8-2012

Mentoring of nurse managers the experience of new nurse managers in rural hospitals : does mentoring make a difference?

Leigh Lindsey 1972-
University of Louisville

Recommended Citation

Lindsey, Leigh 1972-, "Mentoring of nurse managers the experience of new nurse managers in rural hospitals : does mentoring make a difference?" (2012). *Electronic Theses and Dissertations.* Paper 835.
https://doi.org/10.18297/etd/835

MENTORING OF NURSE MANAGERS
THE EXPERIENCE OF NEW NURSE MANAGERS IN RURAL HOSPITALS:
DOES MENTORING MAKE A DIFFERENCE?

By

Leigh Lindsey
B.S., Western Kentucky University, 1995
M.S., Vanderbilt University, 2003

A Dissertation
Submitted to the Faculty of the
College of Education and Human Development of the University of Louisville
and
Graduate Studies and Research at Western Kentucky University
In Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy

Department of Leadership, Foundations, and Human Resource Education
University of Louisville
and
College of Education and Behavioral Sciences
Western Kentucky University

August 2012

MENTORING OF NURSE MANAGERS
THE EXPERIENCE OF NEW NURSE MANAGERS IN RURAL HOSPITALS:
DOES MENTORING MAKE A DIFFERENCE

By

Leigh Keeton Lindsey
B.S., Western Kentucky University, 1995
M.S., Vanderbilt University, 2003

A Dissertation Approved on

May 21st, 2012

by the following Dissertation Committee:

           Dr. Beverly Siegrist
Dissertation Co-Chair

           Dr. Bud Schlinker
Dissertation Co-Chair

           Dr. Jennifer Mize Smith

           Dr. Meera Alagaraja

           Dr. Brad Shuck

ABSTRACT

MENTORING OF NURSE MANAGERS
THE EXPERIENCE OF NEW NURSE MANAGERS IN RURAL HOSPITALS:
DOES MENTORING MAKE A DIFFERENCE?

Leigh Keeton Lindsey

May 21st, 2012

The aim of this study was to examine rural nurse managers' experiences with

mentoring once assuming their new management role. This research study used

qualitative methods to examine mentoring experiences in relatively new and

inexperienced nurse managers in the rural setting. Social Learning Theory was used as

the theoretical framework, and the conceptual framework consisted of Stewart and

Krueger's (1996) concept analysis of mentoring in nursing. Stewart and Krueger's

concept analysis identified the following six essential attributes of mentoring in nursing:

a teaching-learning process, a reciprocal role, a career development relationship, a

knowledge or competence differential between participants, a duration of several years,

and a resonating phenomenon.

Ten nurse managers working in six different rural hospitals in southcentral

Kentucky were interviewed for this study. While mentoring had occurred for

participants, it occurred at varying degrees. Six of the participants reported mentoring

relationships consistent with Vance and Davidhizar's (1996) definition of mentoring used

for this study. Three participants reported being mentored once assuming their new role;

however, further discussion with the nurse manager revealed a relationship more

consistent with receiving training or having a temporary preceptor. One participant understood the meaning of mentoring, but she was unable to identify a mentor since assuming her role as nurse manager.

Data analysis of this study's participant responses revealed several common themes: *difficult transition to management role; perceptions of having a mentor; desirable traits of a mentor; investing time in people and training; and discovering individual leadership style on the job.* Responses showed the importance of mentoring and that it was valued by new managers. Further research in the needs of new managers could help hospitals do more to help the new manager feel supported, which would contribute to the manager's longevity in the position.

TABLE OF CONTENTS

PAGE

CHAPTER I

INTRODUCTION

The research for this study focused on new rural nurse managers and their

experiences with mentoring. Chapter one introduces the nursing profession and provides

the background on the reason a shortage of nurses exists and the role that nurse managers

play in retaining nurses. Chapter one also discusses the existing problems for nurse

managers, the purpose of this study, research questions guiding the study, participants

used to gain information, and methods used to collect and analyze data. Last, Chapter

one explains the assumptions used to guide the study, the significance of the study,

limitations, and operational definitions of common terms used.

Background

According to the United States Department of Labor's Bureau of Labor Statistics

(2009), registered nurses (RNs) make up the largest health care occupation. Currently,

there are 2.9 million individuals who hold licensure to work as registered nurses in the

United States. Despite this large number of RNs, a nursing shortage exists and is

predicted to worsen over the next several decades (Buerhaus, 2008; Kovner et al., 2007;

U.S. Department of Labor: Bureau of Labor Statistics, 2009; Janiszewski-Goodin, 2003;

Sigma Theta Tau International, 2001). The American Association of Colleges of Nursing

(AACN) Nursing Shortage Fact Sheet (2010) reported "In April 2006, officials with the

Health Resources and Services Administration (HRSA) released projections that the

nation's nursing shortage would grow to more than one million nurses by the year 2020"

(p. 2). The U.S. Department of Labor's Bureau of Labor Statistics (2009) projected more than 581,500 new RN positions will be created through 2018, which would increase the size of the RN workforce by 22%. Employment of RNs is expected to grow much faster than average (growth of 20% or more) when compared to all other professions. Despite the increases in the RN workforce and high rate of employment opportunities, other confounding factors exist that override the increases in job opportunities. AACN (2010) stated:

> In the July/August 2009 *Health Affairs*, Dr. Peter Buerhaus and coauthors found
> that despite the current easing of the nursing shortage due to the recession, the
> U.S. nursing shortage is projected to grow to 260,000 registered nurses by
> 2025. A shortage of this magnitude would be twice as large as any nursing
> shortage experienced in this country since the mid-1960s. (p. 1)

The rapidly aging workforce of RNs remains the primary contributing factor for the future nursing shortage. Buerhaus (2008) revealed that over the next two decades the average age of the RN will increase, and vast numbers of RNs will no longer work due to aging and/or retirement. At the same time, demand for RNs will increase due to large numbers of baby boomers requiring more health care services, resulting in a large and prolonged shortage of nurses to hit the U.S. in the latter half of the decade.

According to the U.S. Department of Health and Human Services' (2010) National Nurse Sample Survey of 2008, the average age of the registered nurse workforce continues to grow. In 2008 the average age of the total RN population (including those not employed in RN roles and those who are retired) equaled 47.0 years, a rise from 46.8 years in 2004. This age was the highest average age since the national sample survey

began in 1975. The survey also showed the average age of employed nurses rose from 45.4 in 2004 to 45.5 years in 2008. This aging workforce reflects the fact that fewer younger nurses are entering the workforce, more of the current workforce is baby boomers who are entering their 50s and 60s, and older graduates from initial nursing education programs are entering the RN population. In the 2008 sample survey, 9.4% of all RNs were under 30 years of age. When broken down by degree type, the average age of diploma graduates approximated 32.9, associate degree graduates approximated 33.1, and baccalaureate or higher graduates was approximately 27.5 years of age.

The AACN Nursing Shortage Fact Sheet (2010) provided additional contributing factors impacting the nursing shortage. Nursing school enrollments are not growing fast enough to meet the projected demand for registered nurse (RN) and advanced practice registered nurse (APRN) services. Enrollment into baccalaureate nursing programs increased by 5.7% in 2010, yet this increase will not meet the projected demand for nursing services. The fact sheet reported "With the passage of the Patient Protection and Affordable Care Act in 2010, more than 32 million Americans will soon gain access to healthcare services, including those provided by RNs and APRNs" (p. 2). Additionally, a shortage of nursing school faculty exists, resulting in limited enrollments into nursing school programs.

According to the AACN Nursing Shortage Fact Sheet (2010), U.S. nursing schools turned away over 67,000 qualified applicants from baccalaureate and graduate programs in 2010 due to insufficient numbers of faculty, clinical sites, classroom space, and clinical preceptors, and budget constraints. Faculty shortages negatively affect nursing school enrollments, which negatively affects the number of qualified nurses

entering the workforce. The lower number of qualified students and nurses poses a threat to numbers of nurses prepared for the faculty role.

Further adding to the nursing shortage is that a number of new nurses leave positions at higher rates than experienced nurses (Thompson, Wieck, & Warner, 2003). According to Kovner et al. (2006), work satisfaction remains an important issue for RNs and their managers because of its relationship to staff turnover, which can lead to organizational shortages and absenteeism. Results from studies regarding RN work satisfaction should interest hospital and nursing administrators and policymakers so the necessary actions can occur to decrease RN turnover (Kovner et al., 2006). Johnson and D'Argenio (1991) reported "A leadership crisis has been identified as one of the greatest challenges facing the nursing profession today" (p. 249). Leininger (as cited in Johnson & D'Argenio, 1991) identified a critical shortage of capable nurse leaders. Johnson and D'Argenio listed the following as some of the many challenges faced by nurse managers (NMs), requiring the skills of an effective leader: complex health care systems, technological advances, issues of cost management, the worsening nursing shortage, and changes in nursing education. Nurse managers must possess competence, flexibility, creativity, persistence, patience, and effectiveness to perform their jobs effectively. Nurse managers have difficulty possessing the leadership skills required and need effective leadership training to remain successful in their positions. Several factors contribute to the lack of leadership skills among nurse managers. First, for nurse managers whose highest degree earned is an associate degree in nursing, there is a lack of education with a focus on leadership, as the majority of associate degrees in nursing programs do not include leadership courses or training in their curriculum. The United

States Department of Labor: Bureau of Labor Statistics (2009) described several differences between the associate degree nurse and the baccalaureate degree nurse. Typically, a bachelor of science in nursing (BSN) program is offered by a college or university and takes approximately four years to complete. An associate degree in nursing (ADN) program is usually offered by a community or technical college and takes two years to complete. Licensed graduates of either program qualify for entry-level positions as a staff nurse. However, bachelor's prepared nurses receive more training in areas such as communication, leadership, critical thinking, nursing theory, research, etc. Because of the broader scope of educational training for the baccalaureate nurse, advancement opportunities may be limited for those with the associate degree. Other factors contributing to the lack of leadership skills include a long passage of time since the nurse manager received leadership training in the baccalaureate, and many nurse managers were promoted into their position because of excellence in clinical skills, not necessarily because of leadership or managerial potential. Mentoring of new nurse managers can assist the nurse manager in gaining the skills necessary for the new management role.

The concept of mentoring originated in Homer's Odyssey (Andrews & Wallis, 1999). Mentor, a wise friend of Odysseus, took responsibility for raising Odysseus' son during his absence. This image depicted the mentor as an older, wiser male who took on the responsibilities of a younger man's learning and development. Mentoring can occur in any environment but often occurs in a professional arena. Its first appearance in nursing literature occurred in the early 1980s (Andrews & Wallis). The role of the mentor includes one of adviser, role model, coach, problem solver, teacher, supporter,

counselor, and guide (Ali & Panther, 2008). Barker (2006) described mentoring as "a process designed to bridge the gap between the educational process and the real-world experience" (p. 56). Vance and Davidhizar (1996) explained a mentoring relationship as one that "will socialize a person to the professional norms, values and standards, will provide entry into the inner circles of the profession, and will promote the profession's growth by ensuring continuity and quality leadership" (p. 199). Effective mentoring depends on the relationship between the mentor and mentee (Andrews & Wallis, 1999). Greene and Puetzer (2002) described a mentor, with respect to nurses, as "an experienced staff nurse who serves as a role model and resource person to a new staff member. The mentor commits to a longitudinal, supportive relationship with an assigned new staff member" (p. 68). According to Greene and Puetzer, the mentor helps the mentee by acting as a role model when at work. The mentor also helps to familiarize the mentee with the unit's social norms and helps the mentee to feel comfortable in the organization. Although several definitions of mentoring exist in the literature, the commonalities of the definitions include: mentors are experienced in their field, mentors share their knowledge and previous experience to guide the mentee, the mentoring relationship is long term, the end goal is for the mentee to achieve competency in the new role, and both mentor and mentee benefit from this professional relationship.

In addition to outlining the impact that mentoring has on the nurse manager role, this study specifically addresses the importance of mentoring the NM in the rural setting. Rural nursing is a unique type of nursing that has received little attention in the literature. The U.S. Department of Health and Human Services National Nurse Sample Survey (2006) from March 2004 reported the majority of RNs (83.9 percent) resided in

metropolitan areas. The U.S. Department of Agriculture (2008) describes rural areas as those outside of urban areas and urban clusters. Urban areas comprise larger populations (50,000 or greater) that include a city center and densely settled areas around them. Rural areas consist of all territory located outside of urbanized areas and urban clusters. The U.S. rural population was 59 million (21 percent) in 2000 (U.S. Department of Agriculture, 2008).

Rural hospitals and their patients have unique circumstances because of the distance away from large cities and large hospitals. The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality [AHRQ] (1996) reported health disparities between urban and rural Americans. "Compared with urban Americans, rural residents have higher poverty rates, a larger percentage of elderly, tend to be in poorer health, have fewer doctors, hospitals, and other health resources, and face more difficulty getting to health services" (AHRQ, 1996, para. 2). Rural areas have unique obstacles because of their remote locations, and rural hospitals differ significantly from their urban and suburban counterparts. One in three adults living in rural America has poor health, and nearly half have at least one major chronic illness. Traumatic injuries occur more often in rural areas, and outcomes are worse because of transportation problems and lack of advanced life support training of hospital staff. Economic factors have forced rural hospitals to perform more outpatient procedures and decrease inpatient stays. Alcoholism and drug abuse are more common in rural areas, yet only one in five rural hospitals has treatment services for such conditions (AHRQ, 1996).

Eldridge and Judkins (2003) explained that the rural environment has different characteristics affecting how nurses and nurse administrators carry out their role.

Characteristics of rural health care include health factors such as "having higher risk factors and proportionally older and poorer compositions of rural populations as compared to urban" (p. 9). Eberhardt et al. (as cited in Eldridge & Judkins, 2003) reported that a greater number of people 65 and older live in rural versus urban areas. More rural residents have personal health habits which are considered to be high risk health behaviors such as smoking, obesity, and drinking five or more alcoholic beverages per day. Hospitalization and death rates are higher in rural areas as well. Provider shortages exist in rural areas; only ten percent of physicians practice in rural areas, whereas, the rural population comprises 20% of the national population. "Forty-five percent of rural health care administrators report a very limited supply of nurses in their region versus 10% of urban administrators" (Eldridge & Judkins, p. 11).

Eldridge and Judkins (2003) described rural nurses as generalists who "must be comfortable functioning with significant autonomy, increased responsibility for action and decision-making" (p. 11). A broad base of knowledge is essential, as is creativity and resourcefulness. Commonly, rural nurses may work in more than one department during one shift. Because of the small, close-knit communities in which rural nurses live and work, rural nurses do not have the same level of anonymity as their urban counterparts. Fewer rural nurses hold a baccalaureate degree or higher and tend to be older than urban RNs. Because of the unique circumstances that rural nursing practice brings about for nurses and nurse managers, Eldridge and Judkins listed six essential competencies for rural nurse administrators: financial management, leadership, workforce management, cross-disciplinary management, integration of need-based community services, and maximizing resources.

The Problem

Nurses often are promoted into a managerial role for which they are not adequately prepared. The role of nurse manager is unique and requires specific skills and training in order to experience long-term success. The impact of the nurse manager role cannot be overstated. The effectiveness of the nurse manager can have a direct impact on the unit's productivity and morale, and decisions directly affect staff nurses as well as patients. Nurse managers can have a positive or negative impact on the level of job satisfaction of the unit, which in turn has an impact on patient outcomes. If the morale and job satisfaction levels are low due to an ineffective nurse manager, the number of nurses leaving the unit will increase, further worsening the nursing shortage problem. Even worse, if job satisfaction levels remain low, then patient outcomes suffer as well. Nurse managers often suffer from job dissatisfaction as well when they do not feel supported by upper administration, fellow managers or their own staff. If the dissatisfaction continues, the nurse managers leave their roles, allowing for another staff nurse to apply for the new opening; thus, the cycle continues.

Mentoring of the novice nurse manager by a more experienced nurse manager creates an environment of trust and support and helps the novice navigate through the difficulties of role transition. Proper mentoring can alleviate the shortage of qualified nurse managers by fostering a supportive learning environment for the new manager and can prepare the NM for long-term success.

Purpose

The purpose of this study is to examine the experiences of mentoring among nurse managers in rural hospitals. Nurse managers often are promoted into their new role

without adequate preparation for the required administrative duties. Without adequate mentoring for the new position, the changing of roles often leads to feelings of anxiety, stress, isolation, and inadequacy, resulting in job dissatisfaction. If NMs do not make changes to better prepare for the demands of the job, they likely will leave the management role and may even leave the profession altogether. Adequate mentoring of rural NMs can better prepare them to meet the demands of the new role, improve their job satisfaction as well as that of the staff, and ultimately help to decrease the nursing shortage.

Research Questions

Based on the research problem, the following research questions are proposed:

1. To what extent do nurse managers in rural hospitals experience mentoring after acquiring their new role?

2. How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?

3. What are the most beneficial pieces of advice rural nurse managers received from a mentor?

4. To what extent has mentoring influenced rural nurse managers as leaders?

Participants

Participants for this study consisted of nurse managers of rural hospitals in south central Kentucky. Much of south central Kentucky qualifies as rural based on the U.S. Department of Agriculture's (USDA) (2008) definition of rural which determines rurality based on population per square mile. The USDA qualifies rural populations as communities outside an urban area or cluster. Urbanized areas and clusters are those

with a central city and a population density of at least 1,000 people per square mile, and are surrounded by areas with a population density of at least 500 people per square mile (a total population of 50,000 or more). If the community does not qualify as urban, then it qualifies as rural.

Many rural communities are farm communities and/or those with little to no economic development. Rural communities often suffer from economic depression because of the limited opportunities for work and lack of high paying jobs. The hospitals that serve these communities have unique circumstances because of their isolation from larger hospitals. Hospital employees often reside in the surrounding rural community.

According to the U.S. Department of Health and Human Services' (2010) findings from the 2008 National Sample Survey of Registered Nurses, an estimated 46,473 RNs are licensed in the state of Kentucky, with 41,520 (89.3%) employed full time as RNs. Of the nurses employed in Kentucky, 54.1% hold an associate degree in nursing as the highest degree.

Methodology

Data collection occurred via qualitative methods. A qualitative design was chosen because of the desire to understand personal experiences of first-line managers in rural hospitals with regard to mentoring. Because very little research exists that specifically describes the experience of mentoring for NMs in rural hospitals, the qualitative design provided the best venue for addressing this research. Semi-structured interviews served as the main source of data collection, along with observation of the nurse manager in their work environment. The benefit of interview came from the richness of the details given by the interviewee.

Assumptions

Many of today's nurses are ill prepared for the role of nurse manager. Often, a nurse receives a promotion to NM after displaying clinical competence in the role of "staff nurse," where direct care (bedside care) is provided to patients. The dilemma that arises from the promotion of the competent bedside nurse to NM is that the role of the NM requires different competencies than that of a bedside/staff nurse. Nurse managers are required to possess knowledge of leadership and management skills; conflict management skills; finance and budgeting skills; and political savvy in dealing with hospital management, other nursing departments, dealing with bed shortages, etc. Many of those skills necessary are acquired via additional education and training, as well as on-the-job training. Nurse managers who hold an associate degree in nursing as their highest degree may face more challenges than their BSN and MSN counterparts because of the lack of educational preparation.

Ideally, nurses who apply for the managerial roles do so out of a desire to meet their own professional goals. Many nurses who are competent at providing patient care do not want to change roles because they enjoy their job and the flexible schedules; they perceive the role of manager as one that is thankless, with longer hours, and may not feel up to the challenge of working with the many different personalities of staff nurses, higher management, etc. Hence, the best candidates may not even apply for the NM position, which leads to a pool of applicants who may not be adequately qualified or may be trying to "escape" a staff nurse position without truly understanding the intricacies of transitioning from a staff nurse to an administrative role.

According to the U.S. Department of Health and Human Services' Findings from the 2008 National Sample Survey of Registered Nurses (2010), the majority (45.4%) of the nurses entering the workforce held an associate degree in nursing as their highest degree. The curriculum of the associate degree program focuses on preparing the new graduate for technical skills and does not include a course solely dedicated to nursing theory, leadership or management. Western Kentucky University's Associate Degree of Nursing webpage states "The purpose of the associate degree nursing program is to provide the educational resources toward meeting the regional needs for registered nurses" (Western Kentucky University, 2011). Because the majority of nurses entering the workforce hold an associate degree as their highest degree, many of the staff nurses promoted into NM positions lack an adequate educational foundation to meet the demands of the role.

New nurse managers must undergo a transition from expert (in their old role of staff nurse) to novice (in their new role of NM). Without adequate mentoring for the new role, this transition leads to feelings of anxiety, stress, isolation, and inadequacy, often leading to job dissatisfaction. If the NM does not make changes to better prepare for demands of the role, they likely will leave management and may leave the profession altogether. This departure of NMs eventually leads to a gap in available and qualified nurse managers to mentor the upcoming new nurse NMs, and the cycle will continue.

Based on this scenario, the following assumptions were made:

1) Nurses who display competence at the patient care level are asked to assume a managerial role, regardless of educational preparation and experience as managers.

2) Many nurses do not have adequate preparation or training for the administrative role, e.g., no previous courses of management, leadership theory, finance, education, etc.

3) Once in the new role, the new manager needs mentoring.

4) If adequate mentoring does not occur for the nurse manager during the role transition, this often leads to job dissatisfaction and eventually causes the nurse manager to leave the role, further complicating the dilemma of the nursing shortage and negatively affecting patient outcomes.

Significance of Study

Hader, Saver, and Steltzer (2006) reported that 55% of surveyed nurses indicated their intention to retire between 2011 and 2020. The majority of the 978 respondents identified themselves as nurse managers (exact number of NM respondents not provided by authors). The nursing shortage requires nurse managers to perform at their highest level and make a positive impact on the work environment, as well as patient outcomes, to prevent more nurses from leaving their positions. As already outlined, new nurse managers must receive effective mentoring as they transition into their role to serve effectively and with confidence. The satisfied manager is more likely to stay in the role and provide continuity for staff and patients.

Also, as already outlined, rural nurses face different challenges than their urban peers, yet the rural nurse managers who are new to the position have the same learning and mentoring needs as their urban counterparts. Mentoring has been examined in the nursing literature in the past using mainly survey methods. The majority of research found in the nursing literature focuses on mentoring of nursing students or new nurse

graduates. No studies could be found that focused specifically on rural nurse managers with respect to examining their experiences of mentoring after attaining their new role. This dissertation will add to the small base of research already available and will add insight to the mentoring needs of new nurse managers in rural hospitals.

Limitations of Study

Limitations of qualitative studies occur because results are not generalizable to the population, but they are useful due to the richness of detail obtained in the interview and observation. Qualitative research does not lend itself well to replication. Qualitative studies provide in-depth information about groups or cultures and prompts new research questions; they do not predict future behaviors. If enough data is not collected, false assumptions can arise with regard to behavior patterns; conversely, too much data can lead to ineffective processing and coding due to the large volume. Last, it takes time to build trust with participants that will facilitate full and honest self-representation. Short-term observational studies are at a particular disadvantage where trust building is concerned (Colorado State University, 2011).

Operational Definitions

Registered nurse. A registered nurse is one who has obtained a science degree with a focus on nursing and has passed a national licensure exam known as the NCLEX. Three educational tracks are available to become a registered nurse: bachelor's degree, an associate degree, and a diploma from an approved nursing program. Advanced practice nurses — clinical nurse specialists, nurse anesthetists, nurse-midwives, and nurse practitioners — need a master's degree (U.S. Department of Labor, 2009). Registered nurses perform different tasks based on the job role. Nurses often provide services that are

helpful to the promotion, maintenance, and restoration of a person's health and well-being.

Nurse manager. A variety of job descriptions exist for NMs. For this research, a nurse manager is a nurse who works as a mid-level manager over a nursing unit or multiple units. The nurse manager holds a supervisory and administrative role over nursing staff. Job functions include staffing the unit, creating budgets, hiring and firing staff nurses, taking corrective actions toward nurses who do not follow policy, meeting regularly with higher administration, addressing patient complaints, etc.

Mentor. Several definitions exist for mentoring. Dorsey and Baker (2004) described mentoring as a planned relationship between a person who has more experience with a person who has less experience for the purpose of achieving identified outcomes. Greene and Puetzer (2002) explained that mentoring incorporates support, guidance, socialization, well-being, empowerment, education, and career progression. Barker (2006) introduced mentoring as a process designed to bridge the gap between the educational process and real-life experiences.

The definition of mentor used for this study includes Vance and Davidhizar's (1996) explanation of mentoring: "A mentoring relationship will socialize a person or persons to the professional norms, values, and standards, will provide entry into the inner circles of the profession, and will promote the profession's growth by ensuring continuity and quality of leadership" (p. 199).

Summary

Chapter one introduced the topic of mentoring, the importance of mentoring rural nurse managers, and how mentoring can affect the nursing shortage. Many reasons exist

16

for the current and future nursing shortage, such as an aging RN workforce, universities turning away qualified applicants because of lack of faculty and space, and newer nurses leaving their roles at higher rates than experienced nurses. The nurse manager impacts the nursing shortage by affecting the level of job satisfaction of staff nurses. Rural nurse managers face the same challenges as their urban counterparts, but they also face unique challenges because of geographic isolation from larger hospitals in urban and metropolitan areas. In addition to the introduction, chapter one outlined the research problem, the purpose of the research, and the research questions. Chapter one also discussed the chosen methodology for collecting data, significance of this study, and this study's limitations.

The Chapter two literature review includes five sections. The first discusses mentoring in nursing; the second discusses nursing managers and the importance of mentoring; the third focuses on the uniqueness of rural settings and the challenges faced in those settings; the fourth addresses non-nursing views of mentoring; the fifth and final section outlines social learning theory and how it applies to mentoring, as well as provides a conceptual framework to guide this research.

Chapter three discusses the methodology of data collection and reasons for choosing a qualitative approach. Chapter four provides findings from the interviews and the emergence of themes based on the constant comparative analysis. Chapter five discusses implications, strengths, weaknesses, and recommendations for future research. This dissertation will add to the limited base of research already available and will provide insight into the mentoring needs of new nurse managers.

CHAPTER II

LITERATURE REVIEW

The research for this study focused on new rural nurse managers and their

experiences with mentoring. This chapter discusses a literature review of the three

following three topics: mentoring in the nursing profession, nurse leaders, and mentoring

in rural settings. The first section of the literature review includes mentoring in the

nursing profession; policy and its effect on mentoring; national organization statements

on mentoring; nurse-to-nurse mentoring; how mentoring impacts staff satisfaction,

retention, and patient outcomes; and the mentoring of students. The second section

focused on nurse leaders, to include roles and characteristics of a nurse manager; training,

retention, and satisfaction; and mentoring of nurse leaders. The last section will discuss

mentoring of nurses in the rural setting.

Mentorship in Nursing

Stewart and Krueger (1996) used a literature-based method developed by Rodgers

(1989, 1993) to present an evolutionary concept analysis to provide a clearer

understanding of the concept of mentoring in nursing. Stewart and Krueger credit

Rodgers with the idea that concepts contribute to knowledge development, even outside

the context of an existing theory, through explanation or description. Applying Rodgers

method of concept development in nursing will increase understanding of the changing

nature of mentoring in nursing. Stewart and Krueger's intent for this article included

developing a theoretical definition for mentoring in nursing.

Stewart and Krueger's (1996) literature review began with a computer search of the nursing and allied health literature using the search words "mentorship and nursing." The search limitations included reviewing literature from 1977 to 1994. Two hundred twenty-six (226) references resulted. The authors also reviewed previously unpublished research abstracts using the same search words and criteria. The total number of literature references equaled 307. The authors randomly selected 100 articles for a working sample and finally selected a total of 82 articles and abstracts (26% of the initial literature studies reviewed). To strengthen consistency and peer review to the literature review, the investigators reviewed each other's categories and coding processes (Stewart & Krueger, 1996).

Six essential attributes of mentoring in nursing were revealed by Stewart and Krueger (1996). The attributes included a teaching-learning process, a reciprocal role, a career development relationship, a knowledge or competence differential between participants, a duration of several years, and a resonating phenomenon.

- A teaching learning process. Davidhizar (as cited in Stewart & Krueger, 1996) believed mentoring facilitates learning because the protégé can learn from the mistakes and successes of the mentor. As a result of time spent with the mentor, the protégé learns from the mentor's knowledge and success and learns critical thinking skills as well. Ardery (as cited in Stewart & Krueger, 1996) described the process of mentoring in nursing as the "transmission of knowledge" (p. 313).

- A reciprocal role. Powell and Slagle (as cited in Stewart & Krueger, 1996) characterized the mentoring role as one that develops into a two-way, give-

and-take relationship. Young (as cited in Stewart & Krueger 1996) described

the evolution of the relationship as one that changes over time and the dyad

eventually are redefined through the mentoring relationship. Another author,

Darling (as cited in Stewart & Krueger, 1996), "believed that a relationship

had to shift toward reciprocity or else it would end in a rift" (p. 314).

- A career development relationship. Sixty percent of the final literature sample

  (N = 49) focused on career development. Those who had mentors

  experienced a greater likelihood of engaging in greater numbers of career

  development activities, completed their PhD sooner, moved into

  administrative positions sooner, achieved tenure, etc.

- A knowledge or competence differential between participants. A differential

  of knowledge, power, or position exists between the dyad in the mentoring

  relationship. An experienced nurse mentors a new nurse, a faculty member

  mentors a student. Holloran (1989) stated the mentor holds the higher

  organizational position.

- A duration of several years. The literature review reflected that mentoring

  relationships usually occurred over several years. Depending upon the

  context of the mentoring relationship, it could last as short as 2.5 years or as

  long as 33 years. Relationships in academia typically lasted longer than the

  relationships in the clinical setting.

- A resonating phenomenon. The data from the review revealed that those who

  had been mentored were more likely to mentor others in the future.

From these attributes, Stewart and Krueger (1996) defined mentoring in nursing as the following:

> A teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The nurse dyad relies on the relationship in large measure for professional outcomes, such as research and scholarship; and expanded knowledge and practice base; affirmative action; and/or career progression. Mentoring nurses tend to repeat the process with other nurses for the socialization of scholars and scientists into the professional community and for the proliferation of a body of nursing knowledge. (p. 315)

Stewart and Krueger's (1996) literature review also clarified the differences between mentoring and other concepts related to mentoring such as role modeling, sponsoring, precepting, peer strategizing, collaborating, and coaching. Stewart and Krueger listed implications for future research to include examining positive and negative outcomes associated with matching of protégés and mentors, determining the effectiveness of multiple versus one mentor, and determining the impact mentoring has had on the proliferation of nursing knowledge.

The next section discusses how policy affects the mentoring process in the field of nursing. The references used for this section concentrate on policies from multiple countries including Hong Kong and England.

Policy and its effect on leadership and mentoring. Chan (2002) conducted a retrospective study of nursing education reform that took place in Hong Kong from 1985

to 2000. The purpose of Chan's study included analyzing and reporting the results of the retrospective study, more specifically the barriers and facilitators to nursing leadership effectiveness. Chan identified nursing leadership as having a tremendous impact on influencing government's policy making for the nursing profession. The author stated, "The slow development of nursing education reform in Hong Kong might be related to the effectiveness of nursing leadership" (p. 615).

The case study method was used by Chan (2002) to gain a better understanding of the factors influencing the effectiveness of nursing leadership in the process of nursing education reform during a changing socio-economic-political climate in Hong Kong. The data collection methods included document searches and interviews. Written information came from documents such as minutes from meetings, press releases, and annual reports. The author conducted 27 semi-structured interviews to gather information from key informants such as nurse administrators, nursing academics, and presidents of nursing professional organizations. The key informants possessed experiential knowledge vital to the aim of the study, which increased the validity of information provided. Analysis of data occurred by dissecting the tape-recorded interviews. The author coded the data and identified categories.

The findings of Chan's (2002) study revealed two core categories that described situational factors: barriers and facilitators. Barriers described the variables that hindered nursing leadership effectiveness such as medical dominance, socialization of nurses, and lack of educational opportunities. Facilitators described favorable factors in the environment that promoted nursing leaders' effectiveness such as the socio-economic-political environment, the health care system, and academic institutions.

Chan (2002) proposed that situational variables facilitate leadership effectiveness, as well as relationship of nurse leaders and their followers. In the conclusion, the author states, "This study suggests that to be effective, leaders have to analyse the situation, take the opportunities, and gather forces to overcome barriers in achieving the goal of leadership" (p. 621).

Cameron and Masterson (2000) examined the factors affecting the functioning of the Nurse Executive Directors and their views on the realities of nursing management in the new National Health Service (NHS) in England. The researchers used a qualitative method to obtain data. Data collection occurred via semi-structured interviews that explored the development of new professional roles and why, which professional group had led the developments, and any other issues deemed pertinent to new role development. Thirty-seven nurse executives took part in the interviews. Selection of a subset of six interviews occurred; from this subset, the authors extracted codes which represented themes that emerged from the transcript analysis. These codes served as the basis for the coding frame for the remaining transcript analysis.

Results from Cameron and Masterson's (2000) study came from the findings of a larger project [Exploring New Roles in Practice (ENRiP) project] funded by the Department of Health in England. The NHS developed new nursing roles as a result of NHS reform, which resulted in a decentralization of management. One of the new roles developed as a result of the NHS reform included the nurse executive director.

Cameron and Masterson (2000) reported that the ENRiP project mapped the development of new professional roles within the acute sector. Sample selection for their study came from a 20% purposeful sample of acute hospital trusts in England. The

sample consisted of five trusts in each of the eight NHS regions. The selection of trusts included teaching and non-teaching hospitals, rural and urban hospitals, and acute and combined services hospitals. Findings revealed several themes: complexity of organizational structures, how the new roles fit into staffing and professional strategies, the impact of the labor market, the influence of the medical profession, top-down drivers for change, purchasing power, pots of gold, training for innovation, and managing risk (Cameron & Masterson).

Examples given by Cameron and Masterson (2002) of the complexity of organizational structures findings included new role development occurring in an unstructured way; the authors referred to this as "muddling through." The nurse executives reported the new organizational structure influenced their capacity to respond to change; e.g., some of the nurse executives held the title but had no management authority.

Training for innovation examples included nurse executives expressing a need to "provide adequate education and training to support the new role" (Cameron & Masterson, 2002, p. 1086) of nurse executive. Some nurse executives felt the individual in the new role should enroll in master's degree courses; other nurse executives thought the in-house programs of education and support would suffice for the new nurse executive. A few respondents expressed significant concerns over the lack of job specific training and its effect on safety and competence. The nurse executives expressed concern regarding the lack of role preparation, which they felt made their risk management more difficult.

Analysis raised awareness of the professional development of the nurse executive

role in England. Cameron and Masterson's (2000) research suggested a mandatory

framework for the regulation of the new nurse executive role, otherwise the executives

will continue to muddle through their new position. Lastly, the authors suggested that

success of the new role depended on two factors: personal relationships within the

organization and upper management's commitment to the development of professional

leadership. Without this level of commitment and support from other leaders, nurse

executives will maintain little control of their professional agenda.

Nurse-to-nurse mentoring. Currie, Tolson, and Booth (2007) reported selected

findings from a Ph.D. study that explored how graduates from a bachelor's program in

Scotland engage in practice development as they begin their careers. The purpose of the

study consisted of the authors entering the world of the graduate specialist practitioner,

examining how they engage in the process of clinical practice development, and learning

of their concerns and how the graduate acted to resolve their concerns.

