KNOWLEDGE AND USE OF ANTI-SHOCK GARMENT AMONG MIDWIVES IN CENTRAL HOSPITAL, BENIN CITY, EDO STATE.

Enuku, C. A.
&
Adeyemo, F. O.

ABSTRACT

This study assessed midwives' knowledge and use of Non-Pneumatic Anti-Shock Garment in management of postpartum hemorrhage. A descriptive design was adopted for this study. The population are registered midwives working in Central hospital Benin City. Taro Yameh's formula was used to determine the sample size of 150 participants and a simple random sampling technique was used to select the respondents that took part in the study. A self- developed structured questionnaire was given to experts for face validation, while the reliability was determined through internally consistency and reliable with a Cronbach's alpha value of 0.799. Data was analyzed and presented in percentages, graphs and inferential statistics using the chi square (χ^2) test at 95% confidence interval. The result revealed that majority of the respondents (93.3%) claimed that anti-shock garments are available in Central hospital Benin City. Also, the ***result showed that more than half of the respondent****s were knowledgeable about use of NASG in preventing post-partum Hemorrhage. Out of the 150 respondents used for this study, 68.6% demonstrated knowledge on application of NASG and similar trend is observed among respondents on knowledge on other methods of prevention of PPH. Further, the result revealed that only 16.6% reported that they use NASG 11 – 20times, Lastly, this study showed that there is a significant association between knowledge of NASG and its use which is at P<0.05. In conclusion, the study showed that the Midwives knowledge of NASG are good but its use is p****oor.***

Keywords: Knowledge, Use, Anti-Shock Garment, Midwives

INTRODUCTION

Of the 287,000 maternal deaths occurring annually, over 99% happen in low – income countries (WHO, UNICEF, UNFPA & WORLD BANK, 2012) Postpartum hemorrhage (PPH) is one of the leading causes of maternal mortality, accounting for one-quarter of global maternal deaths (WHO,2012) With great progress being made to reduce maternal mortality globally, PPH still remains a leading killer of women of reproductive age. A significant number of maternal morbidities and mortalities related to postpartum hemorrhage (PPH) can be prevented with the implementation of active management of the third stage of labour (AMSTL), particularly the administration of uterotonics, such as injection oxytocin or oral misoprostol within 5minutes of delivering (WHO 2012, FIGO 2012, AIFIREVIC et al 2007). Despite these measures women still die of postpartum hemorrhage. Adesokan (2010) defined postpartum hemorrhage as 'excessive bleeding from the genital tract at any time following the birth of the baby up to 6 weeks after delivery which is in excess of 500mls or any amount sufficient enough to cause cardiovascular collapse which is detriment to the life of the woman.' Even though, PPH is a killer, it is still one of the obstetric emergencies with proven effective intervention. Such intervention is the use of Lightweight, neoprene covering that resembles the bottom half of a wetsuit which is referred to as 'Non-Pneumatic anti-shock Garment'(NASG) otherwise known as 'life wrap'

The garment has six segments that fasten with Velcro around the woman's legs, pelvis, and abdomen. The abdominal segment incorporates

a small foam ball that applies pressure to the uterus. The NASG works by decreasing pelvic blood flow (Hauswald, Williamson, Baty, Kerr, & Edgar-Mied, 2010), in particular, by increasing the resistive index of the pelvic blood vessels (hypogastric and uterine arteries) (Lester, Stenson, Meyer, Morris, Vargas, & Miller, 2011). The NASG can be applied by any healthcare staff after a brief training, and it results in the reversal of hypovolemic shock and the stabilization of the patient for many hours, during transport, examinations, and delays in receiving definitive treatments such as blood, procedures, and surgeries. The NASG is applied as soon as signs of hypovolemic shock are identified. Ifintravenous fluids are not already running, veins are easier to find after placement of the garment. The NASG is not replacement for standard care; shock/hemorrhage protocols should be followed in addition to NASG application. The NASG is left in place for vaginal procedures; for abdominal surgery, only the abdominal and pelvic panels are opened.

