THE CLINICAL NURSE EDUCATOR MENTORSHIP SUPPORT MODEL

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by

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Abstract

Because the nursing shortage is a present and looming issue to health care and nursing practice, organizations and researchers have invested a great deal of time and resources looking into ways to rectify this situation. Mentorship is one strategy gaining steady interest as a possible way to lessen the impact of this problem. Though much is known anecdotally about mentorship, empirical research is limited. Formal mentoring program evaluation and nursing graduates' experiences of transitioning into practice have been studied the most.

This Grounded Theory study, in an attempt to explore new dimensions in mentorship research, examined the role of the Clinical Nurse Educator in shaping an organizational culture of mentorship. This study is important because it looks beyond the mentoring relationships that exist between the experienced and less experienced nurse toward understanding the processes and influences exterior to this relationship, namely, nursing leadership and organizational culture for example, the Clinical Nurses Educator's involvement in mentorship with colleagues and their participation in mentoring programs within the Health Region.

The researcher interviewed Clinical Nurse Educators in acute care settings to determine their role in shaping a mentoring culture. The findings indicated a flourishing use of informal mentorship between Clinical Nurse Educators, staff nurses, and fellow educator colleagues. From the data, a theoretical model was developed to explain the Clinical Nurse Educator's role of supporting a mentoring culture. Five themes of perceived nursing environment, work functions, mentorship beliefs, relationships, and organizational values were found to influence the Clinical Nurses Educator's ability to

support mentorship. Also uncovered were the personal and professional mechanisms of informal mentorship that Clinical Nurse Educators used to support an organizational culture of mentorship on their units.

Understanding the Clinical Nurse Educator's role in supporting an organizational culture of mentorship will create awareness of those mechanisms currently in place, inform organizations about ways to strengthen mentorship in the workplace, emphasize the need to support mentorship in the acute care setting, add to the empirical nursing literature on mentorship, and highlight new areas for mentoring research.

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Chapter 1 Background

1.1 Introduction and Background

Canada may be heading toward an unprecedented nursing shortage. In fact, the Canadian Nurses Association (2009) is forecasting a deficit of almost 60,000 full-time Registered Nurses by the year 2022. Recruitment and retention of nurses will continue to be a top priority of health care organizations for the next decade. One strategy showing potential in countering the current and deepening shortage is recruitment and retention of nurses, supported by mentorship. Empirical evidence concerning mentorship in nursing is scarce and the majority of information available is anecdotally weighted. Many aspects of mentorship in nursing remain unknown. Particularly, knowledge is needed on the role that nursing leaders, such as the Clinical Nurse Educator (CNE), play in shaping organizational values which are known to have an impact on the recruitment and retention of nurses. This study proposes to examine the self-perceived role of the CNE in creating an organizational culture of mentorship in the acute care setting. The ultimate goal is to develop theory that will add to the existing knowledge on mentorship; practically, the results may help health care organization in their efforts to recruit and retain nurses.

1.2 Statement of the Problem

In 2007, the Saskatchewan Union of Nurses reported more than 1,000 known full-time nursing vacancies in the province (Leader-Post, 2007). Since this time, the nursing union and the Saskatchewan Government forged a partnership agreement using dedicated funding in the amount of 4.35 million dollars to hire 800 Registered Nurses in the province by 2012 (Saskatchewan Union of Nurses, 2008). Compared to some other

Canadian provinces, Saskatchewan has one of the highest retention rates of new graduate nurses. According to the Nursing Education Program of Saskatchewan (NEPS) Employment Exit Survey (2008-2009), 93.9% of the NEPS graduates had already found work placements prior to program completion, or intended to stay within the province to work. These high retention rates may do little to shield Saskatchewan from the current and further impending Canada wide nursing shortage caused by the anticipated retirement of the "Baby Boomer" generation, those exiting the profession due to lack of job satisfaction, and fewer young people entering the nursing profession (CIHI, 2007; CNA, 2009). Although these factors are general recruitment and retention issues in Canada, Saskatchewan has much higher retention rates at two and five years post graduation (NEPS Employment Exit Survey, 2008-2009). These rates are compared to Ontario, where retention rates are lower, such that the Ontario government implemented a work retention target of 70% full-time status Registered Nurses in their hospitals (Baumann, Crea-Arsenio, Idriss-Wheeler, Hunsberger, & Blythe, 2010). In a news release dated October, 2010, the Government of Saskatchewan reported they it allot an additional 170 nursing training seats for the new nursing programs in Saskatchewan (Government of Saskatchewan, 2010).

As the nursing shortage becomes more pronounced (CIHI, 2007), it is becoming increasingly important to look within health organizations to understand nursing leadership and the vital role that nurse leaders play in shaping, safeguarding, and influencing the values set by organizations. These factors may play an important part in the recruitment and retention of new nurses, and the retention of senior nurses in the health care system. In nursing, such a leadership role is carried out by intermediaries,

described by Ferguson, Milner and Snelgrove-Clarke (2004) as nurses possessing both the clinical judgement and the research understanding necessary to link theory and practice in a clinical setting. Among these intermediaries is the CNE.

In the literature, the role of the CNE is defined as a nurse leader who is responsible for supporting students, new nurses, new employees, and experienced nurses. The CNE's duties include arranging clinical placements, participating in the recruitment and retention of nurses, creating policies and procedures, and fostering career development (Conway & Elwin, 2007; Leners, Wilson, Connor & Fenton, 2006; Milner, Estabrooks & Humphrey, 2005; Pollard, Ellis, Stringer & Cockayne, 2007). In addition, the CNE has a leadership role in setting standards for quality of patient care, formulating unit and agency-wide policies, teaching new or modified approaches to patient care, creating healthy workplaces, and translating research into practice (Jowett & McMullan, 2007; Kalb, 2008; Milner et al., 2005). Therefore, the CNE is well positioned in the organizational structure to translate and promote its cultural values to both experienced practitioners, the pre-existing *community of practice,* and to those new to the practice setting (Wenger, 1998; Wenger, McDermott & Snyder , 2002).

In many disciplines, mostly in business, mentorship has been widely studied (Kinjerski & Skrypnek, 2006; Payne & Huffman, 2005). In health care, mentorship research has focused on aspects such as retention, recruitment, job satisfaction, and positive patient outcomes (Bassi & Polifroni, 2005; Block, Claffey, Korow & McCaffrey, 2005; Leners et al., 2006). However, little is known about the CNE's role in creating or supporting an organizational culture of mentorship. This unexplored area of mentorship is the focus of this study.

1.3 Research Question

How do CNEs perceive their role in creating an organizational culture of mentorship in the acute care setting?

The specific research objectives will be to:

1. Describe the role of the CNE in creating and enhancing the organizational culture of the agency.
2. Identify CNE characteristics and practices that support an organizational culture of mentorship.
3. Link CNE beliefs, practices, and expertise with the support of a mentoring unit and organizational culture.

1.4 Significance of the Issue

This study will contribute uniquely to the research on mentorship by providing valuable insight into the role of the CNE in creating a culture of mentorship in the acute care setting. It will offer researchers and administrators a glimpse beyond the traditional didactic mentoring relationship most commonly investigated in nursing, towards nurse leaders' contributions to the mentorship process. Understanding the CNE's role in fostering mentorship could inform organizations about ways to strengthen their culture of mentorship. Understanding the concepts involved in this form of mentoring relationship may guide the efforts of those working to solve the nursing shortage issue by creating environments that are satisfying and supportive, thus facilitating recruitment and retention. This research will address a gap in the literature on the role of nursing leadership in mentorship and identify areas for further research.

Chapter 2 Literature Review

2.1 Overview of the Availability of Research on the Topic

Despite the plethora of articles written about mentorship in nursing, little empirical research exists to support some of the key assertions made by authors. Further lacking are empirical studies addressing the role of nurse leaders in developing and supporting mentoring environments. Therefore, the author decided to include business literature to demonstrate the link between the concepts of leadership and organizational culture.

2.2 Search Techniques Employed

Three main concepts were identified as important to include in the literature review: (a) mentorship in nursing, (b) the CNE's role in the acute care setting, and (c) organizational culture. The following databases were used in the search: Cumulative Index to Nursing and Allied Health (CINAHL), MEDLINE with Full Text, Journal Storage (JSTOR), PsycINFO, Pro Quest Dissertations and Theses, and Google Scholar. Articles were also collected through a review of the reference lists of articles already located, and those shared by colleagues. The limits placed on the search included articles that were peer reviewed, published between the years 2000 to 2011, and available in the English language.

The truncated expressions of *mentor** and *nurs** were used in combination with the search terms: *educator, practice educator, advanced role, role, clinical educator, hospital based educator, staff educator, staff development, clinical nurse educator, continuing education providers, leadership, role-model, clinical education, knowledge*

translation, transformational leadership, culture, community of practice, environment, and *organizational culture.*

The selection criteria used to determine which articles to include consisted of only those pertinent to the three concepts aforementioned in the search strategy and those that would add clarity to defining key concepts of the study.

2.3 Areas to be Addressed

This literature review will cover both the empirical and non-empirical literature concerning the CNE and mentorship in nursing. Specifically, it will address the beliefs about mentorship in the nursing context; it will also address the CNE's unique in the acute care setting, and environmental work factors as they relate to the recruitment and retention of nurses. This literature review will also include references from the business literature where mentorship has been more extensively studied to highlight the similarities and differences in practice. The review content will be used to discuss important study concepts.

2.4 Thematic Synthesis

The non-empirical literature will be analysed and presented to demonstrate the current beliefs about mentorship in the acute care setting. The terms thematic, anecdotal, and non-empirical literature are used to describe articles or sources that are not research in nature. Empirical research refers to research articles.

2.4.1 Defining mentorship. Mentorship first began to appear in the nursing literature in the 1980s (Andrews & Wallis, 1999) and continues to be a popular topic of discussion. Mentorship can be traced back to Greek mythology in the story of Homer's Odyssey, where a character named Mentor assumed the responsibility of rearing

Odysseus' son, Telemachus, during his absence and time spent in the Trojan War (Andrews & Wallis, 1999; Barnard, 2002; Thomka, 2007). Traditionally in nursing, mentorship has been described as a relationship between an older, more experienced male aiding a younger, less experienced male in his development and learning (Andrews & Wallis, 1999). The definition of mentorship in the business context has similar meaning though the terminology is more consistent with business jargon. Kram (1983) described mentorship as the offering of developmental assistance to a junior employee by a senior colleague in the organization.

In the United Kingdom, the term mentorship has often been used interchangeably with the term preceptorship (Race, & Skees, 2010), resulting in a lack of clarity of the meaning and characteristics of the terms (Yonge, Myrick, Billay, & Luhanga, 2007). A key difference between the two terms is that mentorship is more encompassing and concerned with both the personal and the professional development of neophytes (Barnard, 2002) while preceptorship tends to be more narrowly focused on learning and support in the clinical setting (Yonge et al., 2007).

There is a difference of opinion in the anecdotal literature concerning the role of the mentor. In the United Kingdom, the term mentor refers to a clinical teacher assigned to assist students in practice settings with responsibilities closely resembling the features of preceptorship (Yonge et al., 2007). In North America, mentors are not usually linked to academia but rather are experienced nurses working for an organization accepting to act as mentors of less experienced nurses. For the purpose of this study, the North American meaning of mentorship will be used.

2.4.2 Beliefs about mentorship. The preoccupation with mentorship in nursing stems from the need to find long-term solutions for the recruitment and retention of nurses (Bally, 2007). There is a general consensus in the anecdotal literature that mentorship is beneficial to mentors, mentees, health care clients, and health care organizations. Mentorship is believed to benefit mentees through assisting them with orientation to practice, aiding in the development of problem solving skills, offering coaching and support for adjustment to the work environment, and sharing both the formal and informal norms of the profession (Barnard, 2002). Mentorship is considered to be useful in promoting professional development and job satisfaction of both the mentee and mentor (Funderburk, 2008), which is known to have an impact on retention (Thomka, 2007).

Similarly, in the business literature, mentorship has been associated with career promotion and job satisfaction (Ragins & Scandura, 1999). Although in both the nursing and business settings professional development is a goal of mentorship, upward mobility is not emphasized in nursing due in part to the need for high numbers of skilled workers at the bedside. In business, mentorship is used to groom protégés to one-day run the company (Grossman, 2007). Mentors in the business setting were often two hierarchical tiers above their protégés (Raabe & Beehr, 2003) while in nursing, mentors are most likely to be colleagues at the same level in the organizational structure.

Barnard (2002) identified personal satisfaction as being the primary benefit experienced by the mentor. In the business literature, a sense of personal satisfaction and fulfilment were also identified as the most important benefits to the mentor (Ragins & Scandura, 1999). Mentors, in the business context, may also benefit from peer and

supervisor recognition resulting in job promotion (Ragins & Scandura, 1999). In nursing, mentoring peers has also been associated with increased recognition and job promotion (Shermont, Krepcio & Murphy, 2009).

Mentorship is thought to have an indirect influence on health care clients through creating a more skilled workforce and enhancing nurses' self-confidence as well as satisfaction with their professional identity (Funderburk, 2008). It is asserted that mentorship can positively influence the nursing work environment through strengthening nurse-to-nurse relationships (Bally, 2007) and bridging generational gaps that exist in the current nursing workforce (Funderburk, 2008). Formal mentoring programs are attractive to administrators because they provide greater organizational control over new employees' introduction to the work environment and culture (Tourigny & Pulich, 2005).

A few authors, although acknowledging the possible benefits of mentorship, speculate on the detrimental effects of ineffective mentorship along with other environmental and cultural factors which can lead to circumstances of high turnover rates as a by-product of weak organizational commitment to mentoring, a lack of dedicated resources, and non-supportive work environments (Nettleton & Bray, 2008; Race & Skees, 2010; Tourigny & Pulich, 2005). The business literature also points out possible drawbacks with the use of mentorship. In particular, negative consequences for the mentor such as being replaced by the protégé, being accused of favouritism in the workplace, and having poorly performing protégés reflect negatively on their judgement (Ragins & Scandura, 2009).

2.4.3 Types of mentorship. The two main types of mentoring identified in the nursing literature are formal and informal mentoring. Formal mentoring programs are

usually highly structured with organizational approval, outlining specific mentoring objectives within a set timeframe, whereby the mentor and mentee pairs have been selected and matched by a third party (Dyer 2008; Tourigny & Pulich, 2005). In contrast, informal mentoring is usually unstructured and occurs spontaneously between a mentor and mentee who are drawn together by mutual attraction and shared interests (Tourigny & Pulich, 2005).

There are contradictory views in the anecdotal literature about which type of mentorship is most commonly used in nursing and the type of mentoring that would be most advantageous. According to Tourigny and Pulich (2005), the current tendency is to rely on informal mentoring schemes; consequently, organizations are missing out on the opportunity to strengthen job satisfaction and the organizational commitment of their members. Conversely, Thomka (2007) stated there is a shift away from formal mentoring programs in nursing towards the creation of practice settings that informally foster mentorship.

It is difficult to say with certainty where the current emphasis lies as the empirical evidence is so limited; however, more research articles could be found investigating formal mentoring programs in nursing than informal relationships (Grindel & Hagerstrom, 2009; Halfer, Graf, & Sullivan, 2008; Latham, Hogan, & Ringl, 2008; Newhouse, Hoffman, Suflita, & Hariston, 2007; Scott & Smith, 2008; Van Eps, Cooke, Creedy, & Walker, 2006) . The business literature on mentorship reported a reliance on informal mentoring schemes, thought to have a greater impact on work culture, although organizations are seeking to duplicate the benefits of mentorship with more formalized programs (Raabe & Beehr, 2003). In the business setting, formal mentoring programs are

preferred to target the mentorship of women (Ragins & Cotton, 1999) whereas because nursing is a female-dominant profession, this is not an issue.

2.4.4 Mentorship and the nursing environment. Bally (2007) raised an important point about the environment in which some nurses are working; an alarming number of nurses are leaving the profession due to stress and anxiety caused by exposure to *horizontal violence* in the workplace. Bally defined *horizontal violence* as behaviours such as, "gossiping, criticism, innuendos, scapegoating, undermining, intimidation, passive aggression, withholding information, insubordination, bullying and verbal and physical aggression" (p.143). Horizontal violence is also known as *lateral violence* or *bullying* in the nursing literature. In the United States, more than 50% of new graduates were found to leave their first job within the first year of practice at a financial cost to the system of approximately $42,000 to $64,000 USD per nurse (Funderburk, 2008). Job satisfaction is known to play a key role in nurse retention and one of the top factors influencing job satisfaction was co-worker relationships (Funderburk, 2008).

Thomka (2007) argued that in order for mentorship to work in securing intellectual capital, it is paramount to consider the work environment. Work environments that are inhospitable to the values associated with mentorship may render the intervention futile. Organizations that value mentorship are accountable, share a common mentoring vocabulary, offer educational opportunities, and convey the value of their employees (Dyer, 2008). These authors have addressed the important role that *organizational culture* plays in the acceptance and fostering of mentoring attitudes. Organizational culture is defined as a shared value system evolving over time that guides its members in solving problems, adapting to external environments, and managing

relationships (Wooten & Crane, 2003). For Schein (2004), a leading author in *organizational culture,* the concepts of culture and leadership are closely intertwined, and the role of leadership is to create and manage culture. Other organizational context authors point out the importance of mentorship in organizational culture (Kram, 1983; Raabe & Beehr, 2003; Ragins & Cotton, 1993, 1999; Ragins & Scandura, 1999).

2.4.5 The definition of Clinical Nurse Educator. One such leader in the nursing context that plays an important role in creating and managing organizational culture is the CNE. Different terms that have been used to refer to a CNE in the nursing literature include *educator, clinical staff educator, hospital-based educator, educator consultant, practice educator,* and *clinical educator.* The designation of CNE can mean many different things; it may refer to a Clinical Academic Educator or a Nurse Educator employed by universities to assist undergraduate or qualifying nursing students in their clinical practicum or a professor teaching nurses the fundamentals of practice (Culleiton & Shellenbarger, 2007; Ortelli, 2006; Robinson, 2009).

An Educator Consultant, Staff Educator, Hospital-Based Educator and Practice Educator usually refer to a nurse working for an organization with the main responsibilities of the clinical and professional development of the staff (Beres, 2006; Forsyth, Rhudy, & Johnson, 2002; Hodges, 2009; Mateo & Fahje, 1998). Practice Educator is the most commonly used term in the United Kingdom to describe a nurse with clinical expertise who is employed by hospitals to oversee staff educational development. What creates further ambiguity is that a CNE may refer to either a nurse working in the academic setting or in a clinical setting.

In the literature, the CNE is defined as a clinically experienced nurse working in the hospital setting with the responsibilities of supporting students, new nurses, new employees and experienced nurses, and nurses assuming a mentoring, arranging clinical placements, participating in the recruitment and retention of nurses, creating policies and procedures, and fostering career development (Conway & Elwin, 2007; Leners et al., 2006; Milner et al., 2005; Pollard et al., 2007). Occupying a leadership position, CNEs are responsible for setting quality practice standards, formulating nursing unit and agency-wide policies, teaching new or modified approaches to patient care, creating healthy workplaces, and translating research into practice (Jowett & McMullan, 2006; Kalb, 2008; Milner et al., 2005).

The job description of the CNE in the study is defined as a nurse responsible for integrating nursing skills, knowledge, theory, and principles of adult learning used in delivering patient care, providing supervision to nurses, coordinating, participating in research, updating clinical standards, providing clinical leadership, utilizing both formal and informal strategies for staff development, clinical problem solving, and working collaboratively with staff, students, and clients and families in resource development (Saskatoon Health Region CNE Job Description, 1998). The CNE is required to possess a bachelor's or master's degree in nursing, or continuing education. Along with these academic requirements, the nurse should have a minimum of three to five years of clinical experience in the related area of practice. The CNE attributes must include: having teaching abilities, having strong clinical skills, demonstrating leadership abilities, having change agent capabilities, posessing good interpersonal skills, being self-directed,

having a commitment to continued professional development, and having the ability to integrate research into practice (Saskatoon Health Region CNE Job Description, 1998).

2.5 Research Literature

To date, most of the research has studied academic nurse educators (Davis, Stullenbarger, Dearman, & Kelley, 2005; Raymond & Profetto-McGrath, 2005). Few studies have involved educators in the clinical setting. The research completed on CNEs in acute care settings focuses on the impact of the newly created Practice Educator role in countries belonging to/or influenced by the United Kingdom (Considine, & Hood, 2000; Jowett, &McMullan, 2007; Van Eps et al., 2006). Although few studies could be located directly linking the CNE to mentorship, an interesting trend was noted where a number of the formal mentoring programs either consulted CNEs or were entirely developed by them (Newhouse et al., 2007; Persaud, 2008; Scott & Smith 2008; Sigsby, Selzer, & Wilson, 2006; Van Eps et al., 2006). This trend would suggest that, although CNEs are not usually the focus of mentorship, nurses working in those positions are advocates for the use of mentorship. This finding further signifies the important role they play as mediator between the needs of new employees and the needs of the organization.

2.6 Qualitative

Research concerning the CNE role in the clinical practice setting is very limited. Among the qualitative articles that were retrieved for this literature review, only two involved the CNE directly (Jowett & McMullan, 2007; Manning & Neville, 2009) and one article described the role CNEs had in developing and participating in a group mentorship model (Scott & Smith, 2008). More details about the key findings of these articles will be described under its own heading in 2.6.2 Outcomes.

2.6.1 Frameworks. Two frameworks identified in the qualitative studies regarding program development were *Bridge's Transition Theory* (2003, 2004) and a quality improvement framework called *Deming's* (1982) *Cycle of Plan, Do, Check and Act* (Manning & Neville, 2009; Van Eps et al., 2006). Bridge's (2003, 2004) theory states that with any circumstance of change, individuals will go through three distinct stages of personal transition and growth (Manning & Neville, 2009). This theory is relevant as work-role transition is a common theme found in the nursing mentorship literature. Deming's (1982) Cycle of Plan, Do, Check and Act is a continuous four step improvement tool that has been widely used in health care to improve the quality of service delivery (Van Eps et al., 2006).

2.6.2 Outcomes. Manning and Neville (2009) conducted a qualitative study exploring the experiences of CNEs in their work-role transition from being a staff nurse to becoming a CNE. An interesting outcome of the study was that novice CNEs were found to have sought out informal mentorship from senior clinicians. This study outcome signifies the need to investigate the informal use of mentorship and networking among senior nurse clinicians in order for it to be a recognized and legitimized as a mechanism for support to nurses in role transition (Manning & Neville, 2009). The study alluded to the idea that mentorship by senior CNEs may exist. This proposed thesis study will be important to help identify what current CNE mentoring mechanisms may be in place in order to address this gap in knowledge.

Jowette and McMullan (2007) conducted a mixed methods study, more qualitatively dominant, to evaluate the effectiveness of the new role of Practice Educator in the United Kingdom from the perspective of Practice Educators, students, and mentors.

