES OF THE MENTOR

The study revealed that the mentors perceived that the mentors' roles are mainly to guide, advise, support, teach and be a friend to the mentees because these roles were selected by more than 50 percent of the mentors. The other roles that were selected by less than 50 percent of mentors include being a model, a colleague, a supervisor, a counsellor, a facilitator, an evaluator, a coach and a trainer.

These findings are in line with the findings of Mhlaba (2011) that emphasise that the role of the mentor is to serve as a facilitator, to guide the mentee in the application of theory to practice in the clinical settings and to help the mentee to feel connected. In support of this, Jokelainen et al., (2011) also mention that the mentors' roles should facilitate students' learning in clinical placements and help to strengthen students' professionalism. According to these researchers, as mentors and mentees work together in co-operation they soon start to interact as colleagues and friends. They further state that mentors have the role of providing mentees with encouragement and support and they act as role models for mentees, showing them different aspects and functions of the nurses' work. Mentors also enhance the attainment of professional competence and the articulation of theory with nursing practice in

mentees by providing direct teaching, guidance, advising and counselling (Mntambo, 2009 & Mhlaba, 2011). Mentors also play an important role in promoting learning through support, role modelling, socialising students in the profession and acting as assessors (Mogale, 2011). These roles are achieved by presenting peer mentoring as additional training for students to improve hands-on clinical nursing. This encompasses teaching and advising students on how to communicate and interact with patients (Jokelainen et al., 2011).

The findings of this study reveal that the majority of respondents in the mentee cohort 78.7 percent (n = 74) to 50 percent (n = 47), selected the most important roles of the mentor as: being an advisor, a supporter, a teacher, guide and model as the important roles of the mentor. Other roles that were selected by less than 50 percent of the mentee respondents were supervisor, facilitator, trainer, friend, colleague, coach, evaluator and counsellor. Research findings by (Nablsi, Arwa, Lina and FaAtheih, 2012 & Botma et al., 2013) indicate that students often experience anticipatory fear associated with their first practical placement and students view their mentor as someone who will support, guide, assess and supervise them. Mhlaba (2011) argues that during the mentoring process a mentor assumes the roles of teacher, counsellor, assessor and intervener to help the mentee's personal and professional growth and development. Researchers (Bulut, Hisar and Demir, 2010; Zannini, Cattaneo and Brugnolli, 2011; & Kaphagawani and Useh, 2013) posit that mentors support students in their socialisation in clinical placement, ease the clinical learning process and facilitate the development of circles of supportive friends and colleagues. The current study findings also tally with the findings of Mntambo (2011) which highlights that the mentor has to be prepared to be a role model who encourages and motivates students and sets standards for practice. As a role model, the mentor should be exemplary in his/her appearance and be skilled in scientific technique. The mentors should display the characteristics and the type of activities required by mentees. Metcalfe (2010) also highlights the fact that mentees see mentors as experienced, able to share their knowledge and able to foster leadership skills in others.

The role of teaching, guiding, advising and supporting were chosen as important roles by both mentors and mentees. The difference in the percentages of roles chosen by each group gives an indication of what the mentees expect from mentors and how the mentors perceive and accept their roles to be in the mentorship relationship.

Both groups were further asked to select five roles that they viewed as very important and to rank them in order of importance. In order of merit, mentors selected guide, advisor, teacher, model and supporter. The merit list of the mentees consisted of teacher, supporter, advisor, guide and model/friend respectively. This is contrary to the findings of a study that was done by Gidman, McIntosh, Melling & Smith (2011) where the roles of the mentor that were considered as very important were assisting and guiding while advising and counselling role were considered least importance, the reason being that in the UK the mentors follow specific standards that were set by the Nursing and Midwifery Council (NMC) which emphasise the preparation, support and assessment of students to ensure that they are competent upon registration. Mentoring is considered a valuable resource for students' clinical learning in the UK as opposed to South Africa where the clinical settings are poorly resourced. Students also receive less accompaniment, the mentors get no preparation and training for their role and the SANC, as the regulating body, has no guidelines for student mentorship. Although students consider all roles of the mentor as significant, the roles that have a direct impact on clinical learning were considered the most significant (Gidman et al., 2011). If the mentors may perform their roles with diligence, a faster and smooth transition from student nurses to competent professional nurses can be ensured (Mogale, 2011).

Cross-tabulations were done to check for association between age of respondents and the roles of the mentor and no statistical significance was found since the Chi square was > 0.005.

5.3.3   THE QUALITIES OF THE MENTOR

Some respondents in both cohorts agreed that the mentors appear to command respect for what they talk about. In the open-ended questions only a few respondents reported that the mentors had non-judgmental but caring attitudes and that they treated them with respect and dignity. In his study, Mogale (2011) found that some mentees reported that the mentoring relationship with their mentors was ruined because of personality incompatibility, power-mongering attitude of mentors and by the fact that the mentors treated them without any degree of dignity. Similarly, Al Hamdan et al., (2014), emphasise that mutual respect between mentor and mentee and a non-judgemental attitude is important for success of the mentoring programme.

The findings of this study revealed that an attained percentage of 60.7 percent of the mentors and 81.9 percent of the mentees agreed that mentors are easy to approach. Some mentees commented in the open-ended questions that the mentors formed a link and a buffer between them as new comers and the clinical staff on their first days in clinical settings. Mentors should be supportive and should create an open and comfortable learning environment for mentees. Previous studies, Mogale (2010); Gisi (2010) & Mhlaba (2011), have emphasised that mentors should be approachable, available, organised and friendly. The results are also consistent with the findings by Giordana and Wedin (2010) where the mentees did not feel intimidated and vulnerable at the hands of mentors and therefore considered the care and warmth that mentors provided them with as a security blanket. In support of this, Hodgson and Scanlan (2013) state that mentors are approachable, knowledgeable, honest, friendly, patient, experienced, enthusiastic, and willing to spend time with the mentees

The respondents of this study agreed that mentors are competent at their job. The qualities that attributed to this are underpinned in Mhlaba (2011) as good communication skills, a sound knowledge of current clinical practices, the ability to correct students, the ability to teach, being experts in their own field of practice, openness, patience and good attitude towards others. Joubert and de Villiers (2015) mention that mentors should also be selected based on their competencies and skills.

The results indicated that mentors offer support and guidance to the students, so that they are able to make sense of their practice. These findings are in line with Enns and Sawatzky (2009) who highlight that mentors are responsible for rendering support and guidance to the students. This can be achieved through providing a caring environment where students will be able to practice clinical skills.

Respondents agreed that mentors should question in a non-threatening but purposeful manner. Mentors should use questioning as a tool to challenge mentees and to stimulate critical thinking. To be effective, questions should be meaningful so that they can facilitate understanding (Yob and Crawford, 2012). This is echoed by Dennison (2010) where the peer mentors were encouraged to address clinical questions encountered by mentees and help them to seek resources such as textbooks and hospital policies to answer questions.

This study revealed that a significant percentage of respondents, 92.9 percent (n = 52) of mentors and 94.7 percent (n= 89) mentees agreed that mentors are empowering, enabling,

caring, open and facilitative. Mhlaba (2011) posits that the mentors' responsibilities include welcoming and orientating mentees to the clinical settings so that they become familiar with the physical layout of the nursing unit and the routine of the ward. This promotes a sense of belonging, relieves anxiety and eases the students' transition in the clinical setting. In line with these findings, Teatheredge (2010) also mentions that mentors should be able to calm the mentees' anxiety in a new placement thus helping them to settle, focus, learn and understand how the unit works. Consistent findings are found in Yob and Crawford's (2012) study which revealed that mentors encourage mentees to take control of their own learning and facilitates the development of independence and autonomy. In this way, the development of transferrable skills such as a communication skills, problem-solving abilities, leadership and self- management skills is enhanced. Teatheredge (2010) mentions that by empowering students, mentors enable them to find their own answers and solve problems.

The findings of this study also demonstrate that (87.5 percent; n = 49) mentors and (89.4 percent; n = 84) mentees agreed that mentors provide critically constructive and positive feedback. This is supported by Green and Hawley (2009) as they stress that mentors must challenge the mentees to grow by providing timely constructive criticism of the mentees performance and mistakes and should have regular contact with mentees to engage in open negotiation of responsibilities. McKimm (2009) concurs with these findings and suggests that a discussion of the student's performance helps to increase the potential for learning as well as the professional development of the student. Feedback also encourages the awareness of strengths and weaknesses by clarifying the areas for improvement and actions to be taken to improve performance. Mckimm (2009) adds that feedback is a vital part of education and training and if it is done in a constructive manner, it can help to develop learners and motivate them to acquire clinical skills and knowledge in the clinical settings. In their research study Ambrosetti and Dekker (2010) mention that feedback should be provided without judgement or criteria because it is a form of academic support provided to students. Provision of feedback also entails creating a comfortable learning environment, and providing an explicit representation of the job or skill. Mentors provide feedback by way of offering encouragement, using specific strategies such as role modelling, observing the mentee in action as they work alongside them (Ambrosetti and Dekker, 2010). Mhlaba (2011) highlights that mentees value feedback that they receive from mentors because it helps them identify their shortcomings and to understand where they went wrong. Teatheredge (2010) indicates that mentees rely on mentors to identify their weaknesses at the earliest stage

possible in clinical settings so that they can address the issues promptly. Henning, Weidner, and Marty (2008) indicates that feedback promotes interdependence and socializes students to seek constructive criticism and collegial interactions in future professional practice.

Correlations between the respondents' level of training and the qualities of the mentors were performed using the Mann Whitney test and the findings revealed that there were higher rankings from the first year respondents who agreed and strongly agreed that the mentors possess the listed qualities compared to respondents who are in 2nd, 3rd and 4th year level of training. This could be attributed to the fact that the as new comers, the first year respondents had positive attitude towards the programme and their responses were unbiased.

Cross-tabulations were performed on the responses of mentors and mentees on the qualities of a good mentor. It was found that there was a general agreement that the mentors were not intimidating and that, they were easy to approach and they provided subtle guidance whilst ensuring that mentees made their own decisions.