WHO (2012) explained that postpartum hemorrhage still a leading cause of death with 25%. Balachandram, (2005), Bias, Eskes, Pel, Bonsel and Bleker (2004) and Magann, Evan, Flutechnison, Collins, Lanneau, G. and Mirrison, (2005) posited that a woman suffering from PPH can die within two hours unless she receives immediate and prompt medical care. WHO further discussed that despite the introduction of the first aid device in Nigeria in 2008, there has not been a significant reduction in maternal morbidity and mortality as Nigeria and India at the country level accounted for a third of the global maternal death with India at 19% (56,000) and Nigeria14% (40,000). Onasoga et al (2015), said that midwives are the first point of contact for most women during pregnancy and labour and all women are at risk of PPH, therefore midwives' knowledge and use of the NASG is very important in management of postpartum hemorrhage in reducing maternal death. Ijaya, Aboyeji, and Abubakar (2013) explained that PPH is the most common cause of obstetric haemorrhage and one of the five leading causes of maternal mortality in world, Nigeria inclusive. Lertakyamanee. Chinachoti, Tritrakam, Muangkasem, Somboonnan, Onda and Kolatat, (2009) and Anya and Anya (2009) observe that current treatment protocols for PPH and hypovolemic shock include the administration of uterotonics, bi-manual massage of the uterus, manual removal of placenta, repair of lacerations, blood transfusion and surgery. There are many emergency referral cases to Central hospital, Benin on daily basis from health facilities within the Benin City. Of importance is the several numbers of post-partum hemorrhage cases that could be referred to the hospital from private, state and local health facilities on weekly basis. Cases that are lucky to get to the hospital alive too may die in the process of identifying the source of bleeding if there is no NASG to prevent further bleeding during the process. It is a known fact that NASG can be applied by anyone that has received training for it; and not necessary midwives or only health personnel. Hence this study was to assess midwives' knowledge and use of Non-Pneumatic Anti-Shock Garment in management of postpartum hemorrhage.

Objective of the study

1. To identify if Anti-shock garments are available in Central Hospital
2. To assess the knowledge of the functions of Anti-shock garment among midwives in Central Hospital, Benin City, Edo State on Anti-shock garments.
3. To determine the use of Anti-shock garment among the midwives Central Hospital, Benin City, Edo State.

Research questions

1. Are anti-shock garments available in Central Hospital, Benin City?
2. What is the knowledge of midwives about the functions of anti -shock garments in Central Hospital, Benin City?
3. Do midwives in Central Hospital, Benin City use anti-shock garments?

Hypothesis

There is no significant relationship between the knowledge of anti-shock garment and its use as a method of managing obstetric hemorrhage.

METHODOLOGY

The study adopted the descriptive research design. The study was done in Central Hospital situated along Sapele Road, Benin City Edo State. The hospital is a Government owned hospital. The hospital was created in 1902 by the British government before independence with head quarter at Ibadan. In 1963, Midwest State was created with the headquarter in Benin City. At this point in time, it was under the Ministry of Health till 1970. In 1970, Hospitals Management Board was established by an edit by then Military under Ogbemudia's regime. Edo State Hospitals Management Board was the first to be established in Nigeria. Central Hospital started with the name General hospital in the early seventies and was changed to Specialist Hospital which now metamorphosed to Central Hospital in the eighties. It is made up of various departments that render specialized care to patients with varied problems. It is in charge of curative health care and training of personnel. It has a Staff strength of seven hundred and twenty working in twenty-six departments. There are thirty-two units with four hundred and twenty bed spaces and two hundred and seventy-one midwives working in these units of the hospital.

Population: The target populations for this study are 271 registered midwives working in Central hospital Benin City.

Sample Size Determination and Sampling Technique: Taro Yameh's formula was used to determine the sample size of 150 participants and a simple random sampling technique was used to select the respondents that took part in the study

Instrument for data collection: A self-developed structured questionnaire which consist of 4 sections; namely A. Socio-Demographic data of respondents, B. Knowledge of Anti-shock,

C. Use of Ant-shock, D. Factors influencing the use of Anti-shock

Scoring of knowledge: A total of five questions (questions 9, 10, 11, 13, 15) were used to assess the respondents' knowledge. Minimum and maximum scores were calculated as 0 and 18. The scores were converted to percentages and graded as follows: scores below 50% were graded as having poor knowledge while those 50.0% and above were graded as having good knowledge.

Validity and Reliability: Experts were given for face validation, while the reliability was determined through internal consistency and reliable with a Cronbach's alpha value of 0.799.

Method of Data Analysis: The method for analyzing data collected was descriptive which involved the use of percentages, graphs and inferential statistics using the chi square (χ^2) test. Level of significance was set at 5% [0.05] such that significant associations were established when $p < 0.05$.

Ethical Consideration: Ethical clearance was obtained from the Director of Nursing Services. Inform consent was obtained from respondents before participation.