The term mentor, in this study, was used to refer to nurses employed by academic institutions to assist nursing students with integration into practice in their final year of studies (Jowette & McMullan, 2007). The researchers uncovered some role confusion concerning the Practice Educator in promoting clinical competence; some educators interpreted this finding to mean promoting the clinical competence of mentors while others felt it was being a role-model to students. This difference in the interpretation of promoting clinical competence demonstrates practice CNEs' identification with both the theory and the practice role, confirming the assumption of their crucial positioning as a link agent between the two. Ways in which the Practice Educators were successfully able to support the mentors was by being available, being visible in the clinical areas, meeting individually with mentors, and communicating with managers on behalf of the mentors and students (Jowette & McMullan, 2007). Students felt the Practice Educators' communication skills were their main strength (Jowette & McMullan, 2007). Interestingly, the effective Practice Educator traits identified in the study coincide with the taxonomy of effective or "good" mentor traits found in the thematic nursing literature; good mentors are willing to meet regularly with protégés (Barnard, 2002), they are good communicators (Dyer, 2008), possess effective interpersonal skills, and provide supervisory support (Andrews & Wallis, 1999). These outcomes lend further support to the assumption that the CNEs act as mentors to staff members in the acute care setting.

A qualitative research study by Scott and Smith (2008) collates many of the important concepts being linked together by this proposed thesis research. The study was a program evaluation of a cost-effective strategy of group mentoring that was initiated, developed, and designed by CNEs who also assumed the role of mentor to new hires in a

small rural hospital in the United States. The project was a year-long group mentoring project consisting of three phases: 1) the orientation phase to the hospital; 2) the precepting phase to the new hires' respective units and exposure to mentorship; and 3) teaching the new hires how to precept others (Scott & Smith, 2008). This study is important because it not only identifies the CNE as the developer of the mentoring program but also as a participant, role-model, and transformational leader. The program introduced a new aspect of teaching the new hires to welcome other newcomers, thus creating the possibility for a larger mentoring impact towards environmental change and the creation of a mentoring culture. This study by Scott and Smith really addresses the potential that CNEs may have in creating and supporting mentoring environments. The new hires taking part in the year-long group mentoring reported that the program helped them to develop a sense of security and being cared for by the organization (Scott & Smith, 2008). This finding is similar to the suggestion in the thematic literature that exposure to formal mentoring programs may help to strengthen the commitment of employees toward the organization (Tourigny & Pulich, 2005).

Another concept that was uncovered in the literature review was the need for new nursing staff and students to understand the dynamics of both the organization culture of their workplace and the professional culture of nursing. A descriptive study by Fox, Henderson, and Malko-Nyhan (2005) explored how new staff perceived supportive elements implemented by the organization to assist them in their integration. After six to nine months, new orientees revealed details about their need to know the system and align themselves with "good" people. One of the roles of the CNE in the acute care

setting may be mentoring the staff about how to become politically savvy and aware of the organizational culture in which they work.

Van Eps et al. (2006), in a descriptive exploratory study of students' evaluation of a year-long mentoring program, found that exposure to mentorship was important in the students' professional socialization and learning the culture of nursing. This finding is similar to the assertion in the thematic literature that mentorship is believed to benefit the mentee through assisting with orientation to practice and sharing both the formal and informal norms of the profession (Barnard, 2002). This study is again an example of how the CNE is in a position of leadership where this knowledge of organizational values and practice values could be role-modeled.

2.7 Quantitative

Quantitative articles about the CNE as defined in this thesis study were limited. Only two of the articles measured the impact of the CNE's work in the acute care environment (Considine & Hood, 2000; Milner et al., 2005). One researcher tried to determine the effectiveness of mentorship between CNE graduate students acting as mentors and undergraduate nursing students at risk of program failure (Riely & Fearing, 2009). Other mentoring articles addressed new nurses' levels of organizational commitment, intent to stay with their employers, job satisfaction, retention and socialization (Gregory, Way, Lefort, Barrett, & Parfrey, 2007; Grindel & Hagerstrom, 2009; Halfer et al., 2008; Kovner, Brewer, Greene, & Fairchild, 2009; Latham et al., 2008; Newhouse et al., 2007).

2.7.1 Research designs. The research designs used in the quantitative studies included: a non-experimental predictive survey (Gregory et al., 2007), a secondary

analysis of a predictive model of research (Milner et al., 2005), a quasi-experimental, post-test only control group (Newhouse et al., 2007), a pre-experimental design (Considine & Hood, 2000), two longitudinal studies over a one-year period (Grindel & Hagerstrom, 2009; Halfer et al., 2008), and descriptive studies (Kovner et al., 2009; Latham et al., 2008; Riley & Fearing, 2009). The authors of the longitudinal studies reported difficulties with data collection over time that jeopardized the accuracy of the research results.

2.7.2 Sampling methods and sample characteristics. Convenience sampling was the most commonly reported technique used in the studies (Considine & Hood, 2000; Grindel & Hagerstrom, 2009; Halfer et al., 2008; Kovener et al., 2009; Latham et al., 2008; Newhouse et al., 2007; Riely & Fearing, 2009). One group chose random sampling (Gregory et al., 2007) while another used a stratified sampling of nurses belonging to a nursing association in Canada (Milner et al., 2005). The sample sizes ranged from 18 to1933 nurses and study response rates were generally above 29.4%. The sample population was typically new graduate nurses, females, White, and working in the acute care settings.

2.7.3 Variables of interest. The research variables seemed to fit into one of two categories that either looked at educational support or organization fit. Variables of educational support are those things that focus on practice development. Organizational fit refers to the variables that examine how employees are integrating and settling into the organization they work for. The dependent variables of interest in the studies included: retention, socialization, organizational commitment, intent to leave (Newhouse et al., 2007), job search behaviors (Kovner et al., 2009), vacancy rates, patient satisfaction,

prevention of falls and pressure ulcers (Latham et al., 2008), long term job satisfaction (Halfer et al., 2008), research utilization (Milner et al., 2005), new nurse confidence (Grindel & Hagerstrom, 2009), tutorials, case studies, role play, direct clinical support, and competency standards (Considine & Hood, 2000). All of the studies involved measuring the impact of formal mentoring schemes.

2.7.4 Major findings. Most of the studies reported positive outcomes from using mentoring strategies. Many of the researchers reported an increase in job satisfaction as a result of exposure to the formal mentoring programs (Halfer et al., 2008; Kovner et al., 2009; Latham et al., 2008). Grindle and Hagerstrom (2009), who examined the effects of a mentor-mentee program on job satisfaction, reported no change in levels of job satisfaction in the first six months of the program. This finding raised an important point about the measure of job satisfaction and the exposure to formal mentoring programs less than six months in length. Grindle and Hagerstrom (2009) felt that measuring job satisfaction within the first six months of work does not give an accurate reflection of true satisfaction as the participants may respond based on their expectations of satisfaction rather than their actual experience. Also, their responses may be confounded by issues of transition into practice.

Kovner et al. (2009), who tried to determine the factors associated with newly licensed nurses' intent to stay with their employers, found that being White female, and volunteering to work overtime increased the probability of job satisfaction while factors decreasing the probability of job satisfaction included being non-White female, and having to work mandatory overtime. Kovner et al. (2009) included mentorship as one of their study variables. This finding is an interesting link between the demographic of the

sample and the probability of job satisfaction. Halfer et al. (2008) found no relationship between job satisfaction and the generational age of which nurses belonged.

Other positive outcomes reported from formal mentoring programs include a hospital-wide increase in patient satisfaction, stronger partnerships between academia and health care services (Latham et al., 2008), increase in nurses reported self-confidence (Grindel & Hagerstrom, 2009; Riley & Fearing, 2009), and decreased number of employee turnover (Halfer et al., 2008; Latham et al., 2008; Newhouse et al., 2007). Halfer et al. (2008) reported a decrease in a calculated turnover rate from 20% to 12%.

Gregory et al. (2007), who used a causal model to test how support offered by organizations affected the impact of work culture, trust, and satisfaction of new employees, found that organizational culture had only an indirect effect on the employee's intent to stay. This finding is interesting in that it challenges the anecdotal literature that suggests the possibility of a more direct link between organizational culture and employees' intent to stay with an organization (Thomka, 2007).

In a study by Considine & Hood (2000) about the effects of the appointment of a CNE in an emergency department, the researchers found a significant change in the attitude of nursing staff towards competency standards during the study. The participants reported the most effective type of support given was direct supervision in the clinical area. This study demonstrated that the establishment of CNE in acute care areas is an important means of support for front line nurses.

2.8 Gaps in the Literature

Researchers included in this literature review have recommended more work is needed in understanding the causes and deterrents for turnover in nursing. In particular,

there is a need to explore job market factors and their influence on RNs' work behaviors (Kovner et al., 2009), create leader support at the bedside, conduct environmental work studies, develop and test systematic mentoring interventions (Latham et al., 2008), design more longitudinal mentoring studies, identify career development supports are in place for RNs (Halfer et al., 2008), and create formal programs that promote the organizational commitment of employees (Grindel & Hagerstorm, 2009).

Although some authors have started to ponder whether or not generational differences play an important part in work behaviors, not enough is known about nurse characteristics and how they may influence turnover intentions (Newhouse et al., 2007). What the literature review has exposed is that more research is needed to explore how mentorship fits into the nursing context. None of the studies have addressed the role CNEs plays in shaping or promoting a culture of mentorship. Nursing leaders such as CNEs may be an untapped potential to expanding the knowledge on mentorship in nursing practice.

2.9 Summary

In summary, although there is no research directly linking CNEs to the creation of mentoring environments, the research articles presented in the literature review addresses that CNEs are in a unique position of influence. This influential position may enable CNEs to foster mentoring attitudes. The research also demonstrates that nursing leaders play a role in shaping the organizational culture of work settings. These findings are consistent with how leadership and organizational culture are also linked in the business sector. In many of the mentoring program development articles, the CNE was implicated in the process through program development. Mentorship, although much talked about in

nursing circles remains unexplored at a qualitative level, meaning that there is a need to explore the concept further. There are so many unknowns about how mentorship works. Clearly this is a topic requiring further study.

Chapter 3 Method

3.1 Methodology

The Grounded Theory approach (Glaser, 1978, 1992, 1998, 2001; Glaser & Strauss, 1967) was selected as the methodology to guide this qualitative study. Grounded Theory comes from the discipline of sociology and was developed by Glaser and Strauss in the 1960s (Artinian, Giske, & Cone, 2009). This methodology enables researchers to identify the main concern of the subjects under study along with the behaviors they use to resolve their main concern (Artinian et al., 2009). There are other research authorities in Grounded Theory methods but this study will mainly adhere to the references coming from a *Glaserian approach*. The Glaserian approach is a term used to describe the methodology coming from the perspective of one of the theory originators Barney Glaser. His approach was selected for two reasons: 1) he places a strong emphasis on inductive theory generation, meaning the theory emerges from the responses of study participants and 2) he emphasizes that the emergent theory is validated by the participants and not by any outside instrumentation or measures (Artinian et al., 2009). References from other authors using the Glaserian perspective will be included in the proposal as they sometimes offer a more comprehensible summation of Glaser's work.

3.2 Overview of Methodology

Using a Grounded Theory approach means there is a strong emphasis on inductive theory development (Glaser & Strauss, 1967). It can be described as a "grassroots" form of theory generation. This type of qualitative research helps to identify the main concern or problem amongst a group of people and the ways in which they resolve their concern (Glaser, 1992). Grounded Theory as the name suggests can be used to generate theory

about the prediction and explanation of human behavior (Glaser & Strauss, 1967). Theoretical frameworks and middle-range theories on the process of mentoring are lacking in the nursing literature (Grossman, 2007). Therefore, this methodology can be used to go beyond the description of mentorship in nursing towards much needed theory development.

3.3 Assumptions of the Method

The assumptions of a method are the underlying beliefs or conditions that must exist in order for the methodology to work. According to Artinian et al. (2009) the assumptions of the Grounded Theory method are that: (a) the consistent and proper use of the method will result in uncovering the main concern of participants; (b) there is a social organization of each group that is there to be discovered; and (c) the concerns of participants are the central focus of the study.

3.4 Rational for Use

The goal of this study was to uncover the role CNEs play in creating and enhancing a culture of mentorship. Grounded Theory offers explanatory theories of human interaction within a particular social context (Munhall, 2007). In this instance, there is no existing mentoring theory that can be used to study the research question; thus, conducting a Grounded Theory study was necessary to uncovering the behaviors and processes involved. Grounded Theory has often been used in the nursing discipline to help generate theory about a phenomenon in which little is known (Artinian et al., 2009; Schreiber & Stern, 2001).

3.5 Appropriateness to Question

The research question asks, what is the perceived role of the CNE in creating an organizational culture of mentorship in acute care settings? This question is not asking about the experience, but rather the behaviors, which is consistent with Grounded Theory methodology. With this question the researcher hoped to obtain data identifying the behaviors or actions employed by CNEs in the creation of/or support of the agency's organizational culture. The goal was to find out how CNEs contribute to the agency's organizational culture. It was also hoped that the question would reveal CNE characteristics and practices that support an organizational culture of mentorship. Lastly, the objective was to link CNE beliefs, practices, and use of expertises with the support of a mentoring culture.

3.6 Researcher as Research Instrument in Qualitative Research

The researcher as research instrument was an important concept to be cognizant of while conducting the study. What this means is being aware of how the previous experiences and beliefs of the researcher influences all aspects of the study (Denzin & Lincoln, 2000). Glaser (2011) would refer to this concept as preconceptions and warns researchers not to fall into the trap of getting too fixated on their own ideas about the phenomenon under study.

3.6.1 Challenges as researcher as instrument. Although the researcher was mindful of the possibility of her past experiences or preconceived ideas about the study interfering with the grounded theory process, inexperience led to a few examples of how the researcher's perspective made uncovering the core variable more difficult. Some preconception was noted right from the beginning of the study with the wording of the

research question. “What is the CNE’s role in creating an organizational culture of mentorship?” The use of the word *creating* was already a preconception of the CNE’s role. A less preconceived wording might have been: what is the CNE’s role in an organizational culture of mentorship? The second question allows for the discovery of what their role was to unravel more naturally. The journey towards discovering the core variable concerning the CNE’s role in an organizational culture was only detected through a negative case who challenged the use of the word *creating*.

Once the core variable of *supporting* was discovered, the researcher was then challenged to examine the way the role of the CNE was viewed. The concept of a *negative case* is described in the study methods in chapter three of this thesis. The researcher, relying on her past experience as a CNE in the province of Quebec, needed to contemplate on differences in practice between Montréal and Saskatoon. Firstly, CNEs in Saskatoon are in-scope whereas in Quebec they are not, but are a part of a separate scheme of nursing education and research in the agency.

Secondly, CNEs in the study, though represented by the same job description, function differently depending on the unique needs of each unit. Further, there are sub-divisions of CNEs such as Core Educators and unit CNEs. This is a dynamic that was unfamiliar to the researcher. What was discovered through analysing the data was that the researcher needed to set aside the preconceived notions of the CNE’s role and examine it for what it is in the context of this health region. Having past experience as a CNE did however allow for the researcher to relate to the challenges and demands of working in an acute care setting. The memoing process of data analysis helped the researcher to put the data and the conceptualizing challenges into perspective.

3.7 Procedures

3.7.1 Ethical approval. Firstly, ethical approval for the study was obtained by the researcher from the University of Saskatchewan Behavioural Ethics Committee on January 31st, 2011. After receiving an ethics certificate from the University of Saskatchewan, an application for operational approval from the Health Region was submitted and operational approval for the study was granted on March 14th, 2011. Once the necessary requirements to conduct the study were met, participant recruitment started right away. Ethical and operational approval was sought only within the local Health Region as the researcher intended to try and recruit participants locally with a secondary plan of recruitment from other health regions if needed. Only local Health Region approval was needed.

3.7.2 Setting. The Health Region is located in a Western Canadian province. The region provides a number of services to the city that include: hospital, long-term care, public health, and community based programs (Saskatoon Health Region website, 2010). The study was conducted in an urban setting in Saskatchewan, within the city's hospitals: hospital A - which is an acute care community teaching hospital, hospital B - which houses a rehabilitation and transitional care unit as well as many speciality centers, and the hospital C - a tertiary and teaching hospital affiliated with the University of Saskatchewan and main trauma center for the province (Saskatoon Health Region website, 2010).

These sites were chosen because they offered access to the greatest number of CNEs in the acute care setting. Sixty-three CNEs appeared on the Saskatoon Health Region's directory list prepared by the Department of Nursing Affairs in Saskatoon,

Saskatchewan. Neighbouring hospitals in Saskatchewan, for example, Regina and Prince Albert were also considered in the circumstance that data saturation could not be reached locally. However, use of these regions was not necessary.

3.7.3 Mentoring context. In considering the research findings, it is important to acknowledge the pre-existing mentoring context in which the study was set. This is central because it determines the participant's level of exposure to the concept of mentorship, as well as the possibility for sensitizing attitudes. In order to establish prior participant exposure to mentorship in the Health Region, it was necessary to interview *key informants* possessing intimate knowledge regarding the past and current use of mentorship. A key informant is different from a study participant in that they are not anonymous, they contribute information that could influence the study, and are considered an authority in the general area of interest.

The current thesis study included two key informants who were involved in the delivery of mentoring programs within the health region. One of the key informants works with People Strategies (former Human Resources Department) in the Division of Workforce Planning and provided a history of the development of a formal peer mentorship program in the health region along with the current and future program direction. The second key informant was instrumental in the development and implementation of a nursing specific mentorship program that was part of a provincial initiative.

3.7.3.1 How mentoring came about. The following information came from an interview with the key informant from People Strategies in the Division of Workforce Planning. In 2005, the Workforce Planning Program distributed an employee opinion

survey to all of its employees throughout the region. Among other things, the results of the survey indicated that the employees expressed a need for mentorship in the workplace. As a result of this feedback, pilot mentorship projects were run in various departments such as in the food and nutrition department and representative workforce department. Out of these pilot projects, formalized programs were created offered by the province.

In 2008, two mentorship programs were launched simultaneously within the Health Region. One program that ran for two years was called *The Provincial Nurse Mentorship Program* which had a peer mentorship component to it. The second program was called *The Graduate Nurse Job Program.* This program was also funded by the province but was offered to new nursing graduates to help ease their transition into the workplace. The Graduate Nurse Job Program offered a four month supernumerary status and financial incentives for participants and was perceived by nursing employees as "the official mentorship program". When the provincial government decided to cut program funding in 2010, many employees felt that all mentoring programs ceased. However, a component of the supernumerary nursing incentive still exists in hard-to-recruit areas such as long term care and rural nursing, but the funding only covers a six week period.

In 2009, the health region launched an employee mentorship program that received core funding from the health region along with provincial funding covering the nursing component. This is the program that many of the study participants referred to as the "generic program" in large part because the focus was no longer just on the nursing department but it was inter-professional. The concept for the program was, "Everyone Needs a Mentor". This program offers mentorship to all new employees to the health

region, as well as local nursing graduates. The People Strategies mentorship coordinator is a member of a Workforce Planning team but is responsible for the delivery of the mentorship program. In particular, she is involved in connecting with potential mentor/mentee volunteers, facilitating workshops, providing ongoing support to those enrolled in the program and whenever issues arise, working with collaborative partners, and sending out evaluation forms once participants have been enrolled for a period of 12 weeks. The mentorship coordinator works closely with the nursing unit managers who are the point of entry to the program for new nurses. The mentorship program is promoted through career fairs, on the health region's website, and in information packages given to perspective hires through managers at the time of their interviews. The mentorship coordinator admits that there is room for expansion on the promotion of mentorship through the CNEs; currently there has been little collaboration with CNEs. Some of the CNEs involvement in the program has been through their manager partners who have requested their input in the pairing of the mentors and mentees.

Plans for expansion to the current mentorship program in the health region include working on more opportunities for inter-professional mentorship and encouraging a team approach for client centered care.

3.7.3.2 The Graduate Nurse Job Program. The following information about the Graduate Nurse Job Program was obtained from an interview with the previous nursing mentorship program coordinator. Under the provincial Health Ministry's division of the Workforce Planning Branch, this program was designed to help ease the transition of new graduate nurses into the workplace. More than 12 million provincial dollars was allocated to this initiative. Initially, two pilot programs were carried out in different parts of

Canada. One of the pilot projects was in Halifax, Nova Scotia and the second was in Regina, Saskatchewan. In April 2008 the program officially started in the Health Region. The nursing mentorship coordinator, who was the program coordinator at the time for two health regions, found it difficult to find enough staff to accommodate the new graduates for the full four months and as a result the initial candidates were exposed to shorter periods of mentorship. In addition, it took time to gain Nurse Managers' acceptance of the program because the goal was to have nurses functioning independently faster to accommodate the needs on the unit. The benefits of having new nurses take part in the full length of the program were soon understood and the four month supernumerary option became the most favoured by nurses and managers.

The program was unique in that it assisted new graduates into speciality areas such as obstetrics, emergency, intensive care, and neuroscience. Workshops and exposure that nurses on the units were having resulted in a large number of staff having knowledge about mentorship in the workplace. Approximately 200 graduate nurses took part in the program over the two year period that it ran. The program allowed the Health Region to have a close evaluation of how new nurses were transitioning into the workplace. Pairing of the mentoring dyads was largely done by the Nurse Managers because they were the front line point of entry into the program.

When the nursing mentorship coordinator was asked if there had been any employee exposure to the concept of mentorship prior to the nursing programs, she revealed that a series of workshops were delivered in the Health Region. These workshops were part of an effort to integrate the concept of mentorship into the Health Region and one group that attended these sessions was the CNEs. The information

collected from these interviews was important because it established the kind of exposure the participants had to the concept of mentorship. Although CNEs did not take the lead in delivering these programs, the nature of a close working relationship on the units between managers and CNEs would have exposed them to how mentoring relationships evolved, and the impact mentoring had on the unit, thus allowing them to determine if it added value to nurses or the work environment.

When examining the description of mentorship provided by the participants in the study, their accounts were fairly consistent with definitions seen in the literature. This is important because the researcher needed to establish a meaning of what was being discussed. In the literature, mentorship is often confused with preceptorship. Having the participants speak about mentorship from similar understandings of the concept strengthens the evolving theory. The participants described mentorship as an informal spontaneous relationship that forms between two people, the less experienced person being the mentee and the more experienced person being the mentor. A good mentor possesses the following characteristics; being supportive, having strong clinical knowledge, being a role model, being open, offering advice, offering moral support, having leadership characteristics, being intuitive, being able to give guidance, being experienced, being caring, being available, being accessible, and accepting.

3.7.4 Participant recruitment. The strategies for participant recruitment included posting study flyers at all three hospitals between the dates of March 23rd and June 29th, 2011. The Health Region hospital administration controls all postings in the hospitals and flyers had to conform to their specific criteria. See Appendix I for a copy of the study flyers. Postings were done by hospital volunteers every 14 days and new flyers

were submitted for each time period. The flyers were displayed in the elevators at all three hospital sites. They were also posted on community boards within the hospital, for example, outside of the staff cafeteria, at lobby entrances, and on any nursing department that would agree to post them. A total of 38 flyers were posted, 6 at hospital A, 7 at hospital B, and 15 at hospital C along with about 10 on hospital community boards.

