ADEA MENTORING PROGRAM MEMBER MANUAL

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Australian Diabetes Educators Association

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Chifley Community and Wellbeing Hub

6/70 MacLaurin Crescent

Chifley ACT 2606

PO Box 163

WODEN ACT 2606

ACKNOWLEDGEMENTS

The Australian Diabetes Educators Association (ADEA) established the Mentoring Program for its members in 2008. The aim of the Mentoring Program is to support members who are striving to achieve recognition as an ADEA Credentialled Diabetes Educator (CDE), to support CDEs who are transitioning to a new role in diabetes education and to offer a mechanism for professional development of leadership skills for existing CDEs.

The original mentoring pilot program was undertaken by Jan Alford, Shirley Cornelius and Jane Giles and ADEA thank them enormously for their future vision of the value of mentoring for CDEs.

A thank you for early contributions to the ADEA mentoring program also go to: Ann Nosworthy, Pam Grierson, Janine Wright, Wendy Pittick, Maree Diemel, Toni Wilson, Jane Adams, Chris Lester, Lauren Botting, Wendy Livingston, John Jones, Wendy Bryant, Gaye Renfrey, Jill Vincent, Jan Demaine, Jenny McWha, Mandy Frier, Jenny Matthews, Yve De Britt, Gail Westman, Nola McFarlane, Roger Lindenmayer, Fran Brown, Gloria Kilmartin, Narelle Harvey, Anne Muskett, Lois Bury, Sue Hayes, Ian Harmer, Linda Rennie, Gaynor Garstone, Helen Phelan, Kaye Neylon, Wendy Logan, and Jane Bullen.

The ADEA Mentoring Program was evaluated in 2015 and a summary of the findings and recommendations can be found on the ADEA website.

A review of the Mentoring Program has been undertaken by the ADEA Credentialling Committee in line with the program moving to an online format.

We acknowledge those responsible for this review and greatly appreciate their contribution: Elizabeth Obersteller, Jan Alford, Maxine Schlaeppi, Lynnette Randall, Wendy Bryant, Lisa Grice, Maggie Lasdauskas, Helen Phelan, Dianne Bond, Lauren Botting, Glynis Dent, Chris Lester, Lois Rowan, Rachel McKeown, Kerry Oddy, and Julie Mueller.

An ADEA mentoring partnership for the initial credentialling program is a formal professional relationship between a CDE (mentor) and a diabetes educator (mentee) to promote learning and development and to assist the diabetes educator through the credentialling process. The mentoring partnership must be active for a **minimum of six months.**
The mentoring partnership is a reciprocal relationship between both parties, with each partner bringing knowledge and skills that can be utilised to enhance the CDE role.

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INTRODUCTION

Background

The Australian Diabetes Educators Association (ADEA) promotes best practice in diabetes education and care through: conducting and commissioning research to establish evidence based standards for diabetes education and care; a planned and systematic approach to providing and supporting education, training and professional development for providers of diabetes education and care; and advocating for equitable access to quality diabetes education and care services for all people with diabetes.

ADEA has long been committed to a formal mentoring program as part of its activity in supporting both entry level practitioners and more experienced practitioners achieve their full potential as competent and expert providers of diabetes education and care. Mentoring has always been a core activity within the ADEA Credentialling Program.

In 2004, ADEA commissioned a review of other mentoring programs with a view to establishing its own program and in 2006 a pilot mentor and preceptor program was conducted. The ADEA Mentoring Program has been developed based on the key elements of successful mentoring programs as identified in the commissioned review and the lessons learnt from the ADEA pilot program. Since 2008 there has been a formal ADEA Mentoring Program.

Program Goals

The overarching goal of the ADEA Mentoring Program is to provide a structured mentoring program that is responsive to the changing career cycles and learning needs of ADEA members and that is tailored to the needs of geographically or professionally isolated diabetes educators, diabetes educators seeking initial credentialing or re-credentialling following lapsed credentialling, and credentialled diabetes educators who are transitioning from one career phase to another.

The specific objectives of the program are to:

- provide a structured framework to establish, support and monitor mentoring partnerships between diabetes educators seeking initial credentialling or re-credentialling following lapsed credentialling (mentees) and more experienced credentialled diabetes educators (mentors)
- promote mentoring as an activity that can form part of the ongoing cycle of professional development.

Target Groups

The ADEA Mentoring Program is available to Members of ADEA. Mentors for diabetes educators seeking initial credentialling or re-credentialling following lapsed credentialling are drawn from the ADEA membership and are ADEA Credentialled Diabetes Educators® (CDE's). Mentors for CDE's who wish to utilise a mentoring partnership as part of their ongoing professional development can be from any health profession relevant to the CDE's professional development needs.

In keeping with the above objectives, the following target groups have been identified for participation:

1. **Diabetes Educators seeking initial credentialling or re-credentialling following lapsed credentialling**. These participants should:

- be working in diabetes education and care. This may involve working in a position related to diabetes across clinical, management/administration and/or research
- have commenced or completed an ADEA accredited graduate certificate in diabetes education and management
- have completed the elearning mentee module on the ADEA website http://www.adea.com.au/credentialling/mentoring-program/online-mentoring-program/

2. **Current Credentialled Diabetes Educators**. These participants may:

- have taken on more complex and/or leadership roles
- be diversifying their practice or moving into a new practice area
- be transitioning from one career phase to another.

3. **Full Members of ADEA not eligible for ADEA Credentialling**. These participants should:

- be working in diabetes education and care. This may involve working in a position related to diabetes across clinical, management/administration and/or research.

WHAT IS MENTORING

Principles of Mentoring

Mentoring involves two parties and is a relationship between a less experienced and a more experienced worker.

Mentors are individuals with advanced job related skills and knowledge who are committed to facilitating their protégés skill development.[1]

A mentor is a guide, tutor, advisor and guardian. A mentor is not a preceptor or a coach.

While coaching or preceptorship is about setting and working towards structured learning outcomes with the coach taking a teaching role, mentoring is about facilitating another person's learning and personal development through role modeling and personal support.

The role of the mentor is an ongoing one - maybe even lifelong, while the role of coach or preceptor is generally limited to a specific timeframe with designated outcomes.[2]

Mentors must be able to assist mentees with career and professional development as well as personal support. They act as facilitators.

> *"A mentor may act as guide, teacher, coach, counselor, role model, sponsor or advocate, to pass on life experiences and knowledge in order to motivate, support and enhance the personal career development of the mentee. They should be approachable reasonable and competent and be committed to lifelong learning. Mentee characteristics in effective mentoring relationships include having a positive attitude to work or career, willing to take risks and to learn. Mentoring relies on both parties sharing trust respect and confidentiality as well as clear principles."*[3]

The mentor/mentee relationship is reciprocal. Although the mentor is a senior partner they should also take the opportunity to learn and develop with their mentee.