RESULTS

As presented in Table 1, 51 (34.0%) of the respondents were aged 32 – 38 years, followed by 42 (28.0%) aged 39 – 45 years and 33 (22.0%) aged 25 – 31 years. More than two thirds 102 (68.0%) were married while 30 (20.0%) were single. Most 126 (84.0%) were Christians while 24 (16.0%) were Muslims. Seventy-two (48.0%) of the respondents were Bini, 29 (19.3%) were Esan and 14 (9.3%) were Yoruba. The cadre was distributed with 50 (33.3%) being NO II, 30 (20.0%) NO I, 15 (10.0%) SNOs and 9 (6.0%) PNOs. ACNO 28(18.7%), CNO 18(12.0%)

TABLE 1: Socio-demographic characteristics of respondents

Variable	Frequency (n = 150)	Percent
Age (years)		
25 – 31	33	22.0
32 – 38	51	34.0
39 – 45	42	28.0
46 – 52	24	16.0
Sex		
Male	21	14.0
Female	129	86.0
Marital status		
Single	30	20.0
Married	102	68.0
Separated	6	4.0
Divorced	12	8.0
Religion		
Christianity	126	84.0
Islam	24	16.0
Ethnic group		
Bini	72	48.0
Esan	29	19.3
Yoruba	14	9.3
Igbo	12	8.0
Urhobo	9	6.0
Delta igbo	5	3.3
Etsako	3	2.0
Hausa	2	1.3
Others*	4	2.7
Cadre		
NO II	50	33.3
NO I	30	20.0
SNO	15	10.0
PNO	9	6.0
ACNO	28	18.7
CNO	18	12.0

Mean age = 41.7 ± 13.9 years *Others* included Afemai, Ora, Owan and Isoko*

Table 2: Distribution of respondents on availability of anti-shock garment

	Yes	No
Anti-shock garment is availability in our hospital?	140 (93.3)	10 (6.7) *

*percentages are written in parenthesis.

As presented in Table 2, out of the 150 respondents studied, 93.3% claimed that anti-shock garments are available in their hospital while only a very small proportion 6.7% responded that anti-shock garment is not available in their hospital. This could be explained by two factors; there were not exposed to the garment while undergoing their training and maybe because they have not work in hospital unit were anti-shock garments are commonly used.

Table 3**:** Respondents' knowledge about the function of NASG,

	Yes	**No**
Knowledge on the use of NASG to prevent Post Partum Haemorrhage (PPH)	95 (63.3)	55 (36.6) *
Knowledge on the application of NASG	103 (68.6)	47 (31.3)
Knowledge on other methods of prevention of PPH	117 (78.0)	33 (22.0)

*percentages are written in parenthesis

Three areas of knowledge about the function of NASG was assessed and presented in Table 3. As presented in Table 3, more than half of the respondents 63.3% were knowledgeable about use of NASG to prevent post partum Haemorrhage while only 36.6% were not knowledgeable in this area. Out of the 150 respondents 68.6% demonstrated knowledge on application of NASG while 31.3% did not. Similar trend is observed among respondents on knowledge on other methods of prevention of PPH 78.0% responded yes while only 22.0% responded no.

TABLE 4: Frequency of times of application of NASG

Frequency of use per annum	Frequency	Percent (%)
Once	46	30.6
2 – 5 times	49	32.6
5 – 10 times	30	20.0
11 – 20 times	25	16.6
Total	150	100.0

As presented in Table 4, 32.6% reported that they use NASG 2-5times per annum, 30.6% reported that they use NASG once per annum, 20.0% reported that they use NASG 5 – 10times per annum while only 16.6% reported that they use NASG 11 – 20time**s.**

Test of Hypothesis

There is no significant relationship between the knowledge of Anti-shock garment and its use as a method of managing obstetric hemorrhage.

Table 5: Knowledge of NASG and its use by respondents

Knowledge of NASG	Ever used NASG		
	Yes	No	Total
	n (%)	n (%)	
Good	59 (54.1)	50 (45.9)	109 (100.0)
Poor	4 (9.8)	37 (90.2)	41 (100.0)
Total	63 (42.0)	87 (58.0)	150 (100.0)

Using the formula $\chi^2 = \Sigma(O - E)^2/E$

O	E	O – E	$(O - E)^2$	$(O - E)^2/E$
59	45.8	13.2	174.2	3.8
50	63.2	13.2	174.2	2.8
4	17.2	13.2	174.2	10.1
37	23.8	13.2	174.2	7.3
Total 150				

χ^2 = 24.000. The calculated chi square was 24.000.