The research was also promoted in person to the CNE groups at each of the three hospital sites. In order to do this the Director/Professional Leader of Nursing Affairs was contacted and e-mails requesting permission to attend the bimonthly CNE meetings at each site were sent to the chairs of those committees. The first CNE meeting was attended at hospital C on April 28th, 2011 and there were approximately 12 CNEs in attendance. The second meeting took place at hospital A on May 10th, 2011 with a group of approximately 15 CNEs and the last meeting attended was at hospital B on June 9th, 2011 with approximately 8 CNEs in attendance. Meeting with the CNEs in person allowed for them to ask questions about the research and better assess whether they were interested in participating. The meetings also helped to clear up some misconceptions about the research. For example, some of the CNEs thought the research was a part of the formal mentoring program delivered by People Strategies (former human resource department) and therefore assumed that because they were not directly involved in that program, they would not qualify to participate. These misconceptions were addressed at the CNE meetings and the number of participants enrolling increased significantly. Meeting with the CNEs in person proved to be the most effective method for participant recruitment.

Advertisements looking for study volunteers were placed in the Saskatchewan Registered Nurses Association News Bulletin Spring 2011 edition on page 47. This magazine was chosen because of its wide readership throughout the province. Unfortunately, none of the participants reported volunteering in response to the advertisement. To review the advertisement placed in the RN New Bulletin please refer to Appendix F. A study advertisement was also placed in a newsletter produced by the Saskatchewan Union of Nurses, May 2011, page 10, called the SUNSpots. This bulletin is the official newsletter of the nurses union and it is published five times per year. The union newsletter was chosen because CNEs are members of the Saskatchewan Nurses Union and it was felt that this was a way of reaching this target audience. Again there was no indication from the participants who volunteered that this advertisement prompted their enrolment. Refer to Appendix G to view the research advertisement placed in the Saskatchewan Union of Nurses' newsletter.

3.7.5 Sampling process. In this section, the researcher will discuss the sampling process that was used in the thesis study: the sampling criteria, sampling techniques, sample size, participant characteristics, and the importance of negative cases.

3.7.5.1 Sampling criteria. Participants were selected based on the following selection criteria: 1) they had to be designated the title of Clinical Nurse Educator and be employed by the Health Region; 2) they could be male or female; 3) diploma, masters, or baccalaureate prepared; 4) and working in an acute care setting.

3.7.5.2 Sampling techniques. *Purposive sampling* was used initially to invite CNEs to participate in the study. Purposive sampling involves a selection of people who can inform the research (Munhall, 2007). This approach is the most suitable type of

sampling method for this research design because the goal is to compile rich forms of data from a particular group. A *snowball technique* of asking established participants to share the researcher's contact details with other possible participants was also employed to help recruit more CNEs (Munhall, 2007). The snowball sampling technique was the second most effective way of recruiting participants.

Another form of sampling that was used in the study is called *theoretical sampling*. Theoretical sampling is the deliberate selection of participants based on *theoretical relevance*, those who can speak to the relevance of emerging categories from the data (Glaser, 1978). Theoretical sampling was achieved by requesting a second interview with participants who could speak about themes uncovered during data analysis, or during the first round of interviews with participants who are believed to be very knowledgeable about a particular aspect of the research question as the data analysis evolved. As the process of data analysis progressed, additional and in some cases more specific questions were asked to follow the researcher's hunches about trends in the data.

3.7.5.3 Sample size. *Theoretical saturation* is a component of Grounded Theory method whereby no additional data are discovered through data collection and the researcher can develop properties of the categories (Glaser & Strauss, 1967; Glaser, 1978). This notion is important as sample size in Grounded Theory is concerned more with the collection of rich data as opposed to having a large number of participants (Schreiber & Stern, 2001). The sample sizes used in Ground Theory studies can vary. Other studies have used sample sizes of 9 and 33 participants (Mills, Francis, & Bonner, 2007, 2008). The target sample size for this study was 15 participants. The researcher believes that saturation was reached at around 12 interviews; however, an additional five

interviews were carried out to confirm this belief and begin theoretical sampling. Theoretical sampling can start before saturation is reached due to constant comparison analysis. There were a total of 17 participants that took part in the study. One of the participant interviews was used as a test case. The test interview will be discussed in more detail under section 3.9.3. The participation rate was estimated to be approximately 29%. This rate is taking into account a possible 63 CNEs that appeared on the Health Region directory and excluding nine who worked under the Rural Health Services Division, five who occupied administrative roles in Nursing Affairs, and a further two administrators. This exclusion left a total of 16 participants out of 55 CNEs whose names appeared on the list. Although this participation rate may be considered fairly representative in qualitative study terms, the goal of sampling in Grounded Theory is more concerned with reaching saturation. A closer breakdown of the CNE representation of participants from each site showed 50% of the CNEs from hospital A were recruited, 37.5% of the CNEs from hospital B, and 24% of the CNEs from hospital C.

3.7.5.4 Negative cases. An important aspect of the theoretical sampling is the need to include contrast or negative cases (Glaser & Strauss, 1967). The researcher was vigilant to seek out participants who were reporting information not uniform with the group. Seeking out negative cases enriched the research, in that it turned up new leads that challenged the homogeneity of the collective themes (Schreiber & Stern, 2001). Drawing on these contrast experiences and explaining how they fit into the scheme of the theory deepened the analysis of the data and challenged the researcher's personal beliefs about mentorship. The interviews turned up two negative cases that will be discussed in detail in chapter four of the findings.

3.8 Consent Processes

Two types of consent were used in the study. The participant's right to withdraw from the study was stressed in all research documentation and with each encounter with them. If a participant had expressed the desire to withdraw from the study, the data collected from them would have been removed and destroyed. All of the participants chose to remain in the study.

3.8.1 Informed consent. Firstly, a written consent was obtained from each participant. This written consent was collected prior to the first interview. Information about study expectations in terms of time commitment, interviews, confidentiality, and resources were explained to each participant.

3.8.2 Process/ ongoing consent. The second type of consent used was a *process* or *ongoing consent*. As the name suggests, process consent happens on an ongoing basis. It is the action of reconfirming the participant's desire to remain in the study each time they are interviewed (Munhall, 2007). This type of consent is verbal and was audio recorded prior to each interview. At the start of each interview taping, the participants were asked if they consented to continue participating in the study. The use of process consent re-enforces the participants' uncoerced right to participate or not, as well as to withdraw consent at any time. All of the data was stored in the researcher's home office. Consent forms were stored separately from all other data collected to protect the confidentiality of the study participants. Upon completion of the research, all of the data and consent forms will be handed over to the research supervisor to be locked away at the University of Saskatchewan for a period of five years.

3.8.3 Consent forms. Please refer to Appendix A for a copy of the study consent form.

3.9 Data Collection Process

This section will describe in detail the data collection process including collection of participants' demographic information, interviews, the test interview, audio journals, and memoing.

3.9.1 Demographic information. Demographic information was collected during the first meeting with participants. The demographic information form requested specific information regarding the interviewee's contact information, age, gender, job title, educational background, work experience, clinical background, and exposure to mentorship. Participants were also given the option of having a copy of the research results sent to them once the analysis was completed and presented. Almost all of the participants requested a copy of the research results so they could have feedback from their participation in the study. For a more detailed look at the demographic information form, please refer to Appendix B. Collecting participants' demographics allowed for descriptive statistics to be drawn about the research sample. Having descriptive statistics helps with the transferability of the research results, by informing the readers of the research about the study population. A summary of this demographic information collected can be found in section *4.1. Sample Characteristics.*

3.9.2 Interviews. The purpose of the study, expectations, and subjects' rights were explained to all of the study participants. Prior to each initial interview a written consent and contact information were obtained. Participants were asked to read the consent form and were given the opportunity to ask questions prior to any data collection.

A total of 20 interviews were conducted with each interview lasting between 30 and 110 minutes. The interviews were conducted at a mutually agreed place outside of the clinical area in which the CNE worked. Many of the CNE chose to meet in their offices which were often located away from the clinical area. Although some CNEs shared their offices, their co-workers were not present at the time of their interviews. Some chose to meet in their homes or at the research assistant office on the University Campus. Meeting away from the clinical area was important for a number of reasons. First, it helped to keep their involvement in the research confidential and maintain their privacy. Secondly, it helped to avoid distractions that may occur due to the hectic nature of the acute care environment. Lastly, it minimized the intrusiveness on the part of the researcher to the CNE in their work environment.

The interviews were conducted using a semi-structured interview guide consisting of open-ended questions prepared in advance to help facilitate the conversation. To review a copy of the initial interview guide please refer to Appendix C. The interview guide was amended over the course of data collection and analysis. In Grounded Theory, data analysis begins with data collection so it was important to add new questions to follow theoretical leads being uncovered by the data analysis that was happening concurrently with data collection. For example, on May 26th, 2011, after having conducted and analysed the first five interviews, the researcher thought that certain aspects of the topic were not being addressed in the discussions. Moreover, it was noted around the fourth interview that the length of the interviews were becoming shorter. Therefore, the researcher worried that the shortening of the interviews was a missed opportunity to collect rich data. After much contemplation, additional questions were

added to the interview guide. These questions focused on the CNE's description, role, and experience with mentorship, along with their opinion about what influences unit culture; and specifically, how they felt they influenced unit culture. To view the amended interview guide please, refer to Appendix O.

Three of the 17 participants were asked to take part in a second interview to discuss the preliminary findings of the research. The second interviews were important to elaborate on the categories and properties of the emerging theory. They also allowed for participants to help explain how the emerging categories were linked. The decision to conduct second interviews with the same participants rather than continuing to sample new participants was in large part due to the limited population that could be accessed. Further, active recruitment for the study had been open for a period of five months and no new volunteers were coming forward. The second interviews were not incorporated as a form of verification but rather an opportunity to deepen the understanding of the emerging theory. The second interviews were a form of theoretical sampling. The questions asked in the second interviews were very specific to the categories and core variable uncovered in the emerging theory. To view a copy of the second interview guide please refer to Appendix P. Although the Grounded Theory method does not endorse audio taping interviews (Glaser, 1998), because this research was the investigator's first attempt at conducting research, taping the interviews helped to safeguard the loss of valuable information divulged by the participants as well as to enhance the ability to audit the research results.

3.9.3 Test interview. As mentioned earlier in this thesis, there were a total of 17 participants that took part in the study; however, one of the participant interviews was

used as a test interview. According to Denzin and Lincoln (2000), a test interview is a good exercise to help to refine the skills of the researcher. Being that it was the researcher's first attempt to interview a participant, it was felt that it would be good to analyse the experience in order to gain insight for future interviews. The first participant to volunteer for the study came from a health district outside of the initial recruitment area. This individual received an e-mail from a colleague in the Health Region about the research. In the first few weeks of recruitment in the local area no volunteers came forward so it was decided to include this volunteer and consider opening up recruitment from other Health Regions. Understanding the valuable information that this CNE could offer, it was decided to conduct the interview. This was the researcher's first interview and it was not only helpful in terms of collecting research data but also for testing the use of the interview questions, obtaining consent, and assessing the ease of completing the demographic collection form. In reflecting on how the first interview went, the researcher was satisfied that the interview guide had enough open-ended questions to facilitate the discussion. It was also noted that the employment and clinical background section on the demographic collection form was ambiguous and required further explanation. There were many commonalities in the data collected from this individual and the other 16 participants from the local Health Region; however, issues such as travelling long distances between sites, dealing with physician shortages, teaching long term care nurses to treat acutely ill patients, and dealing with a lack of resources, differed from the larger group. The data collected was included and treated alongside all of the data with these differences in mind.

3.9.4 Audio journals. One approach of qualitative studies used is participant observations. Three of the participants were chosen to create audio journals of their daily activities that were transcribed verbatim and entered as data. One of the unique aspects of Grounded Theory methodology is that all information is considered data regardless of the form in which it is collected (Glaser, 2001; Schreiber & Stern, 2001), as for example, field notes, memos, reflections, etc. By inviting some of the participants to create an audio journal it was hoped to capture everyday activities of the CNE they may overlook as important to the research question. Audio journals are better known in the literature as diaries. Elliott (1997) stated that diaries are an alternative to observing participant behaviors which may not be as accessible and those diaries can be used as a tool to either record or reflect on things. According to Crosbie (2006), diaries are a good method of capturing how individuals make use of their time. Audio journals were chosen as a means of participant observation because they are a less intrusive alternative to having the researcher enter the clinical area and observe the CNE at work. Direct clinical observation in this case may have been interpreted by CNEs or their peers as an evaluation of their work. Three participants were chosen to create an audio journal based on their willingness and activity in the clinical area. For further details on the audio journal assignment please refer to Appendix D of this thesis. The results from the audio journals will be further discussed in chapter four of the findings.

3.9.5 Memoing. Memoing was used throughout the data collection and analysis process. This strategy involves the noting of thoughts, feelings, and descriptions of occurrences during the interviews such as body language and mood of the participants as well as the researcher (Munhall, 2007). These notes were created in the NVivo data

management program and could be viewed alongside the participant transcripts. Two types of memos were created and labelled as either operational or theoretical memos. Operational memos were notes that described technical issues that arose during the research, for example problems with equipment. Theoretical memos were a trail of the conceptualization of the theory as well as the researcher's reflections about the research process. Having a decision-making trail about changes in the direction of the research increases the study transparency and organization.

A transcriptionist was hired to transcribe all of the interviews along with the audio journals. The transcriptionist was asked to sign a confidentiality agreement that was approved by the university ethics board to safeguard participants' confidentiality. Glaser stressed the importance of being immersed in the data (Glaser, 1998). In some cases researchers are encouraged to do the audio transcriptions themselves. A strategy of cleaning the transcripts once they are received was a way for the researcher to stay close to the data. Cleaning the data is the process of comparing the transcripts to the audio recordings for accuracy and removing any identifying data that remained. This process allows for the re-listening of each interview before coding the text.

3.10 Data Analysis

In Grounded Theory, data analysis starts with data collection (Glaser, 1992; Glaser & Strauss, 1967; Munhall, 2007). The demographic information collected from the participants was summarised and descriptive statistics to describe the sample were drawn up. Participants were assigned a gender neutral pseudonym in an effort to disguise their identities. Because nursing is a female dominant profession, male participants run a greater risk of being identified in the study. Assigning pseudonyms helped to conceal the

participant's gender and separate the interviews. Unfortunately, there were no male participants in the study; however, the pseudonyms were still helpful in concealing the identity of participants. To view the list of gender neutral pseudonyms refer to Appendix L. The data were managed using NVivo 9 data management software. This software is an established tool used in qualitative research that was useful in the coding, categorizing, and retrieval of the information. The researcher learned how to use the software by attending the online workshop about the software capabilities and attending beginner and intermediate training offered by the Information Technology Services at the University of Saskatchewan.

3.10.1 Coding process. Data analysis involved moving through stages of data organization towards theory development. The coding process will be described according to Schreiber and Stern's (2001) three levels of coding.

3.10.1.1 First-level coding. The data were reviewed line-by-line, and in some cases by paragraph, paying particular attention to words, phrases, and sentences that could be used to assign codes to the data (Glaser & Strauss, 1967; Schreiber & Stern, 2001); this process led to a long list of open-codes that were created to summarize these pieces of information. In this stage of data analysis, the researcher was looking for similarities or differences in the data by comparing incident to incident (Schreiber & Stern, 2001) or constant comparative analysis (Glaser & Strauss, 1967).

3.10.1.2 Second-level coding. This level of coding involved the examining and collapsing of the uncovered open-codes into categories, which are higher level concepts (Schreiber & Stern, 2001). It is at this stage where no new open-codes are found and

coded, and the researcher is able to focus on looking for similarities between existing coded concepts. It is a regrouping of the coded concepts into categories.

3.10.1.3 Third- level coding. It is at this stage where the analytical focus shifted from identification of concepts to understanding how concepts are related (Schreiber & Stern, 2001). It is at this stage where theory development takes place depending on the researcher's ability to think abstractly or what Glaser (1978) refers to as their theoretical sensitivity. It is at this stage in the analysis that conceptualization is paramount.

Although the coding process has been outlined in three stages it is important to keep in mind that both coding and analysis can happen in any order. For example, one can be open-coding while theoretically coding for categories. The coding process was presented in this more linear fashion in order to show the progression towards theory development.

3.11 Use of the Literature

Theoretical sensitivity is an important concept as it refers to the researcher's personal ability to have the theoretical insight necessary for the conceptualization of the data and the relationships among the data (Munhall, 2007; Glaser, 1978). Once the foundations of a theory regarding the role of the CNE in creating a mentoring culture had been formed, the literature was again consulted and integrated to explain and fill in the gaps of the emergent theory. The literature was consulted again because Grounded Theory methodology acknowledges research literatures as data and this information was used to explain the emergent theory. Conversely, because the research will add to the existing body of knowledge on mentorship, the theory will also fill in the gaps in the literature.

In the initial stages of constructing a study about mentorship it was necessary to scan the literature to see what had been looked at and to establish a need for further inquiry. Once the research had been carried out, it was again necessary to consult the literature because the main concern, its categories, and properties have been revealed by the participants. Therefore, chapter five will discuss the literature as it pertains to the emergent theory. This could not be done beforehand as with Grounded Theory methodology the researcher does not know the main concerns of the participants until the data analysis is complete.

3.12 Audit

Although the researcher did not contract to have an audit conducted on this Grounded Theory study, discussions with the research supervisor provided a second opinion on the analysis. In addition, adherence to the methodology including taping interviews, transcribing interviews, and memoing about theoretical hunches and exploration facilitated the auditability of this research. Further, the research supervisor was consulted through all stages of the research as support for adhering to ethical, methodological, and theory development issues.

3.13 Issues of Rigour

According to Glaser (1998), the legitimacy of the theory product is determined by how well the emerging theory is able to meet four specific criteria for judging Grounded Theory: fit, work, relevance, and modifiability (Glaser, 1992). The notion of *fit* refers to how well the variables in the data are represented by the emergent theory (Glaser, 1992). The emergent theory needs to be able to address the most variation of the identified study variables. The concept of *work* refers to the emergent theory's ability to explain the

processes uncovered (Glaser, 1992). *Relevance* refers to whether or not the emergent theory addresses the main concern of the participants (Glaser, 1992). Lastly, *modifiability* is determined by the theory's ability to be modified when new data about the process is uncovered (Glaser, 1992). The four criteria are given the same level of importance as they are all considered equally important in judging Grounded Theory. Neglecting any one of the four criteria would jeopardise the authenticity of the emergent theory. A way to ensure the emergent theory truly accounts for the social process occurring is through the researcher's diligence to the Grounded Theory methodology.

3.14 Limitations and Delimitations

Limitations to the Grounded Theory method are that it is time consuming and requires the researcher to actively engage in following leads to generate theory (Glaser & Strauss, 1968). Another challenge with Grounded Theory is that it is hard to predict when or if theoretical saturation can be reached.

This study will not be used to audit the work of the CNEs. The researcher will accept the information collected from the interviewees at face value and has chosen not to include direct participant observation in the research design to minimise disruption to the participant's work environment.

3.15 Ethical Issues

The thesis study does not deal with information of a sensitive nature and was not anticipated to pose a greater than minimal risk to the participants. If any of the participants felt distress or retaliation as a result of being involved in the study, they would have been disqualified from the study immediately and directed to receive services from the Employees Assistance Program offered by the Health Region.

3.16 Timelines

The total research process was anticipated to take a period of one year to complete. This included obtaining ethical and operational approval, participant recruitment, data collection and analysis, and inductively formulating theory resulting in a thesis. Ethical approval was sought in December, 2010 and allowed for a one month approval wait time. Upon receipt of approval from the University of Saskatchewan, an operational approval application was sent to the Health Region. Both ethical and operational approval was granted by March 14th, 2011.

Recruitment of participants began in March, 2011 and ended in August, 2011. Data collection and analysis began in May, 2011 with the first participant and the data collection process took a total of four months ending at the end of August, 2011. Writing of the thesis occurred throughout the months of August and September, 2011, and the thesis was ready for defence in December, 2011, as anticipated.

Chapter 4 Findings

4.1 Sample Characteristics

All of the participants worked in an acute care setting and were designated the title of CNE. The specific nursing areas are not listed as they would compromise the anonymity of the participants due to the small population of CNEs in the Health Region. One of the participants has since changed employment and is in another nursing role that has a teaching component. All of the participants were females with a similar background, with the majority identifying themselves as Canadian. A number of the participants disclosed in the interviews that they were employed on a part-time basis; however, that information was not collected on the participant demographic collection form. The majority of the participants had clinical experience in critical care areas of nursing before assuming the role of CNE. The researcher chose to report the age of the participants, as well as their nursing experience, and years of CNE experience by average in order to provide a general picture of the group without singling out any of the participants. The average age of the CNE was found to be 43.8 years. The average number of years of experience in the role of the CNE was found to be 4.8. Again if these numbers could be listed separately you would see a split between two groups, those with a large number of years of experience and those with one year or, in some cases, less. The majority of the CNEs (88%) reported having a bachelor's degree in nursing. Interestingly, 56% did not receive mentorship training; however, 82% reported having experienced mentorship in the workplace, whether formally or informally. Table 1 summarizes participant characteristics.

Table 1

Participant Characteristics

Measure	Average	Percentage
Age of CNEs	43.8 years old	
Years of CNE experience	4.8 years	
Years of nursing experience	21 years	
Highest level of education		
– Diploma		12%
– Bachelor		88%
Having a second job		24%
Having received mentorship training		
– Received		44%
– Did not receive		56%
Experienced mentorship in the workplace, formally or informally		
– Experienced mentorship		82%
– Did not experience mentorship		18%

4.2 Theory Development

The process towards theory development operated on many analytic levels simultaneously. It started with interviewing participants and assigning open-codes to the data collected. The timing between each interview was deliberately spaced allowing for review of data and contemplation before conducting the next. In this sense, both data collection and data analysis were happening at the same time. A constant comparative analysis technique was used to look for patterns concerning how new data collected fit with existing data. The process of open-coding continued until the participants' responses became almost predictable. At this point, the researcher felt the initial open-codes had been identified and the task then became looking for patterns or ways of sorting the generated codes in a meaningful way. It was upon the suggestion of the research

supervisor to print out the codes and sort them by hand that helped with the identification of categories.

After sorting the data, five categories were identified; however, it was still unclear what the *core variable* was. A core variable, according to Glaser (1978), is what accounts for the most variation in a pattern of behaviors. There was uncertainty about what the categories had in common and how they were related. The relationship between the categories and their properties is what helps to integrate the theory and make it dense (Glaser, 1978). It was at this stage that the researcher began to draw pictograms in an effort to understand links between the identified categories. Finding a core variable, or an integrating variable if you will, is what made the difference between mere description of the data and discovering the human process. In the initial stages of theory development, the CNEs' *relationships* with the nursing staff seemed to be a frontrunner in the search for the core variable but once all of the categories were identified it was apparent that *relationships* was part of a much larger pattern of behaviors. Alone, the variable of *relationships* was unable to explain all of the other identified variables.