Currie et al. (2007) used a grounded theory approach because "Distinct aspects of

grounded theory methods include the use of the constant comparative approach to data

analysis and theoretical sampling" (p. 587). The two methods of data collection used

included survey and interview. The survey questionnaire served as a means of selection

of participants for the face-to-face interviews based on the characteristics the participant

held, employing theoretical sampling. This type of sampling requires a process of

selecting the next area to study by asking, "What group should be turned to next and for

what theoretical purpose?" (p. 587). All graduate specialist practitioners from a

bachelors nursing program in Scotland from 1999 to 2003 were surveyed, totaling 227

graduates. The response rate was 45% ($n = 102$). Selection for interviews was guided by theoretical sampling. Inclusion of participants resulted from their responses to the initial questionnaire. Final selection included 20 participants.

Findings reported by Currie et al. (2007) focused on the dimensions of position and the impact of managerial responses toward practice development of the new graduate. The results suggested that the use (or abuse) of structural power still exists, and the position of the new graduate influenced his or her ability to engage in practice development. The helpful manager can empower the new graduate to feel as if they are making a difference. Another finding in this study, with respect to the dimension of people, revealed that the enabling or blocking power of the senior manager affected the ability of the new graduate to practice at a specialist level. The respondents relayed that the educational level of the manager influenced the responsiveness to the new graduate; managers with master's level degrees were reported as much more supportive of the professional development activities of others.

Implications from the Currie et al.'s (2007) study revealed that the ward manager's attitude strongly influenced the opportunities for new graduates (not in leadership positions) to engage in the organization. Currie et al. explained, "The nurse manager acts as a gatekeeper who either enables or blocks the new graduate's involvement in practice development" (p. 590). The authors also noted the "direction and control by others may impede the application of new knowledge or inhibit role development" (p. 591). Strength of the relationship between novice and manager matters: the stronger the relationship of the new graduate with the manager, the more the new graduate will experience empowerment from the manager and vice versa. The

relationship between the manager and the graduate specialist can influence the graduate

specialist's work and ultimately affect the graduate's potential for reaching the level of

expert practitioner. Recommendations for managers included implementing mechanisms

to demonstrate commitment to identify barriers to practice development, including

horizontal violence.

Ryan, Goldberg, and Evans (2010) explored mentoring relationships between

nurses in the intrapartum (labor and delivery) setting. The researchers noted that

understanding mentoring relationships and the transfer of knowledge from nurse to nurse

was essential to providing a positive, supportive practice environment, as well as a key

component in the recruitment and retention of nurses. The theme of relational learning

highlighted in this paper explains how perinatal nurses engage with their coworkers and

engage with their patients.

A qualitative feminist phenomenological design was used to explore a human

lived experience. This type of methodology "considers a gender-centered, embodied

exploration of human experiences" (Ryan et al., 2010, p. 184). The authors explained

feminist phenomenological research as that which explores the social relationships that

shape the lived realities of women. Ryan et al. (2010) stated, "From a feminist

perspective, this offered participants valuable insights into the mentoring experience and

potentially aimed to improve perinatal nursing care, patient outcomes and influence

health care policy development" (p. 185).

Ryan et al. (2010) used purposeful sampling to recruit five registered nurses who

worked on a labor and delivery unit in eastern Canada. Data collection occurred via

phenomenological interviews, observation of patient care, and use of reflective

journaling. Inclusion criteria for participants included working as registered nurses on the labor and delivery unit for at least two years, in addition to also having experience as a mentor or mentee. For data collection, five unstructured interviews were conducted lasting 60-90 minutes. Six questions (provided by the authors on page 185) guided the interview sessions. After the interviews took place, two practice observations of 6-12 hours occurred on the labor and delivery unit. The observations served two purposes:

1. The researcher looked for, and listened to, the stories of how nurses engaged with one another and with birthing women and how this engagement influenced nurses' learning.

2. Observations were focused and allowed for a deeper understanding of the context of mentoring within perinatal nursing.

In addition to observation, Ryan et al. (2010) journaled, which allowed the researcher(s) to link thoughts, data, and theory to the research data.

Thematic analysis of the data revealed four themes:

1. the meaning of nurse-to-nurse mentoring

2. mentoring as relational learning

3. mentoring as embodied learning

4. contextual understanding of nurse-to-nurse mentoring

The researchers' discussion focused on relational learning. Understanding of relational learning came through a feminist phenomenological method revealing that effective mentoring aids the transfer of perinatal nursing knowledge from the expert to the novice. The mentor models positive actions and attributes and fosters a sense of enthusiasm and passion for the new nurse mentee. Eaton, Henderson, and Winch (as cited

in Ryan et al., 2010) noted that "role modeling and demonstration by expert nurses have been found to facilitate student nurse learning and to improve the uptake of best practices" (p. 187).

Conclusions from the Ryan et al. (2010) study included promoting an understanding of the importance of mentoring and experiential learning in perinatal nursing. Novice nurses depend heavily on their more experienced colleagues for support and mentoring. This study revealed that informal mentoring occurs on a daily basis within the professional development of nurses. For relevance to clinical practice, this study's findings should encourage nurse leaders and nurse administrators to support mentoring relationships by providing adequate time, resources, and feedback to improve the practice environment and retention.

The following subsection reviews studies that have examined job satisfaction of staff nurses and nurse managers. Inclusion of these studies occurred because of this author's comments on the importance of the role of the nurse manager and how a well-mentored nurse manager can positively affect the workplace environment.

Job satisfaction, retention of nurses, and patient outcomes as a result of mentoring. Bae, Mark, and Fried (2010) examined how nursing unit turnover affects key workgroup processes and how these processes affect the impact of nursing turnover on patient outcomes. The authors posited that the impact of nursing turnover on quality of patient care is not well understood, and the underlying mechanisms of the relationship between turnover and patient outcomes has not received attention in the research.

Bae et al. (2010) applied a conceptual framework at the nursing unit level to examine the impact of turnover on workgroup processes (workgroup cohesion and

workgroup learning) and patient outcomes (patient satisfaction, average length of stay, medication errors). The authors identified the framework as the input-process-outcome (IPO) framework.

Workgroup processes were identified as the functions that allow or inhibit the ability of team members to combine their abilities and behaviors (Bae et al., 2010). When turnover occurs, workgroup processes are disturbed leading to disruptions in communication, which leads to increased turnover. Unit level patient outcomes include patient satisfaction, length of stay (LOS), patient falls, and medication errors. Patient satisfaction serves as an indicator of nursing care quality. Length of stay indicates hospital efficiency. Improved communication between nurses and physicians results in reduced LOS. Medication errors are more likely to occur when coordination between nurses and physicians, and nurses and pharmacy, remains minimal or absent.

A secondary data analysis was run on data previously obtained with the Outcomes Research in Nursing Administration Project II (ORNA II). The ORNA II project used a non-experimental, longitudinal causal model design. The nursing unit served as the unit of analysis. The ORNA II study examined relationships among RN staffing adequacy, work environments, and organizational and patient outcomes. The sample for this study consisted of 268 nursing units at 141 randomly selected hospitals. Nursing units provided monthly unit turnover rates for six consecutive months, and nursing staff filled out questionnaires measuring workgroup processes. Bae et al. (2010) measured patient outcomes by assessing unit-level average length of stay, patient falls, medication errors and patient satisfaction scores.

Bae et al. (2010) used the IPO conceptual framework. The input variables (IVs)

for this study included nursing unit turnover, the numerator equaled the total number of

RNs who left the nursing unit over a specified period of time, and the denominator

equaled the total number of RNs on staff during the same time period. Process variables

(PVs) included workgroup cohesion measured using a subscale from the Nurse Job

Satisfaction Scale, which measures perceptions of nurses who work together and get

along. The Cronbach's α of the four-item subscale for this study equaled .76. Workgroup

learning included learning from errors and failures associated with patient safety.

Workgroup learning was measured by using the Error Orientation Questionnaire.

This questionnaire measured the degree to which unit staff evaluated and diagnosed the

source of errors. Cronbach's α for this questionnaire equaled .92. Outcome variables

(OVs) included patient satisfaction, average LOS, patient falls, and medication errors.

Assessment of patient satisfaction occurred through a 13-item Likert-type survey that

assessed the patient's satisfaction with overall courtesy, friendliness of nursing staff, and

promptness of nursing assistance. Cronbach's α for this survey also equaled .92. Average

LOS included the average number of inpatient days of care on the nursing unit. Patient

falls referred to an unplanned descent to the floor. Medication errors consisted of using

only those errors that required increased nursing observation or medical intervention for

patients as a result of the medication error. Measurement of the rate of patient falls and

medication errors was obtained by taking the total number of incidents of these two OVs

per 1,000 patient days (Bae et al., 2010).

The unit of analysis for Bae et al.'s (2010) study consisted of the nursing unit.

Data collection of the variables occurred at the individual level and required aggregation

at the unit level. Results indicated the relationship between workgroup cohesion and nursing unit turnover as not significant ($\beta = -0.008$, $p = .09$). A significant association was found between workgroup cohesion and patient satisfaction ($\beta = 0.079$, $p < .01$). Higher levels of nurse education were related to lower levels of medication errors ($\beta = -1.239$, $p < .01$) and decreased patient satisfaction ($\beta = -0.183$, $p < .05$). Other significant findings by the authors included nursing unit turnover was related to patient falls ($\beta = -0.297$, $p = .02$).

The most important finding of this study, as reported by Bae et al. (2010), was the adverse impact of turnover on workgroup learning; units with higher levels of turnover experienced lower levels of workgroup learning. The authors concluded that the findings support the need to increase workgroup cohesion and coordination to improve patient satisfaction.

Limitations of the Bae et al. (2010) study included not assessing the variable of managers' support and supervision within the context of workgroup processes and organizational effectiveness. Bae et al. (2010) recommended future research needs to occur to account for this variable because the unit manager's level of support and effectiveness impacts the nurses' intent to stay. Last, limiting turnover remains critical to delivering high quality patient care.

Shirey (2004) performed a literature review to better understand the relationship between stress in the work environment and strategies to mediate the job-related stress. Langford, Bowsher, Maloney and Lillis (as cited in Shirey, 2004) offered the following definition of social support: the assistance and protection given to others, especially individuals. This definition assumes reciprocity occurs, involving exchanges of resources

between at least two individuals. Conceptual elements of social support included antecedents (social network, social embeddedness, and social climate); critical attributes (emotional support, instrumental support, informational support, and appraisal support); and consequences (positive health status such as personal competence, effective coping behaviors, decreased anxiety, etc.).

Shirey's (2004) literature review resulted in 15 empirical articles with inclusion criteria set by the researcher. From these, three major themes of empowerment, job strain, and motivation emerged showing "a link to social support and stress in the work environment" (p. 315). The empowerment theme revealed a benefit that comes from access to information, knowledge transfer, and close personal relationships which enhance one's overall feeling of well-being. The literature reviewed suggested that "as staff nurses perceived a decrease in level of collegial support, they perceived an increase in frequency of job stressors" (p. 315). Laschinger and Havens (as cited in Shirey, 2004) demonstrated that social support strongly related to work effectiveness. Last, staff nurses reported high levels of empowerment when managers used leadership behaviors that increased employee perceptions of autonomy and confidence.

The next theme, job strain, came as a result of Shirey's (2004) review of six articles. The articles established a relationship between social support and stress to job strain. Hendel, Fish, and Aboudi (as cited in Shirey, 2004) used a descriptive correlational survey to study nurses seasoned in combat crisis. The research revealed that 85% of nurses in the study experienced a sense of calm as a result of social support from their nurse managers. With respect to job strain, Shirey (2004) also reported "a relationship exists between work stress, social support, sickness absenteeism and gender"

(p. 317). Vaananen et al. (as cited in Shirey, 2004) indicated that women have longer absences than men. "Lack of co-worker support increased the frequency of very long sickness among men and lack of supervisor's support among women" (p. 317).

The third and last theme, motivation, came from Shirey's (2004) review of three articles that established a relationship between social support and stress with reference to motivation. Two major findings within the motivation theme emerged. First, as Baker, Israel, and Schurman (as cited in Shirey, 2004) reported, social support from supervisors in a stressful work environment decreases negative job feelings and work related stress. Second, Morano (as cited in Shirey, 2004) reported that stressors in the workplace predisposed the nurse to stress reactions, physiological responses, and psychological responses. In a study by Janssen, deJonge, and Bakker's (as cited in Shirey, 2004), nurses reported their level of emotional exhaustion increased when workload levels were high and when they received little social support. Shirey (2004) reported, "Intent to leave was associated with unrealized career-related expectations associated with limited growth opportunities" (p. 317).

Shirey (2004) suggested that social support influences stress in the work environment. The presence and quality of the network is more important than the size of the support network. Shirey also noted:

> Given that nurse managers are documented to have a significant impact on nurse
> retention, more studies must be made available to document the cascading effect
> of social support from the CEO, to the nurse executive, to the nurse manager, to
> the staff nurse, and ultimately to the patient. (p. 318)

Anthony et al. (2005) described the roles and skills of nurse managers (NMs), whether they possessed the desired skills, and what characteristics they exhibited that served as barriers to nurse retention. Anthony et al. also described the strategies that the NM believed would improve retention. The authors supported the rationale by stating, "there is little [evidence in the literature] about nurse manager activities that are directly geared toward nurse retention" (p. 147).

Anthony et al. (2005) used a conceptual framework previously identified by Donabedian (1966). This framework uses structure, process, and outcome as the guide for examining components that influence medical care. Structure included the environment in which care takes place and where the NM facilitates an environment that supports one-to-one care or an one that supports the group practice of nursing. The process involved the performance of management activities that occurs between and among managers, nursing staff, patient, and other health care providers. Outcome included a change in the nursing unit function related to patient care or the work environment as a result of the structure or process.

A qualitative method was used to obtain data. Anthony et al. (2005) used focus groups to answer questions about the role of the NM. A consortium group (consisting of nurse leaders from academia, practice, and administration) created interview questions after examining the literature. The clinical leaders of the group pilot tested the interview questions by testing at their respective facilities; revisions occurred as a result of the feedback given from the pilot test. The final set consisted of eight questions. The authors received Human subjects' approval from the clinical setting.

Data collection occurred via four different focus groups. Placement into a focus group occurred based on the educational background of the NM. Initially, the authors decided to have one group each for diploma prepared, associate prepared, baccalaureate prepared, and master prepared nurses. A low participation response resulted from the diploma and associate nurses, and a large response occurred from baccalaureate nurses. Therefore, the authors combined the diploma and associate nurses into one group, separated the baccalaureate nurses into two groups, and kept the master prepared nurses as one group. Inclusion criteria of NMs in the study included having held their role for a minimum of six months and having budgetary responsibility for their unit (Anthony et al., 2005).

The sample for Anthony et al.'s (2005) study included 32 NMs. Each group consisted of six to nine NMs who came from four to five different hospitals. Nurse managers averaged 45 years of age, 21 years of nursing service, and eight years of management experience. The NMs oversaw an average of 45.4 full-time employees.

Data analysis occurred via content analysis of transcribing, reading, and rereading the audio-taped interviews. Anthony et al. (2005) used Nudist QRS5 (a computer program) to manage the data. One of the study's authors, Standing, performed the data analysis that remained blind to the groups' identification (of education separation). The findings were organized by the questions in the interview guide, after which the consortium group members separated the findings into either structure, process, or outcome. Review of analysis by the consortium group members added to the validity of the findings.

Anthony et al. (2005) reported results for "What are the key roles of nurse managers?" (p. 149). Results fell primarily under the classification of structure. Reported roles ranged from technical (providing supplies) to professional (hiring, scheduling, retaining staff) to administrative (acting as human resource manager, staff mediation), and to fiscal (budgeting, payroll responsibilities). Process roles for the NM included listening, empowering, and conflict resolution. Outcome roles included patient focus and patient satisfaction.

Results for "Do key roles of nurse managers differ by education?" (p. 150) varied by focus group. All nurse managers identified staffing, nurse retention, and ensuring good patient outcomes as key roles. Nurse managers from the diploma/associate group identified administrative aspects of structure (managing patient admissions and finding patient beds) as a key role. The baccalaureate group placed emphasis on professional aspects of structure such as recruiting, educating, and professional growth of their staff; process aspects from this group focused on communication and leadership. Nurse managers at the master level included structural roles such as human resource manager and acting as a mediator between the nursing staff and executive level management. Similar to the baccalaureate group, the process role for the master's level group included conflict resolution and crisis management. All groups identified maintaining positive attitudes stakeholders as a key outcome role (Anthony et al., 2005).

Results for the following two questions focused primarily on structure and process: "What skills do nurse managers need to retain staff? To what extent do you believe most managers have those skills?" (p. 150-51). Structural answers included flexibility, mentoring, patience, and self-confidence. Process answers included

communication skills, leadership skills, and conflict resolution. Answers related to outcomes focused on patient safety and patient satisfaction. All four focus groups' respondents reported that their skills for retaining staff were developed over time. Last, the results for "What characteristics of your unit's team facilitate or are barriers to retention?" (p. 151) include mentoring and socialization to the unit. Other answers included teamwork, nurturance, and unit culture (Anthony et al., 2005).

Anthony et al. (2005) concluded by noting that the information obtained from this study validated that the role of the first line manager remains multi-faceted and complex. The participants in this study relayed the impact their role had on nurse retention. Also, the NMs acknowledged their role as pivotal, but also overwhelming. First line managers hold the best position to promote change in creating a positive work environment; hence, the NM needs adequate support and resources in order to remain successful in that role.

In 2005 Block, Claffey, Korow, and McCarrey performed a literature review regarding mentoring. The researchers reviewed the impact nurse mentorship programs have on nurse retention and healthcare organizations and also highlighted essential components of mentorship programs. The authors noted that the literature reveals a positive correlation between nurse mentoring programs and nurse retention rates. The increase in retention rates inversely affects hospital expenses related to hiring and training and has a positive effect on adequate staffing and patient safety issues. Block et al. described mentoring as relationships that encompass "support, guidance, socialization, well-being, empowerment, education and career progression" (p. 135).

Block et al. (2005) explained the differences between the nursing shortage of the 1980s and the current shortage. The shortage during the 1980s was due to insufficient

numbers of nurses to fill positions. The current nursing shortage exists as a result of

nurses leaving their bedside positions to fill other roles in nursing. Budd, Warino, and

Patton (as cited in Block et al., 2005) stated that 21% of 700 nurses surveyed indicated

they planned to leave their position (delivering direct patient care) within the upcoming

five years for reasons other than retirement. Block et al. cited Aiken, Clarke, Sloane,

Sochalski, and Silber (2002) with the finding that one in three nurses under the age of 30

intend to leave their job within one year. Letvak (as cited in Block et al., 2005) found

that 50% of nurses who intended to leave their nursing job reported burnout, frustration,

and lack of support as the main reason for leaving their organization. Block et al.

reported the cost related to turnover remains costly, ranging from $30,000-$145,000

depending on location and specialty. Lastly, Block et al. noted the types of relationships

found in the literature between patient outcomes and a nurse's patient load. For every one

patient added to a nurse's load, the risk of mortality increases by seven percent, cited

from Aiken et al. (2002).

The literature review specific to nurse retention programs cited Hale (2004) using

the Hale Mentorship Assessment tool for nurses. Block et al. (2005) noted the findings

from Hale's study found "the presence of a mentoring relationship improved retention,

confidence, competence, and personal and professional growth in new graduate nurses"

(p 136). The Hale Mentorship Assessment tool had a Cronbach's α of .97. The survey

was sent to 800 new nurse graduates, with a reported return rate of 18% (N = 144). Hale

indicated that the respondents reported improved self-confidence, job satisfaction, and

satisfaction with their career. Hale suggested that mentorship programs offer peer

support and promote satisfaction, resulting in retention.

Almada, Carafoli, Flattery, French and McNamera (as cited in Block et al., 2005) "evaluated the retention rate of new graduate nurses in a small community hospital when provided with a trained preceptor" (p. 137) who had received training in adult learning styles, communication styles, conflict resolution, and personality traits. The preceptor and preceptee worked side by side for an eight-week orientation process. Goals of orientation included technical skills, critical thinking, use of resources, and social integration. The study used both quantitative and qualitative research to yield data. Return rate for the survey was 89% (40 responses) (the initial number of surveys sent not reported in this article). The overall satisfaction score equaled 93.7%, with "the most important aspects for job satisfaction being the length of orientation, the matching of preceptor with preceptee, and the availability of professional development staff" (p. 137). The hospital's retention rate of new graduate nurses increased by 29%, the vacancy rate decreased by 9.5 %, and the hospital reportedly eliminated its use of travel nurses. Results of this mentorship program revealed an increase in staff satisfaction and retention and a decrease in hospital expenses.

Angelini (as cited by Block et al., 2005) studied the "relationship between the provision of mentorship strategies for staff nurses and their career development" (p. 138). Interviews were conducted with 37 staff nurses and eight female nurse managers from four acute care hospitals. Participants recognized that mentorship plays a critical role in their career development, and 95% reported their peers and nurse managers as the most influential in the mentor relationship. Two mentorship models emerged from this study, the structural mentorship and process oriented mentorship. The structural mentorship model used three mentoring influentials: environment (workplace), people (coworkers

and family), and events (occurrences critical to their career development). The process mentorship model consisted of four phases. The first, mentoring characteristics, consisted of the mentoring influentials from the structural model. The second consisted of mentoring dimensions, leading to phase three, mentoring strategies. The last phase consisted of career development outcomes. Angelini reported that mentoring seemed "vital to improving the nursing workforce at the bedside" (p. 138), and mentoring improves work satisfaction and retention among nurses.

Block et al. (2005) concluded with the thought that mentoring remains more than an orientation program, it consists of a long-term commitment for organizational success. Nurses value mentoring relationships, and experienced nurses have a responsibility to the profession to enhance the professional development of new graduates.

Kovner, Brewer, Wu, Cheng, and Suzuki (2006) wanted to examine factors contributing to nurses' job satisfaction using a theoretical model proposed by Price (2004) and Gurney et al. (1997) that addressed work satisfaction and voluntary turnover. The target population for the study included all RNs in MSAs in the United States. Approximately 78% of RNs live in MSAs. The sampling design included two-stages: first was selection of MSAs, next was random selection of RNs from all RNs in each MSA. Sampling of RNs occurred from 29 states and the District of Columbia, accumulating a total of 4,000 RNs from 40 MSAs with equal probabilities of selection. The final return rate of the 4,000 RNs surveyed approximated 38% ($n = 1,538$).

Work attitudes were measured with scales used in previous research. Job satisfaction was measured using Quinn and Staines's five-item scale. The Cronbach's α for this scale equaled .86. Demographic data from the survey revealed "working RNs

were primarily women, white, married and 14.2% had children under the age of six years old living with them" (p. 74). The average age of RNs in this study equaled 46.4, with an average of 18.8 years of experience and an annual income of $49,940. This data reflects the findings of the National Sample Survey of Registered Nurses (NSSRN) performed in 2001 (Kovner et al., 2006).

Data analysis occurred by using ordinary least squares regression to examine a linear relationship of work satisfaction. The model explained 54% of the variance in work satisfaction, with the majority of variation explained by work setting variables such as supervisory support, work-group cohesion, autonomy, and high variety of work. Low organizational constrain significantly contributed to satisfaction. Other interesting findings included that wages were not associated with satisfaction, yet distributive justice which relates to fairness of pay was related to satisfaction. The only benefit associated with satisfaction was paid time off. Kovner et al. (2006) noted, "Although much has been written about the need for RNs to have support from mentors, this variable was not related to satisfaction in our sample" (p. 77). The authors continued by suggesting that supervisory support and work group cohesion were related to RN satisfaction, both of which support aspects of mentoring. Employers have the potential to influence these factors.

Kovner et al. (2006) concluded with recommendations to managers to consider factors that they can change or control to increase worker satisfaction. Factors that organizations can control include supervisor support, paid time off, autonomy, variety, promotional opportunities, and distributive justice. The authors also suggested that

supervisors receive training in areas that would foster work group cohesion, thereby, increasing worker production and satisfaction.

Wieck, Dols, and Landrum (2010) examined attributes that increase retention of nurses in all of the generations in today's workplace. The aim of the researchers' study was to provide a generational assessment of nurse job satisfaction, work environment satisfaction, and desired characteristics of managers.

Two research questions drove this study:

1. What characteristics do nurses value in their managers?

2. What are the retention priorities of each generation in the hospital setting?

Mixed methods (survey methodology and focus discussion groups) were used to gather data. This article reported the results of the online descriptive survey. Wieck et al. (2010) distributed 5,553 surveys, with 1,773 returned (a 31.9% return rate). The authors used the Nurse Work Index-Revised, a Likert-type survey, to measure nurses' satisfaction. Cronbach's α from previous use equaled .96; for this study, it equaled .97. Cronbach's α of subscale inquiries from previous studies ranged from .84 - .91. For this study, the autonomy subscale equaled .82, control of practice equaled .82, nurse/physician equaled .83, and organizational support subscale equaled .87.

Results from the Nurse Work Index-Revised revealed an overall satisfaction with the nursing environment, with a mean (M) = 160.10 and a standard deviation (SD) = 33.4 (a perfect score equaling 228). The researchers categorized the generations into the following groups: Millennials (18 - 26 years of age), Generation X (27 - 40 years of age), and Baby boomers (> 40 years of age). The nurse/physician relationships exhibited the most satisfaction for all three generations. Millennials had the least satisfaction, with

control over practice and organizational support (M = 2.78, 2.79). Generation X nurses

had the least satisfaction with autonomy and control over practice (M = 2.74, 2.75). Baby

boomer nurses provided the answer of "most satisfied" in almost all areas, with least

satisfaction given for control over practice and satisfaction with work environment

(M = 2.81, 2.82). The baby boomer group had significantly more satisfaction than the

Generation X group (f = 6.067, degrees of freedom = 2, p = .002). A difference in

satisfaction existed between baby boomers and millennials, but it was not a statistically

significant difference (Wieck et al., 2010).

Wieck et al. (2010) noted that data regarding future retention of nurses continued

to give reason for concern. One-third of the millennial nurses planned to leave their job

within the next two years, and two-thirds planned to leave within the next five years.

Large numbers of Generation X nurses planned to leave as well, with 40% planning to

exit nursing within five years. Despite the high levels of satisfaction, 61% of the entire

RN sample planned to leave their current job within 10 years.

Tulgan (as cited by Wieck et al., 2010) proposed the idea that the younger

workforce wants their nurse manager to lead them, not manage them. New nurse

managers need mentoring from more experienced nurse managers to assist the novice

manager with transforming management skills into leadership skills. The new nurse

manager needs support and motivation to communicate effectively with each generation

in order to meet their differing needs and demands.

A recommendation specific to management was early manager development.

"Hospitals must develop a system for identifying potential managers and put them into

manager training and development early in their [work] tenure" (p. 15). This strategy

allows younger nurses to feel valued, as well as provides a pool of nurses ready and willing to fill the gap once the older generation of nurses seeks retirement. Another recommendation by Wieck et al. (2010) was to conduct manager training on generational awareness, conflict resolution, time management, and customer service. The focus of manager training should shift from developing nurse managers to developing nurse leaders.

Wong and Cummings (2007) described findings of a systematic review of studies that examined the relationship between nursing leadership and patient outcomes. National Canadian nursing associations, such as the Registered Nurses Association of Ontario and the Canadian Nursing Advisory Committee, have warned of a developing shortage of nurse leaders and the reasons behind it. Wong and Cummings noted that the U.S.'s Institutes of Medicine (IOM) published two reports (2000, 2004) recommending changes in the nursing work environments as an approach to increase patient safety. The latter IOM report (2004) specifically targeted "strong nursing leadership" as a necessary strategy to create safe environments for patients to improve patient outcomes.

Five inclusion criteria were used by Wong and Cummings (2007) for reviewing studies for this systematic analysis:

1. Leadership, including styles, behaviors, or practices, must have been measured. Methods of evaluating leadership styles included a self-report, direct observation of leader behaviors, or assessment of leadership by followers.

2. The nurse leader must have held a formal leadership role (first line manager, middle manager, or senior/executive manager).

3. The study had to address the impact of leadership on patient outcomes, to include patient outcomes, patient satisfaction, and incidence of adverse events.

4. Only research studies (qualitative or quantitative) were included.

5. The report must have stated a relationship between leadership and patient outcomes.

Wong and Cummings (2007) wrote, "The first author reviewed 1,214 titles and abstracts using the five inclusion criteria" (p. 511). They chose 99 articles (8%) that included both nursing leadership and outcomes. The first author had a third person evaluate a random sample of 250 abstracts and titles; 100% agreement occurred, thus establishing inter-rater reliability. Of the 99 articles chosen, a final selection of seven eligible studies resulted. Each article underwent review and scrutiny by each author. The researchers used a rating tool to assess the strength of the study, categorizing it as strong, moderate, or weak. For this review, all studies qualified as strong and remained as a part of the systematic review.

The authors reported that the studies were strengthened because all but one included utilization of a theoretical or conceptual framework, and acceptable sample sizes were utilized. Also, studies with measures for leadership and patient satisfaction used instruments with established reliability and validity. Four used advanced multivariate statistical procedures, hierarchical linear modeling, or structural equation modeling. Weaknesses of the seven were "related to design, measurement and analysis. All studies utilized non-experimental, cross-sectional, or descriptive designs that limit interpretations of causality" (Wong & Cummings, 2007, p. 54). Only two studies utilized random

sampling and more than half did not report a response rate or reported a low response rate (less than 60%).

Results of Wong and Cumming's (2007) systematic review revealed four of the seven studies included in the systematic review used two specific leadership models or theories: Bass and Avolio's (1995) transformational leadership, and Kouzes and Posner's (1995) leadership practices model. McNeese-Smith (1999); Anderson, Issel, and McDaniel (2003); and Pollack and Koch (2003) (as cited in Wong & Cummings, 2007) found that positive leadership behaviors were associated with more effective teamwork, which led to more positive outcomes. Houser (as cited in Wong & Cummings, 2007) "explained that empowering leadership may relate to patient outcomes by promoting greater nursing expertise through increased staff stability and reduced turnover" (p. 517). Another powerful finding from Wong and Cummings' review indicted a strong relationship between leadership and reduced adverse patient events and patient complications. Anderson et al. (as cited in Wong & Cummings, 2007) reported a significant relationship between positive leadership practices and a reduction in adverse patient events in nursing home residents. Houser reported an indirect relationship existed between leadership and a reduction in patient falls and medication errors due to staff expertise and stability. Overall, Wong and Cummings' findings of the systematic review found positive relationships between positive leadership behaviors and improved patient outcomes, as well as patient satisfaction. Effective nursing leadership remains essential for practice environments that support nurses in preventing adverse patient outcomes.

Recommendations proposed by Wong and Cummings (2007) for future research include using longitudinal studies that examine different leadership styles and strategies on the work environment and the impact on patient outcomes. Wong and Cummings recommended the use of multi-site settings for data collection, as well as continued use of advanced multivariate statistics to strengthen findings. Last, the researchers suggested an emphasis on developing transformational nursing leadership as an important organizational strategy as a means to improve patient outcomes.

Agency for Healthcare Research and Quality (AHRQ) (2004) reviewed six studies that revealed "hospitals with lower nurse staffing levels, nurses who spent less time with patients, or fewer registered nurses tend to have higher rates of poor patient outcomes including pneumonia, shock, cardiac arrest and urinary tract infections" (para. 1). As the nurse to patient ratio worsened, pneumonia levels increased, and vice versa. The higher the education level of the nursing staff, the better the mortality rates for the patients.

Another finding of interest from AHRQ's (2004) review indicated an increase in nurse staffing levels did not significantly decrease a hospital's profits, in contrast to increases in non-nurse staffing. AHRQ suggests that the costs associated with adverse events equal considerable amounts, and hospitals could altogether avoid these adverse events and the associated costs via appropriate staffing.

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) addressed hospital nurse staffing and its effects on patient mortality, nurse burnout, and job dissatisfaction. The authors noted that appropriate staffing with minimum patient-to-nurse ratios requires that management have a thorough understanding of how nurse staffing affects patient outcomes and nurse retention. According to Aiken et al., "job dissatisfaction among

hospital nurses is four times greater than the average for all U.S. workers, and one in five hospital nurses report that they intend to leave their hospital jobs within a year" (p. 1,987). The purpose of Aiken et al.'s study was to determine the association between the patient-to-nurse ratio and patient mortality, failure-to-rescue, and factors related to nurse retention.

Findings from 168 non-federal acute care hospitals in Pennsylvania were reported by Aiken et al. (2002). The researchers used a cross-sectional analysis of linked data from 10,184 staff nurses surveyed and 232,342 patients discharged from hospitals from April 1, 1998, to November 30, 1999. Measured outcomes included risk-adjusted data to assess mortality risks, nurse reported job dissatisfaction, and burnout.

The researchers obtained and used discharged patient abstracts from the Pennsylvania Health Care Cost Containment Council ranging in dates from 1998 to 1999. Aiken et al. (2002) examined outcomes from 232,342 patients between the ages of 20 - 85 who underwent general, vascular, or orthopedic procedures in the 168 selected hospitals from the dates of April 1, 1998, to November 30, 1999.

Aiken et al. (2002) mailed surveys to a 50% random sample of registered nurses on the Pennsylvania Board of Nursing rolls with a response rate of 52%. The researchers used approximately one-third of the respondents, to include the 10,184 nurses who were part of this study. Inclusion into the study required that the nurse must hold a staff nurse position involving direct patient care, and the nurse must work at a hospital that had at least ten other nurses responding to the questionnaire. Two nurse job outcomes were examined in relation to staffing: job satisfaction (rated on a 4-point scale) and burnout (measured with the Emotional Exhaustion scale of the Maslach Burnout Inventory).

Analysis of data was conducted via logistical regression models to estimate the effects of staffing on nurse outcomes and patient outcomes. "The final adjusted [odds ratios] (ORs) indicated that an increase of one patient per nurse to a hospital's staffing level increased burnout and job dissatisfaction" (Aiken et al., 2002, p. 1990) by factors of 23% and 15% respectively. Nurses who work in environments with 8:1 patient ratios are 2.29 times as likely as nurses who work in a 4:1 ratio setting to suffer from high burnout, and 1.75 times as likely to suffer from job dissatisfaction. The data also indicated that 43% of nurses who suffered from high burnout and job dissatisfaction intended to leave their current positions within the next 12 months, while only 11% of nurses who are not experiencing burn out and have job satisfaction intend to leave. Additionally, after adjusting for patient and hospital characteristics, "each additional patient per nurse was associated with a 7% increase in likelihood of dying within 30 days of admission" (p. 1991).

Aiken et al. (2002) concluded by suggesting that nurse staffing legislation represents a credible approach to reducing patient mortality and increasing nurse retention as a way to address the problems with nursing job satisfaction and shortages. By reducing nurse-to-patient ratios to 4:1, a decline in nursing turnover could result. Last, Aiken et al. noted that burnout and dissatisfaction predict nurses' intentions to leave their current job within a year.

Mentoring of nursing students. Allan, Smith, and Lorentzon (2008) performed a literature study of new leadership roles on student nurse learning specific to the British setting. According to the authors, "A literature study is wider than a literature review and allowed us to critically analyse and evaluate the literature and other sources of

information on a topic, including stakeholder interviews..." (p. 546). The authors identified stakeholders as nursing faculty, nurse education managers, heads of nursing schools, a deputy director of nursing education, and a participant in a national leadership program. The authors constructed the paper into two sections: literature discussing the structural and policy changes which affected the nature of leadership, and analysis of ten qualitative interviews of stakeholders in higher education that focused on learning in professional nursing practice.

Allan et al.'s (2008) study was designed to in two stages: the literature study and empirical data collection. The focus of the literature and policy was the United Kingdom. Three questions were utilized in reviewing the literature:

1. What is the main focus of the paper?

2. What are the paper's main findings?

3. What learning implications for leadership are included in the paper?

Thematic analysis of the literature review revealed four themes: (a) changes in clinical leadership, (b) evaluation of the move to higher education in the 1990s, (c) the nature of professional learning in nursing, and (d) student nurses' learning experiences.