Computation of the degree of freedom (df)

Df = (R - 1) (C - 1). R represents the number of rows in the chi-square table above minus one while C represents the number of columns in the chi-square table minus one.

(2 - 1) (2 - 1) = 1. At 5% significance level for the degree of freedom the critical value of chi square is 3.841. Since the calculated chi-square value of 24.000 is more than the chi-square critical value of 3.841, we simply reject the null hypothesis (H_{o1}) of no significant relationship between the knowledge of NASG and its use as a method of managing obstetric haemorrhage.

DISCUSSION

Our study was to assess midwives' knowledge and use of Non- Pneumatic Anti-Shock Garment in management of postpartum hemorrhage. One hundred and fifty [150] midwives participated the study. Majority of the participants were within the ages of 32 – 38 years and 39 – 45 years.

More than two thirds of the participants were married while 20.0% were single and most of them were Christians. The cadre of the participants were mostly 33% NO II, 20%, 19% PNOs. ACNO and 12% CNO

Our study revealed that majority of the respondents (93.3%) claimed that anti-shock garments are available in Central hospital Benin City.In the three areas of knowledge about the function of NASG assessed, result showed that more than half of the respondents were knowledgeable about use of NASG to prevent post-partum Hemorrhage. Out of the 150 respondents used for this study, 68.6% demonstrated knowledge on application of NASG and similar trend is observed among respondents on knowledge on other methods of prevention of PPH. This was consistent with a related study done by Onasoga, Awhanaa, Amiegheme (2010) in Bayelsa State in which 73.9% of their respondents were know legible about the use of anti-shock garment. This also support the findings of Olowokere, Adekeye, Ogunfowokan, Olagunju and Irinoye (2013).

Our result revealed that only 16.6% reported that they use NASG 11 – 20times, this means that many of the midwives have either applied NASG on PPH woman on few occasions or had never applied it. This is not encouraging because knowledge is not enough but its use is paramount in reduction of PPH and maternal

mortality. Supporting our result, is the report of John and Catherine (2013) which affirmed lack of adequate training and underutilization of the anti-shock garment in most developing countries of the globe. Our result is inconsistent with the findings of Miller *et al* (2007) because, NASG is in common use by emergency medical teams in the United State to stabilize patients before and during transfer to the hospital.

Lastly, this study showed that there is a significant association between knowledge of NASG and its use which is at $P<0.05$. Though there is high level knowledge NASG but its use is poor

Conclusion and Recommendations

The study showed that the Midwives knowledge of NASG are good but its use is poor. The severity of the obstetric haemorrhage was the most popular factor influencing the use of Anti-shock garment among the midwives in Central Hospital, Edo state. It's unavailability also militates against its use in the hospital.

The following recommendations were made based on the findings from this study

There is urgent need for training and retraining of personnel of private, state and local government health facilities, as well as the community birth attendants on the application of NASG. This will assist in stabilizing the bleeding woman and preventing complications as well as maternal death before getting the woman to the referring hospital.

In-service-education unit of Central hospital, Benin should organize on regular basis workshop on the use of NASG for all its health personnel; and the hospital authority should make NASG abundantly available for the use of the personnel.

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MENTORING IN NURSING: STRATEGY FOR PROFESSIONAL DEVELOPMENT

Oluwatosin, O. A.
&
Edward M. I.

ABSTRACT

Mentoring is an important aspect of Nursing as it is a professional means of passing knowledge, skills, behaviors and values to a less experienced individual. However, this aspect is often neglected as it is time consuming and tasking. It is therefore recommended that there should be a renewed orientation to thorough mentoring to enhance quality nursing practice.

INTRODUCTION

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2002). Within the nursing profession, mentoring is described as a valued relationship and a nurturing process in which an experienced nurse supports the professional growth and career development of another. Mentoring another nurse is a professional means of passing along knowledge, skills, behaviors and values to a less experienced individual who is often referred to as the "mentee" or "protégé" (NLN, 2006).