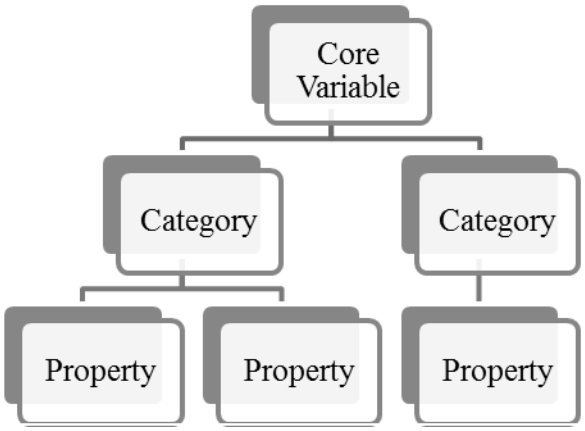
If one were to draw on an analogy towards theory development, it could be compared to tidying a messy closet. In the beginning, all of the clothes and items are disorganized. There would be many ways to approach the task of organizing. What the researcher decided to do was remove everything from the closet to see what was there. Next, items were sorted by likeness, for example, all tops in one pile and all pants in another; these piles would represent categories. Also, items not belonging in the closet could be taken out of the piles. Once this initial sorting was complete, each pile could be examined more closely and divided up further. In the case of the tops, they could be

further sorted into long sleeves, short sleeves, dress tops etc., or a differentiation of categories into properties. Somewhere in the reordering of the closet, the motivation for organizing would be seen. For example, the intention may be to store clothes away for different seasons, to prepare for a summer vacation, or simply to organize the space. It is easy to see that even the simple task of organizing clothing is done to serve a specific goal or what Glaser might refer to as the main concern. How people go about solving the main concern is the process.

What was discovered until this point in the data analysis was that items could be categorized but the conceptual jump to understanding the process was only uncovered with the discovery of the core variable. Figure 1 is a chart depicting the way the researcher organized the data. The table contains the same terminology that will be used throughout the description of the data analysis and discussion of the research results.

Figure 1

Organization of the Data



4.3 Core Variable

The following section will define a *core variable* and discuss its significance to theory development, describe how the core variable was uncovered in this Grounded Theory study, and discuss the research core variable in relation to Glaser's criteria for identifying core variables.

A core variable, "accounts for most of the variation in a pattern of behaviors, it has several important functions for generating grounded theory: integration, density, saturation, completeness, and delimiting focus" (Glaser, 1992, p.75). A core variable must be something that underpins all aspects of the theory development. It must be integrated throughout all of the theory variables. It should be the concept that draws all of the other study variables together. The core variable of the study must have "density" or what the researcher refers to as "weight". It must be able to account for the social processes occurring. In order to identify the core variable of a study, the concept has to reach data saturation. Saturation is reached when the researcher feels there is no new information about the concept to be discovered. If a core variable has not reached saturation it may be considered a category or a property and therefore insufficient to explain the theory. A core variable must be complete and able to explain the categories and concepts of the emergent theory. Lastly, a core variable delimits the focus of the study, meaning it sets the boundaries concerning the theory's capacity to explain the social phenomenon.

Glaser (1978) stressed two important points for grounded theorists to consider concerning the core variable of a study: 1) only variables uncovered relating to the core variable are included in the theory, and 2) the core variable happens in relation to the

participants' main concerns. The researcher used these two points to assist her in distinguishing the core variable among the identified categories. Once the researcher was certain the core variable had been identified, the remainder of the categories were examined in terms of their relevance to the core variable.

In Grounded Theory, more than one core variable may be uncovered (Glaser, 1978); however, the data analysis of this study revealed only one. Discovering the core variable was in large part due to information collected from a *negative case.* As described earlier in chapter three of this thesis, negative cases are those interviews where the information differs dramatically from what was said by the larger group. During the fifteenth interview, while discussing the role of the CNE in setting the unit culture, the participant shared that it was the nurse manager's role to set the unit culture and the CNE's responsibility to support it. It was realised in that instance that none of the CNEs actually stated that they were culture setters. The discussions around their role always seemed to be descriptions of ways they supported mentorship in the workplace, whether through the expectations of a formalized program or by their own initiative. It was at that moment, the core variable of the CNE's role being one of *supporting* an organizational culture of mentorship emerged. After examining the data and the codes again in light of this new theoretical hunch, it was apparent that CNEs were *supporting* an organizational culture of mentorship. The CNEs knew and understood the goals of the Health Region in relation to creating a mentoring work environment. Their knowledge about the goals of the Health Region coupled with their own beliefs about mentorship in their professional practice resulted in their assuming an informal role of support.

The following excerpt is part of the statements made by a participant when the core variable was realized. All of the participant narratives used to describe the data in this thesis will be written using their assigned pseudonyms to maintain their anonymity. All identifying information regarding where participants work or their clinical areas has been removed.

> I'm not sure people get how important a good manager is in setting the culture of the unit. I actually just think that's the most critical role in a unit, is a strong manager with good people skills but also citing culture about patient care stuff. (Toby)

When the same participant was asked to describe her role in the unit culture dynamic she replied, "Support. Support...by doing what they want me to do. By trying to please them and by making sure that regional policy works its way down" (Toby). In these two excerpts, Toby clearly identified the CNE role as one of supporting a unit culture. Her link with the organizational culture is clearly seen in the latter part of her second statement where she talks about "making sure regional policy" is carried out on the unit. This second statement is very important because it gives one the sense of how the CNE is positioned between the organization and the nursing unit. This negative case made a huge impact on uncovering the core variable of the study. The interview provided valuable information that helped to link all the identified study variables together.

4.3.1 Criteria for identifying the core variable. This section will discuss the core variable of *supporting* identified by the researcher in this study in relation to the 11 criteria outlined by Glaser (1978), intended to aid grounded theorists in identifying the core variable of a study. The 11 core variable criteria include: being central, reoccur frequently, relates to other categories, relates meaningfully, grabbing implications, carry-

through, completely variable, dimension of the problem, prevent sociological interest (conducting research out of pure interest) and deductive elaboration, and visible in all relations (p.95-96).

The researcher identified the concept of *supporting* as able to account for the greatest variation in the categories that emerged from the data analysis. It was the only variable concerning the CNE's role that was pervasive throughout the data. The data could be viewed from the perspectives of being either characteristics of supporting a mentoring culture or categories that influenced the CNE's ability to support a culture of mentorship. The concept of *supporting* was able to draw all of the variables identified in the research together. *Support* was a word the participants used often to describe their role in a mentoring culture.

Once the researcher was aware of the possibility of *supporting* being the core variable, evidence of this theoretical hunch was visible throughout the data, from isolated paragraphs in the transcripts to categories discovered through data analysis. The concept of *supporting* became the essence that resonated from the interviews with the study participants. The link between the concept of *supporting* and the categories was realised quickly. There was one point in the data analysis where the researcher decided to take a break from the data because the theory was developing quickly. Glaser (1978) has a section of his book that is dedicated to *theoretical pacing*. Glaser describes theoretical pacing as important time away from the data, to do other things so as to avoid stifling the analysis and allowing the researcher to grow with the data. The researcher was content when deciding to return to the data analysis that the core variable and its ability to link the categories were still apparent.

Supporting as the research core variable took more time to saturate and was the main topic of discussion during theoretical sampling and the second interviews with participants. The characteristics of supporting a mentoring culture were saturated more quickly than the categories influencing the CNE's ability to support a mentoring culture and their properties. One of the more difficult categories to obtain concrete examples of the CNE's ability to support a mentoring culture was under the perceived organizational culture. Although the CNEs identified organizational culture as a category, they had not contemplated much on how it reflected on their ability to provide and support a mentoring culture.

The researcher believes that the concept of *supporting* has what Glaser refers to as "*grab*" because it has implications for a mentoring culture. One can easily imagine and begin to formulate a theory around the role of support in mentorship. The researcher was able to carry through the analysis based on *supporting* as a core variable. The identified core variable is also easily modifiable. It was readily able to change under new conditions as new data was collected. The CNEs' ability to support a mentoring culture changed with variations in each of the identified research categories. The properties of each category thought to influence the CNEs' ability to support a mentoring culture, either had a positive or negative influence. The research categories uncovered and their influence on the CNEs' ability to support a mentoring culture will be discussed in detail under section 4.4 of this thesis.

Glaser (1978) stated that, "a core category is also a dimension of the problem" (p.96). In the case of this research study, *supporting* was revealed as the participants' main concern in relation to their role in an organizational culture of mentorship. It was a

variable that emerged despite the researcher's earlier preconceived belief that the CNE's role was to create an organizational culture of mentorship. Having the core variable emerge from the data collected from the participants, means it will complement the categories uncovered as opposed to being a deductive elaboration. Ignoring the core variable of *supporting* and superimposing the variable of *creating* would have resulted in a forcing of the data to fit the researcher's preconceived ideas about the CNE's role.

Lastly, a core variable can be a process, condition, dimension, consequence, or any theoretical code (Glaser, 1978). The concept of supporting in this instance can take on any one of the aforementioned characteristics in relation to the other research variables. The core variable of supporting can be a process defined by its characteristics and the way CNEs enact support for a mentoring culture, a condition in that certain contextual elements are required for support to be given, a dimension due to its pervasiveness throughout the study, and a consequence of what the CNEs feel is appropriate to the clinical setting and to professional practice.

4.4 Characteristics of Support for a Mentoring Culture

Study participants expressed the challenges of creating a formalized mentoring program as being a lack of resources, as well as time to dedicate to the project in light of their other priorities. The challenges they described are much like what organizations experience with mentorship program development. Instead, what the CNEs were recounting was their use of informal mechanisms in supporting a mentoring culture. The CNEs revealed that they learned to support mentorship on a local level, be it with individuals or groups. Ten characteristics of the ways CNEs supported a culture of mentorship were identified in the data and include: promoting mentoring relationships,

mentoring patient advocacy, supporting learning and development, building trust, boosting staff morale, listening, being approachable, offering support with ethical dilemmas, building confidence, and mentoring colleagues. Each of these characteristics will be discussed in more detail and accompanied by narratives to demonstrate their importance.

4.4.1 Promoting mentoring relationships. One of the ways in which CNEs support a culture of mentorship is though the promotion of mentoring relationships. They do this through careful and deliberate pairing of individuals during their work orientation training. The CNEs stressed the importance of coupling new hires with a person having complementary personalities. They understood the value of building a relationship from the start to facilitate new nurses' transition into the clinical setting. In the following example, Leslie (CNE) described some of her thought processes in pairing new hires during their orientation period.

> When I buddy them, I've been trying to pick people who I think will have fairly consistent abilities to work together well so that once maybe they're done the buddying that they'll be good partners to just be referring to. (Leslie)

Another participant described how she liked to identify experienced nurses with an interest in mentoring in advance, in order to have a pool of mentors to call upon. She would then pair these mentors with new hires and arrange for them to attend the mentorship workshop together during the general Health Region orientation week called, Welcome on Board Week (WOW). Casey (CNE) described how having the pair attend orientation together helped to foster a relationship before the orientee was exposed to the unit. "I'll have people willing to be mentors and I'll get them lined up to go to the

mentorship workshop in the WOW week together" (Casey). Notice the use of the term *mentor* in Casey's pairing account. The CNEs often used the terms *buddy* and *mentor* interchangeably in the interviews. This use of the terms interchangeably demonstrates that the CNEs understand the importance of fostering a relationship for the new hire upon their introduction to the clinical setting. The use of the term *mentor* also means the CNEs understand that the new hires require more support than a preceptorship experience which focuses predominantly on skill acquisition and does not necessarily address the other psychosocial needs of the orientee.

The CNEs supported a culture of mentorship through the promotion of mentoring relationships by being attuned to staff nurses' needs. The CNEs were quick to identify resource people that could assist the new orientee if they were perceived to be struggling in their work. In the following scenario, Joe (CNE) described a situation where she tried mentorship as a strategy to help a new employee who was struggling to fit in on the unit. This particular case had a positive outcome and not only did the new employee benefit from the mentoring experience but she in turn became a mentor to others:

> It's not formal, but it is an actual mentorship, is another new grad that we've had here that she's struggling and so I actually approached her about would she be interested in doing something like that [having a mentor] and then identify the staff member that she felt she had a good rapport with and I felt would be good in that mentor role. And so I connected them. (Joe)

The participants reported that while they do play a role in encouraging mentoring relationships, they are often unaware of the outcomes of these relationships, partly because building on the relationship is the responsibility of the staff nurses and they seldom receive feedback. Other CNEs have been approached by unit managers to help

them in pairing staff nurses for the mentorship program offered through the Health Region. The CNEs felt they were asked to be involved because of their close contact with the nurses and ability to assess nurses' skills and work attitudes with co-workers. This recognition of CNEs' close working nature with nurses is an important element in their ability to support a culture of mentorship, in particular, through the promotion of mentoring relationships.

4.4.2 Mentoring patient advocacy. The CNEs were also found to support a mentoring culture through encouraging patient advocacy. The CNEs accomplished this either by role-modeling advocacy behavior or by giving nurses suggestions for becoming more involved as seen in the following example. The CNEs did this action to increase the collaborative approach to patient care and support nursing professional practice. In the following excerpt, Casey (CNE) described how she mentored patient advocacy with an experienced nurse on her unit.

> One day an older nurse was concerned about something, the message that a patient was getting from her surgeon. And the surgeon and all the residents showed up shortly thereafter. And I said, go into the room with them...listen to everything they say because then you can help interpret that to the patient afterwards. You can ask a question to verify. If the patient has a question you can say, 'I don't think she understood this'. And this nurse with 25 years experience looked at me and she said, 'Can I?'(Casey)

The nurse in this scenario has probably experienced a number of changes to her practice throughout a 25 year career. The CNE in this circumstance is trying to encourage inter-professional collaboration and help the nurse to assume the role of patient advocate. Encouraging the nurse to be a patient advocate helps to build confidence in the nurse's practice and encourages her to be more involved in the team approach to patient-centered

care. Supporting the nurse to act on her concerns that the patient may not fully understand her course of treatment will help to create an environment with open communication and improved patient care.

4.4.3 Supporting learning and development. One of the ways which CNEs felt they had the most influence on supporting an organizational culture of mentorship was through their role as a staff educator. There are several examples in the data of how CNEs helped to support staff learning and development. The CNEs identified with the importance of nurses being content while being challenged in their work environments. They talked about the various ways in which they tried to engage staff in learning and development, for example, hosting "lunch and learn" sessions, encouraging nurses to attend grand round lectures, and creating interactive quizzes around policy changes.

The participants believed that encouraging staff to learn and develop was a direct form of mentorship. The following examples illustrate this point. In the first excerpt Merle (CNE) explains how her role is to keep challenging nurses to develop in their practice. "... I always found it was my role to keep encouraging them and keep giving them new learning experiences so that they could get better in their roles"(Merle).

In the second example, Kelly (CNE) talked about how her role is to prepare nurses for unforeseen challenges they may encounter from the moment they enter the practice setting. The is an example of how CNEs challenge nurses to not only address the patients' immediate needs, but also to anticipate patients' future needs as a result of their complex medical state.

> It's preparing the staff for when they come into very challenging disease processes so that they're more prepared for when they come upon these cases so that they can deal with them more effectively instead of it just

> coming out of left field and they go, oh, my goodness, what do I do about this? So my role starts from when they first start... (Kelly)

Another CNE recounted an encounter she had with a nurse who was looking to change her area of practice. The nurse was considering applying to work in the emergency department; however, the CNE advised her to try an intensive care unit first, taking into consideration the nurse's character and how she liked to be in control of her patient assignment.

> But I said to her...I know you want to get somewhere else but I would think maybe ICU versus Emerge[ncy]. Just because...she likes to be in control of things. And down there, she might not be. So, would that be a good experience right now maybe if she'd taken the ICU course and gone to ICU, get that behind her where you focus more on one patient and there's not too many extraneous factors coming in...And then she's got that background if she wants to try Emerge then she's got the critical care part of it. (Lou)

In the above scenario, Lou (CNE) could relate to the nurse's desire to try a different area of practice. Instead of discouraging the nurse from seeking other opportunities, she supported her by making suggestions that would best fit with the nurse's character and the nursing environment. One could easily argue that it is the role of CNEs to be preoccupied with continued staff development and yes, this is a large part of their function. Nevertheless, fostering of professional development is also one of the goals identified in mentorship. It was the enthusiasm the CNEs displayed, and their approach to supporting learning, that demonstrated their sincere and vested interest in the growth and development of nurses in their practice that conveys a mentoring aspect to teaching.

4.4.4 Building trust. The CNEs discussed the importance of building trust with the nurses on their units. Building trust was identified as a characteristic of the way CNEs supported a mentoring environment. The participants mentioned that if they did not have the respect and the trust of nurses, than their efforts would be useless. Novice and experienced CNEs described ways to build trust such as: having an open door policy, being present in the clinical area, making only necessary changes to practice, being professional and discreet in personal matters, and getting to know individuals by their names. In the following narrative, Jean (CNE) described the importance of maintaining trust with nurses. The CNEs revealed that nurses often go to them with practice or performance issues of co-workers. At times, nurses are uncomfortable addressing the issues on their own and may rely on the leadership of CNEs to bring the issues into the open. These situations need to be handled with sensitivity so that the individual is not singled out, yet necessary practice changes are met.

> So that you're someone that they can go to and trust that their concerns will be handled in a professional way...privately or... an issue they bring to your attention will become an issue that's brought up with everyone if that's what needs to be done. (Jean)

The CNEs identified building trust as particularly important with new graduate nurses as it often takes them time to become comfortable with the unit nurses. This is evident in the following excerpt where Casey (CNE) talked about how she is approached by new graduates with a practice question. “Sometimes I have new grads coming to me saying, ‘I was scared to ask anyone else, so can I ask you this question?’” (Casey)

Building trust with the nurses creates an environment where individuals can access the support and advice of colleagues in a culturally safe place. In the following

excerpt, Toby (CNE) described the importance of having an atmosphere which is "safe" for reflection on nursing practice.

> ...a safe place for reflection which is possibly what would come out of a good mentorship relationship. Because I think you need to be able to reflect on your practice: what did I do, how would have done that, or I'm going nuts because I have no idea what to do next. I have no idea how to priorize right now...it doesn't even need to be a coaching sort of relationship. It just needs to be to a safe place to reflect because I think for the most part, most of us can figure out what we need to do. But it's to be able to do it but you have to be able to talk about it and to work through in a safe place. (Toby)

4.4.5 Boosting staff morale. The nursing environment by the nature of the work can be very stressful. Employees can sometimes become discouraged by the demands placed on them to meet patient needs. New graduates are especially susceptible to becoming overwhelmed by a brand new environment. It takes new graduates time to learn coping mechanisms such as assignment organization and prioritizing patient care. In those moments, the role of CNEs in boosting staff morale becomes crucial. One way in which a participant described supporting a mentoring culture was through boosting staff morale. She did this by sharing a personal experience of how she and co-workers banded together to make the best of working night shifts. This sharing of her personal experience led to other new nurses adopting similar behaviors and the outcome was reported positive:

> Very honest, I mean, the morale is kind of low. So then we talk a lot about that. What can you do about it, right? And so we use personal examples and one I always use is when I worked in Emerg. I worked purely nights. So there was a set of us that worked all nights and three of us in particular had made a pact and we just said, 'no matter what happens on our shift we're going to have a good shift'... And we always had fun. And it was just a pact; we just decided it was kind of that whole, choose your attitude, right?...I just taught a different course and used the same

> example and one of the girls said, 'you told us that before and we do that and it really works.' (Alex)

Participants have described different ways in which they help to boost staff morale such as listening to staff frustrations and challenging them to find feasible solutions to their problems, creating fun learning activities that are incorporated into their daily work routine, and being appreciative with nurses by letting them know when they have done a good job. In the following example, Adrian (CNE) discussed how important it is to show appreciation for the work nurses are doing,

> Another thing...if I ask them to do a task for me, I'll ask them if they have time to do it. I don't demand it. And if they say yes, then I make sure I thank them every single time and I just tell them how appreciative I am for them having done that for me. (Adrian)

Showing appreciation for the work the nurses are doing also conveys respect and creates a good work environment and relationship between nurses and CNEs.

4.4.6 Listening. Being an active listener is a characteristic of the way that CNEs support a mentoring culture. In large part, listening is a means for them to be in tune with what is going on in the nursing unit. It is a way for CNEs to understand the concerns of the nurses and better judge the need for clinical support. In some cases, when events are happening, the CNEs stressed that a situation may not always call for action but rather offering the opportunity to be heard and understood. The participants in the study provided examples of many instances in which they listened to nurses, fellow CNEs, and staff nurses collectively. The following are some examples of how CNEs used listening to support a mentoring culture.

In the first example, Joe (CNE) talked about a situation where she as an educator was feeling overwhelmed and contemplating leaving her position, and how the support of a fellow CNE, who just listened to her worries and concerns, convinced her to continue her work. One can see in this brief dialogue that the act of listening helped Joe come to her own conclusions about her feelings of being over-whelmed.

> I've called [on] her... and she'd be like, 'I'm just going to come to your office', and she comes and we have a little chat. And I'm like...okay, I'm not going to quit my job today, then. Thank you very much. (Joe)

Other participants have stated that sometimes staff nurses have met with them to vent about their work day or were pulled away from the unit by CNEs to take a break and step out of a stressful situation. Oftentimes, it was discovered that nurses confided in CNEs about issues extending the limitations of their role and their capacity to respond. In other words, nurses go to them with issues that need to be addressed by nursing management. In those cases, the CNEs would listen to the concerns to see if there was a teaching aspect to the situation, and if not, they would redirect that individual to the appropriate person that could help them; in most cases the appropriate person was the unit manager.

In this next example of how CNEs use listening to support an organizational culture of mentorship, Alex (CNE) described how she intervened with a group of nurses who were upset about what they perceived as a lack of support from management. The CNE in this scenario used her listening skills to help redirect the group's frustration towards a more constructive use of their energy.

> So I heard them [staff nurses] talking throughout the day about their culture...and they finally just had enough and they were going to have this big nursing meeting and they were going to give it to whoever would take

> it, right, management. So I just said, 'okay, let's stop for a minute and let's sit down, I've got about an hour.' And I said, 'I'll answer any question you want the best I can.' And so we just did that for an hour. We talked about management and what they felt or perceived was a lack of support for management. So I said, 'you know, that's great...but you need to go back to management with a problem and suggested solutions.' I said, 'for every time you come with a problem you should come with solutions and not that they have to...but that you could.' (Alex)

The reported outcome of the CNE's intervention to listen to the concerns of the nursing group was a less tense working environment. The nurses were able to first vent their frustrations, and then were able to channel their actions in a more constructive way. Further, by taking the time to listen to the nurses' concerns the CNE was able to gain insight concerning patient care issues on the ward. The CNE in this scenario was able to listen from a neutral perspective as she did not represent management.