> *"An effective mentoring partnership is a two way street for sharing problems, information and higher work level through direct interaction."*[4]

[1] *Restifo V, Yoder L Partnership: Making the Most of Mentoring, Nursing Spectrum, University of Chicago Hospitals.*

[2] *Sarre D, Coaching vs Mentoring Bringing Clarity, Australian Institute of Management (SA Branch) Presentation 1st July 2004*

[3] *Restifo V, Yoder L Partnership: Making the Most of Mentoring, Nursing Spectrum, University of Chicago Hospitals.*

[4] *Indigenous and Public Health Media Unit, The Aboriginal and Torres Strait Islander Co-ordinated Care Trials National Evaluation Report Vol 2 1999, Department of Health and Aged Care, Commonwealth Government, Canberra.*

Mentoring Models

There are a variety of definitions and models for mentoring partnerships and programs. They may be:

- informal or formal partnerships
- operate in a one to one or group environment
- may be conducted face to face, by telephone or email or in other e-learning environments
- based on a traditional model of a more senior and experienced mentor and more junior and less experienced mentee or on a peer learning partnership. The former model tends to be more common at the early stage of a career in a particular field while the latter model may be more useful at later career stages.

Mentoring versus Preceptoring and Supervision

All practitioners will be familiar with supervisory relationships or situations where, as novices, practitioners are coached to attain competence with respect to a particular area of practice. While there are elements that are common to successful outcomes for both types of relationships, there are distinct differences between the two relationships. The following table highlights some of the common elements and key differences between these two relationships.

Table 1 Australian Mentor Centre. Mentoring and Preceptoring – A Snapshot of the Differences and Similarities

ITEM	MENTORING	SHARED	PRECEPTORING
Focus	**Profession/career focus** (stimulate, guide and reflect)	Interpersonal and communication skills ~ Resource, network and information advisor ~ Clinical competence and career pathway knowledge ~ Motivating and encouraging skills – role model ~ Goal setting and planning skills ~ Reflective and practice skills ~ Coaching and teaching skills ~ Emotional intelligence awareness	**Skills/clinical/placement focus** (demonstrate, monitor and assess)
Driver	**Internal (Mentee's Needs)** (mentoring partnerships are generally driven by the needs of the mentee, which in turn drives the roles and boundaries of the partnership)		**External (Competency Needs)** (preceptoring partnerships are generally driven by the need of the student to attain competence – so the competency becomes the driver of the partnership)
Participation	**Voluntary/optional** (preferred – ideally mentor and mentee have choice to participate in mentoring and in the mentoring process)		**Mandatory/required** (generally – may be a required part of a formal or structured education, registration or credentialing process)
Communication	**Face-to-face or distance** (may use a combination of communication methods)		**Face-to-face** (generally face-to-face – may include technology based tele-health)
Duration	**Longer or shorter term** (may extend over a number of years OR be limited by the needs of the mentee)		**Shorter term** (normally limited to the duration of clinical placement or related activity)
Choice	**Choice of mentor** (opportunity to choose own mentor or have guided choice)		**Assigned preceptor** (preceptor assigned – preceptor and student may have very little choice in the partnership)
Supervision and Assessment	**No supervision or assessment involved** (generally mentors are not required to supervise or assess – this changes the dynamics of the partnership; mentors are generally not line supervisors)		**Supervision and assessment may be involved** (preceptors may be involved in direct line supervision and assessment of the student's clinical or related competencies)

The most significant difference between the two relationships is that in a mentoring partnership, there is no supervision or assessment of competence involved. Indeed, the dynamics of the partnership may be destroyed if this is the case. Mentors are generally not line supervisors.

(***Note***: With respect to the ADEA Credentialling Program, mentors may choose to also act as their mentee's referee when the mentee is preparing a credentialling application. However, the mentor and referee roles are distinct and it is not required that the same person fulfils both roles. Neither party should expect that these roles are fulfilled by the same person. ***Mentees who are working towards credentialling and their mentors should establish and confirm such expectations at the start of their mentoring partnership.*** Mentors may assist mentees identify an appropriate alternative referee.)

Benefits of a Mentoring Program

The benefits of mentoring programs are wide ranging. Mentoring relationships are not only of benefit to the mentee who has sought the partnership but also to the mentor. The benefits also extend beyond the individual partnership to employers and to the organisational capacity of ADEA to achieve its strategic objectives.

Benefits to Mentors

- obtain new perspectives, opinions
- extend networks
- increase awareness of own skills and understanding of role
- enhance problem solving and communication skills
- refresh own perspective of profession
- gain additional recognition and respect
- meet challenges and feel sense of achievement
- give something back to the profession
- contribute to the future of diabetes education and care
- develop confidence and advanced skills
- attain re-credentialling points.

Benefits to Mentees

- enhance knowledge and skills
- increase confidence in skills
- achieve or sustain job satisfaction

- gain employment, promotion or feel sufficiently supported to stay in field or job role
- extend networks
- improve role definition
- transfer knowledge to practice
- attain competence against National Core Competencies for Credentialled Diabetes Educators
- gain recognition as a Credentialled Diabetes Educator
- feel empowered.

Benefits to Employers

- retain staff
- reduce recruitment and selection costs
- enhance service delivery
- develop services to best practice standards through benchmarking
- improve communication within organisation
- enhance management and problem solving skills
- develop networks for collaboration
- increase access to resources and information for both clients and professional staff.

Benefits to ADEA

- expand and retain diabetes education and care workforce
- contribute to improved health care and best practice in diabetes education and care
- increase member satisfaction
- increase numbers of Credentialled Diabetes Educators
- increase number of Credentialled Diabetes Educators with advanced skills
- build individual and organisational capacity to lead change.

HOW THE ADEA MENTORING PROGRAM OPERATES

The ADEA Mentoring Program was formally introduced in 2008.

Role of the ADEA National Office

The ADEA Mentoring Program is supported by the ADEA National Office.

The ADEA Mentoring Program Member Manual is available to ADEA Members wishing to participate in the ADEA Mentoring Program. It is available for download from the ADEA website.

Both mentors and mentees who have used tools and resources they have found valuable in their mentoring partnerships are encouraged to send these to the ADEA Credentialling Officer for posting on the ADEA website Mentoring Program page.

Relationship to ADEA Credentialling Program

Participation in a mentoring partnership over a **minimum** period of six (6) months is a mandatory requirement for applying for recognition as a Credentialled Diabetes Educator. All applications for initial credentialling require demonstrated participation in a formal registered mentoring partnership.

Relationship to ADEA Re-credentialling Program

Mentoring is a key component of professional development and constitutes one aspect of the leadership demonstrated by Credentialled Diabetes Educators. Participation in a mentoring partnership, either as a mentor or mentee, is a key category within the ADEA Re-credentialling Program. All claims for re-credentialling points for acting as a mentor will require that the mentoring partnership for which points are claimed is a partnership registered with the ADEA National Office. Ad hoc contacts will not count towards re-credentialling points within the Mentoring Category.

Registration of Mentors

Credentialled Diabetes Educators who wish to become Mentors for initial credentialling must undertake the elearning mentor module and then register as a mentor by filling in the registration form and be approved by the ADEA. Both the modules and the registration form are available at http://www.adea.com.au/credentialling/mentoring-program/

Within this programn, Mentors can elect to have their details posted on the Mentor Register on the ADEA website.