5.3.4 THE ROLE OF THE MENTEE

The current study indicates that nursing students agree that mentees should act professionally in relation to time management, dress, attitude and confidentiality. Li et al., (2010) stress the importance of respect and they state that in the mentoring relationship both mentors and mentees are required to respect each other's individual differences and to maintain confidentiality of their partners and patients. Al-Hamdan et al., (2014) also highlights that absolute confidentiality is a characteristic of a successful mentorship relationship. In the open-ended questions the mentors stated that the mentees were very respectful towards them and were always punctual at work. They reported that the majority of mentees were knowledgeable and were helping with basic patient care needs.

The study findings revealed that mentees should take responsibility for their own learning, communicate their learning needs, actively participate in and seek out learning opportunities and must be honest about their levels of competence. These roles entail that mentees need to absorb the mentor's knowledge, demonstrate the ambition and desire to know and then practice what they have learned. Mentees must be eager to learn and must be inquisitive so that they will acquire knowledge and become skilful. It is important that the students do not become too reliant upon the mentor but must take responsibility for their own learning early

in their training (Gopee, 2011). This is consistent with the findings of McKimm (2009) who states that enacting the role of the mentee encourages ongoing learning and development and identifies learning opportunities in the working situation. This researcher further mentions that mentees can achieve these roles by taking the initiative to ask for help and advice and to tackle more challenging tasks and assignments in order to learn. They should not hesitate to ask for specific guidance and advice. In support of this, Teatheredge (2010) mentions that by being self-directed and taking responsibility for their learning needs in the clinical practice, mentees become independent and autonomous in their own learning. Similarly, Hodgson and Scanlan (2013) mention that a mentee must be willing to learn, be career-committed, competent, and have strong self-identity and initiative. The mentee's role is one of an active participant (Paris, 2010). Mhlaba (2011) agrees that the cornerstone of mentoring is self-directed and student- centered learning. The mentees must be commitment to participate in the rendering of the nursing care in the nursing units, ask questions when they are not sure, take an initiative and to be available for any activities that are done in clinical setting. It also emerged in the open - ended questions that some mentees were eager to learn, inquisitive and were helping with basic patient care needs.

The respondents in this study agreed that mentees should practice good communication and a willingness to work with the team. Jokelainen et.al., (2011) mention that students should be treated as equal partners and colleagues in clinical settings. To promote team work, students should be encouraged to interact as professional partners in a co-operative relationship with other nursing unit staff members and mentoring should be presented as co-work between mentors and students in patient care situations. Working together as nursing professionals means students should work with mentors and perform different kinds of nursing activities in every shift. This facilitates the development of mutual, trusted communication and interaction as well as collegiality between mentors and mentees. These researchers stress that mentors must demonstrate a positive attitude towards students as human beings. This includes respecting and honouring the students both as persons and as learners. Students should be taken care of, shown empathy, interest and understanding (Jokelainen et al., 2011). Mhlaba (2011) emphasizes that as nursing students are in clinical settings, they need to be supported by mentors until such time that they are well grounded. They should be actively involved in clinical practice and should engage in personal relationships with experienced individuals in order to learn about the profession and to promote professional socialisation. McCall and Hughes (2010) indicate that clinical involvement is a key factor for future practice as it

provides hands-on experiences and enhances communication and technical skills. Students who feel that they are part of the team and feel appreciated by nursing unit staff, become involved in their own learning through interaction with staff members (Smedley and Morey, 2010). This enhances the transition of knowledge development into practice (Lisko and O'Dell, 2010).

It emerged in the study that students should evaluate the peer mentoring programme and give feedback. Teatheredge (2010) states that mentees should take the initiative to ask for feedback because it is critical for their personal and professional growth and development. Honest feedback allows for an opportunity to improve and to move towards fulfilling potentials (Teatheredge, 2010). The research study by Al-Hamdan et al., (2014), indicated that mentors requested more feedback after the placement, including the mentee's thoughts about their mentor's performance. An important aspect of the mentorship programme is to obtain students' views on the evaluation of the effectiveness of the programme and to utilize this feedback for improvements and innovations (McIntosh and Gidman, 2010). Botma et al., (2013) & Robinson and Niemer (2010) highlight that incomplete programme evaluations and mentor feedback can impact negatively on the success of a mentoring programme.

5.3.5   BENEFITS OF PEER MENTORING

Mentors' benefits

The findings of this study add to previously identified benefits of peer mentoring in the literature including improvements to self-confidence, personal and professional growth, critical thinking, leadership skills, and interpersonal and communication skills, as well as reduced anxiety, developing an increase in confidence, maturity, and responsibility (Stone et al., 2013; Jokelainen, 2013; Al-Hamdan et al.,2014).

This study revealed that the overwhelming majority (94.6 percent; n = 53) of mentors strongly agreed/agreed that peer mentoring enabled the application of principles of teaching and learning. Teaching is one of the four functions of the registered nurse in South Africa. Third year students do four peer teaching procedures as part of their Ethos and Professional Practice module to gain teaching practice. It came out strongly in the open-ended questions that mentors were thankful for the opportunity they had been given to do peer teaching and mentoring. They expressed the view that more opportunities should be created for senior

students to teach their peers. It was claimed that enacting the role of peer mentor enabled the development of teaching and leadership skills. This is supported by Henning et al., (2008) who indicates that nursing students involved in peer teaching and learning get an opportunity to improve their psychomotor skills and improve their overall clinical knowledge. In addition, they also improve their critical thinking skills and depend less on their clinical instructors. Contradictory findings, however, were discovered by Al-Hamdan et al., (2014) where most students reported that they felt uncomfortable in teaching and assessing other students and only a few reported to have gained teaching skills and to have mastered the principles of teaching and learning.

The mentors reported that they also learned to assess and evaluate junior nurses and to give reports on their progress. Jokelainen et al., (2011) indicated that student mentoring includes facilitation of achievement of professional competence and professional growth of the students. Reflective learning and critical thinking are crucial for students to learn to be able to develop new thinking and practices in clinical nursing when working as professional nurses in the future. In support of this, Rosenau et al., (2015) indicate that as a result of engaging in peer mentoring, students discovered that they have a potential for teaching and that they want to teach in the future. The respondents in their study reported to have gained large amounts of knowledge which prepared them to work towards being the best they can be in their nursing careers. The mentoring experience enables development of a stronger foundation on which to build a possible teaching career in a positive manner. Students also develop leadership skills and insight into how to integrate teaching into their professional career development. They gain important skills that they can incorporate into all aspects of the future nursing careers including public speaking, leadership, collegial teaching, listening skills, communication skills, patience, collaboration, the ability to seek feedback, and an increased consciousness of how to approach and teach patients (Rosenau et al., 2015). The development of teaching and leadership skills as a result of engaging in peer mentoring is confirmed by researchers such as Giordana and Wedin (2010); Christianson and Bell (2010); Dennison (2010); Yob and Crawford (2012) & Jokelainen (2013).

It is encouraging to note that all mentor respondents (100 percent; n= 56) and 94.6 percent (n= 89) mentees strongly agreed that teaching is an important role for nurses. The mentees have embarked upon the journey of nurse training with a vision of becoming qualified nurses. Barker (2009) posits that being a mentor involves teaching, educating, supporting and helping students to become confident and competent in their nursing practice. This researcher

explains that mentors encourage their mentees to become more independent in terms of their learning. It is through a reciprocal effective mentoring relationship that the mentees can make the transition from student nurse to registered practitioner. This relationship indicates effective communication and a willingness to learn from each other, which can enhance the mentoring process. The quality of the mentoring relationships can affect students' achievement and progress (Barker, 2009). Hodgson and Scanlan (2013) indicate that mentoring empowers both the peer mentors and mentees because when students embrace the peer mentoring relationship, the mentees become empowered and develop a high self-esteem. They become motivated to mentor and teach other new nurses and the cycle of teaching continues. In line with these findings, Roberts (2010) mentions that peer mentoring facilitates the development of a vicarious learning process whereby mentees learn from the experiences of their peer mentors. This researcher further states that through the process of listening and reflecting on the experience of others, learning occurs. In support of this, Henning et al., (2008) highlights that the underlying premise of peer teaching is that the student who teaches a peer gains a deeper understanding in the subject matter or clinical skill, because the process of teaching inherently requires a deepening of knowledge. Peer teaching is a type of cooperative learning in which both the mentor as a teacher and the mentee as a learner, mutually benefit from their interactions. The peer mentors also benefit from a review of material that they teach, improved communication skills, and increased self-confidence. On the other hand, Botma et al., (2013) mention that reciprocal learning occurs as a result of peer mentorship because the mentors learn from the fresh and up-to-date knowledge that the mentees possess. Rosenau et al., (2015) highlight that peer mentoring fosters an enhanced understanding of professional responsibility to engage in collegial teaching practice and mentorship.

From the findings of this research, it appears that the peer mentoring experience prepares peer mentors for their role as registered nurses. Teaching is one of the competencies required of registered nurses as stipulated by the SANC. McKenna and French (2011) mention that the preparation of future registered nurses who wish to embrace a professional culture of teaching others is promoted by the provision of opportunities to teach. Peer teaching prepares the nursing students for their future roles as registered nurses and enhances their psychomotor skills and their attitudes. Peer mentoring also provides mentors with skills, knowledge and experience on which to begin to build the teaching aspect of the nursing practice. As mentors

pass their experiences on to mentees, they automatically get prepared for what they are going to encounter, once they are actually qualified nurses (McKenna and French, 2011).

This study revealed that peer mentoring presented the peer mentors with a number of benefits including enhanced sense of achievement and confidence in their knowledge and skill level, reflection on their own learning and on their own practice, gaining an opportunity to review knowledge and stay current with skills, feelings of gratitude for engaging in a rewarding experience and acquisition of skills and positive work ethics. Similar findings were discovered by Dennison (2010); Kurtz, Lemley and Alverson (2010) and Joubert and de Villiers (2015). Peer mentors gain intrinsic rewards by feeling that they are contributing to the mentees' education and helping them to succeed in such a challenging profession (Gisi, 2011).