Role modeling was explained by Allen et al. (2008) as a relationship that occurs between the less experienced nurse and the more experienced nurse, and it allows students to work alongside practicing nurses. "Mentors remain the key leaders for learning in current nursing curricula" (p. 552). Regular student-mentor contact and effective sponsorship by the mentor allow the learner access to cultural knowledge and practices. The type of mentoring, as well as the frequency, plays an important role for the learner, as the mentor-mentee relationship has more value to the learner than would

an advisor or counselor relationship. Learning in clinical placement occurs among mentors and clinical practice facilitators rather than through nursing leadership. Allen et al. reported clinical placements have limited the opportunities for trained nurses to serve as role models in nursing care for student nurses.

Allen et al.'s (2008) conclusion of the literature study revealed that learning in clinical practice continues to be affected by several factors. Nursing leadership (managers and educators) have three questions that remain unresolved. First, the question of "What is nursing?" remains difficult to answer, and the literature study did not support a conclusive answer. Second and third questions are "What should nurses learn and from whom?" The interviews indicated concern because the students learned more from healthcare assistants than from nurses and/or nurse managers. Stakeholder interviews revealed their opinion that student nurses should learn basic nurse functions and patient care from trained nurses and faculty to enable them to possess skills for future supervision. Implications for nursing leadership include the issues of workforce planning and role modeling within our profession.

Thompson, Wieck, and Warner (2003) compared the traits that nursing students desired in a manager versus the traits that experienced perioperative nurses desired in a manager. Perioperative nursing suffers from a shortage because of the difficulty in recruiting sufficient numbers of new nurses. The researchers credited the shortage to three factors: too few nursing graduates educated in the perioperative specialty, a diminished number of nurses completing nursing programs, and cultural influences of the emerging workforce. They noted that the natural manager development model includes

promoting successful employees into management positions. Thompson et al. used three

questions to guide this study:

1. What are the top 10 desired traits in a manager as expressed by nursing

   students?

2. What are the top 10 desired traits in a manager as expressed by perioperative

   nurses?

3. Is there a relationship between career status and ranking of traits?

The authors stated, "Managers play a significant role in employee retention, therefore,

this study explored what nurses, current and future, want in a manger" (p. 247).

Descriptive and comparative methods were used to determine participants'

perceptions of the top 10 characteristics desired in a manager. The average age of

perioperative nurses ($n = 35$) was 46.4 (SD = 7.2), and the student group ($n = 57$) had an

average age of 25.2 (SD = 4.1). The survey contained a list of 56 desirable leadership

characteristics. The operational definition of a desirable characteristic used for this study

included a descriptor viewed as positive and conducive to making a person desire to work

for someone who possesses the characteristic. The list of characteristics used for this

study came from a modified Delphi study, as well as from a literature review performed

by this study's authors. The list of traits received validation from a national sample of

nurse administrators and leaders ($n = 42$) and were grouped into four subscales: attitudes,

intrinsic qualities, acquired skills, and personal. Thompson et al. (2003) tested the survey

on five different groups of students. Differences among the groups were examined using

a Kruskall-Wallis test, which revealed no difference in 53 of the 56 traits. The three

remaining traits showed some difference (nonjudgmental, empowering, and advocate) but

were not ranked in the top 10 of any group. The similarity in findings among the five groups lend confidence in the reliability of the instrument measures. The authors emphasized that "there is no way to categorically determine that the instrument measures reliability within an age cohort; therefore, readers are cautioned about making an assumption of reliability for this instrument" (p. 253).

Thompson et al. (2003) provided surveys to a convenience sample of perioperative nurses ($n = 50$) attending an Association of Perioperative Registered Nurses (AORN) meeting ($n=50$), and a convenience sample of bachelor nursing students ($n = 33$) and associate's degree students ($n = 24$). The return rate for the perioperative nurses was 70% ($n = 35$) as opposed to 100% for students ($n = 57$).

Data analysis occurred via SPSS. Thompson et al. (2003) also used a Spearman rank correlation to determine whether a relationship existed between rank and the group to which respondents belonged. A 70% congruency rate existed between the two groups when comparing the top 10 traits. The perioperative nurse group listed supportive, fair and integrity as their first, second, and seventh desired traits, whereas, the students did not include these traits on their top 10 list. Conversely, the students listed professional, respect of subordinates, and positive attitude as their second, third, and fourth desired traits and perioperative nurses did not include these traits on their list. A Spearman rank correlation revealed a significant relationship between rank and the group to which respondents belonged. This correlation indicated that the students ranked the same seven traits much differently than did the perioperative nurses; e.g., students ranked "team player" first on their list, and nurses ranked it as ninth. Last, the researchers noted that

the emerging workforce desires a work environment that provides support, positive feedback, team players, acceptance, and personal attention.

Thompson et al. (2003) concluded that perioperative managers must use coaching strategies that promote open and approachable management styles into management and leadership training. The authors also recommended that perioperative nurse managers place priority on the practice environment, to include a culture of retaining young nurses who want to work as part of a team and "want to be led, not managed" (p. 258).

The research of Myall, Levett-Jones, and Lathlean (2008) explored the role of the mentor in nursing practice in the United Kingdom. Specifically, the authors wished to examine the perceptions of nursing students and mentors. The design of the study involved administering a survey to academicians, practice mentors, and prequalifying students. The sample consisted of recruitment of participants via the main higher education institute providing the nursing and midwifery education within the Strategic Health Authority in England. Students received invitations to participate in the questionnaire via internet. The representative sample of students came from five different university sites, with enrollment at different stages in their education programs.

A total of 161 questionnaires were received (10% return rate). Screening of questionnaires was conducted to ensure the existence of a representative sample. A random stratified sample of practice mentors resulted with a return of 156 questionnaires, with a return rate of 21%. Data on students was collected via a 27-item questionnaire made available via the university's website. Open- and closed-ended questions captured data related to recruitment, placement experience, mentoring, and student participation in university life. For mentors, a 31-item questionnaire contained quantitative and

qualitative data to elicit the mentor's view on their role, relationship with students and support received for their role as a mentor. Myall et al. (2008) did not provide information related to the inter-rater reliability of the instruments used for neither the student nor the mentor questionnaires. The authors used SPSS to analyze quantitative data from both questionnaires to descriptive statistics. Analysis of the open-ended questions occurred by coding and categorizing to identify the main themes.

The researchers found that the students' experiences indicated they felt the allocation of a designated mentor was "important," as well as the quality of the relationship between mentor and mentee. Most students reported positive experiences with their mentor and considered their mentor to have knowledge and skill in their area of practice. Terms that the students used to describe a "good" mentor included "supportive," "helpful," "knowledgeable," "experienced," "enthusiastic," and "committed." Last, the amount of time that students spent with their mentor influenced their experience, with regular meetings helping to strengthen the relationship. Students viewed their mentor as a source of support, and 76% reported the level of support they received from their mentor met their needs. Students also considered their mentor as important in helping them feel connected to their new role, along with the mentor's ability to maximize opportunities for the student to learn (Myall et al., 2008).

In the Myall et al. (2008) study, 50% of the mentors had five years or more of experience as a mentor, and they understood the purpose of their role and the importance of supporting students. Seventy-seven percent of mentors reported ensuring that students received an orientation to their new clinical site. Mentors acknowledged an awareness of the significance of their role in assisting students with linking theory to practice. Sharing

knowledge among mentors ensured their own practice stayed evidence-based. Mentors also reported their role was rewarding, increased job satisfaction, and contributed to the future of the nursing profession.

Conclusions of Myall et al.'s (2008) research confirmed that mentoring remains an integral part of the students' experiences and aides them in a sense of "connectedness" to their learning. The nature and quality of the relationship between mentors and students remains an essential aspect to the mentoring process. The authors recommend creating national standards for mentorship to assist in clarifying roles and responsibilities of the mentor. A system of mentorship, once in place, will aide in narrowing the gap between theory and practice.

Summary of common themes in section one (mentorship in nursing). The first section of the literature review encompassed a vast array of literature regarding mentoring in nursing, to include policy and its effect on leadership and mentoring; nurse-to-nurse mentoring; job satisfaction, retention of nurses and patient outcomes; and the mentoring of nursing students. Each subsection reiterated the importance of mentoring and its role in the field of nursing.

Several important findings come from this first subsection. First, the research studies reviewed in this subsection indicated the need for mentoring of nurses on all levels. Nursing students (Myall et al., 2008); new staff nurses (Currie et al., 2007; Ryan et al., 2010); and nurse managers (Shirey, 2004) all need mentoring in order to increase levels of confidence and job satisfaction. Second, several studies stress the importance of linking mentoring to RN job satisfaction, RN retention, and patient outcomes (Bae et al., 2010; Aiken et al., 2002; Kovner et al., 2006). Hospitals benefit from nurses who mentor

one another because of the improved patient outcomes and patient satisfaction (Wong &

Cummings, 2007; Bae et al., 2010; Aiken et al., 2002; AHRQ, 2004; Block et al., 2005).

Additionally, hospitals and the nursing profession benefit from mentoring of nursing

students (Myall et al., 2008; Thompson et al., 2003; Allen et al., 2008; Anthony et al.,

2005). Last, informal mentoring occurs on a daily basis and provides many benefits to

nurses (Ryan et al., 2010).

The second section of the literature review focuses on nurse managers. The

previous subsection outlined the importance of mentoring among nurses (Currie et al.,

2007; Ryan et al., 2010) and how the nurse manager plays a key role in nurse satisfaction,

nurse retention and patient outcomes (Shirey, 2004; Bae et al., 2010; Wong &

Cummings, 2007). The following section of the literature review is divided into three

subsections designed to describe roles and characteristics of the nurse manager; training,

retention, and satisfaction of nurse managers; and mentoring of nurse managers.

Nurse Managers

Roles and characteristics of nurse managers. Persson and Thylefors (1999)

described the role of ward managers at mid-size hospitals in Sweden. As in many other

countries, Sweden has suffered difficulties in its healthcare system due to financial

strains. As reported by the authors, "The fundamental principle of the Swedish health

care system is that the public sector is responsible for providing and financing health

services for the entire nation" (p. 65). The number of physicians and nurses has declined

due to financial constraints. Other complicating factors include an aging population and

a reduction in the resources allocated to the health care system. These changes have led

to the creation of a more efficient system, resulting in the ward manager assuming a

broader scope of responsibilities. The Swedish government has allocated resources to develop more efficient leadership at Swedish hospitals, to include recruitment and training for managers. The research for this study had two purposes: (a) to describe and analyze the expanded managerial role of ward managers in the Swedish medical environments with respect to motivators, content, skills, and competence, as well as problems and challenges; and (b) to consider the managerial and organizational implications of current experience for the next generation of ward managers.

This study took place at a teaching hospital with approximately 2,500 employees. Persson and Thylefors' (1999) collected data from 33 ward managers. Descriptive statistics for the respondents revealed the ward managers had worked at their present job for almost nine years and had been managers for 11 years. The average age was 49, and they managed an average of 31 persons. All ward managers were female, and the combined years of managerial experience equaled 363 years. Data collection occurred via interview, Personal Competencies Questionnaire, and the Leadership Dimensions Questionnaire. The interview tool contained 28 questions specific to managerial work (e.g., role content, managerial competencies, challenges, motivators, etc.). Interviews took place in a face-to-face setting. The Personal Competencies Questionnaire assesses ability and consistency in 18 core management areas, e.g., analyzing events, directing others, self-assessment and self-development, etc. The Leadership Dimensions Questionnaire consists of 36 stems similar to the Ohio questionnaires, with an intent to measure leadership styles across three dimensions: consideration, structure and change. The questionnaires were self-reported by the nurse managers, rather than their subordinates.

Persson and Thylefors' (1999) data analysis resulted in six headings: motivators for leadership; the role of the ward managers; demands, assets, and shortcomings; challenges and problems; the manager's future; and future managers. The authors assessed motivators for leadership by asking the question "What attracted you to your current position?" Most ward managers revealed they had taken their position at the request of a chief executive, but they also stated they would not have taken the position without other motivating factors. The most frequent statement revolved around "an interest in personal growth." The second most common statement was "an interest in leadership."

Ward managers from the Persson and Thylefors (1999) study described their role by percentage of time spent on managerial duties: planning (13.5%), supervision (15%), consideration (21%), administration (20.7%), organizational development (14.9%), patient and research (10.1%), and other functions (5%). Assessment of demands, assets and shortcomings resulted by asking the question, "What skills and competencies are demanded in your managerial role?" The most common response fell under the category of "consideration or people orientation," e.g., a willingness to listen to others. Many ward managers stressed the ability to handle difficult situations such as conflicts. Challenges and problems included the ward manager's concern for survival of their unit. Improving the psychosocial working environment, e.g., developing coworkers' professional competence, also was a category under challenges and problems. Other challenges expressed by seven ward managers included a poor relationship with their clinical directors. This sentiment was supported by statements such as, "a feeling of loneliness" and "insufficient administrative education." Of importance, 21 ward

managers reported their ability to handle the conflict of combining roles of nurse and manager by identifying themselves as managers, not nurses.

Persson and Thylefors (1999) noted that the issue of manager's future revealed that 15 planned to stay in their current position and 17 intended to leave. Of the 17 planning to leave, only three indicated they would return to nursing. Many NMs stated that becoming a ward manager represented an irreversible step, e.g., either because of an increased awareness of their leadership abilities or because they felt they had lost too many technical skills while being away from direct patient care. For future managers, the advice offered most frequently by the 33 ward managers included: "A manager is lonely," "A manager needs social competence," "A manager needs administrative, economic, and leadership skills; get some management training" (p. 74). Other pieces of advice included, "you need to be an educated nurse," and "managerial work will be facilitated...by support from colleagues and mentors" (p. 74).

Implications provided by Persson and Thylefors' (1999) research revealed the need for career planning and support for nurses in management positions. The authors noted, "The support system for ward managers is particularly inadequate. Instituting mentorship programs, providing individual or group guidance, and developing...informal networks could strengthen support" (p. 78).

Shirey, McDaniel, Ebright, Fisher, and Doebbeling (2010) used a qualitative method to describe stress and coping as perceived by today's nurse managers. The authors explained that NMs play a crucial role in establishing the work environment, and their actions serve as precursors for establishing healthy workplaces. Minimizing nurse

manager stress and enhancing NM coping behaviors are strategies consistent with engaging and retaining both NMs and staff nurses in the profession.

The sample for this study included 21 nurse managers employed at three U.S. acute care hospitals. Shirey et al. (2010) noted that using three different facilities increased the sample size and allowed for observations in different organizational environments. The study participants included all women, 95% white, and their work experience ranged from 12 - 35 years. Three of the nurse managers had three years of experience or less (novice), and 18 had more than three years of experience. Ninety-one percent worked eight to 10-hour days, and 48% reported working an additional 5 - 9 hours per week at home. Sixty-six percent of the NMs had responsibility for up to 110 employees. Eighteen (86.7%) NMs held a minimum of a baccalaureate degree in nursing, and four held a master's degree. Shirey et. al (2010) used the term nurse manager as one who holds the title of nurse manager for at least one year and has 24-hour accountability for at least one patient care unit.

Participants of the Shirey et al. (2010) study completed a demographic questionnaire and a 14-question face-to-face interview that incorporated components of the Critical Decision Method (CDM). The CDM uses random incidents to understand how workers make judgments and decisions in the work setting. This methodology helped the researchers to increase their understanding of complex work environments and illuminated practice differences between the expert and novice nurses. All interviews lasted 1.5 - 2 hours. Themes emerged from factors identified by NMs when recalling details experienced with stressful situations. The recalled event occurred within the week

prior to the interview, but analysis also included details occurring before and after the situation that may have influenced decision making.

Results from Shirey et al's (2010) analysis included three main themes: (a) sources of stress, (b) coping strategies, and (c) health-related outcomes. Subthemes of sources of stress included situations in general that are sources of stress (people and resources); factors that increase stress (specific responsibilities related to the role and peripheral issues that arise in the role); factors that decrease stress (focusing on the positives, having support, completing work/achieving targets, and quality downtime); and emotions associated with stress (pure positive, pure negative, and mixed emotions). Subthemes of coping strategies included using a combination of strategies (using emotion-focused versus problem-focused coping); experience and differences in coping strategies (responses varied based on the NM's experience and whether employed in a co-manager model); and co-manager model and differences in coping (co-managers used cognitive reframing to put issues in perspective). Co-managers reported more support in their roles and felt empowerment from their CNO and from each other. Health-related outcomes subthemes included psychological outcomes (67% of the sample reported adverse psychological outcomes such as feelings of overwhelmed, heightened sense of awareness); physiological outcomes (86% reported some sort of adverse physiological stress such as physical exhaustion, high blood pressure, or difficulty with sleep); and functional ability (attentiveness, productivity, procrastination).

Shirey et al. (2010) concluded with the idea that the NMs' reference to the overwhelming nature of their work suggested that the role is misunderstood and unrealistically configured. With the span of control and complexities of day-to-day work,

the authors pose the question regarding whether it is reasonable to expect the NM

position to use only one FTE (full-time employee). The authors also noted that the

novice managers in this study were at risk for turnover because of their need for better

support, mentorship, and recognition.

Surakka (2008) reported that leadership in health care and associated problems

have similarities throughout the world, and problems in nursing administration have

similar issues regardless of locale. Surakka described Finnish health care in the

following manner: the number of elderly people in the population continues to rise while

the healthcare work force is decreasing and demanding better working conditions and

higher salaries. The background for this study included pressures for cost efficiency to

become a reality in health care. Surakka's study described and compared the

characteristics of the NM's work in different hospital environments and at different

times.

Surakka (2008) wrote, "The nurse manager's work has been studied from a

number of perspectives, including staff, the organization and co-workers...Nevertheless,

it is still not clear what the nurse manager's everyday workplace activities are, and the

topic is largely understudied" (p. 526). Data collection occurred by reviewing 155 diaries

of nurse managers to help Surakka gain a better understanding of the NM's everyday

activities. The NM kept the diary for one week and recorded the content of the work.

The NM also included routine activities that may not have occurred during the one week

of diary recording. They were asked to review their diaries and reflect upon whether they

were doing the right things in their role as NM. Another source of data collection

occurred via focus group interviews. Eight groups of NMs, a total of 47, participated in

the interviews, which were focused on their knowledge of management and leadership issues and their opinions of professional culture. Three research questions guided the interviews:

1) What is the work of nurse managers?

    a. What is the content of nurse managers' work as described by themselves?

    b. How have the different management and leadership approaches affected the manager's work?

2) Has the work of nurse managers changed over the last 10 years?

3) How should the work of nurse managers be modeled?

Initial data analysis occurred using qualitative content analysis. Quantitative analysis subsequently occurred to further describe the nurse managers' work and the extent of different activities required of the NM role. The author used a longitudinal design for this study.

Results from Surakka's (2008) research found that the NM's work consisted of responsibility activities such as organizing, cooperating, and communicating, accounting for 53% of their time. Accountability activities included supporting staff, ensuring staff competencies, and development activities (practice improvement measures, problem solving, etc.) and accounted for 23% of their time. Bedside nursing activities included direct nursing care, indirect nursing care, nursing expertise, and handyman tasks and accounted for 14% of their time. The remainder of the NMs' time was spent with underlying premises of work (a place for others to come to complain or "dump their

emotions," and outcome-orientation (time spent reflecting on the future and future changes).

Surakka (2008) explained:

In this study, the changes in the nurse manager's work in the 2000s were mainly characterized by the fact that they spent less time in both direct and indirect nursing care. The nurse manager's role changed from nurse to nurse leader. (p. 530)

Shared governance was widely implemented in the hospitals in Surakka's (2008) research, and the nurse managers reported success in integrating the different leadership models into their daily work lives. As a result of Surakka's study, a new leadership model for nurse managers emerged. The top part of the model represents the "head and brain," e.g., knowing and understanding the work remains essential for one's nursing practice. The accountability activities represent the "heart" of the model (e.g., the emotional involvement of the nursing staff is essential in order for the NM to succeed). The leader's accountability and expertise act as the cornerstones of success as a leader. The bottom of the management model represents cooperation between NMs and their superiors. If the underlying premise of the NM's work was clear and internalized, then the NM experienced a sense of empowerment. This new model will help nurse leaders assess who should take a leadership position in health care.

Kleinman (2003) highlighted the importance of moving away from the traditional mechanism by which staff nurses were promoted to the role of NM, a promotion based on clinical expertise. This new role for the NM resulted in the manager feeling unprepared for the responsibilities of the business and administrative aspects of nursing units.

Kleinman also noted that there is no mention in the U.S. literature that addresses the role preparation of NMs for their current roles. The purpose of Kleinman's study included obtaining information from mid-level and senior executive managers regarding their perceptions of their roles and the competencies and educational foundation required to perform these roles.

A survey questionnaire designed to obtain information from mid-level and senior nurse executives (NEs) was used by Kleinman (2003). The questionnaire contained 22 items that asked for demographic information, as well as Likert-type and rank order questions regarding competencies for management roles and educational requirements. The survey, developed by the author, had content validity established by a small group of experts who provided feedback to expand the comprehensiveness of the survey. Kleinman noted that reliability for the instrument was not evaluated, and IRB approval was not required for this study; these two factors added to the limitations of the study. Kleinman used purposive sampling to target attendees of a regional American Organization of Nurse Executives conference and members of the Organization of Nurse Executives of New Jersey to receive the questionnaire. The author did not provide return rate information.

The respondents for Kleinman's (2003) study included 35 NMs and 93 NEs. Both groups were similar in age, gender, and years in current position. Eighty-four percent of the NE group held a master's degree, while 31.5% held a master's degree. Kleinman wrote, "Of the respondents in both management groups who held a graduate degree, a higher percentage possessed a master's degree in nursing...most in nursing administration" (p. 453). One respondent held a combined MSN/MBA degree; and

others held graduate degrees in public administration, health, or business. Nurse

managers and NEs were asked to indicate the relative importance of several competency

areas necessary for the roles of NM and NE. Both groups ranked staffing/scheduling,

management, and human resources (HR) as most important. Perceptions for the two

groups differed regarding competencies for the NE role. Nurse managers rated finance

and management as the most important, while NEs rated strategic planning, finance, and

HR as the most important. Kleinman wrote, "Nurse managers do not perceive or are

unaware that NEs have a strong role in strategic planning for the organization" (p. 453).

The author noted that both groups indicated that a master's degree would enhance

employability, but the NM group did not rate the importance of a graduate education as

highly as the NE group for role performance. Eleven percent of the NMs reported

graduate education as not important for NM job performance, while only 1% of the NE

group reported the same. A majority of NEs (69%) rated the graduate degree as "very

important" or "extremely important," while 51% rated it as the same importance.

Kleinman (2003) credited the differences in perceptions to the experience of NMs from

on-the-job training. A difference also existed between the two groups regarding types of

graduate degrees: 20% of the NM group perceived the MSN in nursing administration as

the preferred degree, while 34% chose the combined MSN/MBA degree as preferred.

Kleinman noted that this data is a reflection of the differences in the level of graduate

education between the two groups.

Kleinman (2003) concluded with:

It is incongruent to emphasize the importance of graduate education for all levels

of nurse managers and administrators without providing a strategic plan that

outlines how role preparation may be enhanced for emerging nurse leaders who have not yet obtained a graduate degree. (p. 454)

Kleinman (2003) also asked that NEs consider two issues regarding NM role preparation. The first was that nursing and hospital administration support NMs in their acquisition of a graduate degree. Second, she asked that hospital and nursing administration develop strategies for NMs who do not possess a graduate degree, particularly those who were promoted based on clinical expertise. Those strategies would assist with gaining business knowledge and skills required for success in the new position.

Manfredi (1996) described the leadership activities of nurse managers. Nurse managers continue to find themselves in positions that require high-quality performance with few available resources. The role has expanded from operating one unit to managing operations on several units. This change places nurse managers in a role critical to the success of organizational goal achievement. Kotter (as cited in Manfredi, 1996) explained that leadership and management are two distinctive and complementary systems, both required for success.

The author applied seven concepts of leadership gleaned from a literature review as the guide for the conceptual framework. The seven concepts include: goals, change, influence, power, growth, mentoring, and vision. This literature review will focus on the aspect of mentoring. Murray (as cited in Manfredi, 1996) explained mentoring as "an effective strategy for developing a skilled workforce" (p. 318) in a complex and cost-conscious work environment. The focus of mentoring includes role development and introduction of the employee to the organization's culture. Mentoring consists of two

aspects: relationships and directionality. The mentor acts as a role model, advisor and guide, and promotes the career of another (Manfredi, 1996).

Subjects for Manfredi's (1996) descriptive study included 42 nurse managers in acute care settings. One-hundred percent of those invited agreed to participate. An open-ended questionnaire was constructed by the author. Manfredi designed guide questions based on the seven leadership concepts listed previously and forced the interviewees to focus on leadership activities rather than management tasks. A sample of the questions was provided in the journal article. Data collection occurred via face-to-face interviews conducted by graduate students enrolled in a graduate leadership course. Graduate students received training for the interview session from the author. Mock interviews took place to orient the graduate student to the data collection process. The participants granted permission for their session to undergo tape recording.

Manfredi's (1996) data analysis included descriptive analysis of the 42 nurse managers and content analysis of the interviews. Content analysis consisted of data reduction, data display, and conclusion verification. Summary of responses for mentoring focused on availability, networking, educational counseling, and career opportunities/counseling. Examples of availability include the NM being available to staff for listening, advising, and serving as a sounding board. Networking consisted of the NM emphasizing the importance of introducing staff to other professionals, within and outside of the organization, to help staff with career progression. Educational counseling meant that the NM encouraged and enabled their staff to obtain advanced degrees. Acts of career opportunities/counseling implied that the NM placed the staff in positions to assist in their professional growth; i.e., helping nurses with career ladder

programs and working with charge nurses to improve their management skills. Many NMs commented on the importance of recognizing the potential in others.

In conclusion, Manfredi (1996) emphasized the congruence of the findings with those already existing in the literature regarding the seven leadership concepts. Manfredi wrote, "Nurse managers spend a great deal of time developing goals, and motivating staff toward goal achievement...They spend a great deal of time attempting to develop staff and identifying needs for further personal/professional growth" (p. 326). Nurse managers also indicated they viewed mentoring as an important aspect of their role. Manfredi also reported that NMs are more likely to engage in long-term mentoring with their own assistants, prepping them for future leadership roles. Leadership skills prove essential to fulfill the complex role of nurse manager.

Training, retention, and satisfaction of nurse managers. Shirey, Ebright, and McDaniel (2008) described the healthcare work environment, noting that overwork and stress are factors contributing to the nursing shortage. The authors stated, "Understanding the impact of the nurse manager role expansion is crucial for developing interventions that retain nurse managers and support them to be more effective in their roles" (p. 125). The purpose of Shirey, Ebright, and McDaniel's research was to gaining a better understanding of situations contributing to stress in nurse managers and the decision-making processes nurse managers used to address stressful situations. The authors used a qualitative descriptive design to accomplish their study.

The sample for the Shirey et al. (2008) study consisted of a convenience sample of five nurse managers working in a hospital system in the midwestern U.S. All participants were Caucasian and ranged in age from 39 - 51 years of age. The

participants' work experience ranged from 17 - 28 years in nursing and 5 - 17 years as NMs. The highest degree in nursing was a baccalaureate degree, and the NMs reported working 8 - 13 hours per day and up to an additional 12 hours per week at home. The definition of nurse manager used for this study included (a) having the job title of nurse manager, (b) having 24-hour accountability for the performance of their unit, and (c) having at least one year of experience as a nurse manager.

The researchers obtained approval from the investigational review board for their study. Participants completed a demographic questionnaire, as well as a semi-structured face-to-face interview. Shirey et al. (2008) tape recorded the interviews, and each interview lasted between 1.5 to 2 hours. The interview consisted of open-ended questions that incorporated components of the Klein Critical Decision Method. This model is a five-step method that uses a retrospective interview strategy to focus on non-routine difficult task analysis. Themes arose from factors that NMs recalled when recounting their specific difficult situations. Analysis included details leading up to and surrounding the situation to capture factors influencing decision making during each individual situation.

Results from Shirey et al.'s (2008) research included eight themes: nurse manager work, sources of stress, emotions, value conflicts and moral distress, coping strategies, perceptions of social support, relationships and communication, and health outcomes. The first theme, nature of nurse manager work, involved their basic role expectations as gatherers and disseminators or information. An advanced skill identified by the more experienced and most educated NMs was the ability to sensor the "temperature of the unit" (p. 127). This function allowed the NMs to detect problems early before becoming

larger problems. Nurse managers referred to "invisible work," which meant the NMs worked behind the scenes to gather resources and perform work that should be delegated but cannot because of lack of qualified personnel.

According to Shirey et al. (2008), the second theme, sources of stress, referred to role complexity and perceived demands of the position. All NMs identified complexity, conflict, and ambiguity as sources of stress. A large span of control (ranging from 50 to 132 full-time employees) added to the complexity of the role. All NMs reported feeling overwhelmed due to incompleted work. Despite feeling overwhelmed, all nurse managers described their work as meaningful and important. The third theme, emotions, also arose from the interviews. Emotions related to the nurse manager role were classified as positive and negative. The biggest source of the joy came from connecting with staff, mentoring, and teaching. The most reported negative feeling was anger. Sources of anger derived from unrealistic expectations and a sense of powerlessness. Spouses were considered to be biggest sources of support for three of the five nurse managers. Participants also reported often feeling worried.

The fourth theme revolved around value conflicts and moral distress. Value conflicts resulted from feeling pushed to the point of nearly crossing the line. Participants reported incidents surrounding budget and financial considerations as painful and anguishing. The fifth theme, coping strategies, is emotion focused and problem focused. Emotion focused strategies included engaging in distraction activities and seeking comfort from empathetic friends. Problem focused strategies included pursuing formal education, negotiating to work one day a week from home, etc. Social support, the sixth theme, addressed perceptions of social support. All five nurse managers cited

the importance of support in their roles. Three of the participants reported most of their support came from non-work relationships, and two reported primary support from their director. All participants felt they gave more support than they received (Shirey et al, 2008).

The seventh theme, titled relationships and communication, resulted from nurse managers viewing relationship building as crucial to their role. Nurse managers felt relationship building was very important but also viewed it as part of their "invisible work," and it was often sacrificed because of multiple commitments. They saw communication and alignment as key methods to avoid political silos in the workplace. The last theme, health outcomes, referred to psychological, physiological, and functional outcomes. Psychological stress referred to reports of a "restless mind," irritability, impatience, etc. Physiological stress referred to shortness of breath, tense muscles, and physical exhaustion. None of the nurse managers reported engaging in regular physical exercise. Functional outcomes referred to the fact that none of the nurse managers reported the other two types of stress as interfering with their ability to do their job. Shirey et al. (2008) suggested that nurse managers may not have awareness of the long-term effects of work stressors on their health.

Shirey et al. (2008) concluded that performance expectations for nurse managers in acute care settings has been unrealistic. The expectations have increased nurse managers perceptions of stress, made coping more difficult, and potentially harmed nurse managers and the well-being of the work environment. The authors close with this statement regarding nurse managers, "...It is crucial that their role be better understood, effectively supported, and more realistically configured" (p. 131).

Lee and Cummings (2008) described findings of a literature review that examined the determinants of front line nurse managers' job satisfaction. Nurse managers play a vital role in dealing with the nursing shortage and they can help lessen the loss of staff nurse. Front line managers act as "the vital link between senior management and staff nurses as providers of care. Leadership is critical to provide guidance for solving complex problems related to nursing care delivery" (p. 768-9).

Three inclusion criteria for Lee and Cummings' (2008) literature review included: a) using peer reviewed research that measured job satisfaction of front line managers. Front line managers held leadership roles responsible for managing a unit or team, and whose responsibilities included coordination of patient care, managing staff schedules, payrolls and performance reviews; b) using studies that measured job satisfaction along with any predictors of job satisfaction; c) using studies that addressed the relationship between job satisfaction, front line managers and the respective causes.

Lee and Cummings (2008) reported the first author reviewed 1,874 titles and abstracts using the aforementioned inclusion criteria. Selection of 48 abstracts and titles occurred. The second author evaluated a random sample of 200 abstracts and titles using the inclusion criteria, with an inter-rater reliability result of 100%. Of the 48 studies initially selected, exclusion of 30 studies occurred because the study did not measure job satisfaction, the role of the manager did not include a front line position, or the study's focus did not pertain to the subject matter; this left 18 studies for review. The authors used a tool used previously by Estabrooks et al. (2001, 2003), Cummings and Estabrooks (2003), and Wong and Cummings (2007) to establish strength of the study. Three categories for strength of study included strong, moderate, and weak. (The authors

included the tool in the systematic review.) Removal of four additional quantitative studies occurred because of their quality assessment rating. Finally, 14 studies remained: 12 quantitative, one mixed methods, and one qualitative.

Results included 12 predictors grouped into five categories of front line managers' job satisfaction. The five categories include: organizational change, organizational support, job characteristics, the managerial role, and educational development. For the purposes of this report, this researcher will focus on the findings of organizational support and job characteristics. Lee and Cummings (2008) cited Burns (1992) and Laschinger, Purdy, Cho, and Almost (2006), indicating, "Managers that either had or perceived they had organizational and social support from their supervisors had higher levels of job satisfaction" (p. 773). Managers who participated in organizational processes reported higher levels of job satisfaction. Laschinger, Almost, Purdy, and Kim (2004) (as cited in Lee & Cummings, 2008) found that, with respect to job characteristics, nurse managers who felt empowered (structurally and psychologically) had the resources to do their jobs and reported a higher level of job satisfaction. Organizational support for managers by their supervisors remains a crucial component of their level of satisfaction. The concept of support included allowing front line managers to feel as if their voice matters (Lee and Cummings).

The authors noted that nursing leadership development remains important to healthcare organizations because of the vital role the manager plays between senior leaders and staff nurses. Strong nurse leaders/managers play a significant role in the retention of staff nurses and promotion of quality patient care. Front line managers

ensure the effectiveness of their nursing staff, as well as create a supportive environment that influences retention (Lee and Cummings, 2008).

Four recommendations for future research were made by Lee and Cummings (2008): (a) both span of control and workload of nurse managers needs attention in order to improve job satisfaction; (b) studies should be conducted that further examine organizational support and the relationship to job satisfaction; (c) additional research should examine the factors that affect job satisfaction at various managerial levels; and (d) future research should examine the causes of front line managers' job satisfaction.

Skytt, Ljunggren, and Carlsson (2007) recognized that first-line nurse managers play a central role within healthcare organizations. The authors cited Manfredi (1996) with describing the first-line nurse manager as, "A Registered Nurse holding twenty-four-hour accountability for the management of a unit(s) or area(s) within a healthcare organization" (p. 294). The authors introduced their topic by reporting the results of various studies that revealed the intentions of first-line nurse managers to stay at their current post ranged from 45% to 75%. The objective of their study was to examine the reasons for first-line nurse manager resignations, their perceptions of difficult situations, experiences of support, and satisfaction with work.

A descriptive retrospective design was utilized for this study. Skytt et al. (2007) used a study-specific questionnaire as well as letters from nurses to gather data on those who had left their first-line nurse manager position. The study took place at two hospitals in a county in Sweden serving approximately 270,000 persons. These two hospitals had undergone restructuring from 1993 - 1998 where five hospitals were merged into two, and where decentralization had taken place that allowed managers total responsibilities

for budgeting, financing, and human resources. Hospital directors gave permission for the study to occur at their facility, and the human resources director provided a list of 45 individuals who had left their posts as first-line nurse managers between 1999 and 2000. In 2001, the participants received a letter describing the research. Thirty-two persons answered the questionnaire and wrote a letter. Skytt et al. included a copy of the questionnaire in their report, which asked five questions aimed at obtaining their reason for leaving, the number of years had they served in their position as first-line nurse manager, their level of satisfaction with their last work situation, their current work situation, and their level of satisfaction with their current work situation. The intent of the letter included eliciting information from the first-line nurse managers regarding the main reason for leaving their post, difficult situations as a manager, support given during the difficult situations and whether the support qualified as helpful.