4.4.7 Conveying approachability. The CNEs in the study talked about the importance of conveying approachability in establishing a mentoring work environment. The participants stressed the importance of discussing practice issues with nurses in a non-critical and non-judgemental way. Many CNEs had the approach that they are open to discuss any situation and to try and collectively come to a resolution. The approachability of the CNE helps them to remain current with what is happening on the unit. The participants conveyed their approachability by having an open-door policy where nurses could stop by to see them at any time or reach them by their pager. The CNEs affirmed that nursing staff were their number one priority and office work such as policy writing would be put on hold to accommodate them. The CNEs understood that their availability to staff translated into better patient care. In the following excerpt, the participant described her approach to dealing with challenging situations. "And it's not

that you're going to find any negatives from me… we try and sort things out" (Lou). Lou (CNE) further explained how she felt her age and years of experience having a positive effect on younger nurses with regards to her approachability.

> ..they may have a co-worker that is a mentor but I'm always there if they have any questions, any concerns... it's more like you guys are the same age as my kids, so I know what they'd come to me for. There are some things that, you know, you can ask questions of someone that's more motherly I guess. (Lou)

4.4.8 Support with ethical dilemmas. Whether a nurse is senior or junior on a unit, there is always the potential for encountering ethical dilemmas. Sometimes the intimate nature of the care that nurses provide can create an attachment and grief when the outcome is not what the nurse had hoped for. In these moments, having someone to help put the situation in perspective may be beneficial in coming to terms with what transpired. In the following excerpt, a CNE described her experience in helping a nurse work through an ethical dilemma.

> Anyway, there was this one patient, end stage COPD, end stage heart disease, end stage everything, and the nurse felt really bad because that was her last person to check on... So I walked her through [it] because that person ended up dying. She felt frustrated because the family wanted her to do something... So I said, 'so what did you do to make the family feel better?' And she walked me through what she did. She did everything absolutely correct. What did you do to make the patient feel better? She walked me through the steps... But she just felt so guilty because she didn't save them [the patient]. And I said, but did they need to be saved or did they need to just be made comfortable so that they could go to that better place. And so after we talked she did feel better. You know how we deal with all those ethical dilemmas and that's what it was... So you made the patient comfortable, you made the family comfortable, but you have an ethical dilemma because you didn't save them. Because as nurses we think we can fix everything. (Kelly)

The participants described ways in which they help nurses work through ethical dilemmas by discussing stressful events with them, helping them come to terms with the events, or linking them to employee assistance programs.

4.4.9 Building confidence. CNEs tried to empower nurses by helping them to build on their nursing skills. In some cases, new employees are so inundated by their work they are unaware of how their co-workers feel about them. This is the case where Sally (CNE) felt the need to intervene with a new nurse after receiving numerous complaints about her work performance from her co-workers.

> We defined goals and then we re-evaluated. After we defined the goals of how I wanted to see her progress and then I spent time with her out on the unit. It was more about prioritizing her day rather than what actions she was doing. Her nursing care was really good, but her prioritization wasn't good and we worked on that. Within two months she improved and we didn't hear any more complaints about how she was doing on the unit and her next evaluation was, 'I'm happy with you. You've now progressed to where I thought you should be,' and she felt so much stronger. (Sally)

As a result of the CNE's intervention, the new nurse was more confident in her work and her colleagues were better able to accept her into the team. Other ways CNEs helped to build on nurses' confidence was through encouraging them to take on a leadership role in the unit, by sharing special nursing skills or expertise they had, or asking them to be involved in unit projects. Building confidence is an important part of creating a mentoring culture because having a confident workforce helps to eliminate some negative work behaviors that may be related to insecurities.

4.4.10 Mentoring colleagues. The participants provided many examples of how they were mentored or mentored colleagues into the CNE role. Several of the CNEs credited the promotion of this mentorship to their department manager. It was reported

that the manager always assigned new CNEs a mentor to help them in their role transition. Some CNEs were passionate about becoming mentors to their colleagues because they did not have the mentoring experience themselves when they started and did not want others to experience the isolation they felt. Mentoring of colleagues was reported to have worked well if the mentor was accessible, worked in a similar unit, and was at the same hospital site. Many CNEs who shared offices stated that their office mates had become tremendous support systems for them. In the following excerpt, Sally (CNE) expressed how she felt her mentoring experience with a colleague was a positive.

> When I started the role or when I was interviewed for the role I asked if they would have someone as a mentor for me. So they did designate one of the CNEs as my mentor and she was very helpful and answered all my questions. I'd still go back to her to this day and ask. (Sally)

It was noted that when CNEs felt there were little mentoring opportunities for them on the units, in particular units where the staff was very experienced, they tended to shift their focus to mentoring their CNE colleagues instead. This phenomenon will be explained in further detail under the section of CNE's relationships.

4.5 Research Themes

In this section, the researcher will describe the themes that were uncovered in this thesis study through the data analysis process. The five themes were: unit environment, the CNE's functions, the CNE's beliefs about mentorship, the CNE's relationships, and perceived organizational values. The researcher will also discuss how these themes relate to the core variable of supporting a mentoring culture and how they influence, whether positively or negatively, the CNE's ability to provide support. Once again participant

narratives will be used to demonstrate properties of each of the themes and all identifying information concerning the participants has been removed.

4.5.1 Environment. The nursing environment was one of the themes found to have an influence on the CNE's ability to support a mentoring culture. The identified properties under the theme of environment are: work setting, unit culture, turnover, and patient acuity and specialized treatments.

The CNE work setting was identified as one of the properties under environment that had a bearing on their abilities to support a mentoring culture. A number of the participants reported that they had (either currently or previously) worked on more than one clinical site/unit. In some cases, participants reported providing coverage for up to four clinical areas, and many of these areas had experienced radical service delivery changes. The problems reported with changing work settings was the limited time one could dedicate to a unit, making the establishment of relationships more difficult. Also, CNEs' offices may not be physically located in areas which they cover, making it more challenging for nurses to contact them for support. Not being physically located in the unit meant that encounters with nurses were mostly planned interactions, thereby decreasing the chance of spontaneous, and in the words of one of the participants, "teachable moments" that allow for informal mentorship to be at play. In the following excerpt, Leslie (CNE) described what mentoring moments meant to her.

> So it's a moment where you just happen into the right conversation or sit down at the right time that you can just go hey, you know what... you should go meet up with this person for lunch or you should talk to this person, I think they'd you know really help you...figure that sort of stuff out and...That seems to be more how I find mentoring moments to be. (Leslie)

This work setting dynamic also limits the amount of individualized or face-to-face teaching that CNEs do, which they considered important for building relationships with nurses. Working between multiple units/sites often strained the resources of the CNEs as the units may have had more than one clinical focus requiring specialized support.

The unit culture was another property of the environment found to have a huge impact on CNEs' ability to support a mentoring culture. One of the participants acknowledged that unit managers could set the tone of the unit culture by either rewarding or punishing certain work behaviors. Contrary to this belief, Leslie (CNE) talked about how she believed staff nurses were responsible for setting the unit culture. "I think it's the workers. So sometimes it's a few of them who are outspoken and loud, and sometimes it's the whole group. It depends on the unit" (Leslie). The CNE in this case felt that if nurses on the unit were not open to mentorship that it would be very difficult to instill.

The same participant provided an example to further her point. She recalled that a unit she was covering started experiencing a turnover in new nurses shortly after their completion of orientation training. While trying to elicit exit information from the exiting new staff, it was discovered that these individuals were being paired with the same person. The experience of being matched with that individual played a big role in new hires choosing to leave the unit. This CNE warned that improper pairing was one of the dangers of trying to promote mentorship in a clinical area where staff nurses have an "eat their young" mentality. The "eat their young" expression is commonly used in nursing to describe negative nursing attitudes and behaviors some nurses have towards new nurses. Often new nurses or experienced nurses moving into new clinical areas come up against

these bullying type attitudes from existing staff. This phenomenon is described in the nursing literature as *horizontal violence.* In the following narrative, Leslie (CNE) described how trying to foster mentorship among nurses with an "eat their young" mentality will actually reinforce the bullying dynamic.

> Culture is very important. Because you can't encourage mentorship in a unit that has an 'eat their young culture.' It's very difficult. You actually end up matching; generally matching people up with somebody who is going to then focus their attention on that person. (Leslie)

The attention that Leslie was referring to is negative attention where through the action of pairing makes the new nurse a target of bullying.

The readiness of the nursing environment is an important factor for CNEs to consider when trying to foster mentoring relationships among co-workers because, as seen in the example above. Promoting mentorship in an environment that does not value it may have the opposite to the desired effect. One of the factors reported to prompt shifts in unit culture is turnover. Some participants who have experienced working in areas with high employee turnover said that the influx of new workers can cause paradigm shifts that can either be positive or negative. In some cases, they have reported losing some of the established mentorship on a unit because the demands for support by the new nurses become too great for the more senior nurses to tolerate. In this case, the more senior nurses become fatigued and saturated with mentorship. Inversely, a large influx of junior nursing staff also has the ability to transform environments where collegiality was not the norm and change it to a more positive work environment.

There is a new direction within the Health Region to have the majority of the staff nurses' annual certification training done by on-line methods. In some clinical areas the

project is already up and running. This educational modification of incorporating the use of technology detracts from the in-person contact that CNEs would normally have with the nurses. The concern is that if teaching is moving in a technological direction, CNEs will be challenged at finding ways to keep contact with nursing staff to continue their informal mentorship.

The following two examples show how the use of technology can limit CNEs contact with nurses. The first comment is by Lou (CNE), who talked about how doing order entries on a computer limits her teaching interactions. *Order entry* is the term used for processing medical orders. There is a policy and procedure to follow when processing medical orders to ensure patient safety. A limited interaction with the nurses about the order entry process not only limit CNE/nurse interactions, but also increases the chance of error due to decreased teaching and assessment opportunities.

> You can be doing one thing for one minute and then you're on to another trail the next minute. Computer order entry, again I had a lot to do with that. And it first came out because I was training the nurses. I don't do as much with it now on the ward because IT has taken over more with the passwords and things like that. (Lou)

Another comment:

> And technology can be very difficult because the health region is moving to all online learning modules and so where you used to go out and see your staff to do this... now the staff just has to hand you a piece of paper and sometimes they don't even have to hand you the paper because the managers are getting e-mailed a little list of, okay these are the people that have completed... So they can just go on and look and say okay, well I have 75% completion out of my staff on this. So it takes some of the reasons that you had for being face-to-face with people away. (Leslie)

In the second narrative by Leslie (CNE), one can almost sense that the CNE is expressing a feeling of being replaced by the on-line re-certifications.

Increases in patients' level of acuity and the specialization of treatments sometimes means that CNEs are pulled to the bedside to give direct patient care. One of the participants explained being asked to provide direct patient care can work in favour of supporting mentorship or against it. Because the CNE may be pulled to the unit to fill in for patient care shortages, this situation often means that the unit is too busy to allow for the CNE to focus on updating nursing skills or sharing in patient assignments. This information reinforces the idea that simply being clinically present does not always translate into mentoring opportunities. The following two excerpts address the impact that changes in the patient's level of acuity have on the CNE's ability to support a mentoring culture.

> But the high acuity can lead to, you know... It can provide opportunity to mentor more and to... Because they need that support...But then at the same time I find that high acuity can just mean sometimes they just seem so busy. (Shannon)

Another comment:

> ... I found even since last year, as we had a lot more sicker patients than we've had more new staff, my role has shifted from instead being able to do more of the, okay, let's get some more education out and let's help the staff that's already there, versus I have to spend so much time doing help with the workload and getting out on the floor and helping with weird things that have never happened before or this person is so sick, can you come out and show me how to use this, and show me how to use that. You know, I've never had to do this before and so I spend so much more of my focused time now on reactionary stuff. (Leslie)

4.5.2 CNE's functions. The CNE's functions or tasks were a theme found to influence their ability to support mentorship; in particular, policy and procedure writing, office work, committee involvement, and basically anything that removed CNEs from the clinical area. The CNEs in the study tended to have a different focus in their work

depending on the needs of the unit(s) they cover. For instance, in a unit where nurses are very experienced, the need for CNE bedside support may be less and so policy and procedure work may be more emphasized. Another example would be in areas with high turnover; these CNEs would allocate the majority of their time to new nurse orientation. In most cases, tasks considered as office work still need to be carried out regardless of the particular unit needs. Although the CNEs understand the importance of office work in supporting best practice in the workplace, there were many examples in the data where it was also considered an obstacle to providing informal mentorship.

The following comment demonstrates how the CNE understands the importance of policy and procedure work. “We do lots of policy and procedure development just because in order to do the learning there has to be something to support the staff once we've left” (Alex). Participants have also complained about the amount of time it takes to respond to work e-mails and sorting through information shared by other services over the intranet.

> And I spend 25 percent of my time...alone in my office trying to develop presentations, keeping up with the communication around the hospital and, you know, what do my nurses need to know, what can I delete that they don't need to know, and how am I going to pass things on. (Casey)

The following table summarizes the description of what the participants reported their work functions to be, in no particular order. It can be noted that some of the descriptions of their work functions are also attributes of mentorship that can be found in the literature such as: encouraging, coaching, and supporting staff. This may lead one to believe that the nature of their work might predispose them to mentorship.

Table 2

Inventory of CNE's Functions

Policy and Procedure Work	Teaching	Encouraging Staff
Certifications	Orientation	Creating Learning Packages
Being Visible	Office Work	Committee Work
Technology Training	Informal Teaching	Coaching Staff
Supporting Staff	Formal Teaching	Choosing Equipment
Teaching Problem Solving	Gathering Statistical Data	Assessing Learning Needs
Information Sharing	Evaluating Best Practice	Assisting with Accreditation
Acting as a Resource	Performance Appraisal	Facilitating Communication
Preparing Staff for Work Challenges	Planning Annual Education Days	Collaborating with Other Services
Handling Problems that Arise on the Unit	Providing Coverage to Multiple Sites/Areas	

4.5.2.1 Audio journals. This section is meant to compare the information retrieved from the participants' audio journals and the work functions reported in participant interviews. Three audio journals were created from different acute care areas, two being in critical care and one being a general medicine unit. The participants were asked to audio record notes of their activities for a three day work period. As stated earlier in the thesis, a component of qualitative studies is participant observation. Having participants create an audio journal was a way to have a glimpse of a typical work day for the CNE. In Grounded Theory everything is data; this is an example of data triangulation, meaning data collected for the study coming from different sources. In this study, for instance, the sources of data consist of interviews, audio journals, key informants, memos, and the literature. The CNEs' functions recorded in the audio journals were found to be fairly consistent with what was reported in the interviews, with the exception of some of the day-to-day operations that appear to take up a substantial part of the CNE's work day. The day-to-day operations were described as checking e-mails,

photocopying learning materials, and looking for equipment and caring for equipment. Other functions uncovered in the journals that were not reported in the interviews were tasks such as attending health region functions, doing chart reviews, enlisting staff to help teach on the unit, offering personal support to nurses, and acting as a mediator between staff nurses and new medical residents. The journals did not include reflection on the work tasks, only what CNEs were doing on a daily basis.

4.5.3 CNE's beliefs about mentorship. The beliefs CNEs hold concerning mentorship were reported to influence their ability to support it in practice, specifically in terms of their perceptions of the need for mentorship, elements needed in the workplace, ideas concerning the term *mentorship,* and formalized versus informal mentoring practices.

The first property of CNEs' beliefs about mentorship that will be discussed is the perceived need for mentorship. The majority of the CNEs held the belief that mentorship was more associated with new graduate nurses coming onto a unit. In most cases where little employee turnover existed: CNEs felt that mentorship was not a high priority. The following narrative by Jamie (CNE) demonstrated this point. Jamie is responding to the question posed by the researcher, "Do you think there is a need for mentorship on your unit?"

> Certainly if we had more staff coming through. Right now I don't think so because everybody's settled and been here a long time. But having said that, because of the age everyone is, they'll be a huge out flux of people because everybody will be retiring at the same time. So I think in that capacity, it would be beneficial. (Jamie)

Most of the CNEs working in areas of little staff turnover understood the future need for mentorship and talked about ways in which they could prepare for this event

such as strategizing how to incorporate mentorship into the orientation phase of learning, trying to preserve the expertise of senior nurses before they retire, and thinking of ways to create better support systems for new employees. In the following excerpt, the CNE discusses how the need for mentorship will grow and her challenge will be to gather as much information possible to help bridge the knowledge gap. "So I think it [mentorship] just has the potential to grow... or maybe they can gap my knowledge deficit right now... so then I can help the people that are coming in... so we're not at a loss" (Kim).

The participants reported there was potential to do more with regards to mentorship but there was a lack of resources for them to carry this out. Mainly, there was a lack of availability of time as many of the CNEs are employed on a part-time basis. This lack of a full-time hours not only made their work with mentorship difficult but all of their other duties as well. This point is demonstrated in the following excerpt where a participant talked about the challenges of meeting the work demands being a part-time employee.

> So I think that's the biggest thing. I wouldn't say lack of resources but I think the lack of availability of the other educators, like from the other two units because they're only part-time as well, I find that's a big negative as well. (Adrian)

One of the participants expressed that the term *mentor* made the interactions feel too formalized. She argued that mentoring types of relationships and behaviors on the unit existed long before people started naming it mentorship. This CNE suggested that perhaps the term *role-model* better described the relationship. In the following quote from Jacky (CNE), one can see how the nurses may perceive the word *mentor* to be too formal with a set of expectations implying greater responsibilities.

> Probably if I said *mentoring*, they [staff nurses] would probably say what do you mean by mentoring? So, if I said buddy them for a few shifts then yes, they're fine with that, most of them. Some won't but…I think some feel like they don't know enough that they could provide that [mentorship] for a new nurse which is not true but that's how they feel. (Jacky)

There was some debate among the participants about whether mentorship should be a formal versus an informal process. Some CNEs felt that having a formalized program was too contrived and short lived. Other CNEs felt that there was a need to structure mentorship so more nurses could benefit from the exposure. It was clear in the data that CNEs' beliefs about mentorship influences their ability and willingness to support a mentoring culture.

4.5.4 CNE's relationships. The CNE's relationships with staff nurses and CNE colleagues were identified as crucial elements of their capacity to support mentorship in the workplace. The properties identified under this category were: relationships among CNEs, relationships between CNEs and nurses, and CNEs' perceptions of how they were viewed by the nursing staff and how that influenced their relationships.

A second negative case during the sixth interview challenged the researcher to investigate and think deeper about comments made by a participant who reported that she was not a mentor to nurses. This negative case challenged the researcher's belief that CNEs had a role in mentorship. This data was not consistent with the rest of the group who expressed they were partaking in mentorship on an informal level or had experienced mentorship from a colleague. In the following excerpt, Kim, a fairly new CNE responded to the question, "Do you consider yourself a mentor?"

> I don't know because... I'm helping them gain information. I guess it's a different type of mentorship... when I think of mentorship, I think of.... the

> RN on the floor and you're helping a younger nurse... I don't do that here because we don't have any young nurses. The nurses have been here for 30 years and they kind of know their role, I guess, with bringing out new stuff and making sure they're up to date on things. (Kim)

It was observed that CNEs with less experience in their position had a more difficult time to identify with the mentoring role. They expressed how consumed they were with learning to provide educational support and had not considered mentorship as a part of what they do. On the other hand, more senior CNEs readily identified some aspects of their work with mentoring behaviors. A trend was noted by the researcher where new CNEs sought mentorship while senior CNEs had a tendency to seek out colleagues to provide mentorship to. Although the more junior CNEs could see the value in mentorship, they were not at a stage where they felt comfortable taking on this role. Further, some of the more novice CNEs occupied positions in areas where staffing had been fairly stable and there was little turnover; therefore, they experienced an age or nursing experience gap with their staff nurses.

Proximity was a key concept in building and maintaining relationships with nursing staff. Nearly all of the CNEs felt that there was a direct relationship between their clinical presence and the opportunities for informal mentorship to occur. The following diagram is a mentoring potential diagram that illustrates CNEs' beliefs about proximity and the overlap that would allow for mentoring opportunities. This diagram deals not only with CNEs' direct involvement in mentorship but also their ability to support a mentoring environment. In order for the CNEs to support other mentoring relationships they need to have a close understanding of the group dynamic and the challenges that nurses are facing on the unit.

4.5.4.1 Mentoring potential diagram.

The researcher is not suggesting that proximity alone will result in increased mentorship in the workplace; this experience has been opposite in times of shortage when CNEs are pulled to fill nursing shortages. Yet, the participants identified proximity as a key element necessary to increase the opportunities for supporting mentorship in the clinical setting or the point of contact on the diagram representing a space for mentoring potential.

Although CNEs are members of the nursing union, or as they refer to it as "being in-scope", they are sometimes confused with the role of management. This role confusion has been reported by the participants to sometimes cause difficulties in building relationships with the nursing staff. A large part of the CNE's job is to collaborate with other nursing leaders, in particular, the unit managers, and often the clinical coordinators at each site. One of the CNEs expressed how some of the nurses mistake her role for one of management. When CNEs are perceived as management, it creates a distance between

them and some staff members. The following comment by Lou (CNE) demonstrates this point. “I think some [nurses] do, you know, sometimes I thought I’m feeling hurt at times. ‘Oh, the boss is coming’ – no not the boss. ‘One of the bosses is coming down the hall’, things like that” (Lou).

The majority of CNEs have reported that nurses come to them with both personal and work related issues. Some of the participants expressed frustration with not being able to address situations such as staffing levels or ordering new equipment in areas where a permanent Nurse Manager may be absent. The following three examples show how CNEs are sometimes mistaken for management by staff nurses.

> Sometimes I call myself ‘[name of the manager] No power’ because I don’t have any power as far as administration things, like increasing staff. Sometimes I think they ask me about things…and then I redirect [them]...like staffing levels, equipment…and I said, ‘I hear you but this is the person that you have to talk to get that changed.’ (Kelly)

In the following comment, the participant was asked if she was ever mistaken for management and this was her reply, “I find like the floor staff definitely... have this vision that the three of us, so the manager, the clinical coordinator and I, are the bosses. That’s the word they use, bosses” (Joe).

In this last comment one can feel that the CNE sometimes feels a divided loyalty between the interests of staff nurses and her management team.

> I mean, this role can be challenging because you want, need to be part of the management team. So there’s a clinical coordinator, there’s a manager, and then there’s me. So we have to be a team and we have to kind of show a united front almost but I like to try to identify with the staff too because I feel that’s how then I can have an effect with them. Because if I feel too removed from them, too aloof from them, too, oh, she’s part of management, I feel I lose my credibility. (Shannon)

The CNEs felt having a strong leadership role in the clinical setting was equated to having an elevated status of authority that is not in their scope of practice. The reality is that CNEs possess expert power but not legitimate power. This perception of leadership and authority can work for and at times against the CNEs' ability to support a mentoring culture. It can work for their promotion of a mentoring culture because nurses trust in their insight and experience to engage in informal mentorship with them. This perception of authority may work against them because it can create a distance between them and staff members who perceive management negatively when they are upset with work conditions or the organization.

Surprisingly, even with the existence of clinical teams composed of the CNEs, Clinical Coordinators, and Nurse Managers on some units, a large number of the participants reported working disjointedly from their Nurse Manager counterparts. The researcher was surprised that, in some cases, there was little collaboration between the two clinical leaders. This finding has important implications because, if it is true that Nurse Managers set the unit culture, and the CNEs support the culture, then one would question the congruence of their culture vision. Having a similar vision of unit culture would promote more definitive outcomes as a result of similar actions taken to create and promote a specific culture.