Please note: Mentors do not have to be part of the ADEA Mentor Register on the ADEA website that is publicly available. This is optional for Mentors who would like to express their availability those looking for a mentor in diabetes. Mentees may seek their mentors via the register or by contacting their Branch Executive or through their own personal networks; however ALL Mentors for initial credentialling and any partnerships that would like to claim CPD points for re-credentialling must be registered with and approved by ADEA.

Registration and Monitoring of Mentoring Partnerships

A register of mentoring partnerships will be maintained by the ADEA National Office. All mentor / mentee partnerships that seek recognition by ADEA for the purposes of initial credentialling or claiming re-credentialling points must submit a jointly signed Mentoring Agreement. The template can be found by visiting the ADEA website. The date of signing is regarded as the starting date for the mentoring partnership.

At the completion of a mentoring partnership, both mentor and mentee are required to independently submit a Notification of Completed Mentoring Partnership and Evaluation Form. The form can be found by visiting the ADEA website

Both mentor and mentee should retain a copy of both the Agreement Form and Notification of Completion forms as evidence of their participation in a mentoring partnership if they wish to claim credentialling or re-credentialling points.

The register will be monitored by ADEA National Office. Where mentoring partnerships are still 'active' (Notifications of Completion have not been submitted – after twelve (12) months), the mentor and mentee will be contacted by the ADEA National Office to determine the status of the mentoring partnership.

Promotion of the Mentoring Program

The ADEA Mentoring Program will continue to be promoted through:

- ADEA credentialling and re-credentialling programs
- *Australian Diabetes Educator*
- ADEA website
- coordinators for ADEA accredited courses
- ADEA annual report.

Monitoring and Evaluation of the Mentoring Program

The following performance indicators have been identified for the ADEA Mentoring Program:

- number of mentoring partnerships registered with ADEA
- nature of mentoring partnerships registered (entry level diabetes educators seeking credentialling, existing CDEs seeking mentoring, others seeking mentoring)
- percentage of registered partnerships that are completed to satisfaction of both mentor and mentee
- number of registered partnerships that are voluntarily dissolved
- goal attainment within mentoring partnership
- participant satisfaction with mentoring program.

Regular reports will be provided to the ADEA Board and Membership against these performance criteria.

Who can be a Mentor?

Mentors must be currently Credentialled Diabetes Educators of at least 12 months standing.

Before registering as a potential mentor with ADEA or before entering a mentoring partnership, Credentialled Diabetes Educators should familiarise themselves with the ADEA Mentoring Program and read Roles and Responsibilities of Mentors and Mentees (Resource II) and Characteristics of Effective Mentors (Resource III). It is also a requirement that they must have completed the online elearning mentor module for Mentors.

Duration of Mentoring Partnerships

Mentoring partnerships should be maintained for a minimum of six (6) months in order to be claimed for in respect of the ADEA Credentialling and Re-credentialling Programs. Mentoring partnerships may be extended for longer periods by mutual agreement between the mentor and mentee.

Conflict Resolution and Dissolution of Mentoring Partnerships

ADEA members assume responsibility for their own mentoring partnerships. Suggestions for exploring contributing reasons for unsatisfactory partnerships are provided in Resource VIII. If partnerships are terminated, mentors and mentees should notify ADEA National Office using the Notification of Completed Mentoring Partnership and Evaluation Form .If mentors or mentees believe there has been a serious breach of professional behaviour during the mentoring partnership, they should use the ADEA Complaints Process.

ADEA National Office Contacts

The ADEA Mentoring Program is monitored by the ADEA Credentialling Officer (cde@adea.com.au) and supported by the ADEA Professional Services Manager (po@adea.com.au).

HOW TO INITIATE AND PROGRESS A MENTORING PARTNERSHIP

It is anticipated that the majority of mentoring partnerships will be initiated by the mentee. The following stepped approach is written predominantly from the mentee's perspective. However, both mentors and mentees should be guided by the following steps to ensure that their partnership progresses satisfactorily and meets ADEA requirements for credentialling and points claims.

Familiarise yourself with the ADEA Mentoring Program

- read the ADEA Mentoring Program Member Manual
- talk to other ADEA members who have previously been involved in the program
- complete the online elearning module for Mentees
- contact the ADEA National Office if you have further queries.

Find a Mentor

- reflect on your reasons for entering a mentoring partnership

- read Roles and Responsibilities of Mentors and Mentees (Resource II)
- read Characteristics of Effective Mentors (Resource III)
- identify possible mentors by checking the register of available mentors on the ADEA website or contacting your Branch Chairperson (Note: you can also approach Credentialled Diabetes Educators that you know)
- contact possible mentors and have an informal discussion to ascertain your interest in, and their willingness to progress a partnership. Ensure you clearly communicate your reasons and purpose for wanting a mentoring relationship. If you are working towards credentialling, clarify with your mentor if you want them to, and if they are willing to act as your referee
- have your prospective mentor register as a mentor with ADEA
- have your prospective mentor complete the online elearning module for Mentors.

Formalise and Register your Partnership

- once your prospective mentor has been deemed a suitable mentor by ADEA, complete a Mentoring Agreement. This is a jointly signed agreement. The date the Mentoring Agreement is signed is deemed to be the starting date for the mentoring partnership
- submit the Mentoring Agreement to the ADEA National Office. It is the responsibility of the mentee to submit the Mentoring Agreement ***within two (2) weeks*** of signing the Mentoring Agreement
- discuss with your mentor and agree on when, how and where (if face to face) you will meet and the proposed frequency of your contact. It is highly recommended that contact allocation be a **minimum 1 hour per month.**

Establish Learning Objectives and Document Professional Development Plan

- reflect on your current practice to identify broad focus areas where you would like to develop your knowledge, skills or competence
- discuss these areas with your mentor and begin documentation of your professional development plan
- identify and document your goals, objectives and strategies. Ensure they are SMART (Resource IV – SMART Goals).

Maintain a Reflective Practice Journal

- see Reflective Practice (Resource V)
- reflective practice journals are for personal use and are not required to be submitted but may be useful as evidence in the event of auditing.

Maintain a Record of your Contact and Progress against your Professional Development Plan

- establish an agreed format for documenting your mentoring partnership

- maintain a record of all contacts. It is suggested that at a minimum the date, duration, focus of the discussions, next meeting date and agreed activities before next meeting are documented. A record of contact will be especially important if either party is audited during re-credentialling.

These records are to be submitted as a part of your initial credentialling application online.

Close the Mentoring Partnership

- review attainment of your goals with your mentor and document outcomes in your professional development plan and/or reflective practice journal
- agree with mentor / mentee to close the mentoring partnership
- submit your Notification of Completed Mentoring Partnership and Evaluation to the ADEA National Office.