Overview of Mentoring

The concept of mentoring is not new. It dates back to the ancient Greeks. Young men who demonstrated great leadership potential were mentored by Socrates. During the Middle Ages Master craftsmen would accept promising students as apprentices, guiding them through all aspects of the craft. Mentoring is a process involving informal transmission of knowledge and psychosocial support that is relevant to work, career, or professional development. It entails informal/formal communication between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the mentee) (*Idemudia, 2013).* Mentoring is a life educational model based on the principle of a more experienced mentor guiding his or her student, often called a mentee. A mentor may provide spiritual, emotional or financial counseling for their proteges. It is more than a traditional teacher/student relationship (Pollick and Foster, 2017),

Mentoring entails the formation of a relationship or partnership between the mentor and the mentee. It is a process in which a person who is experienced, wise, and trusted guides an inexperienced individual. The mentor acts as a "role model and advocate to pass on life experiences and knowledge. Ali and Panther (2008) stress that mentoring is considered an important role that "every nurse has to assume". According to Canadian Nurses Association (2004) the act of mentoring leads to an ongoing relationship in all domains of nursing practice, administration, education, research, and direct care. Mentoring is a life educational model

based on the principle of a more experienced mentor guiding his or her student, often called a mentee. It is more than a traditional teacher/student relationship.

A mentoring relationship can occur at any phase of an individual's career, whether a new graduate, an experienced nurse assuming a nurse manager or clinical nurse specialist position, or an established clinician taking on a leadership position as the chairperson of a shared governance council (Hnatiuk, 2013). The relationship is a non-reporting one and replaces none of the organizational structures in place. It is additional to other forms of assistance, such as developmental assignments, classroom instruction, on-the-job training, and coaching.

Mentor was an Ithacan noble in Homer's *Odyssey*. A wise counselor to his friend Ulysses. Mentor was entrusted with the care, education, and protection of Ulysses' son, Telemachus (Johnson, 2002). In nursing, mentor is a talented nurse who is willing to share expertise and organizational insight in order to prepare the mentee for greater performance, productivity or achievement in the future (Henk, 2005). A good mentor has leadership experience, is available and responsive, believes in the capabilities of the mentee, has vision, knows how to access professional networks and seeks to enhance political awareness (Escobio, 2005). The mentee is a nurse with a desire to learn, a capacity to accept constructive feedback and coaching, an ability to identify personal and professional career goals, and a willingness to take risks. The mentee exhibits a desire for job success and seeks challenging assignments and new responsibilities. The mentee actively seeks the advice and counsel of an experienced nurse mentor.

In mentoring, trust must exist between both mentor and mentee. Each partner must be willing to devote time and energy to the mentoring process. A foundation of trust between both partners is the key to a successful mentor-mentee relationship.

Perspectives of mentoring in Nursing

Opportunities for nurse mentoring can be found in all areas of nursing: practice, education, administration and research. The clinical practice setting provides an excellent arena for an experienced nurse to share nursing insights with a novice nurse who is motivated to move forward quickly along the continuum from inexperienced novice to expert nurse. Mentoring is a relationship between two nurses based on a mutual desire for more developmental growth in nursing c**areer**.

Clinical experience plays an important role in developing nursing students' learning and in order to enhance clinical experience, it is important to provide students with appropriate supports and guidance. Student nurses benefit from being taught by a trained mentor and to receive practice based teaching relevant to their specific needs (Tichelaar, Riklikiene, Holland, Pokorna, Antohe, Nagy, Warne, & Saarikoski, 2013). When effective, the mentoring process has the ability to produce nurse educators who are committed, caring, well-qualified professionals dedicated to the development of the future generation of nurses and the advancement of the profession of nurses (Hubbard et al., 2010).Mentoring offers students of nursing the opportunity to develop into caring professionals through direct involvement with clinical practice in partnership with one's mentor, thereby reducing the theory practice gap (*Theobald, 2002*).

Model for the Practice of Mentoring

According to Wagner and Seymour (2007) in a Model of Caring Mentorship for Nursing, mentoring is a multidimensional relationship that energizes personal and professional growth

mentoring is about relationship and relationship building. It requires knowing self and committing self to another. The model represents two interacting elements. One element is the internal reflective work of knowing caring self (carer) on cognitive, affective, and transformative levels in relationship with others (the cared-for). The second element is the resulting actions of the carer that emanate from reflective levels, identified as task oriented, interactive, and transformative levels of caring for another. Each level is nonexclusive but rather a continuum of caring capacity.