Descriptive statistics were used to analyze data from the questionnaire. Sixty percent ($n = 19$) of managers stated "of their own accord" as the reason for leaving their first-line nurse manager post. The other 13 respondents left because of reorganization or other changes. Respondents' work experience as first-line nurse manager ranged from 1 to 22 years. Seventy-five percent of the first-line nurse managers still worked within the county hospital system; the majority worked as registered nurses. Respondents who perceived satisfaction with their current work situation had an increased level of satisfaction than when they worked as a first-line nurse manager ($p < .001$) (Skytt et al., 2007).

Skytt et al. (2007) used constant comparative analysis to establish themes and categories of the submitted letters. Three themes emerged: "have to leave or have

something to go to," "role conditions and expectations are difficult to combine," and "important support is close but sometimes difficult to get" (p. 297). "Have to leave or have something to go to" included personal motives, organizational reasons, and a poor relationship with and lack of respect from the head of the department. "Role conditions and expectations" included unclear conditions, lack of interest from superiors, and difficult staff matters. "Important support is close but difficult to get" included needs for personal, emotional and strategic support from leadership; an expressed wish for a distinct organizational course to identify shared values and understand the explicit goals of the leadership; support from specialists; and development and education to address the recurrent education and in-service training needed.

The researchers noted that the results showed that most managers resigned due to reorganizations or changes within the organization. Supervisors or upper management who did not fulfill their managerial role were viewed as difficult. Also, first-line nurse managers found it prohibitive to implement changes because they had no role in the decision-making process. First-line nurse managers reported inefficient support and feedback and lack of trust in the hospital director as reasons to leave their post. Eleven of the first-line nurse managers reported that, if the organization had not undergone restructuring, they likely would have remained in their post (Skytt et al., 2007).

Skytt et al. (2007) concluded that reorganization and other changes stood out as the main reason for first-line nurse managers leaving their posts. Their relationship with the hospital director strongly influenced the overall work situation, and ultimately affected their decision to resign.

Stengrevics, Kirby, and Ollis (1991) conducted research via survey to determine "factors contributing to nurse managers' job satisfaction" (p. 61). Stengrevics et al. noted that nurse managers positively influence job satisfaction and retention among nurses. In 1989 the Massachusetts Organization of Nurse Executives (MONE) and the Massachusetts Council of Nurse Managers (MCNM) established a joint task force on Nurse Manager Support to identify factors contributing to job satisfaction and to present recommendations. Stengrevics et al. reported the findings from the survey and the recommendations made by the joint task force.

The survey used by Stengrevics et al. (1991) consisted of 30 Likert-type questions assessing salary and benefits, sources of support, budgeting, staffing, power and control, and retention. A total of 486 questionnaires were distributed, with a return rate of 51.8% (N = 252). The authors provided no validity or reliability data. Key findings relative to "sources of support" indicated over 50% of NMs were dissatisfied with educational reimbursement; 56% reported inadequate support to meet the educational needs of their staff; over 90% felt supported by their peers; 67% felt adequately supported by their supervisor; and 58% felt supported by their hospital administration and medical staff. "Budgeting" results revealed a 52% dissatisfaction rate because of their lack of knowledge of the budget process. "Salary and benefits" results indicated that 53% reported dissatisfaction with their salary, 37% reported dissatisfaction with their benefits package, and financial incentives were desired by 74%. "Power and control" revealed that some managers were required to assume responsibility for more than one unit; 60% categorized their feelings as uncomfortable when referring to their additional duties. "Retention" referred to dissatisfaction with salary and the intent of the nurse manager to

leave the position; 67% experienced negative stress with their work, and 25% planned to resign as a result of the stress.

Recommendations from the joint task force which included 16 suggestions. Several of the recommendations are listed below (Stengrevics et al., 1991):

Recommendations for role support included:

1. MONE should develop standards for defining the role, responsibilities and educational requirements.

2. Nurse managers should be provided with the necessary resources.

3. Healthcare organizations (HCOs) should acknowledge the significance of the management role and differentiate the nurse manager from other nursing positions.

Recommendations for compensation:

4. HCOs should develop compensation programs for nurse managers and incentives for reward performance.

Recommendations for communication:

5. Nursing executives within institutions should organize nurse manager forums for information sharing, team building, and problem solving.

6. Nursing executives should encourage nurse manager involvement in professional organizations such as MCNM.

Recommendations for education:

7. Individual nurse managers should assume responsibility for their own education and professional development.

8. MONE and MCNM should develop a proposed core curriculum for nurse manager orientation.

Stengrevics et al. (1991) closed their report by adding that nurse managers are the core of the nursing department. They will select and motivate future nurse managers, so ensuring the satisfaction of today's nurse managers will positively affect the healthcare system.

Parsons and Stonestreet (2003) described factors contributing to a health system's successful retention of nurse managers. In the background section of the report, Parsons and Stonestreet describe first-line managers as, "The glue that holds the hospital together" (p. 120). The authors go on to explain, "Report after report identifies the importance of the nurse manager in retaining nursing staff" (p. 120). Parsons and Stonestreet cited a report by the American Organization of Nurse Executives (AONE) that revealed vacancy rates for nurse managers as highest in the West (8.5%) and South (8.2%). Silvetti, Rudan, Frederickson, and Sullivan (2000) (as cited in Parsons & Stonestreet) expressed "concern with the development of nurse managers and the decreasing numbers of qualified managers to handle the expanded and multifaceted responsibilities" (p. 121).

Parsons and Stonestreet (2003) used a Health Promoting Organizations Model. This model incorporates the definition of "a community that designs activities and programs, to improve social and environmental living conditions that enable people to increase control over and improve their health" (p. 121). The authors used a qualitative design with open-ended questions. Participants had held their nurse manager position for at least 2 years, employed in one of the health system's five hospitals with a 1,562

hospital-bed capacity within a large metropolitan city in the Southwest. Interviews were

taped, each lasting approximately 45 minutes. The researchers used descriptive statistics

to examine the participant sample, and narrative analysis identified themes. A list of

major themes became evident after listening to each interview twice, followed by

transcription. Trustworthiness and credibility were added to the data through several

methods. First, a computer software package performed an audit trail. Peer review of the

data collection and the audit by an experienced qualitative nurse researcher gave

dependability to the results. Last, nurse managers reviewed the findings to validate them.

The sample for Parsons and Stonestreet's (2003) study consisted of 28 nurse

mangers. The mean age of the managers equaled 46 years. Work experience as a nurse

equaled 22 years, 13 of those years in nursing management (7.8 years working in their

current position). Ninety-three percent of participants were Caucasian and 10.7% were

male. The dominant themes included communication, administrative management

philosophy, effective administrative systems, successful personal practices (work/life

balance), quality of care, and retention. Subthemes of communication included

availability of the boss to listen and provide guidance, effective communication, and clear

expectations and feedback. One example given stated, "Right now, the support that I get

from the administrator is very important…any time I have a problem, she makes herself

available to me" (p. 122). Subthemes of administrative management philosophy included

participation in planning and decision making, and empowerment to change. An example

provided states, "The nurse administrator, she is the reason that many of us are here,

because she and the VP are here" (p. 123). Subthemes of effective administrative

systems included resource management systems and meaningful orientation and

professional development systems. One participant noted, "We need ways to help us grow and develop our skills differently" (p. 123).

Shared implications for executive level management pointed to the nurse managers' attitudes of "We are in it with you! We want to be on the team together" (p. 124), reflecting the dominant themes of retention: communication, listening, feedback, and shared decision making. Littell (as cited in Parsons & Stonestreet, 2003) reported that organizational climate remains the most important predictor of job satisfaction in mid-level nurse managers. Parsons and Stonestreet suggested executive strategies to retain nurse managers based on the themes found in the research. The suggestions include:

- Relationship building with nurse managers (includes listening and providing guidance)

- Administrative management philosophy (includes involving nurse managers in planning and decision making, empowering)

- Effective administrative systems (includes developing orientation and professional development systems, to include leadership skills)

- Support work/life balance for nurse managers

- Recognize quality of care in the nursing units

- Recognizing and rewarding nurse manager retention.

Balasco-Cathcart, Greenspan, and Quin (2010) articulated the experientially acquired knowledge, skills, and ethics embedded in the nurse manager practice and described how these developed:

Expert nurse managers in their best practice are able to engage in demanding relational work, to see what is at stake in particular open-ended situations and to intervene in ways that assure good outcomes while supporting the ongoing development of nursing staff. (p. 441)

Little information exists of how NMs actually learn to develop this skilled practical knowledge or how senior nurse leaders can support their NMs. Balasco-Cathcart et al. (2010) designed and carried out a narrative project at Brigham and Women's Hospital in Boston to describe the experientially-based knowledge embedded in NM practice.

Balasco-Cathcart et al. (2010) noted that literature exists on competencies nurse managers need to possess. The competencies provide a framework for measuring performance outcomes and serve as an accountability measure to satisfy accreditation and regulatory requirements. In addition, the role competencies serve as the basis for orientation and academic programs to ensure that nurse managers can demonstrate the knowledge and skill of each competency. The authors suggested that the list is not enough to make a good nurse manager because the list of competencies does not describe how or when a nurse manager would accomplish what needs to be done. In addition to competencies, the nurse manager must have the ability to effectively respond for each situation. Nurse managers work through others and, therefore, must accurately assess a situation to determine the correct interventions. They have an awesome amount of responsibility to sustain quality, safety, innovation, efficiency, and financial performance at each level.

The authors used Patricia Benner's method of practice articulation, whereby the nurse manager participants wrote their personal experience narratives of their own practice. Balasco-Cathcart et al. (2010) wanted the nurse managers to experience firsthand the use of narrative as a tool for reflective practice. Participants individually read aloud the narrative account of his or her management practice for interpretation by their peer group. The peer group established public language to each nurse manager's experience, followed by a conversation discussing the practical knowledge, human relations, and ethical behaviors embedded in the narrative. The peer group helped the nurse manager/author to reflect and focus on their own work by providing insight and validation.

Experiential learning in nurse manager practice development was described as "A practice is much more than the application of theory to a particular situation: it requires seeing in the actual situation what needs to be done to bring about the best outcome" (Balasco-Cathcart et al., 2010, p. 442). The authors noted that teaching a NM how to work effectively involves more than overlaying business, management, and leadership skills onto nursing practice. The authors quote Florence Nightingale (1860), "It is as impossible in a book to teach a person in charge of the sick how to manage, as it is to teach her how to nurse. Circumstances must vary with each different case" (p. 442). Nightingale's emphasis was on understanding the importance of context. Benner, Tanner and Chelsa (2009) (as cited in Balasco-Cathcart, 2010) explained experiential learning as learning which requires attentiveness, "a recognition that the practice itself is a continuous source of knowledge development and skill acquisition" (p. 442), and self-reflection is a planned activity.

The sample for this study consisted of five groups of nurse managers who attended eight weekly seminars lasting two hours each. A total of 32 nurse managers participated and each participant wrote and read a narrative exemplar to their group. The narrative piece reflected an example of best practice or a story of practice breakdown in which critical learning occurred. The experience level ranged from new NMs to those with more than 10 years. Each seminar was facilitated by a consultant and a program coordinator, a seasoned nurse executive, and a nurse manager who have experience with narrative interpretation.

Balasco-Cathcart et al. (2010) chose one paradigm case from one nurse manager for the example of this paper. Results from this case revealed that complex leadership challenges serve as a source of significant experiential learning for the person and the group. Writing and reading the narrative helped to transform understanding and management of practice. Nurse managers required ongoing support and development by senior leadership to sustain the complexities of practice development. The narratives reinforced the fact that management development remains a long-term process based on continuous experiences, as well as intellectual and emotional exercises. Experiential learning will help nurse managers create learning environments on their own units.

Mackoff and Triolo (2008) introduced the topic of nurse managers and ways to retain them by writing, "The short tenure of nurse managers suggests the urgent need for a new model to understand and build engagement that translates into longevity and excellence in nurse managers" (p. 118). The authors presented data from a national qualitative study funded by the Robert Wood Johnson Foundation and reported their findings in two parts. Part one, as presented in this article, described aspects of

professional engagement as well as implications for developing and retaining nurse managers. A separate article addressed part two. The authors expressed concern regarding the nursing shortage by describing the relationship between two well-established research trends: the forecasted nursing shortage coupled with the strong correlation between nurse retention and the relationship of staff nurses with their nurse manager. Mackoff and Triolo sought to discover the reasons that nurse managers leave and how to retain them as employees. The primary purpose of their research was to identify the dimensions of individual engagement, as well as the implications for developing and sustaining nurse managers.

Data was obtained from in-depth face-to-face interviews with a convenience sample of 30 long-term and high-performing NMs in six hospital settings. Mackoff and Triolo (2008) gained approval from the Institutional Review Board. Selection of participants was initiated from nominations by their chief nursing officer. Criteria for selection included having five or more years of experience as NM and designation of "outstanding" in the position. Participants received questions prior to their 90-minute interview. Mackoff and Triolo used the Nurse Manager Engagement Questionnaire (NMEQ) to "highlight experiences and enduring values in individuals and organizations linked to nurse manager engagement" (p. 119). The NMEQ also used two future-oriented questions to gather suggestions for new nurse managers as well as factors NMs believed would create a desired future for the role of nurse manager. Analysis of the taped interviews included studying the interviews for key elements of the individual and the organization. Next, themes and subthemes were noted for each individual interview, as well as across all six sites.

Mackoff and Triolo (2008) revealed ten dominant signature behaviors of engaged nurse managers:

1. Mission driven (refers to the characterization of being motivated and driven to action by a sense of meaningful mission, e.g., oriented toward a purpose)

2. Generativity (an element that went beyond descriptions of nurse mentoring. Generativity refers to the capacity to find pleasure and satisfaction in caring for and contributing to the next generation)

3. Ardor (the depth and breadth of passion expressed by the NMs. Ardor means warmth, animation, excitement)

4. Identification (responses suggested that the nurse managers achieve their work by identifying with the work of others. This aspect seems to compensate for the nurse managers loss of or lessened patient care)

5. Boundary clarity (defined as the capacity to build strong connections with others without losing a sense of self. Nurse managers reported ways that boundaries allowed them to maintain their focus while facing strong feelings from others)

6. Reflection (refers to the ability to examine experience and learn from it)

7. Self-regulation (a capacity to manage their internal emotional states, e.g., patience)

8. Attunement (learning about a reality different from their own, e.g, understanding diverse perspectives)

9. Change agility (leadership behaviors and attitudes that drive and seek model

   change. Nurse managers performed change agility by challenging the process,

   welcoming and initiating change, and seeing change through learning)

10. Affirmative framework (refers to optimism and resilient behaviors exhibited

    by the nurse manager to deal with stress and challenges)

In conclusion, Mackoff and Triolo (2008) focused on two ideas emerging from this research. The idea included "the engaged nurse managers' capacity to maintain the line of sight between their management work, patient care and organizational mission" (p. 123). Nurse managers expressed frustration with the inability to see the impact of their work has direct patient care. The second idea included distinguishing the signature individual elements of "those that are dispositional and others that are teachable" (p. 123). Teachable elements can be learned and enhanced through practice and can become part of a curriculum, such as through a 360 self-assessment or case studies. Mackoff and Triolo also recommended pairing the nurse manager with a mentor who can provide feedback to the new nurse managers while they proceed through some of the developmental tasks required of their new role.

Gould, Kelly, Goldstone, and Maidwell (2001) aimed to identify areas where clinical nurse managers perceived they would benefit from further training. The authors also made recommendations for planning future programs to meet the needs of NMs. Gould et al. indicated that a review of the literature revealed that since the 1980s the continuing professional development needs of NMs have been overlooked in spite of the complex tasks expected of them. This gap in the literature justified the need for the

study, and the study addressed the sources of work-related stress and variables related to job satisfaction.

The sample consisted of clinical nurse managers employed in all four hospital National Health Service (NHS) trusts where training needs were served by a major educational consortium. All clinical nurse managers (N = 197) received invitations to participate. Design included interviews conducted with a random sample of 15 NMs employed in a wide range of clinical settings. Interviews allowed for in-depth collection of qualitative data, followed by transcription and analysis for themes. From the resulting themes, the authors developed the survey for the remainder of the study. Questionnaires were mailed to the remaining clinical nurse managers (n = 182). The survey created quantitative data; of the 118 returned, 99 were usable for data (Gould et al., 2001).

Qualitative findings came from the 15 clinical managers interviewed. The results revealed respondents felt clinically competent but lacked confidence when dealing with human resource issues. Other areas of low confidence included lack of knowledge regarding managing budgets, information technology, role modeling, leadership, research, risk management, etc. Quantitative and qualitative data from the survey showed evidence that continuing professional development is one of the most important factors influencing job satisfaction and the recruitment and retention of qualified nurses. Nurse managers who ranked their preparation for their role as "poor" or "very poor" were more likely to report lower levels of job satisfaction. Results indicated a link between satisfaction with the role of clinical nurse manager and the perception that continuing professional development needs have been met. No differences existed in perceptions

between post holders in any of the four trusts despite variations in patient populations served (Gould et al., 2001).

Johnson and D'Argenio (1991) wrote, "A leadership crisis has been identified as one of the greatest challenges facing the nursing profession today" (p. 249). The purpose of this report involved measuring the effectiveness of a management training program on the leadership behavior and effectiveness of a group of nurse managers. The authors credit Leininger (1974) with identifying a critical shortage of nurse leaders. They noted that the nurse manager must have the qualities of competency, adaptability, flexibility, creativeness, persistence, patience, and effectiveness. The NM also must effectively manage human and monetary resources. The authors state that nurse managers "need leadership training to function effectively in their positions" (p. 249).

Situational Leadership Theory, introduced by Hershey and Blanchard (1988), was utilized by Johnson and D'Argenio (1991) as their theoretical framework. Situational leadership theory posits that no one leadership style works best for every situation; instead, an effective leader is one who can change the style to meets the needs of the situation. Two dimensions exist for this theory: task behavior and relationship behavior. The authors sought to answer four questions:

1. Did the leadership style of the NM change following a management training program?

2. Did the leadership Effectiveness Score of NMs improve following a management training program?

3. Were the changes sustained over a 12-month period?

4. What relationship(s) existed between the leadership styles and Effectiveness

   Scores of NMs as perceived by staff and self-perceptions at pre-training, six

   months post-training, and 12 months post-training?

Data collection occurred at a 178-bed hospital in northern New England. The

initial sample consisted of a convenience sample of 11 nurse managers and three to five

of their respective staff nurses. The nurse managers had held their current positions

ranging from six months to 25 years. None had prior management experience before

assuming their current roles. At the one year mark, eight of the original nurse managers

and 27 of the original staff nurses remained employed at the collection site (Johnson &

D'Argenio, 1991).

Leader Effectiveness and Adaptability Description (LEAD-Self and LEAD-

others) instrument was used by Johnson and D'Argenio (1991) to collect data. Reliability

and content validity have been established for this instrument through prior use (p. 251).

As previously mentioned, the survey was administered to nurse managers and their staff

at three separate times: pre-training, six months post-training, and 12 months post

training. The intervention for the nurse manager included participating in a 68-hour

management training program provided by the hospital's staff development department

that occurred over a six-month period. The training included areas such as providing

knowledge and skill development in the areas of planning, organizing, leading, and

controlling. The training also included an eight-hour workshop which covered leadership

theories, leadership styles, power, and authority.

Results from Johnson and D'Argenio's (1991) pre-training style showed that

nurse managers viewed themselves as having a dominant style of high task/high

relationship (HT/HR) followed by high relationship/low task (HR/LT). None of the nurse managers classified themselves as high task/low relationship (HT/LR) or low task/low relationship (LT/LR). The staff viewed their nurse managers as having the dominant style of HT/HR with two supporting styles of HR/LT and LT/LR. These two groups showed a statistically significant difference in scores between nurse managers and staff for the LT/LR style.

At six months post-training, the leadership style results revealed a 22% change toward a more even distribution of scores among the four leadership styles for nurse managers self-perceptions, yet the mean frequencies revealed a two-style range. For the staff perceptions, the leadership styles decreased from three to two, indicating the staff viewed the leadership styles as more restricted. No significant changes existed at the 12-month survey. Effectiveness scores between the two groups showed improvement between the pre-training and six month post-training, but the improvement did not continue to the 12-month post-training assessment. Scores indicated that the nurse managers who had dominant and supporting leadership styles would be less effective with followers of high or low readiness levels (Johnson & D'Argenio, 1991).

Findings from the Johnson and D'Argenio (1991) study showed that it was possible to obtain short-term changes in leadership behaviors through involvement in leadership training. Also, the styles selected by the nurse managers and staff were not the most appropriate for a given situation; using the inappropriate style leads to frustration and anxiety among staff. Implications include the need for training by nurse managers to improve their diagnostic skills in identifying the readiness level of staff in specific situations.

Mathena (2002) described nurse managers as internal stakeholders who play an essential role in managing change, cultural integration, retention, and direction of staff attitudes. Mathena noted that nurse managers often undertake complex and expanded roles for which they have no adequate training, resources, and support. The purpose of Mathena's study was described as: "There is scant literature regarding what nurse manager skill sets should be cultivated to effectively support and lead nursing staff..." (p. 138). Mathena explained the unique role of nurse managers: "Nurse managers, who make up the largest layer of hospital middle management, are in a unique position to interface directly with not only nursing staff, but with many other healthcare workers...Their leadership is critical..." (p. 136).

The author used a combination of Peter Senge's (1990) work on learning organizations and Hershey and Blanchard's (1988) Situational Leadership Theory as a framework for the study. Mathena (2002) explained learning organizations as those where people continually expand their capabilities, and people learn how to learn together. This model consists of five components: personal mastery, mental models, building a shared vision, team learning, and systems thinking. The Situational Leadership Theory model supports leaders as they assist their followers toward professional development. Professional growth is fostered by the leader until the followers acquire more control over their own practice.

Mathena's (2002) sample included nurse managers within five Harvard-affiliated hospitals located in the Boston area. The author received approval from the Internal Review Board of Indiana University. The tool used for this study contained two sections. The first yielded demographic and descriptive data such as gender, age, number of years

as a manager, number of years in organization, educational preparation, etc. This section also included a learning assessment to determine the nurse managers' perceptions of how they best learn and the barriers encountered toward professional development. The second section of the tool used a five-point Likert-type scale in two categories: perceived importance of the skill set to a successful nurse manager and the perceived need for professional development in the skill set.

Ninety-one surveys were sent out, with a return rate of 60% (N = 55). The respondents represented a group of seasoned nurses with extensive experience in the management role, average age of 47 years and an average of 17.8 years within the organization. Most of the respondents held advanced nursing degrees (75% held a master's degree and 2% held a doctorate). Results included the following eight categories arising from the responses: interpersonal, clinical, technical, financial, staff development, resource management, political, and general skills. Sixty-seven percent reported lack of time, and 29% reported lack of resources as major barriers to professional development. Fifty-eight percent identified mentoring as most critical to effective learning at the nurse manager level, with an average of 10 hours per month needed for role development. Nurse managers rated general skills, interpersonal skills, and staff development skills as the top three most important skills necessary for their success as nurse managers; however, financial skills, technical skills, and general skills were rated by NMs as the most important areas where professional development was needed. Those with greater than or equal to five years of experience rated their learning needs as higher than those with less than five years of experience. A significant negative

correlation (-.317) existed between the perceived importance of political skills and the length of tenure within the organization (Mathena, 2002).

The conclusion as reached by Mathena (2002) that nurse managers valued communication skills, yet they believed they would benefit most from additional education in the areas of financial management and technical skills. Also, this group of nursing leaders felt that hands-on experience and mentorship remain key factors to the development of skills needed for success in their role.

Mentoring of nurse managers/leaders. McCloughen, O'Brien, and Jackson (2009) described "features that are integral to initiating mentoring relationships that focus on nursing leader development" (p. 326). This study presented a central theme of esteemed connection - creating a mentoring relationship found in a larger study that explored nurse leaders' experiences with mentoring.

McCloughen et al. (2009) used hermeneutic phenomenology as the framework for their research. The authors describe this type of phenomenology as one that concerns itself with "creating meaning and developing a sense of understanding of the life world through description and illumination of lived experience" (p. 328). McCloughen et al. also used key concepts of the German philosophers Martin Heidegger and Hans-Georg Gadamer to inform the study. Central concepts to the philosophers' ideas include the presence of history in understanding, and language acts as the fundamental mode of our being and is linked with understanding. The researchers chose this methodological framework because of the need to obtain rich descriptions, use of reflection, and the importance of language as a means to describe experience.

Participants were selected through purposeful sampling because of their ability to share their knowledge. Thirteen nurse leaders (10 females, three males) from eastern Australia agreed to take part. McCloughen et al. (2009) felt saturation of data occurred with these 13 participants and that no further insights could result with further interviews. Face-to-face interviews lasted approximately 90 minutes. Unstructured interviews encouraged participants to give subjective perceptions of their experiences. Open-ended clarifying questions were used to further explore meaning, as well as questions specific to mentoring experiences. Field notes enhanced description and context of each interview.

McCloughen et al. (2009) analyzed data using van Manen's (1990) approach and Radnitzsky's (1970) hermeneutical approach to phenomenology. van Manen's three-step approach includes holistic reading of the interview text; selectively reading the texts several times to identify phrases revealing about the phenomenon; and reading the text in detail so that every sentence is searched to determine what is revealed about the phenomenon described. Radnitzsky's principles include understanding of texts through a back and forth process. Final evaluation takes place when meaning occurs without any contraindication. As previously stated, this study focused on only one of the essential themes from the broader study, esteemed connection: creating a mentoring relationship. For this group, mentoring relationships resulted from a distinctive union that set the foundation on which mentoring relationships grew (McCloughen et al.).

Findings from the McCloughen et al. (2009) study revealed three subthemes indicating the relationship went beyond the initial union: considering each other with positive regard (a distinctive union of the mentee-mentor that provided the framework); developing respectful boundaries (once the personal connection took place, the

parameters of the mentoring relationship would grow); and honoring key human characteristics (includes respectful boundaries and human characteristics that allowed the relationship to continue to grow and sustain itself).

Recommendations from McCloughen et al. (2009) for healthcare organizations and tertiary education institutions include contributing substantial resources to developing formal programs of mentorship to support the nursing profession. The authors stated the importance of realizing the full potential of mentoring relationships and maximizing the benefits of mentoring for the profession.

Madison (1994) investigated the general characteristics of mentoring relationships and their effects on professional lives, as perceived by nurse administrators. An adult developmental theoretical framework was utilized to research the problem statement, develop the survey instrument, and analyze the survey data. Madison posed two research questions:

1. How do nurse administrators describe the characteristics of mentoring relationships?

2. How do they perceive the effects of those relationships on their professional lives?

Madison (1994) used a descriptive, retrospective exploratory survey as the design for the study requesting typical demographic data. Open-ended statements allowed for exploration into opinions and perceptions regarding the effects of the mentoring relationship. The self-administered survey consisted of 14 questions, with questions one through six addressing descriptive and demographic data and questions seven through 14 addressing perceived effects of the mentoring relationships on the professional lives of

the survey population. Five nurse managers reviewed the questions for content validity and reliability. Madison did not report the Cronbach's α for this instrument.

Participants for Madison's (1994) study included members of the California Society for Nursing Service Administrators (CSNSA). This organization limits its membership to those who work as nurse managers, nurse administrators, and directors not affiliated with a union or employee representative group. Managers qualify if they serve in an acute care facility or an extended care facility. The CSNSA belongs to the larger American Society of Nursing Service Administrators. Surveys were sent to 637 members and 367 responded, a response rate of 58%.

Results from Madison's (1994) study indicated that 56% ($n = 205$) of nurse executives who responded indicated that they had one or more mentoring relationships. Nearly half (48%, $n = 176$) of respondents who classified themselves as mentors ranged in age from 36 - 45, and 22% ranged in age from 46-55. Half of the respondents stated their mentoring relationship lasted from six months to two years, and another 24% described their relationship as lasting five or more years. Ninety-seven respondents ($n = 356$) attributed changes in their professional lives to their mentoring relationships. Three-fourths of respondents involved in mentoring relationships cited an improvement in their self- confidence as a result of the relationship. Other significant findings include 80% of respondents who had experienced a mentor-mentee relationship rated their experience as very valuable, which supports the perception that nurse administrators regard mentoring in a positive light.

Unexpected findings also were reported from Madison's (1994) research. The first unexpected finding included the young age of the mentors, which may have existed

because of the prevalence of younger and more educated women entering the nursing profession. Another unexpected finding included the high percentage (33%) of male mentors identified. To explain this discrepancy the author stated, "These findings indicate that nurse administrators are occasionally willing to cross the gender gap to acquire a mentor" (p. 22).

Madison (1994) found that answers to the three descriptive questions depicting the perceptions of nurse executives and their mentoring experiences resulted in mostly positive comments (99%). Seventy-seven percent of the respondents described their communication exchanges as give and take and non-judgmental. Terms provided by the respondents that specifically described mentoring (versus role modeling) consisted of "deeper," "loved," "involved," and "total trust." With respect to future studies, Madison suggested the use of qualitative research as a means to expand on the current understanding of mentoring.

Holloran (1993) examined the experiences of mentoring among nursing service executives. The nurse executives surveyed in this study played the role of protégée (mentee) in the mentoring relationship. Hollaran used Vance's (1977) description of mentor — one who serves as a more experienced career role model, who guides, coaches, and advises the less seasoned worker.

A quantitative study with a descriptive, exploratory intent was used for this study. Holloran (1993) mailed 393 surveys to female nurse executives working in medical center teaching hospitals. Of the 393 surveys sent, 274 nurse executives responded, a response rate of 69.7%. Random sampling of hospitals occurred via the American Hospital Association's pool of 7,000 hospitals. The self-administered survey, Mentoring

in Nursing Service: A Survey of Nursing Service Executives, consisted of 28 forced-choice questions and four critical incident questions.

Results of Holloran's (1993) study found that 71% (n = 195) indicated they had a mentor, and 29% (n = 79) had no mentor. The vast majority reported their reason for not having a mentor was that, "no one with expertise was available to serve as a mentor for me" (p. 49). The five most commonly occurring positive behaviors reported by participants included: "showed confidence in me," "encouraged independent decision making," "mentor's knowledge and energy inspired me," "demonstrated behaviors I tried to imitate," and "provided opportunities to show what I could do" (p. 50). Other major findings reflected that when a protégée perceived the mentor as having a commitment to or investment in the relationship, the relationship existed on a deeper level. Also, 86% of respondents rated the mentor relationship as more important to their career development versus their career advancement.

Holloran (1993) noted that consistent differences existed between those nurses who had had a mentor versus those who did not. The two groups agreed upon only one cluster of behaviors (recognition and encouragement) as important, enhancing the belief that nurse executives not engaged in a mentoring relationship can only guess at what benefits emanate that relationship. Negative behaviors also exist in mentoring relationships. Twenty-eight (14%) respondents reported intimidation, anxiety, manipulation, or demand for loyalty as behaviors they felt while in a mentoring relationship.

Of the 195 executives who responded to Holloran's (1993) study and reported they had a mentor, 178 (92%) reported a critical incident experienced by protégés served

as evidence of the mentor's confidence in them. Two themes emerged from the critical incident data: power of belief and power of control. (The author did not report the method used for data analysis.) Power of belief referred to the mentor's ability to foster growth in the protégé, i.e., the protégé must be worthy of the invested time and energy if the more experienced professional believed in them. Conversely, the power of control referred to the mentor smothering the creative aspects of the mentor-protégé relationship. Examples of this type of behavior included over-possessiveness toward the protégé, rejection of the protégé, and misuse of power.

Implications from Holloran's (1993) study showed that, while nurses can elevate themselves to an executive level without mentoring, the presence of a mentor helps the nurse leader succeed and move to higher positions of power and authority. A major contribution of having a mentor was the mentor's ability to instill self confidence in the protégé, as well as the mentor's assistance in the protégé's role development. For the profession of nursing, mentoring provides an informal mechanism for career development and leadership succession. Mentoring also provides a means of transmitting nursing values and culture to emerging leaders. Last, the author noted that mentoring occurs with professional relationships; and, as such, one should not enter the relationship with a casual attitude (Holloran, 1993).

Paliadelis, Cruickshank and Sheridan (2007) investigated nursing unit managers (NUMs) in Australia. The researchers explored how NUMs cope and what they believed helped or hindered them in their role. The purpose of this article included reporting of one aspect of a larger study performed by the same authors in 2006 that explored the

working lives of nursing unit managers in Australia. Paliadelis et al. focused on the support of nursing unit managers in this research.

A qualitative feminist approach was used to conduct individual interviews with 20 NUMs employed in the public health care system in Australia. Paliadelis et al. (2007) chose a feminist methodology approach because "this study aims at giving the NUMs a more effective and authentic voice" (p. 832). Feminist theory examines power relations, which is a valid tool when examining workplace issues.

Participants' interview results indicated that NUMs valued support from their nursing colleagues, but they received little support from within the organization in which they served. The managers felt their organizations lacked any means of formal support, and that learning through trial and error often occurred. Managers coped with their new role of NUM by seeking informal support and insights from others more experienced. Support from their colleagues played a significant role in coping and managing stress brought on by the new role. Paliadelis et al. (2007) explained, "This peer support was seen as invaluable to the survival of these NUMs and may offer an instructive model for developing more formal supportive networks for nurse managers" (p. 831). Themes of "lack of formal support" and "caring for each other" emerged from the results of their research.

The Paliadelis et al. (2007) study found a strong informal support system among NUMs, yet the NUMs "felt poorly prepared for their new role and unsupported by the organization as a whole" (p. 835). The authors noted that the peer support found among these NUMs may positively contribute to job satisfaction and retention. Of more concern was the lack of support received by the NUMs, indicating they are not valued by the

organization. The authors concluded that informal support structures, if more actively

endorsed, may enhance the availability of the benefits in the network for other nurses and

NUMs.

Patrick and Laschinger (2006) reported on structural empowerment and perceived

organizational support for middle level managers. This study's purpose was to examine

the relationship between structural empowerment and perceived organizational support,

along with the effect of these factors on job satisfaction. Middle level managers are

positioned in the middle of the management hierarchy, top management lies above them

and first-line management lies below. Examples of middle management in a hospital

may include section supervisors, directors of multiple departments, etc.

The theoretical framework used for Patrick and Laschinger's (2006) study

included Kanter's (1977, 1993) theory of organizational behavior. According to Kanter

(as cited in Patrick & Laschinger, 2006), "work environments that provide access to

information, resources, support and the opportunity to learn" (p. 14-15), as well as access

to formal and informal power systems within the organization, lead to the perceived

empowerment of the employee which benefits the organization through improved

attitudes and increased effectiveness. Perceived organizational support implies a

generalized belief that upper management values middle level managers' contributions

and cares about their welfare.

Based on the aforementioned descriptions of structural empowerment and

perceived organizational support, Patrick and Laschinger (2006) hypothesized that "(1)

structural empowerment is positively related to middle level managers' perceptions of

organizational support, and (2) structural empowerment and perceived organizational support are positively related to middle level nurse managers' role satisfaction" (p. 16).

