

**Committing to Mentorship: Nurse Managers' Perceptions of their Roles in Creating
Mentoring Cultures**

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By Noelle Kimberly Rohatinsky RN, BSN, MN, PhD(c)

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Abstract

Nursing employees are drawn to healthy work environments and the nursing unit manager plays a key role in establishing and maintaining a positive workplace culture. Employee mentoring is one strategy that has been found to contribute to healthy work environments and thus facilitates recruitment and retention of staff. However, very little research exists that explores the nurse manager's role in creating a mentoring culture on the nursing unit. The purpose of this study was to develop a theory of nurse managers' perceptions of their roles in creating a mentoring culture on the nursing unit. The objectives included: (a) exploring managers' perceptions of their role in creating a mentoring culture, (b) discovering the processes of creating a culture of mentoring, and (c) exploring the organizational features supporting and inhibiting this process of developing a mentoring culture. Glaserian grounded theory methodology was utilized for this study and the core variable of "Committing to Mentorship" emerged. Knowledge of mentoring gained from this study may assist to sustain the healthcare system by creating and enhancing quality workplace environments through increasing job satisfaction and recruitment and retention of highly skilled individuals and creating positive workplace experiences for staff and students. Ultimately, the implementation of knowledge gained from this study may assist to produce positive patient outcomes and patient satisfaction by constructing and nurturing a culture of learning and safety.

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Chapter 1

1.1 Introduction

Healthy work environments are integral to the recruitment and retention of nursing employees, and the nursing unit manager is essential in creating this milieu. Employee mentoring is one method that has been found to contribute to healthy work environments and thus serves as a means of recruiting and retaining staff (Greene & Puetzer, 2002; Laschinger & Finegan, 2005; Wagner, 2006). However, little research exists that explores nurse managers' roles in creating a mentoring culture on the nursing unit. The purpose of this study was to develop a theory of nurse managers' perceptions of their roles in creating a mentoring culture on the nursing unit in order to expand the nursing knowledge base related to mentoring. Developing an understanding of nurse managers' roles in creating a mentoring culture may assist healthcare leaders to create positive work environments for nursing staff that aid in their recruitment and retention. This chapter provides an overview of the problem, a description of the study purpose and objectives, and a discussion of the relevance and significance of the study.

1.2 Background and Statement of the Problem

Nationally and internationally there has been great interest in health human resource planning and healthcare organizations are concerned with recruitment and retention of their employees (Canadian Institute of Health Information [CIHI], 2007; World Health Organization, 2006). Various associations and government agencies have proposed strategies to assist with the endeavour of recruiting and retaining healthcare professionals. For example, suggestions have been made to create and sustain quality workplaces not only to attract and retain registered nurses, but also to improve their health and well-being (Canadian Nurses' Association [CNA], 2007; Registered Nurses Association of Ontario [RNAO], 2006, 2010; Ross, 2009). Other

strategies proposed have been to support workplace transition and to provide opportunities for continuing education and professional development (CNA, 2007; RNAO, 2006, 2010; Ross, 2009). Mentoring has been found to aid in the recruitment and retention of employees through targeting each of the aforementioned strategies, thus fostering registered nurse development and facilitating a positive work environment (Greene & Puetzer, 2002; Laschinger & Finegan, 2005; Wagner, 2006).

Grossman (2007) defined mentoring in nursing as "...a guided, nonevaluated experience, formal or informal, assigned over a mutually agreed-on period of time that empowers the mentor and mentee to develop personally and professionally within the auspices of a caring, collaborative, and respectful environment" (p. 2). Mentoring relationships are dynamic, mutually beneficial, learning relationships between a more experienced person (a mentor), and a less experienced person (a protégé or mentee) (Johnson & Ridley, 2008; Zachary, 2005). In this study, the less experienced individual is described using the term *protégé*.

Yonge, Billay, Myrick, and Luhanga (2007) identified that the terms mentorship and preceptorship were often confused. For clarity, the term preceptorship was defined as "... a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role" (CNA, 1995). The novice may be a student or practising nurse (CNA, 1995, 2004). While the concepts of mentorship and preceptorship overlap, Billay and Yonge (2004) differentiated that mentorship consisted of a collegial, nurturing relationship, whereas preceptorship focused on teaching and learning of the novice. Myrick, Caplan, Smitten, and Rusk (2011) recognized that preceptorship was the term commonly used for practicum experiences in undergraduate nursing education. For the context of this study, mentorship is

referred to as the collegial relationship between registered nurses, whereas preceptorship is referred to as the formal relationship between a registered nurse and a nursing student. Few studies have been conducted that investigate nurse managers' perspectives of the nature of mentorship in nursing and more specifically, of their role in creating a mentoring environment for registered nurses on hospital units.

1.3 Purpose and Objectives

The *purpose* of this study was to develop a theory of nurse managers' perceptions of their roles in creating a mentoring culture on the nursing unit. The *objectives* included: (a) exploring managers' perceptions of their roles in creating a mentoring culture, (b) discovering the processes in creating a culture of mentoring, and (c) exploring the organizational features supporting and inhibiting this mentoring culture. More specifically, the *research questions* were: (a) What are managers' perceptions of a mentoring culture and their roles in creating it? (b) What processes are involved in creating a mentoring culture?, and (c) What are the organizational features supporting and inhibiting a mentoring culture?

1.4 Relevance and Significance of the Study

The researcher explored an in-depth understanding of nurse managers' roles in creating a mentoring culture within a healthcare context. Because of the variety of settings in which these managers worked, the results from this study can apply to most areas in the healthcare environment for mentoring. This study builds upon and strengthens knowledge of mentoring from nurse managers' perspectives and contributes to a more comprehensive knowledge base. Because much of the empirical mentoring literature is from the business context, there is limited empirical evidence specific to the area of mentoring in nursing. Although similarities exist in business and healthcare organizations, these contexts are not the same.

Mentorships in business traditionally involved an upper-level executive serving as the mentor, and a lower-level employee as the protégé; both may have been from different departments. Some of the goals of the relationship in the business context were protégé job promotion, increased salary, and exposure to advantageous projects (Allen, Eby, Poteet, Lentz, & Lima, 2004; Young & Perrew, 2004). Conversely, in healthcare environments, mentors and protégés were commonly equal-status peers who worked on the same nursing unit (Ronsten, Andersson, & Gustafsson, 2005). The intent of mentoring in nursing often related to the development of practice knowledge and the integration of the newcomer into the practice setting. Thus, the goals for protégés in the healthcare environment and business were different due to the nature of the environment and the contextual factors of each discipline. Because differences were noted and because of the limited empirical literature on mentoring in nursing, this current study can be considered a substantive contribution to advancing the nursing knowledge base related to mentoring from a Canadian healthcare system perspective.

Knowledge of mentoring gained from this study may enhance first line nurse managers' understanding of their roles in creating mentoring environments for employees. This mentoring knowledge may also assist managers in creating and enhancing quality work environments through increasing job satisfaction of registered nurses, increasing recruitment and retention of skilled individuals, and creating positive workplace experiences for registered nurse staff and nursing students. Ultimately, the implementation of knowledge gained from this study may help to produce positive patient outcomes and patient satisfaction by constructing and nurturing a culture of learning and safety in the healthcare workplace.

Chapter 2

2.1 Literature Review

The researcher undertook an evaluation of the literature prior to commencing the study. She discusses healthy work environments, their characteristics and outcomes. There is an examination of nurse managers' roles in creating healthy work environments. In addition, the researcher provides an overview of mentoring including a discussion of mentoring outcomes, benefits, negative experiences, characteristics, phases, and types. The researcher also describes the connection between healthy work environments and mentoring. There is a discussion of the role of nurse managers as leaders and creators of mentoring cultures. Finally, the researcher identifies gaps in the literature.

2.1.1 Healthy Work Environments

From an employee perspective, a healthy work environment can be defined as a workplace characterized by the following attributes: promotion of the physical and mental well being of staff, job satisfaction among employees, active recruitment and retention strategies, low turnover, positive inter-staff relationships, opportunities for professional development, clinical leadership, and participation in decision making (Pearson, Laschinger, Porritt, Jordan, Tucker, & Long, 2007). These components were similar to some of the “magnet hospital” designation characteristics in the United States (Kramer & Schmalenberg, 2004). In Saskatchewan, Ross (2009) proposed that in order to recruit and retain nurses, quality workplaces needed to be created.

Considerable research has been conducted on the influence of nurses' work environments on nurse and patient outcomes (Aiken et al., 2001; Aiken, Clarke, & Sloane, 2002; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken & Patrician, 2000; Lake, 2002). The previous

research has made a substantial contribution to knowledge in this area. However, one component that was not addressed in these foundational research initiatives was the influence of mentoring on nurse and patient outcomes.

2.1.1.1 Characteristics of healthy work environments. There were several characteristics that contributed to healthy work environments including: staff participation in decision making, collaborative relationships with nurse managers, physicians that support nurse autonomy, opportunities for professional development, staff reward and recognition, and appropriate staffing protocols (American Association of Critical Care Nurses [AACCN], 2005; American Organization of Nurse Executives [AONE], 2003; Kramer & Schmalenberg, 2002). One important characteristic of a quality workplace was staff engagement and participation in decision making (AACCN, 2005; AONE, 2003; Ross, 2009). Including staff members who were directly affected by a change in the decision making and the implementation of the change was essential for its successful integration (Canadian Nursing Advisory Committee, 2002; Grossman & Valiga, 2009; Heath, Johanson, & Blake, 2004; Kovner, Brewer, Wu, Cheng, & Suzuki, 2006). Furthermore, encouraging staff to be involved with various ward and health region committees helped promote the creation of healthy work environments through engagement of staff (Parsons, Cornett, & Golightly-Jenkins, 2006; Ross, 2009).

Previous research revealed that nursing staff believed that mutually collaborative relationships among staff members, physicians, and nurse managers facilitated a positive work environment and increased job satisfaction (AACCN, 2005; Domm, Donnelly, & Dietrich-Leurer, 2007; Heath et al., 2004; Kalisch, Lee, & Rochman, 2010; Kramer & Schmalenberg, 2002; Kovner et al., 2006; Parsons et al., 2006). A sense of teamwork, where all members of the team were valued, respected, and recognized for their views, was integral in fostering a healthy

work environment (Heath et al., 2004; Kramer & Schmalenberg, 2004). When nurse-physician relationships were considered collegial and there was mutual respect for all team members, nurse autonomy was more reasonably facilitated (AONE, 2003; Kramer & Schmalenberg, 2002, 2004). In these healthy work environments, nurses can become empowered, and as a result, the professional status of nursing can become enhanced (AACCN, 2005; AONE, 2003).

Another characteristic contributing to quality work environments was found to be the opportunity for and encouragement of professional development and education for nurses (AONE, 2003; Canadian Nursing Advisory Committee, 2002; Kramer & Schmalenberg, 2002, 2004; Parsons et al., 2006; Ross, 2009). In particular, Baumann et al. (2001) called for increased mentoring and professional development of nurses; they further recommended that employers create learning environments for staff where they could participate in educational activities and mentoring programs. Kramer and Schmalenberg (2004) also discussed peer evaluation as a method to promote continuing professional development among nursing personnel. To encourage professional growth, AONE (2003) suggested utilizing professional development tools to assess individuals' competencies and work related learning needs, and to provide a method to implement and evaluate learning goals among staff.

Recognition and reward of staff contributions and involvement also influenced staff perceptions of a healthy work environment (AACCN, 2005; AONE, 2003; Baumann et al., 2001; Domm et al., 2007; Smith, Hood, Waldman, & Smith, 2005). Baumann et al. (2001) suggested that reward and recognition be given to nurses who acted as preceptors or mentors. It was recommended that a culture of appreciation, which reflected the multigenerational and multicultural aspects of the workforce, be engrained in the organization (AONE, 2003). AONE

(2003) also suggested that individual and group achievements contributing to organizational goals be recognized and rewarded with financial and other incentives.

Appropriate staffing was another characteristic of healthy work environments. Staffing assignments that matched patient needs with nursing staff expertise and abilities helped promote a healthy work environment (AACCN, 2005). AACCN (2005) recommended that nurse-patient ratios were not solely used to determine the appropriateness and adequacy of staff when caring for patients because patient acuity and staff experience also played a role in this determination. AACCN further stated nurses must play an active role in implementing and evaluating staffing-model tool effectiveness in order to contribute to healthy work environments (AACCN, 2005).

2.1.1.2 Outcomes of healthy work environments. If healthy work environments were established and maintained, several positive outcomes resulted. Perceived job satisfaction of nurses was a key outcome (Domm et al., 2007; Hall, 2005; Kramer & Schmalenberg, 2004; Race & Skees, 2010; Ross, 2009; Smith et al., 2005; Upenieks, 2003). Nurses also described an increased perception of professional fulfillment in a positive work environment (Kramer & Schmalenberg, 2008). Furthermore, retention of nursing staff and decreased turnover were also noted as common outcomes (Cohen, Stuenkel, & Nguyen, 2009; Domm et al., 2007; Hall, 2005; McGillis-Hall, Lalonde, Dales, Peterson, & Cripps, 2011; Ross, 2009). In addition, healthy work environments supported nurses to be less stressed and prevented burnout (Hall, 2005).

2.1.1.3 Nurse manager's role in establishing healthy work environments. In order to ensure patient safety, to promote quality patient outcomes, and to meet the dynamic demands of the healthcare environment, nurse managers must continually scan their unit environments to make certain that healthy work environments were established, supported, and maintained (Hanson, Fahlman, & Lemonde, 2007; Heath et al., 2004). Nurse managers were found to be

integral in establishing and maintaining positive work environments (Heath et al., 2004; Kane-Urrabazo, 2006; Manion, 2005; Ross, 2009; Stordeur & D'Hoore, 2006). Staff-perceived supervisor support was significant in influencing a healthy work environment and in bolstering retention for nurses (Cohen, Stuenkel, & Nguyen, 2009; Kovner et al., 2006; Kramer, Schmalenberg, & Maguire, 2004).

Systematic research reviews showed that a transformational leadership style on nursing units was most commonly associated with healthy work environments (Cummings et al., 2010; Marriner-Tomey, 2009; Pearson et al., 2007). Transformational leadership was described as a style and a process where employees were inspired, motivated, and engaged in the environment (Grossman & Valiga, 2009; Sullivan & Decker, 2009). In these environments, employees tend to be committed to and take ownership of the vision of the unit, while exhibiting their own leadership characteristics (Grossman & Valiga, 2009; Sullivan & Decker, 2009). Within this type of leadership, nurse managers involved staff in decision making, readily communicated with them, and established a trusting environment for learning (Grossman & Valiga, 2009). These characteristics allowed for healthy work environments to be created and maintained.

Schein (2004) defined culture as learned, shared basic assumptions of a group that were passed down to new members. Organizational culture acted as a guide for members to allow them to understand what was valued within the organization and how to guide their behaviours based on those values (Scott-Findlay & Estabrooks, 2006; Wooten & Crane, 2003). Nurse managers were primarily responsible for nurturing this positive organizational culture through the use of their leadership skills (Stordeur & D'Hoore, 2006).

2.1.2 Mentoring

The concept of mentoring has been investigated at length in the business and organizational behaviour literature (e.g., Allen, Eby, & Lentz, 2006b; Allen et al., 2004; Bryant & Terborg, 2008, Eby & Lockwood, 2005; Joiner, Bartram, & Garreffa, 2004; Payne & Huffman, 2005; Van Emmerik, 2004a, 2004b). Conversely, mentoring from a nursing perspective continues to be relatively novel and there is a limited empirical literature base on mentoring in nursing (e.g., Beecroft, Santner, Lacy, Kunzuman, & Dorey, 2006; Halfer, Graf, & Sullivan, 2008; Jakubik, 2008; Jakubik, Eliades, Gavriloff, & Weese, 2011; Latham, Hogan, & Ringl, 2008; Newhouse, Hoffman, Suflita, & Hairston, 2007; Wolak, McCann, Queen, Madigan, & Letvak, 2009). By contrast, anecdotal and thematic literature on mentoring in nursing abounds (e.g., Barnard, 2002; Block, Claffey, Korow, & McCaffrey, 2005; Burr, Stichler, & Poeltler, 2011; Cottingham, DiBartolo, Battistoni, & Brown, 2011; Greene & Puetzer, 2002; McKinley, 2004; Tourigny & Pulich, 2005; Woodard-Leners, Wilson, Connor, & Fenton, 2006). Empirical and anecdotal nursing literature on mentoring in hospitals focused on evaluating mentoring programs. Areas in mentoring that have been investigated in both the business and nursing environments included outcomes and benefits of mentoring, negative mentoring experiences, characteristics of effective mentors and protégés, the roles and responsibilities of each individual in the mentorship, phases of mentorship, and types of mentoring. Each researched area will be discussed.

2.1.2.1 Outcomes of mentoring. Mentoring was viewed as mutually beneficial because positive outcomes have been reported for both mentors and protégés. In business and nursing environments, mentors reported increased personal fulfillment, career success and satisfaction, increased creativity, learning and development of leadership skills, and greater feelings of

generativity (Bozionelos, Bozionelos, Kostopoulos, & Polychroniou, 2011; Eby & Lockwood, 2005; Greene & Puetzer, 2002; Johnson & Ridley, 2008; McKinley, 2004). Protégés described increased socialization and acceptance in the organization, decreased stress, increased confidence and competence, and assistance with career planning and psychosocial support (Eby & Lockwood, 2005; Greene & Puetzer, 2002; Johnson & Ridley, 2008).

2.1.2.2 Benefits of mentoring for employees. The identified benefits of mentoring were investigated largely in business environments. Mentoring has been shown to enhance job satisfaction and reduce burnout under adverse working environments (Allen et al., 2004; Van Emmerik, 2004a). Additionally, employees that had a network of mentors obtained more positive career outcomes including career success and job satisfaction (Dawley, Andrews, & Bucklew, 2010; Eby, Allen, Evans, Ng, & DuBois, 2008; Kay, Hagan, & Parker, 2009; Van Emmerik, 2004b). Mentoring programs and relationships, in both nursing and business organizations, were found to create a positive work environment for staff, and acted as a retention strategy for both new and experienced employees (Allen et al., 2004; Dawley et al., 2010; Eby, Durley, Evans, & Ragins, 2006; Joiner et al., 2004; Halfer et al., 2008; Latham et al., 2008; McKinley, 2004; Newhouse et al., 2007; Payne and Huffman, 2005; Woodard-Leners et al., 2006; Zachary, 2005). The personal learning that participants acquired through the mentoring relationship positively influenced job satisfaction and had a reduced effect on intent to leave and turnover (Lankau & Scandura, 2002). Furthermore, mentored protégés were found to be more committed to the organization, expressed greater job satisfaction, and declared greater intentions to stay in the position, as compared to their non-mentored counterparts (Allen et al., 2004; Okurame, 2009).

Bryant and Terborg (2008) posited that peer mentoring was essential for knowledge sharing between staff, and that it was a method for fostering knowledge creation in the

workplace. Peer mentoring promoted a culture of learning and knowledge generation amongst staff. Raabe and Beehr (2003) identified peer mentoring as more effective in reducing turnover and promoting job satisfaction and organizational commitment than did traditional hierarchical mentoring relationships. Informal mentoring was suggested as a method for generating a continuous knowledge life-cycle in organizations (Karkoulian, Halawi, & McCarthy, 2008). That is, informal mentoring assisted knowledge sharing and utilization within the organization. Explicit and tacit knowledge were readily created, shared, and applied in daily decision making activities (Karkoulian et al., 2008). In addition, Kim (2007) proposed that formal mentoring had the potential to foster leadership development among employees in the workplace. Mentors were informal leaders in the work environment, and role modeled leadership behaviours for the protégé, provided psychosocial support needed to develop the protégé into an informal leader, and provided career development opportunities that fostered informal or formal leadership development (Kim, 2007). CNA (2009) also believed that mentorship was integral in developing nurse leaders. Because the healthcare environment was highly demanding and in a constant state of flux, fostering leadership development in registered nurses was seen as essential in dealing with the challenges encountered within the hospital organization (Grossman & Valiga, 2009).

2.1.2.3 Benefits of mentoring for organizations. Research from the business environment indicated that organizations benefited from employees engaged in mentoring relationships. For example, organizations were more effective when mentoring was present because new employees understood what values and behaviours were expected of them and what they could expect from the organization (Singh, Bains, & Vinnicombe, 2002). Mentoring built relationships and thus humanized the workplace wherein a caring organization was perceived, thus increasing employee job satisfaction (Verplanken, 2004; Zachary, 2005). Singh et al. (2002)

studied employees' perceived benefits of mentoring to the organization and found that there were human resource benefits including accelerated development of staff, groomed future leaders, and increased diversity of employees. Furthermore, culture and change benefits were noted because mentoring appeared to aid in the management of change, provided stability in times of change, and strengthened organizational culture. Finally, communication benefits were described as mentoring assisted with communication and facilitated socialization of employees into the organization more quickly (Singh et al., 2002).

Horvath, Wasko, and Bradley (2008) found organizations that offered formal mentoring programs were more likely to attract potential employees than those that did not do so. An organization with a mentoring culture promoted personal and organizational productivity, creativity, growth and development, and learning (Zachary, 2005). Because relationship skills were developed and strengthened through mentoring in the organization, employees became more committed to the organization (Bozionelos et al., 2011; Zachary, 2005). The research showed that overall informal and formal mentoring relationships were beneficial for the mentor, protégé, and the organization. If these benefits were as applicable to the nursing unit and healthcare organization as they were to business environments, then knowledge could be shared amongst nurses, leaders could be developed within the unit, nurses could become more committed to the organization, the work environment could be enhanced, and nurses could be more effectively recruited and retained on the unit.

2.1.2.4 Negative mentoring experiences. Not all mentoring relationships were positive ones. Because mentoring was typically based on the relationship between two individuals, most negative mentorship experiences originated from relational problems and ranged in severity (Eby, 2007). Eby (2007) defined relational problems as “real or perceived aspects of mentor-

protégé interactions that minimize, negate, or undermine the personal and professional growth of one or both members” (p. 324). Examples of relational difficulties included failure of mentors or protégés to fully engage in the relationship, difficulty relating to one another, mentor neglect of the protégé, and protégé unwillingness to learn (Eby, Butts, Lockwood, & Simon, 2004; Eby & McManus, 2004; Simon & Eby, 2003). Career sabotage, deception, and exploitation were considered serious relational problems that could be exhibited by mentors or protégés (Eby, 2007; Eby et al., 2004). In a mentoring relationship where problems existed, behaviors such as jealousy, overdependence, and personality clashes could be present (Eby et al., 2004; Johnson & Ridley, 2008). Outcomes of negative mentoring experiences lead to personal and professional growth that was minimized, negated, or undermined (Eby, 2007).

2.1.2.5 Characteristics of effective mentors and protégés. In order for mentoring relationships to be successful, mentors and protégés must engage in certain roles and responsibilities. Common mentor roles included: teaching of new skills, assessing learning needs, arranging experiences, evaluating outcomes, challenging the protégé when necessary, socializing the protégé to the role of the nurse and the nursing unit culture, sponsoring the protégé for personal and professional advancement, counselling the protégé by providing psychological support, career advising by suggesting work and learning opportunities, and role modeling unit culture and nurse behaviours (Barnard, 2002; Greene & Puetzer, 2002; Grossman, 2007; Hamlin & Sage, 2011; McKinley, 2004). Researchers showed the mentor must be approachable, have effective interpersonal and communication skills, give honest and timely feedback, and be willing to meet regularly and commit the time necessary to develop and foster the mentorship (CNA, 2004; Greene & Puetzer, 2002; Hamlin & Sage, 2011; Provident, 2005).

Authors have proposed that protégés also have roles and responsibilities in the mentorship process. Protégés must take responsibility for their development by identifying personal and professional goals they want to achieve; utilize effective communication skills; demonstrate willingness to ask questions, receive feedback, and ask for assistance when needed; display eagerness to try new things and to take advantage of learning opportunities; and be committed to the mentoring relationship (Barnard, 2002; Greene & Puetzer, 2002; Grossman, 2007; Hamlin & Sage, 2011; McKinley, 2004, Provident, 2005). Therefore, both mentors and protégés played an active role in the mentorship.

2.1.2.6 Phases of mentoring. The mentoring relationship has been shown to change over time and can be described as a series of phases. However, the most commonly used descriptions were Kram's (1983) terms of initiation, cultivation, separation, and redefinition. The initiation phase involved developing trust and establishing goals. In the cultivation phase, the mentor assisted the protégé to achieve the goals that were created. The separation phase began when the protégé displayed some independence from the mentor. Finally, the redefinition phase was achieved when the protégé became completely independent from the mentor and the relationship became a professional friendship (Kopp & Hinkle, 2006; Kram, 1983). Regardless of the type of mentoring (informal or formal), the relationships typically went through these phases to some degree.

2.1.2.7 Types of mentoring. Multiple mentoring opportunities provided several options for learning within the organization, and they included formal and informal mentoring approaches. An informal mentorship developed from mutual identification, attraction, and respect between the mentor and the potential protégé. It involved either a spoken or unspoken commitment to the relationship and was frequently unstructured (CNA, 2004; Tourigny &

Pulich, 2005). Formal mentorships were structured relationships developed by the organization and could include organizational direction and input into the establishment of program objectives, expectations, responsibilities, duration of the mentorship, evaluative procedures, and formal training (Zachary, 2005). Formal mentoring programs typically involved organizational selection and matching of mentors and protégés (Tourigny & Pulich, 2005).

The nature of mentoring relationships has evolved in business and nursing contexts. Traditionally, the mentoring relationship has been a one-to-one, hierarchical relationship, where the mentor was an upper-level employee and the protégé was a lower-level employee (Joo, Sushko, & McLean, 2012). However, mentoring relationships have changed to meet the needs of the protégé and the organization. In mentoring cultures, diverse mentoring opportunities were often promoted and made available, including one-to-one mentoring, reverse mentoring, group mentoring, and distance mentoring (Marcinkus-Murphy & Kram, 2010; Zachary, 2005). Nevertheless, there generally exists a differential in knowledge and skills between the mentor and protégé regardless of setting.

Grossman (2007) described *multiple mentoring* as a relationship where the mentor, protégé, or both were involved in simultaneous one-to-one mentoring relationships with a number of individuals. Different mentors or mentoring networks may be used to meet the developmental learning needs of the protégé. Also, the demand for mentors may be greater than the supply, necessitating that individuals mentor more than one protégé.

Another type of one-to-one mentoring, *peer mentoring*, has been more common in business and nursing as organizations become flatter in their hierarchical structures (Bryant & Terborg, 2008; Grossman, 2007). Peer mentoring was described as a lateral relationship where the employees were equal-status peers, and where the mentor was more experienced than the

protégé in the environment (Harmer, Huffman, & Johnson, 2011; Marcinkus-Murphy & Kram, 2010; Ronsten et al., 2005). Peer mentoring was more reflective of the nursing unit environment where nurses were colleagues and no hierarchical relationship existed between the employees (Ronsten et al., 2005).

Reverse mentoring, also called *reciprocal mentoring*, was described as a type of mentoring where an individual with expertise in a certain area mentored a less experienced, but organizationally senior individual (Chaudhuri & Ghosh, 2012; Zachary, 2005). This example was commonly seen with the use of technology. For instance, a newer employee to the organization may have advanced technological skills and the “mentor” for the new employee may not possess those technical skills. Thus, the newer employee would serve as the mentor, teaching the veteran how to use a certain computer program for example.

Zachary (2005) proposed that *group mentoring* fostered a more connected work environment. Group mentoring entailed one mentor involved in mentoring several protégés who met as a group simultaneously to share learning experiences and knowledge (Emelo, 2011). Finally, *distance mentoring* was becoming more common with enhanced technology because this method provided an interactive way to learn, especially if employees were isolated, as is in the case of rural or remote nurses (DiRenzo, Linnehan, Shao, & Rosenberg, 2010; Dobson, 2011; Zachary, 2005).

2.1.3 The Relationship between Healthy Work Environments and Mentoring

The researcher proposed that a reciprocal relationship existed between healthy work environments and mentoring. Mentoring can create healthy work environments, and positive work environments can foster mentorship. For example, a positive organizational culture helped create mentoring environments because in this type of healthy workplace, staff members were

more engaged and enthusiastic about their work, were more willing to assist others, and were more committed to the organization (Laschinger & Finegan, 2005; Wagner, 2006). In all likelihood, these individuals would be more likely to mentor others. The CNA (2006) stated that mentoring was seen as a contributing factor to quality practice environments. Individuals involved in mentoring relationships reported enhanced personal and professional development, increased job satisfaction, and decreased intention to leave (Eby & Lockwood, 2005; Greene & Puetzer, 2002; Johnson & Ridley, 2008; McKinley, 2004). Mentoring has also fostered healthy relationships among staff and professional development opportunities (Eby & Lockwood, 2005). These outcomes of mentoring were key components to healthy workplaces as described by Pearson et al. (2007).