The CNEs were asked if nurses sought career advice from them as this behavior was identified in the CNE literature. In asking this question, the researcher made a classification of the data under a separate node of information that was missing but was expected. The participants were able to speak about nurses seeking career advice. They

revealed that nurses sometimes consulted them about changing jobs and inquired about the work conditions of other departments. Some CNEs described that nurses will go to them with a plan already in place and ask for their advice. Seeking career advice from the CNEs demonstrates the closeness of their relationship to nurses in some instances.

4.5.5 CNE's perceived organizational values. The perceived organizational values concerning mentorship was a theme that surfaced as important to CNEs in their ability to support a mentoring culture. The main properties uncovered in this category have been identified by the researcher as accessibility to a formal mentorship program, adequacy of work conditions to support mentorship, and collaboration with CNEs.

One of the participants stated that she felt the organization valued mentorship but that the concept was not well established in her clinical setting, because of stipulations imposed on the formal mentoring programs. For example, when the "Graduate Nurse Job Program" was in place, it only applied to new graduate nurses; therefore, areas with few or no new hires did not have exposure to the mentoring experience. Teaching about the benefits of mentorship was and continues to be a component in the delivery of the formalized program. The CNE also felt that unit nurses could benefit from formal workshops in mentorship regardless of whether they were enrolled in the program. Ideally, in order to broaden the impact of mentorship, it was felt that the program should have been offered to all nurses entering a new area of practice regardless of their employment status. Similarly, with the current "Everybody needs a mentor program", the specific criteria also limits those accessing the program; however it is now offered inter-professionally and not just within the department of nursing. The participants felt that past and current mentoring programs only address the need for mentorship of a select

few. In this view, making use of the formalized mentoring program offered by the health region will only have an impact on those areas experiencing a high influx in new people. In the following narrative, Leslie (CNE) talked about the accessibility issue to the health region's mentorship program. "While...everyone could have a mentor, they [the health region]have tied it so tightly...the only people who can qualify for the *everybody needs a mentor program*...are people who are new to health region" (Leslie).

Another property under the theme of perceived organizational values was the adequacy of work conditions to foster mentorship. The participants stressed the importance of having the necessary resource and structural supports in place to help nurses carry out their practice. The following comment demonstrates how the CNE feels nurses will better accept participating in mentorship when they feel supported at the bedside. Sometimes asking nurses to take part in practice changes, such as being involved in mentorship, is perceived as another obligation tacked on to their workload. "And I think that people have to realize...if you ask some people to be a mentor they think...not another thing to do. And you need to define the advantage to the whole organization..." (Jamie). The CNE explained that reinforcing basic structural support for nurses will result in a better acceptance of mentorship. In the following example, Leslie (CNE) discussed the link between having adequate resources and the embracement of mentorship.

> But as it filters down top to bottom it [mentorship] loses its support, and as it filters, by the time it gets to the staff the staff don't feel supported. Because if they were supported they would have enough staff people, they would have enough equipment, they would have enough...(Leslie)

The last property uncovered under the theme of perceived organizational values was CNE collaboration. A criticism of the current mentoring program is that CNEs have

limited participation. The lack of CNE involvement in the Health Region's formal mentoring program is a missed opportunity to reinforce a mentoring culture on the units. Mandating mentorship as a health care directive for all nursing leadership may lead to a more consistent and formalized approach to instituting a mentoring culture within the organization. Currently, the alternative to the formal mentoring program is an informal style mentorship applied sporadically among CNEs, who have an inclination to promote it. The following comment by Shannon (CNE) demonstrates the lack of collaboration with CNEs in the formal mentorship program.

> You know I don't know if we have involved anybody [nursing staff] in that program [peer mentorship] as it is now. I'd be interested to know that. I don't think...I'm trying to remember if the manager here has ever had a conversation with me about it. (Shannon)

It is evident from the results of this study that CNEs are strong advocates for the use of mentorship. The researcher believes that their collaboration in the Health Region's peer mentorship program would only strengthen the campaign to reinforce a positive work environment.

4.6 Organizational Values

A close inspection of the Health Region's organizational vision, mission, values, and strategic direction obtained from their website revealed that they value respect, compassion, excellence, stewardship, and collaboration. The Health Region has made a pledge to create a positive experience for those they serve, in how they work and interact with one another, and how they deliver their service. One can easily understand how mentorship would fit with their goal to create positive work interactions though the term *mentorship* is not used directly in their values and mission statements. Also, one of the

main four components of their strategic direction plan for 2010 to 2013 is to transform the work experience into something positive. It is clear from their outlined values, promise, and strategic direction that the Health Region has made a positive work experience one of their top priorities (Saskatoon Health Region Strategic Plan, 2010-2013).

4.7 CNE Mentorship Support Model

The following section will describe the *CNE Mentorship Support Model* that was discovered through the process of conducting this Grounded Theory research. The researcher will provide a description of the model along with its conceptualization, the structural components of the model, and address the *Basic Social Process* occurring in the substantive area under study.

4.7.1 Basic Social Process and theoretical model development. According to Glaser (1978), the *Basic Social Process* is a type of "processural" core category containing two or more distinct stages (p.96). The difference between a core variable and a basic social process is that a core variable has the capacity to integrate all of the other research variables that don't possess stages (Glaser, 1978). The stages of a basic social process are important because they connect the conditions and properties of variables together. Stages are also essential because they add a time dimension to the social process identified. A basic social process is usually identifiable by the use of a gerund, signifying a process, movement, or change over time (Glaser, 1978). According to Glaser (1978), "BPSs are theoretical reflections and summarizations of the patterned, systematic uniformity flows of social life which people go through, and which can be "captured" and further understood through the construction of Basic Social Process theories" (p.100).

In this thesis study, *supporting* was the basic social process that was identified. It was discovered that the CNE's role in shaping an organizational culture of mentorship was one of supporting. The researcher has identified the study core variable as a basic social process because it contains two distinct stages of condition and consequence. Stage one of the basic social processes uncovered in the theoretical model consists of five themes that set the conditions for the CNE to be able to support a mentoring culture. Stage two is signified by the CNEs ability to utilize informal mentoring mechanisms to support a mentoring culture. In this instance, Stage one creates the conditions for Stage two to occur. The five main themes of the theoretical model are the CNE's perceptions of the nursing environment, functions, mentorship beliefs, relationships, and organizational values. The CNE's role of supporting a mentoring culture is the basic social process that was uncovered through the use of the Grounded Theory methodology.

In order to understand the significance of the theoretical model discovered in the thesis study, the differences between theoretical terms must be clearly defined in order to appreciate their meanings. According to Reed and Shearer (2009), a model is a simplified portrayal of a theory, events, structures, or systems. A theoretical model helps to demonstrate the relationships between the concepts uncovered in a study. Theoretical models and grand theories differ, in that, grand theories represent global paradigms and are highly abstract while theoretical models are selective representations of the concept under study (Reed & Shearer, 2009). This means that grand theories are not particular to any one group or setting. Because grand theories are abstract and not grounded in one setting, they have few predictive capabilities. In this thesis study, a theoretical model was found to represent the conceptualization of the data more appropriately.

In the nursing theory literature, grounded theories have often been associated with middle-range theories (Reed & Shearer, 2009; Tomey & Alligood, 2006). This is because of their similar characteristics and usefulness. For example, like middle-range theories, grounded theories usually deal with a limited number of concepts at a specific level (Reed & Shearer, 2009). Also, similar to middle-range theories, components of grounded theories can be empirically tested (Reed & Shearer, 2009). According to Glaser (1978), basic social processes are not middle-range theories because they are dense and integrated. Nevertheless, the researcher agrees with the nursing literature that places grounded theories in the category of middle-range theories because of the similarities aforementioned.

4.7.2 Components of the theoretical model. *The CNE Mentorship Support Model* was fashioned after Newton's Cradle. Newton's Cradle is a kinetic energy model that demonstrates *Newton's Laws of Motion*. The thesis model is an example of an *analog model* because it is constructed in the resemblance of an already familiar subject matter (Reed & Shearer, 2009). The researcher felt that Newton's kinetic energy model provided the basic structural components to describe the concepts of the CNE's role in supporting a mentoring culture. Newton's kinetic energy model specifically describes motion and the researcher felt that it would convey the movement and interactive nature between the basic social process, identified themes, and study context.

The CNE Mentorship Support Model consists of a basic frame referred to as a cradle. From the cradle, five spheres are suspended in balance. While all of the spheres move, the two outermost spheres experience the most fluctuations in movement, whereas the three inner spheres conduct the oscillating energy to either end.

The cradle structure of the thesis model represents Stage Two of the CNE's support for a mentoring culture. The CNE demonstrates support for a mentoring culture through the use of informal mechanisms that include: promoting mentoring relationships, mentoring patient advocacy, supporting learning and development, building trust, boosting staff morale, listening, being approachable, offering support with ethical dilemmas, building confidence, and mentoring colleagues.

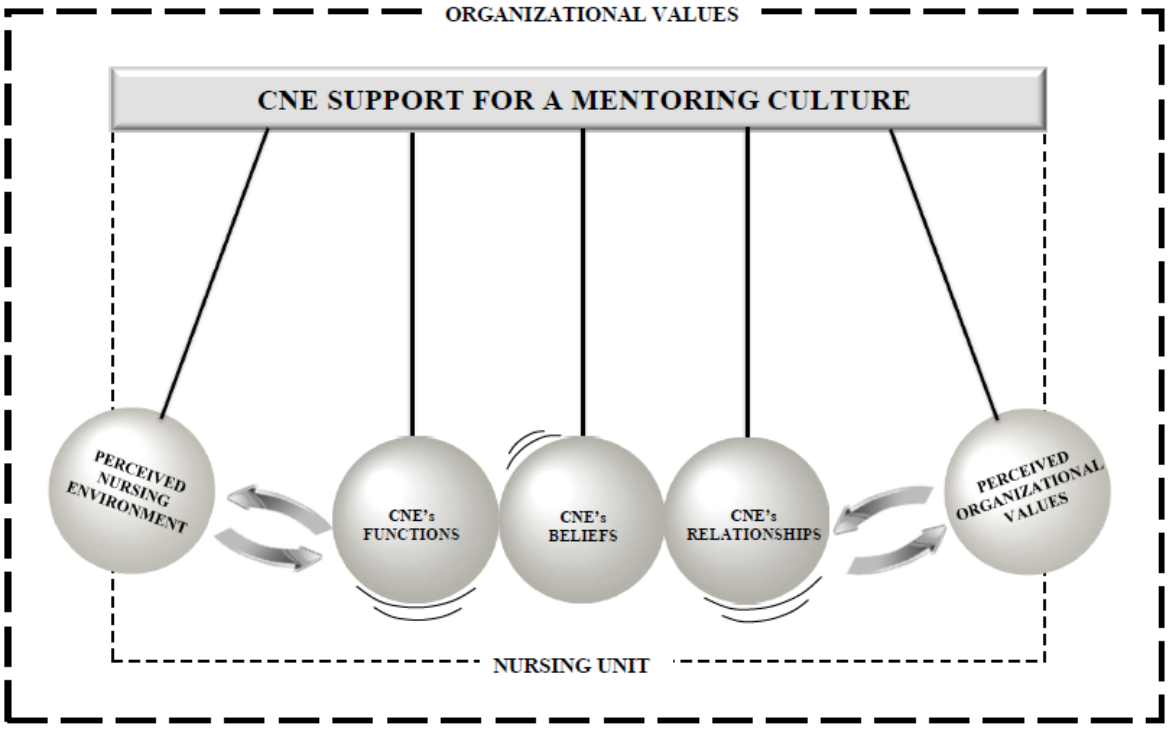
The five suspended spheres represent Stage One or the five themes found to influence, whether positively or negatively, the CNE's ability to support a mentoring culture: perceived nursing environment, CNE work functions, mentorship beliefs, relationships, and organizational values. The two dotted lines around the structure establish the boundaries of the social process occurring. The inner dotted line, under the canopy of support, symbolises the nursing unit while the bolder outer dotted line represents organizational values.

Notice the positioning of the themes *nursing environment* and *beliefs about organizational values* at the opposite ends of the model. This is because the researcher felt these themes are more prone to influences in the external environment. Examples of an impact on nursing environment would be changes in the organizational structure such as amalgamation of services, as witnessed between three hospital sites locally, or a large influx on new nurses as seen with the recruitment of Filipino nurses to the province in 2008. These changes had a direct impact on the nursing environment in terms of resources and accommodations in practice. The CNE's beliefs about the organization may be directly influenced by new programming in the Health Region, such as the implementation of a peer mentorship program. The movement of these spheres is

generated by both outside organizational influences and the properties within. The researcher also believes that the movement generated from opposite spheres of the structure creates a ripple effect that moves from left to right whereby perceived organizational values affect the nursing environment and vice versa.

Diagram 1

4.7.2.1 CNE Mentorship Support Model



Chapter 5 Discussion

5.1 Introduction

The purpose of this Grounded Theory study was to explore the CNE's role in shaping an organizational culture of mentorship. In this chapter, the researcher discusses the assumptions of organizational culture, CNEs' mentoring practices, how the *CNE Mentorship Support Model* explains the Clinical Nurse Educator's (CNE) transformational leadership style in supporting a culture of mentorship, why understanding the CNE's role is important, and the implications these findings may have on nursing practice. This chapter will also include a discussion about the themes found to influence the CNE's ability to support mentorship compared to what is known in the nursing research literature. Further, the researcher will discuss the study limitations and strengths and conclude with areas for future research.

5.2 Assumptions about Organizational Culture

Earlier references were chosen for the discussion of organizational culture in this section to provide the historical context of how it came about and what the assumptions are surrounding this concept. More recent articles about organizational culture in health care will also be used to discuss organizational culture in the health care sector.

The bulk of our early understanding about organizational culture came from the disciplines of psychology, sociology, and anthropology (Brown, 1998; Schein, 1996) and slowly moved from an individualistic perspective to a systematic one (Schein, 1996). The drive to understand organizational culture was motivated by the need to find solutions to societal problems between the 1940s and 1960s, such as World War II and inter-racial conflicts (Schein, 1996).

According to Brown (1998) organizational culture can be divided into two main categories, one belonging to *metaphor* and the other being *objective entity*. In the field of organizational studies, the two most common metaphors that have been used to describe organizations have been "machine" and "organism" (Brown, 1998). The position of objective entity can be further broken down into two groups, the organization as *entity* and, the branch that Schein belongs to, organization as *a set of behavioural and/or cognitive characteristics* (Brown, 1998).

There are many schools of thought describing, defining, and theorizing about the collective nature of an organization (Brown, 1998; Goffee & Jones, 1996; Hatch, 1993; Meek, 1988; Schein, 1996). There are many definitions of organizational culture and each is reflective of one's beliefs about its origins, whether it is an entity or a mental space (Brown, 1998). The definition of culture used in this study is, "a set of shared, taken-for-granted implicit assumptions that a group holds and that determine how it perceives, thinks about, and reacts to its various environments" (Schein,1996, p.236). Before one can accept the role of the CNE in supporting an organizational culture of mentorship, one has to assume that culture can be changed by an individual's actions/beliefs.

Schein's definition of culture allows for the influence of individuals on helping to shape the culture. Schein argued that organizations cannot be seen as an entity because entities are unable to learn and that learning only happens on an individual basis (Schein, 1996). This is an important point because it sets the backdrop for understanding the CNEs role in this thesis study in supporting an organizational culture of mentorship. However, there is clear opposition to Schein's belief about organizational culture in the

literature. Meek (1988) argued that organizational culture cannot be created. She believed, "it is something an organization 'is' not as something that an organization 'has..." (p. 470). The researcher understands the two perspectives on the characteristics of the organizational culture and has approached the study from the perspective of Schein's work. It is important to point these differences out to the reader so that they may judge the research findings accordingly.

The literature on organizational culture in the health care setting clearly comes from the traditions that believe culture is a mental space that can be shaped by individuals' actions and beliefs. This approach is evident in the foci concerning organizational culture. The literature on organizational culture in health care is concerned with factors influencing it, such as political power (Koerner & Wesley, 2008), leadership (Wooten & Crane, 2003), work attitudes (Bally, 2007), organizational structures (Cowen et al., 2008) and, not surprisingly, mentorship (Block et al., 2005). The following statement by Cunningham (2003) demonstrates this point. "Organizational change occurs when a critical mass of people within an organization begin to experience one another and the world in which they work differently - a shift of minds" (p. 46).

The historical perspective of organizational culture, the practices in the health care system, and the researcher's assumptions were important to establish because it demonstrates that the thesis study is aligned with current beliefs in the health care sector about organizational culture. The researcher's assumption is that organizational culture is something that can be created or altered by individuals. Further, that workplace culture is not static but rather open to both internal and external influences by employees and administrators.

5.3 Informal Versus Formal Mentoring Involvement

The CNE's role in an organizational culture of mentorship was revealed to be one of support. The participants in the Health Region were found to be mainly engaging in an informal type of mentorship. In this study context, the researcher defined informal mentorship as entering into or fostering relationships not part of a structured program with the objectives set through spontaneous or deliberate encounters in the clinical setting. The CNEs enacted mentorship either directly, by providing mentorship to colleagues or staff nurses, or indirectly through encouraging interactions between individuals with the purpose of encouraging mentoring relationships. Experienced CNEs also provided mentorship directly by mentoring novice CNEs. They also supported a mentoring culture with staff nurses through the personal and professional mechanisms discovered through data analysis.

The major difference between the formal practices of the participants in the study and CNEs' association with mentorship as seen in the literature was their lack of involvement in the development or facilitation of formal mentoring programs within the Health Region. The literature concerning the CNE's association with mentorship often showed that CNEs were consulted in the development/implementation of formal mentoring programs for health care agencies (Newhouse et al., 2007; Persaud, 2008; Scott & Smith 2008; Sigsby, Selzer, & Wilson, 2006; Van Eps et al., 2006). The study participants did not offer an explanation as to why this was not happening in this Health Region. One could speculate on the reasons why CNEs were not more involved. Perhaps this difference in level of involvement is a reflection of how the issue is viewed. For instance, perhaps mentorship is seen as a management rather than an educational matter.

It could also be due to the CNEs' level of "busyness" that they are unable to assume more duties. The only link the CNEs were found to have with the Health Region's peer mentorship program was through their consultation with some unit managers who requested their assistance in finding suitable mentors for new hires.

In this study the formalized aspect of mentorship and the CNE's involvement was not a major finding. What the study did uncover was the existence of a thriving informal support for mentorship in most acute care areas, with the exception of a few units consisting of highly experienced staff nurses and little employee turnover. The participants felt that having experienced nurses and little turnover in a clinical area limited staffs exposure to mentorship mainly because nurses were not taking part in the peer mentoring program. The characteristics of a highly experienced staff and little employee turnover may not be solely responsible for the lack of mentoring behaviors.

Manning and Neville (2009) found that experienced CNEs are more likely to provide mentorship and support while more junior CNEs felt like 'imposters' for not having the requisite clinical skills or knowledge. It may also be that junior CNEs are preoccupied with their own role transition and meeting the expectation of the position, such that they are unable to offer mentorship (Andrews & Wallis, 1999). In fact, the thesis study revealed that these junior CNEs assumed the role of a mentee and sought mentorship from their more experienced colleagues. This behavior was supported in the research literature in a qualitative study conducted by Manning and Neville (2009) in which they found that novice CNEs expressed feeling overwhelmed in learning a new skill set, developing new relationships, and maintaining friendships while being a leader.

The researchers identified similar coping mechanisms used by the novice educators such as finding a mentor and developing support networks (Manning & Neville, 2009).

The transitioning from expert clinician to novice educator adds credence to the work of Patricia Benner and her *From Novice to Expert Theory* (Benner, 1984). Although this theory has often been used to explore and describe mentorship in the nursing context, the theory actually explains the stages of transition nurses go through in their career development (Benner, 1984). The theory explains how nurses move along their career trajectory from novice to expert depending on the circumstances in which they are challenged. In role and career transitions nurses do not always move in a linear fashion and expert nurses entering a new area of practice can assume the role of advanced beginner again (Benner, 1984). The researcher witnessed this phenomenon in the thesis study. Novice CNEs, although recognized for their leadership skills and advanced expertise, were not at the capacity where they felt they could mentor others. Manning and Neville (2009) offered a similar transitioning model, except that it was comprised of three stages: entering transition, learning to communicate in a new way, and new identity formation. Both of these nursing theories could be used to explain why junior CNEs in this study felt they did not have a mentoring role.

5.4 Personal and Professional Mentorship Supporting Mechanisms

The types of mentorship that CNEs were actively engaging in could be divided into two groups, either personal or professional mentorship supporting mechanisms. Personal mentorship support mechanisms were identified by the researcher as behaviours such as: building trust, boosting staff morale, listening, conveying approachability, or building confidence. These personal mechanisms are evident throughout the literature

mostly as the attributes of a "good mentor" (Andrews & Wallis, 1999; Barnard, 2002; Dryer, 2008; Ferguson, 2010; Gordon, 2000; Grindel & Patsdaughter, 2000; Race & Skees, 2010). The nursing literature on mentorship described some of these personal characteristics of mentorship as outcomes of exposure to mentorship, for example, building confidence, boosting staff morale, and building trust. This study however, demonstrated that the CNEs felt these were not just outcomes of exposure to effective mentorship but rather ways they supported mentorship.

In a pilot study by Hubbard, Halcomb, Foley, and Roberts (2010) who distributed a nurse educator survey at the 18th Annual Nurse Educator Conference in the Rockies (2007), the researchers found seven main themes concerning the Educator's role in facilitating mentorship, one of which was open communication. The authors stressed that having open communication, being able to ask for help, and listening were all important factors of effective communication (Hubbard et al., 2010). These finding were similar to the current study in that listening and conveying approachability were mechanisms that were identified as important ways that CNEs supported mentorship with colleagues and nursing staff.

In a study by Jowett and McMullan (2007) looking at the effectiveness of the Practice Educator Role in Britain, the ability to communicate was found to be the Practice Educator's main strength. Participants of that study felt the Practice Educator's responsiveness to situations in practice was an important part of their ability to provide support to nurses and they were therefore seen as credible and accessible. This capacity for open communication by the CNE may be a portal to building trust with the nurses. In a group mentoring study conducted by Scott and Smith (2008), participants revealed that

having others to talk to allowed them to bond, vent frustrations, and keep focused by creating a "circle of trust". These personal characteristics of mentorship are vital in their ability to establish and maintain relationships with nurses supportive enough to provide and promote mentorship.

Similar results of personal characteristics of mentorship could be found in research conducted with students and new graduate nurses. In a descriptive exploratory study involving students taking part in a year-long mentorship program, the experience was reported to have enhanced their confidence in their nursing abilities and overall enhanced their professional development (Van Eps et al., 2006). Beliefs about mentorship in the anecdotal literature also suggest that effective mentorship will help to increase the self-confidence of both the mentee and the mentor (Funderburk, 2008; Grindel & Hagerstrom, 2009), improve morale, and promote professional development (Race & Skees, 2010).

