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The Preservation of Intellectual Capital of Nurses Working in the Community Hospital

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THE PRESERVATION OF INTELLECTUAL CAPITAL OF NURSES

WORKING IN THE COMMUNITY HOSPITAL

by

Gloria Reidinger

Dissertation

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Olivet Nazarene University

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the Degree of

Doctor of Education

in

Ethical Leadership

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THE PRESERVATION OF INTELLECTUAL CAPITAL OF NURSES

WORKING IN THE COMMUNITY HOSPITAL

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Gloria Reidinger

Dissertation

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Dissertation Adviser

May 1, 2010
Date

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Dissertation Reader

May 1, 2010
Date

_____
Dissertation Coordinator

May 1, 2010
Date

_____
Program Director

May 1, 2010
Date

_____
Dean of the School of Graduate
and Continuing Studies

May 5, 2010
Date

_____
Vice President for Academic Affairs

5-5-2010
Date

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DEDICATION

I dedicate this dissertation to my loving parents—to my father, who instilled in me the value of education, and to my mother, who taught me the joy of patience. You are forever in my heart.

ABSTRACT

by
Gloria Reidinger, Ed.D.
Olivet Nazarene University
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The purpose of this study was to examine nurse mentoring, succession planning, and

perceived professional responsibility as a means of sustaining intellectual capital in a

community hospital. Nurses completed the Alleman Mentoring Activities Questionnaire

and the Nursing Intellectual Capital Inventory, and they participated in focus groups. This

study has created opportunity for dialogue around mentoring and succession planning

activities. Findings from this study were restricted to the state of mentoring at the time of

the study as perceived by those who returned surveys or participated in focus groups.

Further research is needed to gain a better understanding of the needs and expectations

for mentoring activities within the organization and for nurses in general as a means to

support succession planning.

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CHAPTER I

INTRODUCTION

Major challenges face the health care industry (Sherrod, 2006) as the nursing profession prepares to lose a wealth of knowledge and expertise with the retirement of "seasoned leaders, clinicians, and educators" (Buerhaus, Staiger, & Auerbach, 2000, p. 2948). According to the 2004 National Sample Survey of Registered Nurses conducted by the U.S. Department of Health and Human Services (2004), the average age of registered nurses was 46.8 years. More than 47% of the nurses reported being over 50 years of age. Only 8% of responders were under the age of 30. The American Association of Colleges of Nursing projects a shortage of new nurse graduates related to the growing shortage of nursing faculty (Falk, 2007). The National League for Nursing (2005) estimates that 75% of current faculty will retire by 2019.

The baby boomers (born between 1946 and 1964) will begin retiring in large numbers by 2010 (Kaye & Cohen, 2008). When nurses retire, it can be difficult to measure what they take with them when they leave. They take their organizational knowledge (Hart, 2007), also known as intellectual capital (IC; Weston, Estrada, & Carrington, 2007). As a result of nurse retirement, health care organizations will be dependent on the assets of the remaining employees (Collins & Collins, 2007). A strategic plan must be developed with a vision for the future and with mentoring as an essential element (Cadmus, 2006).

Statement of the Problem

The purpose of this study was to examine nurse mentoring, succession planning, and perceived professional responsibility as a means of sustaining intellectual capital in a community hospital servicing Chicago's northwest suburbs. The focus of this dissertation is to gain knowledge with the intent to preserve IC in an aging workforce environment.

While mentoring is often an informal process for professional development (Thomka, 2007), succession planning is more deliberate and requires allocating time and financial resources for educational and developmental activities (Bolton & Roy, 2004). Neither mentoring nor succession planning will prove beneficial unless their benefactors have the ability to learn from others (DeLong, 2004).

Background

The term "intellectual capital" was first used in the business world by Stewart (1991) as a replacement for the accounting term "intangible assets." Edvinsson and Malone (1997) described IC as the "hidden dynamic factors that underlie the visible company of buildings and products" (p. 11). Since its inception, IC has come to represent wisdom that is utilized, shared, and expressed in the workplace (Weston et al., 2007).

Intellectual capital has been the focus of recent publications. Stewart (2001) described IC as knowledge assets that include "talent, skills, know-how, know-what, and relationships" (p. 11). An organization's IC has been considered the sum of its "human capital (skills and knowledge), structural capital (patents, processes, databases, networks, etc.), and customer capital (relationships with customers and suppliers)" (Stewart, p. 13). Cohen and Prusak (2001) added another element to IC, identified as social capital (trust, shared values, and understanding). The value of an organization lies in the collective

intelligence of every individual within the organization (Friedman, 2005). As workers near retirement, organizational leaders need to tap into the knowledge that will be leaving with the retired employee (Kaye & Cohen, 2008).

Are organizations making efforts to promote the transfer of knowledge from those with the greatest IC to their successors before those with the knowledge leave the organization? Successful organizations create a culture that generates employee commitment, encourages education, and fosters sharing (Weston et al., 2007). Mentoring may be one method to support the development and retention of IC in the workplace (Thomka, 2007).

An abundance of literature presents the benefits of mentoring (Allen, Eby, Poteet, Lentz, & Lima, 2004). McKinley (2004) reported that "mentoring has been used in many disciplines to develop expertise and leadership" (p. 206). Mentoring has been shown to have a positive impact on job satisfaction, leadership behaviors, and retention (Hamilton, Murray, Lindholm, & Myers, 1989; Thomka, 2007). Mentoring programs have been used to improve work environments by enhancing communication (Latham, Hogan, & Ringl, 2008) and facilitating staff development (Buck, 2004; Nedd, Nash, Galindo-Ciocon, & Belgrave, 2006). Mentoring is essential in developing future leaders (Redman, 2006). Nurses have a responsibility to mentor other nurses for the future (Cadmus, 2006).