2.1.4 The Role of the Nurse Manager as Leader

There was a difference between the characteristics of a manager and those of a leader. For example, the literature reported that managers were appointed to their positions of authority, goals were arranged by the organization, emphasis was on effective day-to-day operations rather than creative visioning, and goals were generally short-ranged with direction to maintain the bottom line and cost-effectiveness (Grossman & Valiga, 2009). Trent (2003) described managers as concerned with stability and maintaining the status quo. Managers were involved with coordinating and directing actions and assigning resources in order to achieve the goals of the organization (Carroll, 2006). Management roles were shown to include planning, staffing, organizing, directing, controlling, problem solving, conflict managing, delegating, clarifying, and decision making (Carroll, 2006; Kent, 2005; Spurgeon & Cragg, 2007).

Grossman and Valiga (2009) identified five characteristics of leadership: showing vision, possessing strong communication skills, exercising change management, engaging in

stewardship of resources, and developing and renewing followers. Leaders who were responsible for creating visions and engaging others in reaching them excelled in the communication of same. Leaders were effective change agents: They identified needed change and empowered and encouraged other members to assist with the change. Stewardship qualities entailed promoting the good of the group as opposed to self-interests. Finally, leaders continuously focused on developing and regenerating followers: They created, promoted, and supported leadership development to develop a cadre of leaders around them (Grossman & Valiga, 2009). The role of the leader was to generate and communicate the vision, mobilize the team to reach the goal, and recognize and reward others (Kent, 2005). Leaders were creative, and they inspired and motivated others (Spurgeon & Cragg, 2007).

While management and leadership are separate concepts, one would believe that nurse managers would also be leaders in their respective work environments. Effective leadership has been shown to be crucial in creating and maintaining healthy work environments (RNAO, 2006). Nurse managers influenced the culture of nursing units and played roles in retaining, motivating, and developing the unit employees. For instance, if nurse managers were effective in their roles as leaders, employees were more engaged, satisfied, and less likely to leave the unit (Wagner, 2006). Effective leaders who recognized and appreciated their employees' contributions and supported their development created a more positive work environment (Trinka, 2005). Also, if employees experienced support, feedback, and coaching from their manager, increased job demands did not result in employee burnout (Bakker, Demerouti, & Euwema, 2005).

RNAO (2006) recommended that nurse managers as leaders should use transformational leadership styles to develop and sustain positive work environments. These qualities included building trusting relationships, leading change, balancing competing priorities, creating an

empowering environment, and creating an environment that supported knowledge integration (RNAO, 2006). Authors have described transformational leaders as having four key characteristics including idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Avolio, Walkman, & Yammarino, 1991; Bass & Avolio, 1994). Leaders who demonstrated idealized influence were role models for their followers who were admired, respected, and trusted. Transformational leaders who used inspirational motivation displayed optimism and enthusiasm to motivate and encourage others towards a shared vision. Leaders who stimulated their followers to be innovative and creative with challenging situations used their intellectual stimulation. Finally, transformational leaders who demonstrated individualized consideration mentored the employee by focusing on their own needs and creating new learning opportunities for them (Bass & Avolio, 1994). Nurse managers who utilized a transformational leadership approach created increased job satisfaction, empowerment, and organizational commitment for their staff, which also resulted in increased employee satisfaction with the leader (Chiok Foong Loke, 2001; Cummings, Hayduk, & Estabrooks, 2005; Gullo & Gerstle, 2004; Leach, 2005).

The researcher recognizes that not all managers will be leaders, and as a result, it may be more difficult to create a mentoring environment using only managerial skills. In this instance, a valuing of and a commitment to a mentoring culture from an organizational perspective is suggested, which could include a formal mentoring program being instituted, promoted, and supported. This type of organizational mentoring culture may be more successful in such a scenario because the goals and visions for the nursing unit would be organization-driven, focusing on the status-quo and cost-effectiveness (Grossman & Valiga, 2009).

However, if nurse managers, using their leadership skills, could create an environment where employees feel valued, supported, and engaged, the researcher believes that mentoring relationships would more likely be fostered. Managers who are leaders would more likely have engaged employees where mentoring could be developed. Also, if a culture of leadership was promoted by the organization and nurse manager, more nursing staff may become informal nurse leaders, which may encourage the development of a culture of mentoring.

2.1.5 The Role of the Nurse Manager in Creating a Mentoring Culture

Authors have asserted that organizational culture was controlled and changed by management (Kane-Urrabazo, 2006; Manthey, 2007; Stordeur & D'Hoore, 2006). Singh et al. (2002) proposed that organizational culture was essential to the success of mentoring programs because if mentoring was embedded in the culture, it would become the norm. Furthermore, Zachary (2005) posited that implementing a mentoring program without simultaneously creating a mentoring culture within an organization would decrease the program's sustainability and success. Creating a mentoring culture was thus beneficial to employees and the organization as a whole.

One of the primary individuals responsible for developing and sustaining the mentoring culture was the nurse manager. Curran (2001) and Hogan, Moxham, and Dwyer (2007) believed nurse managers were in an ideal position to create positive work environments and to implement organizational change, because they served as the link between upper-level management and staff nurses. Nurse managers were also considered key individuals in influencing mentoring development, and in implementing and using it among nurses on hospital units (Alburger 2007; Latham et al., 2008; Smith, 2007; Thomka, 2007).

The manager's perspective on mentoring was one of the areas that has had limited empirical examination in both the business and nursing environments. Previous research has focused on mentoring managers into their own leadership positions (Flowers, 2005; Mathias, 2007; Sosik & Lee, 2002; Thrall, 2006), and the role of managers in influencing organizational culture to create positive work environments to recruit and retain staff (Anthony et al., 2005; Cassida & Pinto-Zip, 2008; Manion, 2005; Manthey, 2007; McGraw, 2008). According to the databases consulted, there has been no empirical research specifically examining the manager's role in creating a mentoring environment for employees. One anecdotal article has been written on creating a mentoring culture on the nursing unit and it proposed strategies that could be integrated by both nurse managers and staff nurses (Bally, 2007). However, there was scant literature on how a culture change could specifically occur to create and ensure sustainability of a mentoring culture (Bally, 2007; Kane-Urrabazo, 2006).

Furthermore, the processes to create a culture of mentoring on the nursing unit, as well as the organizational supports to assist in the creation of a mentoring culture, have not been reported. Mentoring programs are appearing in healthcare environments, and nurse managers are commonly seen as primary implementers of these programs on their nursing units (Latham et al., 2008; Thomka, 2007). Nurse managers often have competing demands for their time and resources, including pressure from upper-level administration and from staff nurses, mixed with budgetary constraints and organization and unit-driven priorities (Sullivan & Decker, 2009). Therefore, examining the managers' perceptions of mentoring and mentoring cultures, the perceived processes in place, and the organizational supports needed to encourage the creation of a mentoring culture is necessary to gain a deeper comprehension of the role of mentoring in hospital environments. The researcher proposes that if a culture of support, mentoring,

engagement, autonomy, and professional development of staff could be created, it would contribute to a healthy workplace, which would in turn foster retention of staff.

2.1.6 Gaps in the Literature

Healthy work environments are seen as influential in recruiting and retaining nurses. One of the methods to create healthy work environments is through effective mentoring of employees. Because differences are noted between the business and healthcare contexts, and because of the lack of empirical literature on mentoring in nursing, it is imperative that all aspects of mentoring be examined from a nursing perspective, in order to advance disciplinary knowledge in this area. There is a significant gap in nursing-specific research on mentoring from a nurse manager perspective.

More specifically, there has been no empirical research examining managers' perceptions and roles in creating a mentoring environment for nurses. Researchers need to discover how to facilitate a mentoring culture on nursing units in order to create a positive work environment where employees can be more effectively recruited and retained. This research will contribute to this agenda.

2.2 Chapter Summary

The researcher completed a review of the literature examining several concepts and relationships. The concept of healthy work environments was discussed and included a description of their characteristics and outcomes. The researcher considered nurse managers' roles in establishing a healthy work environment. The concept of mentoring was described at length. The researcher proposed that a reciprocal relationship existed between healthy work environments and mentoring. Nurse managers' roles as leaders and as mentoring culture creators

were addressed in the literature review. A review of the literature revealed significant gaps that supported a need for the study to be conducted.

Chapter 3

3.1 Methodological Considerations

In this chapter, the researcher will discuss several methodological considerations and an explanation of the methodological approach used. Following her discussion on the methodology used, she will address details of the research design from this study, including sample and sampling strategies, ethical considerations, data collection, and analysis. The researcher will share strategies adopted for enhancing rigor and trustworthiness. Also, the researcher includes a discussion of researcher as instrument in this chapter. To conclude, the researcher provides context by describing mentorship programs offered within the participating health regions.

3.2 Methodological Approach

Glaserian grounded theory methodology was used in this study (Glaser & Strauss, 1967; Glaser, 1978). Grounded theory is used by many disciplines as a method to generate middle range theory to explain the main concern of participants and how these individuals try to resolve or manage their concerns. Grounded theory has its roots in sociology and was founded in 1967 by Anselm Strauss and Barney Glaser. The theoretical underpinnings of grounded theory were rooted in and guided by symbolic interactionism. Meaning was rooted in social contexts and created and modified through interactions (Wuest, 2007). Symbolic interactionism had three premises:

...human beings act toward things on the basis of the meanings that the things have for them; the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows; and these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969, p. 2).

Some authors contended that pragmatism was also considered an underpinning of grounded theory as it emphasized practicality and usefulness (Charmaz, 2000; Wuest, 2007). Glaser and Strauss (1967) established four criteria for usefulness and applicability in the development of grounded theory including fit, understandability, generality, and control. The emergent theory must *fit* the substantive area in which it is to be used. If the theory does not have the appropriate fit, the individuals in the substantive area will not know how or when to apply it. The only way to ensure that the theory fits the data is to inductively develop the theory and not force the theory to fit deductively (Glaser & Strauss, 1967). The theory must also be *understandable* to individuals in the area; if the theory was derived inductively and was true to the realities of the area, it would be understandable. If the theory was not understandable, individuals would not be willing to apply the theory in their everyday situations (Glaser & Strauss, 1967). Furthermore, the theory must be *generalizable* to a variety of situations, beyond the one from which it was developed. The goal was to make the theory broad enough to fit dynamic situations, and flexible enough to be modified as the situation warranted. Thus, the theory would be seen as a process and the individual utilizing the theory would be a “theory developer” (Glaser & Strauss, 1967). Fourth, the individual utilizing the theory must have adequate *control* in situations to make using the theory worthwhile. The individual must understand the theory, its concepts, and have flexibility in situations to utilize the theory in the area, or be able to modify the theory (Glaser & Strauss, 1967). These criteria had pragmatic underpinnings because they ensured that the individuals involved in the substantive area in which the grounded theory was developed were better able to apply the theory to the situation, making it more useful (Glaser & Strauss, 1967).

Grounded theory originated within the modernist phase of qualitative research, where attempts to formalize and legitimize the value of qualitative research were being sought. During that time, the postpositivist paradigm of inquiry was becoming more popular, and social processes were being investigated (Denzin & Lincoln, 2005). Although qualitative in nature, grounded theory originated from a postpositivist paradigm (Annells, 1996; Kennedy & Lingard, 2006; Lomberg & Kirkevold, 2003; MacDonald & Schreiber, 2001; McCann & Clark, 2003b). The postpositivist paradigm incorporated a critical realist ontology and a modified objectivist epistemology (Guba & Lincoln, 2005; McCann & Clark, 2003b). This perspective proposed that a reality exists but it can only be incompletely apprehended or approximated in research due to the inability of researchers to fully comprehend the phenomena because of the limitations of human knowledge (Guba & Lincoln, 2005). In the postpositivist paradigm, a modified objectivist epistemology was present where the researcher and the participant were said to be independent from each other because objectivity was maintained. However, this perspective recognized that in some qualitative research methodologies, the “emic” or insider viewpoint could be valuable (Annells, 1996). This approach was further described by Glaser (2002), when he stated that participants would tell the researcher what was going on and how to view it.

3.2.1 Purpose of Glaserian Grounded Theory

Glaser (1978) stated “the goal of grounded theory is to generate a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved” (p. 93). The theory was to be inductively derived from the data and was to be used to describe dominant social processes within human relations and the individual meaning attributed to these interactions from the context in which they occur (Glaser & Strauss, 1967; Rinaldi-Carpenter, 2007; Wuest, 2007). Grounded theory was described as a method to discover the current main concern of research

participants and how these individuals try to resolve or manage the concern (McCallin, 2003a). Grounded theory research consisted of a core integrating category and interrelated concepts and categories from which a middle range substantive theory could be derived (Artinian, 2009; Glaser, 1978; McCann & Clark, 2003a). A substantive theory concentrated on one empirical area that focused on specific social processes. Formal theories, which were more generalizable and conceptual than substantive ones, could also emerge from grounded theory and were derived from performing studies on several different types of substantive cases (Glaser & Strauss, 1967). Generation of a substantive theory was the goal of this dissertation.

3.2.2 Assumptions of Grounded Theory

Glaser and Strauss (1967) were not explicit in expressing assumptions of grounded theory methodology. However, Artinian (2009) believed there were three assumptions of grounded theory that could be inferred from Glaser (1998). First, the main concern and core category would emerge; second, social processes were present and could be uncovered; and third, participant concerns were to be the centre of the study (Artinian, 2009).

3.2.3 Rationale for Choosing Glaserian Grounded Theory

Grounded theory was an appropriate methodology for exploring nurse managers' perceptions of their roles in developing a mentoring culture on their units. This methodology has frequently been used in the social sciences and in nursing (McGhee, Marland, & Atkinson, 2007); and Artinian (2009) believed that grounded theory could be utilized to research any problem in nursing provided that two conditions were met. First, the researcher must let the participants define the problem; and second, the researcher must trust participants' attempts to resolve the main concern would emerge through the research process. Thus, this methodology

was used in exploring nurse managers' roles in creating a mentoring culture and the researcher endeavored to not force preconceived ideas, but to trust in the process.

Because of the inductive nature of grounded theory, this methodology is particularly useful in studies where little information on the topic exists, allowing for the basic social psychological and social-structural processes to be discovered (Benton, 2000; Locke, 2001; Schreiber, 2001; Wuest, 2007). Upon reviewing the literature, there was no empirical research that examined nurse managers' perceptions of their roles in creating a mentoring culture. Consequently, the researcher contended that grounded theory research was ideal to explore this area.

Wuest (2007) believed that using grounded theory was relevant in nursing environments because the method created an understanding of human behaviour and relationships in such contexts. Using grounded theory allowed for an understanding of how individuals dealt with evolving situations (Schreiber, 2001). Knowledge to guide practice could be obtained regarding nurse managers' perceptions of their roles in creating a mentoring culture.

Birks, Chapman, and Francis (2006) asserted that nursing was a pragmatic profession, and thus the pragmatic nature of grounded theory research fit well with it. The theory was grounded in the data and had practical applicability and utility. Additionally, because the grounded theory approach produced a middle range theory, it could be useful in nursing to build the disciplinary knowledge-base on mentoring, and to contribute to theory development in nursing contexts and ultimately to advance nursing science (Hall & May, 2001; Rinaldi-Carpenter, 2007). Grounded theory methodology could create a theory to guide and alter nursing practice. Also, a theory of the perceptions of the nurse managers' roles in creating a mentoring

culture has the potential to contribute to creating positive work environments for staff and patients.

Furthermore, grounded theory was ideal for organizational research, in which the nursing unit was classified as an organization. As such, grounded theory described organizational reality that could be readily understood by registered nurse employees and their managers (Lansisalmi, Peiro, & Kivimaki, 2004; Locke, 2001). As a result, if nurses could identify with the situations and processes presented by grounded theory research, they would be more likely to utilize the theory, and strategies derived from it. These strategies could eventually lead to the development of improved workplaces. Locke (2001) also believed grounded theory research was appropriate for investigating complex organizational contexts and processes which would in turn provide for greater understanding of multifaceted issues that were common in organizations. The nursing unit and hospital environment are complex organizations with many factors contributing to creating a mentoring culture.

McCallin (2003a) explained that grounded theory described what was actually happening, that is, how participants identified and perceived problems and tried to resolve them, rather than what should be happening. For example, when conducting grounded theory research on the nurse managers' perceptions of their roles in creating a mentoring culture, the research process allowed for a greater understanding of actual nurse manager perceptions as opposed to theoretical conceptualizations of the issues. Thus this research contributed to the body of knowledge in the area of mentoring in the management process.

Grounded theory was useful when there was little research in the substantive area, and it thus could advance nursing knowledge. It was also helpful to comprehend issues pertaining to understanding human behaviour, relationships, and complex organizational contexts. Therefore,

grounded theory was an appropriate methodology for examining nurse managers' perceptions of their role in creating a mentoring culture based on the rationale provided.

3.3 Sample and Sampling Strategies

Sample size, participant selection, and type of data sampled were not predetermined in grounded theory research, because they were dependent upon the emerging theory and whether theoretical saturation was reached (Glaser & Strauss, 1967). Initial sampling was purposive, because Glaser and Strauss (1967) suggested participants were initially chosen based on a general perspective of their ability to speak to the subject area. Initial decisions in sampling were not based on theory. As the categories and theory emerged during a study, the sampling transitioned into theoretical sampling (Glaser & Strauss, 1967).

Glaser and Strauss (1967) defined theoretical sampling as "...the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (p. 45). As the categories were created and the theory developed, participants and data were sought that could further evolve and saturate the emergent categories and further develop the theory (Glaser & Strauss, 1967). When no new data emerged to develop the properties of a category, that is, when similar instances were being repeated in the data, then theoretical saturation was reached and sampling was complete. "Theoretical sampling helps us to define the properties of our categories; to identify the contexts in which they are relevant; to specify the conditions under which they arise, are maintained, and vary; and to discover their consequences" (Charmaz, 2000, p. 519). Thus, theoretical sampling assists the researcher to develop categories and explain the relationships between them.

In order to achieve maximum variation for theory development, Glaser and Strauss (1967) suggested that the researcher should attempt to broaden the assortment of data collected in order to ensure saturation. Data collection methods used in grounded theory studies could include interviews, participant observation, document and literature reviews, field notes, and participant journals in order to enhance saturation (Charmaz, 2000; Rinaldi-Carpenter, 2007; Wuest, 2007). In this study, interviews, document and literature reviews, and field notes were used.

Also based on the emerging theory, Glaser (1978) suggested altering interview questions, interviewing different participants who could offer varying perspectives, re-interviewing the same participants to seek greater understanding of a particular category, or collecting data from a multiple settings to allow for maximum saturation. “Negative cases”, described as participants whose situations do not confirm the emerging theory and in fact, may challenge the theory, may present themselves during data collection and analysis (Schreiber, 2001). Schreiber (2001) stated that by making the theory inclusive of negative cases, greater comprehensiveness of the situation under study occurred and thus a rich robust theory was produced at an increasingly abstract level.

3.3.1 Setting

The original *setting* for this dissertation was the Saskatoon Health Region in the province of Saskatchewan, Canada. This health region includes both urban and rural health care facilities. However, due to limitations imposed by senior leadership in recruitment of nurse managers in the Saskatoon Health Region, the researcher felt it necessary to broaden the recruitment to additional health regions in order to include a diverse blend of urban, rural, acute care, and long term care nurse managers. Therefore, health region ethical approval was expanded to include three additional health regions within the province of Saskatchewan: Regina Qu’Appelle Health

Region, Prince Albert Parkland Health Region, and Heartland Health Region. Due to small numbers of volunteering participants initially, ethical approval was received for snowball sampling and for placing a study advertisement in the provincial nursing association newsletter. Loiselle, Profetto-McGrath, Polit, and Beck (2011) described snowball sampling as participant selection through referrals from former participants in the same study. In this study, participants were asked to forward the researcher's study information to other managers who may be interested in participating. Snowball sampling and study advertisement added participants from two additional health regions: Sun Country Health Region and Kelsey Trail Health Region. Overall, six health regions were accessed for the study. See Appendix A for a description of the participating health regions.

3.3.2 Participants

Purposive and theoretical sampling was used to recruit participants. *Participants* were nurse managers working in acute care hospitals, long term care, and integrated facilities from within various health regions in both urban and rural locations. *Inclusion criteria* comprised of first line nurse managers of either gender who were able to speak English fluently. Laschinger and Wong (2007) described first line managers as managers who have responsibility for nursing and acute care units, where staff nurses report directly to them, and where there is no level of management below them. The nursing units and facilities utilized depended upon the managers who volunteered to be a part of the study. The length of time that participants had been in their position and whether they knowingly attempted to create a mentoring environment were irrelevant. Other participants included mentorship coordinators from the representative health regions, who could provide context to the existing status of formal mentorship within the province. Saturation was reached at 27 managers.

3.3.3 Sampling

The researcher gained the appropriate ethical approvals from the University of Saskatchewan research ethics board and the individual participating health regions. Following these ethical and organization approvals, numerous avenues were pursued to target all managers, including attending facility or health region-wide manager meetings, and sending them written letters of invitations and brochures via email or mail. In order to recruit participants, the researcher approached nursing unit managers and informed them of the study details. To encourage participation, the researcher identified how participants and the nursing unit may benefit from partaking in the study. If interested in participating, managers were responsible for contacting the researcher. Written informed consent was obtained and interviews using an interview guide were conducted by the researcher (see Appendix B for the Informed Consent Form).

Artinian (2009) and Schreiber (2001) both suggested that an interview guide could assist novice researchers to initiate the interview. Schreiber cautioned that a highly structured interview guide had the potential to influence the type and quality of data received by promoting the researcher's agenda instead of the participant's. Thus, guiding questions were developed and were used sparingly. In addition, Schreiber (2001) suggested the interviewer ask participants if there was anything else they would like to add and ask if there was anything the participant would like to share with someone who was experiencing the same phenomenon. These considerations were taking into account when creating the preliminary interview guide. (See Appendix C for the Preliminary Interview Guide.)

Interviews were approximately 60 minutes in length, with the possibility of a second interview if required for clarification or validation of the emerging theory. As suggested by

Glaser (1970) and Glaser and Strauss (1967), as data collection progressed and theoretical sampling occurred, interview questions were adjusted to reflect theoretical sampling and sensitivity. (See Appendix D for the Revised Interview Guide One). The interview questions became more specific to the phenomenon under study as the theory developed by substantiating, expanding, or refining properties of concepts or relationships between concepts (Wuest, 2007). Specifically in the Revised Interview Guide Two (see Appendix E), the researcher asked participants about proposed conceptual relationships, based on the emerging theory derived from the data, including memo writing and the constant comparative process (Schreiber, 2001). The researcher did not contact all managers for a second interview to further clarify or validate the emerging theory. Managers who had a thorough understanding of mentorship, who could speak at depth about the topic, and who agreed to participate in the second interview were interviewed again. Six additional secondary interviews were completed. All categories were saturated, meaning that subsequent data was redundant. Thus, sampling and data collection ceased.

Artinian (2009) stated it was helpful for novice researchers to audio-record interviews so that ideas and key concepts that were missed during the original interview could be examined. Also, Wuest (2007) believed that recording interviews preserved all data until the core variable emerged, because at the beginning of the grounded theory process, the researcher did not know what was relevant. On the other hand, Glaser (1998) suggested that interviewers could remember salient points, and he advocated against audio-taping. For the purposes of this study, interviews were audio-taped and transcribed verbatim to avoid missing key points.

Interviews were completed at a private and comfortable location at the discretion of the participants such as in managers' offices, homes, and various neutral locations. Field notes were also taken by the researcher during the interviews. Because the researcher was a novice,

transcripts were reviewed with the supervisor to critique the researcher's interviewing technique to ascertain what could be improved upon, and adjustments made accordingly. For example, the researcher talked a lot during the first couple of interviews due to nervousness. However, after discussion and reflection with the supervisor, the researcher made a conscious effort to let the participants talk about what was important to them.

3.4 Ethical Considerations

The researcher obtained written informed consent from participants prior to the interviews and they were reminded that the study was voluntary and they could withdraw at any time. Participants were also reassured that confidentiality would be maintained. Participant names were removed from the transcripts, and study results were reported in a coded format to ensure anonymity. In addition, participants will be able to obtain a copy of the study findings, once available, as stated in the written informed consent. The dissertation supervisor oversaw all aspects of the study to ensure it met all standards and maintained rigor.

Minor potential risks and benefits were associated with this study. Although this eventuality was not needed, if a participant had become emotionally upset during an interview and in need of professional assistance, plans were in place for a referral to an appropriate health professional. A benefit to the interview process was that participants may have felt the interview session was therapeutic because they were able to openly discuss their thoughts and feelings surrounding mentorship. Furthermore, through reflection, they may have been better able to understand the mentoring process and their role in creating a mentoring environment for their staff.

3.5 Data Collection and Analysis

3.5.1 Constant Comparative Analysis

Once the interviews were transcribed, they were reviewed for errors and notations on emotions, behaviours, and environmental factors by comparing the original audio-recordings and the interviewer's field notes. The researcher simultaneously collected, coded, and analyzed data using constant comparative analysis (CCA) to develop coding and theoretical memos, and to develop the theory. Using CCA, the researcher constantly compared data against itself, other data, and the emerging concepts and theory at all times during the grounded theory process (Boychuk-Duchscher & Morgan, 2004; Glaser & Strauss, 1967; Schreiber, 2001). The researcher continuously hypothesized about the relationships between concepts and categories and constantly examined these propositions against the data until a core category and a theory emerged (Schreiber, 2001). CCA directed theoretical sampling and ensured that the emerging theory would not be merely descriptive and lack conceptual depth (McCann & Clark, 2003b). Thus, CCA enhanced the theoretical sensitivity and assisted the researcher in creating a theory that was grounded in the data. Data continued to be collected, coded, and analyzed until no new categories emerged and existing categories were saturated, thus reaching theoretical saturation (Glaser & Strauss, 1967). Saturation was confirmed at 27 participants and 33 interviews. After nineteen interviews, saturation of most categories was noted and the researcher began to revise the interview questions to further substantiate, expand, and refine properties of categories, concepts, and relationships between concepts, as Wuest (2007) suggested. The interview questions became more specific to the phenomenon under study as the theory developed. After 27 interviews, second interviews were completed with managers to further clarify and validate the emerging theory, as well as to discuss proposed relationships between concepts.

3.5.2 Theoretical Sensitivity

Glaser (1992) defined theoretical sensitivity as "...the researcher's knowledge, understanding, and skill, which foster his generation of categories and properties and increase his ability to relate them into hypotheses, and to further integrate the hypotheses, according to emergent theoretical codes" (p. 27). Theoretical sensitivity can be based partially on previous research or on personal or vicarious experience. It is the capability to understand and give meaning to the data (Glaser, 1978, 1992); and it is the ability of the researcher to think inductively and abstractly about the data in order to generate the theory (Schreiber, 2001). If researchers were unable to think theoretically about the data, they would have conceptual description only, not grounded theory (Glaser, 1992). If researchers are theoretically sensitive, they "...can theoretically and conceptually think about the data from a distance, while simultaneously maintaining an in-close level of sensitivity and understanding about the process and their involvement in that process" (Walker & Myrick, 2006, p. 552).

At the beginning of the study, the researcher obtained interview data and examined it from specific and abstract levels, asking "what is going on here?" (Schreiber, 2001). In developing theoretical memos, the researcher in this study proposed several explanations and constantly compared them against the data: All possible rationalizations, conceptualizations, and relationships were considered using theoretical insight. Schreiber (2001) rationalized that theoretical sensitivity prevented researcher bias of promoting one theory over others, and it maintained rigor in grounded theory studies as researchers continuously challenged their "pet" theories against the emergent data. Memoing has been suggested as a method to promote theoretical sensitivity, as the researcher makes notations about developing conceptualizations

and theory to compare against the data (Schreiber, 2001). To promote theoretical sensitivity memoing was completed in this study and is further discussed in section 3.5.4.

3.5.3 Coding

Coding was the process where the researcher categorized the data and constantly compared the resulting codes with the emergent data to sequentially develop concepts, categories, and relationships, and ultimately to create a theory (Schreiber, 2001). Glaser (1978) described the coding process as two types of codes being generated: substantive and theoretical codes. Substantive coding focused on developing categories, whereas theoretical coding focused on conceptual description to form an emergent theory. Both substantive and theoretical coding occurred simultaneously, but more emphasis was placed on one or the other depending on the part of the research process with which the researcher was involved. For example, the focus was on substantive coding in the beginning coding stages, and theoretical coding during the theoretical sorting and theoretical memo integration. The process of coding allowed the researcher to become increasingly theoretical with the data and allowed the theory to be generated (Glaser, 1978).

3.5.3.1 Substantive coding. Substantive coding consisted of open and selective coding. During *open coding*, the researcher codes data in every way possible; that is, the researcher “...codes for as many categories that might fit; he codes different incidences into as many categories as possible” (Glaser, 1978, p. 56). The researcher verified and populated individual codes to saturation through the open coding process. Through the categories obtained by open coding, the researcher was able to guide the research process through theoretical sampling depending on the categories created. According to Glaser (1978), the goal was to saturate the

categories and write many theoretical memos during this time to ensure objectivity with the data and this goal was reached by the researcher.