 McKenna and French (2011) added "reinforcement and revision of learning, provision of feedback, promotion of responsibility, increased self-confidence, role modelling, developing teaching, communication, appraisal as well as organisational and team working skills" to the list of benefits to peer mentoring. Similarly Henning et al., (2008) point out that peer mentors experience a sense of personal growth and development, joy and satisfaction in helping others. Peer mentees also develop organisational skills, become more self-reflective of their clinical practice, and sometimes realize they want to be mentors in the future. These researchers also add that peer mentors learn to prioritise patient care and the ability to multitask. Christiansen and Bell (2010) added that providing psychosocial support to mentees makes the mentors feel important, respected and valued.

This study also revealed that peer mentors experienced the feeling that engaging in peer mentoring was time and effort well spent. This contrasts the findings of El-Sayed, Metwally and Abdeen (2013) where students felt that their peer-teaching experience was not worth the time and effort spent on it and only a few of them expressed their belief that the teaching is an important role for nurses. These researchers attributed this to lack of preparation of mentors for their teaching role especially because it was their first time to act as teachers. They also believed that the mentors might have had the feeling of having a responsibility that is beyond their capabilities.

The findings of this study indicated that the peer mentors felt that mentoring provided an early exposure to being a role model. Gopee (2008) states that role modeling is learning by imitating the behaviours of an exemplar who is in expert senior nurse. Mentoring is an

intense form of role modeling (Gopee, 2008). These results corroborate the findings of Rosenau et al., (2015) where other students choose to become peer mentors to first-year nursing students not only to help decrease anxiety and to create a supportive learning environment, but to give back by being positive role models as well. Similarly, McKenna and French (2011) highlight that mentoring provides an early exposure to being a role model because students who enact the role of mentors as peer teachers are exposed to more opportunities for modelling behaviours which reinforces their previous learning.

Mentee benefits

Study results indicated that the mentees benefited from the peer mentoring programme because they experienced less anxiety, adapted to the clinical environment easily and were less intimidated but more comfortable in clinical settings. In the open–ended questions the mentees reported that the mentors formed a link and a buffer between them as new comers and the clinical staff on their first days in the clinical area This is consistent with the findings of Teatheredge (2010) who stated that an effective mentor is able to calm the mentees' anxiety, especially in a new placement. This helps them to settle, focus, learn and understand how the unit works.

Respondents felt that it was easier to approach a peer mentor for assistance than the instructor and that they experienced less anxiety when performing nursing skills in the presence of their peers rather than in the presence of the instructor. Similar results were found by McKenna and French (2011) when they stated that mentees in their study reported that they felt comfortable learning skills with senior peers, and were able to learn from their experiences. The constant support that the mentees get from their mentor enables them to practice nursing skills and gain experience because they presume that the clinical area is a safe environment in which they are able to learn through experience, are able to examine their mistakes without ridicule, share their lack of knowledge, and experiment in decision-making and problem solving (Dennison, 2010). In line with this, Christiansen and Bell (2010) indicate that it is the informal and non-hierarchical relationship that encourages peer students to be more open to disclose areas of uncertainty as well as misconceptions among themselves and this also allows them to take steps easily to address such areas. The closeness in age and common ground in college-life experiences allows peer students to relate to the interpersonal challenges more successfully than with an educators and this enables them to identify

impending obstacles to their success and to propose potential alternatives (Bonin, 2013). Peer mentoring provides a more relaxed, less intimidating, more user-friendly learning experience than sessions conducted by registered nurses. For this reason, some first year students feel comfortable learning with more experienced peers. (Stone et al., 2013). Contradictory findings were discovered by El-Sayed et al., (2013) where few students who were taught by peer teaching felt less motivated to practice a skill in the presence of their peers rather than an instructor and to communicate and interact with other students. This is attributed to the fact that they did not have teaching experience as they were teaching for the first time and they also thought that their peers might believe that they did not have the knowledge and clinical practice skills compared with instructors. Ross (2014) indicates that a nursing student that portrays high levels of anxiety when being assessed by a registered nurse or nurse educator makes more errors and may subsequently not achieve success.

This study revealed that students developed self-confidence and independence and that their abilities to perform clinical skills were increased. This is in agreement with the study findings of Christiansen and Bell (2010) who mention that peer mentoring encourages the students to take greater control of their own learning and this facilitates the development of more autonomous learners and practitioners. Bourgeois, Drayton & Brown (2011) also reported that students did not feel threatened in clinical settings because they were working with peer mentors in pairs and as colleagues. Stone et al., (2013) mentions that cooperative learning allows the new students to gain confidence and experience a decrease in anxiety when dealing with certain situations in clinical placements. Junior students also learn to problem-solve issues with their patients more independently and take care of higher acuity patients, leading to an increase in their self-confidence (Stone et al., 2013). Nursing students, as adult learners need to be able to study independently and take responsibility for their own learning. If they are not able to adapt to this independence, their academic and clinical performance can be negatively impacted (Ross, 2014).

It emerged from this study that the students felt that communication with their peer mentors is freer than with the instructor. Peer learning may result in information being more readily accepted by students because individuals often turn to those who have similar experiences for advice and guidance (Dennison, 2010 & Joubert and de Villiers, 2015). This could decrease anxiety associated with learning due to familiarity of the peer with the student's issues (Stone et al., 2013). Kaphagawani and Useh (2013) posit that besides learning the art and science of

nursing, students also develop interpersonal relationship with others because mentoring promotes social interaction among students as peers.

The research findings clearly indicated that mentoring facilitated the mentees' ability to relate to and apply theory. The regulations and minimum requirements of the pre-registration course in nursing include all the requirements for enhancing the professional and personal growth of students in becoming independent, safe and professional nursing practitioners. The SANC R425 emphasises on meaningful integration of theory into practice with regard to every nursing subject. Coetzee (2013) also stresses the need for nurse educators to create meaningful learning opportunities and experiences which students can utilize to correlate theory and practice. Clinical practice allows students an opportunity to practice the skills that they were taught at college in a real-life situation. They also get an opportunity to witness nursing procedure that they may have not been taught at college. They attend to patients with different kinds of illnesses, even the very rare and complicated conditions and are able to experience evidence-based practice. This is in line with Stone at al. (2013), who stress that mentors as senior nurses, are in a good position to assist students to apply theory to practice because mentors have a better understanding of patients' conditions and are more familiar with current clinical practices and would thus be able to assist students in performing the clinical tasks with greater ease and with better skills. When students actively participate in the learning processes as provided by peer mentoring and take an initiative, they learn more than those who are not mentored. In support of this, Mntambo (2011) indicates that learning that occurs in clinical setting is more meaningful than that which is acquired in the classroom setting because theory is implicit in clinical practice. The clinical learning process facilitates the cognitive, psychomotor and affective development of student nurses and this is the primary aim of nurse education as stipulated by the SANC (2005). According to Mhlaba (2011), peer mentoring is a process where clinical and college staff work together in linking theory to practice towards ensuring that the students acquire the best possible clinical skills, knowledge and professional development which will give them the confidence to provide quality care in a clinical setting. Mntambo (2011) supports this assertion and adds that students should not be left alone to correlate theory and practice. The nurse educators are compelled to take part in clinical teaching and learning and to ensure that the clinical support that they give to students is grounded on the latest and updated knowledge. Nurse educators are also expected by the SANC (2005) to do clinical accompaniment of students whereby

they spend at least 30 minutes per fortnight per student to ensure proper integration of theory and practice.

In addition to clinical learning, students also learn survival skills. Senior peers can provide junior students with psychosocial support and reassurance in a context that allows for asking questions and expressing uncertainty (Christianson and Bell, 2010). Henning et al., (2008) highlights that mentees benefit from peer mentoring because they experience less anxiety, increased self-confidence and increased comfort in the clinical environment.

Cross-tabulations between level of training and benefits of peer mentoring indicate that the majority of first year mentees agreed with the stated benefits of peer mentoring compared to second year mentees. This indicates that, as junior nurses, the evaluation was done immediately after they had engaged in the programme and they still remembered their experiences. The p values that were obtained were of no statistical significance as they were > 0.005.

5.3.6 BARRIERS TO PEER MENTORING

Despite notable gains that students obtained from peer mentoring, this study revealed that they also experienced a plethora of challenges that impacted negatively on peer mentoring in clinical settings. Due to the daily challenges and demands of modern nursing, many mentors find it difficult to fulfil their role effectively.

The findings indicate that mentors experienced conflict of interest due to the demands of the nursing programme and peer mentoring. Similar findings were discovered by Stone et al., (2013) where some mentors in their study reported anxiety and apprehension when taking part in peer learning. They felt that they were responsible for other students' education, were underprepared and were concerned that their own grades would be negatively affected by group work and dynamics. On the other hand, Christiansen and Bell (2010) found that mentors felt that sharing the responsibility for the development of another student brought affective gains especially if it was successful. They developed confidence in their own knowledge and skills. The encouragement and support they provided to mentees enhanced their own self-esteem and self-worth as they recognise that the junior student's success is an outcome of their efforts (Christiansen and Bell, 2010).

Noteable barriers of this study included the fact that peer mentors identified that the time available to attend to both the mentees and patients was insufficient and that performing mentoring duties in a very busy clinical setting with very sick patients can prevent a program from succeeding. The nursing units are often so busy and crowded that there is no time to meet the students' learning needs. This is supported by Botma et al., (2013) who also indicate that the mentor–mentee relationships are challenged by increased clinical workload which makes it difficult for the mentor to be available for the mentee at all times. Mentoring is impossible when the nursing units are short-staffed as this causes pressure on the mentors who have to attend to both patients and mentees. Mhlaba (2011) argues that as a result of staff- shortage, the students are treated as workforce and carry a workload and this prevents them from being exposed to a wider range of experiences necessary to meet their learning outcomes. Chuan and Barnett (2012) add that the learning opportunities are compromised if there is increased workload. Wade and Hayes (2010) indicate that a mentor needs a lower patient assignment because in addition to the provision of nursing care, the mentor has to teach and model clinical reasoning. Similarly, Lascelles (2010) identified that the mentees become emotionally drained if they are not with their mentors during their initial clinical exposure because during this time, they expect their mentors to be available and accessible. They get comforted by knowing that they have someone to go to for support and guidance.