Complete Credentialling or Re-credentialling Professional Development Records

- upload or enter your log of contacts on the Credentialling or Re-credentialling Professional Development Record for your credentialling application
- upload copies of the Mentoring Agreement and the Notification of Completed Mentoring Partnership and Evaluation to your credentialling application
- upload your certificate of completion for the online elearning module to your credentialling application.

RESOURCES TO SUPPORT MENTORING PARTNERSHIPS

The following resources have been developed as part of the ADEA Mentoring Program or contributed by ADEA members from their experience in acting either as mentors or mentees.

All ADEA members are encouraged to submit tools or resources that they have found useful in mentoring partnerships to the ADEA Credentialling Officer for posting on the ADEA website.

RESOURCE I – BEST PRACTICE AND LINKS TO MENTORING

Best Practice

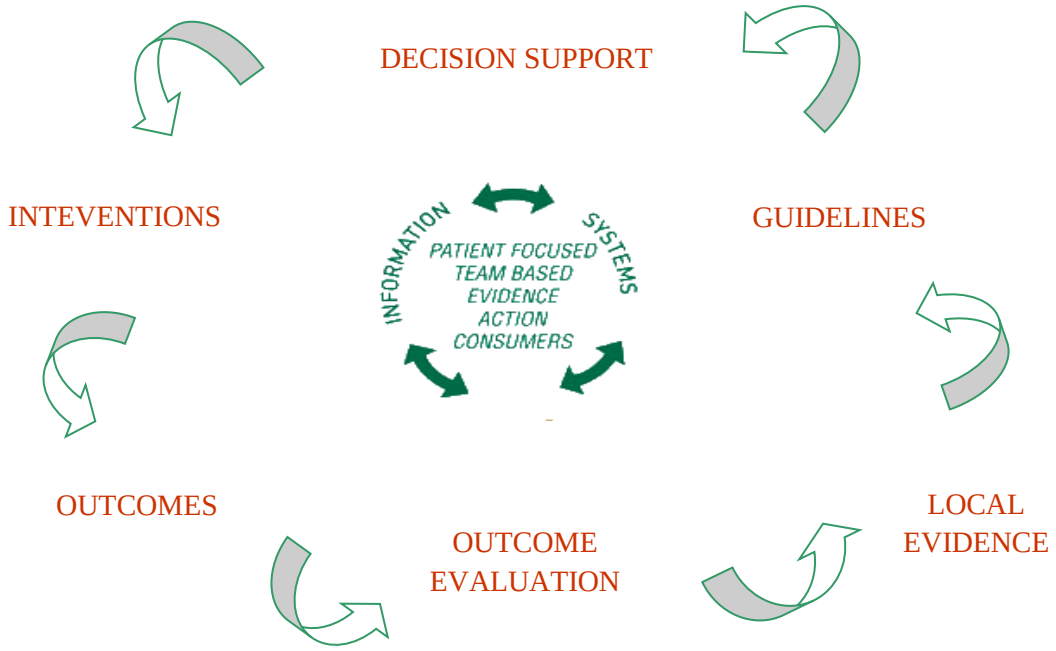
Butler et al write, "Best practice is the pursuit of excellence in service delivery".[5]

Best practice is evidence based. It uses agreed and recognised guidelines for care delivery, and it is supported by effective decision support and information systems, which enable objective evaluation of care outcomes.

Such guidelines are usually developed by experts in the field using their combined knowledge and expertise and are agreed and endorsed by a learned group of people (eg Australian Diabetes Educators Association).

Following the provision of health care interventions the provider, using best practice principles, evaluates the outcomes for the consumer and if not satisfied that the consumer has achieved the best possible outcome from the intervention, investigates how practice can be improved.

Improvements that are identified are then incorporated into revised care guidelines.



The model above demonstrates how the components of best practice fit together to provide patient centered, team based care in which consumers participate in the decision-making processes.

The model demonstrates that *information systems* are a key component in delivery of best practice.

5 Leigh J, Wong P, Philips P, Mortimer H. The Clinical Support Systems Program The Medical Journal of Australia May 2004:180 (10Suppl):S74-S75

In order to be able to evaluate care, providers must ensure that they keep accurate, comprehensive records that follow a consistent format. This does not mean that they must have sophisticated computer systems (although this can help). It means that they should always use the same systems for collecting and recording patient data and for *evaluation of outcomes*.

Therefore assessment tools need to be consistent with agreed care *guidelines* and they need to be validated and accepted by the profession in which they work.

Consistent assessment tools and intervention guidelines provide a *decision support* system for the care provider, likewise for outcome measuring tools.

When outcomes are measured they can be used to contribute to the local body of professional knowledge (*local evidence*). They become validated when the same outcome is shown consistently for a group of consumers over a period of time.

If these outcomes are different than those expected they could be used to modify the care guidelines firstly at a local level and then perhaps more broadly.

In summary:

- best practice has a measurable impact
- it is the result of partnerships between service providers, care recipients and the community
- it is socially, culturally, economically and environmentally sustainable
- best practice is a key management tool.

The Links between Best Practice and Mentoring

In today's health care environment the delivery of best practice interventions is based on the use of evidence based guidelines. The implementation of a mentoring program assists in the promulgation of guidelines. Mentors can provide support and advice for mentees in understanding and following guidelines and evaluating service delivery against expected outcomes. As experienced health care practitioners, mentors can then assist mentees in the development of improved local guidelines if evaluation demonstrates that this is appropriate.

Through mentoring, organisations such as the ADEA can ensure that published guidelines (such as *Guidelines for Subcutaneous Injection Technique)* are implemented and their use evaluated. Mentees can discuss the difficulties they may have with implementation with their mentor and the more experienced mentor can discuss solutions and advise on modification if these are appropriate.

Through mentoring the mentee is supported to develop confidence, skills and judgment. Mentoring can assist in diminishing professional isolation experienced by many specialist allied health and nursing professionals (especially in rural and remote areas).

The diminution of clinical/professional isolation should lead to improved retention within the professions and the networking engendered by mentoring should lead to improved quality of practice.

(Above extracted from *Principles of Mentoring and Best Practice – A Briefing Paper* prepared for ADEA by Ann Nosworthy Consulting)

RESOURCE II – ROLES AND RESPONSIBILITIES OF MENTORS AND MENTEES

Mentors' role and responsibilities

The mentor's role is to listen, provide constructive feedback and help their mentee consider options. They may refer them to resources and facilitate decision making and share their own experiences. They might help to identify areas for development, coach their mentee and allow opportunities to practice new skills. They may be a sounding board, ask questions to cause further exploration for ideas or to challenge their mentee's thinking. They provide guidance, not direction, and do not solve problems but act as a collaborator in the problem solving process.

Primary responsibilities you have as a mentor include:

- maintaining confidentiality
- being accessible
- listening actively to your mentee
- promoting responsible decision making
- motivating and supporting your mentee to achieve their goals
- ensuring a professional relationship
- acting as a role model
- recognising when it is time to relinquish the mentoring role.