Succession planning has been identified as an additional strategy to maintain knowledge within an organization (Bolton & Roy, 2004; Redman, 2006; Sherrod, 2006). Like mentoring, succession planning focuses on the professional development of an individual. However, succession planning differs from mentoring in that succession

planning focuses largely on the organization's needs rather than developing an interpersonal bond between the persons involved (Bonczek & Woodward, 2006).

In a search of the literature, no studies were found that clearly addressed the impact of mentoring relationships or succession planning on the cultivation of IC. More specifically, no studies were found that considered the mentor's perceived professional responsibility for mentoring his or her potential successor.

<div align="center">Research Questions</div>

The research was guided by the following questions:

1. To what extent was mentoring experienced by nursing personnel?

2. What impact does mentoring have on the cultivation of IC in the community hospital setting?

3. How do nurse personnel in the community hospital perceive their professional responsibility to mentor others as a means of succession planning?

<div align="center">Description of Terms</div>

The following definitions provide clarity to the unique terms used in this dissertation project:

Advanced practice nurse (APN). Nurse holding an additional license as a nurse practitioner or clinical nurse specialist.

Director. Nurse with management responsibilities for entire clinical areas or service lines.

Educator. Nurse with specific responsibilities related to education, program development, and orientation of new nurses.

Formal mentoring. A mentor role that is assigned by the organization with stated

Objectives.

Health care industry. Hospitals and persons who provide services there (e.g.,

physicians, nurses).

Informal mentoring. A mentoring relationship based on mutual identification and

attraction as well as personal development needs.

Intellectual capital. Knowledge resources such as information, intelligence, and

wisdom.

Mentee. The person being mentored; sometimes referred to as the protégé.

Mentor. An individual, often older and more experienced, who provides

guidance for the personal and professional growth of a protégé.

Manager. Nurses assigned to the role of clinical unit leaders or managers.

Protégé. The person being mentored; sometimes referred to as the mentee.

Registered nurse. A person holding a state-issued license to practice nursing.

Staff nurse. An individual who has completed formal nursing education, has

successfully gained licensure, and does not have formal responsibilities for education or

management.

Succession planning. A business strategy that prepares for the exit of key

employees by developing qualified individuals to take their places.

Significance of the Study

The significance of this study was that it facilitated discussion around mentoring

and succession planning to prepare for the departure of an aging workforce. Additionally,

it brought to the forefront potential concerns associated with preserving IC specific to the

study organization. Acknowledgement of the potential value of positive mentoring relationships and their influence on cultivating IC may stimulate the development and support of future mentoring activities. While results from this dissertation are specific to the organization studied, findings may generate interest to examine intellectual capital in other settings.

Process to Accomplish

The basic premise guiding this study was the statistical data validating the presence of a workforce moving toward retirement age. The community hospital reviewed for this study employed 1,200 registered nurses at the time of this study. The average age of the nurse employees was 46.8 years. Twenty percent of the nurses were 56 or older, while 17% were 36 or younger (Northwest Community Hospital, 2008).

A mixed-method approach was employed, utilizing a descriptive two-phase research design. The study population included all nursing staff at a suburban community hospital. To answer research questions one and two, a convenience sample of all nurses employed in the nursing profession at the study hospital was invited to participate in the study by completing the Alleman Mentoring Activities Questionnaire (AMAQ; Alleman & Clarke, 2000) and the Nursing Intellectual Capital Inventory (NICI; Reidinger, 2008). The sample included nurses from each of the following categories: staff nurse, educator, APN, manager, and director. The AMAQ was chosen for its validity in measuring the amount and quality of mentoring activity. The NICI was constructed with the intent to gather demographic information and to quantify nurses' degrees of professional development activities and levels of organizational participation.

To answer research question three, a purposive sample of nurses from each of the categories—staff nurse, educator, APN, manager, and director—participated in focus groups to gain knowledge related to activities currently in practice at the study organization that might support succession planning. Additionally, the semistructured interview examined nurses' perceptions of professional responsibility to mentor other nurses as a means of cultivating intellectual capital.

The AMAQ and NICI were distributed to all nurses who met study criteria. Intended subjects were nurses employed in the nursing profession in the following job categories: staff nurse, educator, APN, manager, and director. E-mail and unit-based flyers were used to introduce nurses to the study and to encourage them to complete the questionnaires. E-mail was utilized to provide educators, APNs, managers, and directors with a link to an online version of the questionnaires. Content of the e-mail provided instructions, explained the purpose of the study, and informed the subjects that their participation was voluntary. Unit mailboxes were used to provide staff nurses with a paper copy of the questionnaires due to their limited access to the Internet at work. A cover letter that provided instructions, explained the purpose of the study, and informed the subjects that their participation was voluntary was attached to each set of questionnaires. Consent to participate was implied by individuals completing and returning the questionnaire. A 4-week window was provided to complete the questionnaires, with an e-mail prompt sent after 2 weeks as a reminder.

Responses to the AMAQ and NICI were entered into the Statistical Package for the Social Sciences (SPSS) as they were received. At the end of the 4-week data collection period, final analysis was completed. The AMAQ focused on mentoring

behaviors described as guiding activities, helping activities, or encouraging activities. An additional section on the AMAQ measured mentoring outcomes experienced by study participants. The NICI focused on particulars of the respondent and included age, years of service, level of professional development, degree of organizational involvement, and intended year of retirement.