Findings of this study indicated that the mentees felt that their clinical learning and support was affected because the mentors had limited time to spend with them due to the fact that they had other clinical commitments. These findings are in line with the views of several researchers (Gopee, 2011; Ven Veeramah, 2012 and Winterman et al., 2014) who stated that time constraints and competing commitments hinder the mentoring of the students in clinical settings. These researchers also mention that mentors are overwhelmed by the mentoring responsibilities because they do not have protected time away from clinical duties to fulfil their mentoring role effectively. They also stress that sufficient time is required for the mentor and mentee to work together with the same patient. In support of this, Ross (2014) posits that similar off-duty times should be allocated for the nursing students who are participating in the mentoring programme to allow a positive relationship to build.

It also emerged in this study that students felt that they lacked the understanding of the programme requirements and that they were not adequately prepared to carry out the role of peer mentoring in clinical settings. In support of these findings, (Andrew, Brewer, Buchan, Denne, Hammond, Hardy, Jacobs, McKenzie and West, 2010 & Mhlaba, 2011) found similar

results concluding that the mentors felt that they were unsure of their role because they had no formal induction and training. Al-Hamdan et al., (2014) reported that the mentors' needs are not always recognised by the nursing school and the health care organisation and this makes them sometimes feel unrewarded and ill-prepared. They added that preparation of students for mentoring serves as an empowerment tool and support system. Stone et al., (2013) highlight that nurses have a responsibility to share knowledge with others. However, many are reluctant to undertake teaching, feeling unprepared for the responsibility. The orientation of mentors and mentees regarding their roles, responsibilities and the outcomes of the programme was also mentioned by researchers such as Dennison (2010); Stone et al., (2013) & Joubert and de Villiers (2015). In line with this, Wilson, Sanner & McAllister (2010) emphasise that mentors should be trained to ensure that they have the skills and knowledge necessary to support students who might be daunted by some of the obstacles they face during their transition from school to tertiary educational life. They further state that the deliberate and extensive preparation and orientation to become mentors contributed to the uniqueness of the programme.

The research findings further revealed that students found that working with limited equipment and other resources was a stumbling block to peer mentoring. Similar findings are reflected in Mogale (2010) and Mhlaba (2011) as they too indicate that shortage of material resources such as equipment and supplies to execute nursing care, prevented students from undertaking nursing procedures thus missing teaching and learning opportunities. The availability of all necessary equipment in the clinical setting does not only promote quality nursing care but effective mentoring as well because equipment is also required for demonstration of practical skills (Mogale, 2011). The SANC philosophy indicates that, for the learning process to take place, there should be a clinical nursing laboratory for orientation of the students and a real-life situation in the nursing units, with learning materials available to facilitate learning (SANC, 1992).

Other impediments for effective peer mentoring that were revealed from this study were conflicts of interest due to the demands of the nursing programme and from the peer mentors as well as lack of recognition of the demand of the role of peer mentoring by nurse educators. Veeramah (2012) discovered that lack of opportunity to study is a barrier to mentoring. The researcher indicated that the mentors can perform their role more effectively and with improved confidence if the nurse educators can provide them with regular support. In

support of this, Gopee (2011) highlights that it is imperative that nurse educators offer the peer mentors more assistance and guidance.

The findings of this study indicated that 69.2 percent; (n= 47) agreed that there was lack of support for the peer mentoring programme from clinical staff members. Nettleton and Bray (2008) in their study of barriers of mentoring in the UK found that only a few respondents identified managerial support as a barrier and a large number found it to be helpful. This is made possible by the fact that the NMC guidelines and standards for mentoring are followed by all stakeholders and consequently, the unit managers and lecturers work in collaboration to ensure that the students become safe and competent practitioners upon graduation in order to protect the public from malpractice.

The findings in this research were consistent with Botma et al., (2012) in concluding that mentors are challenged by mentoring too many students at the same time. The number of mentors in the programme become reduced by high attrition rate and there are always fewer senior students than juniors. The fact that there are few mentors makes the ratio of mentor to mentee high. Some mentors in Joubert and de Villiers (2015) were overwhelmed by having to mentor more than one student at the same time in a busy nursing unit and felt that the number of mentees that they were allocated, made it difficult for mentorship to be effective. On the contrary, in Gisi's (2011) study, the mentorship programme had mentoring groups of 1:5 (1 mentor against 5 mentees) and they performed better than the control group.

From the findings of this study it became apparent that mentors were also challenged by having to assist learners whose skill levels were below the expected standard and who display a lack of initiative and motivation. In the open–ended questions, some mentors in this study mentioned that the mentees were very respectful towards them and were always punctual at work. In their study of the learning experiences of mentees and mentors in a nursing school's mentoring programme, Joubert and de Villiers (2015) found that the peer mentors felt that there were instances where mentees did not meet the mentors' expectations, instead they seemed to be inexperienced. Some of them did not show enough interest and came to the clinical areas unprepared. Some mentors appreciated that the mentees had a sense of responsibility and were always willing to help to address basic needs of patients. Mhlaba (2011) pointed out that successful mentoring depends on the students' commitment to participate in the rendering of the nursing care in the nursing units, to ask questions when they are not sure and to be available for activities that are done.

It also emerged that most of students felt that the practice opportunities for the students were insufficient because of the short duration of the placement. This was dominant in the open-ended questions of this study where the mentees suggested that the period at which they are mentored be extended to at least the whole month of their initial exposure to the clinical settings. The length of the programme must carefully be chosen to meet the needs of the mentees. Similarly in Ellison and Hunt (2010) mentees expressed a desire for structured mentorship to extend beyond one semester. Consistent findings were obtained by Joubert and de Villiers (2015), where the mentors stated that the time that the mentees were exposed to the mentor was too short for the amount of information that needed to be disseminated and the mentees had the same experience and recommended that the duration of their placement be extended. These researchers recommended that enough time should be allocated for mentors and mentees to bond and for mentees to be briefed on important matters. Insufficient practice opportunities available for the students to meet their competencies because of shorter placement period was also mentioned by Veeramah (2012), where a semester-long mentorship programme was designed to equip the mentors with knowledge and skills that would enable facilitation of teaching and learning in practice. Students in Bourgeois et al., (2010) reflected that if they had been allocated to clinical settings for longer than two weeks, they could have developed a greater rapport with staff and became even more a part of the team. They requested that the length of their clinical allocation be increased so that they would have more time for clinical exposure (Bourgeois et al., 2010). Middleton & Duffy (2009) also emphasised that students need to be allowed to spend a specific period of time in clinical settings under the guidance of professional nurses and peer mentors so that they get time to practice.

It was evident from this study that students did not experience discomfort with cross-cultural and cross-gender mentoring. Similarly Al Hamdan et al., (2014) state that cross-gender mentoring relationships that are also cross-cultural may be challenging because they have dimensions of racial taboos, which exist as a result of the interaction of race and gender dynamics. Studies by Al Hamdan et al., (2014) stated that matching of age and gender is not regarded as important in nursing mentoring although it may assist some partnerships. These researchers have highlighted that large age differences between mentor and mentee may lead to paternalistic relationships. They also indicated that mature staff cope better with the additional stress of studies. With regard to gender, Al-Hamdan et al., (2014) suggested that same-gender matches may be more productive than mixed-gender matches. Gender is rarely

considered in nurse mentoring mainly because the workforce has historically been predominately female. In other professions, such as medicine, there is concern about the potential for power imbalances in mixed-gender mentoring partnerships because it may limit the benefits (Al Hamdan et al., 2014).

From the research findings, it is evident that the respondents perceived that the discrepancy between what is taught in class or in simulation and what is actually implemented in the clinical setting causes anxiety and confusion. Mentees expect mentors to be clinically competent and to display credibility by keeping up to date and expanding their knowledge (Robinson, Cornish, Driscoll, Knutton, Corben and Stevenson, 2012). Kaphagawani and Useh (2013) state that students become anxious and confused if they practice something different from what they learnt in the classroom which may negatively affect their performance in the clinical learning. Conflicting practices between the ideal nursing taught and that of clinical setting result in students being confused, stressed and anxious. This may indicate that students are not effectively learning to prepare themselves for work they do after qualifying. Learning takes place when students apply what they have learned in the classroom situation and practiced in a simulation laboratory to the reality of nursing (Kaphagawani and Useh, 2013). Some mentees in this study were dissatisfied that the mentors challenged and presented them with the unfamiliar duties and expected them to know everything even things that they had not heard of before.

The findings of this study show that mentors that appear to be uncertain about their knowledge and actions make students nervous and anxious. Mentoring involves the sharing of valuable tacit knowledge through effective engagement, and respectful communication (Hodgson and Scanlan, 2013). In line with this, Ferguson (2010) mentions that the new nurses appreciate senior students who share knowledge. Peer mentors must demonstrate confidence in whatever they say and do so that junior nurses will trust them. They must keep abreast with knowledge so that they are able to supervise juniors with authority of knowledge. Teatheredge (2010) found that the mentees regarded mentors who admit that they do not know, as good mentors because they encouraged the mentees to do research and then share the findings so that they will learn together. It emerged from this study that the mentors were grateful for the reciprocal learning that took place during mentorship because the mentee had an up-to-date knowledge which they shared with them.

This study revealed that the reluctance of mentors to fulfil their roles as well as mentors who are not dedicated and unfriendly, challenge the effectiveness of mentoring. Findings by (Robinson et al., 2012) indicate that mentors should be committed to the advancement of the nursing profession and should demonstrate willingness to educate other nurses. Effective mentors are those with good listening skills which involve a willingness to listen to the student and to explain practice. Mentors who give feedback whether it is difficult or easy to hear and to give it in a fair and honest way, empowers students and fosters professional growth. Robinson et al., (2012) also indicate that the mentor must have an interest in and an aptitude for teaching. Similarly Botma et al., (2013) & Al-Hamdan et al., (2014) revealed that some mentors are not as good as others. One of the reasons for this is that senior student nurses have no choice but to become mentors because this is their module requirement. The other reason is that since not everyone can be a nurse, so not everyone can be a mentor as well. Effectiveness of the mentoring also depends on the students' ability, skills, motivation and attitude.

From the statistical findings of this study, it appears that a large percentage (52.5 percent; n=30) of first year mentees disagreed that they were poorly prepared for the mentoring relationship. This is attributed to the fact that they were still immature and lacked insight into what to expect from the programme compared to the senior third year students who are experienced, mature and insightful and know how things should be done. Another reason could be that first year students feel so comfortable learning with more experienced peers (Stone et al., 2013) that they may disregard any individual challenges that emerge during this process.