Mentee Responsibilities

Mentees can approach their mentors to discuss issues and ideas. They may want feedback or advice or a chance to debrief. Through the questioning of the mentor, the mentee may achieve a greater clarity about a situation or see a different perspective

Whatever is discussed, however, it is the mentee who makes the decisions and takes any actions required. The mentee is responsible for their decisions and actions.

Good mentees are:

- motivated
- proactive
- open minded
- self-directing
- introspective
- self-disciplined
- enthusiastic

Mentees typically want:

- advice on career paths/options
- to learn how to develop maximum potential
- assistance in forward thinking
- to set career goals and strategies for achieving them
- to expand networks and broaden horizons
- to learn new skills
- a person who has been successful to use as a role model

- communicative
- appreciative.

- to raise their profile
- to get the big picture view
- to develop better life perspective – balance work and home
- awareness of promotional opportunities
- help with job applications
- access to a variety of resources.

RESOURCE III – CHARACTERSITICS OF EFFECTIVE MENTORS

An effective mentor has been described as one who:

M- Manages the relationship

E-Encourages

N-Nurtures

T-Teaches

O-Offers mutual respect

R-Responds to the Mentee's needs.[6]

M	**Manages the relationship**	• Has high level self-management skills • Is assertive • Has good knowledge of the organisation • Models effective leadership and management skills • Has excellent interpersonal skills.
E	**Encourages**	• Motivates others • Is a good role model • Able to provide clear objective feedback.
N	**Nurtures**	• Able to promote personal growth • Has ability to maintain work-life balance • Acknowledges need to maintain health • Respects higher goals, values and spiritual needs.
T	**Teaches**	• Able to undertake needs assessment • Able to facilitate learning • Provides resources.
O	**Offers mutual respect**	• Accepts differences in values, interests etc.
R	**Responds to Mentee's needs**	• Does not seek to impose advice on the basis of one's own needs.

[6] *Clutterbuck, David. (1985) Everyone needs a mentor. Institute of Personnel Management, Bugbrooke, UK.*

RESOURCE IV – SMART GOALS

Your learning plan forms the foundation for your mentoring partnership. Even if your learning plan is 'a work in progress', it is better to have a plan that changes over time to meet changing needs and circumstances than to have no plan at all. Having a clear picture of your overall goals, shorter term objectives and the proposed strategies to achieve them, provides not only the pathway to achieving goals but also a means of evaluating your success in achieving goals. Develop your learning plan, including goals, objectives and strategies, in partnership with your mentor.

Goals – What you want to achieve

Objectives – What you need to do to achieve your goal

Strategies – How to achieve your objectives.

Be SMART

S – Specific

M – Measurable

A – Achievable

R – Realistic

T – Time framed

Examples:

- 'I want to develop my project planning skills.'

  Becomes SMART by:

  'By 15 December, I will have produced a written plan for Project X, identifying the aims, objectives, implementation strategies, required resources and evaluation strategies.'

- 'I want to learn how to deal with difficult co-workers.'

  Becomes SMART by:

  "Over the next 3 months I will develop 4 different approaches to deal with difficult co-workers. I will use these approaches and, using reflective practice, will analyse and evaluate each approach.'

What type of goals?

The following list describes some areas in which learning goals may be set:

- knowledge and skills development in specific areas of practice
- development of attitudes that help in the workplace
- problem solving or project planning skills
- career orientation
- service implementation or development.

Consider ...

Utilise ADEA publications and guidelines as the basis for developing your learning goals. For example:

- conduct a self assessment against the ADEA *National Core Competencies for Credentialled Diabetes Educators* or the ADEA *National Standards of Practice for Credentialled Diabetes Educators*
- conduct an audit of your service against the ADEA *Clinical guiding principles for subcutaneous injection technique*
- reflect on your practice in relation to the Domains of Practice for *Credentialled Diabetes Educators identified in The Role and Scope of Practice for Credentialled Diabetes Educators in Australia.*

RESOURCE V – REFLECTIVE PRACTICE

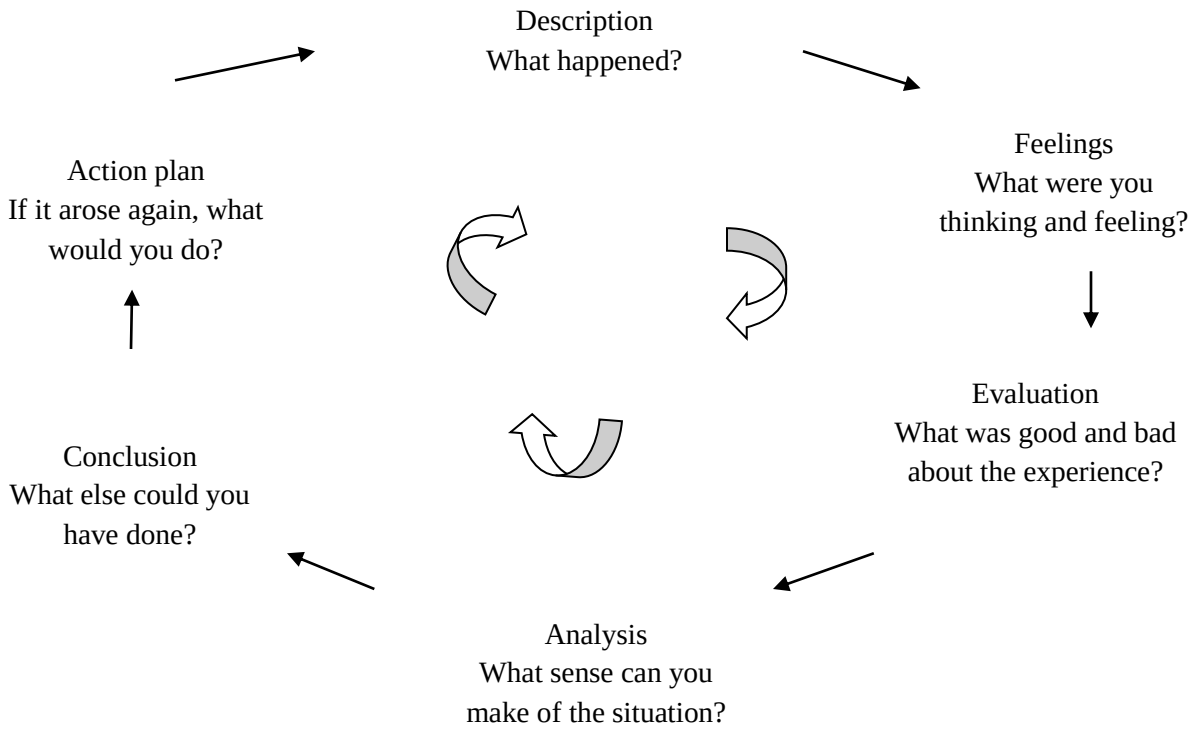
Mentees are encouraged to actively maintain a reflective practice journal during their mentoring partnership.

What is reflective practice?