Descriptive statistics were employed to look at demographic details specific to the current state of the study organization. Frequencies for age, years of service, educational preparation, and job classification were identified. Age, years of service, level of involvement in professional development activities, and organizational participation were key to quantify intellectual capital in each of the study groups—staff nurse, educator, APN, manager, and director. Independent sample *t* tests were run to compare mean total mentoring scores for each of the AMAQ subscales based on job role, highest level of education, and length of employment at organization. Analysis of variance (ANOVA) was utilized to determine differences of professional development scores and organizational involvement scores based on age, highest level of education, and length of employment. ANOVA was utilized to examine differences of AMAQ scores based on level of involvement in professional development activities and organizational participation. Findings related to mentoring behaviors helped to determine interview questions for the focus groups.

Nurses participating in the questionnaire segment of the study were invited to indicate interest in attending a focus group by providing their names and contact information to the study investigator on the bottom of the cover letter or by e-mail. A

purposive sample was selected from the self-identified nurses to ensure representation from the five categories of nurses—staff nurse, educator, APN, manager, and director.

The focus groups' intent was to collect personal narrative related to mentoring experiences by the participants and to explore both the presence of activities supporting succession planning and the nurses' perceptions of their personal responsibility to mentor. More specifically, the focus groups identified to what extent nurses believe they have an ethical duty to mentor new nurse graduates and to mentor for the purpose of succession planning. One-hour tape-recorded focus groups specific to each of the five categories of nurses—staff nurse, educator, APN, manager, and director—were scheduled. Focus groups included a minimum of four and a maximum of six nurses at each session. Two sessions for each category allowed nurses to choose the most convenient time to participate. After an explanation of the focus group process, participants voluntarily signed a consent document stating that they agreed to be tape-recorded. A semistructured interview process was utilized to engage participants in a discussion around succession planning activities and perceived professional responsibilities for mentoring. Additional questions were used to provide further clarification of responses.

Focus group recordings were transcribed by a transcription service. The transcription for the first focus group was verified by listening to a replay of the original recording while reading the transcription. This process was repeated for the final focus group. Inductive and deductive analysis was utilized to organize and interpret qualitative data (Patton, 2002).

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In this chapter, current literature on mentoring, intellectual capital, and succession planning was reviewed. Earlier supporting literature was also included where relevant. While literature from the fields of social science, business, and education are included in this review, literature specific to nursing was given priority.

Mentoring

Mentoring has been defined as a relationship in which a more experienced individual helps a less experienced individual develop personally and professionally (Kram, 1985; Levinson, Darrow, Klein, Levinson, & McKee, 1978). Both the mentor and the mentee have specific functions in the relationship. The mentor functions as a role model, socializer, and educator (Greene & Puetzer, 2002), while the mentee is expected to exhibit "openness to receiving help, learning, and caring; career commitment and competence; a strong self-identity and initiative" (Vance & Olsen, 1998, p. 24). In this section, literature specific to mentoring was addressed. Topics examined include historical perspectives, structures of mentoring relationships, mentoring outcomes, mentoring ethics, mentoring research, and mentoring in nursing.

Mentoring – Historical Perspective

In one of the first studies of mentoring relationships, Levinson et al. (1978) researched the career development of adult men. Levinson et al. found that mentors play a role in developing the protégés' self-esteem and work identity.

Findings from their study suggest that the mentor relationship is the most important relationship in young adulthood.

The extensive work of Kram (1980, 1983, 1985) is frequently cited in literature specific to mentoring. Kram (1983) focused on the characteristics and influences of developmental relationships. The study took place in a large public utility of 15,000 employees. Eighteen developmental relationships between young managers and senior managers were evaluated by means of extensive interviews.

Results from Kram's (1980) initial work on mentoring identified two key functions of mentoring: career functions and psychosocial functions. Career functions are believed to enhance career advancement; they include sponsorship, exposure and visibility, coaching, protection, and challenging assignments. Psychosocial functions are those "aspects of the relationship that primarily enhance sense of competence, clarity of identity, and effectiveness in the managerial role" (p. 614).

Kram (1985) described four predictable phases of a mentoring relationship. Phase one is the initiation and takes place during the first 6 - 12 months of the relationship. During this phase, both parties have strong positive thoughts. During phase two, the cultivation phase, positive thoughts that began in the initiation phase are tested against reality. The cultivation phase lasts from two to five years. Phase three, the separation phase, is marked by significant changes to the relationship. The separation phase begins

two to five years after the initiation phase, when the mentee is ready to take on responsibilities without close guidance and support. While the separation phase may cause much anxiety, the fourth phase, known as the redefinition phase, takes place several years after the initial relationship began.

According to Ragins and Scandura (1997),

Termination of mentoring relationships is necessary not only because it allows protégés to move out of relationships that no longer serve their needs but also because termination allows protégés to seek and develop new relationships that may better serve their emerging career development needs. (p. 946)

Structures of Mentoring Relationships

Mentoring relationships are identified as either formal or informal, and they differ in how the relationships are initiated. Informal mentoring relationships develop spontaneously and often grow over an extended period of time. Informal mentoring relationships result from a mutual agreement between the mentor and protégé that may contribute to the success of these relationships (Ragins & Cotton, 1999). Organizations have less control in the informal mentoring relationship; this may lead to protégés participating in activities that are relevant to career development, but not necessarily beneficial to the organization (Tourigny & Pulich, 2005).