Glaser (1978) proposed rules for open coding that were followed by the researcher in this study. Open coding began by asking three neutral questions: “What is the data a study of?; What category or property of a category, of what part of the emerging theory, does this incident indicate?; What is actually happening in the data?” (p. 57). By asking and answering these questions, Glaser proposed that the researcher would become theoretically sensitive and more conceptual with the data. Other rules included analyzing the data line by line or by incident to incident; and having researchers independently code their own data. These approaches allowed researchers to fully saturate the categories, prevent omission of categories, and create a dense theory. Also, because a list of codes was not possible to determine in the beginning stages of the grounded theory research process, having another individual code the data while the researcher developed the categories was extremely difficult. Glaser stressed the importance of interrupting coding to memo, so researchers would not lose the conceptual thought process; and this technique was done many times during this study. While coding, the researcher did not assume a variable was relevant until it emerged as relevant, and therefore, earned its way into the theory in order to prevent forcing preconceived ideas on the data (Glaser, 1978). When a potential core category became apparent and a possible theory emerged from the data, open coding was considered complete (Glaser, 1978).

Selective coding involved processing data around a core category or variable (Glaser, 1978) and the researcher began to selectively code for that core variable (Walker & Myrick, 2006). Other variables were not completely dismissed, but their importance was diminished (Glaser, 1978). A core variable emerged from the dissertation and further data were collected and

theoretically sampled based on it. Furthermore, the researcher limited coding to variables that related to and enhanced the core category. The core category integrated variables and described most of the variation in patterns of behaviour, explained what was going on in the data, and described how individuals resolved the main concern in the substantive area (Glaser, 1992). The grounded theory was developed around the core category. Glaser (1978) proposed several criteria that assisted the researcher in determining a core category. A core category was central and reoccurred frequently; that is, it was related to several other categories and their properties, and it appeared in the data repeatedly. The core category had explanatory power and implications for a formal theory (Glaser, 1978). In this study, the researcher used open coding for the first 25 interviews. Selective coding began on the 26th interview.

Core categories were present in all grounded theories and could be any type of theoretical code describing a condition, consequence, process, or dimension (Glaser, 1978). One specific type of core category was called a basic social process (BSP), but not all grounded theories had a BSP. A core category was usually a BSP, but did not have to be (Glaser, 1998). A BSP was processural: It had two or more stages representing a process and was labelled with a gerund (Glaser, 1978). These stages represented variations in the pattern of behaviour that changed over time (Glaser, 1978).

Glaser (1978) described two types of BSPs: basic social structural processes (BSSP) and basic social psychological processes (BSPP). A BSSP focused on the global structural processes intrinsic among organizations and other groups, an example of which would be *bureaucratization*. A BSPP described individual, psychological processes related to the area under study, an example of which would be *becoming* (Glaser, 1978; Reed & Runquist, 2007). Generally, a BSPP was more prevalent than a BSSP. There were two methods of finding BSPs:

discovery, as outlined in this paper, and emergent fit where the BSP was already known and the researcher further elaborated on it or developed it into a formal theory (Glaser, 1978). The grounded theory generated in this study was a BSPP.

3.5.3.2 Theoretical coding. Theoretical coding involved integrating the substantive codes at a conceptual level to propose relationships and to develop the theory (Glaser, 1978, 1998). Theoretical codes emerged during coding, memoing, and sorting (Glaser, 1998). Theory was generated around the core category. Glaser (1978) proposed 18 coding families that assisted the researcher to conceptualize possible theoretical relationships and properties between the core category and other concepts and categories in order to elevate them to a more abstract level. These coding families are not all-inclusive and Glaser (1978) encouraged researchers to create their own additional coding families.

Only variables related to the core category were typically included in the theory (Glaser, 1978). If the emergent theory only described concepts and was unable to establish the main concern of participants and how they try to resolve the problem, Glaser (1998) suggested that the lack of integration of the processes and the properties of the categories may be an issue. Glaser (1998) stated the researcher could not utilize a theoretical code unless it emerged from the data, although the researcher could use the coding families to assist in identifying theoretical codes that were present. In this study, the coding family of “process” seemed most relevant as the theory emerged. “Process is a way of grouping together two sequencing parts to a phenomenon” (Glaser, 1978, p. 74). A more detailed explanation of the process will be provided when the theory is described in Chapter 5 (see section 5.2).

3.5.4 Theoretical Memos

In this study, memoing was included during data collection, coding, and analysis by using written and audio digital theoretical memos. Glaser (1978) believed that memoing was an essential component in doing grounded theory and should continue throughout the entire process. He stated, “Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding” (Glaser, 1978, p. 83). Memos reflected the conceptual speculations and thinking processes of the researcher (Montgomery & Bailey, 2007). Memoing assisted the researcher to hypothesize and identify the relationships among concepts and the emerging theory, and assisted the researcher to conduct subsequent data collection with the emerging theory in mind. Memoing was a continuous, reflective process of the researcher’s internal dialogue with the data (McCann & Clark, 2003a).

The three purposes of memoing were to identify the researcher’s pre-existing assumptions, to keep track of decisions made by the researcher to contribute to an audit trail, and to hypothesize relationships among concepts (Glaser, 1978; Glaser & Strauss, 1967). Glaser emphasized that it was imperative the researcher stop and memo in order to prevent loss of thoughts regarding the data. The length of the memo was not predetermined and the manner in which the memo was written was irrelevant as long as memoing was performed.

Theoretical memos served important purposes in the grounded theory study (Glaser, 1978). For example, the researcher defined and expanded properties and conditions of each category through memoing which resulted in saturation, and the data were interpreted to a more theoretical level. Also, hypotheses regarding the relationships between categories were proposed and from these proposed relationships, a beginning theory was generated. Glaser recommended keeping memos organized by labelling them by category or property, and highlighting any

categories or properties and the relationships between them to facilitate theory development. Glaser believed that memos forced the researcher to slow down and think about the categories, properties, dimensions, and relationships between the data, and the potential theory to ensure it had fit, relevance, and workability. Finally, memos provided direction for theoretical sampling by identifying gaps in the analysis and potential new directions for the emerging theory (Glaser, 1978). Memos increased in their conceptual abstraction and theoretical progression as the research progressed, as the categories became saturated, and as the theory became more mature (Glaser, 1978).

In this study, the researcher memoed for the three purposes as outline by Glaser. At any time needed the researcher would create either written memos on the computer or audio memos using a digital voice recorder. Memoing allowed the researcher to think about the categories, properties, dimensions, and relationships between the data, and the potential theory. As a result of memoing, the researcher was able to hypothesize about relationships between categories and begin to develop the emerging theory. As the research progressed and the theory emerged, memos became increasingly more abstract and theoretical.

3.5.5 Literature Review

Glaser (1978) warned about performing a literature review too early in the study and thus superimposing preconceived concepts and ideas that may not fit with what the data were actually describing. That is, the data would be forced into preconceived categories or the researcher would be directed into deductive hypothesis testing, rather than allowing the categories to emerge. Glaser (1978, 1992) recommended collecting the data first, developing categories and their properties, and once the theory was grounded in a core category, reviewing the literature. Glaser (2001) further expanded on this topic by recognizing the requirements of funding

agencies and ethics committees. For instance, he accepted that the researcher would have some knowledge or theoretical sensitivity in the general area of interest and some bias might occur with this pre-knowledge. However, he stated that this bias should be rectified and data put into perspective when using the constant comparative method (Glaser, 2001). This approach however is difficult if one has experience in the area of study and has previously conducted research in the area.

Several authors supported the need for a middle ground approach to the literature review (Cutcliffe, 2000; McCallin, 2003b; Suddaby, 2006). For instance, the research proposal can be focused on a general area of study, but the specific problem will not be delineated until data were collected and analyzed (McCallin, 2003b). It was also naïve to think that a researcher with a program of research had no background information on the topic under study (Cutcliffe, 2000; McGhee et al., 2007; Schreiber, 2001). Recommendations have been suggested to deal with Glaser's concern regarding the literature review. Cone and Artinian (2009) suggested performing a brief overview of the literature in the broad substantive research area to determine whether a gap in the literature existed in order to provide the rationale for performing the study to review committees. Suddaby (2006) stated that using grounded theory research was not an excuse to ignore the literature, but cautioned the researcher to be aware of the potential of being influenced by preconceived notions during the initial process.

For Glaser (1978), the additional literature review was completed as and after the theory emerged and could influence theoretical sampling as well. The literature would be theoretically sampled and treated like a data source that was constantly compared, coded, analyzed, and memoed (Benton, 2000; McGhee et al., 2007). Various sources of literature could be used, such

as professional and non-professional sources and supplementary materials like data from other studies (MacDonald, 2001).

For this doctoral dissertation, a review of the literature was performed to rationalize the need for this study and to identify gaps in the literature. The researcher recognized the potential for being influenced by preconceived biases. However, because limited literature existed on this exact topic, the researcher felt that this potential bias was placed in perspective through memoing, and the researcher used the constant comparative method to keep this bias in check, as recommended by Glaser (2001). Furthermore, the second literature review was not completed until the substantive theory emerged.

3.6 Rigor

Tobin and Begley (2004) defined rigor as the manner in which integrity, competence, and quality of the research process were demonstrated. Methods to ensure rigor in the grounded theory research were incorporated in this study. To fit better with qualitative research methodologies, Lincoln and Guba (1985) described qualitative rigor as trustworthiness. Lincoln and Guba's (1985) trustworthiness criterion for establishing rigor within a qualitative framework included the categories of credibility, transferability, dependability, and confirmability.

Lincoln and Guba (1985) described *credibility* as whether the reality of the participants was correctly represented by the researcher. Strategies used to maximize credibility in this study included triangulation, peer debriefing, negative case analysis, and member checks (Lincoln & Guba, 1985). Triangulation examined different sources of information, and in this study included manager and mentorship coordinator interviews and document reviews. In order to allow for exploration of areas that may remain implicit or unexplored and to test emerging hypotheses, peer debriefing with the researcher's supervisor was performed. Negative case analysis allowed

for a more complete explication of the emerging theory to create a more robust grounded theory. One negative case was found and will be further described in Chapter 4 (see section 4.1.4.9). Member checks were used to clarify and validate the emerging theory with participants. During secondary interviews, the researcher described the emerging theory to participants and asked them to share their thoughts on the theory. In addition, participants' own language was utilized to code, categorize, and develop the theory in order to strengthen credibility.

Transferability referred to the generalizability of findings by providing a substantial description of the context and experience in order to allow others to visualize applying the theory in their contexts (Lincoln & Guba, 1985). *Dependability* was described as leaving an audit trail so that others could follow the researcher's thought and decision making progression throughout the research process, and was evident in researcher memos. Finally, *confirmability* referred to the ongoing documentation of the research process including memoing, verbatim transcription of interviews, and field note documentation (Lincoln & Guba, 1985), and these components were included in the study. The researcher considered and included credibility, transferability, dependability, and confirmability to ensure rigor in this study.

Glaser (1978) also proposed four criteria for judging the quality of grounded theory: fit, work, relevance, and modifiability. In order to achieve *fit*, the categories created should emerge from the data: Data should not be forced to fit into preconceived categories. *Work* means that the theory should explain, predict, or interpret what was happening in the substantive area. The theory should have *relevance* to the individuals in the substantive area by focusing on the main concern and processes to resolve the main concern. When new data emerged, the theory should be *modifiable* by qualifying the theory while maintaining aspects of what had already been generated (Glaser, 1978; MacDonald, 2001).

In this dissertation, the researcher derived categories from the data. The resulting theory helped explain what was happening in the clinical area from managers' perspectives. During the secondary interviews, managers were asked if the proposed theory had relevance to them and their reactions were positive. Finally, as new data emerged, the theory was modified to accommodate for new information, including the negative case.

Theoretical sensitivity is a method of maintaining rigor in grounded theory studies to prevent researcher bias. All possible rationalizations, conceptualizations, and relationships were to be considered using theoretical insight. Schreiber (2001) stated that theoretical sensitivity prevented researcher bias of promoting one theory over others without sufficient data to do so. Memoing has been suggested as a means to promote theoretical sensitivity and rigor (Elliot & Lazenbatt, 2005; Schreiber, 2001). In this study, the researcher memoed about the emergent theory in order to compare it with the data; memoing was used to track the decision making processes of the researcher. Morse, Barrett, Mayan, Olson, and Spiers (2002) suggested implementing methods to ensure qualitative rigor during the research process, as opposed to evaluating the rigor after the study had been completed. For example, these researchers recommended using constant comparative analysis and theoretical sampling to allow for corrections to be made during the research process for the purpose of redirecting the data collection, coding, or analysis as needed. The researcher utilized the above mentioned strategies to ensure that rigor was upheld whilst performing the grounded theory study.

3.7 Researcher as Instrument

Robson (2002) defined reflexivity as “...an awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process” (p. 22). Glaser (1978, 1992) recognized the influence of the researcher's

personal experience and training on formulating questions and hypotheses to guide theory development. This belief was evident in his definition of theoretical sensitivity, which was “...the researcher’s knowledge, understanding, and skill, which foster his generation of categories and properties and increase his ability to relate them into hypotheses, and to further integrate the hypotheses, according to emergent theoretical codes” (Glaser, 1992, p. 27).

Reflexivity also relates to using personal experience and beliefs to compare “...against data collected rather than exploring them for the impact they may have had on the process...” (Neill, 2006, p. 258). In 2001, Glaser rejected reflexivity proposing that the constant comparative method would be able to expose and correct the researcher’s influence on the data (Neill, 2006). Cutcliffe (2000) agreed with Glaser and stated that testing out researcher hunches and hypotheses during interviews would be a way to self-correct meaningless preconceived ideas if they were not relevant for the participants.

Cutcliffe (2000) felt it was necessary for the researcher to acknowledge prior experiences and knowledge and their potential effects on theory development. McGhee et al. (2007) believed reflexivity prevented prior knowledge from distorting the researcher’s perceptions of the data. Charmaz (2000) and McGhee et al. (2007) recommended memoing as a means to set aside previous experiences and reading to assist with reflexivity. Given these positions, I discuss my lived experience of being a nurse and nurse researcher, and the potential impact these personal experiences may have had on my research. This reflexivity process allowed me to be more aware of my potential preconceived notions and “pet theories”. I also acknowledge that using the constant comparative method during the grounded theory process assisted me to keep my personal values, beliefs, and assumptions regarding the data in check.

I personally define mentoring as an informal or formal process by which new individuals are socialized into their professional roles by more experienced individuals. As a non-mentored staff nurse and a mentored nurse educator and nurse researcher, who had previously performed research in the area of registered nurses' mentoring perceptions, I recognized that I had some biases and assumptions regarding mentoring. For example, I felt that mentoring was needed to assist new nurses with socialization and transition onto the nursing unit, and I thought that mentoring was mutually beneficial to all involved and aided in the recruitment and retention of staff. I believed that mentoring should be encouraged by organizations, and I assumed that nurse managers had a central role to play in creating a mentoring culture on their unit. If I had not been careful, these biases could have influenced the questions I asked and how I asked them during the interviews. As well, these beliefs could have impacted how I analyzed, coded, and processed the data to develop the emerging theory.

By being reflexive and using theoretical sensitivity, I attempted to prevent these biases from negatively influencing the research process and outcomes. McCallin (2003b) suggested the researcher set aside personal perspectives and hypotheses in the area of interest in order to fully understand the participant's problem. Because I conducted this research from a postpositivist paradigm, I identified and attempted to set aside my own biases and maintain objectivity.

In terms of preparing to conduct this research, I read literature on mentoring, leadership, grounded theory, and culture. However, I found no research literature on nurse managers' roles in creating a mentoring culture based on the databases available to me; therefore, I did not have preconceived ideas derived from the literature that I risked forcing onto the data. Glaser (2001) stated that any reading around the general area should be corrected by using the constant comparative method.

Because of my previous experience as a nurse and a nurse researcher, the manner in which I performed grounded theory research, the way I thought about the data, and the way I identified categories and codes were different from other researchers (Artinian, 2009). Using my own theoretical sensitivity, I examined the data from a nursing perspective. My nursing background affected the way in which I asked my interview questions, analyzed my data, and generated the theory. This perspective had the potential to introduce some bias into the way I collected, coded, and analyzed data. Also, my employment as a nurse in the hospital system may have had an impact on my ability to recruit nurse manager participants and to establish their comfort level in order for them to share their perspectives.

I was new to performing qualitative research and using the grounded theory process, so it took some time to become comfortable with this methodology. For example, I needed to assess my interview techniques and to identify strategies to improve the process to identify the participants' main concerns and their attempts to resolve their issues. I needed to continue to work on utilizing the constant comparative method, on thinking at an increasingly theoretical level to allow the theory to emerge, and on getting guidance from my supervisor or committee members as needed in order to generate a theory grounded in the data. Thus, my personal experience had the potential to impact my research, processes, and outcomes during the study. However, by using reflexivity, theoretical sensitivity, and the constant comparative method, my past experience should have assisted me with theory development, not have hindered it.

3.8 Context

In order to provide background and context for mentoring in the province, provincial mentorship coordinators were interviewed by telephone, email, or in person. These individuals

provided information on the history of mentorship in the province. In addition, they described the existing, formalized opportunities for mentorship within the various participating health regions.

In 2008, the province of Saskatchewan funded two provincial nursing mentorship programs: the Graduate Nurse Job Program and the Provincial Nursing Mentorship Program. In the Graduate Nurse Job Program, new graduate nurses were offered supernumerary full time employment in which they were paired with mentors to assist them with their transition to practice. Funding for the Graduate Nurse Job program has since ceased. During that same time period, the province also funded the Provincial Nursing Mentorship Program Initiative, which offered non-supernumerary peer-to-peer mentorship. Nurse peers in the same work areas would offer new graduate nurses mentorship, support, and guidance in making the transition to their new roles.

This provincial program was funded by the Ministry of Health and was in existence at the time this study was conducted and written. It was organized by six regional mentorship coordinators spread throughout the province (Government of Saskatchewan, 2011). Mentorship coordinators were hired to develop and implement a mentorship program within their regions; their roles differed slightly depending on the needs of their health regions. Coordinators from the participating health regions in the province were contacted to provide context on the existing state of mentoring programs for the study. At the time of the study, there was no mentorship coordinator for the Kelsey Trail Health Region. The researcher contacted the coordinators for the remaining health regions and they were asked to correspond by telephone, email, or in person.

3.8.1 Saskatoon Health Region and Heartland Health Region

The mentorship coordinator for the Saskatoon Health Region was also the mentorship coordinator for the Heartland Health Region. Since 2009, the Saskatoon Health Region has made

a commitment to all new employees. They are provided with information about the mentorship program and both protégés and mentors are invited to attend a voluntary workshop. This workshop is offered every other week. It is a formal mentorship program in that the health region assists to match mentors and protégés, and assists to develop those relationships. Employees can individualize it to meet each pair's own learning needs and goals. The relationship is not a pre-determined length of time, but is based on the protégé's learning needs. Evaluation of the relationship is encouraged at regular intervals to determine if goals have been met or if new goals need to be established. Mentors are selected by managers or clinical nurse educators who have knowledge of both new and experienced staff members. A formal evaluation is sent to the dyads at the 12-week point in the relationship.

The mentorship coordinator has several roles. She organizes and maintains the mentorship program, coordinates the mentorship workshops, works with the managers to encourage staff participation in the mentorship program, provides on-going support to mentors and protégés, and assists to build a culture of mentorship within the health region. The coordinator sends out a series of emails to each dyad about mentorship and encourages the relationship to continue. For example, the emails discuss how to build the relationship at the beginning, strategies to maintain the relationship, and ways to close the relationship.

The purpose of the mentorship workshop is to develop relationships between mentors and protégés. Employees learn about what is mentoring, the theory behind mentorship, relationship development and progression, conversations to have in the relationship, setting goals, prioritizing learning needs over time, tips to make the mentorship work, and effective and ineffective personal behaviours. Participants are also given a mentoring handbook that was developed by the health region. The workshop is evaluated at the conclusion of the day. The health region covers

the replacement costs for the mentors and protégés to attend the workshop. By 2011, approximately 300 new employees had taken advantage of mentorship by attending the workshop and establishing mentoring relationships. For the rural areas, new employees can attend the large workshop in the city or alternatively the coordinator can go out to the rural areas and conduct the workshop if there are a large number of new employees.

In order to promote the mentorship of new employees, the mentorship coordinator participates in most of the new graduate registered nurse panel interviews, talks to the new nurses about the mentorship program, and encourages new staff to ask their managers to provide mentorship. In order to promote mentoring to potential employees, the coordinator has developed an external website that explains the mentorship program. All external job postings include a statement about mentorship, and mentoring is promoted at various career fairs.

Since 2009, the Saskatoon Health Region has instituted a yearly mentorship symposium and it is an opportunity to build a culture of mentorship by promoting greater awareness of what mentoring is, how the mentorship program operates, and how to encourage and sustain mentoring. It is a professional development opportunity for mentors, protégés, and interested employees. This symposium is also a forum to thank mentors and protégés for contributing their time and recognizing their contributions. For the past year, there has been a recognition portion to the symposium where employees can nominate mentors or managers who are supportive of mentorship for awards.

In an effort to recognize mentors for their contributions, they are sent a letter from the chief executive officer of the health region thanking them for their time and effort. Digital stories, from previously involved participants, discussing the impact of mentoring are shown at the mentorship workshops and within various other venues in the health region. All mentorship

award nominees are sent their nomination letter (that was written about them) as a form of recognition and reinforcement for their great contributions. (C. Stewart, personal communication, September 21, 2011).

3.8.2 Regina Qu'Appelle Health Region

The Regina Qu'Appelle Health Region received funding in 2003 from the provincial government to introduce a trial mentoring program (Smadu & Loos, 2008). This program was in existence from September 2004 to April 2005 and had three intakes of new graduates. A total of 29 mentors and 34 protégés volunteered and attended a one-day workshop on mentoring. Dyads were matched or protégés chose mentors. From this pool of mentors and protégés, 15 dyads were formed. Several times throughout the program, focus groups were conducted and evaluative surveys were given. This trial program was found to be beneficial and recommendations were made to extend it province-wide (Smadu & Loos, 2008).

Another mentorship program was piloted in 2007 in this health region and was then adopted by the provincial government to disseminate to all health regions. The Nursing Mentorship program is offered to any new graduate registered nurses (RNs) and licenced practical nurses (LPNs) who gain employment within the health region. New nurses apply to the program and mentors are arranged for them. The new graduate functions independently on the unit or facility but has the additional support of an experienced nurse to offer mentorship. The new graduate and the mentor may or may not work the same rotation and may or may not work on the same unit or facility. The relationship mainly occurs outside the work environment unless the mentor and protégé work the same shift or rotation. The dyad meets in person, by email, or by phone. The protégé has access to mentorship for up to 12 months following graduation. The

dyad meets weekly for the first month, then bi-weekly for the next month, and monthly until the relationship ends.

The mentorship relationship provides guidance, support, encouragement, ways to transition into the role, and advice on the reality of the work environment. Experienced nurses share knowledge, wisdom, and insight with protégés to help advance their career. An innovative, web-based mentoring tool was created by the mentorship coordinator and is available to all participants in the program. The web-based mentoring tool is the first of its kind in the province.

The coordinator promotes knowledge about the mentorship program in various ways. She speaks at the educational institutions to the soon-to-be nursing graduates about the program and encourages them to apply. The coordinator speaks with the nurse manager group about the program, their role in it, and the advantages of participating. There are mentorship bulletin boards at each of the three acute care sites within the health region, which have information, brochures, and application forms. She met with the rural nurse manager group and promoted the program to their areas, as well. The program is promoted through the internal E-Link newspaper available to all health region staff. The human resources department also forwards an application form and brochure with each letter of offer to the new graduate hires.

The manager of a unit or facility puts out an expression of interest to the staff seeking potential mentors. Criteria for being a mentor include having worked at least 2 years on the unit; having interest in the program; desiring to help a new colleague succeed; having a positive attitude, compassion, understanding, dependability, and competence in their own practice; demonstrating leadership; and having time and effort to put into the relationship. Mentors are then approached and may either accept or decline the offer.

The mentorship coordinator described her role as promoting the mentorship program, managing personal information, delivering the program within the health region, providing the workshops to the participants, managing finances, reporting to Saskatchewan Health, and evaluating the program. The mentorship coordinator believed follow-up was the key to the success of the program, because if participants did not feel supported, they would not continue with the relationship. She randomly selects a few participants to evaluate the program at a midway point in the relationship. Because people start at different times and the length of the relationship varies, she has difficulty in finding a midway point for everyone. Each participant knows that a final evaluation will occur at the conclusion of their relationship. The coordinator helps them trouble shoot if problems arise and makes sure they are aware of her assistance if they need it.

Mentorship workshops are offered approximately three times a year. The workshops are open to the mentors and protégés enrolled in the program, and if space allows, others interested in becoming mentors. Content discussed at the workshops includes the mentoring process, the advantages of participating in a mentoring program, the roles and responsibilities of the participants, the guidelines for the relationship, the presence of horizontal violence and its impact in the work environment, the impact of the generational diversity, and the possible pitfalls in mentorship and what to do if they arise. As well, personnel from the national new graduate support network, *Nursing the Future*, are invited to come and speak to the participants to discuss how their group provides new graduate support. The representatives from *Nursing the Future* review the Transition Theory Model[©] so that the participants understand what new graduates are experiencing as they transition into the workplace. The workshop is a safe place to discuss anything that concerns the participants in relation to the mentorship.

The coordinator describes the mentorship program as both formal and informal. She describes it as formal in that there is a definite process involved with accessing the program, and it is informal as to how the mentorship develops. The program is based on the needs of the new graduate. The guidelines of how often to connect are suggestions only and the dyad can choose to meet more or less frequently. Contact between the mentor and protégé is seen as informal because the majority of contact occurs outside of work hours.

A Mentoring Bursary was established between the health region and the Saskatchewan Union of Nurses Recruitment and Retention committee. Mentors have access to \$500 towards their own professional development activities and opportunities for each protégé they mentor. The unit that hires and mentors the protégé has access to \$500 towards a purchase that would benefit the entire unit. Guidelines were developed about how to access the funding and what constitutes allowable purchases. A committee was established to adjudicate all applications. The monies can be used towards expenses like workshop attendance, conference attendance, textbook purchases, tuition fees for further educational opportunities, to name a few. Participants receive a certificate of appreciation and a pin that confirms their participation.

The mentorship program has been well supported by senior leadership. The program continues to expand to all new hires in the human resources department and soon the program will be offered to the nurse manager group. The therapies department within the health region has developed a mentorship program and have asked for the mentorship coordinator's input. (P. Leblanc, personal communication, September 30, 2011).

3.8.3 Prince Albert Parkland Health Region

The coordinator for this health region is the mentorship coordinator for four separate health regions in the province: Prince Albert Parkland, Prairie North, Mamawetan Churchill

River, and Keewatin Yatthe. When starting in her role and prior to initiating the program, the coordinator consulted and gathered feedback from all levels of service providers, human resource consultants, directors, vice-presidents, managers, supervisors, educators, and new nursing graduates. With these individuals, they discussed how the mentorship program should look, and established approaches that would meet each individual health region's needs. In her region, the coordinator feels that the need for education and awareness at all levels with regards to mentoring is a priority. She wants to provide details such as how the mentorship process works, how individuals support it in the workplace, and how people become engaged in it. To promote the mentorship program, the coordinator visits post-secondary institutions to increase awareness and attends the health region orientation as well. All new employees are notified by the human resources department that a mentorship program exists and contact information for the coordinator is given. Experienced staff members are notified about the program through the managers, directors, and educators of the nursing units and through both unions. The coordinator provides information about upcoming workshops to the first line managers, educators, and supervisors in the region.

Mentorship workshops are offered at least four times a year, and both mentors and protégés are encouraged to attend. The dyad has either been formally paired up by the manager or informally paired by the mentors and protégés themselves. Individual nurses that are interested in mentorship but have not entered into a relationship are also able to attend. Both RNs and LPNs attend, as well as other employees that are interested in mentorship. The coordinator plans to expand the formal mentoring program to all health region employees in the future.

During the workshops the coordinator uses evidence-based practice to provide general information about mentoring. Content of the workshop includes information on the mentoring

relationship, the roles and responsibilities, the formal and informal types of mentorship, the awareness of boundaries, the benefits, the building of the relationship, and the learning plans. Generational diversity and learning styles are also discussed. There is also a partnership agreement that is signed. Attendees are given a list of mentoring tools and resources to help facilitate the relationship, to encourage reflective journaling, and to establish the relationship.

In the workshop, the coordinator advises participants that they can make the relationship their own and can individualize it to best meet their needs. The relationship length is at the discretion of the dyad, and they can meet as often as they would like. She encourages the dyad to get to know each other and discuss what their needs and wants are for the relationship. The coordinator readily offers her services to the mentor and protégé as a support to assist them to work through the mentoring process.

After the workshop, through phone calls, emails, and online surveys, the coordinator follows up with the dyad to see how the relationship is progressing. The mentors and nursing units are able to apply for professional development funding after a minimum of eight weeks. During this application process, the coordinator is able to obtain feedback about the characteristics of their mentorship, such as how often the dyad met, what the relationship entailed, and whether it was perceived as successful. The online surveys ask details such as the length of the relationship, the frequency of meetings, and the perceived benefits of the relationship for the individual. Professional development funding can be used to attend conferences and workshops, to pay for licencing fees, to purchase personal digital assistants (PDAs), or any activities that would enhance work-life balance or a healthy workplace.