One aspect the researcher failed to explore with the study participants in the thesis study was how they felt they benefited from providing mentorship to others. It might have been interesting to glean from the respondents who were actively engaging in mentorship what their perceived benefits were so that it could be compared to the reported benefits in the nursing literature. Further, it would have been interesting to note what motivated them to enter into or promote mentoring relationships. In the case of experienced CNEs mentoring more novice CNEs, participants reported their motivation came from wanting their colleagues to feel supported as they did not when they assumed the role. These findings show that CNEs are able to empathize with colleagues and their

struggles during role transition. They were also able to identify when a co-worker was struggling and offered their support.

The professional mentorship support mechanisms identified by the researcher in the study included: promoting mentoring relationships, mentoring patient advocacy, supporting learning and development, support with ethical dilemmas, and mentoring colleagues. According to Milner et al. (2005), the primary goal of the nurse educator is to facilitate the professional development of practicing nurses. Interestingly, one of the purposes of mentorship in the nursing literature is to aid in one's professional development (Brown, 1999; Funderburk, 2008; Jakubik, 2008; Lev, Kolassa, & Bakken, 2010). This information would suggest that the goals of mentorship are tantamount to the professional mandate of the CNE.

No research could be found in the mentorship literature to support the CNE's role in mentoring for patient advocacy. Race and Skees (2010), however, presented the argument that having more qualified nurses would have a direct impact on the quality of nursing care and patient outcomes. Wooten and Crane (2003) also asserted that fostering an effective organizational culture can result in better quality, efficiency, safety, and patient and employee satisfaction. To date there have not been any studies that directly measured the impact of mentorship on patient care outcomes. Similarly, there have not been any studies published examining the CNEs' involvement in pairing individuals for the purpose of mentorship. This is an important point because there are references made in the literature warning of the dangers of mismatching mentoring dyads (Beecroft, Santer, Lacy, Kunzman & Dorey, 2006; Tourigny & Pulich, 2005). This finding, coupled with the example that one of the study participants shared about losing new hires soon

after their orientation due to improper pairing, would suggest that having the appropriate person involved in mentor/mentee matching is a key aspect to effective mentorship. It also may confirm that CNEs are ideally situated in the clinical setting to participate in the matching. It is also interesting that some Nurse Managers in the Health Region recognized CNEs as valuable in this pairing process.

Although research could not be found concerning how CNEs support nurses with ethical dilemmas, a study conducted by Storch et al. (2002) looked at nurse leaders as moral agents. The authors discussed how practice realities can create a climate for moral and ethical distress. They specifically identify organizational climate, policy guidelines, and financial, temporal, and human resources as contributors (Storch et al., 2002). What the researchers found was that often nurse leaders lack the moral courage to effect improved practice environments.

According to Erlen (2001), the state of the current healthcare system compromises the nurse's ability to provide safe and competent care resulting in moral distress. In the case presented in this research study, the CNE helped a nurse come to terms with caring for a dying patient and his/her family. Taking into consideration the study by Storch et al. (2002), it would be interesting to note if CNEs were offering social support alone or if they were also working on changing policy to support ethical practice, such as helping to clarify policies concerning advanced care directives or creating awareness concerning resources available.

If the reason CNEs were introduced into the practice setting was to increase the quality of nursing care and professionalism (Milner et al., 2005), it is not surprising that CNEs are supporting learning and development in their practice. A study by Considine

and Hood (2000) examined the effects of the appointment of a CNE in the emergency department and found that staff nurses valued in-service education as important and there was a marked positive change in attitude of nursing staff towards competency standards. Though education of the nurses is a mandate of the CNE position, the CNEs felt that challenging the staff to learn and develop was also a means of mentorship. What the CNEs described was not simply passing on information or updates but rather looking for ways to spark the enthusiasm of the nurses and encourage them to be passionate about their practice.

Lastly, the CNEs professional mechanism of mentoring colleagues did appear in the nursing literature. In a study that looked at work-role transition from staff nurse to CNE, the researchers discovered the use of mentorship and networking among senior CNEs (Manning & Neville, 2009). The thesis study results also recognized senior clinicians' support as a legitimate mechanism used in CNE role transition. This demonstrates the need for mentorship in all levels of nursing. Currently, the focus in the nursing mentorship literature has been on new graduate nurses transitioning into practice but what these findings indicate is that all nurses could benefit from mentorship.

5.5 Significance of the CNE Mentorship Support Model

The *CNE Mentorship Support Model* illustrates the role of the CNE in supporting a mentoring culture in an acute care environment. The cradle labelled as "Support for a Mentoring Culture" of the theoretical model structure on page 92, illustrates that support is the backbone of the social process. It is also a visual portrayal of how the basic social process of *supporting* integrates all of the components uncovered in the Grounded Theory. Having the themes of influence suspended from the bridge of support shows how

they are each connected yet still fluid and react off each other. This is an important feature because the unit culture is not static and the influences will have a positive or negative effect on the support structure.

The CNE's description of their role in an organizational culture as being one of support is representative of how they perceive themselves in the organization. Many of the CNEs expressed that being "in scope" is somewhat of a double-edged sword. They felt that although it kept them bonded to their nursing peers, it also limited their ability to lead change or make direct changes to clinical practice.

The *CNE Mentorship Support Model* is important because it creates a base from which to further explore the role of the CNE in an organizational culture of mentorship. The model is not a description of CNEs' experiences but rather the processes they are engaging in. There are currently no models that address the significance of the CNE's role in mentorship. Drawing attention to this issue may influence CNEs, other nursing leaders, and front-line nurses, and assist organizations in their recruitment and retention efforts. Indirectly, it may influence nursing practice, patient satisfaction, and patient outcomes.

Current mentoring models are focused on transitions into practice using theories such as *Transition Shock Theory* (Duchscher, 2008) and *From Novice to Expert* (Benner, 1984) to guide research. Still, there are no specific nursing theories demonstrating the role of nurse leaders in mentorship. The dimensions in business mentorship studies are not always directly applicable to nursing due to variations in practice. For example, organizational structures in business often have more room for upward mobility of their employees whereas in nursing, there is a greater need for mentorship of front-line nurses

(Grossman, 2007) which has created an emphasis on professional development without necessarily career advancement in the organization hierarchy.

5.5.1 CNE's transformational leadership style. In the business literature, a leader must have followers in order to be considered a leader (Goffee & Jones, 2000); otherwise they may just be referred to as a visionary. In the case of CNEs, they do not supervise nurses; therefore, their leadership role is unique even from other nursing leaders such as Nurse Managers. Although there is literature concerning the leadership of Nurse Managers and front-line nurses (Curtis, De Vries, & Sheerin, 2011; Germain, & Cummings, 2010; Johansson, Andersson, Gustafsson, & Sandahl, 2010; Patrick, Laschinger, Wong, & Finegan, 2011), little is known about the leadership styles of CNEs.

A research project conducted by McIntosh and Tolson (2008) looked at leadership as part of the nurse consultant role and found their role resonated with the attributes of *transformational leadership.* Utley, Anderson, and Atwell (2011) described transformational leadership as a process that inspires others to work towards a common goal. The authors explained that transformational leaders display individual consideration, intellectual stimulation, inspirational motivation, and idealized influence. The examples provided as ways leaders display each of these four components were by: actively listening to employees' concerns, encouraging problem solving and creating opportunities for intellectual growth, being optimistic and developing a team spirit, and role modeling desired behaviors (Utley et al., 2011).

The CNEs in this thesis study also resemble what is known in the nursing literature about transformational leaders. Accepting that CNEs use a transformational leadership style strengthens their role as supporters of a mentoring culture. Understanding

the CNEs' leadership role as transformational is important in distinguishing them from other nursing leaders such as the Nurse Manager. The researcher is not presuming that Nurse Managers cannot be transformational leaders but that their role also carries with it supervisory responsibilities that the CNE's role does not.

A study conducted by Tomey (2009), who examined nursing leadership and management's effect on work environments, found correlations between style of transformational leadership and the education level of nurses, quality of patient care, patient satisfaction, nurse satisfaction and retention, and healthy workplace environments. If organizations and nurses were to understand and develop the CNEs' transformational leadership style, it may inform nursing practice resulting in better patient care outcomes. Knowing their positioning and potential for influence will enable groups, including the CNEs themselves, to direct attention and create awareness of issues important to nursing practice.

5.6 Themes Influencing the CNE's Ability to Support Mentorship

This section will discuss the five themes that influence the CNE's ability to support a mentoring culture compared to what is known in the research literature. The five themes identified in the study are: the CNE's perception of the environment, relationships, functions, beliefs about mentorship, and organizational values. One has to keep in mind that much of the mentorship phenomenon is still unexplored and in some cases there may not be any research to support the theoretical model that evolved from this study. In that instance, what is known about mentorship among other groups such as graduate nurses and academic educators, and identified outcomes of mentoring programs

will be used to give plausible explanations for the research results and how they are connected.

A great deal of attention has been paid to nursing work environments in recent years. Poor work environments have been linked to burnout and high staff turnover (Bally, 2007; Gardner & Walton, 2011). It is accepted that fostering change and growth in poor work environments can be a challenge (Nettleton & Bray, 2008; Race & Skees, 2010; Tourigny & Pulich, 2005). The same holds true for implementing a mentoring culture. A culture committed to long-term mentorship has the potential for increased job satisfaction, staff retention, and better patient outcomes (Race & Skees, 2010). Current mentoring programs have been criticized because little research has been done to investigate the long-term effects (Jakubik, 2008). Authors argued that organizations have to move beyond a quick fix approach and reliance on short-term mentoring programs to more long-term and sustainable solutions such as creating mentoring environments (Thomka, 2007; Race & Skees, 2010).

The results of this Grounded Theory study revealed that nursing work environments play an important role in one's ability to foster mentorship, in particular, work setting, unit culture, turnover, and patient acuity and specialized treatments. Evidence could be found in the nursing literature to support environment as an important factor to consider when implementing mentorship. According to Hubbard et al. (2010), having a supportive work environment plays a major role in fostering mentorship, for example, having administrative support, a good work atmosphere, and a non-competitive environment. A non-supportive environment has been identified in the literature as a barrier to mentorship (Hubbard et al., 2010).

The research on magnet work environments has listed important elements that impact professional nursing practice: nurses being valued for their contributions to patient outcomes; managers who advocate for nursing; adequate resources to provide quality care; and collaborative relationships with the medical staff (Gardner & Walton, 2011). The term *magnet hospitals* refer to institutions possessing attributes that workers value making them attractive work environments (Kramer, Schmalenberg & Maguire, 2008). Having adequate resources to manage patient assignments is linked to patient acuity and the provision of specialized treatments. Trying to implement mentorship in an environment that is not conducive to the values of mentorship may just be a futile effort that runs the risk of wasting valuable resources.

A large part of what makes up the work environment is not just the infrastructure and systems in place to support it but also the work attitudes of employees. Hubbard et al. (2010) concluded that collegiality was essential. The nursing literature has exposed the phenomenon of horizontal violence among nursing staff as an obstacle to mentorship. Bally (2007) talked about the importance of addressing this serious nursing issue. In the thesis study, some of the participants recognized horizontal violence as being a detriment to mentorship and have reported avoiding trying to foster mentorship in those areas. This may be considered by some to be a soft approach to the bullying behaviors demonstrated by some nurses. Some authors would argue that it is the responsibility of nursing leaders to adopt zero tolerance policies to these destructive behaviors (Bally, 2007; Race & Skees, 2010). Although CNEs do not have managerial powers to reprimand staff members who exhibit bullying behaviors, their leadership team partners certainly do and

CNEs can be instrumental in reinforcing best practice with effective policies and teaching sessions to bring awareness to the problem.

The thesis research results highlighted the importance of the CNEs' relationships as fundamental to supporting a mentoring culture. The concept of relationships has always been emphasized in mentorship traced back as far as it origins. While little is known about CNEs' relationships in mentorship, a developing body of literature has looked at the mentor/mentee dyad, particularly with novice nurses (Barnard, 2002; Funderburk, 2008; Grindel, & Hagerstrom, 2009; Race & Skees, 2010; Thomka, 2007).

A positive mentoring relationship has been characterized as one in which both parties benefit from the exchange. According to Funderbunk (2008), the relationship is more long-term where the mentor believes in the mentee and the connection empowers both individuals. Funderbunk further added that mentoring can be applied to all nurses and should not just be reserved for new graduates. The idea that mentorship applies to all nurses no matter where they are in their learning or career trajectory was also seen in the thesis study where CNEs entered into mentoring relationships with both experienced and inexperienced staff members.

Certain barriers cited in the nursing literature to forming effective mentoring relationships include a lack of time commitment and scheduling constraints (Beecroft et al., 2006; LaFleur & White, 2010), lack of commitment to mentorship, incompatibility, lack of availability (Hubbard et al., 2010), and poor personal and interpersonal skills (Andrews & Wallis, 1999). The majority of these barriers are related to direct contact or what the researcher in this study refers to as *proximity*. The CNEs who took part in the study stressed the importance of being present in the clinical setting. They felt that their

visibility was important not only to convey their availability for support but also to precipitate informal chance encounters for mentorship.

One of the issues raised in the thesis study concerning the impact on mentoring relationships was workload. Mentor workload also appeared in the literature as something mentors found difficult to balance (Moseley & Davies, 2007; LaFleur & White, 2010). Those CNEs who reported being heavily involved in policy and procedure development, committee work, and replacement of absent nurses on the units felt their ability to support mentorship was dramatically reduced. A factor perhaps augmenting the stress of workload on the participants was the fact that the majority worked on a part-time basis.

Mentorship is listed under the "Being Accountable" ethical responsibilities of Registered Nurses in the Canadian Nurses Code of Ethics (2008). The responsibility states, "Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, and other health-care team members" (Canadian Nurses Association, 2008, p.19). The fact that mentorship appears in the professional code of ethics is a strong statement of how fundamental it is thought to be to practice. That being said, the nurse's personal beliefs about mentorship have a strong influence on their ability and the ways in which they endorse it. For instance, participants in the thesis study had many beliefs concerning mentorship and their role that included the perceived need for mentorship, workplace support, mentorship terminology, and formalized versus informal mentoring practices.

Firstly, the majority of CNEs in the study linked the need for mentorship with new nurse graduates and new employees to the Health Region. If one were to consider their exposure to mentorship and the literature, they would see that this belief is in

keeping with the trends that exist. For example, the mentorship program services in the Health Region are directed to new graduate nurses by the Health Ministry of the province and the emphasis in the literature has been on the transition of new nurses into practice (Van Eps et al., 2006; Grindel & Hagerstrom, 2009; Halfer et al., 2008; Kovner et al., 2009; Jackubik, 2008; Latham et al., 2008; Newhouse et al., 2007; Scott & Smith, 2008).

A few of the CNEs were able to perceive the need for mentorship beyond this aspect to more experienced nurses who were transitioning to new areas of practice. If one's beliefs about mentorship center on new graduates and there is little turnover in the CNE's nursing unit, this may lead one to conclude there is not a pressing need for mentorship. Perhaps senior nurses may also benefit from mentorship in new knowledge and skills because a large emphasis in the nursing profession is on continuing education.

Comparable to what was discovered under the section on environment, the CNEs in the study pointed out that certain structural and work attitudes needed to be in place for mentorship to thrive. They talked about the necessity of having adequate staffing, proper equipment, and resource support as essential. Their argument was that the better equipped nurses were to deal with work demands, the more open nurses would be to the idea of mentorship.

On a second interview with one of the participants about CNEs' beliefs and how they affect their ability to support mentorship, she revealed that if staff nurses were more educated about mentorship and understood the benefits, there would be greater commitment from them. Some of the mentoring benefits listed in the literature include a positive impact on person or practice, personal satisfaction, professional success (LaFleur & White, 2010), increased skilled workforce resulting in better patient care, increased

self-confidence, and an increased satisfaction with professional identity (Funderburk, 2008). These benefits need to be emphasized or explored with in-services on mentorship.

In general, the participants in the study had a common understanding of what the term mentorship meant. The CNEs felt that if staff nurses were approached about becoming mentors, their request would be met with hesitation on the nurses' part. The reason for this hesitation would be because nurses feel the term *mentor* is too formal. Participants stated that if nurses were asked to "buddy" with a new worker that they would be more open to accepting the challenge. The expectations that nurses felt from being called a mentor were more than what they were willing to accept. It is not only in practice where confusion exists about what mentorship means. It is well known in the nursing literature that there is no consensus on the definition of mentorship. As stated earlier in the background information section of this thesis, there is controversy surrounding its definition (Andrews & Wallis, 1999; Yonge et al., 2007).

Another aspect of controversy in the mentorship literature is about whether the implementation of mentorship should be a formal or informal approach (Thomka, 2007; Tourigny & Pulich, 2005). This split in perspective concerning what type of mentorship is needed was also evident in the responses of the participants. Though a couple of the CNEs felt mentorship in the workplace needed to be more formalized, the majority of them saw lasting value in fostering informal mentoring relationships.

According to Race and Skees (2010), in order for mentorship to work, the goals and vision of the mentoring program need to be aligned with those of the organization. Having the two operate on different levels reduces the effectiveness of the mentoring impact. In the case of this thesis, it was discovered that there is room for more

involvement of the CNEs in promoting both formal and informal mentorship in the clinical setting. In order to establish an effective mentoring culture, it is important for the goals of CNEs and those of the organization to be aligned. Socialization of new nurses often begins with the orientation process and then gets reinforced through interactions throughout the nurse's employment (Kane-Urtabazo, 2006). Because the CNE is often the entry contact person during this orientation process, it is important they represent the values of the organization. The CNEs lack of involvement in the formal mentoring program delivered by the Health Region may influence their participation in mentorship on their respective units.

5.7 Study Limitations and Strengths

Each research study carries with it limitations and strengths. A limitation of this study was that only CNEs' perspectives were obtained. Their perceptions were not validated with other members of the organization. Additionally, the results of this study only apply to a select group of CNEs from one Health Region that is primarily urban, including a tertiary care hospital that is associated with a university. The reader must keep this in mind when discussing the transferability of the results to other CNE groups. The inconsistencies in the CNE role within Health Regions, inter-provincially, and throughout other parts of Canada also challenges the model's direct applicability to other groups.

Having a sample of similarly employed CNEs was identified as research strength. The sample consisted of all CNEs working in acute care areas from the same Health Region. This helped to limit some of the variations that could be seen across clinical

sectors. In this way, the study was able to focus on mentoring issues in an acute care environment.

The use of Grounded Theory as a methodology was also considered a strength by the researcher. The research methodology allowed for theory development concerning the CNE's role in supporting an organizational culture of mentorship. Theory development is important as it helps to move what is known about mentorship from rich description to understanding the processes involved. This study is unique, in that CNEs are nursing leaders who represent the organization, and understanding this role opens up a new dimension in the research on mentorship.

5.8 Future Research

Further research needs to be carried out examining the role of the CNE in mentorship in other clinical settings and regions to see if the *CNE Mentorship Support Model* is applicable or if the elements uncovered are particular to acute care areas. Moreover, studies are needed to examine the perspectives of other nursing team members to see if their perceptions of the CNE's role are similar to those of the participants.

There is a need to conduct research regarding CNEs' leadership and how it compares to nurse managers and business managers. Understanding the differences that may exist among nursing leadership members is important in knowing the strengths and influences of each. Along with this need for further research in CNE leadership, is the need to explore variations among CNEs, for example, to look at the similarities or differences between CNEs in urban versus rural settings, tertiary and community based hospitals, and CNE mentorship between Registered Nurses or other unit staff members.

In this setting, there is a need to develop mentoring tools such as scales and questionnaires to measure the levels of CNE support for mentorship in different health care institutions. Lastly, there is a need to operationalize the concepts of the theoretical model for further study.

5.9 Conclusion

In conclusion, the insight gained from this Grounded Theory study on the CNE's role in an organizational culture of mentorship has been useful in uncovering the social processes involved. It uncovered that their main role is one of support and described how they enact their support for mentorship, and the major themes that influence their ability to do so. The research also uncovered the informal mentoring processes where CNEs were involved. The study revealed that transitioning from the role of mentee to mentor was not only reserved for novice nurses but also novice leaders. The research described the intricacies of the CNE's leadership style and showed that it resonates with that of transformational leadership.

The study was able to meet the objectives that were set out for the research purpose which were to describe the role of the CNE in an organizational culture of mentorship, identify characteristics and practices of the CNE, and link the beliefs and practices with the support of a mentoring culture. Glaser (1992) outlined four basic criteria for judging Grounded Theory as fit, relevance, work and modifiability. It is the position of the researcher that the *CNE Mentorship Support Model* demonstrates *fit* because the concepts revealed fit with the data it is representing. The researcher is confident that this is the case because of the close adherence to constant comparison analysis. The model is *relevant* because it answers the main concern of the participants,

that being, what is the CNE's role? The theoretical model describes their role and identifies and describes the themes that influence it. The theoretical model *works* because one can take the model and explain the behaviors of the CNEs and their role in supporting an organizational culture of mentorship in the acute care setting. The researcher believes the theoretical model to be *modifiable* because it demonstrated flexibility as new data was discovered during the conceptualization phase of theory development. The theoretical model may also be useful in examining other CNE populations such as in rural or community settings.

What this research adds to the current understanding of mentorship is that the CNE, as a leader and representative of the organization, plays a role in supporting mentoring environments. The study has given new insight into important relationships that extend the commonly explored dyad seen in the mentorship literature. A third or triad dimension is created in the mentoring relationship which has not been explored in the literature. The study opens new avenues of research on mentoring to explore.

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Appendix A - Participant Consent Form

You are invited to participate in a research project entitled, *The Role of the Clinical Nurse Educator in Creating an Organizational Culture of Mentorship*. Please read this form carefully, and feel free to ask questions you might have.

Researcher: Anna Sewell, BN, RN
College of Nursing, University of Saskatchewan
Telephone: (306) 966-5534
E-mail: anna.sewell@usask.ca

Research Supervisor: Dr. Linda Ferguson
Professor and Director of CASNIE
College of Nursing, University of Saskatchewan
Telephone: (306) 966-6264
E-mail: linda.ferguson@usask.ca

Purpose and Procedure: The purpose of the study is to examine the role of the Clinical Nurse Educator in creating an organizational culture of mentorship in the acute care setting. You are being asked to participate in this study by agreeing to be interviewed and/or possibly asked to audio record your daily work activities. The interviews will be audio taped and are expected to take approximately one hour of your time. As a participant you have the right to request that the recording device be turned off at any time. It is possible that you may be asked for a second interview. The questions that you will be asked in the interviews are designed to let you share your opinion about the role of the Clinical Nurse Educator in creating an organizational culture of mentorship in your clinical area. Two or three participants will be asked to create audio journals of their daily work activities. Participants will be chosen to create an audio journal based on their willingness and how active they are in the clinical area. The purpose of the audio journal is to collect information about mentoring activities in your clinical area. Specifically, you will be asked to carry a hand-held recorder for a period of three work days and make as many entries as you feel necessary about your thought or activities at work. Equipment to create an audio journal and technical support with the equipment will be provided by the researcher. The audio journals will be transcribed verbatim and entered as data. You will also be asked to share demographic information about yourself. The interviews will take place at a mutually agreed upon location. The information collected from the study will be reported in a master's thesis work.