In contrast, formal mentoring relationships are intentional and may result from a voluntary assignment, but they are often matched based on job function (Ragins & Cotton, 1999). Formal mentoring programs are created with specific objectives, including selecting and matching of mentors and protégés as well as guidelines for duration and frequency of mentoring activities. Formal mentoring programs are under the control of

the organization, thus they serve the needs of the organization over the needs of the individual, so relationships may suffer when the match does not meet the expectation of either the protégé or the mentor (Tourigny & Pulich, 2005).

In a study of 175 protégés and 110 mentors representing four organizations, Allen, Eby, and Lentz (2006) examined mentorship behaviors and mentorship quality associated with formal mentoring programs. Using a questionnaire created to measure mentoring functions, participants representing health care, manufacturing, oil, and technology provided information related to mentoring outcomes—specifically, career and psychosocial mentoring, role modeling, and mentorship quality. Findings indicated that there was little difference in mentoring outcomes for protégés based on whether or not the relationship was voluntary. However, "perceived input into the matching process was critical for both mentors and protégés" (p. 575). Additionally, "protégés with mentors who reported greater input also reported greater mentorship quality and role modeling than protégés with mentors who perceived less input" (p. 575).

As organizations downsize and greater expectations are placed on leaders, less time is allotted for mentoring (Eddy, Tannenbaum, Lorenzet, & Smith-Jentsch, 2005). Peer relationships can provide an alternative to formal mentoring relationships and offer a range of functions similar to the developmental functions observed in mentoring relationships (Kram, 1985; Levinson et al., 1978). Kram and Isabella (1985) compared mentoring and peer relationships with respect to career enhancement and psychosocial developmental functions. Developmental functions of mentoring relationships included coaching, counseling, role modeling, and providing challenges. Functions of peer relationships were sharing, strategizing, and giving emotional support and personal

feedback. Confirmation and friendship were functions of both mentoring and peer relationships.

In a study of seven student nurses, Glass and Walter (2000) looked at the relationship between personal and professional growth and peer mentoring. Research methodology included reflective journaling and focus group interviews. Findings showed that friendship was key to peer mentoring. Five themes arose from the research: "sensing belonging, being acknowledged, feeling validated, verbalizing vulnerability, and understanding dualisms" (p. 157). These findings support the functions of peer relationships identified by Kram (1985).

Two less-common forms of mentoring, virtual (Colky & Young, 2006; Teja, 2003) and generational (Stewart, 2006), are beginning to appear in the literature. In the past, mentoring was described as a personal one-to-one relationship (Teja). However, today it is not uncommon for organizations to have employees housed in multiple locations, creating a need to communicate in a virtual environment (Colky & Young). Mentoring from a distance has both benefits and disadvantages. On one hand, there are no limitations to space, time, or location. However, the lack of face-to-face communication can cause the misinterpretation of messages between the mentor and mentee. Regarding generational mentoring, the workplace today is filled with individuals from multiple generations, each with their own lived experiences and methods for learning (Stewart). Generational mentoring takes into account the diversity that comes with each age group, and it capitalizes on taking specific characteristics into consideration when mentoring these individuals (Stewart).

Mentoring Outcomes

Mentoring has been linked to positive outcomes for both the mentee (Allen et al., 2004; Buck, 2004; Eby, Lockwood, & Butts, 2006; McKinley, 2004; Smith, McAllister, & Crawford, 2001) and the mentor (Lopez-Real & Kwan, 2005; McKinley). Eby et al. completed two studies on mentoring. The first study examined how the perceptions of support for mentoring relate to mentoring attitudes and outcomes for the protégé and mentor. Alumni of a large university were contacted 10 years after graduation and asked to complete a survey on mentoring. Four hundred fifty-eight of the 2,250 surveys were returned. Of those, 243 respondents had experience as protégés and were included in the data analysis. The second study examined mentors' perceptions of support for mentoring in relation to their willingness to mentor. Surveys were mailed to 1,522 nonfaculty employees of a large southeastern university. Completed surveys received from 133 respondents who indicated that they had served as mentors were included in the analysis. Findings suggested that "support for mentoring is predictive of protégé and mentor outcomes, over and above other established predictors" and "perceived management support for mentoring appeared to be important in predicting positive outcomes for both mentors and protégés" (Eby et al., p. 284).

Mentoring relationships can increase confidence with positive role modeling and teamwork, resulting in financial benefits due to commitment and retention (McKinley, 2004). Mentoring enhances clinical competence, personal satisfaction, and job satisfaction while promoting the development of nurses who will be called on to be leaders in the future health care environment (Smith et al., 2001).

In a meta-analysis of research on career benefits associated with mentoring, Allen et al. (2004) reviewed 43 studies in an effort to gain a better understanding of mentoring relationships and outcomes. Findings supported the notion that mentoring has positive benefits—but benefits may differ, depending on whether career mentoring or psychosocial mentoring was provided. Career and psychosocial mentoring had relationships that were comparable with job and career satisfaction.