5.3.7 EVALUATION OF PEER MENTORING PROGRAMME.

Overall, the mentorship programme was rated as good by the majority of respondents. This is attributed to the purpose of a peer mentoring programme, which was designed to nurture the junior student's development into becoming a competent clinician. The peer mentors are assigned to support, teach and help redirect inefficient mentee behaviour thus increasing their knowledge base and enhancing their academic and professional growth (Gisi, 2011). It is an interactive learning process which emphasizes active student participation and encouragement to take ownership and responsibility for their own learning (Stone et al., 2013). This can be achieved by allowing the students some independence by giving them

more guidance at the beginning of the placement, then standing back and letting them show initiative and self-motivation afterwards (Gopee, 2011). Researchers (Baker, 2010 & Roberts, 2010) posit that peer mentoring is a type of academic support programme which includes the provision of more contact time for students by a skilled fellow nursing student.

5.3.7.1 The support of mentors by the peer mentoring coordinator

The findings of this study revealed that the overwhelming majority of respondents rated the support received by peer mentors from programme coordinators as good and only a few rated it as poor. According to Botma et al., (2013), the programme coordinator as a person representing the nursing school, should be available, accessible and supportive. They should also see their role extending from the classroom and demonstration rooms into the nursing units and facilitate student clinical support (Mogale, 2011). One of the responsibilities of the programme coordinator is to prepare the mentors to fulfil their roles and responsibilities and to create opportunities where the mentor can establish a positive relationship with the mentee (Botma et al., 2013). The coordinators should also visit the students in clinical settings to supervise the mentors and check if they are doing their job as expected and to motivate and support them and give feedback on the quality of the mentoring process (Wade and Hayes, 2010). According to the *South African Strategic Plan for Nursing Education, Training and Practice (2012/13-2016/17),* nurse educators and professional nurses have a joint responsibility to support and enhance the students' clinical learning experiences. The responsibilities that are outlined for nurse educators entail the maintenance of clinical competence through spending, annually 10 percent teaching time on this in the clinical setting. Furthermore, they need to supervise and support mentors. Professional nurses are also required to work closely with nurse educators and mentors regarding the clinical teaching and supervision of students allocated to their nursing units. Gisi (2011) stresses that it is important that nurse educators acknowledge that peer mentoring does not cut down on their responsibility to directly supervise student nurses but is only additional support extended to them by their peers (Gisi, 2011). They should avail themselves in clinical practice areas and should provide support to students. The level of involvement between the programme coordinator and the mentors assists with the mentor's intellectual and personal growth, cultural understanding and involvement in student support programmes. The positive interaction leads to students who will willingly assist other students with academic challenges (Ross, 2014). The outcomes of clinical support and supervision can be associated with

academic (knowledge, skills, attitudes and values), professional and personal development of students (Pillay and Mtshali, 2008).

5.3.7.2   The support and involvement of unit managers

It is encouraging to note that the findings of this study indicated that the students rated that the support of involvement of unit managers in peer mentoring as good and only a few rated it as poor. In the open-ended questions, some students mentioned that the unit managers must be informed and updated about peer mentoring so that they will be supportive. Joubert and de Villiers (2013), state that it is the responsibility of the peer mentoring coordinator from the college to inform the unit managers about the peer mentorship programme so that the mentors and mentees are allocated together. The unit managers cannot always allocate the mentor and mentee to the same patient due to staff shortages and the number of patients (Botma et al., 2013). It is imperative that the unit managers in health care organisations recognise that mentoring is a career development tool and take the responsibility upon themselves to support the mentors and the mentees (Hodgson and Scanlan, 2013). These authors stress that the nursing profession needs to commit to and embrace the concept of mentoring to provide novice student nurses with supportive learning environments, in which they can grow and flourish.

5.3.7.3   A supportive clinical environment

From the findings of this research it was revealed that a supportive environment was created for peer mentoring and the clinical environment allowed for maximum clinical learning. The organisations that are responsible for training student nurses also have a responsibility to promote a positive learning environment. Teatheredge (2010) suggested that students' development is not just influenced by the organisation, but also by the environment in which their development occurs. The organisation where students undertake their practice placement should promote an atmosphere where learning is encouraged. Mntambo (2009) indicates that for the clinical environment to be supportive, it must be non-threatening, cool and neutral psychologically, emotionally and physically. Such an environment produces highly motivated students who do the best that they can to gain clinical competence. In support of this, Ross (2014) posits that a positive clinical environment is characterised by collaboration between the management staff of the clinical environment and the college staff. He also adds that the clinical environment should be conducive to ensure optimum work integrated learning opportunities for the nursing student. Work integrated learning takes place

under the guidance of mentors, nurse educators and professional nurses in clinical settings. Teatheredge (2010) further mentions that the dynamics and cultural background of the nursing unit team and the individuals within that team can affect the mentoring experience and relationship. Botma et al., (2013) add that it is crucial that mentors create a safe learning environment as well as positive and valuable learning experiences for the mentees in order to enable the development of professionals in the nursing profession. (Botma et al., 2013). The mentors are entrusted with a responsibility of orientating the new students during the first week of placement in a new nursing unit in order to adjust to the culture and climate of the unit and to meet the nursing unit personnel (Jokelainen et al., 2011). Ross (2014) mentions that the degree to which the novice student nurse can adapt to the new environment assists the student to persist with the studies and this promotes retention and prevents attrition in the profession.

5.3.7.4   The support of peer mentorship from clinical staff

The findings from this study also highlighted that peer mentors and mentors regarded the support that the peer mentorship programme received from the staff in the clinical setting to be supportive. Consistently research by Mogale (2011) indicated that lack of student support and guidance in the clinical learning environment by those entrusted with a responsibility of supervision creates uncertainties due to lack of opportunities for students to acquire nursing skills. Positive relationships between students and clinical staff promote learning. It is the responsibility of the clinical staff to support the peer mentorship programme by building a positive relationship with students, thus establishing a caring environment wherein criticism and values can be expressed without destroying the student's self-image (Mogale, 2011). In support of this, Lascelles (2010) emphasises that positive relationships promote learning as the students depend on trained staff for facilitation of learning. The inter-professional working relationships that students develop with other team members are influential in student learning because it allows students to gain a wider perspective of the multidisciplinary team (Lascelles, 2010).

Newton, Billett and Ockerby (2009) indicate that the nursing staff should be flexible in allowing students to experience different nursing procedures and to practice skills themselves. Allan, Smith and O'Driscoll (2011) are in agreement with Waldock (2010) as they highlight that the busy and demanding nature of the clinical environment results in the

staff members forgetting about the supernumerary status of students so much that the students are utilised as part of the workforce. They further emphasise that the students should not experience the clinical component of the teaching-learning programme as work but rather as an opportunity for developing their professional and personal skills whilst caring for patients. The tendency to use mentees and mentors for daily activities creates problems with regard to the outcome of the programme.

5.3.7.5   Feedback provided by mentors to mentees

Evidence in this study indicated that the feedback provided by peer mentors to mentees was regarded as good. Feedback is described by Kaphagawani and Useh (2013) as a collaborative process of providing insight to learners about their performance. Mentees expect mentors to be accessible and supportive and to give frequent constructive feedback. According to McKimm (2009) feedback on clinical performance of students is an essential facet of teaching and learning. The main aim of feedback is to give students a better perception of their performance in the clinical learning environment. Feedback can be constructive and reinforcing/positive. The purpose of constructive and reinforcing feedback is to assist and support students to determine their skills, expertise and strengths, as well as fields that still need professional development (McKimm, 2009). The findings of Lascelles (2010) identified that feedback occurs continuously when the mentors and mentees work together and mentees get direct supervision. This researcher also mentions that feedback gives mentees a baseline about their performance and it also sets the scene for their future placement. Feedback should be given immediately at the end of interaction with each patient or shift. Lascelles (2010) also stresses that feedback should be constructive and should be given in the form of supportive and encouraging words. Mentors can obtain feedback by way of questioning mentees to check their level of understanding following the experiences they had observed. It is imperative that students work directly with their mentors in order to get quality feedback and get it frequently. Feedback enables students to reflect upon their learning to a greater extent than when it is limited or infrequent (Lascelles, 2010). Mentors should also provide positive feedback by pointing out weaknesses and discuss further learning (Gopee, 2011). In support of this, Teatheredge (2010) argues that the mentees should take the initiative to ask for feedback because it is critical to their personal and professional growth and development. Honest feedback gives one an opportunity to improve and to move towards fulfilling one's

potential. According to Botma et al., (2013) mentors should submit a report on each mentee reflecting on what they had learned during the process. Progress of the mentee should be checked by a programme coordinator and feedback given to the mentor.

5.3.7.6   The feedback provided by peer mentees to mentors

A significant finding of the evaluation of the mentoring programme was that mentees should actively participate and seek out learning opportunities, act upon constructive feedback and should evaluate the peer mentoring programme and give feedback. Similarly Botma et al., (2013) concur that mentors also need feedback from the mentees with regard to how well they fulfilled their role as mentor, how they interacted with mentees and whether the mentees learned anything from them (Botma et al., 2013). Researchers, (Jokelainen et al., 2011 & Ross, 2014) posit that time should be allocated for the mentors and mentees to meet at regular time intervals to plan the learning that should take place, to give feedback on the progress of learning that took place and on areas for improvement. During these sessions the mentees should be offered the opportunity to ask questions and discuss difficulties they have experienced and under the guidance of the programme coordinator, develop plans to overcome these difficulties. The meeting stimulates reflection, a valuable learning skill to bridge the theory-practice gap and reduces anxiety experienced novice student nurses. Henning et al., (2008) posits that peer assessment and feedback should form part of a peer mentoring programme because it creates a platform where nursing students can provide one another with constructive criticism regarding their communication skills, clinical problem solving skills, and overall clinical performance.