The design and sample of Patrick and Laschinger's (2006) consisted of random selection from a registry list of 126 middle level nurse managers working in acute care settings. The final sample included 84 nurse managers for a return rate of 74%. The researchers used Laschinger's (2001) Conditions for Work Effectiveness Questionnaire-II (CWEQ-II) to measure structural empowerment. The questionnaire contained 19 items (using a 5-point Likert scale) that measure each of Kanter's (1977, 1993) six empowerment structures and a two-item global empowerment scale used for validation. Previous studies utilizing this questionnaire placed the Cronbach's α range from .79 to .82, and the current study placed the Cronbach's α at .76 to .79. The authors used Eisenberg's (1986) Perceived Organizational Support Survey to measure perceived organizational support. This survey consists of 13 items using on a 7-point Likert type scale. Cronbach's α from prior studies ranged from .83 to .84, and .90 for the current study. To measure role satisfaction, Patrick and Laschinger used the Aiken and Hage's (1966) Alienation and Work scale consisting of six items using a 5-point Likert type scale. Cronbach's α for this study equaled .85.

Results reflected moderate levels of overall empowerment in middle level managers' work environment ($M = 21.06$, SD = 3.16). They reported a moderate degree of organizational support ($M = 4.75$, SD = 1.03) and rated themselves as somewhat satisfied with their current role ($M = 3.62$, SD = 0.73). Nurse managers appeared to be least satisfied with their progress toward achieving their own goals in their current position ($M = 3.47$, SD = 0.76). As predicted in the first hypothesis, a positive

relationship exists between structural empowerment and perceived organizational

support, ($r = 0.654$, $P = 0.0001$). In line with the second hypothesis, the combination of

structural empowerment and perceived organizational support confirmed a significant

amount of variance in role satisfaction ($R^2 = 0.46$, $P = 0.0001$). Empowerment accounted

for 36% of the variance in role satisfaction, with perceived organizational support

accounting for the additional 10%. When middle level managers feel supported from

within the organization, they feel valued and pleased that their efforts received

recognition. Without support, middle managers become frustrated and dissatisfied with

their roles (Patrick & Laschinger, 2006).

An implication from Patrick and Laschinger's (2006) findings included providing

empowering work conditions to have a positive impact on employees' feelings of support

and sense of accomplishment at work. An empowered middle level nurse manager, with

strong organizational support and job satisfaction, acts as a powerful role model for

potential nurse leaders within the organization. The authors conclude with, "Positive

perceptions of organizational support may play an important role in retaining current

middle managers" (p. 13) and attracting future nurse leaders to management.

Upenieks (2002) conducted a qualitative descriptive study "to gain a better

understanding of the types of organizational structures that create conditions for nurse

executive job effectiveness and leadership success in today's healthcare environment" (p.

622). Upenieks applied Kanter's (1977, 1993) theory of organizational behavior for this

study's conceptual framework. As previously explained, Kanter's theory postulates that

leader empowerment comes from both formal and informal systems of the organization.

Formal power comes from jobs that provide recognition, and informal power comes from

relationships and alliances. Leaders with formal and informal power have the ability to access the empowerment structures (opportunity, power, and proportion) that will enable them to successfully accomplish their work.

Two qualitative aims were explored by Upenieks (2002):

1. What types of leadership traits are effective in today's acute environment; do power and gender interface with leadership effectiveness?

2. What are the predominant components of a successful organization that support the role of nurse leader?

Content analysis of the data enabled Upenieks (2002) to gain "insight into the meaning of leadership worth" (p. 624). Upenieks reported that, "Content analysis aims to provide an understanding of the phenomena and enhance the quality of the results by relating the categories to the framework or environment producing the data" (p. 624). The participants consisted of a convenience sample of 16 nurse leaders from four acute care hospitals in two geographic locations. Interviews were conducted with nurse leaders "to identify factors that can influence successful leadership in today's healthcare settings" (p. 625). Most of the nurses interviewed had considerable longevity at their current work setting. Data analysis of the interviews included categorizing and coding the data using deductive and inductive methods. Upenieks established validity by reviewing and coding the interview data, then relating the findings to Kanter's (1977, 1993) theory.

Results of Upenieks' (2002) data analysis revealed that 83% of the nurse leaders interviewed validated the structures of Kanter's (1977, 1993) theory. This finding supports the notion that access to these empowerment structures in the work environment creates a better climate for leaders and staff nurses. Eighty-eight percent of the nurse

leaders perceived informal power as an important aspect of job effectiveness. Longevity

within the organization positively impacted informal power. Eighty-one percent of

participants stated they experienced a significant amount of formal power as a result of

their positions.

The next study by Upenieks' (2003) resulted from a desire to gain an

understanding of what compromises successful nursing leadership in the current health

care environment. A qualitative research design was utilized to conduct the research.

Upenieks (2003) again applied Kanter's (1977, 1993) Structural Theory of

Organizational Behavior as the framework to guide the research. An explanation of

Kanter's theory already has been included in this section of the paper. In this work,

Upenieks (2003) provided more details on Kanter's structural theory by revealing

Kanter's illustrations of the "three work empowerment structures: the structure of power,

the structure of opportunity, and the structure of proportion" (p. 141). Structure of power

refers to access to information, support, and resources. Structure of opportunity refers to

increased role expectations, access to challenges, advancement, etc. Structure of

proportion refers to a quantitative measure of the number of people who represent the

common group versus the minority group (male versus female nurse executives). The

group of higher proportion gains credibility with more ease, has more informal networks,

and moves up the hierarchical structure faster.

A qualitative design was used to gather data for Upenieks' (2003) study. Sixteen

nurse leaders from four different hospitals participated; 12 came from middle

management positions and four held executive level positions. Inclusion criteria of the

nurse executives included the title of "vice president of patient care services" and have at

least five years of service at that level. The middle level managers needed to hold the title of "clinical nurse leader" and have at least 2 - 5 years of experience at that level. Interviews ranged from 60 - 90 minutes, and data analysis occurred through content analysis. Deductive and inductive coding of the data was performed via review of transcripts to identify categories and sub-themes; validity of the data occurred by return of transcripts by several of the nurse leaders interviewed. Upenieks (2003) asked the interviewees to review their responses and generate broad themes that could be identified from the transcript review. Per phone conversation, the author and interviewee discussed and clarified any themes inconsistent with the pre-existing categories.

Results of Upenieks' (2003) 16 interviews include deductive and inductive findings. Deductive findings indicated that nurse leaders supported the work empowerment structures of Kanter's Structural Theory. The analysis found that the factors influencing nurse leader effectiveness included access to formal power, availability of advancement opportunities, access to resources, access to information, and lack of structure of proportion. Inductive findings revealed four other categories considered important factors contributing to successful leadership by nurse leaders: supportive organizational structure, instinctive leadership attributes, teamwork among healthcare professionals, and adequate compensation.

The summary of Upenieks' (2003) findings supported Kanter's (1977, 1993) Structural Theory of Organizational Behavior. Eighty-three percent of the nurse leaders who participated felt that a nurse leader who possessed informal and formal power, access to information, access to resources, and access to opportunity would exhibit job effectiveness. The effective leader will empower clinical staff to become more effective

and have higher levels of job satisfaction. Nurse leaders play a significant role in creating an environment that fosters open communication and partnerships with other key players in the hospital environment. Recommendations for future research include qualitatively exploring power, opportunity, control, and gender issues.

The following subsection focuses on Bellack and Morjikian's (2005) study from the Robert Wood Johnson Foundation's Executive Nurse Fellows. Inclusion of this study occurred because of the recognition and commitment at the national level of the importance of mentoring nurse leaders and nurse executives.

National nursing organization statement on mentoring. Bellack and Morjikian (2005) reviewed the Robert Wood Johnson (RWJ) Executive Nurse Fellows program in a three-part series. The RWJ program is an advanced leadership program for senior executive nurses aspiring to help lead and shape the U.S. healthcare system. The current article, the second in the three-part series, discussed the experiences of mentors and fellows during their three-year fellowship program. While in this program, fellows engaged in mentoring relationships with senior-level executives outside of the healthcare industry to broaden their leadership perspectives.

Bellack and Morjikian (2005) identified that, historically, the nursing profession has neglected mentoring as a tool for encouraging and developing others. The authors noted that, once new nurses have completed the preceptorship, they must navigate through work experiences on their own. The authors wrote, "Nurses who advance in their careers to leadership positions, whether middle manager or executive level, rarely have opportunities to benefit from formal mentoring by more seasoned leaders" (p. 533).

The RWJ program has been in existence since 1998. Each year the program

selects a cohort of approximately 20 qualified nurses in senior executive positions to

participate in the three-year fellowship. In 2005 the RWJ program office conducted an

online survey of fellows from four cohorts (2000, 2001, 2002, and 2003) regarding their

mentor experiences, with a response rate of 79%. Bellack and Morjikian (2005) provided

no additional information on the initial number of fellows contacted or how the current

sample was chosen. The survey gathered data about the mentor's formal position and

asked the following three questions:

1. What were the two or three best aspects of your mentor experiences?

2. What difficulties or challenges did you encounter?

3. What leadership lessons did you learn?

Bellack and Morjikian (2005) identified the majority of mentors as coming from

organizations outside the healthcare field. Examples of industries include manufacturing,

transportation, utilities, banking, airline, publishing, communication, private and public

schools, and government. Examples of job titles include U.S. congresswoman, U.S.

Senator, state governor, chief executive officer (CEO) of a publishing firm, etc. All

mentors had at least one face-to-face meeting with their mentor, although many met with

their mentor at regular intervals. The vast majority of cohorts relied on the telephone and

email for communication.

Fellows who participated in the program identified the best aspects of the mentor

experienced: "learning to stick to core values in times of crisis and personal challenge,

having a safe haven for exploring difficult leadership situations...learning to 'think

bigger,' acquiring competence in speaking and persuasion" (Bellack & Morjikian, 2005,

p. 535) and gaining wisdom and counsel from their mentor. Fellows valued observing their mentor in action. Many fellows commented on the benefits relative to their own needs such as business planning, finance, networking, negotiation skills, political savvy, and work-life balance.

Challenges and obstacles reported by Bellack and Morjikian (2005) included scheduling conflicts between the mentor and fellow. If the mentor and fellow were close in proximity, the relationship proved more successful. Fellows expressed concerns that they imposed on the mentor's time. A lack of chemistry between the fellow and mentor also occurred. Bellack and Morjikian wrote, "Perhaps the greatest obstacles to having an effective mentor experience were the fellow's failure to prepare adequately for the experience by clarifying goals and desired outcomes for the experience, and having unrealistic expectations of mentor or the experience" (p. 537).

Bellack and Morjikian (2005) clarified that the leadership lessons learned fit into one of the program's five core competencies: self-awareness, interpersonal and communication effectiveness, risk-taking and creativity, strategic visioning, and inspiring and leading change. Primary outcomes of the mentor experience for many fellows were increased competence and confidence as a leader, and the desire to give back to the profession by mentoring others in the future.

Summary of common themes in section two (nurse managers). The second subsection of this literature review focused on nurse managers. More specifically, the second subsection focused on roles and characteristics of the NM; training, retention, and satisfaction of NMs; and mentoring of NMs.

Of importance to this study, the research findings from this subsection revealed how ill-prepared many new NMs are for their role and the need for:

- Further training (Kleinman, 2003; Gould et al., 2001; Mackoff & Triolo, 2008; Johnson & D'Argenio, 1991; Mathena, 2002);

- How NMs divided their time performing duties specific to their NM role (Persson & Thylefors, 1999; Surakka, 2008; Manfredi, 1996);

- Intent of NMs to leave their position/retention of NMs (Persson & Thylefors, 1999; Skytt et al., 2007; Stengrevics et al., 1991; Parsons & Stonestreet, 2003; Mackoff & Triolo, 2008);

- Factors affecting job satisfaction of NMs (Stengrevics et al., 1991; Lee & Cummings, 2008);

- NMs reporting job-related stress (Shirey et al., 2010; Shirey et al., 2008; Lee & Cummings, 2008);

- The need for NMs to have a support network while in the NM role (Persson & Thylefors, 1999; Shirey et al., 2010; Manfredi, 1996; Shirey et al., 2008; Lee & Cummings, 2008; McCloughen et al., 2009; Madison, 1994; Upenieks, 2002; Upenieks, 2003; Bellack & Morjikian, 2005).

The third section of the literature review focused on aspects specific to rural nursing including characteristics of rural nurses, the impact of legislative and organizational changes on rural hospitals, and how successful mentoring and leadership in the rural setting can positively impact efforts to retain nurses.

Rural Nursing

Characteristics of rural nurses. Skillman, Palazzo, Keepnews, and Hart (2006)

conducted research funded by the U.S. Department of Health and Human Services Health

Resources and Services Administration to better understand characteristics of registered

nurses in rural areas. Skillman et al. explained that the 1988 National Sample Survey of

Registered Nurses (NSSRN) found that the ratio of RNs to 100,000 ranged from 726 for

metropolitan areas and 385 for non-metropolitan areas. Non-metropolitan areas held 92%

of nurse shortage areas in 1990, and the majority of these counties were not adjacent to a

metropolitan area. Skillman et al. cited Stratton (1993) with identifying isolated

geographic locations with higher RN vacancy rates in a 1990 survey of rural nursing

directors in six states. Skillman et al. explained that health care in the rural U.S. face

challenges such as struggling to recruit and retain providers; rural populations tend to

have a more elderly population, increasing demand for long-term care services; poverty

rates run higher in rural areas; and lack of spousal employment opportunities.

Skillman et al. (2006) performed a comparative analysis to examine the

characteristics of rural and urban RNs in 2000 and analyzed the national RN supply data

using a rural-urban classification system that distinguished among rural area types. The

authors stated, "Better understanding of the geographic variability of RN supply will help

policy makers, health care managers, and educators to tailor their recruitment and

retention efforts to different environments" (p. 152). The authors used data from the 2000

NSSRN, a nationally representative sample of RNs drawn from records of active licenses

in all 50 states and the District of Columbia. The NSSRN uses a stratified, nested design

that oversamples minority RNs and RNs from low-population states. The final 2000

survey consisted of 35,579 RNs. The study population was limited to RNs in the NSSRN who resided in the U.S. and were currently employed, excluding military RNs. One percent of cases lack sufficient data and were excluded from analysis. The final sample consisted of 29,435, weighted to represent 2,204,491 RNs. Skillman et al. assigned the participants to urban, large rural, small rural, or isolated small rural based on their zip codes. with categories derived from the rural-urban commuting area (RUCA) classification. The RUCA classification system combines Census tract information and the standard Bureau of Census' urban area definitions with commuting information to characterize all the nation's Census tracts for their rural and urban status and their functional relationships (Skillman et al.).

According to Skillman et al.'s (2006) review of the NSSRN (2000) data, rural RNs made up 20.8% of the RN population by residence. The average age of rural RNs paralleled that of urban RNs, 43.1 years and 43.4 years, respectively. Males made up 6.0% in urban areas and 6.2% in large rural areas; however, males made up 4.4% and 4.1% of nurses in small rural and isolated rural areas. Nonwhites and Hispanic RNs were underrepresented at similar rates among urban and rural RNs.

The researchers noted that educational training also differed among rural and urban RNs; rural RNs were more likely to possess a diploma or associate degree as their base of education. Forty-six percent of urban RNs held a baccalaureate degree, while 32.3% of rural RNs held a baccalaureate degree. More rural RNs worked full-time than did urban RNs (74.6% vs. 70.8%). The majority of urban RNs (97.4%) worked within the same RUCA, leaving 2.6% of urban RNs to commute to a different RUCA type (rural). Sixty percent of RNs in rural areas commuted to work within the same RUCA,

leaving 40% to commute. Per 100,000 population, 839 RNs worked in urban areas, compared to 836 for in large rural, 679 in small rural, and 411 in isolated rural. When comparing salaries, RNs who lived and worked in the urban setting earned an average of $49,627, while RNs who lived and worked in rural areas earned an average from $40,516 to $42,689. RNs who held less than a baccalaureate degree earned less than their baccalaureate counterpart, regardless of setting. However, RNs with baccalaureate degees who worked in rural areas earned equal to or less than urban RNs with diplomas or associate degrees. Work setting also differed for rural and urban RNs. Proportionately fewer rural RNs worked in the hospital setting (60.4% vs. 54%). Also, more rural RNs worked in public health, long-term care, and ambulatory care settings than did urban RNs (Skillman et al., 2006).

Recommendations by Skillman et al. (2006) included addressing the nurse shortage, specifically in rural areas, by addressing the underrepresentation of minorities and men. Differences in educational preparation were also reflected in the authors' recommendations. The authors felt rural hospitals should address ways for RNs to gain access to further their education, ultimately enhancing their professional status and satisfaction. Last, the authors noted the difference in pay for urban vs. rural nurses, regardless of educational attainment. Skillman et al. acknowledged the salary differential as a major challenge for addressing the nursing shortage; the authors suggested the higher salaries of urban areas may cause an unintended consequence of increasing the supply of urban RNs while decreasing the supply to rural facilities. They finished by stating that characteristics of rural RNs must be better understood if the health care needs of the U.S. population are to be met.

Legislative and organizational changes and their impact on rural hospitals.

Newhouse (2005) explored the impact of legislative, strategic, and organizational

changes on nursing in rural hospitals since 1995. Rural hospitals represented 44% of the

4,908 nonfederal and specialty hospitals and provided care for 16% of the 37.2 million

patients requiring hospitalization in 2001. Newhouse reported, "The Medicare Payment

Advisory Commission (MedPAC), in its report to the U.S. Congress in June 2001, noted

that rural hospitals had lower Medicare inpatient financial margins" (p. 350). Newhouse

explained that the Balanced Budget Act of 1997 led to a reduction in reimbursement to

hospitals, and this legislation has had a direct negative impact on rural hospitals' financial

well-being. The reduction in reimbursement dollars to rural hospitals also was attributed

to the Balanced Budget Refinement Act of 1999, the Benefits Improvement Act of 2000,

and the Medicare Prescription Drug Improvement and Modernization Act.

A rural hospital was defined by Newhouse (2005) as a hospital located outside a

metropolitan statistical area (MSA). Hospitals in rural areas typically have fewer beds

and a smaller patient base. A disproportionate number of rural hospitals over-represent

the top one-tenth of hospitals that provide uncompensated care.

Newhouse (2005) highlighted a report from The Institute of Medicine (2003)

which the Committee on the Work Environment for Nurses and Patient Safety Board

Healthcare Services highlighted the importance of the work environment as a significant

factor in protecting the safety and patients. The American Organization of Nurse

Executives (AONE) established work environment and work force as a research priority

because of the relationship to patient outcomes. Newhouse stated:

Nursing leadership support is necessary to enhance the professional practice

environment. Nursing executives have the responsibility to create and maintain a

professional work environment for nurses. Their leadership in fostering a positive

environment is critical for building an infrastructure to ensure quality care. (p.

351)

Methods of data collection for Newhouse's (2005) research included conducting a

focus group with 11 nurse executives from rural hospitals who attended the April 2004

AONE annual meeting. The focus groups identified how environmental and

organizational changes have affected rural hospital nursing. Recruitment of nurses

occurred via an email notice to all registered attendees, and selection into the focus group

consisted of the first 12 attendees. Two of the 12 participants came from the same

organization; however, only one participated in the focus group, equaling a total of 11

participants. Eight key questions served as the means to attain information. The

following three questions serve as examples of questions utilized in the focus group:

"What strategic activities have affected nursing since 1995?"; "How has the shortage of

the appropriate number of clinically competent nurses affected the ability to deliver

quality care in rural hospitals?"; and "What are the greatest issues facing nursing in rural

hospitals?" (p. 352).

Newhouse (2005) analyzed content by using QSRN6 (a software program), (p.

351). The data revealed three themes: External Environmental Influences (physical

isolation, patient population, services needed, and legislation); Internal Organization

Forces (acuity and volume, technology, staffing, cultural differences, and leadership);

Nursing (staffing, salary, RN-MD conflict, competency, and leadership) (Newhouse).

119

Culture and leadership issues were found by Newhouse (2005) to be nurse executives describing staff with high tenure. Many of their staff worked out of necessity, not professional motivation. Nurse executives viewed their staff as unable to understand the reality of rural practice. They saw themselves as working to improve and change practice but also meeting resistance with their efforts. Partnerships were sought with staff using situational leadership to implement the needed changes. Executives worked to unfreeze established behaviors, build leadership skills, and establish accountability. The nurse executives expressed feelings of professional isolation. Another leadership issue that was discussed, with respect to internal factors, included the frequent turnover of hospital CEOs. The nurse executives indicated that rural hospitals attract novice administrators who have little to no experience and leave the rural setting as soon as they gain experience. Newhouse quoted one participant as stating:

> All the young CEOs…having no clue what they're doing, to learn how to do what they're supposed to do; usually without a mentor. And about every five years, when they create enough chaos, they move on and we get another one. (p. 354)

Newhouse (2005) concluded by reinforcing the issues facing rural hospitals and the nurse executives working in the rural setting. Rural hospital nurses perform an essential role in delivering quality healthcare and ensuring patient safety and satisfaction. Nursing leadership is critical in creating an environment where rural nurses can achieve success.

Mentoring in rural hospitals/settings. Mills, Francis, and Bonner (2007) examined rural nurses' mentoring experiences. The authors explained that mentoring, as

offered by governments and academics, offers a useful and cost-effective solution to the problem of retention of rural nurses in Australia.

Mills et al. (2007) used a grounded theory design to conduct this qualitative study. Theoretical sampling, concurrent data generation and analysis, and constant comparative analysis, reflection, and situational analysis mapping were used as methods to validate and strengthen the findings. Nine nurses, all female, from various states in Australia participated in the interviews. Eight had previously participated in a mentor development program and classified themselves as rural.

Data collection occurred by Mills et al. (2007) through 11 semi-structured interviews (two interviewees participated in the interview twice). Digital recordings and verbatim transcription of the interviews occurred. Data collection and analysis were conducted concurrently. Axial coding related each category to the others, ensuring integration of results. Also, constant comparative analysis occurred throughout data collection until the analysis results revealed saturation of data. Mills et al. used qualitative analysis software for coding the data.

Findings from Mills et al.'s (2007) research revealed an overall theme of "live my work." Rural nurses considered themselves as members of their communities first and as healthcare workers second. Experienced rural nurses used mentoring (with novice nurses) as a means to raise awareness of political actions that can be taken by nurses to protect their roles and capabilities. Also, mentoring meant teaching the novice nurse about image protection and enhancement. For example, one nurse explained that she felt rural nursing is commonly depicted as low-level care, i.e., the rural nurse had difficulty establishing expertise in any one area, yet she may likely care for a multitude of patient

problems in the day-to-day practice of patient care. Another aspect of mentoring was revealed - the need for the experienced rural nurse to protect the novice nurse from the horizontal violence thrust upon them from other nurses. The rural nurse mentor wanted to "protect their young," as opposed to "eat their young." The nurse mentor's tasks included providing explanations for others' behaviors, helping the novice nurse with mastery of skills, and translating other nurses' actions and attitudes. Terms used for the mentoring of novice nurses included "cultivate" and "grow."

Mills et al. (2007) suggested that the definition of mentoring should include socialization into professional community and social world. Mentoring of novice rural nurses includes using lenses of culture, politics and clinical practice. Expected outcomes emerged to include increasing the new nurse's confidence in practice, as well as orientation to the culture of the work environment, which increases retention in the workplace.

Waters, Clarke, and Ingall (2003) evaluated a pilot mentoring program for nurse managers to determine participant expectations of mentoring and outcomes of the pilot program. The study's design consisted of administering pre- and post-workshop questionnaires to attendees of the workshop, as well as post-workshop telephone interviews. The quantitative and qualitative nature of obtaining data allowed the authors to determine participant expectations of mentoring and outcomes of the pilot program, as well as how the participants' mentoring needs might be met.

Site selection for the pilot mentoring program included two rural areas of New South Wales, Australia, and one site in Sydney, Australia. Entry into the program came from those identified as new or less experienced nurse managers seeking mentorship or

support. The entire program consisted of a pre-workshop questionnaire, attendance at a

mentoring workshop, and completion of a follow-up questionnaire. Eighteen experienced

current members of the Nurse Executive Board volunteered to serve as mentors. Criteria

for pairing mentors and mentees was that both individuals voluntarily agreed to establish

a mentoring relationship, the pair had common goals or areas of interest, and the pair

were of the same gender. Additionally, Waters et al. (2003) felt it important to match up

mentors and mentees with similar work locations, e.g., rural settings, because of the

specific nature of rural healthcare.

A combination of methods was utilized by Waters et al. (2003) to analyze results.

Analysis of the questionnaire data occurred using quantitative methods, including

descriptive and comparative statistics. Analysis of interview data occurred using

qualitative methods. The authors noted, "This was a pilot study to determine the

feasibility of the programme. Sample sizes were small, limiting the power and application

of statistical testing" (p. 519).

Results from Waters et al.'s (2003) study included 37 (79%) participants enrolled

in the workshop who responded to the pre-workshop questionnaire (20 mentees, 17

mentors). Sixteen of the 37 (43%) participants submitted post-workshop questionnaires.

Mentors held mainly senior management or executive positions at their facilities;

Mentees held the role of Nursing Unit Manager (NUM). The pre-workshop

questionnaire revealed that many expressed satisfaction with their current management

role (no statistics provided by authors). Eighty percent of mentors reported high levels of

satisfaction with their role, whereas only 40% of mentees reported the same level of

satisfaction.

According to Waters et al. (2003), geographic location affected the responses. Twenty percent of those at the metropolitan site reported opportunities for further training as poor, whereas 50% of mentors and mentees from a small rural program site reported the same opinion. Thirty respondents (81%) who answered the pre-workshop questionnaire reported having a previous mentoring relationship. Of those 30 respondents, 80% felt that the prior mentoring relationship had brought worthwhile experiences to them, and that the relationship had gained greater importance in retrospect. One-hundred percent of respondents rated confidentiality as important or very important. Mentors reported higher confidence levels in their role than did mentees.

The post-workshop questionnaire return rate equaled 16 (43%), but the feedback proved useful. All respondents reported that commitment to an ongoing relationship was highly desirable. Assignment of a mentee should result from common experiences and not through matching of age, gender, and location. The exit interviews conducted via telephone revealed two differing results with regard to mentoring: mentoring should occur from a structured and facilitated process or only at the right time and place. Suggestions by Waters et al. (2003) for the future included greater use of technology to support the mentoring relationship.

Mills, Francis, and Bonner (2007a) described "findings from a constructivist grounded theory study that examined Australian rural nurses' experiences of mentoring, including evidence for a new concept of mentoring – accidental mentoring" (p. 1). Accidental mentoring was described as "a short-term relationship that provides support for the new or novice nurse to get through a critical incident" (p. 1), in spite of the fact that the experienced rural nurse had no plans of acting as a mentor. Seven participants

gave nine interviews, as two shared their stories twice. These nine transcripts underwent concurrent data generation and analysis. Mills et al. (2007a) also used a literature review regarding the rural nurse workforce as a collective frame analysis. Situational analysis occurred through situational and social mapping.

Results of Mills et al.'s (2007a) analysis included a core category of "cultivating and growing rural nurses: a grounded theory," with three subcategories: "live my work," "getting to know a stranger," and "walking with one another." The researchers noted that "live my work" conceptualizes rural nursing. Rural nurses live their work because of their multiple roles as nurse, community member, and health care consumer; they do this through multiple cultural, political and clinical lenses. During the early stage of the mentor/protégée relationship, accidental mentoring takes places because of the mentor's ability to be attuned to trouble or identify a critical incident experienced by the protégée. If a sufficient bond has occurred between the dyad, then mentoring may follow. The second part of the process, "walking with one another," occurs as a result of the mentor's ability to create a safe environment, but also because of the mentor's ability to act as a role model and a critical friend.

The grounded theory model was explained by Mills et al. (2007a) in the following manner: "cultivating and growing rural nurses" acts as the base of the model because it accounts for the influence of collective groups within the social world of nurses. Above the base, a circle exists which represents "live my work;" this circle makes up the keystone of cultivating and growing rural nurses. "Live my work" provides the context for "getting to know a stranger" and "walking with another." These latter two subcategories feed back into the circle of "live my work." This feedback diagram

represents the repeated process and outcomes for the mentor who supports the new nurse. Last, an arched continuum lies above the circle, representing the four properties of cultivating and growing rural nurses: preceptoring, accidental mentoring, mentoring, and deep friendship.

Mills et al. (2007a) emphasized the importance of accidental mentoring because of its short-term support offered to the new nurse. Implications include suggestions (to nurse managers and experienced nurses) such as using accidental mentoring as a means to support the new nurse because of the confidence given. Other benefits of using accidental mentoring include assisting the new nurse with management through the crises that arise during day-to-day clinical interactions. Retention rates of new nurses could improve if nurse managers and experienced nurses utilized this form of mentoring.

Mills, Francis, and Bonner (2008) explored Australian rural nurses' experiences of mentoring. The authors noted that the literature has made clear that a nursing shortage exists, and mentoring acts as a useful strategy for retention of staff nurses. In this study, the authors defined accidental mentoring as "a common short-term relationship established as a result of a new or novice nurse experiencing a critical incident" (p. 600). Mills et al. also distinguish preceptoring from mentoring in the following manner: preceptoring takes place in the work place and focuses on orientation and skill development; mentoring takes places within and outside the workplace and it focuses on all aspects of the protégée's life with the intention of personal and professional development. In this report, the authors did not identify the guiding research questions for the study.

A qualitative research method was used for Mills et al.'s (2008) study. Selection of grounded theory occurred due to its appropriateness for exploring and describing an area of concern for the participants. Strauss and Corbin (as cited in Mills et al., 2008) explained the use of constructivist grounded theory research design as "the common methods of theoretical sampling, concurrent data generation and analysis, constant comparative open, axial and theoretical coding, category saturation and constructing a story line" (p. 601).

Sampling of participants occurred through a nationwide advertising campaign. Nine Australian rural nurses participated, representing five of the eight states. The nurses defined themselves as rural and had previous experiences with mentoring relationships. Eleven semi-structured interviews took place. Eight of the interviews were face-to-face, and the remaining interviews occurred via telephone conversations. Data comparison occurred via constant comparative analysis with other data, resulting in codes and categories beginning to surface. Category saturation began to occur after nine interviews. Theoretical codes came from symbolic interactionism (Mills et al., 2008).

Mills et al. (2008) conveyed findings as a theme of "getting to know a stranger." The process of getting to know a stranger involved the mentors identifying themselves in a new context with their protégée and getting to know the protégée from a new perspective. The three subcategories of this "getting to know a stranger" theme involved "looking after each other," "the importance of a name," and "building a foundation." "Looking after each other" referred to the mentor as recognizing potential and finding opportunities for the novice nurse, or the mentor recognizing an incident that had an emotional impact on the novice nurse and the mentor acting to support the protégée. "The

importance of a name" meant the naming of the relationship, e.g., mentoring relationships, etc. Providing a name for actions in which the nurses already participated (e.g., mentoring) helped to identify their role in mentoring relationships. "Building a foundation" translated into the building of a foundation for the relationship, identifying expectations of the relationship, redistribution of power within the relationship, etc. "It is this incremental change in the dimensions of trust and engagement that occurs over time that can move a mentoring relationship into one of deep friendship" (p. 605).

The authors concluded by stressing the importance of creating supportive environments through mentoring. Understanding the resources that mentors provide to new nurses could lead to empowered workers, a supportive work environment, and a positive impact on the nursing workforce crisis. Mills et al. (2008) identified a limitation of the study as the way in which advertising to participants occurred; the majority of participants had previously attended mentoring workshops facilitated by one of the researchers.

Summary of common themes in section three (rural nursing). The third subsection of this study included research that targeted rural nursing. Specifically, the research used for this section addressed characteristics of rural nurses, legislative and organizational changes affecting rural nursing, and mentoring in rural hospitals.

Skillman et al. (2006) summarized data from the 1988 National Sample Survey of Registered Nurses to highlight characteristics of RNs in rural settings. From this survey it was determined that 20.8% of the RNs lived in rural areas. Those rural RNs were less likely to hold a baccalaureate degree when compared to their urban peers, and they had

lower salaries when compared to their urban counterparts, regardless of the educational level of the rural RN.

The effect of legislative changes on rural hospitals since 1995 was researched by Newhouse (2005). Eleven rural hospital nurse executives attending the annual meeting of the American Organization of Nurse Executives were interviewed. Findings revealed that they experience physical isolation because of the rural setting, which leads to fewer experiences of networking with other peers. The NEs did not see Medicare reimbursement as problematic; rather, treating a high number of uninsured patients was negatively impacting their financial margins. Also, the NEs reported a high turnover of hospital chief executive officers (CEOs).

Mills et al. (2007) examined rural nurses' experiences with mentoring. Reported outcomes from the research included increasing the new nurse's confidence in practice, as well as orientation to the culture of the work environment to increase retention in the workplace. The more experienced nurses felt a need to protect their mentee from some of the horizontal violence that occurs in nursing. Terms used for the mentoring of novice nurses included "cultivate" and "grow." Mills et al. (2008) conveyed the importance of creating supportive environments through mentoring. Understanding the resources that mentors provide to new nurses could lead to empowered workers, a supportive work environment, and a positive impact on the nursing workforce crisis.

Non-nursing Views of Mentoring

Eby, Lockwood, and Butts (2006) conducted two studies to examine how perceptions of support for mentoring relate to mentoring attitudes and outcomes for both protégés and mentors. In the first study, protégés expressed their perceptions of support

for mentoring and mentoring received. In the second study, the authors examined mentors' perceptions of support for mentoring in relation to their willingness to mentor others in the future. Little research exists concerning protégés and mentors' perceptions of workplace support for mentoring.

Three theories were utilized to develop a study-specific hypothesis. Eby et al. (2006) explained that mentoring theory introduced by Kram (1985) "discusses how the culture of an organization plays a powerful role in encouraging or discouraging mentoring relationships" (p. 269). The authors reported that, "In organizations where managers encourage the formation of mentoring relationships, there is an increased likelihood that mentoring relationships will benefit both mentors and protégés" (p. 269). Social learning theory, as introduced by Bandura (1977), proposes that individuals learn by observing others in their social environment, also known as imitative learning. This type of learning will most likely occur if the role model possesses relevancy, credibility, and a sound knowledge base. If no role models exist, then individuals are less likely to learn. Social learning theory also explains inappropriate organizational behavior. If repercussions are not experienced from poor behavior, the behavior will reoccur. Social information processing theory indicates that individuals develop expectations about appropriate behavior based on information from their social environment. The social cues come from peers and managers.

Surveys were used to collect data for the Eby et al. (2006) study. The authors sent surveys to 2,250 alumni who graduated in 1995 from a large southeastern university. Given that the respondents had graduated approximately ten years prior, Eby et al. intended to capture individuals early in their careers and who were likely in the protégé

stage. The majority of respondents reported on current mentoring relationships. A response rate of 20.3% (N = 458) was found. The following definition was provided to participants:

> One type of work relationship is a mentoring relationship. A mentor is generally defined as a ranking, influential individual in your work environment who has advanced experience and knowledge and is committed to providing upward mobility and support in your career. A mentor may or may not be in your organization, and she/he may or may not be your immediate supervisor. Have you ever had a mentor? (yes or no). (p. 273)

> Two hundred forty three (n = 243) reported experience as a protégé and only these participants were used in subsequent data analysis. Respondents represented a wide range of job types such as sales, administrative, and managerial and represented a wide range of industries such as manufacturing, retail, service industry, etc. The average age of the protégé was 30.8 years, and the average age of the mentor was 43.6 years. Forty-three percent of protégés were male, 97% Caucasian. Fifty-nine percent of the mentors were male; 29% of protégés reported engaging in a formal (assigned) mentor relationship, and 88% worked in the same company as their mentor.