> However, career success indicators, such as compensation and promotion, were more highly related to career mentoring than to psychosocial mentoring and behaviors associated with psychosocial mentoring, such as role modeling, acceptance and confirmation, counseling, and friendship, were more highly related to satisfaction with the mentor than was career mentoring. (p.132)

Mentors sharpen their own skills while mentoring others, and they can achieve a sense of satisfaction by being part of a process to support others reaching their potential (McKinley, 2004). In a study of 259 teachers who were mentors in a teacher education program in Hong Kong, 71% responded to a free-response question indicating that the mentoring process had positively enhanced their professional development (Lopez-Real & Kwan, 2005). The most frequently stated mentoring benefits were learning through self-reflection (54%), learning from student teachers (39%), and learning through mutual collaboration (18%). In follow-up interviews with 18 of the mentors, Lopez-Real and Kwan found supporting evidence of professional enhancement for mentors. Mentors reported that they benefited both directly and indirectly from the student teachers they were mentoring. Directly, the mentors learned "innovative ideas and strategies employed

by the student teachers"; indirectly, they learned through the "mutual collaboration and sharing of ideas between the student teacher and the mentor" (p. 23).

Mentoring relationships involve both positive and negative experiences. According to Eby et al. (2006), "It is important to assess both relational costs and benefits in mentoring research in order to gain a complete picture of these influential developmental relationships" (p. 371). While literature on mentoring offers evidence of positive outcomes, mentoring is not without challenges. Dysfunctional mentoring relationships (Ragins & Scandura, 1997; Scandura, 1998) and obstacles to mentoring (Kram, 1985; Woodrow, 1994) have also been reported in the literature. The potential for perceptions of dysfunction occurs when the mentoring relationship is no longer working for one of the parties (Scandura). As the mentee becomes more independent, his or her ideas are more likely to conflict with those of the mentor (Woodrow). Ragins and Scandura studied mentoring relationships that had been terminated. While some of the relationships ended because the protégé had outgrown the need for the mentor, others were much more hostile. Two examples given for dysfunctional mentoring relationships were (a) the mentor becoming jealous of the protégé and attempting to sabotage the protégé's career and (b) the mentor or protégé becoming overly dependent on the other.

Kram (1985) identified five obstacles to effective mentoring:

Obstacle 1: A reward system that emphasizes bottom-line results and does not place a high priority on human resource development objectives creates conditions that discourage mentoring.

Obstacle 2: The design of work can interfere with building relationships that provide mentoring functions by minimizing opportunities for interaction between individuals with complementary relationship needs.

Obstacle 3: Performance Management Systems can encourage mentoring by providing a forum with specific tools for coaching and counseling—however, these systems are often absent, or introduced in a manner that causes individuals to avoid their use.

Obstacle 4: The culture of an organization—through its values, informal rules, rites, rituals, and behavior of its leaders—can make mentoring and other relationships unessential.

Obstacle 5: Individuals' assumptions, attitudes, and skills can interfere with developing relationships that provide mentoring functions—if juniors assume that seniors don't have time to coach—if individuals at every career stage are unaware of the value of developmental relationships, or if individuals lack the interpersonal skills to manage relationships. (P. 161–165)

After a review of literature specific to dysfunctional mentoring and a review of social psychology literature on dysfunctional relationships, Scandura (1998) described outcomes of dysfunctional mentoring relationships for both the mentor and protégé. Causes of dysfunctional mentoring included negative relations, sabotage, spoiling, submissiveness, deception, and harassment. When dysfunctional mentoring relationships continued, protégés experienced decreased self-esteem and job satisfaction and increased stress/anxiety, absenteeism, and turnover. Mentors also experienced the negative impact

of dysfunctional mentoring relationships with increased stress/anxiety, jealousy, sense of betrayal, and overdependence.

In an effort to develop a reliable and valid measure of mentors' negative mentoring experiences, Eby, Durley, Evans, and Ragins (2008) sought to gain knowledge about which protégé characteristics were most difficult for the mentor. A three-part study was undertaken. The purpose of part one was to develop a content-valid measure of mentors' perceptions of negative mentoring experience with protégés. Part two validated the instrument developed in part one. In part three, female faculty members of Research I universities, who had experience as mentors, were invited to complete a survey of 36 items that had been developed by Eby et al. to measure perceived negative mentoring experiences. The response was 439, or 31%. The researchers identified three distinct negative experiences with protégés: "protégé performance problems, interpersonal problems, and destructive relational pattern. Additionally, mentors' perceptions of negative mentoring experiences were related to both mentor and protégé perceptions of relationship process and outcomes" (p. 369).

Ethics in Mentoring

This section reviewed literature relative to ethical concerns with mentoring. More specifically, perceived duty to mentor and fairness in mentoring was addressed. The population targeted in this author's study of community hospital nurses was predominately female; therefore literature pertaining to ethical concerns of cross-gender mentoring was not included in the review.

Leaders have a responsibility to mentor, inspire, advise, and guide those they lead (Andrica, 1996; Faut-Callahan, 2001). According to Vance (2002), "mentoring is a

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professional obligation. Mentoring is a way of being, a way of thinking and working. It's

for every level of nurse, even the most experienced nurses" (p. 9). In support of the value

and necessity of mentoring in nursing, the Association of Operating Room Nurses

(AORN) presented the Responsibility for Mentoring Position Statement at the 2006

AORN Congress (AORN, 2006).

Successful mentoring is associated with establishing a trusting relationship

between the mentor and the protégé (Erdem & Aytemur, 2008). Interviews of 32 protégés

in an academic setting focused on identifying elements of trust and fairness in a

mentoring relationship. Findings from this study suggested that perceptions of fairness

are related to the mentor's level of competence, consistency, ability to communicate,

interest taken in the protégé, and willingness to share control (Erdem & Aytemur).