... more than just thoughtful practice. It is the process of turning thoughtful practice into a potential learning situation. It is the utilisation of good theory in practice ... and is always trying to ensure that the outcome of any action is close to what is anticipated by the theory and the previous experience combined.[7]

Reflective practice is an active process. Reflective practice diaries generally relate to reflection on events, incidents, situations, actions taken or not taken, with a view to improving future practice. The following cyclical model provides a framework for approaching reflective practice.

Reflective Practice Cycle[8]



[7] Jarvis, P. *Reflective Practice and Nursing*. Nurse Education Today, 1992: Vol 12; pp 23-30.

[8] Gibbs, G. *Learning by Doing: a guide to teaching and learning methods*. 1988: Further Education Unit, Oxford Polytechnic. Oxford.

Reflective practice is reliant on memory and interpretation of events. Mentees may want to discuss particular issues with their mentors to seek an alternative interpretation or perspective and use information gained as part of the reflective process.

Characteristics of reflection

- practical wisdom
  - translating knowledge into practice
- reflexivity
  - looking back and reviewing development
- becoming mindful
  - window to look inside one's self
- commitment
  - energy to make change
- contradiction
  - tension between visions of practice and current practice
- understanding
  - making good judgement
- empowerment
  - to take action based on insights and developing a voice.

RESOURCE VI – MEASURING MENTOR POTENTIAL

Darling was one of the early workers in the mentoring field. The following table can be used by both mentors and mentees to assess mentor potential. It can also be used by mentors to reflect on those characteristics that they may like to develop during their time as a mentor.[9]

Characteristics of effective mentors

Key characteristics of mentors are that they be successful professionals who are committed to their careers and to supporting the advancement of promising persons in the profession. They need to be accessible, but the contact does not need to be face-to-face. Some relationships may be conducted by correspondence, telephone, or email.

Mentors should be able to:

- clearly communicate the reasoning behind advice to mentees, helping them to think and perform as professionals
- communicate knowledge by explaining difficult problems or concepts in an understandable way
- encourage mentees to feel free to ask questions, especially in new or difficult situations where an inexperienced person may lack confidence
- provide guidance and remain available in stressful situations
- be honest and direct about performance.

Other ingredients of a successful mentor relationship are:

- attraction – admiration, a desire to emulate, an inspirer, a modeller, envisioner, energiser
- action – undertaken on the mentee's behalf, a successful mentor is an investor, who believes in the mentee and communicates that belief, who invests time and energy through teaching, guiding, helping development (different things are valued by different mentees)
- affect – a successful mentor is a supporter who provides respect and encouragement.

Darling developed a self-administered questionnaire for practitioners to measure their mentoring potential based on the three essential features of the mentor-mentee relationship she identified (see table – A guide to measuring mentor potential). This tool can be used as a prompt for health professionals selecting a potential mentor and for those who have been asked to act as a mentor to assess their own capacity and preparedness for the role. It is not intended as a quantitative rating tool.

Acknowledgement: *Mentoring - A Guide for Accredited Practising Dietitians*. DAA 2002.

[9] *Darling LAW. What do nurses want in a mentor? J Nursing Admin. 1984 Oct;42-4*

1. Model	1 2 3 4 5	'I'm impressed by her ability to...'; 'really respected her...'; 'admired her...'
2. Envisioner	1 2 3 4 5	'Gave me a picture of what nursing can be'; 'enthusiastic about opportunities in...'; 'sparked my interest in...'; 'showed you possibilities'
3. Energiser	1 2 3 4 5	'enthusiastic and exciting'; 'very dynamic'; 'made it fascinating'
4. Investor	1 2 3 4 5	'spotted me and worked with me more than other nurses'; 'invested a lot in me'; 'saw my capabilities and pushed me'; 'trusted me and put me in charge of a unit'; 'saw something in me'
5. Supporter	1 2 3 4 5	'willing to listen and help'; 'warm and caring'; 'extremely encouraging'; 'available to me if I got discouraged and wondered if I was doing the right thing'
6. Standard-Prodder	1 2 3 4 5	'very clear what she wanted from me'; 'pushed me to achieve high standards'; 'kept prodding me if I allowed myself to slacken off'
7. Teacher-Coach	1 2 3 4 5	'taught me how to set priorities'; 'to develop interpersonal skills'; 'guided me on patient problems'; 'said: 'let's see how you could have done it better'
8. Feedback-Giver	1 2 3 4 5	'gave me a lot of positive and negative feedback'; 'let me know if I wasn't doing right and helped me to examine it'
9. Eye-Opener	1 2 3 4 5	'opened my eyes, got me interested in research'; 'helped me understand the politics of the hospital'; '... why you had to look at the total impact something has on the hospital'
10. Door-Opener	1 2 3 4 5	'made in-services available'; 'included me in discussions'; 'said 'I want you to represent me on this committee; this is the information, this is our view'; 'would delegate to you'
11. Idea-Bouncer	1 2 3 4 5	'bouncing things off her brings things into focus'; 'eloquently speaks for professional issues; I like to discuss them with her'; 'we would discuss issues, problems and goals'
12. Problem-Solver	1 2 3 4 5	'let us try new things and helped us figure it out; always had a pencil and calculator'; 'we looked at my strengths and created a way to use them to benefit nursing'
13. Career-Counsellor	1 2 3 4 5	'got me started on a 5-year career plan'; 'I went to her when I was trying to sort out where I wanted to go in my career'; 'I could trust her'
14. Challenger	1 2 3 4 5	'made me really look at my decisions and grow up a little bit'; 'she'd challenge me and I'd be forced to prove my point; I found out if I believed what I recommended'

RESOURCE VII – CRITICAL SKILLS FOR DEVELOPING AND MAINTAINING A MENTORING PARTNERSHIP

Phases in the mentoring partnership

Initiation – initial contact, time to define the relationship, set its parameters. Building rapport is a key element.

Development – focus is on goals and tasks, care needs to be taken to avoid over-dependence, mentor helps mentee discover options. Active listening, questioning and providing appropriate feedback are all important.

Maturity – mentee becomes autonomous, mentor becomes less critical; development of the mentee has peaked.

Disengagement – need for relationship is less evident; acknowledgement of the end of the relationship is important.

Redefinition – if need to or want to redefine the relationship.

Critical skills

- building rapport
- active listening
- questioning
- providing feedback.

Building rapport

Rapport builds the foundation for any relationship. Mentors must be objective and non-judgemental. This does not necessarily mean agreeing on everything. Honesty, openness and confidentiality, along with the skills listed below, are all important characteristics that help build and maintain rapport.

Listening

Use active and reflective listening. *Active listening* involves choosing to concentrate attention and expend energy on communication. It demonstrates your interest in the speaker and encourages them to communicate with you.

Reflective listening involves reflecting back to the speaker. It can mean more than paraphrasing and repeating the speaker's message. It can allow you to explore and examine incongruence between verbal and non-verbal messages.

Questioning

The purpose of questions is to draw out information and gain clarity. It is important that your mentee doesn't feel interrogated or that they are being judged. If they feel that they have to justify themselves, they may block communication which, in turn, could prevent them considering alternatives.