The basic model of Development of Caring Nurse-Self is the basis for the more complex Caring Mentorship Model (Wagner and Seymour, 2007) which illustrates two people interacting. As the mentor (carer) and mentee (cared-for) begin to form their relationship, they come together as individuals with their own stored experiences, reflective questioning, and their capacity to grow in a mentoring relationship. This relationship needs nurturing and a reflective approach to mature. If the mentoring stays at the cognitive, task-oriented level for either one, there will be little to build connection. The potential of the caring relationship can be limited if the carer is stalled at the two lower levels. Each person enters the relationship with self and others with stored experiences from the past that shape present perspective and interactions. Reflection increases understanding and, thus, one's responsive caring for another.

There is a need to make the transition into a more affective realm of deeper personal understanding that leads to asking, "What am I feeling? Who am I? What relationship do I see?" Such reflective questions allow one to examine the relationship between self and another. This increase understanding of a more interactive caring capability where one sees self and other as distinctive individuals with some relational connection, then this brings two individuals in an interactive mentoring relationship with surface connections (Wagner and Seymour, 2007).

Furthermore, (Wagner and Seymour, 2007) indicated that in a transformative mentoring relationship with shared connections, two people's paths crossing and, in the meeting, an "interaction" occurs that acknowledges human presence and importance. There is a connection, an opportunity for caring exchange of self and life story, which can make a difference for the individuals in their separate ongoing journey, but the relationship does not reach its fullest potential. It does require a sense of self, of one's impact on another, and a willing presence and commitment to enter the relationship in a sharing and meaningful way creates an environment of respect, mutuality, and openness, inviting each to share perspectives and to learn from each other. There is a desire to meet again and continue the relationship. A more effective approach was tutoring the mentors to explore reflective activities with mentees individually.

True mentoring is aimed at the mentee's development not on solving specific problems. Increasing the students' motivation to participate, honoring mutual requests for mentor–mentee pairing, and adding the mentors' creative energy and peer support all increased commitment and relationship building, personal presence and shared self-space increased. Rather than focusing on specific problems, create a being together situation where the mentors and mentees shared time together in activities such as inviting the mentee to attend a conference with the mentor; checking in with a mentee on a clinical day; or just taking a walk. Each of these allows a more natural emergence of trust, respect, meaningful relationship, and problem sharing. The interspersed e-mails and telephone calls sustained the connection because each had entered the other's world in ways that had meaning (Wagner and Seymour, 2007).

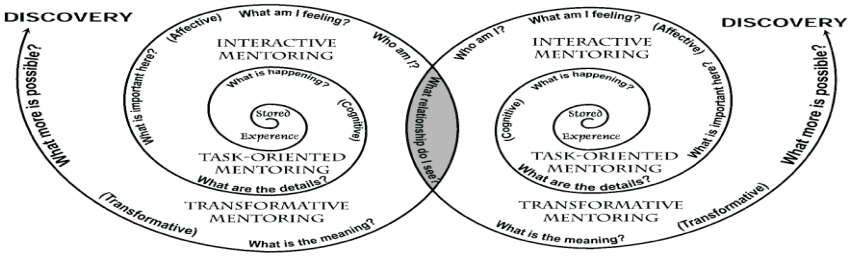
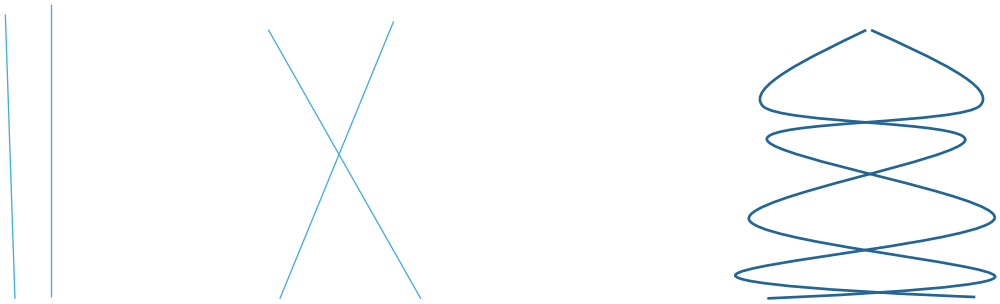


Fig. 1 Caring Mentorship Model (Wagner, 2005b) representing two individuals in a transformative mentoring relationship with shared connections



Separate stories, No relationship

interactive stories, but no binding relationship

co-creating stories, connection dynamic relationship

Fig. 2: Symbolic representation (from left to right) of task -oriented relationship, interactive relationship, and transformative relationship in caring for another (Wagner, 1998)