All participants at the workshop receive a certificate of attendance from their respective health region, a verbal thank you from the coordinator, and other tokens of appreciation such as

pens. The coordinator considered the professional development funding a method of showing appreciation. Mentors are also recognized in their respective health region newsletter. The LPN licencing body recognizes the mentoring relationship as a method of continuing competency. The coordinator explains to the RNs that this mentoring relationship could be used towards their continuing competency requirements as well. Senior leadership is directly involved with supporting the mentorship program. The coordinator reports directly to senior leadership, and the coordinator states she keeps them readily informed as to what is happening with regards to mentorship in the region (N. Dorion, personal communication, October 3, 2011).

3.8.4 Sun Country Health Region

The mentorship program has been in place in the Sun Country Health Region since July 22, 2011. The mentorship program is available to all graduate nurses and new hires, including RNs, Registered Psychiatric Nurses, and LPNs. The coordinator considers the program formal because there is a signed contract between the mentor and protégé. Senior leadership is supportive of mentoring and expanded the program to include LPNs.

The coordinator attends the new employee orientation program and invites new hires to join the mentorship program. Mentors are selected by the nurse manager or mentorship coordinator. Mentors can volunteer their services as well. The coordinator tours the health region every week promoting the mentorship program to nursing staff and nurse managers.

The workshop is offered at least three times per year and has been opened up to other Sun Country health region employees and to neighboring health regions' employees as well. Components of the workshop include describing the purpose of the program, the role of the mentor and protégé, phases of mentoring, differences between preceptoring and mentoring, how mentors are selected, different kinds of mentoring, providing feedback, generational diversity,

horizontal violence, and the health region vision and mission statements. Participants are given information packages filled with journal articles about mentoring, phases of mentoring, a sample contract, and ways of learning. After the workshop and during the mentorship process, the coordinator follows-up with the dyad via email and phone calls.

Program evaluation forms are given to participants. Retention status in the health region is also examined. Managers' input about the program is gathered as well. In order to recognize mentors and mentoring, a mentoring bursary is available that can be applied for and the money used for professional development for the mentor, the unit, or the facility. Money is awarded to mentors and to the participating nursing unit. After the workshop, participants are given certificates recognizing their contributions. (K. Balog, personal communication, October 12, 2011).

3.9 Chapter Summary

This chapter described the Glaserian grounded theory approach and how it was utilized in this study. The researcher described the setting, participants, and sampling strategies. Following a description of the study's ethical considerations, data collection and analysis were explicated in detail. The researcher described the strategies used for enhancing rigor and trustworthiness in this study. The section on researcher as instrument allowed for insight into the researcher's thought process. In order to provide context for the study, the researcher provided a description of the current mentoring programs being offered in each of the health regions.

Chapter 4

4.1 Findings

In this study, there were three objectives: (a) exploring managers' perceptions of their roles in creating a mentoring culture, (b) discovering the processes in creating a culture of mentoring, and (c) exploring the organizational features supporting and inhibiting this mentoring culture. By using the constant comparative method, the researcher determined that participants described a consistent pattern in the process of creating a mentoring culture consisting of many categories. Through constant comparison and coding of data into categories, three main concepts were identified: (a) organizational context (see section 4.1.2), (b) managers' perceptions of mentoring (see section 4.1.3), and (c) mentorship-supporting initiatives on the nursing unit or in the facility (see section 4.1.4). Further data collection, theoretical coding and sampling, and analysis identified relationships among the concepts, and allowed the categories to become saturated and their properties and dimensions developed.

Through the researcher using the constant comparative method, a core variable, *Committing to Mentorship*, emerged from these main concepts. The core variable was pervasive throughout all categories and concepts derived in the study. From analysis of the individual experiences of the participants, the researcher conceptualized the process of creating a mentoring culture and the nurse manager's role in it. The researcher used participants' words to illustrate the various categories and properties within them to provide a rich description of their experiences. (The participants' words are identified using italics in this dissertation). This description supported the emergent substantive theory of nurse managers' perceptions of their roles in creating a mentoring culture. Following a discussion of demographics, the researcher addresses the key concepts and core variable that emerged.

4.1.1 Sample Demographics

Twenty-seven managers were involved in the study, twenty-five of whom were registered nurses and two who were non-nurses. Twenty-five participants were female. The length of time managers had been in their positions ranged from 2 months to 25 years. Fifteen participants worked in the Saskatoon Health Region and the remaining 12 participants worked in five other health regions. Twelve participants worked in rural areas and 15 worked in urban centres. Eleven managed acute care units, seven were in long term care units or facilities, and nine worked in integrated facilities offering a mix of acute care and long term care services. In this study for ease of description, the term “nursing unit” could represent either a single nursing unit or an entire facility, depending on its size. Participants will be identified by the term “MON” (manager of nursing).

4.1.2 Organizational Context

The researcher understands organizational context to be the surrounding organizational factors that may have an influence on managers’ abilities to create, support, and sustain a mentoring environment for their staff. In this study, organizational context consisted of administrative support, mentorship funding, healthy work environments, rural considerations, and mentoring programs. Each category will be described.

4.1.2.1 Administrative support. Most managers believed that the greater organization and senior leadership support played a key role in establishing, encouraging, and sustaining mentorships on the nursing unit. Participants felt that the organization needed to be committed to mentoring throughout the facility. Commitment from an organizational perspective consisted of providing funding for mentorship, creating or supporting formal mentorship programs, and supporting managers in various mentorship initiatives. When describing implementing mentoring

on her unit, one manager said “...*I needed support from higher up in the organization ... The organization had to be committed to it too*” (MON D).

Managers also felt that the greater organization set the tone for the facility. For example, senior leadership established the vision and mission for the facility and encouraged employees to enact the organizations’ values. Organizations were expected to promote and support the mentoring of new employees by including it in their vision and mission, and by supporting it with funding, education initiatives, and mentor recognition. Along those same lines, participants emphasized that organizations were expected to create an awareness of mentoring within the facility by making their mission, vision, and values of mentoring visible to all employees in the region and to potential new employees as well. Managers believed that mentorship needed to be kept at a priority level by the organization through including it in facility newsletters, on the region website, in emails, and in verbal messaging. One manager spoke about mentoring and the greater organization, “...*it becomes part of the strategic direction and understanding that mentorship is necessary if we value our staff*” (MON R).

Managers also expected organizations to recognize and reward mentors by way of letters, awards ceremonies, or other forms of public acknowledgement. This approach was a strategy to let employees know that mentoring was valued in the greater organization. Some participants mentioned individuals in senior leadership positions acting as mentoring role-models to first line managers and all employees. Examples of role modeling behavior included being visible on the unit and acting as mentors in their interactions with managers and staff. Some managers questioned that if senior leadership employees were not acting as mentors to first line managers, then how could managers be expected to act as mentors to unit employees? Managers believed that mentoring may not filter down through the system if senior leadership was not providing

mentoring and mentoring support to managers. Some participants expressed that if they had experienced mentoring from senior administration, they were more likely to mentor other staff members in return.

Managers wanted the greater organization to support them in their mentoring decision-making. Participants believed they knew best what the unit and staff needed, as opposed to mentoring decisions being made by senior administration for the units. A significant finding was that managers wanted the flexibility in making their own mentoring decisions regarding new staff members, but wanted to be supported by senior leadership in those decisions.

Within the previous year, managers stated that they thought the focus of mentoring had waned due to other pressing priorities. Some participants felt their organizations needed to re-prioritize mentoring in their facilities by again promoting and encouraging its use. Managers gave suggestions to encourage its use by promoting it in regional newsletters, bulletin boards, education days, region websites, and staff meetings.

4.1.2.2 Mentorship funding. Funding for mentorship provided by senior leadership or the greater organization was considered important by most managers. “...*you absolutely need senior leadership because if there's no money for it, you don't do it at the end of the day*” (MON Y). This funding enabled participants to allow their employees to attend the mentorship workshops and have new staff act as supernumerary members of the healthcare team. Additionally, this funding enabled experienced staff members to be replaced on the unit so that they could attend mentoring workshops or spend time getting to know their protégés in order to develop the mentoring relationship. Managers expected the organization to allocate funding for the development of the mentorship program workshop and various mentoring education activities for staff. One manager wanted to receive additional mentorship funding, or at least

some leniency when her budget was overextended, *“I need senior management to either say here's the money or we understand if you go over your budget because we're committed to this”* (MON D).

4.1.2.3 Healthy work environments. Managers were clear about what healthy work environments looked like from their perspectives, and were able to describe their beliefs about the relationship between healthy work environments and mentoring. They described healthy work environments as environments where employees worked well together, used a team approach, and helped each other when needed. In this type of environment, employees enjoyed their jobs, wanted to come to work, and had the resources and supports they needed. Workers were engaged in their work and took pride in what they did. Managers stated that employees, in this type of environment, felt valued, respected, listened to, and supported in their decision making. In a healthy workplace, employees' feedback was actively sought. Staff had the proper training, skill sets, and knowledge base to provide safe, competent care for their client population. In a healthy work environment, managers believed they provided clear expectations, were actively present in the facility, and provided equitable treatment to their employees.

When asked about the relationship between healthy work environments and mentoring, managers stated that having a healthy work environment created a foundation for mentoring to occur. Many managers saw a direct relationship between healthy work environments and mentoring. For example, participants mentioned that to help facilitate positive mentoring relationships, a healthy work environment was key, and that this environment led to mentoring. *“If you're mentoring a new employee...you have to have that good work environment to facilitate a successful mentoring [experience]”* (MON N). A few managers believed that if employees were working in a healthy work environment, they would be more likely to mentor others. Also,

some participants stated that having mentoring relationships on the unit fostered a healthy work environment. *“I think that the opportunity to be mentored and have a positive mentoring relationship...develops into a positive, healthy work environment”* (MON K). A few managers identified a reciprocal relationship between healthy work environments and mentoring. That is, positive work environments facilitated mentoring and mentoring fostered healthy work environments.

4.1.2.4 Rural considerations for mentoring. Among the rural managers interviewed, several discussed the impact of being in a rural area on recruiting new staff and mentoring them. Being in a rural environment was particularly challenging for managers, because they believed they had inadequate resources, limited staff, and difficulties recruiting and retaining new nurses. Some rural participants saw mentoring as a tool for recruitment and retention in the rural area. *“There’s so many opportunities and in rural particularly, we’re not really given a pool of applicants and so if we don’t put processes in place to support these people, they’ll leave”* (MON N).

Rural managers identified several strategies used to support new nursing staff in their roles. Participants ensured there were experienced staff members on shift with the novices. Managers paired new nurses with experienced staff members until they indicated they were comfortable. If new nurses were working alone, the manager arranged to have experienced nurses on call to act as resources. Managers offered their contact information after hours in case new nurses had questions.

Managers discussed the importance of properly mentoring new nursing staff because these individuals would typically be in charge of the whole facility, especially on night shifts. *“You’re in charge of the patients, the residents, the staff and the building. It’s a huge, huge*

commitment to come out to work in rural” (MON J). Within rural emergency facilities, there was an unpredictability of the nursing workload and a wide range of patients coming to the emergency department. New nursing staff needed to feel comfortable dealing with the unknown and unexpected.

Another challenge they identified was the lack of physicians in rural environments, which added to new nurse feelings of isolation and increased responsibility. One of the advantages of being in a rural environment mentioned by the participants was that a smaller staff allowed new employees to get to know their colleagues and develop relationships more quickly. Managers saw mentoring as a way to support the new staff, especially if they were new graduate nurses or new to the rural environment. *“I think that’s really important that they feel supported and they know where to go if there is a problem”* (MON N). Mentors were seen as a source of knowledge to let new staff know who to call when a problem arose.

Several rural managers talked about mentoring new staff to become acquainted with the greater community as well, especially if the new nurses were unfamiliar with the rural environment. Participants believed it was important for mentors and other staff members to socialize new staff members into the community, because if the new nurse did not have roots in the area, he or she tended to move to a bigger center after a period of time. Socialization included introducing new staff to community activities, providing information on school options for those with children, and inviting them to community events. Managers indicated that trust needed to be established between the new individual, the employees, and the community members.

Many rural facilities hired internationally educated nurses (IENs) and their socialization into the community was seen as important. Because of cultural differences, the newcomers had to be welcomed to both the facility and community. This welcoming could even include finding

them housing and linking them with other IENs in nearby towns so they could develop their own support group.

Most managers indicated their frustrations with hiring nurses under time-limited contracts, because these nurses typically left after the contract expired. Managers identified that more work needed to be done in order for the issues of recruitment and retention of staff in rural areas to be addressed. Participants discussed the need for providing full-time permanent positions, finding permanent housing, developing relationships with other staff members, and establishing community networks to encourage new staff to be retained.

Participants mentioned that offering mentoring programs only in larger centers as opposed to smaller centers was a concern. Managers identified experienced staffs' hesitancy to drive into the larger centers to attend the mentoring workshops. Reasons were: being uncomfortable driving on the highway; driving in the larger center; attending the workshop alone; lacking funds to pay for mileage, hotel accommodations, or meals; or finding replacement staff to work the shifts while the potential mentor attended the workshop. Managers suggested offering the mentoring workshops in the rural areas either by videoconference or in person. They suggested that some nurses from the other rural facilities would be more likely to drive to another rural facility than to a larger center.

4.1.2.5 Mentoring programs. All participating health regions, except the Kelsey Trail Health Region, had formal mentoring programs established by the Government of Saskatchewan and the health regions. Some managers had built on these established programs and adapted them to meet the needs of their unit. Some managers had a misconception that the mentorship program had ceased to exist since the cancellation of the Graduate Nurse Job Program. Managers believed the mentoring program was important to socialize new nurses into the system and

should continue. However, they reported having trouble operationalizing the program due to competing priorities. Some managers found difficulty in arranging mentorship for their new employees and follow-up on the developing relationship due to their heavy daily responsibilities. For example, many participants stated they had other responsibilities and competing priorities that took them away from operationalizing and supporting mentorship on their unit. Managers stated they were overloaded with many health-region driven initiatives that they were expected to carry out, and numerous continuing education initiatives that they were required to offer. Managers felt that mentoring initiatives suffered due to these more pressing issues.

Some managers identified the difficulty in replacing experienced staff so that they could attend the mentorship workshops with the new nurses. They disliked the limited amount of time between the new staff being hired and the mentoring workshops being offered to provide the experienced staff the time off they needed and the replacements for their assigned shifts. As a result, some mentors were unable to attend workshops with their protégés. Due to their busy schedules, some participants suggested hiring an agent who could help them match the mentor and protégé and help conduct follow-up sessions with the pairs.

Managers believed they had mentoring occurring on the units. *“How do I get a nurse to be functional and be confident and have a more smooth transition? I think it is through that mentoring piece that we’ve offered”* (MON D). Participants felt formal programs should be individualized to meet protégé and mentor needs, flexible enough to be individualized, and long enough (anywhere from six weeks to three months). Some managers said that the program should last until protégés felt comfortable in the position, regardless of the length.

4.1.2.6 Summary. Organizational context affected the degree of success that managers experienced in establishing, creating, and sustaining mentoring environments for their staff. Lack

of administrative support and funding were identified as major obstacles to creating a mentoring culture and supporting mentoring relationships. Healthy work environments were believed to play a direct role in mentorships. Managers in rural areas mentioned rural-specific factors that could have an impact on mentoring success in those specific environments. In most health regions, mentoring programs existed, but managers had specific ideas on how to improve the program to best meet the needs of the employees and managers.

4.1.3 Managers' Perceptions of Mentoring

Managers articulated their thoughts and ideas surrounding mentoring, and the researcher found that common categories emerged from the data. For example, managers felt they needed to have certain personal characteristics that would enable them to support mentorships. They also described common mentoring beliefs they held. Participants discussed their opinions on the perceived benefits, drawbacks, obstacles, and facilitating factors related to mentoring. Managers also raised suggestions for other managers for creating a mentoring environment.

4.1.3.1 Personal characteristics. Managers mentioned several personal characteristics they saw as important to enable them to support mentoring relationships among their staff. Managers felt they needed to be open and positive to the idea of mentorship, and to be encouraging and supportive of mentoring relationships.

It's not just seen as some other initiative or a bother or an inconvenience. And that my responses to staff asking me questions – basically that I model that same behavior that I would expect a senior staff member to do with somebody that they're mentoring. So I think I need to basically model that and support that as best I can. (MON U)

Participants believed they needed to be present on the unit to facilitate mentorships. Being approachable and accessible were considered important, so that staff would feel

comfortable approaching the manager with any concerns and questions about the mentorship process. Managers mentioned the importance of knowing their staff, and they considered how that information could impact the mentoring relationship. *“Being able to have a feel for what’s happening with the staff so that you know those relationships are working and if they’re not – to tweak them right away”* (MON V). If staff had issues in their personal life that could potentially influence the quality of the mentorship, the managers would consider holding off on establishing a mentoring relationship until those issues had been dealt with. *“...all those things are external, but it comes to work and they’re trying not to and so it is really nice if you know some of those things are going on with them”* (MON C).

Another example of knowing staff members was knowing what was important to mentors: What was the motivation behind them wanting to be mentors so the manager could know how to best recognize them for their contribution. *“If I was assigning someone to be a mentor, I would want to know what they want from that experience”* (MON F). Managers said knowing staff members was essential when matching mentors and protégés, and knowing mentors’ strengths and limitations helped them to match protégés and mentors to ensure a good fit between the two individuals.

4.1.3.2 Mentoring beliefs. Managers held various beliefs about mentorship, but three commonalities emerged: (a) everyone is responsible for mentoring, (b) multiple people mentor staff, and (c) mentoring needs to be individualized.

Managers shared their thoughts and beliefs about mentoring and its importance.

You have to be positive about mentoring! You know, if you don’t believe in it, you’re not going to do it, right? I think it’s again it’s that openness and it’s the trust that this is a good thing. That this is great and it’s a benefit to everyone. (MON Z)

So that's what I do and mentoring is a piece of it and it's a chunk of things that you do to do what you need to do in your work. It's not probably the biggest piece of what I do – but it's probably one of the most important pieces. (MON D)

I think the biggest thing is that you have to believe in it yourself to...to encourage your staff to believe in it and, and to really promote it and understand what it, like the value of it and the end results. (MON O)

Some managers believed mentoring was an investment. “*I see mentoring as an investment of future nurses and, investment of my future teammates*” (MON K). Mentoring enabled the unit to have competent and confident employees who provided safe patient care. It also allowed a supportive, learning environment to be created where individuals grew professionally.

As, you know, in a leadership role, as a manager I think that mentoring is the one channel that I have to develop leadership on the unit. So when I'm developing internal leadership, such as developing mentors not just people that are being mentored but the mentors themselves. Then that supports me in my role. (MON AA)

Commonly, managers discussed the challenges in keeping mentoring a priority on their units. Due to their busy schedules and competing demands, they reported struggling to maintain their support of mentoring, but they acknowledged the significance of mentorship.

...in our busy, busy, hectic work days as health care providers, sometimes mentorship does fall by the wayside. We just don't get the chance to do it – or do it well or maybe we fail to recognize that there are little snippets in our day that we can actually be mentoring. (MON P)

4.1.3.2.1 Everyone is responsible for mentoring. Participants believed that each

employee was responsible for mentoring new individuals, regardless of the position they held. *“I think everybody has a part to play, everything we need to learn isn’t always all clinical and so it definitely needs everybody’s support as far as teaching and what value we’re adding to that individual’s experience at work”* (MON AA). MON R further added to this perspective by stating, *“I think everyone has a responsibility to mentor like I mentioned – housekeeping, laundry, kitchen, people that work together on a certain part of the team, have a responsibility – a moral responsibility – to help out their teammates, right?”*.

Managers believed each individual had a role in mentoring new staff. They listed several individuals who were responsible for mentoring new nurses including managers, clinical educators, clinical coordinators, RN staff, LPN staff, special care aides, housekeeping, dietary, laundry, maintenance, therapists, and physicians. Managers believed it was the whole unit or facility that mentored the new employee. Each employee provided new nurses with a different perspective to enable them to see the whole picture and to provide the best possible care for their clients. Furthermore, managers indicated the importance for each professional to know how their colleagues’ jobs fit together in order to provide the best care for their client population. Cross-discipline mentoring enabled new staff to know the roles of each of their healthcare team members.

4.1.3.2.2 Multiple people mentoring staff. Managers specified a team approach to mentoring was ideal. *“I think we all have a part to play in it and I don’t think it’s necessarily just a nurse. I mean they can be mentored on many different things”* (MON O). Managers acknowledged that mentoring individuals were knowledgeable in certain areas, and that each of them contributed to the development of the protégé. Some managers set up formal mentorships with two experienced staff to mentor one protégé. Managers identified that each nurse had a

different way of functioning and provided a different perspective to enhance the protégé's learning. As a result, protégés could reflect on the various ways of performing a certain skill and develop their own approach.

I think our whole unit acts as one big mentor in a sense because you may have questions at any time. You may need that reassurance at any time during your shift and when you're working, you're not paired with somebody extra, you're working with a multitude of different people all of the time. (MON U)

4.1.3.2.3 Mentoring needs to be individualized. Managers stressed that mentoring needed to be individualized to meet protégés' needs. They recognized that not everyone learned at the same pace, and that alterations in program length needed to be made. If the formal mentoring program had ended, but the manager believed that the protégés needed more time, participants thought the program should be extended in order to make the experience successful for new nurses and to help them feel comfortable in their roles. Managers recognized that new nurses had varied backgrounds, experiences, expertise, and learning needs. They felt the mentoring program should provide what new employees needed and wanted to learn. When discussing the mentoring program for each new nurse, one manager stated, *"I've noticed it's different for each one. So how you proceed in their mentorship program or what they take out of that mentorship program is different per nurse....It needs to be personalized"* (MON C).

4.1.3.3 Perceived benefits, drawbacks, obstacles, and facilitating factors. Throughout the interviews, participants identified perceived benefits, drawbacks, obstacles, and facilitating factors for mentoring. Managers discussed both general and specific mentoring benefits for the unit, protégé, and mentor. Mentoring drawbacks, obstacles, difficulties were also discussed. In addition, participants described factors that made mentoring easier.

4.1.3.3.1 Perceived general benefits. Managers reported general benefits of mentoring. For example, they indicated that reciprocal staff learning and mentoring occurred for both the mentor and protégé in the mentorship. Each individual acted as a teacher for the other and had knowledge to share. Besides experienced staff sharing what they knew, new staff members were also able to share their knowledge of the latest research, technology, and innovative procedures. Managers felt that new staff members were refreshing to the unit and added a different perspective. “...*they’re a breath of fresh air because they’re newly trained, they know the newer things that are out there, especially in long-term care, it’s harder to keep up on the new stuff that’s out there*” (MON L).

Another perceived benefit to mentoring was the recruitment and retention of new staff. Participants acknowledged that when people knew a unit had a mentorship program, it could potentially be a recruitment factor. Managers believed new staff wanted to work in a facility where they were supported in order to develop their confidence and competence. One manager described her feelings when talking about mentoring new staff:

If I do this now, my pay off would be over here. They’ll want to stay. I will keep them as a retained employee. I’ll have somebody who’s functional in six months and able to look after really, really sick patients. Whereas if I don’t do that, then they’re going to struggle and possibly leave. (MON D)

4.1.3.3.2 Unit benefits. Managers recognized the more mentoring a unit practiced, the better outcomes clients would have. Through mentoring, employee relationships were developed and strengthened, resulting in a more cohesive team. The team atmosphere facilitated positive client outcomes. Participants acknowledged that relationships between mentors and protégés often continued after formal mentorships were over. Furthermore, managers indicated that

employees who were exposed to mentorship as either a mentor or protégé were more likely to mentor others in the future.

4.1.3.3.3 Protégé benefits. Managers believed that mentoring allowed new nurses to gain competence and function more quickly and efficiently as nurses. They also acknowledged that new nurses were able to become more confident and competent in their role and in their nursing skills. Mentoring allowed new nurses to understand the broader picture of a situation with the guidance from mentors who had previous experience with similar situations. Protégés were often able to see mentors' critical thought processes with regards to the situation. Through mentoring, new nurses were able to explore ideas with their mentors and have supportive people assisting them in working through difficult circumstances.

4.1.3.3.4 Mentor benefits. Participants stressed that not only did protégés benefit from mentorship experiences, so did mentors. For example, a stated benefit for mentors was the personal satisfaction in knowing they participated in helping develop the profession. Managers said mentors were rewarded by seeing that they had contributed in some fashion to the development of an individual nurse. By taking the mentorship workshop and by being a mentor, mentors were exposed to professional development opportunities that had the potential to enhance their own professional practice as well. The workshops allowed mentors to develop their skills in team building, leadership, conflict resolution, and facilitation to name a few.

I think as a mentor you, it's to your benefit to...mentor them into a nurse or mold them almost – it's an opportunity to bring out the best in them and to help them become the team member that you want to work with (MON K).

4.1.3.3.5 Mentoring drawbacks. Managers recognized limitations of being a mentor at times. Participants acknowledged that mentoring took extra time, energy, and patience. Staff

members were often not relieved of their regular duties, but had additional mentoring responsibilities assigned on top of their normal routines. Managers indicated that this added responsibility could be seen as a drawback to mentoring. To prevent mentoring burnout, managers were careful not to assign individuals to be mentors who had taken on that responsibility in the immediate past. However, in some facilities, managers had a limited pool of potential mentors, who tended to be used as mentors on a regular basis. Thus, the potential for burnout occurred. Participants were careful not to assign mentorship to someone who would be considered newer to the profession or to the unit due to the fact that these individuals were still trying to learn their environment themselves. Managers believed that taking on the mentor role had the potential to be more work for the individual. Mentors might feel like they were solely responsible for facilitating the learning of a protégé and as a result, managers sometimes assigned two mentors to share the responsibility of one protégé. Managers recognized that potential mentors may be reluctant to take on the role due to the perceived drawbacks, and they therefore tried to ease these perceived downsides, when possible.

4.1.3.3.6 Mentoring obstacles. Rural managers acknowledged there were limited opportunities for education and learning about mentorship in their facilities. They believed there were many opportunities in the urban centers, but that mentoring education was limited out in the rural areas. Also, few nurses were available to do the job of mentoring, especially in the rural areas where there was a minimal number of RN staff. In many rural and long term care facilities, RNs worked independently alongside other team members like LPNs and special care aides. Participants recognized this isolation could be considered an obstacle to mentoring, when there was not another RN working directly with the new nurse. Along with limited RN employees was the consideration of finding the best person to be a mentor for a new nurse. Managers in rural

and long term care areas, who had minimal RN staff, sometimes struggled with selecting the best mentor for the protégé due to the limited pool of RNs.

Managers mentioned that lack of time was an obstacle for them from encouraging mentoring on the units. Their days were already full with day-to-day routines and numerous meetings. They experienced difficulty finding time to: (a) determine if staff members were interested in being involved in a mentoring relationship (b) monitor how the mentoring relationship was going, and (c) provide the resources that were needed to foster the mentorship.

Lack of funding was also identified as an obstacle to mentoring. Participants stated their budgets were limited and this lack of money inhibited them in providing extra mentoring education initiatives and relieving staff to attend mentoring workshops. This lack of funding also prevented staff from having sufficient time to establish a relationship between the dyad. Rural managers mentioned a lack of money to cover the various expenses of having staff attend mentoring education initiatives in the bigger cities.

Participants acknowledged that the numerous competing health region initiatives were obstacles for mentoring. Managers were forced to implement mandated health region initiatives that left little time for encouraging and supporting mentoring amongst staff. These initiatives took priority over other efforts that the managers felt were important, because the former were prioritized by the senior leadership team or executives.

Managers also perceived that lack of time for mentors was a potential obstacle for someone agreeing to be a mentor. Nurses already have a busy schedule and numerous responsibilities and to add mentoring onto that list, could be considered burdensome and could inhibit some individuals from agreeing to be a mentor. *“...they’re just too busy and they don’t have time to take and spend with someone else or worry about someone else. They’re just trying*

to get their own stuff done” (MON Q).

Some managers discussed the continuous learning environment that occurred on their units. Nursing units often seemed bombarded with students from various professional programs and new staff members requiring orientation. Participants stated this type of environment had the potential to contribute to staff fatigue with the over-extended teaching and learning process. As a result, managers believed that staff may be less likely to undertake additional mentoring responsibilities. As well, with final practicums for RN and LPN students, nurses had preceptor roles for a period of time with these students, so the potential mentor pool became increasingly limited.

Another potential obstacle to mentoring identified by managers was unhealthy work environments and settings where workers were negative and unwilling to mentor others. Participants also discussed individuals’ personalities that distracted from effective mentoring, thus making mentoring more difficult. Perhaps these nurses were unwilling or resistant to mentor, had a negative attitude, were considered a bully, did not have the patience required to mentor, or the ability to clarify or critique in a constructive manner. *“I think the biggest obstacle is the staff themselves, and it’s probably lack of knowledge, lack of exposure, you know, and then they need to see the benefits of mentoring before they buy in” (MON K).* Another potential obstacle to mentoring that participants described was a lack of information about, and exposure to mentoring. Managers believed a lack of accessibility to mentoring education and unfamiliarity with the process could potentially be an obstacle to engaging staff in mentorships.