5.3.7.7   The peer mentoring programme facilitated development of confidence in a new nurse.

The results of this study show that the peer mentoring programme facilitated development of confidence in a new nurse. This is supported by Stewart, Pope and Hansen (2010) who state that the novice student nurses who engaged in a peer mentorship programme adapt to the nursing profession seamlessly and confidently because peer mentors facilitate the accumulation of substantial learning experiences. The mentors assist the students to build confidence in authentic clinical situations by assisting them to achieve the clinical learning

outcomes (Ross, 2014). Nursing is a caring profession and mentors by virtue of being nurses should be compassionate to new student nurses in order to help them in their journey of transitioning from novice to competent clinician (Wroten & Waite, 2009). Gisi (2011) highlights that nursing can be an intensely emotional profession because the patients are sometimes very sick. This can lead to intense feelings if the patient decompensates or dies. Gisi (2011) further states that peer mentoring allows mentees to ventilate their emotions to the mentors because they empathise rather than sympathise with the experience. The support obtained from the mentorship relationship can provide a therapeutic, understanding outlet to junior nursing students as they begin to experience the feelings of grief, joy and pain that come from the daily interactions with patients. Peer mentors can be an excellent support resource for their mentees, thereby decreasing student attrition (Gisi, 2011).

Correlations were established between the ages of respondents and how they evaluated the peer mentorship programme and it was interesting to note that the > 35 years age group rated all the elements of this section as good signifying that they embraced peer mentorship and as matured persons, they were also tolerant of the challenges they encountered. Al Hamdan et al., (2014) mention that mature staff cope better with the additional stress of studies.

5.4   RECOMMENDATIONS

The researcher makes various recommendations based on the scientific evidence obtained from the study after an evaluation of the perceptions of student nurses of peer mentoring in clinical settings. Recommendations were made to the nursing management and the principals of the nursing colleges, and mainly focused on the enhancement and improvement of peer mentorship in clinical settings. If these recommendations are put into practice they should have a positive effect on the reduction of attrition, improvement of retention of student nurses in training, production of competent and safe nurse practitioners as well as improvement in the quality of patient care in South Africa.

5.4.1   Recommendations for nurses' education

This study suggests that the peer mentoring programme should be embedded in the nursing college retention strategy. The peer mentoring programme should be formalised and well-structured and the peer mentors and mentees should be properly trained for their roles to prevent uncertainties. The training time can be timetabled when the groups are on theory

block. The peer mentorship programme should have a programme coordinator who will be responsible for the preparation and training of mentors and mentees for their roles and responsibilities and should constitute a liaison between the nursing college and the nursing unit mangers. A pre-orientation package with information about the mentorship programme and mentor profiles should be organised to prevent uncertainties on the part of the mentees. Support and guidance should be provided on an on-going basis, particularly to the mentors. Feedback and debriefing sessions should be arranged to allow both the mentors and mentees to talk about the challenges they may be encountering. The programme should be extended to at least the whole month of first clinical placement so that the new students will find their feet and become grounded. At the end of the programme both the mentors and mentees should formally evaluate of the programme especially the benefits and barriers and give recommendations on what can be done to improve the programme. Incentives should be provided for the mentors such as best mentor certificate as a token of appreciation as well as the motivation for other students to take mentorship seriously.

5.4.2 Recommendations to nursing management

Arrangements should be made to have the mentors and mentees allocated together in the same nursing unit and to have the same off-duties. The nursing units should be adequately staffed so that the students will not be used as workforce and they should not be used for non-nursing duties nor made to do errands because this results in them loosing valuable teaching and learning opportunities. Peer mentors should be given protected time away from clinical duties to perform their mentoring duties. Adequate resources should be organised such as equipment and supplies which will not only enable the provision of safe nursing practice but will also facilitate demonstration of nursing procedures to student nurses. Nurse educators, unit mangers and all the staff in the clinical setting should work together in the facilitation of student clinical learning and they should all be supportive of the peer mentoring programme. In keeping with the conceptual framework, the nurse educator should be involved as a liaison person who is responsible for providing objective, regular meetings between college and clinical staff. He/she should be responsible for evaluation of the programme, feedback and dissemination of results.

5.4.3 Recommendations for research

There is a dearth of research regarding the effectiveness of peer mentoring programmes in South Africa, although these programmes do exist as a means of academic support. Further

research on this topic is recommended whereby there should be a control group to verify if peer mentoring does have positive effects and benefits for mentors and mentees or not. Research should also be conducted to check if peer mentoring can contribute to academic improvement and better grades.

5.5 LIMITATIONS OF THE STUDY

The population and sample of this study was only limited to one nursing campus of the KZNCN, the perceptions of students were focused only on one nursing campus in eThekwini in KZN, South Africa. Therefore, the results of the study need to be interpreted cautiously and cannot be generalised to the entire situation in the country. The study was also limited during data collection because the target population size was reduced by the fact that some groups of students were in clinical settings that are outside the hospital, such as Psychiatric institutions and Primary Health Care Clinics, and the researchers therefore could not reach those students. Another limitation of this study was the lack of a control group to ascertain whether or not the peer mentorship programme has benefits for both the mentors and mentees. This study could not ascertain the effects of peer mentoring on the students' academic performance and grades.

5.6 SUMMARY OF THE CHAPTER

This chapter has highlighted the importance of interaction between peers, especially with those who are more capable. The social interaction and collaboration between students as peers contributes to an increased learning curve and acquisition of further knowledge that is difficult to occur if students are studying independently.

5.7 CONCLUSION

This study aimed at describing the perceptions of student nurses on peer mentorship in order to enhance the quality of the peer mentorship programme in the clinical setting. The findings of this study revealed that the peer-mentoring programme provides a vehicle for encouraging collegial interaction and learning amongst the nursing students. It also ensures that the

nursing students are appropriately prepared and groomed to be the best nursing service providers. Evidence from this study indicates that both mentors and mentees are clear about the qualities they expected from their mentors which incorporated someone who is friendly, approachable and interested in students. These qualities promote effective mentorship and enhance the learning experience for the students. The evaluation of findings indicated that formal mentoring programmes require considerable organisational and nursing college support and ongoing commitment. Role preparation for mentors and mentees is required for development of effective mentorship relationships. What is remarkable about this study is the fact that it was able to discover that the new generation of nursing students do acknowledge that teaching is an important role of a nurse and both the mentors and mentees indicated that they are willing to teach other nurses in future.

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APPENDIXES

APPENDIX A: QUESTIONNAIRE FOR MENTORS

Questionnaire for Mentors

Students Perceptions of Peer mentoring in the Clinical Settings

Instructions:

- This questionnaire contains 2 sections namely: Section A requires your demographic data and Section B requires your response to 9 constructs.
- Indicate your answer by ticking the appropriate box
- Please make sure you have answered all questions
- Please answer the questions as honest as possible

Section A: Demographic Data

1. What is your Level of Training (Tick one box)

Year 1	Year 2	Year 3	Year 4	Floating

2. What was your involvement in peer mentoring (You may tick both if you were involved in both)

Involvement	Yes	No
Peer-mentor		
Mentee		

3. Gender

Male	Female

4. Age in years

☐ 15 – 19   ☐ 20 -24   ☐ 25 -29   ☐ 30 – 34   ☐ 35-39+

5. Ethnicity

Black	White	Indian	Coloured

Section B: Information on student nurses' perceptions of peer mentorship in clinical settings

6. **What do you view as <u>YOUR</u> most important role as a peer mentor in clinical settings?**

Role	Tick the ones you view as important	Select 5 and number them in their order of importance
Adviser		
Guide		
Teacher		
Trainer		
Counselor		
Coach		
Colleague		
Supervisor		
Friend		
Evaluator		
Facilitator		
Model		
Supporter		

Through your experience in the mentorship programme, what do you regard as qualities of peer mentors?

Respond to the following statements by indicating whether you: * strongly disagree (SD), * disagree (D) * agree (A) or * strongly disagree (SA).

☐ Mark the block underneath the category.

	SD	D	A	SA
7. They appear to command respect for what they talk about.	1	2	3	4
8. They are competent at their own job.	1	2	3	4
9. They are easy to approach.	1	2	3	4
10. They are interested in mentees- personally, showing genuine concern for the mentees learning	1	2	3	4
11. They provide subtle guidance, but ensure that mentees make their own decisions.	1	2	3	4
12. They question in a non-threatening but purposeful manner.	1	2	3	4
13. They are willing to debate, argue, and discuss in a constructive way.	1	2	3	4

	SD	D	A	SA
14. They provide honest answers to the best of their ability, or guide if they do not have the answer.	1	2	3	4
15. They do not afford blame, staying neutral, but compassionate.	1	2	3	4
16. They are empowering, enabling, caring, open and facilitative.	1	2	3	4
17. They provide critically constructive and positive feedback.	1	2	3	4

Through your experience in the mentorship programme, what do you regard as the role of a mentee?

Respond to the following statements by indicating whether you: * strongly disagree (SD), * disagree (D) * agree (A) or * strongly disagree (SA).

□ Mark the block underneath the category.