Eby et al. (2006) developed a measure for perceived organizational support for mentoring, and none existed. The researchers provided definitions for "perceived management support for mentoring" and "perceived accountability for mentoring" to three persons with experience in mentoring and scale development. Each wrote independently, and the authors combined the submitted items. Items were retained that best represented the constructs, with a resulting seven items used for "perceived

management support" and four used for "perceived accountability." After performing a confirmatory factor analysis, Eby et al. dropped one of the seven items used for the perceived management support scale because the goodness of fit test scored lower (.47) than recommended, with a poor overall model fit. The coefficient α equaled .86 for the six-item perceived management support scale and .84 for the four-item perceived accountability scale. The scales used were included in Appendix A of the Eby study.

Results from the Eby et al. (2006) research found that "protégé perceptions of management support were positively related to career-related and psychosocial mentoring received...In addition...perceived accountability was significantly and negatively related to all three types of negative mentoring experiences (distancing, manipulation, lack of expertise)" (p. 275). Regression analysis revealed that established predictors such as gender, organizational tenure, education level of the protégé, and self-esteem level of the protégé accounted for 14% of the variance in protégés' perceptions of career-related support. Also, the participants reported greater career-related mentoring with informal relationships ($\beta = .33, p < .01$). When the perceptions of management support for mentoring and perceived accountability for mentoring were added to the established predictors listed above, six percent variance was added to the 14%, which brought the total variance in career-related mentoring to 20%. As perceived management support for mentoring increased, reports of career-related mentoring increased as well. When reviewing psychosocial support aspects of mentoring, greater psychosocial support was present in informal mentoring relationships. The established predictors, added with protégé perceptions of management support and accountability, account for 24% of variance in psychosocial mentoring.

132

With respect to negative behaviors displayed by the mentor toward the protégé, protégés with male mentors were more likely to report negative behaviors of distancing and manipulation. Protégés with lower self-esteem were more likely to report manipulation. Also, relationship predictors, such as distancing behavior and lack of mentor expertise, were more common if the mentoring relationship qualified as formal. Eby et al.'s (2006) findings support the argument that protégé perceptions of support for mentoring may increase the quality and quantity of mentoring as well as reduce the likelihood that protégés develop problems with their mentor.

The second study reported by Eby et al. (2006) reviewed mentors' perceptions of management support for mentoring and whether the perception influenced their willingness to mentor in the future. Eby et al. noted that few tangible benefits for mentoring others exist, and protégés are the primary beneficiaries of the mentoring exchange. The researchers stated that organizations must maintain a pool of individuals who are willing to serve as mentors.

Eby et al. (2006) used a survey to obtain data from mentors. The authors sent the survey to 1,552 non-faculty employees at a large southeastern university. Surveys were returned by 33 respondents. Eby et al. used a literature review to determine that approximately 53% of those who received a survey were acting as mentors. The authors recalculated the denominator and provided a response rate of 16% (133/823). The following question identified individuals with mentor experience:

> One type of work relationship is a mentoring relationship. A mentor is generally
>
> defined as a higher-ranking, influential individual in your work environment who
>
> has advanced experience and knowledge and is committed to providing upward

mobility and support in the protégés career. A protégé may or may not be in the mentor's department or unit, and she/he may not be your immediate subordinate. Have you ever had a protégé? (yes or no). (p. 280-81)

The average age of mentors was 44.9 years, 43% were male and 98% were Caucasian. Respondents worked in their jobs an average of 7.4 years and for their organization an average of 11.7 years. Average salary equaled $59,614. Respondents represented a wide range of positions such as administrative unit head, manager, and paraprofessional. Job settings included academia, administrative units and athletic units on campus. Twenty percent of mentors reported engaging in formal mentoring relationships, and 64% of the relationships remained ongoing. The average age of their protégé equaled 31.9 years and 75% were women.

The scale used in study one of this research was modified slightly so the items would similarly match to the university context. As in study one, "perceived management support" for mentoring used seven items, and "perceived accountability" for mentoring used four items. As in the first study, Eby et al. (2006) assessed the goodness of fit by using a confirmatory factor analysis. The results revealed two factor loadings below the accepted cutoff of .40; one was the same item that had a low loading on the protégé scale. The scale was revised to a six-item perceived management support scale and a three-item perceived accountability scale. The coefficient α for the six-item scale equaled .86 and .69 for the three-item scale.

Results reported from study two found positive correlations between mentor perceptions of management support and viewing the mentoring relationship as complementary. A significant negative correlation existed between perceived

accountability and willingness to mentor in the future. No significant correlation existed between management support for mentoring and willingness to mentor; no significant correlation was found between accountability for mentoring and viewing the relationship as complementary. The established predictors such as mentor gender, age, organizational tenure, educational level, etc. accounted for 24% of the variance in viewing the relationship as complementary. After adding perceived management support and perceived accountability to the established predictors, the results explained 29% of the variance in relational complementarity. When assessing willingness to mentor in the future, the established predictors explained 14% of the variance; perceived management support and accountability added an additional 6%, accounting for 20% of the variance. Results also revealed that mentors who worked in the unidentified "other" category reported significantly less relational complementarity than those working in all other categories (manager, administrative associate, director). Those working as department head, chair, or director reported more willingness to mentor than mangers and administrative associates. Professionals with academic rank also reported higher willingness to mentor than managers and administrative associates. The quality of previous mentoring relationships also related positively to relational complementarity and future willingness to mentor. Male mentors reported higher willingness to mentor than females (Eby et al., 2006).

Eby et al. (2006) reported their findings "reinforce the importance of support for mentoring as a means to enhance mentoring relationships" (p. 284). As perceptions of management support increased, so did relational complementarity; as perceived accountability increased, willingness to mentor in the future decreased. The authors

stated that this aspect of study two demonstrates the potentially negative side effect of enhanced accountability for mentor behavior; it decreased mentors' motivation to mentor others in the future.

The final section of the literature review discusses the framework that best fits this study based on the literature review and the research questions posed.

Framework

Albert Bandura introduced social-learning theory in 1977 (Latham & Saari, 1979). Social-learning theory explains human behavior in terms of a continuous reciprocal interaction among cognitive, behavioral, and environmental determinants. Modeling of behavior as a basis for learning is critical to social-learning theory. Kinicki (2008) explained that, according to Bandura's theory, "an individual acquires new behavior through the interplay of cognitive processes with environmental cues and consequences" (p. 43). As much as a person can control their environment and the cognitive thoughts of it, that person can change their behavior to fit the environment. Vance and Davidhizar (1996) wrote, "A mentoring relationship will socialize a person or persons to the professional norms, values, and standards, will provide entry into the inner circles of the profession, and will promote the profession's growth by ensuring continuity and quality of leadership" (p. 199). The authors suggested mentoring relationships by nurse executives as a strategy to develop and strengthen leadership, which will assist the nurse executives to meet the diverse demands of the complex environment. Vance and Davidhizar reported that, through social-learning theory, "the protégé acquires important managerial skills by observing an effective senior manager" (p. 201). Kinicki provided a model of social-learning theory that illustrates a triangle with a circle in the middle. The

three points include 'person (psychological self)," "consequences," and "situational

cues." The three points also have reciprocal interaction with the core circle of "behavior

changes."

The purpose of the Latham and Saari (1979) study was to examine the effects of a

behavioral modeling program developed by Sorcher (Goldstein & Sorcher, 1974) to

increase the effectiveness of first-line supervisors in dealing with their employees. The

training program had nine modules developed by Sorcher, which identify effective and

ineffective supervisor performance. The training program included the components of

effective modeling as outlined by Bandura: attentional processes, retention processes,

motor reproduction processes, and motivational processes.

The sample for Latham and Saari's (1979) study included 100 first-line male

supervisors employed by an international company located in the northwestern United

States. The authors randomly selected 40 supervisors and assigned them to training (n =

20) or to the control group (n = 20). The participants were unaware of their designated

group. The mean age of supervisors was 43.34 years (SD = 10.6), and the mean number

of years working in a supervisor role was 5.42 (SD = 4.54).

Latham and Saari (1979) divided the training group into two groups of ten to

facilitate individual instruction. Each group met for two hours per week for nine weeks.

Each session focused on one of nine topics: (a) orientation of new employees, (b) giving

recognition, (c) motivating a poor performer, (d) correcting poor work habits, (e)

discussing potential disciplinary action, (f) reducing absenteeism, (g) handling a

complaining employee, (h) reducing turnover, and (i) overcoming resistance to change.

During each session one trainee assumed the role of supervisor, and another assumed the

role of an employee. The two trainees were not given a script but were asked to recreate an incident than had occurred in the previous 12 months. At the conclusion of each of the nine training sessions, the supervisors were given copies of the learning points for that session.

Results from Latham and Saari's (1979) research were divided into four areas: reaction measures (attentional processes), learning measures (retention processes), behavioral measures (motor reproduction processes), and job performance (motivational processes). Results from reaction measures (attentional processes) came from a questionnaire given to the participants immediate following the final training session. The questionnaire contained five questions, each with a five-point Likert-type scale. The same questionnaire was again given to the participants eight months later. The mean result for the first administration equaled 4.15 (SD = .59), while the mean result for the second administration equaled 4.29 (SD = .51). Results showed no significant difference in reaction to the program immediately following the training and eight months later. Latham and Saari concluded that the initial positive reactions were sustained over time. The results from the learning measures (retention processes) indicated that after taking a test with 85 situations, the mean score of the trainee group was significantly higher than that of the control group. Trainees acquired the knowledge necessary to transfer the principles learned in class to different types of job-related problems.

Behavioral measures (motor production processes) were measured by tape-recording the role plays, followed by 15 superintendents evaluating the recordings. The training group received a hard copy of the learning points to keep with them throughout the role play. The control group was split in half: ten of the participants received the

learning points as well, (without the training); the other ten participants did not receive learning points or training. Planned t tests indicated that the ratings of the trained group (M = 4.11, SD = .67) were significantly higher than those of the control group with (M = 2.70, SD = .66), and without the learning points (M = 2.84, SD = .66). No significant difference existed between the ratings for the two control groups. Latham and Saari (1979) concluded that symbolic and motor rehearsal enhanced learning, as suggested by social-learning theory.

Job performance (motivational processes) results were evaluated by superintendents evaluating the supervisors on behavioral observation scores one month before and one year after the training. The 35-item scale had a Cronbach's α of .95. No significant differences existed on the pre-training between the control group and the training group. Two-tailed t tests of the post-training evaluation showed the training group performed significantly better than the control group.

Latham and Saari (1979) reported that this study supports the approach of training first-line supervisors. Leadership skills can be taught as long as the trainees are given a model to follow, a set of goals, an opportunity to perfect the skill, feedback to the effectiveness of their behavior, and praise for applying the acquired skills on the job. Aspects of this program followed the theoretical framework of social-learning theory.

Conceptual framework. The conceptual framework for this study was chosen based on "best fit" after reviewing the literature and examining different theoretical perspectives such as social learning theory. As previously mentioned in this chapter, Stewart and Krueger (1996) introduced a concept analysis of mentoring in nursing. Rodgers (as cited in Stewart & Krueger, 1996) explained nursing concepts as properties

of objects that can be studied, the building blocks of theory, and aspects that may be quantified. Rodgers also noted that nursing concepts contribute to knowledge development through their descriptive powers. Stewart and Krueger used Rodgers' concept analysis to clarify the meaning of mentoring in nursing and to develop its theoretical definition. The authors outlined eight steps for evolutionary concept analysis:

> selection of concept for the study; description of the setting and sample for data collection; extraction of the defining attributes of the selected concept, along with surrogate terms, references, antecedents and consequences; identification of related concepts; analysis of descriptors; comparisons across disciplines over time; identification of a model case, and implications for further development. (p. 312)

Stewart and Krueger's (1996) application of concept analysis identified the following six essential attributes of mentoring in nursing: a teaching-learning process, a reciprocal role, a career development relationship, a knowledge or competence differential between participants, a duration of several years, and a resonating phenomenon. Each of these six attributes have each been identified throughout the literature review for this study and will act as a guide for the research questions posed for this study.

The attribute of "A teaching learning process" was supported by Ryan et al. (2010) noting that novice nurses depend heavily on their more experienced colleagues for support and mentoring. Myall et al. (2008) examined mentoring of nursing students in the United Kingdom. Mentors from Myall et al.'s study reported awareness of the significance of their role in assisting the student with linking theory to practice.

"A career development relationship" was supported by several authors: Manfredi (1996) wrote "Nurse managers… spend a great deal of time attempting to develop staff and identifying needs for further personal/professional growth" (p. 326). Holloran (1993) noted that while a nurse can elevate herself to an executive level without mentoring, having a mentor helps the nurse leader to succeed and move to higher positions of power and authority. Parsons and Stonestreet (2003) suggested strategies focusing on career development (to retain nurse managers) based on the themes found in their research, including relationship building with nurse managers; involving nurse managers in planning and decision making; empowering; developing orientation and professional development systems, to include leadership skills; supporting work/life balance for nurse managers; recognizing quality of care in the nursing units; and recognizing and rewarding nurse manager retention.

"A knowledge or competence differential between participants" was supported by several authors. Wieck et al. (2010) noted that new nurse managers need mentoring from more experienced nurse managers to assist the novice manager with transforming management skills into leadership skills. As already mentioned in "a teaching-learning process" attribute, Ryan et al. (2010) noted novice nurses depend heavily on their more experienced colleagues for support and mentoring. Mills et al. (2007) noted experienced rural nurses used mentoring (with novice nurses) as a means to raise awareness of political actions that nurses can take to protect their roles and capabilities. Mills et al. (2007) also noted that mentoring meant teaching the novice nurse about image protection and enhancement.

"A duration of several years" was supported by Block et al. (2005), who reported

mentoring remains more than an orientation program; it consists of a long-term

commitment for organizational success. Participants from the Waters et al. (2003) study

reported that commitment to an ongoing relationship as highly desirable. Manfredi

(1996) reported that NMs are more likely to engage in long-term mentoring with their

own assistants, prepping them for future leadership roles. Balasco-Cathcart et al. (2010)

wrote that nurse managers required ongoing support and development by senior

leadership to sustain the complexities of practice development.

"A reciprocal role" was supported by findings from McCloughen et al. (2009)

who examined nurse leaders' experiences with mentoring and found a theme of esteemed

connection. This connection meant that the relationship of the mentor and mentee went

beyond the initial union, considering each other with positive regard, developing

respectful boundaries, and honoring key human characteristics. With regard to

relationship building between the mentor and mentee, Mills et al. (2008) stated, "It is this

incremental change in the dimensions of trust and engagement that occurs over time and

can move a mentoring relationship into one of deep friendship" (p. 605).

"A resonating phenomenon" was supported by Block et al. (2005), who stated that

nurses value mentoring relationships, and experienced nurses have a responsibility to the

profession to enhance the professional development of new graduates. Myall et al.

(2008) noted that mentoring contributes to the future of nursing.

The first research question (To what extent do nurse managers in rural hospitals

experience mentoring after acquiring their new role?) was created based on findings from

the following authors: Kleinman (2003) wrote that promotion to the nurse management

position was based on clinical expertise, which left the new manager feeling unprepared for the administrative duties associated with the management role. Paliadelis et al. (2007) interviewed nurse managers in Australia to explore the coping mechanisms used by those new to their role. The findings from Paliadelis et al.'s study revealed that the NMs felt poorly prepared for their new role. The managers appreciated the informal support networks in their workplace, yet, overall, the NMs felt unsupported from their organization. Twenty-nine percent of the participants from Holloran's (1993) study reported they did not have a mentor because no one with enough expertise was available for mentoring. Attributes from Stewart and Krueger (1996) that support this question include a teaching-learning process, a career development relationship, a knowledge or competence differential between participants, and a duration of several years.

The second research question (How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?) was created as a result of Madison's (1994) study. Madison explored the general characteristics of mentoring relationships, as perceived by nurse administrators, by asking participants to describe the characteristics of mentoring relationships and exploring the perceived effects of those relationships on their professional lives. Nurse administrators from Madison's study attributed changes in their professional lives to mentoring. The participants from Madison's study also noted an improvement in their self-confidence and feeling valued in their role.

The third research question (What are the most beneficial pieces of advice rural nurse managers received from a mentor?) came as a result of this researcher not identifying any research findings specific to this question. Attributes supporting the need

143

for this question include a reciprocal role and a knowledge or competence differential between participants.

Finally, the fourth research question (To what extent has mentoring influenced rural nurse managers as leaders?) arose as a result of the following authors: Upenieks (2002) noted that access to empowerment structures (opportunity, power and proportion) in the work place created a better climate for nurse leaders and their staff. Holloran (1993) reported that mentoring provides an avenue for transmitting important nursing values and culture to emerging nurse leaders. Patrick and Laschinger (2006) found that an empowered middle level nurse manager, with strong organizational support and job satisfaction, acts as a powerful role model for potential nurse leaders within the organization. The purpose of Mathena's (2002) study was described as, "There is scant literature regarding what nurse manager skill sets should be cultivated to effectively support and lead nursing staff..." (p. 138). Attributes from Stewart and Krueger (1996) that support this question include a teaching-learning process, a reciprocal role, and a career development relationship. Two of those supported this question - a career development relationship and a resonating phenomenon.

Findings from this literature review reveal the importance of mentoring today's nurses and nurse managers in order to increase nurse retention and decrease the nursing shortage. Satisfied nurses remain the link between patient satisfaction and good patient outcomes. Nurse managers are in a unique position to directly impact their staff's job satisfaction and positively impact patient outcomes; however, becoming an effective nurse manager does not occur with ease. Nurse managers require mentoring from those more experienced to navigate their way through the specific requirements of their job.

Rural nurse managers face situations unique to rural settings, making it essential that they engage in a mentoring relationship to help them become better adjusted in their new role.

Chapter three will detail why qualitative methods were the best choice to interview nurse managers with regard to their experiences with mentoring while serving in their leadership role.

CHAPTER III

METHODOLOGY

This study examined the experiences of mentoring among nurse managers in rural

hospitals. This chapter addresses the research design, the research context, research

questions, participants, data collection procedures, interview information, and data

analysis procedures. Also addressed are the role of the researcher, ethical considerations,

and how credibility of data was achieved.

Research Design

Bogdan and Biklen (2003) described a phenomenological perspective as an

"attempt to understand the meaning of events and interactions to ordinary people in

particular situations" (p. 23). The phenomenological approach emphasizes the

interpretive understanding of human interaction, and phenomenological research does not

assume to know what things mean to the individual(s) being studied. The researcher

attempts to gain entry into the world of their subjects to better understand how and what

meaning they construct around their daily lives. According to Bogdan and Biklen,

"Qualitative researchers believe that approaching people with a goal of trying to

understand their point of view, while not perfect, distorts the informants' experience the

least" (p. 23).

Examining the experiences of mentoring among nurse managers required a

phenomenological perspective because of the richness of data obtained during the

interviews. As stated in chapter one, very little qualitative data exists on nurses'

experiences of mentoring, especially mentoring of nurse managers. This study illicited first-hand accounts of on-the-job experiences from nurse managers — information that could not be attained via quantitative measures. Consequently, this research adds to existing literature and illuminates the importance of mentoring in the profession of nursing.

Research Context

Rural hospitals face unique challenges which nurse managers must be well-equipped to handle. Eldridge and Judkins (2003) stated the rural environment has different characteristics that affect how nurses and nurse administrators function. Characteristics of the rural health care environment include having higher risk factors, such as higher rates of tobacco and alcohol use and proportionally older and poorer populations. Eldridge and Judkins suggested six essential competencies for rural nurse administrators: financial management, leadership, workforce management, cross-disciplinary management, integration of need-based community service, and maximizing resources.

According to WKU's South Central Area Health Education Center (AHEC) webpage (2011), southcentral Kentucky typically refers to the counties in southern Kentucky located between I-65 and I-75 and south of Louisville and Lexington, Kentucky. Approximately 22 counties make up the southcentral Kentucky region. The vast majority of counties located in this region have populations less than 100 persons per square mile and are 25 miles or more from urban or metro areas. Hospitals used for this researcher's study were located in Scottsville (Allen County), Glasgow (Barren County), Russellville (Logan County), Hartford (Ohio County), Campbellsville (Taylor County),

and Franklin (Simpson County). The counties were chosen because they met criterion of qualifying as rural and having a small hospital which serviced the rural population.

Allen County has a total population of 19,956 persons and 58 persons per square mile. Ninety-six percent of the population consider themselves as white, non-hispanic. In 2009, median household income equaled $36,353, and 18% of the population lived below poverty level (U.S. Census, 2011). The unemployment rate for 2010 equaled 12.0% (U.S.D.A., 2011). The Medical Center of Scottsville has 135 beds, which includes 110 long-term care beds.

Barren County has a total population of 42,173 and 86 persons per square mile. The vast majority (91.5%) consider themselves white, non-hispanic. Median household income in 2009 equaled $35, 993, and 19.7% of the population lived below poverty level in 2009 (U.S. Census, 2011). The unemployment rate for 2010 equaled 12.0% (U.S.D.A., 2011). T.J. Samson Community Hospital is a 196-bed facility, which includes 16 skilled care beds.

The total population of Logan County is 26,835, with 48 persons per square mile. Eighty-nine percent of the population consider themselves to be white, non-hispanic. In 2009 median household income equaled $37, 329, and 18.4% lived below poverty level (U.S. Census, 2011). The unemployment rate for 2010 equaled 10.1% (U.S.D.A., 2011). Logan Memorial Hospital has 92 beds.

Ohio County's population in 2010 equaled 23,482 and 41 persons per square mile. Nearly 95% of Ohio County's population classified itself as white, non-hispanic in the 2010 Census. From 2006 to 2010 the median household income equaled $35,975, and 19% lived below poverty level (U.S. Census, 2011). Ohio County's unemployment rate

in 2010 equaled 9.2% (U.S.D.A., 2011). Ohio County Hospital has 25 beds and provides inpatient and outpatient services.

Simpson County has a population of 17,327 persons and 73 persons per square mile. Eighty-six percent consider themselves as white, non-hispanic. Median household income in 2009 equaled $40,357, and 15% in Simpson County lived below poverty level in 2009 (U.S. Census, 2011). The unemployment rate for 2010 equaled 12.6% (U.S.D.A., 2011). The Medical Center at Franklin has 25 beds and provides inpatient and outpatient services.

The population of Taylor County equaled 24,512 persons in the 2010 Census, with 92 per square mile. Ninety-one percent of the population considered themselves as white, non-hispanic. In 2010 median household income equaled $35,962, and 23% of Taylor County's population lived below poverty level (U.S. Census, 2011). The unemployment rate for 2010 equaled 10.8% (U.S.D.A., 2011). Taylor Regional Hospital is a 90-bed facility and offers inpatient and outpatient services.

Research Questions

The following research questions guided this study:

1. To what extent do nurse managers in rural hospitals experience mentoring after acquiring their new role?

2. How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?

3. What are the most beneficial pieces of advice rural nurse managers received from a mentor?

4. To what extent has mentoring influenced rural nurse managers as leaders?

Participants

Purposeful sampling was used to ensure the inclusion of participants who could offer rich information addressing the research questions under study. Bogdan and Biklen (2003) define purposeful sampling as choosing particular subjects to include because of their ability to facilitate the expansion of the developing theory. The participants included ten mid-level nurse managers at inpatient rural hospitals in southcentral Kentucky. The sample consisted of ten females. Employment ranged from five years to 27 years, with an average tenure of 14.4 years. Participants' experience in a managerial role ranged from three months to five years, with an average of 23.4 months in the role.

Based on the nature of the research questions being explored, participants were purposefully selected to meet three criteria. First, participants were mid-level nurse managers whose responsibilities included the day-to-day operations of their unit. For example, their job description likely includes (but is not limited to) duties such as oversight of their staff of nurses, nursing assistants, and unit clerks; interviewing and hiring new staff; taking disciplinary action against staff; scheduling; assigning duties; ensuring compliance of patient safety standards is met; conducting performance evaluations; managing conflict; addressing patient complaints; and creating and staying within the created budget. Second, participants had no more than five years of experience in an administrative role. The nurse manager who is new to the role will more likely recall feelings and experiences more readily than the nurse manager who has longevity and tenure in the role. Third, participants were employed in a rural hospital. As outlined in chapter one, the U.S.D.A. qualifies rural populations as communities outside of an urban area or urban cluster. Urbanized areas and urban clusters are areas

with a central city and a population density of at least 1,000 people per square mile and are surrounded by areas with a population density of at least 500 people per square mile (a total population of 50,000 or more). If the community does not qualify as urban, then it qualifies as rural.

In summary, the mid-level managers had the information and experiences necessary to help the researcher better understand the everyday experiences of mentoring in rural hospitals.

Data Collection Procedure

Prior to collecting data, approval to conduct this study was obtained from the University of Louisville and Western Kentucky University Institutional Review Boards (Appedix A). According to Bogdan and Biklen (2003), ethical guidelines attempt to insure subjects enter research projects voluntarily, with an understanding of the nature of the study, and are not exposed to risks greater than the gains they might experience. For this study, the participants were informed that: (a) their participation was voluntary, (b) they could withdraw from the study at any time, (c) their responses were recorded with a handheld digital audio recorder, (d) their responses would be kept in strict confidence, and (e) anonymity would be maintained throughout the study. Assurance was provided that their participation was confidential and comments would remain anonymous. Steps taken to ensure anonymity included the following: a number was assigned to each participant to prevent identification by name; the location (the name of city and hospital) was not identified in the transcription; and the taped and written interview data were kept at the researcher's personal residence and not shared with anyone. Each participant

signed a voluntary consent form (Appendix C). Participants were provided a copy of the form for their own records.

The researcher gained entry into this pool of participants by contacting directors of nursing at rural hospitals. To assess the willingness to participate in the study, an email was sent to nurse administrators at six rural hospitals in southcentral Kentucky asking if they would agree to be interviewed with regard to their personal experience with mentoring in their position as a manager (Appendix B). Initial correspondence included a brief description of the study and assurances of confidentiality. To solicit more responses, a follow-up email was sent approximately two weeks after the initial email.

Interviews

Interviews were conducted at the work site of the interviewee. Each interview lasted approximately 25 to 40 minutes with an average of 31 minutes and a total of 5 hours 7 minutes. Interviews were audio taped, with consent of the interviewees, and transcribed verbatim, generating 14 pages of single-spaced text.

Following a review of the participant consent form, the researcher gave a brief introduction to the study, stating the purpose of exploring mentoring experiences among new nurse managers in a rural hospital setting. Semi-structured interview followed a pre-determined guide of open-ended questions, as well as follow-up questions and probes when necessary. The semi-structured format enabled the researcher to explore similar topics across all participants, as well as to build conversation and probe new areas as they emerge (Roulston, 2010). Interview questions explored the participants' views of mentoring, their experiences of mentoring once in their management role, their role transition from staff nurse to nurse manager, etc. At the conclusion of the interview,

interviewees were asked if they could be contacted for further clarification of any points of the interview.

Data Analysis

Lindlof and Taylor (2011) explained that data analysis serves the goal of conceptual development. Analysis includes the process of breaking down and labeling raw data, followed by restructuring the data into categories, patterns, themes, concepts, and propositions. More specifically, a thematic analysis was conducted using a constant comparative method that began with open coding. Bogdan and Biklen (2003) describe the constant comparative method as a research design for data from multiple sources (participants). Analysis of the qualitative data begins with the first interview and is completed at the end of data collection. Components of the constant comparative method include data collection; looking for key issues or recurrent events that become categories; collecting data that can give examples for the categories; writing about the categories using descriptive words while continuing to search for new examples; attempting to discover basic social processes and relationships; and continually engaging in sampling, coding and writing as part of the analysis.

Strauss and Corbin (1998) described open coding as a process in which data are broken down into parts, closely examined, and compared for similarities and differences. As the researcher read and re-read interview transcripts, labels were given to assign meaning to various concepts that emerged. The analysis generated 70 open codes. Units of analysis included words, phrases, sentences, and paragraphs that contributed to understanding the topics of interest.

At the next step, events, happenings, actions, etc., that were found to be conceptually similar or related in meaning were then grouped into categories. According to Strauss and Corbin (1998), "the purpose behind naming phenomena is to enable researchers to group similar events, happenings, and objects under a common heading or classification" (p. 103). Each category was then given properties and dimensions to define its characteristics. Properties are the general or specific characteristics of a category, while dimensions represent the location of a property along a continuum. Grouping concepts into categories is important because it enables the analyst to reduce the number of units with which he or she is working. Categories have analytic power because of their potential to explain and predict.

Once the categories were identified by analysis, using a constant comparative working back and forth among the data, categories were compared and contrasted for larger patterns or themes. A theme was characterized by one or more of Owen's (1984) criteria of recurrence, repetition, and forcefulness. Recurrence is found when two parts of the data reflect the same meaning, even if different words are used. Repetition includes key words or phrases are repeated in two parts of the data; and forcefulness includes significant changes in volume, inflection, positioning, or the use of dramatic pauses or follow-up phrases to show the importance of that part of the conversation. Finally, themes were interpreted, and the data were re-examined for supporting evidence and any contradicting outliers.

Role of Researcher

Creswell (2003) describes qualitative research as interpretive research, with the investigator involved in a sustained experience with participants. Because of the

154

investigator's intense role in data collection, ethical and personal issues are introduced into the research process. Creswell stated that researchers must explicitly identify their biases, values, and personal interests about their research topic and process. Creswell also noted that "gaining entry to a research site and the ethical issues that might arise are elements of the researcher's role" (p. 184). Several methods were listed in which a researcher may counteract potential biases such as the following: including statements about past experiences that provide background data; disclosing connections between the researcher and participants and research sites; recounting steps taken to obtain permission from the human subjects review board; discussing steps taken to gain entry to the setting and to secure permission to study the informants; and commenting about sensitive ethical issues that may arise, such as masking the names of people, places, etc. Several of these points have been addressed in this chapter. The following paragraphs describe this researcher's background experiences, potential biases, and how those were controlled.

This author's previous work experiences include working as a nurse since 1995. Professional roles include working as a staff nurse in the U.S. Army as well as a civilian for a total of six years prior to attending graduate school. After finishing graduate school, this researcher taught in Western Kentucky University's School of Nursing and worked as a nurse midwife and a family nurse practitioner. At the time of this study, this researcher worked full-time as a nurse midwife.

This researcher's professional background could potentially generate particular biases based on the positive and negative experiences with nurse managers. Preconceived notions may exist as to what the nurse managers have experienced with regard to mentoring. To account for biases, data was not collected in the researcher's

"backyard" as Glesne and Peshkin (1992) described. Backyard research includes studying the researcher's own organization, friends, or immediate work setting. Rather, participants were sought in a different geographic area using the contacts of other nursing professionals. Also, as previously described, prior to contacting participants for interviews, permission for the research was obtained from the Institutional Review Boards from both University of Louisville and Western Kentucky University. Gaining entry to participants has been previously described in this chapter, and anonymity of each participant was kept throughout the research process. Anonymity was ensured by assigning each participant a number rather than identifying the participant by name. Also, the names of the hospitals and cities were withheld during the transcription process. The taped interviews and transcriptions were kept at the researcher's personal residence and not shared with anyone.

Other steps taken to account for biases included keeping a journal while collecting data. Lindlof and Taylor (2011) wrote, "fieldworkers often need companions even when there are no colleagues around in whom to confide. Journals and diaries fill this need" (p. 163). Journaling helped to manage data by recording dates of fieldwork sessions, the names of people met and interviewed, etc. However, it also served as a means to vent feelings, doubts, questions, and assumptions while collecting data.

In addition to keeping a journal, member checks were performed with several participants to ensure accuracy and prevent researcher bias. Member checks, as described by Lindlof and Taylor (2011), occur when the researcher takes the findings back to the field to determine whether the participant recognizes them as true and

accurate. Four participants were asked to review a draft of the findings and offer their feedback.

Last, several members of this researcher's dissertation committee reviewed transcripts and verified findings for accuracy. Because some members of the committee had little or no experience in the nursing profession, they were able to assess the relationships between the data and the findings.

The following subsections refer to how qualitative researchers can ensure quality of their findings.

Components of Credible Qualitative Research

Trustworthiness of study. Glesne and Peshkin (1992) noted that time is a major factor in the acquisition of trustworthy data. Time at the research site, time spent interviewing, and time to build relationships with participants all contribute to trustworthy data. Glesne and Peshkin also noted that continual alertness to the researcher's own biases and subjectivity aides in producing a more trustworthy product. Lincoln and Guba (as cited in Glesne & Peshkin, 1992) suggested a procedure for enlisting an outsider to audit fieldwork notes and subsequent analysis and interpretation. Another aspect of trustworthiness, according to Glesne and Peshkin, is to realize the limitations of the study. This researcher detailed the circumstances to help the reader understand the nature of the data, outlined what people or places were unavailable, and discussed the peculiarities of the site(s) and/or participant selection. This researcher also explained the limitations as part of the setting context.

Confirmability. Confirmability is the equivalent to objectivity in conventional research (Lincoln & Guba, 1985). Confirmability refers to the degree to which the

results can be confirmed or corroborated by others. Erlandson, Harris, Skipper and Allen (1993) suggest two strategies for enhancing confirmability. The first strategy is to utilize a research methodology that is clearly explained, open to public scrutiny, and replicable. The second includes using a methodology that guards against the potential for bias or distortion. For this study, this researcher documented the procedures for checking and rechecking the data, e.g., left a data trail, as well as performed an audit of the data throughout the study.

Transferability. Transferability in qualitative research refers to the degree to which the findings can be generalized or applied to other contexts or settings (Erlandson et al., 1993). This researcher enhanced transferability by thoroughly describing the research context (thick description) and the assumptions that were central to the research. Purposive sampling also was used to gain "insight about what is relative to the study" (Erlandson et al., p. 33). Any person who wishes to transfer the results to a different context is then responsible for making the judgment of transferability of findings.

Dependability. Dependability is the qualitative term for reliability of findings. This aspect of qualitative research "provides its audience with evidence that if it were replicated with the same or similar respondents (subjects) in the same (or similar) context, its findings would be repeated" (Erlandson et al., p. 33). Dependability emphasizes the need for the researcher to account for the changing context within which research occurs. Dependability of findings occurred through an audit trail. A reflexive journal served as a record of the study and as a means to analyze potential biases. The audit trail provided a system of checks and balances for the study.

Credibility. Credibility "relates to the degree of confidence in the 'truth' that the findings of a particular inquiry have for the subjects with which . . . the inquiry was carried out" (Erlandson et al., p. 29). In other words, the research findings must be credible or believable from the perspective of the participant in the research. The purpose of qualitative research is to describe or understand the phenomena of interest from the participants' eyes; the participants are the only ones who can legitimately judge the credibility of the results. As suggested by Erlandson et al., this researcher strengthened credibility by peer debriefing, member checks, and triangulation of data.

Summary

Chapter three addressed the research methods used to gain insight into the mentoring of mid-level nurse managers. A qualitative approach using open-ended, semi-structured interview questions explored the mentoring experiences of mid-level nurse managers in rural hospitals. Procedures for this study followed outlined expectations established by qualitative experts in the research field. The processes and procedures followed in the current study produced trustworthy results, as well as research that is confirmable, dependable, and credible.

This chapter presented the study's research design, context, participants, role of the researcher, data collection procedures, data analysis procedures, ethical considerations, and data trustworthiness. Describing the details of the methods used for the study provides a basis for understanding the study results. Chapter four will outline the findings as shared by mid-level managers interviewed for this study.

CHAPTER IV

FINDINGS

Research for this study focused on new rural nurse managers and their

experiences with mentoring. Chapter four presents the findings of interviews conducted

with ten rural nurse managers. Interviews were tape recorded and lasted between 20 to

38 minutes, averaging 31 minutes. All ten participants were females, and time spent in

the nurse manager role ranged from three months to five years. Average time spent in the

role equaled 24 months. Educational backgrounds for the participants ranged from

having an Associate Degree in Nursing (ADN) to having a Master of Science in Nursing

(MSN) Degree.