4.1.3.3.7 Facilitating factors. Managers described facilitating factors that encouraged mentoring relationships among staff. For example, having managers and colleagues that were supportive and encouraging of mentoring relationships and having a teamwork atmosphere

assisted in creating mentorships. Employees that were respectful of one another and had a genuine interest in supporting new staff encouraged the mentorship process. Support from senior leadership, including funding and programming, was considered a facilitating factor. Awareness, education, and promotion of mentoring by the facility, unit, manager, and staff all facilitated employee mentoring. *“I think that by saying that we’re doing the mentorship program, that promotes it. Like for me, they all know thatI really strongly believe in it”* (MON V).

Adequate staffing levels were important for providing time and a decreased workload to mentor others. Managers believed having a mentorship coordinator assisted with facilitating mentoring, because the managers’ schedules were busy. They also stated that having time to develop the mentoring relationship was an important factor. For example, allowing staff time to arrange mentorships and get to know each other was seen as integral to developing the relationship.

4.1.3.4 Suggestions for other managers to create a mentoring environment. When asked if there was any advice that the participants would like to give to other managers interested in creating a mentoring environment, participants gave several suggestions. Managers believed that creating an environment that supported mentoring was difficult and time consuming, but it was worth the effort expended by managers and staff. Managers suggested that in order to create a culture of mentorship, staff needed to be aware of mentorship and be engaged with it. Participants recommended having a dialogue with staff where they could: share their vision for mentoring; ask employees their opinions about mentorship; describe what they thought was important to consider; and outline how the program would work best on their unit.

You need to sit down and have a relationship with your staff. You need to talk about it, about how important it is to you that this happens and get their input and their feedback on how it can work for them and whether they might see it as the important parts of it.

You have to engage, basically (MON R).

Managers felt that being available and present on the unit had an impact in creating that mentoring environment. Along with this availability came the emphasis on role modeling mentoring behaviors in their interactions with staff.

I try to model a behavior that I would want to find or that I would hope that my staff would have to each other. I try to be open, I try to answer positively and I try to direct them in the way they can find the resources that they need to do (MON U).

4.1.3.5 Summary. Managers' perceptions of mentoring encompassed a description of personal characteristics they felt they should possess to enable them to create, support, and sustain mentoring relationships. A description of general mentoring beliefs was provided that discussed how participants felt about mentorship. Managers also voiced their opinions on perceived benefits, drawbacks, obstacles, and facilitating factors to mentoring on their units. Managers proposed suggestions and strategies for other managers to utilize in order to create a mentorship environment in their workplaces.

4.1.4 Mentorship-Supporting Initiatives

Throughout the interviews, the researcher asked nurse managers to describe what supporting mentorship looked like from a nurse manager's perspective, how they supported mentoring relationships, and what they believed their roles were in supporting mentorships. Several key categories emerged from the data that described the processes that enabled a manager to encourage, create, support, and foster a mentoring culture.

Overall, participants believed supporting mentorships through specific actions was one of their roles and responsibilities. *"My role is facilitating the whole process of, seeking out mentors, welcoming the mentee, putting them together, and then being there as a support system for both*

of them through that whole process” (MON K). MON Z believed her role was to provide support to staff, “You know, my educator and I, we’re here. We’re available. We try and have one of us here all the time so that we can support that mentorship... [and] make sure the support is there for the staff to do it”.

4.1.4.1 Communicating. Participants stated that communicating about mentoring occurred in several ways. During the initial interview or on the first day of orientation of a new staff member, many managers described the mentoring program that was available. Managers would encourage staff to find their own mentor that they “clicked” with, and some managers would match mentors and protégés.

Participants expressed the necessity of discussing mentoring with the staff in an effort to create the mentoring culture on the unit.

...bringing folks together to talk about mentorship and have and get ideas from them, you know, from staff and they let us know – what do you think mentorship is all about? How do you think you can help the new people on the block and how could you support them in their learning at this time. So just share the ideas and get staff to talk about and buy into it too. Because sometimes they’re not, they don’t, people don’t buy into the, if it comes from a manager. So if they have the ideas and work with staff to support that piece, and I think sometimes people don’t recognize what mentorship could be. (MON P)

Discussions about mentorship included highlighting the details and importance of the program, promoting it amongst staff, and communicating the positive outcomes of mentoring. Managers stressed that getting commitment from staff regarding mentorship was important and that discussions with staff facilitated that commitment. For example, one manager described her discussion with staff: “You can’t just sit in here and say, ‘There’s a mentorship program out

there and I expect you all to do it'. Okay, fine, but that's not, nothing's going to happen, right?"

(MON R). She felt that telling staff to be mentors would not facilitate their engagement. This manager further described the questions she asked her staff in order to stimulate an interest in mentorship: *"What do you think about the mentor program for nurses? What do you think about it? Could it work better here? Do you want to do it"* (MON R). A few managers had circulated articles regarding mentoring on the unit to increase the staffs' awareness of it; and one manager mentioned that she would like to add more information about mentoring in staff newsletters.

Managers repeatedly stressed that having open communication with staff members was important in changing the culture to incorporate mentoring, and to assist problem solving in the unit. Many managers discussed having an "open door" policy and being available to staff when they had questions or concerns: *"...you have to foster an environment that they can come to you and ask you questions just like any other staff member"* (MON C). Participants also indicated they needed to make themselves readily available to any staff member who had questions about mentoring, and to actively seek out new staff to ascertain if they had any questions or concerns. Managers wanted both the mentor and protégé to approach them individually or as a dyad, if there were any questions or concerns about the relationship.

Most managers followed up with the mentor and protégé individually and as a dyad to see how the relationship was functioning, and if any assistance was needed to meet the protégé's learning needs. Participants frequently asked for feedback from the mentor and the protégé, regarding the mentoring process, the procedures to make the mentoring better for new staff, and the learning needs that still remained. Some managers indicated assessing the mentoring process during yearly performance appraisals as a means of formally following up with the mentor or protégé.

4.1.4.2 Educating staff. Many managers expressed that mentoring education was important for staff. However, some participants discussed the challenge with providing this education in addition to the other competing priorities and lack of time. MON T stated, “...we have other issues that seem to be bigger at this point, it’s not something that we’ve really pursued to a great extent”. MON Y shared a similar perspective:

We had talked about having a mentorship month. You know – let’s talk about mentorship and talk about what we could do and we just haven’t been able to do it yet. Because there is always, you know, we had like medication administration month and you know so there is always messaging and it’s sad that mentorship keeps getting bumped for the ‘issue of the month’. When maybe if we had more mentoring we would have less ‘issues of the month’.

Some managers thought their staff members were quite familiar with mentoring, especially the newer staff members due to education provided in university, at orientation, and from professional associations. They felt the education could be geared towards staff members who had been on the unit for a longer period of time to refresh their memories as to the process of mentoring and the expectations associated with being a mentor. Some managers saw the benefit of providing education to the staff about the mentoring process, the available resources, the comfort in being a mentor, the mentoring benefits, the expectations of being a mentor, and the different learning styles and teaching strategies. One manager and nurse educator worked with mentor staff members before protégés arrived on the unit, discussing what the process was like, what the mentor’s role was, and what was expected.

Some managers mentioned that nurses did not utilize the health region mentoring education and workshops enough and that they rarely asked to attend. As a result, participants

suggested various mentoring education strategies that they wanted to see implemented. Some managers stated they would like short information sessions on mentoring to be provided to their staff on their nursing unit. One manager expressed a desire to have greater mentoring education opportunities for staff working in long term care. Another manager suggested having a region-wide “mentoring week,” where mentorship could be promoted and education be provided. Participants wanted to see mentorship being promoted in a variety of ways in the health region: on the website, on unit posters and brochures, in the health region newsletters, and in the educational institutions.

4.1.4.3 Developing relationships. Participants identified that developing relationships amongst managers and staff members was important in order to best meet the needs of mentors and protégés. Managers saw their role as supporting relationship development amongst staff in general, and between mentors and protégés specifically.

4.1.4.3.1 Developing relationships amongst the manager and staff. Participants stressed the importance of developing relationships with staff members and getting to know their staff. Becoming acquainted with staff allowed managers to be supportive towards their staff, to understand their professional needs, and to be able to strategically select appropriate mentors for protégés. They emphasized the importance of knowing details about their staff, including their marital status or if they had children, and what their aspirations were. *“You need to know your staff. You cannot manage a staff you don’t get to know...so when we do social engagements on the floor, I make sure, as a manager, that I go to them too”* (MON C).

...it’s huge - the relationship between staff and manager. ...I see my staff as people first. They all have needs. They all have issues that they’re dealing with at home and I recognize that piece. I believe as a manager I need to be able to relate to my staff in a

way that I try to be understanding. (MON P)

Participants mentioned having professional conversations with their staff to build that relationship and to be a source of support. Managers believed having conversations with staff allowed them to build rapport and develop respectful relationships. *“Relationships need to be very respectful and we expect that from our staff... If you’re not going to be respectful to them, you can’t expect it back” (MON T).*

Managers stated they wanted to be readily available for their staff, especially those in rural communities where nurses worked more independently. Rural participants reported that staff members could call them anytime at home if they had a question or concern. Managers also made staff aware that there was always a manager on call that could assist them with their concerns if it was after daytime work hours.

Managers described how they frequently “checked in” with new staff, asked how the mentorship was progressing, and if they needed assistance with anything. Managers believed that if relationships were developed, new staff would be more willing to share their insights and ask questions about current practice.

The new person coming in brings a wealth of new knowledge to us and they’re up to date on – or they have different knowledge than we have, and we just need to incorporate it into our practice, so we just need to know about it. (MON V)

4.1.4.3.2 Developing relationships among staff members. Managers acknowledged relationships among employees were important. Participants indicated employees wanted to feel supported, valued, and respected by their peers in the workplace. They stated new staff wanted to develop those relationships so they would feel comfortable asking their colleagues questions or requesting help if needed. *“A lot of it is developing the relationships. ...I think, it all comes down*

to good teamwork, good work relations, the healthy workplace” (MON L). MON P echoed the significance of staff relationships, “Relationships are extremely important amongst staff”. Managers believed that developing those positive relationships facilitated mentoring. “...if you’re uncomfortable with someone or you don’t trust them, you’re not mentoring them. You’re just paying lip service to it” (MON Y). “If you have a good relationship it’s easier to challenge someone, it’s easier to support them, it’s easier to be affirming of them, to appreciate all their gifts, and to be able to express that openly to them” (MON G). Participants felt that the cohesiveness and comfort level of the relationship between mentors and protégés determined how successful mentorships would be.

Some managers stated that allowing staff sufficient time during coffee and lunch breaks to confer with one another was important for starting to develop those relationships. Time for staff to get to know each other increased the comfort level between staff members, and thus created an avenue for new staff members to ask questions or express concerns. *“So that’s another really big piece of what you do as a mentor. You try to get them to fit into and be part of what you think that person should do in the workplace” (MON D).*

There were times when nurses were working in isolation in departments and needed to consult with nurses in other areas. This opportunity gave nurses a chance to connect with one another and discuss any matters that were of concern. In rural areas, in order to support new staff who may have been working alone, nurse managers would have an experienced nurse on call for the new nurse to contact with any questions. Furthermore, participants acknowledged that if relationships were developed among staff members, then when staff needed to call a colleague in to work, they would do so because they were personally invested in their co-workers, especially in rural communities.

Participants specified that one of the roles of mentors was to assist with protégé socialization to the unit and staff culture. Actively inviting them to be a part of the team on the unit, taking them for coffee, and inviting them to ward outings were mentioned by participants. Managers encouraged ward and outside-of-work team-building activities to establish closer staff relationships. Some managers found that new nurses who had their final student practicums on the unit already had started to develop those staff relationships. As a result, the new staff felt more comfortable on the unit, in general, and more comfortable asking questions of others.

Participants found themselves acting as facilitators between staff members if needed. For example, they would introduce mentors and protégés in order to promote beginning connections. If a problem arose regarding specific mentor-protégé relationships, managers would meet with both staff members individually or as a dyad to discuss the issues.

Managers believed that if positive working relationships were fostered in mentorships, these relationships would continue on after the mentoring had terminated.

...one thing that I see as being very positive is that if there's – with new staff particularly – when that relationship is actually established at the beginning and the relationship you can see the chemistry there between those two individuals – even months later when the mentoring relationship might not be as formal as it was in the beginning, there's still that connection. (MON AA)

4.1.4.4 Facilitating mentoring. Facilitating mentoring refers to managers using various methods to make mentoring easier for nursing staff or to make mentoring more likely to occur. Participants used a variety of strategies to facilitate mentoring. The researcher will discuss each strategy used by managers.

4.1.4.4.1 Initiating mentoring relationships. Nurse managers commonly saw themselves as facilitators in initiating mentorships. When meeting with new staff members, many participants discussed mentoring and the processes that occurred on the unit.

I see my role as - I facilitate those - make sure that those connections are made. So when a new person is hired onto the unit, we say that we do mentoring on this unit, we believe in mentoring relationships, and so they are given a choice of a couple different options that they can chose between....You know they can come, get to know the staff and then chose someone who they want to be their mentor and they can formally ask them to be their mentor because we know a lot of that informal mentoring happens or I do offer if they aren't comfortable with those things that I could also pair them with someone. Ask someone for them to be their mentor and set it up that way. (MON V)

In some facilities, managers would inform staff that a new individual would be starting. Participants asked staff if anyone wanted to be a mentor and attend the mentoring workshop with the new individual. Other managers reported approaching staff and saying, *"I have this new nurse coming and I was thinking you might be a good person to mentor with them. Have you ever thought about doing that?"* (MON D). Most managers also stated that the expectation on the unit was that all staff would assist in new employees' learning and development.

Managers often assisted in matching mentors and protégés based on protégé needs and mentor skill sets. They said they were able to introduce the pair, and were able to make suggestions for them. Ensuring the dyads had the resources they needed and ensuring the pairs knew where or how to find needed resources was a role of the manager. *"...my role is facilitating the whole process of..., seeking out mentors, welcoming the mentoree [sic], putting them together and then being there as a support system for both of them through that whole process"*

(MON K). Participants would also help new staff find particular nurse experts. For example, if a new nurse had a question regarding advanced cardiac life support (ACLS) principles, then the manager would introduce the protégé to the ACLS instructor on the ward.

4.1.4.4.2 Being a resource. Most participants indicated that they served as a resource for staff by being readily available to help them trouble shoot problems on the unit or within the mentoring relationship. Managers stressed the importance of making themselves available to answer questions. They would not necessarily provide all the answers, but would assist with brainstorming and make suggestions about possible solutions. They encouraged questions from both partners and offered possible sources of answers. Helping the staff with anything they needed was a common phrase stated by managers.

...I'll have front line staff come and ask me questions about how to do a procedure, whatever it happens to be. And sometimes I'll walk them through it, I'll show them where the policy and procedure binder is, I'll refer them to the educator or if it's something that I do not have an expertise in or haven't done for a long time, I'll bring somebody else in to do that. (MON U)

4.1.4.4.3 Providing resources. Managers felt their role was to provide support and resources to mentors and protégés. Most participants felt that their job was not to tell staff how to do their work, but to provide resources and tools to enable staff to do their jobs effectively and efficiently in order to provide quality care to patients.

And that's where I sometimes see my job is trying to support and providing the resources available for the staff to do their job as best as they can and to support always improving the quality of care that we do. (MON U)

Common resources that managers provided included journal articles, policy and

procedure manuals, unit specific orientation materials, textbooks, computer access, guest speakers, or outside educational opportunities. Other resources were: introducing staff to other individuals in the health region and facility as needed to assist in mentoring relationships; providing contact information for various experts; allowing staff to have the proper equipment to do their job; ensuring staff knew where to go to get information; providing answers to staff questions; or following up with others if the manager could not provide the answer.

4.1.4.4 Providing opportunities. Managers attempted to provide staff with various learning opportunities. In order to best support mentor and protégé relationships, managers said they had to know the learning goals of the relationships. This knowledge enabled participants to support the dyad in reaching those goals by providing such resources as extra time to be spent on attaining goals or by providing needed materials and resources.

Managers frequently asked new staff what their learning needs were and how managers could help facilitate their learning. If participants knew of upcoming professional development opportunities that were of interest to new individuals, managers would advise them when opportunities became available. If the manager knew the new staff member wanted to see a certain procedure or watch a certain operation, the manager would facilitate those events.

Participants mentioned the necessity of providing protégés with additional learning opportunities, especially in rural areas. *“We’re always looking at who might be around to benefit from whatever type of experience is there”* (MON B). The managers would send new staff to other locations to observe various procedures, operations, or acute patient situations, so that novices could gain pertinent exposure in an attempt to benefit them in their current practice. Managers would also ask what new staffs’ goals were in relation to additional training needed. If protégés wanted to take specific courses, managers would try to arrange them. If mentors,

protégés, or managers thought protégés needed more time in a particular area to build competence or confidence, managers would organize that opportunity.

If staff expressed an interest in ongoing education, managers granted education leaves or time off as needed. Some participants provided funding or made staff aware of various funding opportunities, so that staff could attend various educational sessions. Managers took advantage of various in-services and arranged staff time to attend; or if they were in a rural facility, managers would arrange for in-services to be offered in the rural area.

Managers tried to provide opportunities for every staff member to be a mentor and to make the necessary accommodations. For example, if the prospective mentor worked nights or part time shifts, the manager would pair two mentors with one protégé. This strategy allowed the protégé to have a varied experience and allowed the night shift and part-time staff to have the opportunity to mentor.

4.1.4.4.5 Manager as mentor. Most managers saw themselves as formal and informal mentors for both new and experienced staff, as shown by MON C's example: "*...if I feel they're struggling or if they need more time in an area then I try and get them that, what they need*". MON E saw herself as mentoring new staff towards a broader perspective. "*So while I think a ward duty nurse, general duty nurse is a good mentor for a certain perspective of it, I think a manager has a role in mentoring in terms of that bigger picture...*" (MON E). Some participants thought they were able to provide education to staff, to share their knowledge of a certain situation, or to provide them with literature or journal articles as required. Managers also guided staff through certain procedures or techniques, especially in the smaller facilities.

4.1.4.4.6 Manager as mentor role model. Managers said they acted as role models for mentoring.

I model that same behavior that I would expect a senior staff member to do with somebody that they're mentoring.... I try to be open, I try to answer positively and I try to direct them in the way they can find the resources that they need to do. (MON U)

In one facility a manager did not want her staff mentoring each other, because of the lack of best practice being implemented. She felt that she was the mentor to all staff in that she role modeled best practice and provided information on how to use research and critically think in client-care situations. She believed her staff needed to work on best practice skills prior to having staff mentor each other.

4.1.4.4.7 Allowing staff time to mentor. Most participants recognized that mentoring took a considerable investment of time from those involved. These managers acknowledged that mentors and protégés needed time to develop their relationships, to explain various principles and procedures, to be socialized into the nursing environment, and to build the confidence and competence of protégés. *“That’s the one thing that I learned very quickly was that it takes time and you need to make that investment if you’re going to get that quality or that value produced on the other end” (MON AA).*

Managers talked about allowing time for mentors and protégés to get to know each other and possibly reducing mentors’ patient assignments to provide for extra time for mentoring. In Saskatchewan, mentors were allocated an education day to attend a mentorship workshop funded by the government. Participants wanted mentorship to be considered a priority so that more time would be allocated towards mentoring. They wanted staff to either make the time to mentor or be allocated the time to mentor. Managers discussed having additional staff on the unit when available, so that the mentor could take time to meet with and explain things to the protégé.

I think for the nurse that is the mentor we certainly have to make some special arrangements, make sure that we're giving her enough time to do that. If it becomes a workload that doesn't change and you have to be the mentor I think it can be quite taxing, and I'm not sure how effective that would be over a period of time. (MON S)

4.1.4.4.8 Encouraging teamwork among staff. Participants stated that encouraging teamwork was essential to promoting mentoring among staff. If there was an atmosphere of teamwork, participants believed that staff members were more willing to help others, to answer their questions, and to take time to mentor. Managers considered assessing for teamwork abilities when interviewing new staff. They expressed that a lack of teamwork ability was considered a barrier to mentoring.

Managers strategically placed new nurses with or near experienced nurses who worked well in a team, because the latter were more willing to help the protégé. These same experienced staff members were often asked to “check in” with the new nurse to see how they were progressing. One participant described her conversation with experienced nurses:

'Can you guys be the go-to people for her? You know when you're working?' Because I'll look on the roster and say well you're working mostly with this new person so would you mind just seeing how things are going? So that to me is mentorship. (MON P)

4.1.4.5 Establishing guidelines. Managers had distinct expectations for their employees, and felt that expectations must be explicit. They had clear mentoring expectations regarding the roles and responsibilities of the employees on the unit, the mentors, and the protégés. Managers who had established formal mentoring on their unit had typically either discussed the expectations with both mentors and protégés prior to the mentorship, or the expectations of each member were delineated at the mentoring workshop.

4.1.4.5.1 Expectations of employees. Managers had expectations for their employees in that they expected all staff to help each other and that the helpful environment produced a team atmosphere. They expected that new staff would be welcomed onto the unit. Some managers told staff that a mentoring program was available and mentoring and mentoring relationships were expected to be operationalized on the unit. All participants believed that mentoring was a team endeavor, and that everyone should be involved in the process of socializing and integrating a new person into the environment, and that there would be a shared responsibility for integrating the new individual. Along with maintaining that mentoring atmosphere, staff members were expected to assist protégés as needed, be respectful and kind to them, share information with them, and be willing to take the time to teach them things. Many participants brought up the term “eating their young” and managers reported that they expected this behavior would not occur on their unit.

In addition to these general expectations of employees, managers had further expectations for RNs when a new RN started on the unit. The experienced nurses were expected to be resources and supports for new staff members. Nurses were to act as role models. Some managers felt RNs had a professional obligation to mentor new nurses, based on their professional code of ethics and competencies. Managers believed clinical nurse educators, who were RNs, played a key role in educating and integrating new staff members as well. Clinical nurse educators were expected to support mentoring relationships, explain the mentoring process to the staff, act as mentors, and assist new staff in the orientation process on the unit.

4.1.4.5.2 Expectations of mentors. The majority of managers believed good mentors embodied certain characteristics, such as being exemplary nurses with broad nursing skill-sets that included critical thinking abilities and global perspectives. Mentors needed to be

knowledgeable in the mentoring process and possess solid mentoring abilities. Additionally, mentors needed to be able to communicate effectively, be good listeners, be approachable and open minded, demonstrate positive attitudes, be respectful, and be welcoming of new staff. Above all, mentors needed to be willing to be mentors.

So the characteristics I look for in a mentor is somebody that is knowledgeable. Not necessarily senior – but knowledgeable, has good practice, competent and is caring. So is very much aware of what’s going on and willing to go the extra mile. (MON V)

Managers expected mentors to fulfill certain roles and responsibilities. These perceptions could be based on participants’ personal expectations or on expectations outlined in the health region’s mentorship program. The majority of managers thought mentors’ major role was to provide protégés with resources and opportunities for learning. Mentors were expected to communicate openly with protégés and managers about the protégés’ progress. They were to assist with the protégés’ socialization and assimilation into the unit culture, assist protégés with their gradual independence, and be a source of support for them. “...to mentor is to support but ... give them independence in that support, provide them with the ability to carry through and do their job” (MON E).

An assumption of most managers was that staff, who they considered mentors, would exemplify certain characteristics of “good nurses”. One manager did not see her staff as meeting these expectations of “good nurses” in terms of evidence-based practice, and thus she did not want them mentoring each other. She chose to mentor these nurses herself. See section 4.1.4.9 for a further description of the negative case.

4.1.4.5.3 Expectations of protégés. Some managers expected protégés to vocalize what they wanted to learn, to take responsibility for their own learning, and to be open to learning.

“They need to be willing to seek out learning opportunities for themselves because we may not know what they have or haven’t seen” (MON B). New staff members were also expected to share their theoretical knowledge and evidence-based practice foundations with staff. They were expected to ask questions if they were unsure or needed clarification, to be positive, to be open to feedback, and to share their enthusiasm for nursing. Some participants wanted the new nurses to come to work prepared with the learning modules completed and to ask questions if they did not understand a concept.

And that they take initiative to ask those questions, find the resources and then resource and link with some of the other staff if they don’t know – but then to learn from that and build on that knowledge. I expect there to be a continuum kind of – where they’re learning and building so that they can, if someone asks the question, that they can provide that for other staff members as well. (MON U)

4.1.4.6 Implementing programs. Participants talked about their roles in implementing formal mentoring programs that were offered by the health regions. They had a range of familiarity with the current programs. Some misconceptions surfaced about existing programs being offered, in that the Graduate Nurse Job program had been cut, but the general mentoring program was still in effect. However, some managers thought that the whole mentorship program had been cut.

Participants discussed their roles in selecting mentors and establishing pools of mentors from which they could choose. Managers were strategic in how they matched mentors and protégés because this pairing was considered important. They also discussed a strategy of sharing the mentorship duties with more than one mentor, as well as evaluation considerations.

4.1.4.6.1 Selecting mentors. Most participants mentioned the process they used in

choosing an appropriate mentor. They reported that selecting an appropriate mentor for a protégé was difficult at times. Most managers identified the importance of a “good fit” between the dyad members. However, managers may have only met protégés once during their interviews, and sometimes choosing the best mentors was a challenge based on the limited information known.

Sometimes you need to say to yourself, ‘Okay, you know I have this person coming, who do I have..?’ So you grab your little list of people and you say to yourself, ‘all right, now who’s done this recently?’ So we should not always have the same person doing it. Then you kind of go down the list and you say well – ‘she’s too new, she’s got these other things going on, he’s got family issues’. So sometimes it’s a process of elimination to get down to say five names. Now out of these five people that I think could do it, what are their strengths, what do they have to offer, what are their weaknesses? What do I know about the person coming? And honestly sometimes all you’ve done is interview somebody so you really don’t know what they need. (MON D)

Managers considered the length of time RNs had been in their role as irrelevant when selecting mentors. Participants’ decisions to ask staff to be mentors were based on certain characteristics that they expected mentors to possess. Managers wanted mentors who had a good knowledge base and who acted in a professional manner. They also desired someone who was pleasant, welcoming, positive, supportive, a role model, a team player, consistent, patient, and clear. Mentors were recruited in several ways. For example, managers described what the role entailed and then asked staff for mentor volunteers. At other times, managers asked individual nurses, who they thought had mentor characteristics, if they would be interested. Participants did not always ask the same person to be a mentor because they did not want mentor fatigue to develop. In order to prevent that fatigue, managers tried to select different mentors each time.

4.1.4.6.2 Pool of mentors. Managers spoke about asking the same people to mentor new staff because of their mentor qualities and abilities. However, participants discussed the importance of building pools of mentors on the units so that numerous staff members were available to draw from and were available to contribute to that mentoring culture on the units.

And like I said, ideally we should be training all of our staff to be mentors, not just a few, because that's the only way you're really going to get the whole team buying in to some of it... And why should I say one person would be so much better than another? They might be for one person but someone else might be a better mentor for someone else, you know? (MON L)

Many managers thought they had a number of quality mentors from which to draw.

When asked how to build a pool of mentors, one manager replied:

...instead of asking the same person all the time to be a mentor,...you could start out by the next time asking somebody else and to build on that. And I think that when people, once they're asked, and they start doing it, it becomes more comfortable for them so you build capacity that way. ...people don't recognize that they have the capability of being a good support system, a good teacher, a good mentor. So you just ask and build on that. (MON P)

4.1.4.6.3 Matching the mentor and protégé. Managers described how they matched protégés and mentors. Participants identified the importance of knowing their staff members, their personalities, their strengths, and their weaknesses. The challenge was getting to know new staff members, because managers may have only met them once in the interview.

...you don't necessarily know your new nurse very well and you might know your older nurse better and so how do you match up those personalities where they're going to mix

well because they do need to be work together pretty closely and there needs to be a very open and honest connection between them. (MON E)

Many managers talked about having a “good fit” between mentors and protégés. *“I have a variety of staff with a variety of personalities and through my hour with them [the protégé], I think [to myself], I’ve got these two people who will get along fine”* (MON V). Some managers, who did not know protégés well, would place them with mentors who got along well with everyone. *“I look for somebody that’s patient and all of that, that can sort of mesh with everybody, that works well with everybody that they’re working with in their surroundings”* (MON K). If managers felt they had made a poor match between mentors and protégés, they stated that they would readily change the pairings to best meet the needs of protégés. *“I do think that’s what my main role is to try and make sure that if it’s not a good fit, to try and change it... you have to intervene quick. You don’t want it to be a bad experience”* (MON C).

4.1.4.6.4 Sharing the mentorship. Some managers arranged two mentors to work with a single protégé in order to share mentoring responsibilities. Participants said this strategy gave an opportunity for part time employees to be mentors and allowed protégés to observe a variety of perspectives on how to perform procedures. All managers that had tried this strategy said that it worked well and that they would continue to do it. Another benefit to sharing the mentorship was that it allowed newer mentors to be paired with more experienced ones. This approach allowed newer mentors to build their mentorship skills without having to take on the whole mentorship experience.