	SD	D	A	SA
18. Act professionally in relation to time keeping, dress, attitude and confidentiality.	1	2	3	4
19. Practice good communication and a willingness to work with the team.	1	2	3	4
20. Identify and communicate your own learning needs.	1	2	3	4
21. Take responsibility for your own learning needs.	1	2	3	4
22. Be honest about your own ability and level of competence.	1	2	3	4
23. Actively participate and seek out learning opportunities.	1	2	3	4
24. Act upon constructive feedback.	1	2	3	4
25. Evaluate the peer mentoring programme and give feedback.	1	2	3	4

What do you see as barriers to peer mentoring in the clinical settings

	SD	D	A	SA
26. Conflict of interest due to the demands of the nursing programme and from the peer mentors as well	1	2	3	4
27. Lack of recognition of the demand of the role of peer mentoring by nurse educators	1	2	3	4
28. Working with limited equipment and other resources	1	2	3	4
29. Lack of understanding of the programme requirements	1	2	3	4

30. Lack of support from clinical staff members	1	2	3	4
31. Poor preparation to carry out the role of peer mentoring in clinical settings	1	2	3	4
32. Mentoring too many students at the same time	1	2	3	4
33. Inadequate time available to attend to both the mentees and patients.	1	2	3	4
34. Performing mentoring duties in a very busy clinical setting with very sick patients.	1	2	3	4
35. Assisting a learner whose skills levels are below the expected standard.	1	2	3	4
36. Assisting learners who display a lack of initiative and motivation.	1	2	3	4
37. Cross-cultural and cross-gender mentoring create discomfort	1	2	3	4
38. Too wide- age gap between peer mentor and peer mentee.	1	2	3	4
39. Insufficient practice opportunities for the students because of the short duration of the placement.	1	2	3	4
	1	2	3	4

Mentorship programme benefits (Tick the most appropriate)

	SD	D	A	SA
40. Peer mentoring experience was time and effort well spent.	1	2	3	4
41. Peer mentoring enabled the application of principles of teaching and learning.	1	2	3	4
42. Acting the role of peer mentor enabled the development of teaching and leadership skills.	1	2	3	4
43. Gained an opportunity to review knowledge and stay current with skills	1	2	3	4
44. Providing support and encouragement to a junior nurse promoted my personal and professional development.	1	2	3	4
45. Peer mentoring experience prepared me for my registered nurse's role.	1	2	3	4
46. Acting the role of a peer mentor increased my confidence, self-esteem and self-worth.	1	2	3	4
47. Facilitating and aiding learning and development of a less experienced nurse enhances personal-gratification.	1	2	3	4
48. Mentoring provided an early exposure to being a role model	1	2	3	4
49. Providing psychosocial support to mentees makes the mentors to feel important, respected and valued.	1	2	3	4
50. Nurses have a professional responsibility to teach students and peers.	1	2	3	4

In a scale of 1-5, where 1 = poor, 2 = fair, 3= satisfactory, 4 = very good and 5 = excellent, rate your experience with peer mentoring in the clinical placement area.

	1	2	3	4	5
51. The mentorship programme	1	2	3	4	5
52. The support received by peer mentor from programme coordinators	1	2	3	4	5
53. The unit manager's support of peer-mentoring	1	2	3	4	5
54. The unit manager's involvement in peer mentoring	1	2	3	4	5
55. The facilitation of learning by peer mentors in the clinical settings	1	2	3	4	5
56. The feedback provided by peer mentors to mentees	1	2	3	4	5
57. The feedback provided by peer mentees to mentors.	1	2	3	4	5
58. The feedback provided by programme coordinators to peer mentors regarding their role	1	2	3	4	5
59. Supportive environment was created for peer-mentoring in clinical settings	1	2	3	4	5
60. Clinical environment allowed for maximum clinical learning by mentees	1	2	3	4	5
61. Peer mentoring programme facilitated development of confidence as a new nurse	1	2	3	4	5
62. Availability of equipment and other resources enhanced learning through peer mentoring	1	2	3	4	5
63. The staff in the clinical setting were supportive to peer mentors and mentees	1	2	3	4	5

64. Overall how well did the program meet your expectations?

Exceeded my expectations	Adequately Met my expectations
Partially met my expectations	Did not meet my expectations

65. Would you recommend this mentoring program to your friends/peers?

Yes	No	Unsure

Section C: Open-ended questions

66. What other aspects of the peer mentoring program did you find useful?

_____
_____
_____
_____

67. What suggestions do you have for improving and strengthening this peer mentoring program in the future?

_____
_____
_____

68. Are there any other comments you would like to make?

_____
_____
_____
_____

THANK YOU FOR YOUR SUPPORT!

APPENDIX B: QUESTIONNAIRE FOR MENTEES

Questionnaire for Mentees

Students Perceptions of Peer mentoring in the Clinical Settings

Instructions:

- This questionnaire contains 2 sections namely: Section A requires your demographic data and Section B requires your response to 9 constructs.
- Indicate your answer by ticking the appropriate box
- Please make sure you have answered all questions
- Please answer the questions as honest as possible

Section A: Demographic Data

1. What is your Level of Training (Tick one box)

Year 1	Year 2	Year 3	Year 4	Floating

2. What was your involvement in peer mentoring (You may tick both if you were involved in both)

Involvement	Yes	No
Peer-mentor		
Mentee		

3. Gender

Male	Female

4. Age in years

☐ 15 – 19   ☐ 20 -24   ☐ 25 -29   ☐ 30 – 34   ☐ 35-39+

5. Ethnicity

Black	White	Indian	Coloured

Section B: Information on student nurses' perceptions of peer mentorship in clinical settings

6. **What do you view as the most important role filled by a peer mentor in clinical settings?**

Role	Tick the ones you view as important	Select 5 and number them in their order of importance
Adviser		
Guide		
Teacher		
Trainer		
Counselor		
Coach		
Colleague		
Supervisor		
Friend		
Evaluator		
Facilitator		
Model		
Supporter		

Through your experience in the mentorship programme, what do you regard as qualities of peer mentors?

Respond to the following statements by indicating whether you: * strongly disagree (SD), * disagree (D) * agree (A) or * strongly disagree (SA).

☐ Mark the block underneath the category.

	SD	D	A	SA
7. They appear to command respect for what they talk about.	1	2	3	4
8. They are competent at their own job.	1	2	3	4
9. They are easy to approach.	1	2	3	4
10. They are interested in mentees- personally, showing genuine concern for the mentees learning	1	2	3	4
11. They provide subtle guidance, but ensure that mentees make my own decisions.	1	2	3	4
12. They question in a non-threatening but purposeful manner.	1	2	3	4
13. They are willing to debate, argue, and discuss in a constructive way.	1	2	3	4
14. They provide honest answers to the best of their ability, or guide if they do not have the answer.	1	2	3	4

15. They do not afford blame, staying neutral, but compassionate.	1	2	3	4
16. They are empowering, enabling, caring, open and facilitative.	1	2	3	4
17. They provide critically constructive and positive feedback.	1	2	3	4

Through your experience in the mentorship programme, what do you regard as the role of a mentee?

Respond to the following statements by indicating whether you: * strongly disagree (SD), * disagree (D) * agree (A) or * strongly disagree (SA).

☐ Mark the block underneath the category.

	SD	D	A	SA
18. Act professionally in relation to time keeping, dress, attitude and confidentiality.	1	2	3	4
19. Practice good communication and a willingness to work with the team.	1	2	3	4
20. Identify and communicate own learning needs.	1	2	3	4
21. Take responsibility for your own learning needs.	1	2	3	4
22. Be honest about your own ability and level of competence.	1	2	3	4
23. Actively participate and seek out learning opportunities.	1	2	3	4
24. Act upon constructive feedback.	1	2	3	4
25. Evaluate the peer mentoring programme and give feedback.	1	2	3	4

4. What do you see as barriers to peer mentoring in the clinical settings

	SD	D	A	SA
26. Discrepancy between what is taught in class/in simulation and what is actually implemented in the clinical setting causes anxiety and confusion.	1	2	3	4
27. Mentors that appear to be uncertain about their knowledge and actions makes students nervous and anxious.	1	2	3	4
28. Working with limited equipment and other resources	1	2	3	4
29. Reluctance of mentor to fulfil their roles, mentors who are not dedicated and unfriendly.	1	2	3	4
30. Lack of support from clinical staff members	1	2	3	4

31. Poor preparation to carry out the role of peer mentoring in clinical settings	1	2	3	4
32. Cross-cultural and cross-gender mentoring create discomfort	1	2	3	4
33. Too wide- age gap between peer mentor and peer mentee.	1	2	3	4

5. What do you see as benefits to peer mentoring in the clinical settings (Tick the most appropriate)

	SD	D	A	SA
34. Makes adapting to the clinical environment easy	1	2	3	4
35. Makes one to be less intimidated and more comfortable	1	2	3	4
36. Approaching a peer mentor for assistance is easier than approaching the instructor.	1	2	3	4
37. When a clinical skill is taught by a peer mentor, interaction and collaboration with other students increases more than when it is taught by my instructor.	1	2	3	4
38. The feedback received from my peer mentor is from a student's viewpoint, therefore more honest, reliable and helpful than from the instructor.	1	2	3	4
39. Self-confident, independence and ability to perform clinical skills is increased	1	2	3	4
40. Less anxiety is experienced when performing nursing skills in the presence of my peers than my instructor.	1	2	3	4
41. Communication with my peer mentor is freer than with the instructor.	1	2	3	4
42. The peer mentor was more supportive when I was performing a nursing skill.	1	2	3	4
43. Peer mentoring helped in integration of theory and practice.	1	2	3	4
44. Teaching is an important role of nurses	1	2	3	4

45. In a scale of 1-5, where 1 = poor, 2 = fair, 3= satisfactory, 4= very good and 5 = excellent, rate your experience with peer mentoring in the clinical placement area.

	1	2	3	4	5
46. The mentorship programme	1	2	3	4	5
47. The support received by peer mentor from programme coordinators	1	2	3	4	5
48. The unit manager's support of peer-mentoring	1	2	3	4	5
49. The unit manager's involvement in peer mentoring	1	2	3	4	5

50. The facilitation of learning by peer mentors in the clinical settings	1	2	3	4	5
51. The feedback provided by peer mentors to the mentees	1	2	3	4	5
52. The feedback provided by peer mentees to mentors	1	2	3	4	5
53. The feedback provided by programme coordinators to peer mentees regarding their role	1	2	3	4	5
54. Supportive environment was created for peer-mentoring in clinical settings	1	2	3	4	5
55. Clinical environment allowed for maximum clinical learning by mentees	1	2	3	4	5
56. Peer mentoring programme facilitated development of confidence as a new nurse	1	2	3	4	5
57. Availability of equipment and other resources enhanced learning through peer mentoring	1	2	3	4	5
58. The staff in the clinical setting were supportive to peer mentors and mentees	1	2	3	4	5

59. Overall how well did the program meet your expectations?

Exceeded my expectations	Adequately Met my expectations
Partially met my expectations	Did not meet my expectations

60. Would you recommend this mentoring program to your friends/peers?

Yes	No	Unsure

Section C: Open-ended questions

61. What other aspects of the peer mentoring program did you find useful?
_____
_____
_____

62. What suggestions do you have for improving and strengthening this peer mentoring program in the future?
_____
_____

_____
_____

63. Are there any other comments you would like to make?

_____
_____
_____
_____

THANK YOU FOR YOUR SUPPORT!