While programs may make every effort to provide equal access to mentoring,

challenges often exist that are related to the development of the relationship and the

selection requirements set forth by the organization (Warren, 2005). Ethical concerns

may arise in a mentoring relationship if the mentor steps beyond his or her intended role

(Warren). McDonald and Hite (2005) cited three ethical concerns frequently reported in

the literature and related to mentoring relationships: cultural replication, access to

mentoring, and power. Cultural replication has a negative effect on mentoring when it

"reinforces unquestioning acceptance of the existing culture" (p. 571). Power becomes an

ethical concern when it is abused by either the mentor or the protégé (McDonald & Hite).

Training for mentors and protégés should address potential ethical issues specific

to mentoring relationships and provide guidelines that explicitly explain behavioral

expectations (McDonald & Hite, 2005). In a study of 155 employees representing eight

organizations, Kristic (2003) looked at whether perceptions of fairness in the workplace were related to the employee being mentored or nonmentored. All participants completed a questionnaire to establish perceptions of organizational justice. Only those participants who identified themselves as protégés in a mentoring relationship completed a second questionnaire on mentoring functions. Findings from this study on perceived organizational fairness of mentored and nonmentored employees showed no difference between the mentored and nonmentored employees. Kristic suggested that the lack of difference may be attributed to either the nonmentored employee being unaware that mentoring is occurring or the lack of mentoring being a personal choice for the nonmentored individual.

Mentoring in Nursing

Fawcett (2002) described a mentor relationship as one that is long-term, whereas a preceptor relationship is shorter and based on teaching. Important mentor characteristics include patience, enthusiasm, knowledge, a sense of humor, and respect. Assigned mentors may or may not exhibit the qualities that the mentee is seeking. Andrew and Wallis (1999) looked at the concept of mentoring in nursing through a review of literature. Significant in their findings was the confusion that exists regarding the role of the mentor. The term itself was sometimes interchanged with the term preceptor. While many models have been proposed as frameworks for mentoring, none have proven better than another. There was a lack of consensus as to the best way to prepare mentors for their role and whether one mentor or a team of mentors was most effective.

For nurses, the transition from student nurse to graduate nurse can be stressful. Hamilton et al. (1989) studied the impact of a mentoring model for new graduate nurses.

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A shortage of experienced nurses created a problem related to the existing method of orientation, which entailed assigning new graduates to a preceptor. The purpose of the study was to investigate whether using a mentoring model could increase new graduate job satisfaction, improve new graduate leadership behaviors, and increase new graduate retention. A quasi-experimental methodology was used. The sample consisted of new nurse graduates. The nine nurses of the control group were each assigned an individual mentor (preceptor) for five weeks of orientation. The experimental group consisted of one mentor assigned to a group of three nurses for five weeks of orientation and three additional months of practice. There were two experimental teams. Results indicated greater job satisfaction, perceived leadership behaviors, and retention in the experimental group. The researchers concluded that mentoring over an extended period of time may enhance professional development and skills due to consistent feedback. Additionally, one mentor for a group may be beneficial because of the shared team concept.

In a qualitative study with 16 participants, Thomka (2001) focused on new nurse graduates' perceptions of their transition into the professional nursing role. Responses indicated inconsistencies in orientation and the treatment of new nurses, depending on their unit. Their responses related to the "ideal transition" were significant. Seven nurses expressed the need for mentors to nurture and teach skills. Some of the participants described nurturing and supportive mentoring relationships during their transition. The researcher concluded that positive orientation and mentoring strategies are essential. However, mentoring characteristics were not defined for this study.

McKinley (2004) discussed the development of novice nurses through mentoring and the potential for advanced practice nurses to embrace mentoring relationships.

Mentoring is sometimes confused with coaching and precepting. McKinley described precepting as focused on skill development and mentoring as focused on relationship building. Mentoring develops future leaders by supporting professional growth, teamwork, and organizational commitment. McKinley described the ideal mentor as one who is motivated and committed to his or her profession, organization, and mentee.

Thomka (2007) reported findings on unpublished data related to nurses' reports of informal mentoring relationships. The informal relationships were developed over time and described as a "natural evolution." Nurses who identified with previous experiences of assigned or formal mentors described these relationships as detrimental. Thomka called on nurse leaders to create an environment where informal mentoring relationships can thrive. For this to happen, leaders must display positive and nurturing attitudes that do not allow room for less-favorable cultures to develop.

Tourigny and Pulich (2005) described formal and informal mentoring and the advantages and disadvantages of each. Formal mentoring entails assigning a mentor-mentee pair, establishing expectations, and defining the duration and amount of time spent on mentoring activities. Tourigny and Pulich stated that the roles of the mentor include role modeling, facilitating a relationship that invites sharing of personal concerns, and providing feedback to promote professional growth. Formal mentoring programs provide an opportunity for the organization to control objectives and activities associated with mentoring. Advantages of a formal mentoring program may include a higher level of staff satisfaction and a sense among nurses that their profession is highly valued by the organization. Disadvantages of a formal mentoring program include the possibility of a less-than-optimal match, a mentee who may not be committed to the program, and,

because formal mentoring programs exist for a contracted period of time, the possibility that all goals may not be met at the end of the contract.

Tourigny and Pulich (2005) described informal mentoring as a relationship built on mutual identification. The relationship lasts as long as both parties identify a need. Informal mentoring is not controlled by the organization, therefore both positive and negative behaviors may be exhibited by the mentor and then modeled by the mentee. An advantage of informal mentoring is the fact that protégés can select mentors based on their expertise, knowledge, experience, credibility, and integrity. Disadvantages of informal mentoring include the potential for other staff to conclude favoritism as a basis for the relationship, a lack of recognition for the effort, and the possibility that the best-qualified mentors may not have the opportunity to mentor.