4.1.4.6.5 Evaluating programs and mentoring. Managers had a few ways to evaluate the formal and informal mentoring that occurred on the unit. For formal mentoring, some participants met with mentors and protégés, individually or as pairs to evaluate the process. For

informal and formal mentoring, some managers discussed mentoring progress at yearly staff performance appraisal meetings or expressed a desire to do so in the future. Health region mentorship coordinator program evaluations were not described as one of the methods used in the evaluation of the mentorship process. Yet, coordinators described fairly detailed processes for program evaluation.

4.1.4.7 Orienting considerations. Participants described orientation as a time when new employees were shown the routine, learned their role, and became acquainted with “the system”. Staff exposed new employees to as many of the procedures as possible and got them fully functioning as a nurse. In order to ensure consistency in what was being taught to new nurses, to build on their previous learning, and to avoid repetition, some managers believed that having an orientation checklist or package in place was helpful. For orientation, managers also talked about selecting the right persons to orientate new staff members.

I always try and look and see who they're on with so that they have – you know, because you have the folks who are very supportive, who are very keen to help. And so you want to foster that. And so I'm fortunate that I have a group of people who are very good about bringing people in, so it's just to help foster that. (MON Z)

Although managers recognized that mentoring occurred during the orientation process, they stressed the importance of keeping mentoring and orientation separate. “...*I want mentorship to be an aside from orientation. I mean it's part of, but I don't want it so melded in there that it gets kind of lost in it because I think it's too important to lose.*” (MON E)

4.1.4.8 Recognizing mentors. Managers emphasized the importance of recognizing employees for their mentoring contributions. Participants described formal and informal ways in which the health regions and managers recognized mentors for their contributions. Some

managers stated that recognition was to be individualized to mentors and was to be based on knowing the staff, respecting their personalities, and acknowledging what was important to each of them.

...you have to be careful about the person because some people don't want their name listed as mentor or as employee of the month because of the mentoring that they've done or going the extra mile. But some people really do like public recognition so I think it really just depends on the person doing the mentoring, what that reward would be. And I think that it really means that you have to know your mentor and know what's important to them.... (MON F)

Some managers believed that asking staff to become mentors was a form of recognition. *"I think sometimes just being a mentor is a recognition of your skill level and your ability to get along with people and that you're valued just by being asked"* (MON V). Managers acknowledged the lack of funding for recognizing mentors, and they mentioned the creative ways in which mentors were recognized on their unit, in their facility, or in the health regions. For example, managers discussed informal ways to recognize staff members, which were inexpensive, like a verbal "Thank You" or a card from the manager. Celebrating unit mentoring successes and general staff appreciation by recognizing all employees by way of supplying lunches or refreshment breaks for the units were common. Managers identified that mentoring was a team effort and all employees needed to be appreciated for their contributions. MON Z discussed the challenges of recognizing all employees.

If you thank one person, really it's the team, right? And so it's the whole team that needs it and so that's a challenge to do with shift work with days and nights and weekends and you could hit groups but you can't hit everyone. (MON Z)

Some managers expressed their hesitation with recognizing mentors, and said that mentoring was a professional responsibility of nurses, which need not be recognized or rewarded. Participants expressed that they may not know who had informally mentored the new staff, and that they were therefore unable to recognize individuals who had done the mentoring. Although identification was a challenge, managers believed in the importance of informal mentoring and seeking out these individuals. Managers thought that staff may not have realized they were being mentors, but once recognized, managers could support and encourage the relationships.

Most health regions had a formal recognition process for mentors who participated in the formal mentoring program. Examples of forms of recognition were: receiving letters from managers or chief executive officers of the health regions, mentoring certificates, and recognition on the health region websites. In some health regions, recognition of mentor employees took the form of a dinner and presentation of certificates.

4.1.4.9 Negative case. Schreiber (2001) described negative cases as those participants whose situations did not confirm the emerging hypotheses. One negative case emerged in this study. A nurse manager felt that she was responsible for mentoring her staff. She stated she did not want her staff mentoring new individuals because the quality of their evidence-based practice did not meet her expectations. Acting as a mentor, the manager encouraged staff members' utilization and integration of best practice guidelines, and she encouraged their critical thinking when providing patient care. Prior to encouraging her staff to become mentors, the manager felt it necessary to first mentor them in order to develop their practice skills.

Having this negative case assisted the researcher's theory development aspect of the study. It allowed the emerging theory to be challenged. Managers who did not encourage their

staff to be mentors was an atypical finding. As a result, the negative case triggered the researcher to re-examine the data from other participants and allowed for a greater comprehension and subsequent expansion of the “mentor expectation” category. Consequently, the theory became more robust by allowing for alternative explanations that accommodated for a broader range of data.

4.1.4.10 Summary. Supporting mentorships through various initiatives was perceived as a key role and responsibility of managers. Throughout the interviews, several key categories emerged, which described the processes in place that enabled managers to encourage, create, support, and foster mentoring cultures. For instance, participants identified the importance of communicating with staff about mentorship and educating them about what mentoring was and what options were available to aid in its adoption. Managers spoke of the importance of developing relationships between mentors and protégés, as well as between the managers and their staff. In order to make mentoring easier for nursing staff and to make it more likely to occur, managers used a variety of strategies to facilitate mentoring. Expectations were clarified, regarding the roles and responsibilities of employees on the units, and regarding mentors and protégés in the mentoring relationships. Participants identified their roles in implementing formal mentoring programs that were offered. They also indicated that orientation needed to be separate from mentoring. Further, managers highlighted the importance of employees being recognized for their mentoring contributions, and they emphasized the ways in which health regions and managers recognized them.

4.1.5 Conceptual Relationships

During second interviews, managers were asked directly about their beliefs regarding the relationships between organizational contexts, their perceptions of mentoring, and their support

of mentorship on the nursing units or in the facilities. These relationships will be described in greater detail. Additionally, the core variable that emerged will be described.

4.1.5.1 The influence of the greater organization on mentoring implementation on the unit. The researcher characterized organizational context as consisting of administrative support and funding for mentorship, healthy work environments, rural considerations for mentoring, and mentoring programs. When asked about the influence of the greater organization on mentoring implementation, participants strongly agreed that some of the components of the organizational context were essential in order for mentoring to be successfully implemented and sustained on the unit.

They have to be essential because if it's not coming from the top of me, there's not a whole heck of a lot I can do and I'm told what my budget will be for the year, I'm told that I can do this and that and I have a little bit of latitude, but if my bosses aren't behind mentoring, it is just not going to fly so I think it's important for every level to be behind it (MON J).

Most managers considered funding for mentorship on the unit essential. *"You can't do it [mentorship] without some kind of financial commitment on behalf of the organization"* (MON D). Some managers believed that even without financial backing, they would continue mentorship support for staff because they saw mentorship as important and as beneficial to the unit as a whole. However, managers recognized that successfully establishing and sustaining mentorship initiatives on the unit in these instances would be difficult without organizational support. *"...you can have mentorship without organizational context. But I can't imagine how incredibly difficult it would be"* (MON Y).

One manager described the importance of a healthy work environment to mentoring: “...without a healthy work environment, partnerships don’t exist, communication is not there...” (MON K). Some rural managers identified a lack of resources, recruitment opportunities, and mentorship initiatives in their areas, which made mentoring more difficult. Participants reported that formal mentorship programs offered by the health regions were beneficial and facilitated the implementation of mentoring on the unit; but managers sometimes had trouble operationalizing the program due to competing priorities.

4.1.5.2 The relationship between the greater organization and nurse manager mentoring perceptions. The manner in which manager perceptions about mentoring were impacted by the greater organization was examined and responses were mixed. Managers believed that mentorship was fostered from senior management and on down the hierarchical chain. “*I think part of it is the philosophy and beliefs of the organization and how they do their work. And that influences you as a manager*” (MON D).

Managers indicated that if the greater organization supported and promoted mentorship, then these positive beliefs would in turn affect managers’ perceptions about mentorship more positively. Managers felt that having organizational support in terms of mentorship vision and mission statements, funding, and assistance with mentorship program-building eased the establishment and sustenance of programs.

However, a few managers stated that if they felt strongly about mentorship, then they would go ahead to enact those beliefs contrary to the opinions of the greater organizations. “*So if you're strong as a manager and you have strong commitments and beliefs in what way you're going to lead and help people succeed in their work. There's many things you can do despite an organization*” (MON D).

4.1.5.3 The relationship between nurse manager perceptions of mentoring and mentorship support. The researcher asked participants how their mentoring perceptions assisted or inhibited mentoring relationships among staff. Managers believed that if they had positive perspectives about mentoring, they would be more likely to foster mentoring relationships. Conversely, if they had negative perceptions about mentorships, they would be less likely to commit time, resources, and support to foster mentorships. *“Well I think if you really believe in the program, you’re positive about anything. So if you believe in a program you can foster that a lot”* (MON C). Additionally, another manager stated, *“if the manager doesn't believe in it, then it doesn't matter how many things are put in place at the organizational level. It's not gonna happen”* (MON Y).

If I were a manager that didn't believe that this is the way it needed to be....If I had that kind of perception and belief, you can tell right now, it's not gonna work, right? I'm gonna go through the motions, I'm gonna do what I need to do so if anybody looks at it, I'm doing all the right things. But there's no heart and soul in it. And without that heart and soul and belief and commitment, I don't think it's going to work... If they don't believe it's going to work and they aren't committed in their philosophy of how this could be better, the mentorship will go through the motions but I don't think it will be as strong. I don't think you'll probably see as good a result at the end of it (MON D).

Some managers believed that if they were positive about mentorship and supported it, then their beliefs would filter down to the staff level. *“So if I'm positive about the mentorship and I give my staff the opportunity to learn how to be a good mentor and they do a good job mentoring then that person they’ve mentored will then say ‘I’ll mentor someone’”* (MON J). Managers commented that if they valued the mentorship process, staff mentoring was facilitated.

Participants whole-heartedly believed that manager support for mentorship on the units was instrumental in establishing and sustaining mentorships.

4.1.6 Committing to Mentorship

The researcher found that *Committing to Mentorship* emerged as the core variable and was pervasive throughout all categories and concepts. Committing to mentorship can be described as having positive perceptions about mentoring, actively encouraging and supporting mentoring programs and relationships, and having organizational supports and unit-driven initiatives in place to establish and sustain mentoring. To ensure that mentoring was successful and sustained, all employees of the organization needed to be committed, from senior management or the organization as a whole, to first line managers, and to all employees.

Managers demonstrating this commitment displayed actions such as: having informal and formal discussions about mentorship with staff, talking about their philosophies of mentorship, recruiting staff, promoting mentorship programs in the health region, and checking in with mentors and protégés regarding the process. Participants believed that commitment and support for mentorship needed to be demonstrated continuously through the mentorship process. They stated such support should appear at the beginning, middle, and end of formal mentorship programs, or regularly on the units to sustain momentum for informal mentoring. Managers stated that their commitment to mentorship was critical.

You have to make the commitment and I think that is the most important thing is that if you want it done properly then you need to make the commitment to plan it accordingly to have it roll out from there. (MON AA)

If you don't have commitment to mentorship on the unit, you're not gonna help staff to find those, even if it's informal, find those relationships, find people that they can trust.

Certainly if you don't have a commitment to mentorship, you're not gonna go out and enroll them in the programs and make sure that they're replaced and get the time off....

(MON Y)

Participants mentioned that all employees in the organization needed to be committed to mentoring. Actions that demonstrated employee commitment to mentorship included actively engaging in or supporting others in mentorships, participating in mentorship education initiatives, supporting the new nurse in their role, and contributing to a healthy work environment.

Yes, you have to be fully into and believe in the philosophy of mentorship to actually foster an environment that agrees with it. I do think as a manager though, I don't think you can just make it a staff – like one-on-one, I think the whole unit has to be...agree to the mentorship environment to make it work. (MON C)

In mentoring relationships, managers indicated that both mentors and protégés needed to show commitment to mentorship in order for it to be successful. Examples of commitment included actions like participating in the mentorship workshops, assisting to establish learning goals, meeting and communicating regularly as dyads, mutually providing feedback for their partners.

And that partnership—I see it as a partnership, it's always a partnership. It is a commitment from both sides—I'm the person going through the process and the other person is agreeing to help me, but I have to commit to it too. (MON D)

Furthermore, managers acknowledged that the whole organization, including senior management, needed to be committed to mentoring in order for mentoring programs to be successfully implemented and for mentoring relationships to be sustained. Actions that

demonstrated the greater organization's commitment were incorporating mentorship statements into the vision, mission, and values of the organizations, providing verbal and financial support for informal mentorship and formal mentorship programs, supporting managers in their mentorship initiatives on the units, seeking out alternative mentoring strategies for rural facilities as needed, and providing recognition for mentoring.

"... I need senior management to either say here's the money or we understand if you go over your budget because we're committed to this... So there's that organizational commitment that needs to be there." (MON D)

4.1.7 Chapter Summary

This study had three objectives: (a) exploring managers' perceptions of their role in creating a mentoring culture, (b) discovering the processes in creating a culture of mentoring, and (c) exploring the organizational features supporting and inhibiting this mentoring culture. Using constant comparative analysis, the researcher identified that 27 participants described a consistent pattern in the process of creating a mentoring culture. The researcher identified three main concepts: organizational context, managers' perceptions of mentoring, and mentorship-supporting initiatives on the nursing unit. Through further data collection, theoretical coding, theoretical sampling, and analysis, the researcher identified relationships among the conceptual categories, which allowed the categories to become saturated and their properties and dimensions developed. A core variable, *Committing to Mentorship*, emerged as pervasive throughout all categories and concepts. From these data, the researcher conceptualized a theory of nurse managers' perceptions of their roles in creating a mentoring culture.

Chapter 5

5.1 Chapter Overview

This chapter will describe and explore the theory of the nurse managers' role in creating a mentoring culture. The core variable and major concepts of the model will be discussed in relation to the literature. The researcher will propose recommendations for the areas of administration, practice, nursing education, and research based on the study findings. The chapter will conclude with a discussion of study limitations and delimitations.

5.2 A Theory of Nurse Managers' Roles in Creating a Mentoring Culture

Committing to mentorship emerged as the core variable, which the researcher found to be pervasive throughout all categories and concepts. Committing to mentorship can be described as having positive perceptions about mentoring, encouraging and supporting mentoring programs and relationships, and having organizational supports and unit-driven initiatives in place to establish and sustain mentoring. To ensure that a mentoring culture was successful and sustainable, all employees of the organizations needed to be committed, from senior management or the organization as a whole, to first line managers, and to all employees (see Figure 5.1).

The researcher proposes that all concepts in the model (organizational context, manager perceptions of mentoring, and mentorship-supporting initiatives) need to be present to some extent for commitment to mentoring to be fully exhibited and for mentoring cultures to be created and sustained. If all members of the organization demonstrated commitment to mentoring, the manager would be assisted to create a mentoring culture. For example, if an organization demonstrated its commitment to mentoring by providing administrative support, mentorship funding, mentorship programs, healthy work environments, and rural considerations for mentoring, then these actions would bolster managers' abilities to create, support, and sustain

mentoring cultures for their staff (see Figure 5.1). The research suggested that these conditions may not be present in all organizations, but the more conditions that are involved, then the more likely mentoring cultures will be created.

Managers displayed their mentoring commitment in several ways. Managers were open and positive to the idea of mentorship and were supportive of mentoring relationships. They also expressed positive mentoring beliefs and benefits, minimized drawbacks and obstacles, and enhanced facilitating factors with regards to mentorship. If managers demonstrated their commitment by supporting mentorship through these methods, they were more likely to establish and sustain mentoring cultures (see Figure 5.1).

Furthermore, if managers took active roles in supporting mentorships using various initiatives, a mentoring culture would be more likely to occur than if they did not. For example, if managers communicated with their staff about mentorship, focused on developing relationships between themselves and their staff as well as among staff, and took actions to facilitate mentoring, then mentoring cultures could be established. Managers could further support mentoring relationships by establishing guidelines, implementing mentoring programs, educating staff, and encouraging mentoring during and after orientation. Also, by recognizing individuals involved in mentorships, managers could enable mentoring relationships to be sustained. These aforementioned methods that managers could enact to support mentorships would assist to establish and sustain mentoring cultures on their units. The greater the number of mentoring supports managers' enacted, the greater were the chances of mentoring cultures being created and sustained (see Figure 5.1). By displaying actions that supported mentorship, managers demonstrated their commitment to it.

The researcher proposes that if managers and members in the greater organization

verbalize they are committed to mentoring, than they are more likely to demonstrate that commitment through various initiatives as outlined in the model (see Figure 5.1). The researcher proposes that this commitment ultimately could influence the larger organization by creating stronger organizational support for mentoring. Reciprocally, if managers and members of the greater organization demonstrate actions or beliefs as outlined in the model, they demonstrate their commitment to mentoring. This reciprocal relationship is represented by double-headed arrows on the model (see Figure 5.1).

Employee commitment to mentorship could be demonstrated by engaging in or supporting others in mentorships, participating in mentorship education initiatives, supporting new nurses in their roles, and contributing to healthy work environments. The data also showed that if the organizational contextual factors were present and if managers had the personal characteristics, positive perceptions, and mentoring supports in place, then employees were more likely to display their commitment to mentoring. Ultimately, in order for mentoring relationships to be established and maintained, employee mentoring commitment must be present. On the basis of this study, the researcher contends that even if all the other supporting and contextual factors are present, employees will not engage in mentoring relationships if they are not committed to them.

Participants did not describe their influence on the greater organization. However, the researcher believes that managers' perceptions of mentoring can influence the greater organizational context as it relates to mentoring. For example, managers have an influence to direct mentorship funding to where it is needed, to contribute to healthy work environments, to influence development and sustenance of mentoring programs, to affect how mentorship

initiatives are developed in rural areas, and to persuade senior leadership to provide mentorship support. This relationship is reflected by a light blue arrow in the model (see Figure 5.1).

Furthermore, by supporting mentorship initiatives, managers' perceptions of mentoring can be influenced and reinforced. For example, by creating mentoring cultures on units, managers' beliefs and perceptions can be positively reinforced when seeing the beneficial outcomes of these relationships. Managers may be more likely to remove obstacles and reinforce facilitating factors when they see their supporting-mentorship initiatives as successful. This proposed relationship is reflected by a light blue arrow in the model (see Figure 5.1).

Figure 5.1. Committing to Mentorship Model



5.3 Discussion

5.3.1 Committing to Mentorship

From the databases available, limited literature existed regarding commitment to mentorship. Colonghi (2009) stated that better mentoring outcomes were expected when organizations were committed to mentorship. He considered organizational commitment to mentoring to be a long-term commitment. Colonghi suggested that ensuring a proper fit between mentors and protégés, and allowing time for the dyads to meet and develop their relationships were also essential signs of commitment.

Race and Skees (2010) proposed that in order for mentoring programs to be effective, organizations needed to commit to such support. Lynds and van der Walt (2011) were other contemporary researchers who believed that in order for mentoring relationships to be positive and valuable, commitment to the mentoring process was vital. They maintained that mentoring cultures could be created by including and supporting interested mentors and protégés in the decision-making process around mentorship and mentorship programs (Lynds & van der Walt, 2011).

5.3.2 Organizational Context

5.3.2.1 Administrative support. According to managers, the whole organization and senior leadership support played a key role in establishing, encouraging, and sustaining mentorships on the nursing unit. This finding agreed with what Race and Skees (2010) and Zachary (2005) found; executive leadership must be actively involved in and committed to creating and sustaining a mentoring culture. In an anecdotal article, Bally (2007) also suggested that a mentoring culture was dependent upon support from senior executives and managers.

This dissertation supported Race and Skees' (2010) research, because the researcher

found that the organizational context provided the infrastructure needed to enable managers to create and sustain mentoring cultures and that senior leadership were responsible for ensuring the proper infrastructure was created. Weston, Estrada, and Carrington (2007) identified the significance of infrastructure in the hospital environment in promoting and infusing best practices and for maximizing the intellectual capital of nurses by creating learning environments. Nurse managers required the support and engagement of senior nursing executives in hospital organizations to be successful in creating mentoring cultures on their units (Manion, 2005). Managers interviewed in this study expressed views similar to those reported by these authors and believed that organizations assisted them in establishing and creating mentoring cultures.

Jakubik (2008) recognized the importance of the organization to the mentoring relationship and proposed that effective mentoring relationships did not consist of a dyad, but a triad of the mentor, protégé, and the organization. Burr et al. (2010) also suggested the greater organization, as represented by senior administration, was key to initiating and sustaining a mentoring program. Having the organization, as a whole, involved in the mentoring program placed value on the initiative and established program credibility (Burr et al., 2010). Managers in this study expected their organizations to create an awareness of mentoring within their facilities: making their mission, vision, and values of mentoring visible to all employees in the regions and to potential new employees as well.

Zachary (2005) proposed that cultural congruence was required in order for mentoring to be accepted and implemented into organizational life; thus, organizational culture and mentoring must be aligned. Mentoring must be incorporated into the vision and mission statements of organizations and be accepted within organizations' values (Race & Skees, 2010; Smadu &

Loos, 2008; Zachary, 2005). Within the participating health regions studied, mentorship was incorporated into the vision and mission statements.

Race and Skees (2010) identified that mentoring may not be visible as a priority in organizations, as they often have competing demands, especially when there was high employee attrition and retirements, increased budgetary costs and expenditures, and focus on positive patient outcomes. However, if mentoring environments were created, then some of these competing demands may decrease. Some participants in the study felt their organizations needed to re-prioritize mentoring in their facilities by promoting and encouraging its use. Managers gave suggestions to encourage its adoption by promoting mentorship initiatives in such venues as; regional newsletters, bulletin boards, education days, region websites, and staff meetings.

Although managers stated they wanted organizational support for mentorship, some managers expressed the desire to have flexibility in their mentoring decision making. Participants believed they knew best the unit and staff needs, as opposed to mentoring decisions being made solely by administration for the units or the entire facility. These managers knew how best to meet the mentoring needs of their units and staff, because they were closer to the daily routines, than were the senior administrators.

Nevertheless, organizational support for mentoring programs was seen as crucial to its success. Employees who felt supported by their organizations, such as in the case of organization-derived formal mentoring programs, displayed higher job performance, greater organizational commitment, and reduced turnover (Dawley, Andrews, & Bucklew, 2008; Erdogan & Enders, 2007; Loi, Hang-yue, & Foley, 2006). The dissertation findings were compatible with those reported by the aforementioned researchers. Ultimately, having organizational support is not only beneficial for the unit and staff, but also for the greater

organization.

5.3.2.2 Mentorship funding. In this study, managers' mentorship funding was considered essential for the sustainability of the mentorship programs due to their limited budgets. Block et al. (2005) and Zachary (2005) recommended the allocation of mentorship funds, because monetary resources were seen as vital to creating and sustaining a mentoring culture. Some examples of budgetary items included; allotment of money towards establishing formal mentoring programs, travel expenses for staff to attend mentorship meetings or conferences, replacement costs for people attending such events, fees for guest speakers who were experts in mentoring, printing costs for promotional or educational mentoring materials, and purchasing of technological devices or electronic programs to assist the mentoring program. Managers in the study believed that without mentorship funding, mentorship programs could not be sustained.

5.3.2.3 Healthy work environments. All levels of organizations were responsible for facilitating healthy work environments (Kane-Urrabazo, 2007; Shamian & El-Jardali, 2007). Two of the essential elements of healthy work environments included effective communication and collaborative relationships (Heath et al., 2004). Based on the research findings in this dissertation study, the researcher showed that these two elements were underlying components in managers' descriptions of characteristics of healthy workplaces, and that they were important components for supporting mentorship initiatives as well.

Burr et al. (2010) found that employees believed mentoring programs assisted the promotion of healthy work environments. Findings were similar in this study. However, some participants also believed that healthy work environments fostered mentorship. Nonetheless, healthy work environments played an important role in mentorship.

5.3.2.4 Rural considerations. Rural nurse managers discussed the challenges of providing mentoring and professional development opportunities in their areas due to limited resources, opportunities, and staff. Lynds and ven der Walt (2011) highlighted the common challenges to successful mentorship in rural areas including lack of rewards or incentives for volunteering, health care professionals' broad scope of practice in a rural area, and the lack of formal mentoring programs. With limited staff in a rural area, mentor volunteering and selection often became challenging, because of a lack of voluntary mentors to engage in mentorships (Lynds & ven der Walt, 2011). McCoy (2009) also identified these concerns stating that nursing in a rural setting was unique and special considerations needed to be made when new nurses were entering into the rural environment. For example, McCoy mentioned the limited resources for professional development and orientation in smaller hospitals. Other considerations included lack of nursing staff to cover shifts, extra travel time and distance to locations where programs were offered, and additional expenses incurred for mentoring or other continuing education initiatives, which were all seen as challenges to ongoing staff education (McCoy, 2009). McCoy suggested partnering rural nurses with urban hospitals and mentors to allow for collaboration to occur between the areas.

Mills, Lennon, and Francis (2007) saw mentoring as a retention strategy for rural nurse managers to use in their workplaces. Education for potential mentors was viewed as an essential component to the success of the relationship in rural areas, because knowledge of mentoring, mentoring skills, and confidence in the role increased if training was taken (Mills et al., 2007). Ensuring that mentoring education was provided for nurses in rural areas would contribute to the success of mentorship initiatives.

Mills, Francis, and Bonner (2007) discussed rural nurses' experiences with mentoring,

and they found that mentoring did not occur solely in the clinical environment. Considerations were also made for living and working in the same small community. The results found in this dissertation research were similar to these findings. For example, socialization was needed in both the rural facility and the rural community (Mills et al., 2007). In a rural community, nurses may often be seen as part of the community, and the mentors' role was to explain the culture of the rural community to the new staff members by explaining the local practice or methods of communication used between colleagues or community members and the new nurses. Special considerations need to be made to socialize new nurses to their communities as well, in order to increase the likelihood that new employees will develop relationships and be more willing to stay. Participants in this study felt that a lack of connection with community contributed to nurses' migration. Therefore, relationship development within the community is an important factor to consider in order to improve retention rates in rural areas.

From the discussions with rural managers, the researcher contends that greater assistance needs to be put in place to support mentoring of new nurses in rural areas. Strategies could include e-learning opportunities where mentoring workshops are video-conferenced into rural areas to reach a greater number of people and to allow the staff to stay in their rural environments. Mentors assisting multiple protégés could be another solution to limited staffing. A further suggestion could be having mentors from rural facilities pairing with protégés from a different facility. Most rural managers, in this study, ensured that new employees were supported when working alone, by having supports available if needed, such as having other staff on-call to answer questions. This strategy was important to ensure that new staff had resources available to them as needed. Lynds and van der Walt (2011) called for rural facilities and healthcare organizations to collaborate to establish locally adapted mentoring programs that reflected the

unique rural environment. This suggestion was a novel idea to better support and reflect the unique nature, challenges, and opportunities of a rural setting.

5.3.2.5 Mentoring programs. Managers identified the challenges of operationalizing and following up with the program due to their daily competing priorities. The researcher suggests that mentorship coordinators and managers collaborate to resolve operational challenges and build follow-up routines that the managers or mentorship coordinators could implement. To ensure a well-developed mentoring program, a long-term commitment needs to be made by organizations (Colonghi, 2009). A successful program needs to run for several years to allow for the mentoring culture to be established and sustained. Some of the current mentoring programs discussed in this study had been running for a few years with some changes and adjustments made to further enhance the program. The health regions involved had mentorship coordinators to assist with implementing and managing the program. Race and Skees (2010) believed that mentorship coordinators were integral in maintaining the mentoring culture and implementing the program.

Johnson, Billingsley, Crichlow, and Ferrell (2011) found that expanding mentoring programs to all nursing employees including administrators, educators, clinical nurses, and managers helped to create a mentoring culture throughout the organization. In the Saskatoon Health Region, the formal mentoring program had expanded to include all employees. That strategy allowed for a mentoring culture to be pervasive throughout the entire organization. The researcher recommends that mentoring program expansion to all employees be considered in all health regions.

Program evaluation was not discussed by the managers, but it is important when attempting to sustain and improve a mentoring program. The literature showed that monitoring

progress and measuring results should be a continuous, integral part of maintaining accountability for individuals and organizations (Zachary, 2005). This monitoring was important in assessing the impact of the mentoring experience and in making program adjustments (Johnson et al., 2011; Race & Skees, 2010). These processes allowed for mentoring improvements to be made on all levels. There were several options for measuring results depending on the needs of the organization, which included questionnaires, performance reviews, and self-assessments. Zachary (2005) suggested that evaluation criteria for monitoring process and measuring results should be constructed by the key stakeholders at the beginning of the mentoring program planning process.

Monitoring progress can include the mentoring partners reviewing the mutually agreed-upon goals set out in the beginning of the mentoring relationships, or the assessment of self-accountability by mentors or protégés journaling about the experience. The mentoring coordinators could arrange for monthly meetings to share progress and success stories for creating individual or unit specific goals. Feedback forms could be sent to the mentoring coordinator after a mentoring relationship had ended or at a mutually agreed upon time. In the health regions studied, mentoring program evaluation was completed by the mentorship coordinators, which may have been the reason why it was not mentioned by managers.