Tips for better questioning

- rephrase questions to avoid beginning with a 'why'
- ask one question at a time and wait for the answer
- ask questions that prompt deep thinking
- seek to promote insight
- ask about, and listen for, feelings as well as facts
- respond to non-verbal communication with feedback
- use non-verbal communication to keep questions from sounding interrogative
- move from general to specific
- challenge assumptions and generalisations.

Sample questions to try

Career discussion

- what is most important to you in your life and work
- what career options have you considered
- what are you best at and enjoy doing most
- what are your career goals
- are there any constraints for you in planning your career?

Skills development discussion

- what changes are you likely to need to deal with in the near future
- what results would you like to achieve, that you are not achieving now
- what new skills do you want to develop
- what knowledge, information or qualifications do you need to acquire in the near future.

Probing – getting the person to talk more

- can you say a little more about...
- would you expand on that idea
- perhaps you'd like to tell me...

Cushions – softening a confronting question

- do you mind if I ask...
- I'm wondering...
- it seems that...
- would you like to tell me....

Providing Feedback

Feedback is an important part of the learning process. It can be used to motivate and improve performance and most people perform better after receiving feedback. However, before providing feedback, reflect on how you have felt when you have been praised or criticised in the work place. What encourages you, or otherwise?

Components of effective feedback

- based on mutual trust and given in a supportive environment
- given at a time when the receiver is able to accept it
- presents specific descriptions of behaviour or performance, not broad generalisations
- focuses on behaviours that can be modified
- includes plans for developing existing and new skills.

Providing positive feedback does not mean that you cannot point out errors but it does mean that you should:

- find something positive to praise
- make positive suggestions for improvement
- make valid criticisms of a person's work
- share ideas and information rather than give advice
- explore alternative solutions rather than providing answers
- avoid overloading with too much feedback
- make sure the time and place are appropriate.

Giving advice

Be cautious about giving advice. Sometimes advice given prematurely will prevent the real issue being discovered and resolved.

Advice that sounds like a recommendation may detract from the mentee taking responsibility for their decisions and actions. What worked for you may not work for them.

Telling your mentee what you think they should do provides little opportunity for learning to take place.

Consider who bears the responsibility if you advise a course of action that brings unintended negative consequences.

Use anecdotes, examples and metaphors – they are more powerful tools to impart wisdom.

Problem solving

Try the following problem solving approach with mentees:

- define the problem, distinguishing between facts and assumptions
- specify objectives and determine desired outcome
- develop options and alternative actions
- evaluate options, considering positive and negative aspects, before deciding the most appropriate action
- take action and implement the decision
- evaluate and review outcomes.

RESOURCE VIII – DEALING WITH AN UNSATISFACTORY MENTORING PARTNERSHIP OR CONFLICT

Mentoring partnerships are by definition collaborative partnerships, with the mentor and mentee being accountable to each other in defining and working towards mutually agreed goals. Within the ADEA Mentoring Program, mentors are not allocated to mentees. Rather, mentors and mentees establish their own partnerships. Like all partnerships, mentoring relationships are not always successful. They may fail due to reasons ranging from availability of resources to interpersonal relations.

The preceding resource material has been provided to assist ADEA members develop effective partnerships. Should either partner in the mentoring relationship feel dissatisfaction, they should take responsibility for their feelings and, in the first instance, reflect on their role and activity in the partnership to date. If on reflection, the issue remains unresolved, the mentor / mentee should openly, clearly and empathetically communicate their feelings to their mentor / mentee. The view of the other partner should be sought and a problem solving approach be taken to identifying a 'win – win' solution. Partners may wish to *redefine the relationship* or *disengage from the partnership* (see *Phases in the Mentoring Partnership*).

If either or both parties want to terminate the partnership, this should be clearly communicated to the other partner and a mutual agreement about termination reached. The partnership should not just be allowed to 'fizzle out'. While this may be a disappointing outcome for both parties, it is better to end the partnership on mutually agreed terms and move on, avoiding a 'blame' situation.

NOTE: If a partnership is terminated, both parties should complete the Notification of Completed Mentoring Partnership and Evaluation and forward this to the ADEA National Office.

The following tips for mentors and mentees were developed as part of the Dietitians Association of Australia (DAA) Mentoring Program. They provide some additional useful tips to promote effective partnerships or to explore possible reasons for dissatisfaction in either party.

Tips for Mentees

- be honest and open, express your needs and what you see as your strengths and weaknesses as clearly as you can
- be reasonable in your expectations
- don't always assume that the mentor will be available to, or will be comfortable with, providing the help you want when you want it
- keep your mentor advised of your likely needs of their time, especially if there are peaks and lulls in your schedule
- don't make demands; assert your learning needs or what you expect the mentor to do. Present options so you can get advice on the best action you can take yourself
- allow space for your mentor to consider, discuss and respond to your needs in their own way

- it is generally a good idea to keep the partnership business-like. Even if you are discussing personal issues and emotional responses, seek advice that will help you move forward rather than seeking a regular dose of sympathy
- do your 'homework' by preparing for your discussions
- you are responsible for the documentation of your partnership, not your mentor
- recognise and acknowledge the support and guidance you receive
- if you are not comfortable with the way your partnership is working out, let your partner know early. Don't assume that the other will be aware of what is concerning you. You can probably find ways around any problems or if not, you can avoid wasting each other's time by terminating the arrangement amicably.

Tips for Mentors

- the detail of mentoring discussions should be confidential unless the parties agree otherwise
- don't over-commit yourself or allow mentees to do it for you. Be assertive of your needs as well as recognising theirs
- effective mentors help mentees find their own solutions to their problems by helping them talk it through, look at it another way, or try options or resources they hadn't considered
- avoid being a lecturer, a supervisor, or an assessor. It is an adult-to-adult relationship and the mentee, must make and stand by their own judgements. You are not responsible for what the mentee does nor are you required to comment to others about their competency
- mentees are often in a time of significant change – professionally, personally and socially. Be conscious of the overall picture and support and encourage rather than lead from the front or expect too much, too soon
- keep mentees advised of your availability, let them know if you will be away or, if you are busy at the time, make another time to talk
- carefully review any documentation, eg forms or written learning objectives. Ensure, as well as you are able, that mentees are fully exploring the opportunities and challenges that the work environment presents
- refer mentees to others in your network or to resources you know of when appropriate
- if you are not comfortable with the way your partnership is working out, let your partner know early. Don't assume that the other will be aware of what is concerning you. You can probably find ways around any problems, or if not, you can avoid wasting each other's time by terminating the arrangement amicably.

Acknowledgement: *Mentoring - A Guide for Accredited Practising Dietitians*. DAA 2002.

RESOURCE IX – CASE STUDIES

The following two case studies have been provided by ADEA members. They demonstrate two key points:

1. Distance is not a barrier to an effective mentoring partnership. Wendy Pittick and Maree Diemel participated in the ADEA Pilot Mentoring Program. The pilot also contained a preceptor / preceptee arm. Wendy and Maree participated in this capacity. Wendy highlights some of their key strategies for developing an effective partnership.