APPENDIX C: INFORMATION SHEET AND CONSENT FORM

Information Sheet and Consent to Participate in Research

Date:……………………

Dear Student Nurse

My name is Zanele Mlaba from Nursing Department, Howard College, University of KwaZulu-Natal. My contact number is 0825392474 and email address mlabazanele7@gmail.com

You are being invited to participate in a study that involves provision of information based on your experiences with mentoring titled **STUDENT NURSES' PERCEPTIONS OF PEER MENTORSHIP IN CLINICAL SETTINGS IN A SELECTED HOSPITAL IN eThekwini, KWAZULU – NATAL.** The purpose of the study is to describe the perceptions of student nurses on peer mentorship in order to enhance the quality of the peer mentorship programme in the clinical setting. The study is expected to enroll all R425 student nurses who participated in peer mentoring in a selected nursing campus in Durban. You are being asked to take part in this study by completing the attached questionnaires. Completing this form will take approximately twenty minutes of your time. The questionnaire will be given to you upon your voluntary agreement to participate in this study.

Please be aware that participation is voluntary, you are not compelled to participate in this research and you may discontinue your participation at any time you may so wish. There are no foreseen possible risks associated with participation in this study and there is no direct benefit linked to the participation in this study. If you experience any discomfort during the process of completing the questionnaires you may discontinue. In the event of refusal/withdrawal of participation the participants will not incur penalty or loss of benefits to which you entitled.

Potential benefits associated with the study include better understanding of experiences of student nurse with peer mentoring.

This is a no risk involved in this study as there are no invasive procedures used to collect data. The materials collected will not be personal or sensitive in nature. The study data will be coded and your responses will be anonymous. Anonymity will be maintained by not writing your name anywhere on the questionnaire and by using a coding system on the questionnaire in such a way that participants' responses cannot be linked or connected to a name, person, ward or department. Data in filled out questionnaires will be kept safe under lock and key in a safe place for 5 years which will be destroyed.

This study has been ethically reviewed and approved by the UKZN Biomedical research Ethics Committee **(Ref No: HSS/1348/015M)**. Permissions also granted from KZN Provincial Health Research Committee **(Ref No: 296/16 KZ-2015 RP16-333)** to conduct the research at Prince Mshiyeni Nursing Campus.

In the event of any problems or concerns/questions you may contact the researcher on 0825392474 or mlabazanele@gmail.com or the UKZN Biomedical Research Ethics Committee, contact details as follows:

HUMANITIES AND SOCIAL SCIENCE RESEARCH ETHICAL ADMINISTRATION
Research office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 2731 2604557-Fax: 2731 2604609
Email: HSSREC@ukzn.ac.za

CONSENT FORM

I ……………………………………………………………. have been informed about the study entitled **STUDENT NURSES' PERCEPTIONS OF PEER MENTORSHIP IN CLINICAL SETTINGS IN A SELECTED HOSPITAL IN eThekwini, KWAZULU – NATAL** by Zanele Mlaba , a Masters student at the University of KwaZulu Natal, Howard College

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0825392474/ mlabazanele7@gmail.com.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES AND SOCIAL SCIENCE RESEARCH ETHICAL ADMINISTRATION

Research office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 2731 2604557-Fax: 2731 2604609

Email: HSSREC@ukzn.ac.za

_____   _____

APPENDIX D: LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

KwaZulu-Natal College of Nursing

P/Bag X9089

Pietermaritzburg

3200

25 August 2015

Dear Principal

RE-PERMISSION TO CONDUCT RESEARCH AT PRINCE MSHIYENI MEMORIAL CAMPUS

I am a student at the University of KwaZulu-Natal, School of Nursing, doing a Master's degree in Nursing Education. The title of my study is: Student Nurses' Perceptions of Peer Mentorship in Clinical Settings in a Selected Hospital in Durban. My research supervisor is Waheedha Emmamally.

In order for me to get ethical clearance from the research office in the university, I am required to produce a letter of support to conduct a study from the relevant authorities. As I have identified that Prince Mshiyeni has a peer mentoring programme in place, I hereby request a permission to conduct a research study.

The collection of data will involve spending a few hours over four days at your nursing school. I guarantee that the students' participation in the study will be voluntary and that anonymity and confidentiality will be maintained throughout.
The findings of the study will be share with the principal of KZNCN, Prince Mshiyeni nursing campus and the students.

It will be appreciated if my request will receive your favorable consideration.
Yours Sincerely
Zanele Penelope Mlaba
Mobile: 0825392474
Email: mlabazanele7@gmail.com

APPENDIX E: LETTER REQUESTING PERMISSION TO CONDUCT RESERACH

<div align="right">

Principal Mshiyeni Nursing Campus

P/Bag X07

Mobeni

4060

25 August 2015

</div>

Dear Sir/Madam

RE-PERMISSION TO CONDUCT RESEARCH AT PRINCE MSHIYENI MEMORIAL CAMPUS

I am a student at the University of KwaZulu-Natal, School of Nursing, doing a Master's degree in Nursing Education. The title of my study is: Student Nurses' Perceptions of Peer Mentorship in Clinical Settings in a Selected Hospital in Durban.

In order for me to get ethical clearance from the research office in the university, I am required to produce a permission to conduct a study from the relevant authorities. As I have identified that Prince Mshiyeni has a peer mentoring programme in place, I hereby request permission to conduct a research study. The collection of data will involve spending a few hours over four days at your nursing school. I guarantee that the students' participation in the study will be voluntary and that anonymity and confidentiality will be maintained throughout. The findings of the study will be share with the principal Prince Mshiyeni nursing campus and the students.

It will be appreciated if my request will receive your favorable consideration.
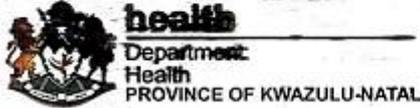
Yours Sincerely

Zanele Penelope Mlaba

Mobile: 0825392474

Email: mlabazanele7@gmail.com

APPENDIX F: LETTER GRANTING PERMISSION TO CONDUCT RESEARCH (KZN DoH)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge Management

Reference: 296/15
KZ_2015RP16_333

Date: 20 October 2015

Dear Mrs ZP Mlaba
Email: mlabazanele@gmail.com

Re: Approval of research

1. The research proposal titled **'Student nurses perceptions of peer mentorship in clinical settings in a selected hospital in eThekwini, KwaZulu Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at KwaZulu Natal College of Nursing.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 22/10/15

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APPENDIX G: ETHICAL APPROVAL (UKZN)

UNIVERSITY OF ™
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

2 November 2015

Mrs Zanele Penelopba Mlaba 215079135
School of Nursing and Public Health
Howard College Campus

Dear Mrs Mlaba

Protocol reference number: HSS/1348/015M
Project title: Student nurses' perceptions of peer mentorship in clinical settings in a selected hospital in eThekwini, KwaZulu-Natal

Full Approval – Expedited Application
In response to your application received on 23 September 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully
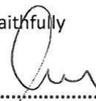
....
Dr Shenuka Singh(Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Ms W Emmammally
cc. Academic Leader: Prof M Mars
cc. School Administrstor: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

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APPENDIX H: LETTER GRANTING PERMISSION TO CNDUCT RESEARCH (KZNCN)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address : 211 Pietermaritz Street , Pietermaritzburg 3200
Postal Address: Private Bag X 9089 Pietermaritzburg 3200
Tel: 033 264 7800 Fax: 033 394 7238 Email: sindizama.mthembu@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

KwaZulu-Natal College of Nursing

Reference: Dr. S.Z. Mthembu
Date: 05 November 2015

Principal Investigator: Mrs. Z.P. Mlaba
Student No: 215079135
University of KwaZulu-Natal

RE: Permission to conduct research at the KZN College of Nursing.

TITLE: Students nurses' perceptions of peer mentorship in clinical settings in a selected hospital in eThekwini, KwaZulu-Natal

Dear Mrs. Mlaba

I have the pleasure in informing you that permission has been granted to you as per the above request by the Principal of the KZN College of Nursing.

Data Collection site(s):   KwaZulu-Natal College of Nursing

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This Research will only commence once this office has received confirmation of approval from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Permission is therefore granted for you to conduct this research at the KZN College of Nursing.
5. The KwaZulu-Natal College will not be providing you with any resources for this research.
6. You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thank You

Dr. S.Z Mthembu
Principal: KZN College of Nursing

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX I: LETTER FROM THE PRINCIPAL

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

KWAZULU-NATAL COLLEGE OF NURSING
PRINCE MSHIYENI MEMORIAL CAMPUS
Physical Address: Mangosuthu Highway, Durban, 4000
Physical Address: Private Bag X10, Mobeni, 4060
Tel: +27(031) 907 8313/ 8314 Fax: +27(031) 906 7772 Email: Rozana.Bridgemohan@kznhealth.gov.za
www.kznhealth.gov.za

Directorate: PRINCIPAL OFFICE

Bridgemohan Rozana Rozana.Bridgemohan@kznhealth.gov.za
19 November 2015

Good Afternoon Ms Mlaba

Permission is hereby granted to collect data from student nurses as requested. Please ensure that data collection does not interfere with teaching and learning activities of learners. Kindly adhere to the stipulations as laid down by KZNCN.

Kind Regards

Mrs Rozana Bridgemohan
Campus Principal
Prince Mshiyeni Memorial Campus
Telephone: 031 9078314
Fax   : 031 9067772
Email: Rozana.Bridgemohan@kznhealth.gov.za

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX J: LETTER TO THE EDITOR

<div align="right">

51 Ndlovu Street

Klaarwater

3609

02 February 2016

</div>

Dear Catherine Eberle

Good day

Request for Editing Services

I am Zanele Mlaba, a Master's student at the University of KwaZulu-Natal. I would like to send my theses which is 170 pages including references for editing. I have used the Harvard's method foe referencing.

My research supervisor is Ms Waheedha Emmamally and her email address is emmamally@ukzn.co.za

Thank You.

Zanele Mlaba

APPENDIX K: LETTER FROM THE EDITOR

04 February 2016

Hi Zanele

My editor, Dennis Schauffer, has agreed to begin your edit tomorrow. We edit using MS Word Track Changes where amendments are inserted in red, deletions are hidden and queries in blue with comments and suggestions in comment balloons to the right of the text.
 We edit for grammar, language usage, tense, syntax, spelling and punctuation. Let me know what you would like to do and thank you for your enquiry.

Kind Regards

Catherine Erbele