Tourigny and Pulich (2005) concluded with details on establishing a formal mentoring program. They supported the development of specific selection criteria to evaluate potential mentors as well as training for those meeting the criteria. Contractual agreements should clarify objectives of the mentoring relationship and the duration and frequency of planned interactions. Finally, the effectiveness of any mentoring program must be measured based on cost and benefits.

Mentoring Research

One early mentoring study by Kram (1980) utilized in-depth interviews of relational pairs within a public utility organization in an attempt to gain a better understanding of organizational context on developmental relationships. Individual interviews were completed on young managers, and then on senior managers who had been identified by the first group. A total of 18 relational pairs participated in the

interview sessions. Additionally, 10 officers of the organization were interviewed to gain knowledge about relationships that had provided developmental support during their years at the organization. Kram's (1980) study found that relationships between young and senior managers can be mutually beneficial:

> The young manager finds a vehicle for aiding career advancement, for aiding his or her sense of competence and effectiveness in the managerial role, and for addressing particular dilemmas of early adulthood. The senior manager finds a vehicle for redirecting creative and productive energies at midlife, for addressing particular dilemmas of middle adulthood, and for building a supportive network through which his or her knowledge and experience can continue to have an impact in the organizational context. (p. 291)

However, organizational context plays an important part in the evolution of mentoring relationships. According to Kram (1985), an "organization's culture, reward system, task design, and performance management system affect relationships by shaping individuals' behaviors" (p. 15).

Alleman and Clarke (2002) identified three specific sets of mentor activities: guiding activities, helping activities, and encouraging activities. The Alleman Mentoring Activities Questionnaire (AMAQ; Alleman & Clarke) was developed specifically to measure the extent of mentoring going on and to assess the impact of the mentoring relationship on the individuals and the organization. Nine subscales provide information related to nine major mentoring functions as identified by Alleman and Clark. The nine mentoring functions are teach the job, provide challenge, teach politics, help with career, protect, sponsor, career counseling, friendship, and trust.

Two studies (Fields, 1990; O'Neill, 2005) examined organizational variables related to mentoring. Fields examined mentors' perceptions of personal and organizational variables related to the strength of mentoring relationships. Fields recruited 125 registered nurses who perceived that they had functioned as mentors. Subjects completed the Mentoring Potential Scale (MPS), Self-Perceived Success in Nursing Scale, Work Environment Scale, and Career Support Scale. The findings from this study supported only the relationship between mentoring potential and the strength of the mentoring relationship. Limitations to the study included limited prior testing of instruments and the fact that survey responses were based on retrospective activity and, therefore, reliant on subjects having accurate memory and perceptions.

O'Neill (2005) studied the influence of three organizational predictors—organizational position, organizational context, and organizational type—on specific mentoring functions. Surveys were mailed to 2,159 MBA graduates in the northeastern United States. Of the 743 surveys that were returned, 479 indicated they had a mentor and were included in the analysis. The study instrument included 36 items intended to measure nine specific mentoring functions. Study findings revealed no significant relationship between organizational position and mentoring. There was a positive relationship between cooperative context and four of the nine mentoring functions. The four functions—role modeling, counseling, acceptance and confirmation, and friendship—are all psychosocial types of mentoring. There was no significant relationship between cooperative context and career-related mentoring functions.

In a study of nursing education administrators, Rawl (1989) gained insight into the characteristics and frequency of mentoring, perceived negative experiences of

mentoring, and positive influences other than mentoring on career development. A 59-item questionnaire created by the researcher was mailed to 600 randomly selected nursing education administrators at NLN-accredited baccalaureate nursing programs across the United States. Four hundred twenty-seven administrators completed and returned surveys. The study found that 67.9% of responders identified with at least one mentoring relationship, and 32.1% reported not having been mentored. The most frequently reported positive influences on career development, other than mentoring, included willingness to work hard, self-motivation, educational preparation, work experience, and willingness to take risks. Negative aspects of mentoring revealed in the study included "power/authority issues, interdependency issues, time constraints, unrealized or mismatched expectations of mentors and protégés, professional/philosophical differences, separation issues, personal differences, and perceptions of others" (p. 166).

Angelini (1992) interviewed 37 nurses, from both teaching and nonteaching hospitals, with a goal to identify perceived mentoring experiences of hospital staff nurses and to describe mentoring and career development as viewed by the staff nurses. Nurses in the study reported that the environment, people, and events were all influential in the mentoring process. A significant finding from this study is that this particular group did not identify with a single mentor; rather, a multidimensional model of relationships was identified as influential in their professional development.

In a study on mentoring relationships, Allen, Poteet, and Russell (2000) asked mentors to report on those characteristics that were most influential when choosing an individual to mentor. Their study examined (a) the relationship between the mentor's perceptions of the protégé's potential/ability and need for help and the mentor's

perceived barriers to mentoring others, (b) mentor advancement aspirations, and (c) mentor gender. Participants in this study were 1,500 first-line managers of a government organization. Results support the notion that mentors are more likely to select protégés based on the mentors' perceptions of the protégés' potential/ability than the protégés' perceived need for help. These results bring to question research that compares career outcomes of mentored versus nonmentored individuals.