Institutional Review Board (IRB) consent was obtained from University of

Louisville and Western Kentucky University. Institutional Review Board standards

require that anonymity of participants be maintained throughout the interview,

transcription, and analysis process. Keeping in accordance with IRB standards of

anonymity, the participants' names have been changed for the presentation of chapters

four and five. The following bullets describe each of the participants:

- Shelly has been a nurse since 1991. She first earned her ADN, then earned

  her bachelor's degree in nursing (BSN) in 2006. She has been in her

  management role for 12 months.

- Mary has been a nurse since 1996, when she earned her BSN. She earned her MSN in 2006. Mary has held her current role of manager for 3 years 3 months.

- Joanie has been a nurse since 1985. She is an associate degree nurse, but is currently enrolled in an RN to BSN program. She has been a nurse manager for exactly five years.

- Allison earned her BSN in 1998. She has held her role of nurse manager for six months.

- Heather has been a nurse since 2000. She has an ADN degree and is enrolled in an RN to BSN program. She has held her role for 2 years.

- Sarah has been a nurse since 2003. She currently holds a BSN degree. She has been a nurse manager for 2 years.

- Emily earned her nursing degree in 2001. She currently holds a BSN. She has been in her role for 13 months.

- Stacy first became a nurse in 2006 when she earned her BSN. She currently holds an MSN. She is the newest participant to become a nurse manager; she has been in her role for 3 months.

- Kelly has been a nurse for 12 years. She currently holds an ADN degree, but is enrolled in an RN to BSN program. She has been a nurse manager for four years.

- Karen has been a nurse for 17 years. Initially, Karen earned her licensed practical nurse (LPN) license, then earned her ADN, BSN and MSN. She took the nurse manager role 14 months ago.

Chapter four will present the research questions, with supporting theme(s) and coinciding categories outlined for the reader. The following research questions guided this study:

1. To what extent do nurse managers in rural hospitals experience mentoring after acquiring their new role?

2. How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?

3. What are the most beneficial pieces of advice rural nurse managers received from a mentor?

4. To what extent has mentoring influenced rural nurse managers as leaders?

As a reminder to the reader, the definition of mentor used for this study includes Vance and Davidhizar's (1996) explanation: "A mentoring relationship will socialize a person or persons to the professional norms, values, and standards, will provide entry into the inner circles of the profession, and will promote the profession's growth by ensuring continuity and quality of leadership" (p. 199).

During analysis, one theme, *difficult transition to management role*, emerged from rich, valuable data; yet, the theme failed to address any of the research questions used to guide this study. Despite not answering a research question, the theme and its supporting categories contained valuable insights into the feelings experienced by new nurse managers and seemed to contextualize other emerging themes. Excluding the findings would result in a less accurate report of participant responses. Therefore, the following section addresses the theme of *difficult transition to management role* and its supporting categories.

Theme: Difficult Transition to Nurse Manager Role

All participants made reference to the wide range of emotions they experienced during the transition to their nurse manager role. Participants felt vastly unprepared for the requirements of their new position; words and phrases used by participants to describe their feelings during this transition included "scared, overwhelmed, nauseous, fear" and were spoken repeatedly by participants. Emily described the transition as, "It's kind of like going from middle school to high school. It's like you feel real comfortable and then things are chaotic." Categories were developed based on the repetition of participants reporting feelings of fear and unpreparedness for their role. Categories included fear of failure, difficulty in figuring out resources, dealing with daily fires, and lack of manager training.

Fear of failure. Feelings of fear arose as a common emotion experienced by participants. Shelly, who has been in her role for 12 months, described her transition experience in the following manner, "It's uncomfortable. Very scary...My biggest fear was that I would come in and make a mess. It's paralyzing. I just now come in and feel comfortable with the day and projects that I've been assigned." Kelly's experience was similar to Shelly's. Kelly stated, "I felt overwhelmed. I was not sure if I could do it. I finally feel good about what I'm doing in my job, and I've been doing this for three years." Participants indicated that their feelings of fear diminished with time as they gained experience in their role.

Difficulty in figuring out resources. Participants in this study identified the importance of knowing who and what their resources were when coming into the new role. Stacy described her need for identifying resources, "A lot of times I haven't known

my resources. They are out there, I just don't know what they are." Emily had similar feelings. Emily reported, "I needed help learning who everybody is, knowing who to go to, knowing who does what job . . . as a small facility, we wear many hats. Having those roles laid out would be very helpful." Because smaller hospitals require one person to hold multiple roles, new managers found it hard to identify resources.

Dealing with daily fires. The term "daily fires" came up in conversation with several participants. Dealing with daily challenges seemed to overwhelm the participants. Heather shared her thoughts, "Every day I have to deal with something I've never dealt with before. They didn't teach you in nursing school how to deal with someone who abuses FMLA (Family Medical Leave Act), manipulates other staff, gets patient complaints." Karen made a similar statement, "I lacked confidence. I felt like I was putting out fires all of the time." Shelly described her feelings:

> I felt like when I first started, the job ran me instead of me running the job. You
>
> just handle the things that come in each day. I thought 'there has got to be some
>
> plan, some vision . . . I just can't handle the problems.'

Mary echoed this idea of 'putting out fires.' Mary described it as:

> You never know daily what you're going to get into. There are episodic events.
>
> It's important for your mentor to be able to see things that you aren't seeing. It's
>
> like you are in a fog. I've had it described to me like you have an ax in each hand
>
> and you're just going at it, (participant makes chopping motion with both hands).

Lack of manager training. Five of the participants reported their facility did little or nothing to help them with formal management training. Many of the participants' responses to the question, "How did your organization help you with

mentoring?" focused on the desire for more training in budget and conflict management. Stacy stated she desired more leadership management training. Stacy explained, "I feel like I need a lot of guidance. I may feel like I have a good idea, a new idea, but I still need a sounding board. I need someone to validate what I'm thinking, or offer me another way to look at things." Allison did not directly admit to wanting manager training, but she shared that she is unsure of how to handle the new responsibilities. Allison stated, "Responsibilities are different from what I've had in the past, like dealing with scheduling. As a staff nurse, you don't have to deal with that."

The remainder of chapter four addresses the research questions guiding this study and the relevant themes emerging from data analysis.

Theme: Perceptions of Having a Mentor

The first research question aimed to investigate the rural nurse manager's experiences with mentoring; specifically, did the rural nurse manager experience mentoring, and if so, how much? The interview questions elicited information from the participants to determine their own definition of mentoring and explored their mentoring relationships.

The extent to which nurse managers experienced mentoring varied according to the nurse manager and the setting. Nine of the ten nurse managers interviewed reported being mentored once they acquired their new role, and one nurse manager identified that she had not been mentored since taking her new position. Each of the interviewees described her own definition of mentoring and related her experience to what she thought it meant to be mentored. Based on the perceived definition, each nurse manager was able to describe why or why not they were able to identify a mentor. Six interviewees

165

identified a mentor based on the definition used in this study, while three described a relationship more closely related to a boss, trainer or preceptor. Training and preceptoring serve as a means to introduce roles and responsibilities to the new employee, but do not necessarily involve professional development (i.e., mentoring) of the new employee. Therefore, the theme *perceptions of having a mentor* captures the differing degrees to which participants experienced a true mentoring relationship, as defined by Vance and Davidhizar (1996). Three categories supported this theme: true mentoring, perceived mentoring and no mentoring.

True mentoring. True mentoring came as a result of the interviewee describing a relationship that was consistent with the definition of mentor used for this study. Six participants described relationships with their respective mentors that involved high levels of trust, open communication, mutual respect, and having easy access to their mentor. Nurse manager Shelly described her mentor in the following manner:

> I have my previous director, she and I have worked together laterally over the years. I have always respected her. She is a very hard worker, intelligent. She encouraged me to apply for this position, even though it would mean losing me from her department. She still encourages me. I'll say to her, "this is what I have going on, this is what I think." She comes to me, asks me what I think. She's a little older and a little more experienced than I am.

Mary described her mentor as her friend. She expressed her mentor as follows:

> She is extremely experienced, and she is also confident in her leadership role. She has a lot of experience to bring to the situation, which is very valuable. There

166

has not been one situation that I've had to talk to her about that she did not have something to share. She doesn't give me advice, she just kind of shares.

Emily portrayed her mentor with a similar statement, "We have an open line of communication. I do not feel like I cannot ask something. I feel like I have some guidance."

Quotes used for this category reflected examples of relationships that went deeper than the boss/employee relationship. Participants respected their mentors because of the mentor's experience and the style and level of communication the participant had with their mentor. An underlying aspect of the relationship between new manager and mentor was the amount of trust between the dyad. Without trust, the dyad would not exist.

Perceived mentoring. Three participants provided information to this researcher which was more closely aligned with a boss or preceptor, not a mentor. Greene and Puetzer (2002) described a preceptorship as "an instructional program in which nurse preceptors facilitate the integration of newly employed nursing staff into the role responsibilities" (p. 68). Participants identified their respective boss as their mentor, yet physical or verbal cues revealed that the participant was describing a boss/subordinate relationship and not a mentoring relationship. An example of perceived mentoring is Allison's description of her mentor:

> My boss, she helps me out the most. It would have been nice to have had the lady that was over [the department] before to have trained me. I didn't have that. I've kind of just been thrown into it. My boss has been a nurse for several years and she's helped me out. She's also new to being the administrator over us.

167

Similarly, Heather also described her relationship with her boss when asked about a mentor. "That's just something that developed from working together," she explained. Heather continued to say:

I would probably consider [my boss] my mentor. She's the one I go to when I have questions. We can discuss things. You have a question, she answers it. I think she's kind of my unofficial mentor if I had to label someone.

Clearly, these participants held a very limited view of what it means to be a mentor. For them, a supervisor's act of helping or answering an employee's questions was enough to perceive a person as a mentor. Others, however, recognized the lack of a mentoring relationship.

No mentoring. One participant, Sarah, provided her own definition of mentoring, "Mentoring means that someone is going to help me along the way and show me what I need to know to be able to perform my job to my fullest capabilities." Based on her own definition, Sarah admitted that she could not identify a mentor. The following description portrays the relationship that Sarah has with her boss:

My boss helps me some. She has helped me with the technical aspect of things. I really felt like I needed help in a lot of places. I feel like she was there to help me with the technical aspects of things, but not to mentor me.

Sarah's definition of mentoring was more reflective of Vance and Davidhizar (1996) on developing the mentee, not merely showing them the ropes of their job. Consequently, she was able to better discern her work relationships and concluded that while she gets help from others, she really did not have a true mentor in her new role.

Theme: Desirable Traits of a Mentor

Question two sought to gain a better understanding of the nurse managers' perceptions of their mentoring experiences, e.g. good, bad, regrets, praises, etc. The interviewees who received mentoring described their experiences using mostly positive language. The role of the mentor was important to them for support. The participants spoke with praise and enthusiasm of their mentors, and similar language was used among the participants to portray the beneficial relationships. *Desirable traits of a mentor* eminated from participants describing the kinds of characteristics which constitute a mentor. Specifically, four categories arose that supported this theme: Open, non-threatening communication, a go-to person, mentor helps the mentee acclimate to role, and mentor has more experience than the mentee.

Mentor maintains an **open, non-threatening line of communication.** Emily referred to her relationship with her mentor as an "open line of communication. I don't feel like I can't ask something." Kelly reported she is "not afraid to take something to her [mentor]. She's open to talk with you." Similarly, Shelly revealed, "I felt like I could tell her when I messed up and she would be honest with me." Mary supported the need for "open dialogue, open communication, non-threatening communication" in a mentoring relationship.

For these participants, being able to approach their perceived mentor with questions about any topic was an important part of the mentoring experience. As noted previously, all participants admitted having difficulty adjusting to their new leadership roles, making open, inviting communication all the more critical as new managers seek resources to aid their transitions.

Mentor is a 'go-to person' and a resource. Stemming from the need to know who and what their resources were, participants felt this to be a key aspect of the mentor's role. Stacy described her mentoring relationship as an "availability, a resource. I never feel like I'm without a resource, which is very helpful." Allison appreciated "having somebody you can go to and ask things. You don't feel like you're alone. There is always somebody you can go to and ask." Mary felt it was important for the new manager to have "access to" the mentor, and the mentor should be "someone that is there for you." Mary also valued mentoring because "you have a go-to person, that's why it's important. You never know daily what you're going to get into. There are episodic events."

Having the mentor available for questions, handling daily challenges, determining resources, etc., was very important to the new manager for several reasons. First, as evidenced by the quotes in this category, the mentor provided the new manager with feedback and direction. Second, as the following category will reveal, the mentor's feedback availability also assists the new manager in gaining confidence in their new position.

Mentor helps the mentee acclimate to/gain confidence in the role. Feedback from the new managers in this study has already revealed feelings of fear and unpreparedness for their new role. Participants appreciated the mentor's availability and feedback, which in turn assisted the new manager with adjusting to the demands of their role.

Joanie reported her mentoring experience has "given me confidence. I have support when I make mistakes." Karen felt the ideal mentor was someone who "Instead

of giving advice right away, they will let you build confidence." Shelly supported these thoughts by stating, "Our personalities matched and it was a good relationship. [Our relationship] helped me to gain confidence."

Conversely, the lack of an available person to show the new nurse manager what their role consisted of was also an issue for new managers. It was important to the participants that they have access to the person who had previously held their role. Several felt insecure or unsure of their duties because no one was there to say exactly what needed to be done. Stacy explained, "Nobody was in the role when I came into this role, so there was no one who knew what needed to be done. I still don't know the whole filing system or what's on that shelf over there." Emily supported the need for having the previous person available to help her by stating:

> The lady prior to me, I took her position, she intended to help but that did not happen. She was skilled in the [information technology] part of the job. She wrote programs and that is all new to me. It was very difficult not having her available.

Allison also reiterated this need by revealing, "It would have been a little nicer if it had been somebody who'd had this position. They could say 'this is how I did it.' I really haven't had that."

Mentor has more experience than the mentee. Participants valued their mentors' experience as nurse managers. Participants wanted to soak up the knowledge that their mentors had acquired over time. Shelly explained the mentor should be "someone who has more experience and will give you honest feedback." Mary appreciated the fact that her mentor has a lot of leadership and management experience.

Mary explained, "[My mentor] is extremely experienced. She is also confident in her leadership role. She has a lot of experience to bring to the situation, which is very valuable." Karen benefited from her mentoring relationship because her mentor "is someone with experience. She shares her experiences, good and bad." Emily reported her mentor as someone who has "taken me under her wing. She did my role for many years, so she was highly educated in my role and could help me immensely." Kelly described her mentoring relationship as "What I already have. An open door policy. Someone who's been there, done that. They guide you and help you think through problems." Participants appreciated their mentors sharing good and bad experiences; participants did not think less of their mentor for sharing bad experiences; instead, the new managers respected their mentor for sharing learning points from these bad experiences.

Theme: Investing Time in People and Training

The third research question sought to uncover the most beneficial pieces of advice that rural nurse managers had received from a mentor. As noted previously, participants in this study felt largely unprepared for their new role on several fronts, primarily when dealing with the budget and also when dealing with difficult employees. Not surprisingly, participants perceived advice as especially helpful when it addressed *investing time in people and training*. Participants varied, however, in the ways they talked about advice. Some recalled pearls of wisdom they had received from their mentors, while others spoke about the advice they would pass along to their successors and others.

Give the new role one to three years before giving up. A pearl of wisdom passed along to Karen was to give the job three years. Stacy was encouraged to "Take your time in the position, don't get discouraged with things because the comfort level will come over time." Heather supported the idea of giving the new role time by stating, "I have found that anytime I have changed roles, it takes one to two years to develop a comfort level. This one (e.g., this role) may take longer. Just because every day I have to deal with something I haven't dealt with before." Emily described her transition into her new role, "I would tell someone coming into a new role to give it at least one year. Don't give up until after a year." Participants who had been in their role for at least one year displayed more self-confidence in their role, and they believed that time in the job was the main reason for feeling more confident.

Adapt positive leadership attributes. Leadership advice varied among participants but mainly focused on developing leadership personality traits, e.g., delegation, treating others fairly, showing consistency when dealing with employees, etc. Joanie shared several pearls of wisdom passed along to her: "Lead by example. Don't get overwhelmed. Learn to delegate." Kelly remembers a pearl of wisdom passed along to her, "Don't immediately open your mouth until you've had time to think about it. I've had to really work hard at that and be fair. Have all of the facts before you ever open your mouth." Kelly also felt it important to remain fair to all employees. She stated, "No good deed goes unpunished. If you bend the rules for one, then do it for everybody."

Although these participants acknowledged advice that had been passed along by their mentor, others talked more about the advice they would pass along to others.

Training in creating and managing a budget. Budget training arose in nearly all of the conversations with participants. Creating and managing a budget was stressful to the new manager because of the lack of experience in this area. Karen described her first experience with creating a budget as "baptism by fire." Karen advised new nurse managers to take some classes on budget. Joanie stated, "Budget is crazy. In the Emergency Department, you cannot predict how many people will be here, how much money you will make. The first year I needed help with budget." Shelly admitted, "Probably the most difficult part in this position is budget. I'd had no experience with budget prior to this job. I sought a different person out for this because my mentor didn't have a lot of experience with that." Mary advised for new nurse managers to meet their financial person as soon as they come into their role. Mary stated, "Have questions about the budget, don't be afraid to ask the hard questions." The next category, which alludes to dealing with difficult employees, also was commonly mentioned by participants.

Training in conflict management. Managing difficult employees was quite prevalent among all participants and very stressful for new nurse managers. Joanie reported "dealing with conflict management, dealing with an employee who needs disciplinary action has been the hardest for me." Allison revealed, "Responsibilities are different from what I've had in the past, like . . . dealing with conflict and dissatisfaction of staff. I'm having a problem with that right now. I've got to figure out how I'm going to deal with that." Karen felt it important for new managers to "Take classes on how to handle difficult people." Although Heather could not recall any pearls of wisdom shared with her, she wanted other nurse managers to learn how to deal with negative attributes of certain employees. Heather shared, "Some of the nurses who have been here the longest

have been the caddiest ones. I had to address some negative personality and work behaviors with a nurse who has been here for 20 plus years." Kelly shared:

> The most difficult part of my job is dealing with difficult employees. I've sat down with people and disciplined them harshly. Some have been able to stay, but some have had to go. It's very emotional, I've lost sleep over it.

In many situations, Kelly and others had learned how to handle difficult situations simply by being forced to do so on the job. However, they had learned from their experiences and were eager to share them to help others who might find themselves in similar managerial roles.

Do not change too much too soon. Several participants advised future nurse managers to not make immediate or abrupt changes when assuming their new role. Joanie wished to share with future nurse managers to not "go in and make a lot of changes at once. See how things are run, then work on improving." Shelly stated, "Take it one day at a time to start with . . . You see things you want to change immediately, but don't change things instantly. Be as laid back as possible." Shelly's advice to new nurse managers was to:

> Not to change too much too fast. Remember the old adage: hire slowly, fire quickly. You get in a hurry to hire people who are not the right fit, and then hang on to them too long. When you know they aren't going to work out, get rid of them . . . there are people who have been here for 30 years who should have been let go of 30 years ago.

These quotes reflected advice to new managers to take time in assessing the situation of the unit for the sake of long-term cohesiveness between the manager and unit

175

staff. As the following category reveals, participants felt it important for the new manager to invest their time in building relationships with their staff.

Spend time developing staff relationships. Building relationships with staff and staff well-being was also important to participants. Shelly advised new managers to "Learn the people and develop relationships." Stacy reiterated this by stating, "The reinforcement of how important it is to listen to your staff, to give them time, support, and care. The listening ear to let them know you care about what it's like." Stacy thought it important for new nurse managers to "Go out of your way to get to know your employees as individuals. See everybody face to face." Mary had similar advice, "Get to know your staff."

In short, these participants spoke differently about advice. Some recalled what mentors had told them, while others took the perspective of disclosing what they would pass along to others. Nonetheless, the content of the advice was quite similar, addressing major areas of concern in transitioning to a new role as rural nurse manager.

Theme: Discovering Individual Leadership Style on the Job

The next research question sought to determine the extent to which mentoring had influenced the leadership of new rural nurse managers. The theme of discovering individual leadership style on the job emerged as participants reflected on the leadership style of their perceived mentor, as well as how they see themselves as leaders. While most participants admitted to learning much about leadership on the job as they practiced their new role, data analysis did not identify one leadership style shared among participants. Moreover, participants differed on the degree to which they believed their leadership had been shaped by their mentor relationship. These differences are reflected

by two related categories: mimicked behaviors from their mentor and identification of desirable leader-subordinate skills.

Mimicked behaviors from their mentor. Approximately half of the participants reported they were able to identify positive or effective leadership traits in their mentor, and they understood it was important to mimic those desirable behaviors. These participants believed that having a mentor helped them to learn how to handle difficult situations and difficult employees, as well as seek help with creating a budget, etc. Mary identified the role of mentor as, "Role modeling correct behavior. Following policies, procedures and practices that have been identified by the facility as good evidenced based practice." Karen's response to how mentoring has affected her leadership style, "It's made me create my own style. I've realized [mentors] have given me good advice, but also take into consideration my employees' styles." Joanie shared, "[My mentor] has been great to make me stop and think and choose my words carefully. She has taught me communication is important. Taught me to stop and think." Allison described wanting to follow in her previous boss's footsteps, "You kind of try to do the same things they did." Shelly shared:

> I guess I have watched others, how they have handled the situation and thought 'that's a good idea.' You don't have just one mentor. One's good at budget, one's good at conflict. I try to mimic that. I know when to pull that skill out . . . On the same hand, I've seen people handle things poorly and learned what not to do.

These participants appear to have observed the leadership styles and traits of their mentors, particularly noting the leader behaviors that are effective and that they

themselves want to adopt and practice in their new positions. Conversely, other participants simply described their own leadership styles independent of their mentor relationship.

Sarah did not feel that mentoring had affected her leadership style. She stated, "I've just had to come up with it on my own and hope that I'm doing it right and hope that it works out okay in the end. In a year and a half, I've only had one person leave."

Identification of desirable leader-subordinate skills. Overall, several commonalities existed among the participants with respect to leadership traits they considered important. First, the most commonly identified trait mentioned among participants was fairness. Participants in this study were very proud of their ability to treat their staff fairly. Second, the participants mentioned shared governance as a way to describe how they wanted to run their unit, creating an environment where their staff felt like they were a part of the team and encouraging staff to participate in decisions affecting the unit. Each of the participants valued their staff's happiness and well-being. For many, however, their relationship with their mentor had no effect on their leadership style because the leadership traits they found desirable were traits they already understood to be important and had adapted into their daily management style.

Stacy described her leadership style as:

A little more open than I thought it would be. I learned a little more about shared governance when I [earned] my master's [degree]. I thought I would be a little bit more of a dictator, but I've had to learn to mix it and do both.

The following statement from Shelly provided an example of the reasoning not to use only one leadership style, but instead, to adopt several different styles:

I think you have to be a chameleon, not use one particular style. I think I am

transformational, maybe I'm not sure . . . At times, you have to be authoritarian.

You have to know how each person responds to each leadership style. You have

to be able to have more than one style.

Karen identified honesty and fairness as her main leadership priority. She stated,

"I am a stickler for fairness. You gain respect among your staff if you are fair." Kelly

supported this idea by stating, "I'm very fair and consistent with discipline. I have

learned by trial and error that you have to tell them when something is not right, but also

follow up with something positive." Heather's desire was, above all else, to be fair to her

employees. She explained:

Well, I've tried to be fair. That's been my number one goal. The whole time I've

tried to be as fair as I can be. Above everything else, no one can say 'she isn't

fair.' I try (although it probably hasn't worked to my benefit) to foster a friendly,

give and take environment.

Mary described her leadership style as "Democratic. Everyone has a seat at the

table and everyone at the table has a voice." Stacy had similar ideas with respect to staff

involvement. She stated, "I try to be very much open to their ideas and encourage them

every day to let me know what they think. I've given surveys to get their input, be

involved, to feel ownership." Sarah referred to her leadership style in the following

manner:

I really don't know how to describe it. I try to make everybody happy to the best

of my ability. I try to let staff have a lot of input on new things or the way we do

things at all . . . I try to let them have ownership.

Summary

In summary, the participants were generally satisfied with the amount of mentoring they had received. They used positive language to describe their personal mentoring experience. Their views on mentoring were positive, and they understood the importance of having a strong mentor when taking on a new role. Following the definition outlined by Vance and Davidhizar (1996), six of the participants described true mentoring relationships, while three described relationships more consistent with a boss or preceptor. One participant was able to define mentoring but was not able to identify a mentor.

The participants easily described desirable traits of a mentor. The described traits were traits they saw either in their mentor or traits they knew to be beneficial in the mentoring role. Aspects of desirable traits of a mentor included having open, non-threatening communication between the mentor and mentee; the mentor being a go-to person; the mentor helping the mentee acclimate to their new manager role; and, the mentor having more experience than the mentee.

Pearls of wisdom passed along to the participants, or pearls of wisdom the participants wished to pass along to future nurse managers, focused on investing time in training and relationships. The participants overwhelmingly identified budget training as a critical need for new managers. Also, participants felt unprepared for the conflict created by difficult employees. Thus, receiving conflict management training to assist the nurse manager in learning to deal with difficult employees came through in nearly all of the interviews.

Last, no common leadership style existed among all ten participants. They were divided on whether they thought mentoring had affected their leadership style. Some had mimicked positive attributes they appreciated in their mentor, while others felt their leadership style was already in place before they assumed their new management role. All participants valued fairness and treating employees as team players as a part of their leader/manager persona.

Chapter five provides a more in-depth discussion of these findings and how they relate to extant literature. Theoretical and practical implications will be addressed as well as limitations and recommendations for future research.

CHAPTER V

CONCLUSION

Chapter five presents a discussion of this study's findings. This chapter also provides an overview of how this study's analyses fit with the conceptual framework, implications, strengths, weaknesses, and recommendations for future research. Last, chapter five concludes with a summary of chapters one through five.

Discussion

The purpose of this study was to examine rural nurse managers' experiences with mentoring once assuming their new management role. This research study used qualitative methods to examine mentoring experiences. Ten nurse managers working in rural hospitals in southcentral Kentucky were interviewed for this study. Several factors were considered for inclusion into this study: (a) willing participation on the part of the rural nurse manager, (b) the nurse manager must have no more than five years of experience in the management role, and, (c) the nurse manager must be employed in a rural hospital. As a reminder to the reader, the following research questions guided this study:

1. To what extent do nurse managers in rural hospitals experience mentoring after acquiring their new role?

2. How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?

182

3. What are the most beneficial pieces of advice rural nurse managers received from a mentor?

4. To what extent has mentoring influenced rural nurse managers as leaders?

Participants in this study shared very insightful information about their mentoring experiences. As chapter four discussed, six of the participants reported mentoring relationships consistent with Vance and Davidhizar's (1996) definition of mentoring used for this research. Vance and Davidhizar's explanation of mentoring stated, "A mentoring relationship will socialize a person or persons to the professional norms, values, and standards, will provide entry into the inner circles of the profession, and will promote the profession's growth by ensuring continuity and quality of leadership" (p. 199). Three participants reported being mentored once assuming their new role; however, further discussion with the nurse managers revealed a relationship more consistent with receiving training or having a temporary preceptor. One participant understood what mentoring was, but she was unable to identify a mentor since assuming her role as nurse manager.

When examining the theme and categories emerging from the data analysis, it is clear that mentoring does make a difference and is very important. First, nurse managers experienced a lot of stress when assuming their new role. They often felt overwhelmed in their role and afraid of failing as a nurse manager. Another common finding among nurse managers came as a result of their need for more training in role specific duties. Many of the participants were unprepared for the tasks associated with their management role because these tasks were not required of them as staff nurses. Examples of desired training included training in creating and managing a budget and training in dealing with

difficult employees. A predominant style of leadership by participants did not emerge from the data analysis. Instead, participants adapted their leadership style(s) based on admirable traits portrayed by their mentor. Also, the participants created their own leadership style based on their individual personalities and the personalities of their respective staff. A consistent leadership quality deemed important by all ten interviewees in this study was the ability to treat their staff fairly in all circumstances.

Another finding from the data analysis was the desirable traits of a mentor identified by new managers. Participants valued open, non-threatening communication with their mentors. They discovered that having a go-to person and a resource person was very important to success in their role. New managers thought an important role of their mentor was to help the new manager gain confidence in herself as a manager. The last finding that helped to support this theme was the participants' desire and appreciation that their mentor had considerable experience as a manager. The idea that the mentor has more experience than the mentee seems an automatic occurrence; yet, it emerged as a category because of the frequency of participants stating its importance.

Trust seems an integral part of a mentoring relationship and was mentioned often by participants when they described their ideal mentoring relationship. Yet, the word or idea of trust is not included as part of the definition used by Vance and Davidhizar (1996) or Greene and Puetzer (2002). Because trust is such an essential component of the mentoring dyad, it seems necessary that this aspect of mentoring be included in future definitions.

Several commonalities existed among the identified mentors. First, the mentor of each participant also happened to be the boss of the respective participant, e.g., none of

the participants identified their mentor as someone who was outside of their direct chain-of-command. Also, none of the mentoring dyads (true or perceived) came as a result of a formal (assigned) mentoring program. Participants in this study sought out their mentors in an informal manner; the most natural person for the new manager to go to as a resource for how to perform their role was their respective boss. Because none of the employers/organizations used in this study had formal mentoring programs for their new managers, it is a natural consequence that new managers would seek out informal mentoring relationships. Considering six of ten participants in this study were able to identify true mentors, the informal path to finding a mentor seems a fairly reliable method for seeking assistance.

Conversely, if the new manager has a personality difference with their boss, it is much less likely (and possibly even detrimental) that the boss will serve as a mentor to the new manager. If this is the case, participants are at the mercy of their organization's size and culture, and it is up to the new manager to seek mentoring elsewhere. Rural hospitals have fewer available personnel for mentoring, so the new manager may have to choose between having no mentor versus having a strained mentoring relationship.

Results from this study indicated that new managers needed a resource and a go-to person to show them how to perform their role. For this to occur, the mentor needs to be on site. Also, the mentor must have first-hand knowledge of the organization's culture and organizational structure in order to best serve their mentee. In other words, this researcher believes that having an outside mentor (a mentor from a different organization) would not serve the new manager well. New managers in the rural setting

need immediate feedback on how to perform their role, even if this means having a boss, not a mentor, show them how to perform their duties.

The next section addresses how the findings of the data analysis fit with the conceptual framework used for this study.

Addressing the Conceptual and Theoretical Framework

This study focused on rural nurse managers' experiences with mentoring after assuming their role as nurse manager. As already addressed in chapter one, rural hospitals are unique because of the long distances to larger, urban hospitals. Managers in this study were aware of the unique aspects of rural settings, and nine participants lived in rural areas as well. Despite the uniqueness of rural settings, many of the participants' responses mirrored what already existed in the literature. This section addresses how their responses "fit" with the conceptual framework previously chosen for this study.

Responses and analysis of participant interviews supported the original chosen conceptual framework. To varying degrees, the six essential attributes of mentoring outlined by Stewart and Krueger (1996) were addressed throughout the interview and analysis process. *A teaching and learning process* referred to the protégé learning from the mistakes and successes of the mentor. By spending time with the mentor, the protégé learns from the mentor's knowledge and learns critical thinking skills. Several participants reported that having their mentor available to them was important, especially when they felt like they had questions or concerns about a situation. Karen benefited from her mentoring experience because her mentor "shares her experiences, good and bad." Kelly mirrored this by stating, "[her mentor was someone who had] been there, done that. They guide you and help you think through problems."

A reciprocal role is a two-way, give and take relationship. This reciprocity occurs with time as a result of evolution of the relationship. Shelly described her mentor as someone she had worked with laterally in previous positions. Mary described her mentor as her friend, someone that she highly respected. Heather described her mentoring relationship as "something that has developed from working together." These examples provide evidence of reciprocity and how the mentoring relationships evolve with time.

A career development relationship is an attribute that arises when those who are mentored benefit from the mentoring and advance in their career as a result. Shelly stated she had known her mentor from working with her laterally and that her mentor had "encouraged me to apply for this position, even though it would mean losing me from her department."

A knowledge or competence differential was echoed in the majority of participants' responses. Participants respected their mentor's experiences and valued the reflection and feedback their mentor could offer. *A duration of several years* reflects a mentoring relationship that exists over several years. Although this aspect of mentoring was not directly assessed in the interview process, several participants noted their relationship with their mentor had been in place for several years. Shelly, Mary, and Joanie had established relationships with their respective mentors, and the longevity of the relationship added value and authenticity to the relationship.

A resonating phenomenon refers to the likelihood that someone who has been mentored will be more likely to mentor in the future. Because participants in this study were relatively inexperienced in their roles, they were unable to comment on their ability

to mentor other new nurse managers. However, many participants were eager to pass along their lessons learned, advice they wished they had been given, etc. Each participant valued mentoring, so it seems likely that these participants will be future mentors to new managers.

Social Learning Theory was the theoretical framework used to guide this study. The main theme reflecting social learning theory was *Discovering Individual Leadership Style on the Job*. The two categories supporting this theme were "Mimicked behaviors from their mentor" and "Identification of leader-subordinate skills." Participants easily identified traits and skills in their mentor(s) that they wanted to mimic, as well as traits that were undesirable. Leader-subordinate skills identified by participants were fairness and establishing a shared governance environment. In essence, these participants valued fairness and shared governance because they learned from prior experience that these traits created positive work environments for employees. By creating positive work environments, participants understood the importance of satisfied employees.

The next section discusses implications arising from this study's findings. Implications mirror this study's emerging themes.

Implications

Implications come as a result of themes emerging from this study. Participants recalled with great detail the feelings they encountered when taking on their new role. Words used to express their feelings included "fear, nauseous, afraid, scary, overwhelmed," etc. The nature of their responses demonstrates the valuable role of mentoring for new managers. Participants who had been in their role for several years seemed to have overcome their feelings of fear; however, participants who were still

inexperienced in management, e.g., one year or less, continued to experience feelings of fear, inadequacy, etc. Because length of time in the position seems to affect the new managers' feelings of self-confidence, this researcher recommends that new managers engage in long-term mentoring relationships.

The need for budget training emerged in every interview. Lack of knowledge in this area caused distress for new managers. Participants were aware of their lack of experience in creating and managing a budget, and they knew to seek out assistance for this specific area. New managers would greatly benefit from extensive budget training, as well as having an awareness of their in-house resources.

Formal leadership training would serve as a strong basis for new managers. As discussed in chapter four, data analysis did not identify one predominant leadership style among participants. In part, this researcher believes this occurred because participants had not had formal leadership courses which outline different leadership styles, e.g., situational leadership, transformational leadership, transactional leadership, etc. Instead, participants identified leadership qualities that were important to them, e.g., treating others fairly, building relationships with staff members, allowing staff members to have input in unit policies, etc.

Providing the new nurse manager with a formal leadership course which discusses leadership theory and styles would assist the manager on several fronts. First, a formal leadership course would aid the manager in understanding that different leadership styles and theories exist, and most leaders do not adopt one single style. Having an awareness of different theories helps the manager to understand how their individual personality and situation can fit into different styles. Second, managers must understand that "manager"

is an appointed position or job title, but "leader" is not. Leadership skills develop over time and require an investment of time, effort, and education from the individual.

Last, based on participants' responses, new managers would greatly benefit from conflict management training. Managing difficult employees and conflict between employees was a difficult aspect of the manager role and brought participants great distress. Over half of participants in this study identified at least one employee who had been a nurse on their unit for a long period of time (several decades), but whom the participant considered to have a difficult personality and creates problems with other employees. Managing the "difficult employee" seems a common occurrence and should be included as part of new manager training. Also, having resources available for these particular situations would benefit the new manager by offering ideas and support during potentially difficult interactions.