Features of mentoring

The following are features of mentoring:

i. Mentoring involves a voluntary and mutually beneficial relationship
ii. Purposeful activities that facilitate career development, personal growth, caring, empowerment, and nurturance that is integral to nursing practice and leadership
iii. The relationship that is based on mutual respect and common goals
iv. The process that is developed over time (Hodgson & Scanlan, 2013)

Phases of mentoring

According to Mentorship Resource Centre (2015), Mentorship is a learning relationship between two or more people, and it typically follows four phases:

Preparing

Negotiating

Enabling growth

Coming to closure

Preparing: This is a discovery phase when you find out if mentorship is right for you. The preparing phase is the discovery stage of the mentoring relationship. Discover your own personal motivation and readiness to be a mentor. Get to know your mentee and build rapport. Create a context for the learning partnership you and your mentee will build together

Negotiating: The business phase, when you help your mentee set learning goals. The negotiating phase is the business stage of the

mentoring relationship. Support your mentee by helping them create learning goals. Create a learning agreement with your mentee, to cover shared responsibilities and ground rules. Establish boundaries with your mentee

Enabling growth: This is working phase, when you support and provide feedback to your mentee. This phase is the work stage of the mentoring relationship – this is where mentors will have the most contact with their mentees. Support your mentee's learning and challenge their assumptions through one-on-one mentoring or mentor-led group work. Provide useful feedback to them to help them achieve their desired learning goals

Coming to closure: This is assessment stage, where you assess the value of your mentoring relationship and move forward. The coming to closure phase is the reflection stage of the mentoring relationship. Assess the value of your mentoring partnership. Identify areas of growth and learning. Celebrate the achievement of learning outcomes (Mentorship Resource Centre 2015).

Criteria for Matching Mentee/ Mentor

Accessibility, Approachability, Career interests, Gender sensitivity, Subject matter/experience, age, language, academic standing, personality, assumptions of mentoring, the mentor and mentee have something in common, there is mutual agreement to work together, there is mutual trust, there is clarity of purpose and both of them have the same focus

Mentoring strategies for professional growth

The focus of mentoring is to enhance individual development and professional growth. The mentor should employ the following strategies to achieve the aforementioned:

Motivate: A mentor should be able to motivate students by being enthusiastic about what he or she does. Motivating mentees involves actively engaging them in academic discourses on wide variety of issues of interest.

Cultural sensitivity: A good mentor should be culturally sensitive. Students from diverse background come with different stereotypes and attitudes which may affect mentoring relationship. A good mentor should not make sensitive remarks about a particular race or ethnic remarks that will affect mentee's academic performance or bring about a layback attitude.

Knowledge: The mentor must have very good knowledge of the subject matter and be able to communicate that knowledge to be effective.

Empower and encourage: The mentor should be able to take mentees to the next level of educational achievement. The reason for mentorship is to recreate oneself in another person. In other words, the mentor should be able to clone him/herself in the mentee.

Nurture self-confidence: A good mentor should inculcate and nurture self-confidence in mentees. Self-confidence should be nurtured in students through active engagements in research, clinical work, seminar presentations and other general academic activities.

Teaching by reflection: A good mentor should be able to deliver his or her services though a positive reflection, that is, “doing what you preach” and not otherwise. The mentor's background and life experiences have additional advantages to a successful mentorship (*Idemudia, 2013)*

Characteristics of a good mentor

A good mentor possesses the following qualities:

Knowledgeable and skilful: A good mentor is knowledgeable, skilful and willing to share skills, knowledge and expertise with mentee.

Role Model: Mentor acts as a positive role model. A good mentor exhibits the personal attributes it takes to be successful in the field. By showing the mentee what it takes to be productive and successful, they are demonstrating the specific behaviors and actions required to succeed in the field.

Personal interest in the mentoring relationship: Good mentors do not take their responsibility as a mentor lightly. They feel invested in the success of the mentee. Usually this requires someone who is knowledgeable, compassionate and possesses the attributes of a good teacher or trainer with excellent communication skills.

Exhibits enthusiasm in the field: A mentor who does not exhibit enthusiasm about his/her job will ultimately not make a good mentor. Enthusiasm is catching and new employees want to feel as if their job has meaning and the potential to create a good life.

Expertise in the mentee's area of need: They continually read professional journals and may even write articles on subjects where they have developed some expertise. They are excited to share their knowledge with new people entering the field.