Zachary (2005) suggested that gathering feedback was an essential component of accountability and occurred in a continuous, cyclical process. Feedback was gathered from key stakeholders, managers, mentoring participants, and organizational leaders, and provided the evidence to identify areas for improvement within mentoring cultures. For example, feedback could be obtained on the aspects that are working well and those that are not, the mistakes that were made, and the possible improvements that could be made to the mentoring process or

relationships. Through this feedback process, communication and participation are encouraged, relationships are developed, and awareness of mentoring is increased. This dissertation confirmed Zachary's (2005) suggestions that managers and mentorship coordinators work together to gather feedback and evaluate mentorships in order to facilitate program improvements and meet the needs of the nurses on individual units.

5.3.3 Managers Perceptions of Mentoring

5.3.3.1 Personal characteristics. Nurse managers in the study exuded several effective leader characteristics that enabled them to develop or maintain mentoring cultures on their units. West, Hungerford, and Yiu (2010) described effective leaders as being optimistic and open, and as using a leadership style appropriate for them and the situation. These leaders also encouraged creativity and feedback, promoted the use of technology, facilitated personal relationships and personal development, and involved members in decision making. Managers in this study had some or all of these characteristics.

Furthermore, West et al. (2010) identified three aspects of effective leaders: vision, influence, and power. They described vision as formulating realistic goals and communicating these goals to others. Influence involved using effective communication skills and developing trust with others that allowed for cooperation to achieve the goals. The authors defined power as the ability to influence others to achieve common goals. The researcher found that these principles were evident in the leadership shown by most of the nurse managers interviewed. For example, participants had a clear vision of mentorship for their units and communicated it in various ways to staff members. They described mentoring programs to new and experienced staff members in order to encourage their participation. These managers also used what influence they possessed to support and facilitate mentorship on their units.

The researcher proposes that nurse managers who exhibit transformational leadership styles with regards to mentoring will have greater success creating and sustaining a mentoring culture. Grossman and Valiga (2009) suggested that transformational leadership occurs when leaders and followers mutually energize and motivate each other to achieve a collective vision. West et al. (2010) stated that transformational leaders encouraged creativity, collaboration, and inspiration to reach the collective vision. The focus of the transformational leader was to inspire, motivate, and empower others to act (Carroll, 2006). The researcher found that nurse managers who showed their commitment to mentoring used their transformational leadership style to mutually energize and motivate other staff to be committed to it as well. Furthermore, Sullivan and Decker (2009) proposed that nurse managers, who had personal characteristics that allowed them to be effective leaders, to be open and positive to the idea of mentorship and encouraging and to be supportive of mentoring relationships were more likely to establish and sustain mentoring cultures through their actions. Through these actions, managers demonstrated they were committed to mentoring.

5.3.3.2 Mentoring beliefs. Managers in this study discussed three major mentoring beliefs: All staff members were responsible for mentoring, multiple mentors should mentor staff members, and mentoring needed to be tailored to the individual. Morrow (2009) believed that every nurse should be responsible for welcoming the new nurse to the unit, answering any questions, and providing guidance as needed. Furthermore, managers mentioned that all employees were responsible for mentoring new nurses regardless of their positions. Inter-professional mentorship of employees has been relatively unexplored in the literature, but several participants in the dissertation discussed its presence and importance. Marshall and Gordon

(2010) described the goal of inter-professional mentorship as learning about and from other professions in order to provide quality care to clients.

Ralph and Shaw (2011) observed that no matter what the discipline, common goals and beliefs must be established for the mentorship to work. Healthcare professionals commonly train in isolation of one another and this lack of interaction has the potential for a lack of understanding of professionals' values, cultures, and knowledge bases. They further maintained that this lack of understanding could in turn lead to ineffective inter-professional mentoring experiences. Ralph and Shaw (2011) proposed that inter-professional education should precede inter-professional practice, and that this strategy must be incorporated into educational programs in order to strengthen inter-professional mentorship in clinical areas. Likewise, Lait, Suter, Arthur, and Deutschlander (2011) found that students involved in inter-professional mentoring learned about different professions and how to work as a team to care for patients. Lynds and van der Walt (2011) recommended inter-professional mentorship as a means to assist with the limited number of staff and the unique nature of rural health care environments. They maintained that by involving several different healthcare professionals in the mentorship process, mentoring cultures could be established, and quality environments where staff work harmoniously together would be attained.

Multiple individuals mentoring new staff members was also a desirable quality of sound mentorship described by participants in the dissertation. This strategy is seen as useful as it is unrealistic to think that one mentor is knowledgeable in all areas. Grossman (2007) described multiple mentoring as a relationship where the mentor, protégé, or both were involved in simultaneous one-to-one mentoring relationships with a number of individuals. Different mentors or mentoring networks may be needed to meet the developmental learning needs of

protégés. Also, the demand for mentors may be greater than the supply, so mentors might be mentoring more than one protégé.

Several authors have written that when organizations establish mentoring programs, the unique needs and goals of protégés need to be taken into consideration and reassessed, as necessary, in order for mentorships to be successful (McKinley, 2004; O’Keefe & Forrester, 2009; Tourigny & Pulich, 2005; Zachary, 2005). Many participants recognized the need for mentoring to be individualized to best meet the needs of protégés. Furthermore, some managers mentioned the need to consider protégés’ unique learning requirements and characteristics when pairing them with mentors. This aspect of personalization is important to consider when establishing and maintaining mentoring relationships.

5.3.3.3 Perceived benefits, drawbacks, obstacles, and facilitating factors. Participants described their perceived benefits of mentoring that were consistent with those appearing in the literature. The managers reported benefits for the units, mentors, and protégés. They described the mutual learning of staff and the recruitment and retention of employees. The study findings confirmed previous research which indicated that mentoring programs and relationships were found to create positive work environments for staff and they acted as a retention strategy for both new and experienced employees (Allen et al., 2004; Dawley et al., 2010; Eby et al., 2006; Joiner et al., 2004; Halfer et al., 2008; Latham et al., 2008; McKinley, 2004; Newhouse et al., 2007; Payne & Huffman, 2005; Woodard-Leners et al., 2006; Zachary, 2005).

In this study, participants believed staff relationships were fostered in mentorships. Managers believed mentoring allowed protégés to develop personally and professionally in their new roles. In the literature, protégés described increased socialization and acceptance in the organization, decreased stress, increased confidence and competence, assistance with career

planning, and psychosocial support (Eby & Lockwood, 2005; Johnson & Ridley, 2008). In the dissertation, perceived benefits for mentors included personal satisfaction and personal development opportunities. These findings were similar to those in the literature, where mentors reported increased personal fulfillment, career success and satisfaction, greater creativity, learning and development of leadership skills, and expanded feelings of generativity (Bozionelos et al., 2011; Eby & Lockwood, 2005; Johnson & Ridley, 2008; McKinley, 2004).

Some of the participants stressed the importance of managers promoting the benefits of mentoring when looking to recruit new mentors or protégés. One suggestion the researcher would make would be to have a previous mentor or protégé advise other staff about the benefits of mentoring in order to generate greater interest in mentoring and to recruit individuals to become involved. When looking for alternative sources of funding for mentoring programs, managers could also to highlight the benefits they have seen on their units and among their staff.

Participants described their perceived mentoring drawbacks and identified what they saw as burdens of being a mentor. They acknowledged that mentoring took a great deal of time, energy, and patience and that mentors were often not relieved of their regular work duties to mentor. Furthermore, managers described the perceived obstacles to mentoring including lack of time, staff, funding, and mentoring information and opportunities, especially in rural areas.

Study findings were similar to those reported in the literature. Several researchers identified lack of time as an obstacle to initiating and maintaining mentoring relationships (Cottingham et al., 2011; Hubbard, Halcomb, Foley, & Roberts, 2010; Hurley & Snowden, 2008; Huybrecht, Loeckx, Quaeyhaegens, De Tobel, & Mistiaen, 2010). Hubbard et al. (2010) also discussed incompatibility of mentors and protégés and lack of a mentorship plan as other potential barriers to mentorship. Lack of a mentorship plan included lack of a formal mentorship

process and inadequate knowledge on how to build mentoring relationships (Hubbard et al., 2010). Hurley and Snowden (2008) identified a lack of opportunity to increase knowledge and skills related to mentoring and unfamiliarity with the mentoring program as potential barriers to mentorship. The research findings also confirmed those of Huybrecht et al. (2010) who reported a lack of available mentors as a barrier to engaging in mentorship opportunities. Thomka (2007) further suggested that either the unit manager or the organization as a whole must identify and remove the real or perceived drawbacks and obstacles so that mentorship could move forward.

Participants also identified facilitating factors for mentorship. These factors included supportive senior leadership and staff, awareness and education for mentoring, mentorship coordinators to assist in the process, and positive staff relationships. They were congruent with those mentioned by Hubbard et al. (2010) who identified facilitating factors such as open communication between mentors and protégés, a supportive environment including administrative support and a learning atmosphere, and accessibility to the dyad members. Facilitating factors will make establishing and maintaining mentorships easier and must be capitalized on.

5.3.3.4 Suggestions for other managers. In order to assist other managers in creating mentoring cultures, managers in the study offered some recommendations. Participants suggested engaging in a dialogue with staff about promoting mentoring in order to encourage its use. In order to build a culture of mentorship on nursing units, participants' suggestions aligned with those of Manthey (2007) that recommended managers must communicate a mentoring vision for their units. By communicating and promoting mentoring, managers display their commitment to mentorship.

Managers identified that being available and present on the unit had an impact in creating

mentoring environments. Being present allowed managers to promote mentoring, to engage in a dialogue with staff, and to encourage mentoring relationships. Zachary (2005) also described these strategies in creating mentoring cultures. Nurse managers in the study felt that role modeling mentoring relationships was important as well. These views echoed those identified by Kouzes and Posner (2007), who had recommended that managers be readily involved in mentoring relationships for themselves, in order to reinforce the value of mentoring to others and to be seen as more credible by the nursing staff.

5.3.4 Mentorship-Supporting Initiatives

5.3.4.1 Communicating. In order to build a culture of mentorship on nursing units, managers must create and communicate a vision that encompassed mentoring (Manthey, 2007). Creating a shared vision for a mentoring culture was an essential element in creating mentoring cultures (Zachary, 2005). Other authors stressed the importance of nurse leaders inspiring a shared vision and enlisting others in the process (Carroll, 2006; Grossman & Valiga, 2009; Kent, 2005; Kouzes & Posner, 2007; RNAO, 2006; Schein, 2004; West et al., 2010). Participants in the study identified the importance of communicating their visions of mentorship to their staff. Furthermore, previous research indicated that effective managers inspired and mobilized others to become involved in creating a shared vision and working towards a goal that was meaningful to them (Carroll, 2006; Kouzes & Posner, 2007; Spurgeon & Cragg, 2007). These actions encouraged employee commitment to mentoring. Some managers discussed facilitating conversations regarding mentorship, in order to capture that essential engagement or active participation in mentorship activities.

Managers in this study frequently reported discussing mentoring programs with new staff, and they encouraged their current staff members to discuss their perceptions regarding

these mentorship programs. Managers, who encouraged mentoring, spoke of having an open-door policy to answer questions from employees regarding mentoring or the mentoring programs. West et al. (2010) suggested nurse managers allow for expression of ideas, facilitation of choices, and encouragement of creativity in order to maximize the resources available to create and sustain effective mentoring cultures.

Communication establishes value, visibility, and demand for mentoring. Using differing methods of communication provided an impetus for learning for all individuals or groups involved or interested in mentoring (Zachary, 2005). Managers in this study promoted mentoring to new and existing staff, encouraged nurses to attend mentorship workshops, and distributed mentoring articles to members on their units. In order to transmit information about mentoring, some strategies managers could use included “lunch and learn” sessions, guest speakers, newsletters, mentoring manuals, intranet websites, and mentoring libraries. These suggestions from the interviews were congruent with those offered by Smadu and Loos (2008). The nurse manager could assist by organizing newsletters about the benefits of mentoring, establishing libraries highlighting best mentoring practices, and facilitating staff meetings related to the rationale for implementing mentoring on their nursing units.

Nurse managers should also alert individuals interested in mentoring about the time commitment required for maintaining successful mentorships, provide suggestions to assist with time management, and ensure that mentoring time will be protected. These actions will build trust and respect between employees and management, which will in turn assist in creating a culture change (Sullivan & Decker, 2009). Individuals involved in successful mentoring relationships, and who are enthusiastic about them, can create enthusiasm for mentoring around them: enthusiasm for mentoring becomes contagious (Zachary, 2005). As a result of this

increased enthusiasm, other individuals would be prompted to seek out mentoring opportunities. Individuals who are champions for mentoring should be encouraged to share their mentoring experiences with other staff in order to spread that enthusiasm.

5.3.4.2 Educating staff. In this study, managers believed mentoring education was important for their staff. Previously, Zachary (2005) showed that mentoring education and training were considered a continuous part of organizational culture and needed to be actively integrated into all endeavours. Block et al. (2005) demonstrated that education regarding mentoring programs was integral to its implementation and sustainability. Mentoring education enabled organizations to outline mentoring standards and best practices that were to be met.

Zachary (2005) proposed mentoring education and training activities that could include, but were not limited to, mentoring orientation workshops and training sessions, mentor speaker series, and annual mentoring conferences. In this study, managers also proposed innovative mentorship education sessions including: implementing short information sessions on their units, having a mentoring week, and promoting mentorship throughout various venues and educational institutions. Another suggestion from the researcher would be to ask managers and staff what their mentoring education needs are and gear educational activities towards their individual requests.

The type of mentoring information requested by managers included information on: the mentoring process, the available resources, the levels of comfort in the role, the benefits of mentoring, the role expectations, and the different learning styles and teaching strategies. Zachary (2005) and Jakubik (2008) also suggested content could consist of a description of formal and informal mentoring, benefits of mentoring, mentoring behaviors, and initiating, sustaining, and improving mentorship.

5.3.4.3 Developing relationships. In this study, managers saw developing relationships as significant for them to establish and sustain mentoring. Participants felt it was important to develop and support relationships with and among their staff members. Cummings et al. (2010) found that managers who had leadership styles that concentrated on people and relationships were associated with greater clinical nurse job satisfaction. Furthermore, Kalisch et al. (2010) established that job satisfaction also increased when teamwork was present in the workplace. Co-worker social support had an impact on new nurse job satisfaction and decreased their intentions to leave (Peterson, McGillis Hall, O'Brien-Pallas, & Cockerill, 2011). Therefore, the study has substantiated previous research results, which showed that promoting and supporting mentoring relationships facilitated job satisfaction. Moreover, if nurses were satisfied in their positions, they were more likely to be retained (O'Brien-Pallas, Tomblin-Murphy, Shamian, Li, & Hayes, 2010).

Managers in the study indicated they wanted to get to know their staff in order to be supportive, to understand their personal and professional needs, and to be able to strategically select appropriate mentors for protégés. They also felt that managers should be available to their staff, and should frequently “check-in” with them. By developing the relationship between them, managers hoped the staff would feel comfortable coming to them for assistance. Smith (2007) believed nurse managers were integral in shaping new nurses’ integration into the environments, and emphasized the importance of managers meeting regularly with new staff members to help them address any needs or concerns. Participants in this study felt similarly to Manion (2005), who believed nurse managers should put their staff first, by caring about them, providing support, and actively listening to their concerns.

Managers also recognized the significance of positive relationships amongst their staff in

order to facilitate mentoring between them. Successful mentoring was based on positive mentor-protégé relationships and must be fostered. Managers reported serving as facilitators in establishing those relationships by introducing new nurses to the rest of the staff, and by pairing new nurses with more experienced ones to assist in establishing mentorships. Participants acknowledged the mentoring relationship took time to build, and they encouraged staff to get to know each other both inside and outside of the work environment.

Relationship development between mentors and protégés was seen as integral in having a successful mentorship experience (McKinley, 2004). Beecroft et al. (2006) found that a trusting relationship between mentors and protégés resulted in the protégé feeling more comfortable asking questions, performing procedures, requesting and accepting feedback, and being socialized into the new role. This type of relationship also allowed mentors to feel comfortable providing constructive feedback, being approachable, displaying a teaching role, and providing moral support (McKinley, 2004). Thus, it was important for managers to take the time to develop relationships with and among their staff in order to support positive mentoring experiences.

5.3.4.4 Facilitating mentoring. Managers in the study used a variety of methods to facilitate mentoring. This study substantiated what Purdy, Laschinger, Finegan, Kerr, and Olivera (2010) found, namely, that positive patient outcomes resulted when managers employed strategies to develop professional growth of staff, to provide access to information required to deliver care, and to provide support, guidance, and time allowing nurses to work more effectively. Kane-Urrabazo (2006) also proposed that managers were responsible for establishing methods that allowed their staff to grow and develop personally and professionally. Through facilitating mentoring, managers in this study were able to allow their staff to grow professionally and work together more effectively.

5.3.4.4.1 Initiating mentoring relationships. Managers who were interviewed described themselves as facilitators of the mentoring relationship by connecting new staff members with experienced ones. Smith (2007) recommended welcoming new nurses with a letter describing who their mentors and contacts were as a way of introduction. Managers would assist to pair protégés with mentors by asking for volunteers or by approaching potential mentors. (A description of the matching process was provided in the “Implementing Programs” section of the dissertation). The managers’ expectations were that all staff would assist in new employees’ learning and development, and this finding was in agreement with Morrow’s (2009) belief that every nurse should be responsible for welcoming new nurses to the units, answering their questions and providing guidance as needed. Thomka (2007) also believed mentorship was fostered when nurses were expected to readily welcome new staff members by sharing their knowledge. The researcher also found that managers acted as liaisons to new staff members, by guiding them in the direction of a particular nurse expert based on protégés’ needs. Thus, this study showed that managers played a key role in initiating mentorships.

5.3.4.4.2 Being a resource. Participants also acted as a resource for new and experienced staff members in relation to unit-specific or mentoring-specific questions. This finding was similar to managers in Anthony et al.’s (2005) study as well. In the dissertation study, participants expressed a need to make themselves available to answer staff questions and to guide them to other resources, if managers did not have the answers. This dissertation corroborated previous research that showed that nurse manager accessibility and support was essential in staff retention (Duffield, Roche, Blay, & Stasa, 2010; Morrow, 2009).

5.3.4.4.3 Providing resources. Managers in this study believed that they were responsible for providing mentoring and educational resources to staff members in order for them to perform

their jobs effectively. These strategies included ensuring staff members were aware of the resources available and knowing how to access them. Race and Skees (2010) also believed that mentoring training and education should be offered on a regular basis using a variety of methods for delivery. Morrow (2009) proposed that by providing resources to support nursing staff, retention of nurses would be enhanced. Managers in the study further discussed the limited financial resources available for mentoring on the nursing unit. Regarding that issue, Dickson (2007) suggested nurse managers would have to use their networking abilities and creativity to find sources of funding to sustain mentoring on their wards.

In order to assist in developing and maintaining mentoring relationships, Zachary (2005) suggested that organizations provide staff with access to mentoring resources including; information on creating and sustaining mentoring relationships, relationship needs assessment tools, progress reports, and online chat-support for individuals involved in mentorships. In the health regions studied, mentoring-specific information primarily came from mentorship coordinators, whereas the unit-specific information came from the managers. The researcher suggests mentorship coordinators and managers work together to consolidate mentoring information.

5.3.4.4 Providing opportunities. In order to best support mentorship amongst staff, managers wanted to know what the learning goals of the relationship were. This knowledge enabled participants to support the dyads in reaching those goals by allowing for extra time to be spent on attaining them or by providing pertinent materials and resources. Some managers even arranged to have staff float to other areas for an observational experience, if staff expressed an interest in learning about a procedure, a particular patient condition, or an operation pertaining to the unit. If mentors, protégés, or managers thought that protégés needed more time in a particular

area to build competence or confidence, managers reported organizing these opportunities as well.

Managers also frequently assessed the learning needs of their staff and assisted to facilitate their overall learning and professional development. Managers promoted upcoming professional development opportunities, allowed staff time off to attend workshops, or arranged for in-services to be given on the unit. By promoting and encouraging education opportunities for staff, an atmosphere of learning was created. As a result, the researcher proposed that staff may be more likely to promote and encourage learning in others. Thomka (2007) stated that learning environments had the potential to allow mentorships to develop and flourish. Other researchers showed that when opportunity and encouragement for professional development and education of nurses was given, a healthy work environment was created (AONE, 2003; Canadian Nursing Advisory Committee, 2002; Kramer & Schmalenberg, 2002, 2004; Parsons et al., 2006; Ross, 2009). By providing various education opportunities, managers contributed to the continuous learning cycle on their units and healthy work environments.

5.3.4.4.5 Manager as mentor. Most managers in this study saw themselves as formal and informal mentors for both new and experienced staff. These findings were consistent with Anthony et al.'s (2005) results, where managers described their role as mentor to staff. Participants in the dissertation believed that they shared their knowledge of certain situations or procedures, offered education, or provided staff with policies or literature if needed.

5.3.4.4.6 Manager as role model. In this study, managers believed that they acted as mentoring role models. This finding confirmed earlier research that showed that nurse managers were integral in promoting a mentoring culture within the organization and served as mentoring role models or champions, by promoting and engaging others in mentoring activities (Kane-

Urrabazo, 2007; Thomka, 2007; Zachary, 2005). By being mentoring role models, Thomka (2007) believed managers created and promoted an awareness of mentoring. All of these findings indicate that managers need to continue to act as role models for mentoring in order to promote and encourage mentorships.

5.3.4.4.7 Allowing staff time to mentor. One of the perceived barriers to mentorship that study participants identified was the associated time commitment with it and the perceived lack of time for staff nurses and managers to accomplish all their duties. As mentioned, a lack of time was also identified by other researchers as an obstacle to initiating and maintaining mentoring relationships (Cottingham et al., 2011; Hubbard, Halcomb, Foley, & Roberts, 2010; Hurley & Snowden, 2008; Huybrecht et al., 2010). Managers recognized that dyads needed time to develop the relationship, to explain various principles and procedures, to be socialized into the nursing environment, and to build the confidence and competence of protégés. Some managers were able to give their employees time off to attend mentorship workshops with their partners, and were also able to reduce their workload when working with protégés. Other participants suggested having additional staff on the unit to allow mentors the time to explain things and to implement protected mentoring time.

Perceived lack of time to mentor was a commonly reported obstacle; thus strategies need to be implemented by the manager and health region to provide staff with more time to mentor. Zachary (2005) had also considered that allowing time to mentor and accessing mentoring-specific resources were essential. Some managers in this study had already allocated some time for mentorship, but further strategies need to be sought out.

5.3.4.4.8 Encouraging teamwork. Participants reported that they encouraged teamwork amongst their staff and considered it to be a facilitating factor of mentoring. Managers believed

that staff members were more willing to help others, to answer their questions, and to take the time to explain procedures if there was a teamwork environment. New staff members were paired with nurses who worked well as a team, because managers believed these individuals were more willing to help others. Heath et al. (2004) and Kramer and Schmalenberg (2004) stated that healthy work environments were fostered when there was a sense of teamwork amongst staff. Thus, one can conclude that encouraging teamwork is an important aspect for managers to consider.

5.3.4.5 Establishing guidelines. Previous research suggested that managers needed to articulate clear mentoring expectations for their staff and to identify staff members' roles and responsibilities (Manthey, 2007). Furthermore, Zachary (2005) found that individual and organizational mentoring expectations must be clarified to uphold accountability and to collectively guide the mentoring effort, and as a result, a sense of ownership prevailed. Managers in this study verbalized their mentoring expectations for their employees. The roles, responsibilities, and expectations of mentors and protégés were outlined by managers and were consistent with those reported in the literature.

Managers who were interviewed expected a team atmosphere from their employees, in which new individuals were readily welcomed and assisted. Nurses were expected to be a resource and support for new staff members. RNs in Canada had a professional responsibility to mentor and guide others as part of their Code of Ethics (CNA, 2008). Some managers in this study made reference to this expectation during the interviews.

Expectations of mentors that the participants shared included willingness to mentor, providing learning opportunities, and communicating effectively. They were also expected to be knowledgeable, approachable, respectful, and positive. Similarly, other sources suggested

mentors needed to be approachable, be skilled in interpersonal and communication abilities, be honest and timely with feedback, and be willing to meet regularly and commit the time necessary to develop and foster the mentorship (CNA, 2004; Provident, 2005). Common mentor roles identified in the literature included: teaching new skills, assessing protégés' needs, arranging learning experiences, challenging the protégé, socializing them to the role of the nurse and the unit culture, assisting to advance them professionally, providing them with psychological support, advising them in career choices, and role modeling appropriate unit culture and nurse behaviours (Colonghi, 2009; Grossman, 2007; Hamlin & Sage, 2011; McKinley, 2004).

The literature indicated that protégés must take responsibility for their development by identifying personal and professional goals they want to achieve, utilizing effective communication skills, demonstrating willingness to ask questions, receiving feedback, asking for assistance when needed, displaying openness to accept new challenges and take advantage of learning opportunities, and being committed to the mentoring relationship (Colonghi, 2009; Grossman, 2007; Hamlin & Sage, 2011; McKinley, 2004; Provident, 2005). Managers in this study spoke of similar expectations of protégés. They wanted protégés to vocalize what they wanted to learn, to take responsibility for their own learning, to be open to feedback, to ask questions if unsure, to show enthusiasm for learning, and to share their knowledge. Because these expected behaviors were consistent with the related literature, the nurse managers in this study had realistic goals and should continue to present them at the beginning of their mentoring programs.

The participants in this study did not mention general expectations outlining the mentoring process. This apparent gap may have been due to the fact that the health regions had formal mentoring programs and all but one health region had a mentorship coordinator who

typically outlined these expectations at the workshops. A responsibility of nurse managers and mentoring coordinators was to establish guidelines with regards to the time commitment for mentoring. Zachary (2005) recommended that managers should specify for partners the minimum time requirements for meeting, and they should protect this time for fostering mentoring relationships.

5.3.4.6 Implementing programs. Even though the costs for implementing and maintaining mentorship programs were high, Burr et al. (2011) and Cottingham et al. (2011) acknowledged that cost savings were possible, when these costs were compared with the turnover and orientation costs of hiring replacement nurses. Participants also discussed their roles in implementing formal mentoring programs offered by health regions. They identified the processes they used for selecting mentors, matching the dyads, and evaluating the mentoring process.

Managers reported recruiting mentors in two different ways. They typically asked for volunteers, or they approached nurses and asked them if they would be interested in participating. Voluntary mentorship seemed to be preferential because individuals were more committed and invested in the relationship (Blake-Beard, O'Neill, & McGowan, 2007). Managers in this study were careful not to ask the same person to be a mentor repeatedly, in order to prevent mentor fatigue and to increase the pool of possible mentors.

Participants also discussed innovative ways to increase mentor involvement and to develop mentor pools. For example, some managers matched two mentors with one protégé to allow part-time employees to be mentors, or to permit nurses who had little experience to be exposed to the mentoring process. Previous research demonstrated that individuals who had mentoring experience were more willing to mentor in the future (Rohatinsky, 2008). These

approaches used by managers allowed newer mentors to build their mentorship skills without taking on the entire mentorship responsibility, allowed protégés to see a variety of different perspectives, and allowed a pool of mentors to be established.

Managers discussed the importance of establishing a “good fit” between mentors and protégés. The literature suggested that appropriate matching was important in formal mentoring programs. In informal mentoring as described by Blake-Beard et al. (2007), the pair self-selected each other based on mutual identification, attraction, and similarity of interests. In formal mentoring relationships, dyads were matched by another individual. In this study, dyads were paired by nursing unit managers or mentorship coordinators.

Participants in this study used the “hunch method” as described by Blake-Beard et al. (2007) to pair mentors and protégés, in which the managers drew upon their personal assessments of the mentors and protégés. Using the hunch method, managers matched mentors and protégés based on the likelihood of compatibility and interpersonal connection (Blake-Beard et al., 2007). By getting to know their staff, managers were able to use this method successfully. However, managers did mention that when they did not know protégés well, matching was a challenge.

A drawback to managers pairing mentors and protégés was that dyad members may not know each other prior to engaging in the relationship. The mentorship took longer to develop because they were becoming acquainted and were identifying protégé needs (Blake-Beard et al., 2007). Protégés and mentors typically expressed a desire to have input into the matching process (Eby & Lockwood, 2005). Employees who had greater input into the formal matching process stated they received and provided more mentoring (Allen, Eby, & Lentz, 2006a). Furthermore, Allen et al. (2006b) discovered that both mentors and protégés perceived greater mentoring

program effectiveness if they had input into the matching process.