2. Credentialled Diabetes Educators can develop innovative strategies for meeting the potentially increasing requests of them to act as mentors. Cheryl Steele describes how she developed a group process for providing mentoring to a number of diabetes educators working towards credentialling.

Preceptoring Partnership and 1600 kilometres – Wendy-Lee Pittick RN CDE, Western Australian Country Health Services – SW Bunbury Hospital

The one day ADEA Mentoring /Preceptoring Pilot Workshop left me with many questions and some intrigue as to how all this theory would really fit in the real world. That world was the possibility of entering a partnership with a colleague who potentially could be living any where within Australia and that posed the question "would the distance be a barrier" to building a successful outcome.

My experience strongly confirmed the answer to be 'No – distance was not a barrier.' My preceptee, Maree Deimel, lived 1600 km's north of me and my work place in the south west of Western Australia. Phone and email technologies allowed us to reach our goals. The key elements contributing to the success of my very positive and rewarding experience of preceptoring included:

- realistic, practical, attainable goals that were creatively tracked on a planning sheet initiated by Maree
- having the commitment to make regular phone link ups at a realistic time of day (usually first thing in the morning). These varied from between 30 to 60 minutes
- booking the next phone meeting at the end of the previous call – initiated by preceptee
- maintaining a progressive time sheet that included start time, finish time, main topics covered and the next appointment. This was my responsibility and emailed promptly after each meeting
- an openness to provide positive constructive feedback and reflection.

Participating in the pilot highlighted many opportunities to promote the values, resources and advantages to having a professional membership with the ADEA.

In addition to the above my tips for successful future preceptoring or mentoring relationships include:

- develop a program learning agreement – this provides each party with a clear understanding of each other's goals and provides a basis for withdrawal if the goals of each party do not match up
- stay focused on realistic goals and time frames.

This very positive experience is one that I'd highly recommend to fellow colleagues.

Providing a Group Mentoring Program – Cheryl Steele RN CDE, Manager Diabetes Education Services, Western Hospital, Footscray, Victoria

As the manager of Diabetes Education Services in the largest Acute Hospital Network in the Western Suburbs of Melbourne the number of diabetes educators (DEs) asking to be mentored has been increasing markedly over the past twelve months. Most of these educators are employed in Community Health Centres. They are usually employed as the sole DE in their centre. Working as a sole practitioner limits the opportunity for these educators to obtain guidance whilst gaining experience in the workplace.

The workload for DEs working in acute health is also increasing dramatically which challenges us all to find ways of using our time in the most effective ways. Providing guidance and mentorship to beginning practitioners in the community is vital. Having experienced and competent DEs in the community provides a referral pathway for patients from the overstretched acute sector to a quality source of ongoing education in the community.

In March 2007 a group mentoring session was held at Western Hospital in Footscray. Six DEs who were seeking mentorship toward becoming credentialled attended the meeting. Another Credentialled Diabetes Educator who was in private practice also attended as a means of assisting her efforts to gain points for her re-credentialling. At this initial meeting we discussed and set the objectives for the group. In order to ensure that the members of the group met the requirements for credentialing at the end of the sessions we familiarised ourselves with the requirements for initial credentialling. We decided that at least 4 group sessions would be required to meet our goals. These sessions would occur approximately each 6 weeks and would include achieving set tasks, discussing case studies and sharing knowledge and experience. In addition members of the group would attend the Western Metropolitan Diabetes Educators Journal Club and keep regular email and phone contact with the Mentor. Each member of the group would also spend at least 24 hours seconding a member of the Western Health Diabetes Educator Team in order to familiarise themselves with the provision of diabetes education in an acute setting. This also allowed the community DEs to meet the endocrinologists working in the area and build relationships with the acute sector.

The first task given to the group was to develop a personal learning plan which would include at least three objectives which each candidate would aim to achieve by the end of the sessions.

In the second meeting each member of the group discussed their learning goals with their peers and provided time lines in which they hoped to achieve their goals. There was discussion around identifying potential barriers to reaching the desired goals within a reasonable time frame. Each member of the group was asked to prepare their CV prior to the next meeting.

At the third meeting each member brought a copy of their CV. The group discussed the necessary components of a CV to address the needs of credentialling. Items had to include such things as scope of practice in their role as a DE.

At the final meeting each member brought their portfolio to check the points tally in each of the compulsory categories for initial credentialling. Tips were provided on the set up of the portfolio and placing items into the relevant categories.

At the conclusion of the fourth meeting three of the group felt that they had met the requirements to apply for initial credentialling. The remainder of the group still needed to complete the necessary 1800 hours of employment in the role of DE prior to being able to submit their application.

All members of the group reported that they found the group mentoring process helpful. The discussions held around referral pathways between acute and community settings; the discussions around management of difficult clients and helpful tips provided by more experienced DEs were considered most helpful by the group. The group also enjoyed the guidance with setting out their credentialing applications. From my personal and professional perspective, I have gained a lot from running the program as well. I now have DEs employed in Community Health Centres within my area who feel confident to manage clients knowing that backup is a phone call or email away should they need it.

To date four more DEs have approached Western Hospital looking for mentorship during 2008. We have decided to run another group program. I would strongly urge other CDEs to consider providing mentorship to their peers seeking to become credentialled.

RESOURCE X – BENEFITS OF A MENTORING PROGRAM

Members may like to copy this resource for their employers to support their case participation in a mentoring program.

Benefits of a Mentoring Program

The benefits of mentoring programs are wide ranging. Mentoring relationships are not only of benefit to the mentee who has sought the partnership but also to the mentor. The benefits also extend beyond the individual partnership to employers and to the organisational capacity of ADEA to achieve its strategic objectives.

Benefits to Mentors

- obtain new perspectives, opinions
- extend networks
- increase awareness of own skills and understanding of role
- enhance problem solving and communication skills
- refresh own perspective of profession
- gain additional recognition and respect
- meet challenges and feel sense of achievement
- give something back to the profession
- contribute to the future of diabetes education and care
- develop confidence and advanced skills
- attain re-credentialling points.

Benefits to Mentees

- enhance knowledge and skills
- increase confidence in skills
- achieve or sustain job satisfaction
- gain employment, promotion or feel sufficiently supported to stay in field or job role
- extend networks
- improve role definition

- transfer knowledge to practice
- attain competence against National Core Competencies for Credentialled Diabetes Educators
- gain recognition as a Credentialled Diabetes Educator
- feel empowered.

Benefits to Employers

- retain staff
- reduce recruitment and selection costs
- enhance service delivery
- develop services to best practice standards through benchmarking
- improve communication within organisation
- enhance management and problem solving skills
- develop networks for collaboration
- increase access to resources and information for both clients and professional staff.
- expand and retain diabetes education and care workforce
- contribute to improved health care and best practice in diabetes education and care
- increase member satisfaction
- increase numbers of Credentialled Diabetes Educators
- increase number of Credentialled Diabetes Educators with advanced skills
- build individual and organisational capacity to lead change.

NOTES