The next two sections address the strengths and weaknesses of this study. Strengths come as a result of the focused, rich data gathered during the interview process. Weaknesses occur as a result of using a small number of participants to gather in-depth data.

Strengths

Strengths of qualitative research come from the focused, in-depth data gathered during the interview process. Interview questions act as a guide but can be slightly altered if the researcher deems it necessary to probe further to gather more data. In the case of this study, the interview questions sought to answer the research questions guiding this study. Data analysis of ten participant interviews resulted in five themes and 21 categories. Emerging themes and categories provided rich, detailed examples of

participants' experiences; obtaining valuable data such as the data obtained in this study would not have occurred if a quantitative methodology had been used. While the findings from this study cannot be generalized to the population, they are consistent among the ten participants and can be transferable to other settings.

Weaknesses

As stated in the previous paragraph, findings from this study are not generalized to the general population of nurse managers. Participants from this study live and work in southcentral rural Kentucky. Living and working in rural Kentucky may alter the participants' views and experiences, resulting in findings that are not representative of nurse managers living in urban areas or a different state. As the primary researcher for this study, my presence during the interview process may have affected the participants' responses. Assurance of anonymity was given to each participant; yet, participant answers still may have been altered because of my presence. Last, the quality of this study's findings could be affected by this researcher's biases. This researcher left a data trail and performed an audit of the data throughout the study to account for potential biases.

The following section provides recommendations for future research. Recommendations come as a result of the implications of this study and provide potential opportunities for future research questions to be answered.

Recommendations for Future Research

Based on the implications, further qualitative and quantitative research could prove useful. Mentoring has been examined in nursing literature, but mainly using survey methods. Nursing students and new nurses are most often the target of nursing

research with regard to mentoring. Data analysis of this study's participant responses revealed several common themes: *difficult transition to management role, perceptions of having a mentor, desirable traits of a mentor, investing time in people and training, and discovering individual leadership style on the job.* Responses showed the importance of mentoring, and that new managers valued mentoring. Further research in the needs of new managers could help hospitals do more to help them feel supported.

As mentioned earlier in this chapter, time in the role seems to be an important indicator of the manager's comfort level; those in the role less than one year seemed uneasy and unsure of themselves, while those in the role for more than a year seemed more comfortable with themselves and with the requirements of the role. Research focusing on the amount of support given early on in the position and how it affects longevity in the role also may prove useful for hospitals. This information could support the need for formal, long-term mentoring programs. Another area of research that could benefit nursing is to examine the differences in educational background among nurse managers and their level of readiness for the role. Participants in this study came from a variety of educational backgrounds, but responses revealed that the higher educated nurses were the ones who identified true mentors. The more highly educated nurses also had a better sense of their own leadership style and the reasons for it.

The next and final section of chapter five summarizes this study and its findings.

Conclusion

This study examined the experiences of rural nurse managers with mentoring. The reported experiences varied among nurse managers, but similarities existed as well. New managers felt overwhelmed when assuming their new role, and they found the

transition to management to be a difficult one. Fear of failure arose as a common feeling. Difficulty in determining existing resources was a common occurrence as well. Dealing with daily tasks, e.g., daily fires, seemed to overwhelm the new manager.

New managers participating in this study expressed a desire for budget training and conflict management, as these two areas were sources of stress and uneasiness once assuming their role. Six of the ten participant experienced true mentoring as outlined by Vance and Davidhizar (1996); three perceived they were in a mentoring relationship but one more consistent with preceptoring; and one participant could not identify a mentor.

Participants identified desirable traits of a mentor, which included having an open, non-threatening line of communication. Managers wanted their mentor to be a go-to person and a resource, and the mentor should assist the protégé in acclimating to their new role. Also, new managers respected and valued the mentor's experiences. Participants believed they benefited from their mentor's experiences, good and bad.

Participants identified beneficial pieces of advice in several forms. First, new managers felt a beneficial piece of advice was to give the role several years before giving up. Time in the position seemed to diminish feelings of fear and inadequacy and increased new managers' self-confidence. Leadership advice included treating others fairly, listening to your staff, spending time developing relationships with your staff, etc. Essential training for new managers included training in budget and conflict management. Leadership styles varied among participants. Some mimicked desirable leadership qualities of their mentors, while others reported already having an existing leadership style of their own.

This study's findings add to the existing database of research because of its focus on rural nurse managers. Qualitative findings are rich in nature because of their in-depth, focused answers to research questions. Themes emerging from the data analysis answered the research questions guiding this study and provide valuable insight into the mentoring experiences of nurse managers in rural settings.

REFERENCES

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of American Medical Association, 288,* 1987-1993.

Ali, P., & Panther, W. (2008). Professional development and the role and mentorship. *Nursing Standard, 42,* 35-39.

Almada, P., Carafoli, K., Flattery, J., French, F., & McNamara, M. (2004). Improving the retention rate of newly graduated nurses. *Journal for Nurses in Staff Development, 20,* 268-273.

Allan, H., Smith, P., & Lorentzon, M. (2008). Leadership for learning: A literature study of leadership for learning in clinical practice. *Journal of Nursing Management, 16,* 545-555.

American Association of Colleges of Nursing, (2010). *Nursing shortage fact sheet, Updated April 2011.* Retrieved from http://www.aacn.nche.edu/media/factsheets/nursingshortage.htm

Anderson, R. A., Issel, L. M., & McDaniel, R. R. (2003). Nursing homes as complex adaptive systems. *Nursing Research, 52*(1), 12-21.

Andrews, M., & Wallis, M. (1999). Mentorship in nursing: A literature review. *Journal of Advanced Nursing, 29,* 201-207.

Angelini, D. J. (1995). Mentoring in the career development of hospital staff nurses: Models and strategies. *Journal of Professional Nursing, 11*(2), 89-97.

Anthony, M. K., Standing, T. S., Glick, J., Duffy, M., Paschall, F., Sauer, M. R., Sweeney, D. K., Modic, M. B., & Dumpe, M. L. (2005). Leadership and nurse retention: The pivotal role of nurse managers. *Journal of Nursing Administration, 35,* (3), 146-155.

Bae, S.-H., Mark, B. & Fried, B. (2010). Impact of nursing unit turnover on patient outcomes in hospitals. *Journal of Nursing Scholarship, 42,* 40-49. doi: 10.1111/j.1547-5069.2009.01319.x

Baker, E., Isreal, E., & Schurman, S. (1996). Role of control and support in occupational stress: An integrated model. *Social Science and Medicine, 43,* 1145-1159.

Balasco-Cathcart, E., Greenspan, M., & Quin, M. (2010). The making of a nurse manager: The role of experiential learning in leadership development. *Journal of Nursing Management, 18,* 440-447.

Barker, E. R. (2006). Mentoring — A complex relationship. *Journal of the American Academy of Nurse Practitioners, 18,* 56-61.

Bellack, J. P., & Morjikian, R. L. (2005). The RWJ Executive Nurse Fellows Program, part 2: Mentoring for leadership success. *Journal of Nursing Administration, 35,* 533-540.

Benner, P., Tanner, C., & Chelsa, C. (2009). *Expertise in nursing practice* (2nd ed.). New York, NY: Springer.

Block, L. M., Claffey, C., Korow, M. K., & McCarrey, R. (2005). The value of mentorship within nursing organizations. *Nursing Forum, 40,* 134-140.

Bogdan, R. C., & Biklen, S. K. (2003). *Qualitative research for education: An introduction to theories and methods* (4th ed.). Boston, MA: Allyn and Bacon.

Budd, K., Warino, L., & Patton, M. (2004). Traditional and non-traditional collective bargaining: Strategies to improve the patient care environment. *Online Journal Of Issues In Nursing,* 9(1), 9. Retrieved from EBSCO*host*.com

Buerhaus, P. (2008). Current and future state of the US nursing workforce. *Journal of American Medical Association, 300,* 2422-2424.

Burns, M. (1992). *The relationship between types and sources of social support, stress and job satisfaction in head nurses* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. AAT 9227441

Cameron, A., & Masterson, A. (2000). Managing the umanageable? Nurse Executive Directors and new role developments in nursing. *Journal of Advanced Nursing, 31,* 1081-1088.

Chan, S. (2002). Factors influencing nursing leadership effectiveness in Hong Kong. *Journal of Advanced Nursing, 38,* 615-623.

Colorado State University: Writing at CSU. (2011). *Disadvantages of qualitative observational research.* Retrieved from http://writing.colostate.edu/guides/research/observe/com2d2.cfm

Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Currie, K., Tolson, D.,& Booth, J. (2007). Helping or hindering: The role of nurse managers in the transfer of practice development learning. *Journal of Nursing Management, 15,* 585-594.

Darling, L. (1984). Mentor types and life cycles. *Journal of Nursing Administration, 14*(11), 43-44.

Davidhizar, R. (1988). Mentoring in doctoral education. *Journal of Advanced Nursing, 13,* 775-781.

Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Q, 44*(3), 166-206.

Dorsey, L. E., & Baker, C. M (2004). Mentoring undergraduate nursing students: Assessing the state of the science. *Nurse Educator, 29,* 260-265.

Eaton, E., Henderson, A. & Winch, S. (2007). Enhancing nurses' capacity to facilitate learning in nursing students: Effective dissemination and uptake of best practice guidelines. *International Journal of Nursing Practice, 13,* 316-320.

Eberhardt, M. S., Ingram, D. D., Makuc, D. M., Pamuk, E. R., Freid, V. M., Harper, S. B.,...Xia, H. (2001). *Health, United States, 2001: Urban and rural health chartbook.* Hyattsville, MD: National Center for Health Statistics.

Eby, L. T., Lockwood, A. L., & Butts, M. (2006). Perceived support for mentoring: A multiple perspectives approach. *Journal of Vocational Behavior, 68,* 267-291.

Eldridge, C. R., & Judkins, S. (2003). Rural nurse administrators: Essentials for practice. *Online Journal of Rural Nursing and Health Care, 3,* 9-16.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods.* Newbury Park, CA: Sage.

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction.* White Plains, NY: Longman.

Goldstein, A.P., & Sorcher, M. (1974). *Changing supervisory behavior.* New York, NY: Pergamon Press.

Gould, D., Kelly, D., Goldstone, L., & Maidwell, A. (2001). The changing training needs of clinical nurse managers: Exploring issues for continuing professional development. *Journal of Advanced Nursing, 34,* 7-17.

Greene, M. T. & Puetzer, M. (2002). The value of mentoring: A strategic approach to retention and recruitment. *Journal of Nursing Care Quality, 17,* 67-74.

Gurney, C. A., Mueller, C.W., & Price, J. L. (1997). Job satisfaction and organizational attachment of nurses holding doctoral degrees. *Nursing Research, 46,* 163-171.

Hader, R., Saver, C., & Steltzer, T. (2006). No time to lose. *Nursing Management, 37*(7), 23-29.

Hale, R. L. (2004). *Mentorship of nurses: An assessment of the first year of licensure* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 1423129)

Hendel, T., Fish, M., & Aboudi, S. (2000). Strategies used by hospital nurses to cope with a national crisis: A managers perspective. *International Nursing Review, 47,* 224-231.

Hersey P., & Blanchard K. (1998). *Management of organizational behavior utilizing human resources.* (5th ed.). Englewood Cliffs, NJ: Prentice Hall.

Holloran, S. (1989). *Mentoring: The experience of nursing service executives* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 9004106)

Holloran, S. (1993). Mentoring: The experience of nursing service executives. *Journal of Nursing Administration, 23*(2), 49-54.

Houser, J. (2003). A model for evaluating the context of nursing care delivery. *Journal of Nursing Administration, 33*(1), 39-47.

Institute of Medicine (IOM). (2000). *To err is human: Building a safer health system.* Washington, DC: National Academy Press.

Institute of Medicine (IOM). (2004). *Keeping patients safe – Transforming the work environment of nurses.* Washington, DC: National Academy Press.

Janiszewski-Goodin, H. (2003). The nursing shortage in the United States of America: An integrative review of the literature. *Journal of Advanced Nursing, 43,* 335-350.

Janssen, P. P., de Jonge, J. D., & Bakker, A. B. (1999). Specific determinants of intrinsic work motivation, burnout, and turnover intentions: A study among nurses. *Journal of Advanced Nursing, 29,* 1360-1369.

Johnson, K. R., & D'Argenio, C. (1991). Management training effects on nurse manager leadership behavior. *Nursing Economic$, 9,* 249-254.

Kanter, R. M. (1977). *Men and women of the corporation.* New York: Basic Books.

Kanter, R. M. (1993). *Men and women of the corporation* (2nd ed.). New York: Basic Books.

Kinicki, A. (2008). *Organizational behavior: Core concepts.* Boston, MA: McGraw-Hill:

Kleinman, C. S. (2003). Leadership roles, competencies, and education: How prepared are our nurse managers? *Journal of Nursing Administration, 33,* 451-455.

Kotter, J. P. (1990). What leaders really do. *Harvard Business Review, 68*(3), 103-111.

Kovner, C., Brewer, C., Wu, Y-W., Cheng, Y., & Suzuki, M. (2006). Factors associated with work satisfaction of registered nurses. *Journal of Nursing Scholarship, 38,* 71-79.

Kovner, C. T., Brewer, C. S., Fairchild, S., Poornima, S., Kim, H., Djukic, M. (2007). Newly licenced RNs' characteristics, work attitudes, and intentions to work. *American Journal of Nursing, 107*(9), 58-70.

Kram, K. E. (1985). *Mentoring at work.* Glenview, IL: Scott, Foresman, and Company.

Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: A conceptual analysis. *Journal of Advanced Nursing, 25,* 95-100.

Laschinger, H. K., Almost, J., Purdy, N., & Kim, J. (2004) Predictors of nurse managers' health in Canadian restructured healthcare settings. *Nursing Leadership, 17*(4), 88-103.

Laschinger, H. K., & Havens, D. S. (1997). The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of Nursing Administration, 27*(6), 42-50.

Laschinger, H. K., Purdy, N., Cho, J., & Almost, J. (2006). Antecedents and consequences of nurse managers' perceptions of organizational support. *Nursing Economic$, 24,* 20-29.

Latham, G., & Saari, L. (1979). Application of social-learning theory of training supervisors through behavioral modeling. *Journal of Applied Psychology, 64,* 239-246.

Lee, H., & Cummings, G. G. (2008). Factors influencing job satisfaction of front line managers: A systematic review. *Journal of Nursing Management, 16,* 768-783. doi: 10.1111/j.1365-2834.2008.00879.x

Leininger, M. (1974). The leadership crisis in nursing: A critical problem and challenge. *Journal of Nursing Administration, 4,* 28-34.

Letvak, S. (2002). Retaining the older nurse. *Journal of Nursing Administration, 32,* 387-392.

Lincoln, Y. S,. & Guba, E. G. (1985). *Naturalistic Inquiry.* Newbury Park, CA: Sage.

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Littell, S. C. (1995). *Organizational climate and job satisfaction in mid-level nurse managers* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 9603899)

Mackoff, B. L., & Triolo, P. K. (2008). Why do nurse managers stay? Building a model of engagement. Part 1, Dimensions of engagement. *Journal of Nursing Administration, 38,* 118-124.

Manfredi, C. M. (1996). A descriptive study of nurse managers and leadership. *Western Journal of Nursing Research, 18,* 314-329.

Mathena, K. A. (2002). Nursing manager leadership skills. *Journal of Nursing Administration, 32,* 136-142.

Madison, J. (1994). The value of mentoring in nursing leadership: A descriptive study. *Nursing Forum, 29*(4), 16-23.

McCloughen, A., O'Brien, L., & Jackson, D. (2009). Esteemed connection: Creating a mentoring relationship for a nurse leader. *Nursing Inquiry, 16,* 326-336.

McNeese-Smith, D.K. (1999). The relationship between managerial motivation, leadership, nurse outcomes and patient satisfaction. *Journal of Organizational Behavior, 20,* 243-259.

Mills, J. E, Francis, K., & Bonner, A. (2007). Live my work: Rural nurses and their multiple perspectives of self. *Journal of Advanced Nursing, 59,* 583-590. doi: 10.1111/j.1365-2648.2007.04350.x

Mills, J. E., Francis, K. & Bonner, A. (2007a). The accidental mentor: Australian rural nurses developing supportive relationships in the workplace. *Rural and Remote Health, 7,* 842. Retrieved from http://www.rrh.org.au

Mills, J., Francis, K. & Bonner, A. (2008). Getting to know a stranger — rural nurses' experiences of mentoring: A grounded theory. *International Journal of Nursing Studies, 45*, 599-607. Retrieved from www.sciencedirect.com doi:10.1016/j.ijnurstu.2006.12.003

Morano, J. (1993). The relationship workplace social support to perceived work-related stress among staff nurses. *Journal of Post Anesthesia Nursing 8*(6), 395-402.

Murray, M. (1991). *Beyond the myths and magic of mentoring.* San Francisco, CA: Jossey-Bass.

Myall, M., Levett-Jones, T., & Lathlean, J. (2008). Mentorship in contemporary practice: The experiences of nursing students and practice mentors. *Journal of Clinical Nursing, 17,* 1834-1842.

Newhouse, R. (2005). Exploring nursing issues in rural hospitals. *Journal of Nursing Administration, 35,* 350-358.

Owen, W. F. (1984). Relational themes in interpersonal communication. *Quarterly Journal of Speech, 70,* 274–287.

Paliadelis, P., Cruickshank, M., & Sheridan, A. (2007). Caring for each other: How do nurse managers 'manage' their role? *Journal of Nursing Management, 15,* 830-837.

Parsons, M. L., & Stonestreet, J. (2003). Factors that contribute to nurse manager retention. *Nursing Economic$, 21*(3), 119-126.

Patrick, A., & Laschinger, H. (2006). The effect of structural empowerment and perceived organizational support on middle level nurse managers' role satisfaction. *Journal of Nursing Management, 14,* 13-22.

Persson, O., & Thylefors, I. (1999). Career with no return: Roles, demands, and challenges as perceived by Swedish ward managers. *Nursing Administration Quarterly, 23*(3), 63-80.

Pollack, M. M. & Koch, M. A. (2003). Association of outcomes with organizational characteristics of neonatal intensive care units. *Critical Care Medicine, 31,* 1620-1629.

Powell, S. R. (1990). *Mentors in nursing in the university setting* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 9112470)

Price, J. L. (2004). The development of a causal model of voluntary turnover. In R. Griffeth & P. Hom (Eds). *Innovative theory and empirical research on employee turnover* (pp. 3-34). Greenwich, CT: Information Age.

Radnitzsky, G. (1970). *Contemporary schools of metascience.* Gothenburg, Sweden: Akademiforlaget.

Rodgers, B. (1989). Concepts, analysis and the development of nursing knowledge: The evolutionary cycle. *Journal of Advanced Nursing, 14,* 330-335.

Rodgers, B. (1993). Concept analysis: An evolutionary view. In B. Rodgers & K. Knafl, *Concept development nursing: Foundations, techniques, and applications.* Philadelphia, PA: Saunders.

Roulston, K. (2010). *Reflective interviewing: A guide to theory and practice.* Los Angeles, CA: Sage.

Ryan, A., Goldberg, L., & Evans, J. (2010). Wise women: Mentoring as relational learning in perinatal nursing practice. *Journal of Clinical Nursing, 19,* 183-191.

Senge, P.M. (1990). *The fifth discipline-the art and practice of the learning organization.* New York, NY: Doubleday Dell.

Shirey, M. R. (2004). Social support in the workplace: Nurse leader implications. *Nursing Economic$, 22,* 313-319.

Shirey, M. R., McDaniel, A. M., Ebright, P. R., Fisher, M. L, & Doebbeling, B. N. (2010). Understanding nurse manager stress and work complexity. *Journal of Nursing Administration, 40,* 82-91.

Shirey, M. R., Ebright, P. R., & McDaniel, A. M. (2008). Sleepless in America: Nurse managers cope with stress and complexity *The Journal of Nursing Administration, 38,* 125-131.

Sigma Theta Tau International (STTI). (2001). *Facts about the nursing shortage.* Retrieved from http://nursesource.org/facts_shortage.html

Silvetti, C., Rudan, V., Frederickson, F., & Sullivan, B. (2000). Where will tomorrow's nurse managers come from? Management case studies. *Journal of Nursing Administration, 30*(4), 157-159.

Skillman, S. M., Palazzo, L., Keepnews, D., & Hart, G. (2006). Characteristics of registered nurses in rural versus urban areas: Implications for strategies to alleviate nursing shortages in the United States. *The Journal of Rural Health, 22,* 151-157.

Skytt, B., Ljunggren, B., & Carlsson, M. (2007). Reasons to leave: The motives of first-line managers' for leaving their posts. *Journal of Nursing Management, 15,* 294-302.

Slagle, J. C. (1986). *The process of mentoring in nursing: A study of protégés' perceptions of the mentor-protégé relationship* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 8620409)

Stengrevics, S. S., Kirby, K. K., & Ollis, E. R. (1991). Nurse manager job satisfaction: The Massachusetts perspective. *Nursing Mangement, 22*(4), 60-64.

Stewart, B. M., & Krueger, L. E. (1996). An evolutionary concept analysis of mentoring in nursing. *Journal of Professional Nursing, 12,* 311-321.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Surakka, T. (2008). The nurse manager's work in the hospital environment during the 1990s and 2000s: Responsibility, accountability and expertise in nursing leadership. *Journal of Nursing Management, 16,* 525-534.

Thompson, J., Wieck, K. L., & Warner, A. (2003). What perioperative and emerging workforce nurses want in a manager. *Association of Perioperative Registered Nurses Journal, 78,* 246-261.

Tulgan, B. (2000). *Managing generation X*. New York, NY: W.W. Norton and Company.

U.S. Census Bureau. (2011). *State and County Quick Facts*. Retrieved from http://quickfacts.census.gov/qfd/states/

U.S. Department of Agriculture, Economic Research Service. (2011). *Data sets: County-level unemployment and median household income for Kentucky*. Retrieved from http://www.ers.usda.gov/data/unemployment/RDList2.asp?ST=KY

U.S. Department of Agriculture: National Agriculture Library, (2008). *What is rural?* Retrieved from http://www.nal.usda.gov/ric/ricpubs/what_is_rural.shtml

U.S. Department of Health and Human Services: Agency for Healthcare Research and Quality. (1996). *Improving health care for rural populations: Research in action.* Retrieved from http://www.ahrq.gov/research/rural.htm

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2004). *Studies show lower nurse staffing levels contribute to poor patient outcomes*. Retrieved from http://www.ahrq.gov/news/press/pr2004/nrstaffpr.htm

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2006). *The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurvey2004.pdf

U.S. Department of Health and Human Services: Health Resources and Services Administration. (2010). *The registered nurse population: Findings from the 2008 National Sample Survey of Registered Nurses.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyinitial2008.pdf

U.S. Department of Labor: Bureau of Labor Statistics. (2009). *Occupational Outlook Handbook: 2010-11 Edition.* Retrieved from http://www.bls.gov/oco/ocos083.htm

Upenieks, V. (2002). What constitutes successful nurse leadership? A qualitative approach utilizing Kanter's theory of organizational behavior. *Journal of Nursing Administration, 32,* 622-632.

Upenieks, V. (2003). Nurse leaders' perceptions of what compromises successful leadership in today's acute inpatient environment. *Nurse Administration Quarterly, 27,* 140-152.

Vaananen, A., Toppinen-Tanner, S., Kalimo, R., Mutanen, P., Vantera, J., & Piero, J. M. (2003). Job characteristics, physical and psychological symptoms, and social support as antecedents of sickness absences among men and women in the private industrial sector. *Social Science and Medicine, 57,* 807-824.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedogogy.* Albany, NY: State University of New York Press.

Vance, C. N. (1977). *A group profile of contemporary influential in American nursing* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT 7804472)

Vance, A., & Davidhizar, R. (1996). The importance of role socialization toward achieving professional status in nursing administration. *Journal of Nursing Science, 1,* 199-203.

Waters, D., Clarke, M., Ingall, A., & Dean-Jones, M. (2003). Evaluation of a pilot mentoring programme for nurse managers. *Journal of Advanced Nursing, 42,* 516-526.

Western Kentucky University. (2011). *Associate of science in nursing program (ASN): Mission statement.* Retrieved from http://www.wku.edu/nursingasn/index.php

Western Kentucky University. (2011). *South Central AHEC Service Area.* Retrieved from http://www.wku.edu/scahec/ahec_service_area_2_page_now.php

Wieck, K., Dols, J., & Landrum, P. (2010). Retention priorities for the intergenerational nurse workforce. *Nursing Forum, 45,* 7-17.

Wong, C. A., & Cummings, G. G. (2007). The relationship between nursing leadership and patient outcomes: A systematic review. *Journal of Nursing Management, 15,* 508-521.

Young, C. (1985). *Women as protégés: The perceptual development of female doctoral students who have completed their initial mentor-protégé relationship* (Doctoral Dissertation). Retrieved from ProQuest Digital Dissertations. (AAT8617341)

APPENDIX A

Informed Consent

INFORMED CONSENT

Project Title: The Experience of New Nurse Managers in Rural Hospitals: Does Mentoring Make a Difference?

Investigator: Leigh Lindsey, MSN, APRN. Dept: Education. Phone: 270-779-2732

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask him/her any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign on the last page of this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1. **Nature and Purpose of the Project:**

It is my understanding that the purpose of this project is to explore the experiences of nurse managers in rural hospitals to determine if mentoring makes a difference.

2. **Explanation of Procedures:**

It is my understanding that the researchers will conduct individual interviews, approximately 45-60 minutes in length, during which I will be asked about experiences with mentoring. Specifically, I may be asked to describe what mentoring means to me; my ideal mentoring relationship; and, professional mentoring relationships in which I have participated.

3. **Discomfort and Risks:**

It is my understanding that this study places me at little to no risk. The probability of harm anticipated is no greater than I would encounter in everyday life.

4.   **Benefits:**

While this study offers no direct benefits or compensation, it is my understanding that I will have an opportunity to give my opinions and experiences which will help generate knowledge that provides insight into the mentoring needs of new nurse managers, more specifically managers in rural hospitals.

5.   **Confidentiality:**

It is my understanding that my responses will be kept strictly confidential. Records will be viewed, stored, and maintained in private, secure files only accessible by the researcher and faculty sponsor for three years following the study, after which time they will be destroyed. All participants will be assigned pseudonyms to ensure anonymity, and any other subject identifiers will be altered or reported only in comprehensive form.

6.   **Refusal/Withdrawal:**

It is my understanding that refusal to participate in this study will have no effect on any future services I may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

_____   _____

Signature of Participant   Date

_____   _____

Witness   Date

It is also my understanding that my participation in an interview will be audio recorded.

_____

Signature of Participant   Date

_____

Witness   Date

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT

THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY

THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD

Paul Mooney, Compliance Coordinator

TELEPHONE: (270) 745-4652

Subject Informed Consent Document

Title of Study:

MENTORING OF NURSE MANAGERS
THE EXPERIENCE OF NEW NURSE MANAGERS IN RURAL
HOSPITALS:
DOES MENTORING MAKE A DIFFERENCE?

Investigator(s) name & address: Meera Alagaraja, PhD, Assistant Professor. Department of Leadership, Foundations and Human Resource Education, University of Louisville, Louisville, KY 40292.

Leigh K. Lindsey, MSN. Doctoral Student. 3366 Montgomery Way, Bowling Green, KY 42104

Site(s) where study is to be conducted: Franklin, KY; Scottsville, KY; Russellville, KY; Glasgow, KY; Columbia, KY; Hartford, KY; Campbellsville, KY; Greensburg, KY; Bardstown, KY; Lebanon, KY; Leitchfield, KY; Horse Cave, KY.

Phone number for subjects to call for questions: 502-852-0617 or 270-779-2732

Introduction and Background Information:

You are invited to participate in a research study. The study is being conducted by Meera Alagara, PhD, faculty at Univ. of Louisville and Leigh Lindsey, MSN, APRN, doctoral student at UL/WKU. The study is sponsored by the University of Louisville, Department of Education and Leadership Foundations. The study will take place at Franklin, KY; Scottsville, KY; Russellville, KY; Glasgow, KY; Columbia, KY; Hartford, KY; Campbellsville, KY; Greensburg, KY; Bardstown, KY; Lebanon, KY; Horse Cave, KY and Leitchfield, KY. Approximately 8-10 subjects will be invited to participate.

Purpose

The purpose of this study is to gain a better understanding of the experiences that new nurse managers in rural hospitals have with mentoring.

Procedures

In this study, you will be asked to undergo an interview, which will last approximately 45-55 minutes. Approximately 14 questions will be asked, but you may decline to any question(s) that makes you uncomfortable. The interview will be audio-recorded.

Potential Risks

There are minimal risks associated with the interview process. Possible risks include psychological risks in answering questions about previous mentoring experiences. There are no foreseeable risks other than possible discomfort in answering personal questions.

Benefits

The possible benefits of this study include helping to add to the existing database of literature on the mentoring needs of nurses. The information collected may not benefit you directly. The information learned in this study may be helpful to others.

Compensation

You will not be compensated for your time, inconvenience, or expenses while you are in this study.

Confidentiality

Total privacy cannot be guaranteed. Your privacy will be protected to the extent permitted by law. If the results from this study are published, your name will not be made public. While unlikely, the following may look at the study records:The University of Louisville Institutional Review Board, Human Subjects Protection Program Office.

Office for Human Research Protections (OHRP),

Methods used to ensure that the data obtained during this interview remains confidential includes: your name will not be included in transcription process; the data will be kept in a locked office at Western Kentucky University; and kept on a password protected computer.

Conflict of Interest

This study involves a conflict of interest because the investigator will use your feedback, along with the feedback of others, as part of the findings for a doctoral dissertation. The investigator will not receive any monetary compensation for the research conducted in this study.

Voluntary Participation

Taking part in this study is voluntary. You may choose not to take part at all. If you decide to be in this study you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

Research Subject's Rights, Questions, Concerns, and Complaints

If you have any concerns or complaints about the study or the study staff, you have three options.

You may contact the principal investigator (Meera Alagaraja, PhD) at 502-852-0617 or the primary IRB contact (Leigh Lindsey, MSN, doctoral student) at 270-779-2732.

If you have any questions about your rights as a study subject, questions, concerns or complaints, you may call the Human Subjects Protection Program Office (HSPPO) (502) 852-5188. You may discuss any questions about your rights as a subject, in secret, with a member of the Institutional Review Board (IRB) or the HSPPO staff. The IRB is an independent committee composed of members of the University community, staff of the institutions, as well as lay members of the community not connected with these institutions. The IRB has reviewed this study.

If you want to speak to a person outside the University, you may call 1-877-852-1167. You will be given the chance to talk about any questions, concerns or complaints in secret. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

_____

_____

_____

This paper tells you what will happen during the study if you choose to take part. Your signature means that this study has been discussed with you, that your questions have been answered, and that you will take part in the study. This informed consent document is not a contract. You are not giving up any legal rights by signing this informed consent document. You will be given a signed copy of this paper to keep for your records.

_____

Signature of Subject/Legal Representative
                    Date Signed

_____

Signature of Person Explaining the Consent Form   Date Signed
(if other than the Investigator)

_____

        Signature of Investigator   Date Signed

LIST OF INVESTIGATORS   PHONE NUMBERS

Meera Alagaraja, PhD   502-852-0617

Leigh Lindsey, MSN   270-779-2732

APPENDIX B

Contact Letter to Nurse Administrators

Dear_____:

Hello. My name is Leigh Lindsey. I am a nurse and currently a PhD student. My dissertation research focuses on new rural nurse managers and their experiences with mentoring. More specifically, I would like to interview nurse managers with less than five years of experience in the management role.

I am contacting you because I would like to interview nurse managers at your hospital if they 1) have less than five years of management experience, and 2) are willing to share their experiences with me. The interview will take approximately 45-60 minutes and will be audio recorded. Participation is voluntary. The information obtained during the interview process will be kept confidential and only seen by myself and members of my dissertation committee.

Examples of interview questions would include having the participant describe what mentoring means to them; describe their ideal mentoring relationship; describe any professional mentoring relationships they have been a part of; obtain demographic data such as number of years working as a nurse, level of education, and amount of time in current role.

If you would please contact me at your earliest convenience to let me know if you would allow me to pursue interview(s) with any nurse managers at your hospital, I would greatly appreciate it.

Thank you for your time and consideration.

Leigh Lindsey, MSN, APRN

Leigh.lindsey@insightbb.com

270-779-2732

APPENDIX C

Research and Interview Questions

Research and Interview Questions

1. To what extent do nurse managers in rural hospitals experience mentoring after acquiring their new role?

2. How do nurse managers in rural hospitals describe their mentoring experiences after acquiring their new leadership role?

   - What does mentoring mean to you?
   - Describe any professional mentoring relationships (on-site or a nursing colleague) that you have been a part of since acquiring your management role.
     - How were these relationships established?
     - How did your organization help you?
     - ***If participant states he/she has not been a part of any mentoring experience, then ask the following:
       - What reasons exist for why you do not have a mentor?
       - At this time, what can you do to initiate a mentoring relationship?
   - List the pros of your mentoring experience
   - List the cons of your mentoring experience
   - Describe your ideal mentoring relationship
   - What unique aspects (if any) of being a middle manager have made mentoring important to you?

3. What are the most beneficial pieces of advice rural nurse managers received from a mentor?

   - What pearls of wisdom were helpful to you when you first came into this role?
   - What pearls do you want to pass along to future NURSE MANAGERs?

4. To what extent has mentoring influenced rural nurse managers as leaders?

   - Discuss the role transition of going from an expert to novice in your current leadership role
   - Describe your leadership style
   - To what extent has mentoring affected your leadership style as a mid-level manager?

- Describe your views on the future of nursing with respect staff turnover and job satisfaction.
    - While in your current leadership role, to what extent have you encouraged mentoring among your staff? Why or why not?

Demographic data
- How long have you been a nurse?
- Please describe your level of education
- How long have you been in your current role?

CURRICULUM VITAE

Leigh Lindsey
3366 Montgomery Way ♦ Bowling Green, KY ♦ 42104
home: 270-904-0754 ♦ cell: 270-779-2732 ♦ leigh.lindsey@insightbb.com

<u>Personal</u> married, 3 children **DOB:** 25 Sep 1972   **Born:** Ft Sill, OK

Licensure: RN #1079460 KY, APRN (CNM and FNP)

Education

PhD	2012	Univ of Louisville/WKU Louisville, KY
MSN	2003	Vanderbilt University Nashville, TN
BSN	1995	Western Kentucky University Bowling Green, KY

Certifications

Certified Nurse Midwife	ACMB	2003
Family Nurse Practitioner	ANCC	2004
Lactation Consultant	IBLCE	2002

Professional Work Experience

Nurse Midwife	Commonwealth Healthcare Corporation Bowling Green, KY	2006-present
Nurse Midwife	Center for Women's Health Bardstown, KY	2003-2006
FNP	WKU Health Services Bowling Green, KY	Fall '05 & '06
Asst Professor	Western Kentucky University Bowling Green, KY	2003-present

Staff Nurse	MTMC, Murfreesboro, TN	Feb-Aug 01
Staff Nurse	67th CSH, Wurzburg, GE	1997-2000
Staff Nurse	Walter Reed AMC, Wash, DC	1995-1997

Military Awards and Decorations

Army Commendation Medal	67th CSH, Wurzburg, GE	2000
Army Achievement Medal	67th CSH, Wurzburg, GE	2000
Army Achievement Medal	Walter Reed AMC, Wash, DC	1997
Distinguished Honor Grad	Tripler Army Medical Center 1997	

Presentations

"Perspectives of African American Nursing Students: Experiences Related To Success"	Sigma Theta Tau	Fall 2008

Publications

"Belize Service Learning Project for WKU Nursing Students"	*Kentucky Nurse*	Jul 2009