Academic Giant"/Clinical Guru: Values ongoing learning and growth in the field. Mentors are in a position to illustrate how the field is growing and changing and that even after many years there are still new things to learn. Good mentors are committed and are open to experimenting and learning practices that are new to the field. They may choose to teach or attend classes to further develop their knowledge and skills.

Respected Senior Person Colleague: Ideally mentees look up to their mentors and can see themselves filling the mentor's role in the future. Mentees want to follow someone who is well respected by colleagues and co-workers and whose contribution in the field is appreciated.

Focused: A good mentor continually sets and meets ongoing personal and professional goals. Sets a good example by showing how his/her personal habits as reflected by personal and professional goals and overall personal success.

Respect the mentee: A good mentor values the opinions and initiatives of others. A good mentor appreciates the ongoing effort of the mentee and empowers him/her through positive feedback and reinforcement.

Motivator: Motivates others by setting a good example.

Benefits of Mentoring

Benefits to Mentee

Clarity of issues: issues related to life and career are understood better and handled with greater clarity and confidence.

New Insight into the profession: New insight is gained on the culture of the profession and her workplace. This leads to development of different perspective and cultural values about the profession and workplace.

Career satisfaction: Mentoring enhances mentee motivation about the choice of career and this on the long run leads to greater likelihood of job satisfaction, career success and professional development.

Enhanced self-esteem: The newly empowered nurse has high self-esteem which enhances ability to mentor another mentee and further professional development as the cycle continues.

Development of leadership skills: The experience of mentoring allows the mentee to gain insight into and develop leadership skills (Hodgson & Scanlan, 2013).

Benefits to Mentor

There are clearly a range of personal benefits that have the potential to arise from the experience of mentoring students. These include:

Enhances leadership and communication skills: The mentor is able to develop leadership and good communication skills

Psychological satisfaction: Personal satisfaction from aiding and abetting the developmental learning of another. This increases job satisfaction which further motivates mentor to continue with the job leading to retention.

Lasting legacy on health care: Mentoring enhances development of skilled nurses who are motivated to provide quality nursing care. This creates lasting legacy/ impact on the health care.

Self-development through reflective practice: As mentor promotes mentee professional development, the mentor is also becoming more grounded in the profession as further researches are made to pass down to the mentee through evidence based and reflective practices.

Expansion of a repertoire of professional skills: Mentoring enables the mentor to have expanded knowledge on skills such as teaching, facilitation, assessment and feedback. This further helps in career enhancement.

Handing over Nursing legacy to the young nurses: Always have young vibrant people around when his/her strength is becoming weary

Benefits to the Profession

Retention of quality nurses: Through mentoring job satisfaction and career development is promoted this in turn leads to retention of quality nurses

Sustainability of culture and values of the system: Retained nurses have interest of the profession in mind hence they are able to sustain the culture and values of the system they find themselves.

Quality care outcome: Quality care outcome is assured as tested and trusted professionals are developed and retained in the profession.

Better research output: As mentor and mentee are developing themselves, more research output are produced in field of nursing and related fields for evidence based practices.

Empower Profession: Talents and skills being transferred from nursing leaders contributes to the development and growth of the profession.

Challenges of Mentoring

Time consuming and tasking: Mentoring is time consuming as mentor has an assigned task to be performed. The mentee on the other hand is just developing, the mentor cannot move at the expected pace so as to be able to carry along the mentee, hence the mentor is slowed down.

Conflicts of interest: The mentor and mentee are having varied goals leading to clash of interest. This affects the pace of growth and achievement.

Inadequate preparation and support of mentors: At times the mentor may not be prepared for the mentoring role or even the organization may not be supportive of the mentoring activities (McCourt, 2012).

The way forward

According to McCourt (2012) the following are ways of resolving some of the challenges of mentoring. The mentors need and should seek more help and educational guidance in completing education Institutions' assessment documentation; The mentors should have regular updates and relevant in-service training and practice development managers and clinical practice facilitators should work with link lecturers to support **mentors**

Conclusion and Recommendations

A successful leader is one who has a successor. Mentoring process provides the opportunity to leave your steps visible long after your exit. The demand on the mentor may be high but the possible outcome for the mentees, their mentors, and professional development outcome makes it a worthwhile venture.

Mentoring has benefits to mentee, mentor and the profession. It provides a unique opportunity for nurses to influence and develop the practitioners of the future.

Structure formal mentoring program may be necessary for young nurses taking up internship position or employment. Renew orientation for thorough mentoring to build self-esteem to enhance quality nursing practice.

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