Potential Benefits: Participants may find it helpful to share information about their role as Clinical Nurse Educator. The information collected in this study will may inform organizations about the important role nurse educators play in the acute care setting.

Potential Risks: I do not anticipate any risks to you in terms of your participation in the study.

Storage of Data: All interview tapes, demographic information, and contact information will be stored securely by the researcher's supervisor at the University of Saskatchewan for a minimum of 5 years and then may be destroyed. Your name and contact information will be stored separately from the tapes and transcribed interviews.

Confidentiality: Your participation in the study as well as the information you share will be held in the strictest confidence. No personal information will be included that could identify you in the reports. A code name will be used if your information is used to describe the study results.

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 supervisor. You may withdraw from the research project for any reason, at any time until the study results have been disseminated. After this time it may not be possible to withdraw your data as the information will have already been shared. You may also withdraw from the study without penalty or reflection on your employment status with the Saskatoon Health Region. Your employer will not know about your decision to participate or not in the study. If you choose to withdraw from the research project the data that you have contributed will be destroyed at your request. Prior to each interview or audio taping you will be asked if you agree to continue participating in the study.

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 or the research supervisor at the numbers provided if you have other questions. This research project has been approved by the University of Saskatchewan Research Ethics Office on 31/01/2011. Any questions regarding your rights as a participant may be addressed to the Research Ethics Office (306-966-2084). Out of town participants may call collect.

Follow-Up or Debriefing:
The results of the study will be published in a thesis that will be added to a national databank of Canadian research. A copy will be available through the University of Saskatchewan. Participants may request a summary of the study findings after the study is complete.

Consent to Participate:
(a) Written Consent
I have read and understood the description provided; I have had an opportunity to ask questions and my 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 B – Demographic Collection Form

Name: _____

Address: _____
_____
_____
_____

Phone Number: _____

E-mail:_____

Summary of findings requested:_____

Code Name: _____ Date: _____

Age: _____ (yrs) Gender: Male ☐ Female ☐

Highest level of education completed: Diploma ☐ Bachelor☐ Masters ☐ PhD ☐

Other ☐ Please specify: _____

Job title: _____ Number of years in this position: _____

Speciality area: _____

Primary employer: _____

Hospital: Royal University Hospital ☐ Saskatoon City Hospital ☐

St. Paul's Hospital ☐ Other Hospital ☐

Please specify which one: _____

Other employment:
_____
_____
_____
_____
_____
_____
_____
_____

Clinical Background:
_____
_____
_____
_____
_____
_____
_____

Years of nursing experience: _____

City: _____

Ethnic Background: _____

Is there a formal mentorship program in your workplace? Yes ☐ No ☐

Have you received any mentorship training? Yes ☐ No ☐

If yes please
specify:_____
_____
_____
_____
_____

Have you ever experienced mentorship in your workplace? Yes ☐ No ☐

Appendix C – Semi-Structured Interview Guide

1. Tell me about your role as a Clinical Nurse Educator. (Prompt, what types of things do you do in your work?)
2. What types of services do you provide?
3. Who do you have the most interaction with on your unit?
4. How would you say your practice influences others?
5. How do you see the organizational culture of your unit?
6. What is your role in the organizational culture on your unit?
7. What role do you have in supporting the mentorship of nurses on your unit?
8. What role could you play?
9. Would you describe the culture of your unit as a "mentoring culture"? (Prompt, describe why you think it is or is not?)
10. How would you describe the organizational culture of the hospital you work for?
11. Does your hospital promote the use of mentorship and if so how?
12. How do you promote or support such a culture? Why?
13. Tell me about the importance of mentorship in your practice.

Appendix D – Audio Journal Guide

The purpose of the audio journal activity is to collect data about mentoring activities in your clinical area. You are encouraged to record activities/thoughts about your daily work activities.

Instructions

1. Hand-held recorders will be assigned to you. The recorders will come with tapes and batteries. Instructions on how to use the recorder will be explained to you by the researcher.
2. Participants are asked to carry the hand-held recorder for a period of three work days and encouraged to record any thoughts or describe any situations or activities they carry out in assisting others.
3. Having the hand-held recorder allows for immediate entry of thought and is less time consuming than a written journal. However, if you feel uncomfortable making entries while you are working, you may wait until the end of the work day to record your thoughts in private.
4. At the end of the three day period the researcher will make arrangements to collect the recorders and tapes.

If you have any questions or require technical assistance on how to operate the recorder you can contact the researcher through the university office at the following phone number (306) 966-5534 or by e-mail at ans448@mail.usask.ca.

Appendix E – Research Timeline

Ethics approval received from Beh-REB	January 31, 2011
Operational Approval from Saskatoon Health Region	March 14, 2011
Begin recruitment of participants	March 23, 2011 to August 30, 2011
Begin qualitative analysis	April 11, 2011
Complete qualitative analysis	July, 2011
Write Thesis	July, 2011 to September, 2011
Thesis Defence	January, 2011

Appendix F – Advertisement in the RN News Bulletin

UNIVERSITY OF SASKATCHEWAN

Clinical Nurse Educators Needed

An exciting study about the Clinical Nurse Educator's role in mentorship is underway in Saskatchewan. We are looking for volunteers to take part and share their knowledge and insight.

Eligibility – Participants must be employed as CNEs in an acute care setting in Saskatchewan.

For more information please call (306) 966-5534 or e-mail ans448@mail.usask.ca

Appendix G – Advertisement in the SUN Spots

CLINICAL NURSE EDUCATORS NEEDED

An exciting study about the Clinical Nurse Educator's role in mentorship is underway in Saskatchewan. We are looking for volunteers to take part and share their knowledge and insight.

Eligibility: Participants must be employed as a CNE in an acute care setting in Saskatchewan. This Grounded Theory study involves meeting with the researcher and taking part in one or two interview(s). Each interview is anticipated to take approximately one hour of your time. Meeting places and times are very flexible. Your participation in the study will be held strictly confidential. The topic of the discussion will be the role of the CNE in supporting or enhancing mentorship on the unit and in the hospital.

Benefits: CNEs may find it helpful to share their thoughts about this issue with the researcher. It is also an opportunity to contribute to the nursing research about mentorship and the important role CNEs play.

For more information please call (306) 966-5534 or e-mail ans448@mail.usask.ca

Not for re-print *submitted by: Anna Sewell, RN (SUN member)*

UNIVERSITY OF SASKATCHEWAN

Appendix H – SHR Organizational Missions and Values

Saskatoon Health Region Strategic Plan 2010-2013

Vision: Healthiest People, Healthiest Communities, Exceptional Service

Mission: We improve health through excellence and innovation in service, education and research, building on the strengths of our people and partnerships.

Values: Respect, Compassion, Excellence, Stewardship, Collaboration

Promise: Every moment is an opportunity to create a positive experience in the way we treat and care for people, in how we work and interact with each other, and in how we deliver quality service. We promise to seize every opportunity.

Strategic Directions:

Transform the Care and Service Experience	Partner to Improve Health of the Community	Transform the Work Experience	Build a Sustainable, Integrated System
Provide exceptional care and services that exceed client expectations and are consistent with best practices	Improve the overall health of the population and reduce health disparities	Create a workplace that optimizes capabilities, capacity, engagement and quality of worklife for providers and learners	Manage and align our resources to ensure sustainability of the health system
• Place clients and families first • Achieve timely access to services • Eliminate harm and avoidable deaths • Provide culturally safe and competent care with a focus on First Nations and Métis people.	• Identify health needs and priorities with community partners • Focus on health promotion, protection and disease prevention • Collaborate with communities and governments to reduce disparities in health status • Begin implementation of the Aboriginal Health strategy	• Work together to create safe, and supportive work places • Develop a highly skilled, workforce with a sufficient number and mix of service providers • Promote teamwork and interprofessional practice • Develop a diverse workforce, ensuring enhanced representation from First Nations and Métis populations	• Maximize efficiencies and reduce waste • Strategically invest in facilities, equipment and information technology • Foster research, learning and innovation • Measure and report performance, benchmarking with high performing health systems and other industries

Appendix I – Recruitment Flyer

Clinical Nurse Educators Needed

An exciting study about the Clinical Nurse Educator's role in mentorship is underway in Saskatchewan. We are looking for volunteers to take part and share their knowledge and insight.

Eligibility - Participants must be employed as a CNE in an acute care setting in Saskatchewan.

This Grounded Theory study involves meeting with the researcher and taking part in one or two interview (s). Each interview is anticipated to take approximately 1 hour of your time. Meeting places and times are very flexible. Your participation in the study will be held strictly confidential. The topic of the discussion will be the role of the CNE in supporting or enhancing mentorship on the unit and in the hospital.

Benefits - CNEs may find it helpful to share their thoughts about this issue with the researcher. It is also an opportunity to contribute to the nursing research about mentorship and the important role CNEs play.

For more information please call

(306) 966-5534 or e-mail ans448@mail.usask.ca

University of Saskatchewan

Anna Sewell RN, BN
College of Nursing
(306) 966-5534
ans448@mail.usask.ca

UNIVERSITY OF SASKATCHEWAN

Appendix J – Ethical Approval

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR	DEPARTMENT	Beh #
Linda M. Ferguson	Nursing	10-348

INSTITUTION (S) WHERE RESEARCH WILL BE CONDUCTED

University of Saskatchewan
Saskatoon SK

STUDENT RESEARCHER(S)

Anna Sewell

SPONSOR

UNFUNDED

TITLE:

The Role of the Clinical Nurse Educator (CNE) in Creating an Organizational Culture of Mentorship in the Acute Care Setting

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF	EXPIRY DATE
24-Dec-2010	31/Jan/2011	Ethics Application Consent Protocol	31-Jan-2012

Full Board Meeting ☐

Delegated Review ☑ Expedited Review ☐

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/

John Rigby, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon, SK S7N 4J8
Phone: (306) 966-2975 Fax: (306) 966-2069

Appendix K – SHR Operational Approval

Associate Vice-President Research – Health
(University of Saskatchewan)
Vice-President Research and Innovation
(Saskatoon Health Region)
Room 247-111 Research Drive
Atrium Building, Innovation Place
Saskatoon, SK S7N 3R2
Phone: (306) 966-8745

DATE: **March 14, 2011**

TO: **Dr. Linda Ferguson**
College of Nursing
University of Saskatchewan

FROM: Martha E. (Beth) Horsburgh
Associate Vice-President Research – Health (University of Saskatchewan)/
Vice-President Research & Innovation (Saskatoon Health Region)

RE: **RESEARCH ETHICS BOARD (REB) #: B2010-348**
PROJECT NAME: The Role of the Clinical Nurse Educator in Creating an Organizational Culture of Mentorship in the Acute Care Setting
PROTOCOL #: N/A

Saskatoon Health Region is pleased to provide you with operational approval of the above-mentioned research project.

Kindly inform us when the data collection phase of the research project is completed. We would also appreciate receiving a copy of any publications related to this research. As well, any publications or presentations that result from this research should include a statement acknowledging the assistance of Saskatoon Health Region.

We wish you every success with your project. If you have any questions, please feel welcome to contact Shawna Weeks at 655-1442 or email shawna.weeks@saskatoonhealthregion.ca

Yours truly,

Martha E. (Beth) Horsburgh, RN, Ph.D
Associate Vice-President Research – Health (University of Saskatchewan)/
Vice-President Research & Innovation (Saskatoon Health Region)

cc: Margot Hawke, Director/Professional Leader, Nursing Affairs

Catalyzing Health Research and Innovation Together

Appendix L – Gender Neutral Pseudonyms

- Alex
- Adrian
- Andy
- Ashley
- Bobby
- Brett
- Casey
- Chris
- Cory
- Dale
- Dana
- Danny
- Devon
- Drew
- Fran
- Jerry
- Jacky
- Jamie
- Jean
- Jess
- Jody
- Joe
- Kelly
- Kim
- Kris
- Lee
- Leslie
- Lonny
- Lou
- Mandy
- Merle
- Morley
- Pat
- Randy
- Red
- Rene
- Robin
- Ryan
- Sally
- Sasha
- Shane
- Shannon
- Sydney
- Taylor
- Teddy
- Terry
- Toby
- Tyler

Appendix M – Participant Letter of Invitation

The Role of the Clinical Nurse Educator in Creating an Organizational Culture of Mentorship

Dear Participant,

You are invited to participate in a research project looking at your experience with mentorship in your role as a Clinical Nurse Educator in the acute care setting.

Specifically, you are being asked to participate by agreeing to take part in one or two interview(s) with a researcher to share your thought on mentorship in your clinical setting. Each interview is expected to take approximately one hour of your time and you will not be asked to attend more than two interviews. The interviews will take place at a mutually agreed upon place between you and the researcher away from your work area. The interviews will be audio taped to ensure that your comments are recorded accurately. The questions that will be asked during the interview will allow you to share your ideas and experience about mentorship and how it relates to your role as a Clinical Nurse Educator. During the interview, you will be asked for some demographic information about yourself that would include things like educational background and years of work experience. A select portion of the study participants will also be asked to create an audio journal about their daily work activities but your participation in this activity is optional.

If you are interested in participating in this study, please contact the researcher at (306) 966-5534 to leave a confidential message. Your employer will not be told of your participation in this study. Taking part in the study will not affect your employment. The information collected from the interviews will be reported in a master's thesis.

The information you share will be held in the strictest confidence. The only person present at the interview will be the researcher. If direct quotes are used in the research report, it will not contain any information that will allow people to identify you. Participation in the study is purely voluntary and you may choose not to answer only certain questions or to stop participating at any time up until the results have been shared. If you withdraw from the study, any information you have shared will be removed from the study and destroyed. As it is customary, the demographic forms and audio-tapes of the interviews will be stored in a locked filling cabinet for a period of five years and then destroyed.

This project was approved by the University of Saskatchewan Research Ethics Office on 31/01/2011 and by the Saskatoon Health Region. If you have any questions or concerns about the study you may contact the researcher at (306) 966-5534. If you have any questions about your rights as a participant in the study please contact the Research Ethics Office at (306) 966-2084.

I am confident that this project will promote awareness of the role the Clinical Nurse Educator plays in creating/supporting an organizational culture of mentorship. With this goal in mind, I very much hope that you will agree to participate in this project. I look forward to hearing from you.

Sincerely,

Researcher: Anna Sewell, RN, BN

College of Nursing

University of Saskatchewan

Telephone: (306) 966-5534

Appendix N - CNE Job Description

SASKATOON CITY HOSPITAL
ROYAL UNIVERSITY HOSPITAL
ST. PAUL'S HOSPITAL
Saskatoon, Saskatchewan
JOB DESCRIPTION

FILE: DATE: July 1998

PREVIOUS DATE: May 1996

TITLE: Clinical Nurse Educator JOB #: 0403

DEPT/DIV: Nursing Development DEPT. #: 6005

AFFILIATION: S.U.N. PAY GRADE:

SUPERVISOR'S SIGNATURE: _____

HUMAN RESOURCES SIGNATURE: _____

JOB SUMMARY:

The Clinical Nurse Educator integrates skills and knowledge from nursing theory and principles of adult learning in the provision of direct patient care, clinical coordination, clinical problem solving education and research for a defined group of patients and/or programs. The incumbent will provide leadership that is visible, pro-active, and promotes the delivery of patient care through the application of practice standards. In consultation with the Manager of Nursing, the individual is responsible for assessing learning needs of staff, planning, and implementing and evaluating designated educational activities/programs either unit-based and/or division wide. The Clinical Nurse Educator will use a consultative approach and research findings to provide support to health-care professionals as appropriate.

SUPERVISION RECEIVED:

Reports to the Manager of Nursing Development in a line relationship and consults with the clinical Manager of Nursing for assigned area(s) of responsibility. Incumbent is self-directed and requires minimum supervision.

EDUCATION:

Requires current SRNA registration and current CPR certification in Basic Life Support, instructor level.

Requires a Baccalaureate degree in Nursing. A Masters degree in Continuing Education or Nursing is preferred.

Requires basic computer skills applicable to nursing units/programs.

EXPERIENCE:

Requires a minimum of three to five years nursing experience in a related clinical area (clinical experience depends on units covered). Previous experience in nursing education is desirable. Understands the nursing process and principles of adult learning. Demonstrates skill in teaching staff. Demonstrates basic computer skills applicable to nursing units. Experience in developing programs/resources for staff in the areas of planning, implementation, quality monitoring and evaluation.

ABILITY:

Requires resourcefulness and judgement to plan, implement and evaluate staff development activities/programs such as certification, orientation, workshops, computer training, and special projects.

Proven teaching abilities and skills.

Demonstrates initiative, self-direction, and leadership abilities.

Demonstrates ability to accept and implement change.

Ability to establish and maintain good interpersonal/consultative relationships and communication patterns.

Demonstrates effective writing skills.

Must demonstrate commitment to continuing professional development.

Demonstrates ability to apply research to nursing practice.

PHYSICAL EFFORT:

An active job requiring moderate physical effort in the form of walking within the unit and facility. Mobility between the sites is required.

ACCURACY: (effect on efficiency, safety or materials)

Adherence to established standards of care (policies and procedures) is expected in the proper use, instruction and handling of equipment, supplies and medications. Accuracy of information imparted is essential to maintain quality client care and efficient departmental operations.

PRINCIPAL RELATIONSHIPS:

- Professional Leader - Nursing
- Manager of Nursing Development
- Clinical Managers of Nursing/Nurse Managers
- Staff members who work on the unit(s)
- Other CNE with similar clinical focus in district
- Physicians
- Social Workers
- Pharmacists
- Pharmacy Clerks
- Home Care/CAU
- Food and Nutrition
- Therapies
- Sask. Transplant Program
- Outreach Programs
- College of Nursing
- College of Medicine
- Director of Medical Affairs
- Diagnostic Services
- City of Saskatoon (EMO., Fire Dept., Police Services)
- Materials Management
- General Managers
- Professional Leaders
- Infection Control
- Property Services
- SIAST
- Community Health
- Clinical Engineering
- Linen Services
- Media
- Information Systems/Computer Systems
- Continuing Nursing Education/ Continuing Medical Education

SUPERVISORY RESPONSIBILITIES:

No line supervision.

ENVIRONMENT:

Normal hospital environment.

HAZARDS:

Some risk of injury or infection.

MENTAL STRESS:

Mental stressors include the following:

- regular involvement as the key player in negotiation and confrontational interactions. These may include
  - clinical problem solving
  - resource utilization
  - assessing bed management
  - relationship issues
- managing, diffusing and resolving confrontational and crisis situations related to clients, families, staff and physicians and other departments
- provides leadership and support in emotionally difficult situations such as death, disability, sudden losses and ineffective coping of the clients, families and staff
- frequent pressures related to multiple complex issues and short deadlines
- front-line management in a changing, highly complex environment demanding quick, accurate and sound judgment/decision making
- regular interaction with diverse groups, with conflicting agendas and opinions, for the purpose of achieving teamwork to produce desired outcomes

GENERAL ACCOUNTABILITY

The CNE provides development initiatives and leadership in all spheres of nursing: clinical practice, education, research and quality improvement.

JOB DESCRIPTION - Clinical Nurse Educator (CNE)

The CNE is an experienced nurse who is an expert in his/her clinical area. The CNE is a role model for staff in client/family care. The CNE is a self-directed practitioner who has effective communication skills and who works collaboratively with all team members for the provision of quality care. The CNE is a change agent who supports others to adapt to changes in both the clinical area and SDH.

1. The CNE through a consultative process is responsible for the establishment, maintenance, evaluation and updating of clinical standards of care for particular groups of clients/families.
   - in the ongoing establishment, maintenance, evaluation and updating of the clinical standards of care for particular groups of clients/families
     - develops, implements and monitors policies, procedures and standards consistent with SDH philosophy
     - consults with clinical Managers of Nursing, staff members, other interdisciplinary team members

  - utilizes current research and practice trends
  - considers standards of professional bodies (SRNA, SALPN, RPNAS)
- involves staff members in the critical analysis of standards
- implements quality improvement initiatives to streamline, update, evaluate clinical standards.

2. The CNE provides clinical leadership in the care of particular groups of clients/families.
   - clinical problem solving
   - serves as an expert clinical resource for staff members, clients/families and interdisciplinary team members
   - assists staff members with planning for complex care needs of clients/families
   - work collaboratively with nurses and interdisciplinary team members to provide quality client/family care
   - demonstrates clinical leadership through participation on varied multidisciplinary committees
   - fosters an environment which enhances critical thinking and independent practice
   - keeps abreast of national and international trends and issues related to health care, research, education and practice
   - leads change and practice direction
   - The CNE utilizes both formal and informal strategies for staff development.
   - works collaboratively with Clinical Managers of Nursing/Nurse Managers and staff members to determine individual and group education needs
   - integrates education activities with the overall unit goals and needs
   - adapts staff education to changing needs of clients/families and agency
   - may have input into staff performance appraisals based on educational and clinical assessments
   - facilitates staff involvement in education and designs formal and informal education activities which match the level (novice to expert) of the staff member
   - develops, coordinates, implements and evaluates specific education projects
   - supports staff members through skills in coaching, conflict resolution, critical thinking, crisis management, problem-solving
   - participates in planning/coordination and/or presenting at professional conferences

3. The CNE works collaboratively with staff, clients/families and students in resource development.
   - utilizes a planned process to assess, develop, implement or evaluate resources for staff, clients/families or students

- involves others in these projects
- serves as a resource and shares information/resources or develops projects collaboratively with staff members in SDH and other Health Districts
- promotes access for all staff to essential supplies, information and support
- participates in research activities within SDH

4. The CNE provides supervision to nurses in the designated practice environment.
    - provides supervision of the clinical practices of nurses
    - works with nurses requiring assistance in nursing practice issues for the purpose of ensuring competent nursing care
    - identifies and informs the unit Manager of Nursing of competency concerns of nurses in a designated work area
    - develops and implements programs for nurses who have a requirement for additional knowledge, skill and/or judgment to ensure competent practice.

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July/98

Appendix O – Amended Interview Guide

May 26th, 2011- Questions added to the original interview guide.

1. In your words, describe mentorship.

2. What mentoring characteristics do you possess?

3. How would you describe your role in mentorship?

4. What are some activities you do that could be considered mentorship?

5. How do you develop/maintain a relationship with staff nurses on your unit?

6. In your opinion, what kinds of things influence the unit culture?

7. How do you influence the culture of the unit?

Appendix P – Second Interview Guide

July 8th, 2011 Questions used for second interviews

1. How important is the work environment in mentorship? How would you describe how the work environment influences your ability to support mentorship?

2. How important is your relationship with staff? What types of things influence your relationship with staff?

3. What are your beliefs about mentorship? How do your beliefs about mentorship influence your ability to support mentorship?

4. How would you describe the culture of the organization you work for?

5. How do your beliefs about organizational values influence your ability to support mentorship?