Some managers in this study talked about the instances in which it appeared there was a poor match between mentors and protégés, or in which the potential existed to have a poor match. Participants stated they would readily change the pairings to best meet the needs of protégés. Beecroft et al. (2006) described examples of poor matches. For instance, some protégés felt they just did not “click” with their mentors, they did not have common interests, they lacked connection, or they lacked guidance (Beecroft et al., 2006). The ultimate outcome of poor matching was that the relationship did not develop and mature, the mentorship was not productive or effective, and the formal program received a negative reputation (Blake-Beard et al., 2007). Therefore, to optimize the formal matching process, managers should allow staff to have input and readily alter the dyad if a poor match occurs to ensure a successful mentorship experience for all.

Managers should evaluate the mentoring process and identify areas for improvement (Burr et al., 2011; Zachary, 2005). Participants in the study discussed how they met with dyads or with individuals to evaluate the process. Some managers mentioned informal and formal mentoring evaluation at yearly employee performance appraisal meetings. Participants did not identify the health region formal mentoring program evaluations as a means to evaluate the mentorship process. Perhaps managers were not aware of the evaluation process that occurred in the formal program. By having greater knowledge of the formal program evaluation and integrating it into the evaluation process, perhaps managers would have less duplication. Also, knowledge gained from evaluations could be used to improve formal programs and better support the entire process. Evaluating the quality of mentoring relationships has been shown to contribute to the perceived and actual mentoring benefits (Jakubik et al., 2011). If employees’

feedback on the process was sought out, they were more likely to contribute to ongoing program improvement.

5.3.4.7 Orientating considerations. Managers interviewed acknowledged that mentoring occurred during the orientation process, but they that recognized orientation and mentoring were separate. Orientation to the new environment was typically short-term whereas mentoring was a longer-term relationship. Orientation focused on acquiring knowledge related to hospital policies and procedures, basic competencies in caring for patients on the units, and the unit's socialization process as shown by Smith (2007). Smith (2007) also demonstrated that mentorship was mutually beneficial and allowed for protégés and mentors to develop professionally. Business researchers Ragins and Kram (2007) demonstrated that ultimately, mentorship focused on the career development of protégés.

Managers in this study emphasized selecting the right person to orientate new staff members. They sought out people for orientating who had similar characteristics that mentors would have. Managers also recognized new nurses needed support and guidance after the orientation period. If there was a good match between new staff members and nurses orientating, then these relationships had the potential to develop into informal mentorships.

5.3.4.8 Recognizing mentors. Managers in this study believed recognizing employees for their mentoring contributions was important. Employees wanted to feel valued and recognized for their efforts (Kane-Urrabazo, 2007; Trinkka, 2005). Researchers agreed that employees should be appreciated and recognized for their mentorship contributions (Block et al., 2005; Dols, Landrum, & Wieck, 2010; Lynds and van der Walt, 2011). One way mentioned by Zachary (2005) in which mentoring was valued and actively promoted within the organization was by rewarding and recognizing mentoring efforts. Burr et al. (2010) identified that

organization-wide recognition for mentoring and mentoring initiatives led to employees feeling valued and assisted in promoting a culture of mentoring.

Zachary (2005) further proposed that financial recognition be given to mentors. Similarly, Lynds and van der Walt (2011) suggested mentoring be rewarded financially through supplying funding for equipment and facility improvements in rural areas. However in this study, the majority of managers indicated that funding was limited for financial recognition. Thus, health regions and managers said they used other methods to recognize and reward individuals involved in mentorships.

In this present study, managers recognized individuals involved in mentorships through verbal appreciation, thank you cards, lunch celebrations, letters from senior administrators, mentoring certificates, and formal presentations. The researcher proposes other suggestions for recognition including presenting mentoring awards and awarding pins or plaques to those who are involved in mentoring. Additional recognition suggestions proposed by the researcher include verbal acknowledgment at staff meetings, at appreciation nights, or during personal discussions. Written appreciation for individuals involved in mentorships could include venues such as posters and facility newsletters.

Kouzes and Posner (2007) found that individuals were more responsive to personal recognition because it was more meaningful. Thus, mentorship coordinators and nurse managers should gather input from employees regarding how they would like to be recognized and rewarded for engaging in mentoring. Managers in this study discussed individualizing the recognition process to make it more meaningful to those receiving the recognition. In order to individualize recognition for mentorship, generational differences should be taken into consideration.

Previous research showed that when managers understood generational diversity and work-related attitudes, they helped to create the conditions to improve work environments, increase retention, and improve quality of work-life for all staff members (Leiter, Price, & Spence Laschinger, 2010; Wolff, Ratner, Robinson, Oliffe, & Hall, 2010). Leiter et al. (2010) suggested that managers' understanding of generational differences allowed them to support healthy relationships between newer nurses and experienced ones. Methods of recognition for participating in mentorships may be different depending on the generation of staff members. Dols et al. (2010) stated that nurses from every generation wanted informal or formal recognition and wanted acknowledgement for their efforts.

Boychuk-Duchscher and Cowin (2004) suggested that four generations populate the nursing workforce: Veterans (born 1925-1945), Baby Boomers (born 1946-1964), Generation X (born 1965-1980), and Generation Y or millennials (born 1980-2000). Lancaster and Stillman (2002) described characteristics and values of such generations. Veterans were near retirement, were overly cautious and conservative, were active team members, were loyal, and were believers in seniority driven entitlement. Baby boomers were characterized as workaholics and were concerned with work performance. They valued life-long learning and risk-taking. Generation X were comfortable with change, self-directed, and motivated by work conditions that valued their talents and abilities. Finally, Generation Y preferred a collaborative work environment and tried to maintain balance between family and work. Members of this generation wanted immediate feedback and expected technology to be used to its fullest capability.

Hu, Herrick, and Hodgin (2004) found that Veterans and Boomers preferred recognition that had a personal touch, whereas Generations X and Y preferred public recognition. Generations X and Y wanted regular reinforcement and immediate feedback (Hu et al., 2004).

The Veterans and Boomers were committed to their employers, and Generations X and Y were committed to their work teams, but not necessarily committed to their employers (Hu et al., 2004). Dols et al. (2010) identified that new graduate nurses expected managers to assist them in their transition by providing quality mentoring experiences: “Young nurses know what they want and will seek out the workplace that meets their needs” (p. 74).

Because of these perceptions, managers should consider generational factors when implementing mentorship recognition, but they should not overgeneralize, keeping individual needs for recognition at the forefront. In this light, managers in this study suggested that using multiple methods would be most effective. Woodard-Leners et al. (2006) showed that mentoring programs that recognized mentors according to their attributes and generational considerations contributed to their perceived job satisfaction. Job satisfaction, in turn, could ultimately lead to retention of nurses.

5.3.4.9 Negative case. All managers interviewed discussed the importance of mentoring others. Perhaps managers who felt strongly about supporting mentorship contacted the researcher for an interview. Some individuals who did not feel strongly or positively about mentorship may have chosen not to contact the researcher. Managers who did not encourage their staff to be mentors was an atypical finding and this perspective was expressed by one of the participants. Because one manager stated she did not want her staff to mentor others, this finding causes the researcher to think that there may be other managers or employees who have the same perspective.

Schein (2004) defined culture as learned, shared basic assumptions of a group that were passed down to new members. Organizational culture acted as a guide for members to allow them to understand what was valued within the organization and how to guide their behaviors

based on those values (Scott-Findlay & Estabrooks, 2006; Wooten & Crane, 2003). Perhaps a lack of positive perceptions regarding mentorship is why creating mentoring cultures in organizations are not automatic. As a result of this negative case, careful attention needs to be heeded regarding all employees' mentorship perceptions. One must be careful because these negative or neutral perceptions about mentorship could be passed on to other individuals. Employee engagement and commitment at all levels is essential in order for mentoring cultures to be pervasive throughout the organization.

5.4 Recommendations

Based on the dissertation findings, there are several recommendations for administration, practice, education, and research that would initiate and enhance the mentorship process. The researcher contends that following through with these recommendations would help make mentorship more visible. These recommendations would also facilitate the establishment of mentoring relationships and mentoring cultures that are pervasive throughout organizations. These recommendations would allow individuals working in these areas to demonstrate their commitment to mentoring. Each recommendation is equally important and is not prioritized in any particular order. Furthermore, suggestions are not limited to these particular strategies. Individuals are encouraged to develop their own strategies to enhance the mentorship process within their organizations.

5.4.1 Administration

1. Organizations should create and implement mentorship-specific policies that include the following suggestions.
 - Organizations should find innovative sources of funding to establish and sustain mentoring initiatives.

- Organizations should institute an organization-wide mentoring program in order to support managers in the mentoring process by way of implementing programs on the unit, pairing dyads, and evaluating the process.
- Managers' transformational leadership skills should be developed in order to have greater success creating and sustaining a mentoring culture. This initiative could be provided within the context of a formal leadership development program.
- Provincially, pressure needs to be placed on government agencies to ensure continued health region support by employing mentorship coordinators and enhancing mentorship initiatives.
- Because of the various competing priorities in nurse managers' roles, they must be allowed time to develop mentoring on their units. This strategy can include mandating a few hours a month towards mentorship initiatives to encourage its promotion.

2. Organizations should expand mentorship access.

- Mentorship opportunities should be expanded to all members in organizations, including but not limited to managers, educators, administrators, pharmacists, occupational and physical therapists, and dietary and housekeeping employees.
- Collectively, organizations and rural facilities need to continue to expand and refine rural mentoring programs. Using technologies like teleconferencing, videoconferencing, or web conferencing would be a reasonable alternative to in-person mentoring workshops given the travel concerns outlined by the participants in this study. Furthermore, advances in technology are making

mentoring possible even when mentors and protégés are in different locations.

Integrating these technologies must be considered.

- Electronic mentoring initiatives using cell phones and computers should be considered for development by organizations. Many people communicate by phone and email, and these methods of communication should be encouraged for those in mentorships.

5.4.2 Practice

1. Managers should use several strategies to promote mentoring in daily activities.
 - When hiring new employees, managers should inquire about individuals' interests in and commitment to mentorship. Managers should also verbalize that mentorship is a priority on the unit so new staff are aware of the expectations.
 - Managers should communicate about and promote mentoring in informal and formal interactions with their staff. Managers should promote the benefits of mentoring when they recruit program participants or when seeking funding. It would be beneficial for managers to use existing nursing unit evidence to highlight the benefits they have seen on their unit and among their staff.
 - Managers should remove barriers to mentorship for their staff. For example, it is recommended that staff have protected time to establish and foster mentoring relationships. Allowing employees paid time away from the nursing unit to build the relationship is beneficial. Also, given the current budget constraints, managers need to seek out alternate sources of mentorship funding.
2. Managers should consider the uniqueness of employees when establishing and recognizing mentorships.

- Reward and recognition for informal and formal mentorships need to be implemented by administration and managers in order to demonstrate and encourage commitment to mentoring. Multigenerational and cultural aspects should be considered when planning recognition.
- Managers should consider the unique needs of protégés and the personalities of the dyad members, to foster a good fit and thus a successful mentorship experience. The mentorship program must be individualized and cultural competence must be taken into consideration.

5.4.3 Nursing Education

1. Faculty should engage in strategies to facilitate nursing student mentorships.
 - Nursing programs should include mentorship-specific content in their curriculum for their nursing students. Curriculum content could contain education regarding mentorship, including but not limited to providing strategies on finding mentors and establishing mentorships at the undergraduate and new nurse graduate level.
 - Faculties of nursing should establish, support, and promote informal and formal peer mentoring programs at the undergraduate level. For instance, senior nursing students are to be provided with opportunities to mentor more junior students. Faculty members are also encouraged to support and promote mentoring of undergraduate students by RNs who work in the students' area of interest.
 - Faculty members should arrange for inter-professional educational experiences at the undergraduate level as these partnerships may assist in fostering inter-professional mentorships upon graduation.

2. Faculty should engage in strategies to promote continued mentoring at the new nursing graduate level.
 - Mentorship coordinators should be invited to speak to senior undergraduate students to describe the mentoring opportunities available in the health regions upon graduation.

5.4.4 Research

1. Research is needed in the area of mentorship commitment.
 - Mentorship commitment is seen as essential to ensuring integration and maintenance of mentoring among nurses. Seeing as there is limited literature on this topic, more investigation is warranted on areas including but not limited to perceptions of greater organizations' perspectives on committing to mentorship and tool development that measures mentorship commitment.
2. Research is needed in the area of inter-professional mentorship.
 - Researchers need to investigate contributing and facilitating factors, barriers, and outcomes of inter-professional mentorship.
3. Research is needed in the area of creating a mentoring culture.
 - Researchers and faculty members should promote more investigation into nurse manager leadership styles on mentoring implementation and maintenance. For example, information is needed on the impact of nurse manager leadership styles on the cultivation and maintenance of mentoring environments. Data on such effects would be useful to have, so that appropriate mentoring supports could be put in place.

- Researchers should examine staff perceptions of nurse managers' and the greater organizations' roles in creating mentoring environments for employees. As well, the greater organizations' perspective in this area could also be studied.
- Researchers should examine staff members' support of mentoring and development of mentorship cultures.
- Researchers should examine positions such as mentorship coordinators' perceptions of their roles in creating a mentoring culture for the organization.
- Researchers should study how positions such as mentorship coordinators and managers could collaborate to create a mentoring culture on the unit.

5.5 Limitations and Delimitations

When completing a study, there are always limitations and delimitations that need to be considered. Because the researcher was a nurse in the hospital system in one of the health regions, this employment may have had an impact on the researcher's ability to recruit nurse manager participants and on the comfort level of nursing managers to share their perspectives. Knowing some of the nurse managers may have helped or hindered the recruitment of participants.

The researcher requested volunteer participants and those who volunteered may have had strong opinions regarding the topic or may have been more interested in the study. The researcher did not examine perceptions of the managers who did not volunteer. When managers chose not to participate in the study, their reason for not participating was not examined as only those managers interested contacted the researcher. Evaluation of the effectiveness of any formal or informal mentoring programs currently or previously implemented was not addressed as that investigation was beyond the scope of this study. This study did not address how nurse leaders

were mentored into their own roles as that examination was also beyond the scope of this study. The researcher acknowledges that mentoring may have occurred for all staff on the nursing unit, but for simplicity and ease, only how the nurse manager created a mentoring environment for registered nurses was investigated. The researcher did not study RNs' and greater organizations' perspectives on how the nurse manager attempted to or did not attempt to create a mentoring environment. Therefore, the authentication of statements made by the managers did not occur because it was beyond the scope of this study. Not all health regions in the province were selected to be part of the study, so the researcher did not study differences in manager perceptions from other health regions.

Because this study was a doctoral dissertation, only one health region was originally targeted. However, limitations were placed on the managers that could be accessed in the original target health region. Therefore, in order to recruit a larger number of potential participants, the researcher targeted other health regions as well after ethical approval. Manager recruitment was initially slow, so adjustments were made to the ethics application in order to accommodate for snowball sampling as a means for recruitment of additional managers. Approval was also obtained for placing an advertisement in the provincial nursing association's newsletter to increase recruitment numbers.

Because the researcher could not approach managers directly due to ethical protocols, reliance was often needed on administrative assistants or chief nursing officers to forward the study letter of invitation, brochures, and follow-up reminders to potential participants. This arrangement posed some risk that the study information would not be received by the potential nurse managers, due to the busyness of the individuals sending out the information on the researcher's behalf.

At times the researcher was challenged by constant comparative analysis. Constant comparative analysis requires that data collection, coding, and analysis occur at the same time (Glaser & Strauss, 1967). Initially, there was a delay in receiving the transcribed interviews from the transcriber. The researcher was eager to interview participants who had volunteered before they lost interest in the study, even though the researcher had not transcribed and coded all previous interviews. In order to be familiar with the interviews that were not transcribed and coded, the researcher listened to the interviews repeatedly in order to become familiar with the responses and what was happening in the data. This strategy allowed the researcher to immerse herself in the data, become familiar with it, and adjust her interview questions accordingly. Had all interviewing, transcription, and coding occurred simultaneously, saturation may have been reached earlier.

5.6 Researcher Reflections

I believe reflecting on the overall research process from a personal perspective is important. As a novice researcher, I was initially nervous about the research process in general. Having not conducted qualitative research before, I felt a little like a “fish out of water”. In order to become more comfortable, I attended a grounded theory workshop in the initial stages of data collection and coding. I had completed much reading on the grounded theory method, but it was the actual application of the process on which I wanted more information. This workshop made me feel more comfortable using grounded theory. I was also unfamiliar with the data management software (NVIVO) and as a result, I attended a course on how to best utilize the software to its fullest potential. These two strategies were helpful in the initial stages of data collection in order to allow me to become more comfortable with the processes of qualitative research.

Memoing was also therapeutic for me in writing out my questions, concerns, and theoretical reflections. I wrote three different types of memos: personal, theoretical, and operational. The personal memos contained reflections on my thoughts and feelings regarding the research process and the theoretical memos were related to relationships and conceptualizations in the data. Operational memos contained my processes of organizing the data. I strongly believe memoing allowed me to raise the data to a more conceptual level.

The sheer volume of data elicited from participants was surprising and overwhelming at times. I did not realize I would have so much rich data with which to work. Open coding the data was somewhat daunting, but I remained systematic in my approach. I have learned that it is important not to rush the coding process in order for all concepts and categories to form.

I was worried that I would not be able to elicit the core variable and theory from the data. It was really a challenge for me to advance to the theoretical level. Through discussion with my supervisor and rereading Glaser (1978), I was provided with reassurance. To assist in the process, I took a couple of weeks away from the data and when I came back to it, the core variable and theory were clear; it was quite amazing. Having time away from the data provided me with a better perspective to see what was right in front of me all along.

This research gave me a much greater perspective and respect for the role of being a nurse manager and the many challenges associated with the position. Having a greater understanding of the manager position allowed me to realize that implementing mentorship on the unit is not as easy as it seems, even though there are formal mentoring programs in place. What I learned through this process was that creating a mentoring culture was multidimensional and the manager was not solely responsible for that culture creation.

I was surprised that the rural context came out so strongly in the data and perhaps it was because almost half of the participants were from rural areas. Every rural manager identified the challenges of mentorship in rural facilities. I personally feel rural mentorship is an area that needs further exploration given these findings. I was also surprised that many managers were not aware of the continued existence of the formal mentoring programs in the health regions. I believe that greater promotion of the programs is needed in order for managers to begin to implement them on their units.

Overall, I believe conducting this study gave me confidence in performing qualitative research and the results have provided me with direction as to the areas on which I will focus my research next. This study has also allowed me to reflect on my personal role as mentor. I am much more cognizant of my role and responsibilities as mentor in my clinical practice and nursing education positions. Although I was always open to mentoring individuals, I am now more willing to initiate those relationships.

5.7 Chapter Summary

This chapter described the theory of nurse managers' roles in creating a mentoring culture. The researcher integrated the literature with the findings, the core variable, and the major concepts of the model. Several recommendations were proposed for the areas of administration, practice, nursing education, and research based on the study findings. The researcher disclosed study limitations and delimitations, and reflected on the research process.

5.8 Conclusion

The three objectives of this study were to (a) explore managers' perceptions of their roles in creating a mentoring culture, (b) discover the processes in creating a culture of mentoring, and (c) explore the organizational features supporting and inhibiting this mentoring culture. Glaserian

grounded theory methodology was used to constantly compare and code data into categories and three main concepts were identified: organizational context, manager perceptions of mentoring, and mentorship- supporting initiatives on the nursing unit or in the facility. Further data collection, theoretical coding and sampling, and analysis identified relationships among the concepts and allowed the concepts to become saturated and their properties and dimensions developed.

Committing to Mentorship emerged as the core variable and it was pervasive throughout all categories and concepts. From analysis of nurse managers' individual experiences, the researcher conceptualized the process of creating a mentoring culture and nurse managers' roles in it. By developing an understanding of nurse managers' roles in creating mentoring cultures, strategies can be implemented to further assist managers and organizations to create mentoring cultures.

Creating a mentoring culture is not as straightforward as it seems. Organizations are on the right track, but commitment to mentorship from everyone involved is crucial. Even though many health regions have formal mentorship programs, this action does not guarantee that mentoring cultures will be automatically created. Creating a mentoring culture is a multidimensional and multifaceted process that requires support from organizations, managers, and employees. The more comprehensive the support, the greater the likelihood for a mentoring culture to be created.

The health care system cannot afford to employ individuals who are not committed to mentoring. Employees expect mentoring programs and healthy work environments where people work well together. If these components are absent, employees will be more likely to leave to go to areas where these conditions are present. This dissertation has provided the building blocks for

creating a mentoring culture from nurse managers' perspectives. If these strategies are followed, they have the potential to ease new nurse transition, create positive work environments, and ultimately aid in recruitment and retention of employees.

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Appendix A

Description of the Participating Health Regions

Health Region	Description
Saskatoon Health Region	Serves 300,000 residents in 10 hospitals, 29 long term care facilities, and many primary health care centers and employs 13,200 registered nurses and other health care workers (Saskatoon Health Region, 2011).
Regina Qu'Appelle Health Region	Serves over 260,000 residents in 8 hospitals, 23 long term care facilities, and various primary health care centers and employs 9,200 registered nurses and other health care workers (Regina Qu'Appelle Health Region, 2011).
Prince Albert Parkland Health Region	Serves more than 77,000 people in 12 communities and includes hospitals, long-term care, and primary care facilities (Prince Albert Parkland Health Region, 2011).
Sun Country Health Region	Serves 54,000 people in 28 acute care and long term care facilities in 19 cities and towns (Sun Country Health Region, 2011).
Heartland Health Region	Serves 43,502 people in 1 district hospital, 6 community hospitals, 9 health centres and some hospitals and centres include long term care facilities (Heartland Health Region, 2011).
Kelsey Trail Health Region	Serves 39,837 people in 13 hospitals and/or health care centres servicing 33 cities/towns/villages (Kelsey Trail Health Region, 2011).

Appendix B

Informed Consent Form



Behavioural Research Ethics Board (Beh-REB)

CONSENT FORM

You are invited to participate in a research project entitled “*Nurse Managers’ Perceptions of Their Role in Creating a Mentoring Culture on the Nursing Unit.*” Please read this form carefully, and feel free to ask questions you might have.

Researcher(s): Noelle Rohatinsky, RN, MN, PhD student, College of Nursing, University of Saskatchewan, 107 Wiggins Road, Saskatoon, Saskatchewan, Phone: (306) 966- 6221, (306) 933-9733 (home). Research Supervisor: Dr. Linda Ferguson, Phone: (306) 966-6264.

Purpose and Procedure: The **purpose** of this study is to develop a theory of nurse managers’ perceptions of their role in creating a mentoring culture on the nursing unit. The **objectives** include: 1) exploring managers’ perceptions of their role in creating a mentoring culture, 2) discovering the processes in creating a culture of mentoring, and 3) exploring the organizational features supporting and inhibiting this mentoring culture. The interview will take about 60 minutes and there may be a need for a second interview for further clarification or further expansion around topics that were previously discussed. The interview questions may be regarding participant descriptions of healthy workplaces and mentoring, supporting and inhibiting factors related to mentoring on the nursing unit, organizational features that support and inhibit mentoring relationships, and types of mentoring relationships and their impact on mentoring. It is important to note that your performance as a nurse manager or the effectiveness of any previous mentoring programs implemented on your unit will not be evaluated. The study results will be reported in aggregate form and no names, nursing units, or any other identifying information will be used.

A copy of the study findings will be made available to the study participants and the participating health region at their request. The study findings will be written up for publication in scholarly journals, presented at national and international conferences, and provided to interested professional organizations or healthcare agencies.

Potential Benefits: You may receive no personal benefits from participation in this study. As there is no research on nurse managers’ perceptions of mentoring, this study will be contributing to the knowledge in this area. Findings from the research could be used to guide development of future mentoring programs in hospitals and health regions.

Potential Risks: Risks to participants are minimal. Informed consent will be obtained and deception will not be used. Although this eventuality is not anticipated, should a participant become emotionally upset in the interview and need professional assistance, a referral will be made to an appropriate health professional. The interview will be audio taped and the interview will remain confidential and you can ask to have the tape turned off and end the interview at any time. The tapes may be destroyed at the end of the five year period from study completion. You can answer only those questions that you are comfortable with. Confidentiality will be maintained and study findings will be reported in aggregate form. The researcher will not specifically identify the nursing units that participate in the study as some of the nurse managers could be identified by their nursing unit alone. To address the potential for unit identification, nurse managers will be labelled as “nurse manager A”, “nurse manager B” and so forth. Participant names will be removed from transcripts as well. You can withdraw from the study at any time with no penalty incurred.

Storage of Data: Interview audio tapes, transcripts, field notes, memos, and signed consent forms will be kept in a locked cabinet at the student researcher’s residence for the duration of the research process. The signed consent forms and master list will be stored separately from the data. Also, the master list will be destroyed when data collection is complete and it is no longer required. Upon completion of the study, the aforementioned data will be stored securely at the University of Saskatchewan under Dr. Linda Ferguson’s care for a period of, but not limited to, five years and then may be destroyed after this time period.

Confidentiality: All information gathered will be kept confidential. Although the data from this research project will be published in scholarly journals, presented at conferences, and made available to interested professional organizations or healthcare agencies, the findings will be reported in aggregate form, so that it will not be possible to identify individuals or nursing units. Moreover, the consent forms will be stored separately from the data collected, so that it will not be possible to associate a name with any given set of responses.

Right to Withdraw: Your participation is voluntary and you can answer only those questions that you are comfortable with. There is no guarantee that you will personally benefit from your involvement. The information that is shared will be held in strict confidence and discussed only with the research team. You may withdraw from the research project for any reason, at any time, without penalty of any sort. If you withdraw from the research project at any time, any data that you have contributed will be destroyed at your request. Your right to withdraw data from the study will apply until data has been pooled. After this time, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data.

Questions: If you have any questions concerning the research project, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided if you have other questions. This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on November 1, 2010. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.

Follow-Up:

A copy of the study findings will be made available to you at your request at any time.

Consent to Participate:

(a) Written Consent

I have read and understood the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix C

Preliminary Interview Guide

1. Describe what you envision as a healthy workplace?
2. Please describe your role, as a nurse manager, in creating a healthy workplace?
3. What does mentoring mean to you?
4. In your opinion, what is the link between a healthy workplace and mentoring relationships among staff?
5. Tell me about actions or situations that facilitate mentoring on the nursing unit?
6. Tell me about actions or situations that make mentoring more difficult on the nursing unit?
7. How do you or are you able to support the mentoring relationship among RNs?
8. What are the obstacles you face in supporting the mentoring relationship among RNs?
9. What do you perceive as administration's role in creating a mentoring environment within the organization?
10. Please give me examples that describe how mentoring is supported within the organization?
11. Please give me examples as to how the mentoring process is inhibited within the organization?
12. Tell me about the registered nurse's role in creating a mentoring environment within the organization?
13. What are your views about formal mentorship programs?
14. What is beneficial about formal mentorship programs?
15. What are the drawbacks to formal mentorship programs?

16. How do you see mentoring being supported in organizations where there is no formal mentoring set up?
17. Is there anything else you would like to tell me about your role in creating a mentoring environment within the healthcare organization?

Appendix D

Revised Interview Guide One

1. Describe what you envision as a healthy workplace?
2. What does mentoring mean to you?
3. In your opinion, what is the link between a healthy workplace and mentoring relationships among staff?
4. How are you able or would you like to support the mentoring relationships among RNs/staff?
5. A lot of managers say they support mentoring relationships among staff. What does mentoring support from a nurse manager perspective look like?
6. What are the obstacles you face in supporting the mentoring relationships among RNs?
7. What do you need as a nurse manager that would enable you to better support mentoring relationships? (resources, supports)
8. How can senior administration better support you in creating that mentoring environment?
9. What characteristics are important for a manager to have in order to provide that mentoring support to staff?
10. Who is responsible for mentoring a new individual - provide some examples. (different disciplines?)
11. What role does mentoring education play in creating mentoring environments? (What type of education would you like to see for managers and staff?)

12. How are those involved in mentoring relationships recognized? How important is recognition of mentors?
13. What role do relationships between staff and between manager and staff play in creating a mentoring environment?
14. What are some inhibiting factors that would prevent mentoring from occurring on a unit?
15. What are some facilitating factors that may promote mentoring in an area?
16. What would be some important characteristics or responsibilities for a protégé to have in the mentorship?
17. How do you see mentoring being supported in organizations where there is no formal mentoring set up?
18. If you could give any advice to nurse managers in creating a mentoring environment what would that be?
19. Is there anything else you would like to tell me about your role in creating a mentoring environment within the healthcare organization?

Appendix E

Revised Interview Guide Two

1. Throughout my interviews, managers have directly and indirectly stated that being committed to the mentorship process as a whole, as a manager, is important to making mentorship work on the unit or in the facility. What are your thoughts?
2. How does a manager demonstrate that they are committed to mentorship? In what ways do you show you are committed to mentorship?
3. Are organizational considerations (senior leadership/administration support, healthy work environments, funding for mentoring, rural considerations) important for the manager to support mentorship on their unit...or do they just make it easier if they are present? What does a manager do if that organizational context is not there?
4. In what way do nurse manager perceptions about mentorship and their personal characteristics assist in or inhibit fostering mentorships?
5. In what way does the greater organization influence nurse managers' perceptions about mentoring?
6. Researcher to describe the theory model and ask managers what their thoughts are – does it fit for them, is it relevant, is it workable?