<div align="center">Intellectual Capital</div>

Intellectual Capital – Historical Perspective

The concept of intellectual capital (IC) was first introduced to the business press in 1991 in an article written for *Fortune* by Thomas Stewart (Stewart, 2001). Stewart (1991) suggested that organizations take notice of intangible assets and place value on talent the same way they do financial statements. Stewart (1991) described IC as the "sum of everything everybody in your company knows that gives you a competitive edge in the marketplace" (p. 44). Hudson (1993) defined human capital as a combination of "your genetic inheritance; your education; your experience; and your attitudes about life and business" (p. 75). Stewart (1994) described IC as the intangible assets of skill, knowledge, and information. Edvinsson and Malone (1997) stated, "Intangible assets are those that have no physical existence but are still of value to the company" (p. 23). Skandia, an insurance and financial services company in Scandinavia, began investigating IC under the leadership of Leif Edvinsson (Edvinsson & Malone). Skandia's first model for intellectual capital was simply "Human Capital + Structural Capital = Intellectual Capital" (p. 11).

The world's first public intellectual capital annual report was released by Skandia as a supplement to their 1994 financial report (Edvinsson & Malone, 1997). Skandia's (1995) report shared with the world one company's attempt to discover, manage, and quantify the intangible values attributed to human capital and structural capital. A reporting model, the Skandia Navigator, was developed as a means to provide a picture of both financial results and development of IC (Skandia).

Intellectual capital was identified in the nursing literature as early as 1995. In an editorial in the journal *Nursing Outlook*, Anderson (1995) used the term intellectual capital when encouraging nursing educators to utilize teaching methods designed to stimulate independent, creative, and critical thought rather than the typical fact-based curriculum. In 1995, the results of the Vermont Nursing Initiative's (VNI's) 5-year program, focused on investing in the IC of hospital nurses, were published (Ceppetelli, 1995). The VNI was made up of 15 unrelated community hospitals in Vermont working together on a shared vision to coordinate a patient-centered system of health care. Utilizing the concept of intangible assets as described by Stewart (1994) and the five disciplines described by Senge (1990)—shared vision, team learning, personal mastery, mental models, and systems thinking—the VNI empowered nurses to learn and share new knowledge. As a result of the VNI, the participating organizations realized a collaborative model that impacted patient care and staff learning (Ceppetelli).

Intellectual capital continues to be a topic of importance in both the business world and the nursing profession, as evidenced by the abundance of recent literature. Every year since 1996, the World Congress on Intellectual Capital and Innovation has provided a forum for students and leaders of IC. Academic researchers present, discuss,

and review the latest issues and trends in management and IC research and practice (McMaster World Congress, 2008).

Characteristics of Intellectual Capital

Edvinsson and Malone (1997) used a tree as a metaphor to increase understanding of IC and its value to the organization. If the organization is the tree, then annual reports, company brochures, and other documents are the trunk, branches, and leaves. However, the part of the tree not visible—its roots—are key to the future health of the tree. Intellectual capital is the roots of a company's value. Two factors that constitute IC are human capital and structural capital, defined by Edvinsson and Malone as follows:

1. *Human capital*. The combined knowledge, skill, innovativeness, and ability of the company's individual employees to meet the task at hand. It also includes the company's values, culture, and philosophy. Human capital cannot be owned by the company.

2. *Structural capital*. The hardware, software, databases, organizational structure, patents, trademarks, and everything else of organizational capability that supports those employees' productivity. Structural capital also includes customer capital, the relationships developed with key customers. Unlike human capital, structural capital can be owned and thereby traded. (p. 11)

Cohen and Prusak (2001) added a fourth dimension to the intellectual capital model: social capital. They defined social capital as "the stock of active connections among people: the trust, mutual understanding, and shared values and understanding that bind the members of human networks and communities and make cooperative action possible" (p. 4).

Intellectual capital has been described as intangible assets (Stewart, 1991; Sveiby, 1997). Sveiby wrote, "Three types of intangible assets are: employee competence (education, experience), internal structure (the organization: management, legal structure, manual systems, attitudes, R&D, software), and external structure (brands, customer and supplier relations)" (p. 12). Intangible assets may be called the invisible part of the balance sheet, but these assets are deemed valuable by successful managers (Sveiby).

Measuring Intellectual Capital

Bontis (1996) wrote that in order for the IC concept to be accepted and developed in organizations, mechanisms for measuring IC must be understood. When measuring human capital, an organization should take into account employee attitude surveys, tenure, turnover, experience, and learning (Sveiby, 1997). Offered here are examples of models that have been used to measure IC.

One method of measuring IC is to utilize "Tobin's q" (Corso, 2007; Stewart, 1997). Named after Nobel Prize-winning economist James Tobin, Tobin's q is a ratio that compares the market value of an asset with its replacement cost. Kaplan and Norton (1996) developed the Balance Scorecard (BSC) as a means of measuring organizational performance across four perspectives: financial performance, customers, internal business processes, and learning and growth. The BSC brings together financial performance (the past) with measures of "critical value-creation activities created by skilled, motivated organizational participants" (p. 8).

Celemi, a Swedish company known for developing and distributing training tools, created an "invisible" balance sheet to identify intangible assets (Sveiby, 1997). The result was the creation of the Intangible Assets Monitor. This monitor evaluates three

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aspects of the organization—customers, internal structure, and employee competence—from the perspective of growth/renewal, efficiency, and stability.

Skandia's 1994 annual report introduced the Skandia Navigator as a reporting model designed to provide a "balanced picture of the financial and intellectual capital" (Skandia, 1995, p. 7). The Navigator is comprised of five areas of focus: financial, customer, process, renewal and development, and human capital. Utilizing the Navigator as a model for reporting provides the company with a "systematic description of the company's ability and potential to transform intellectual capital into financial capital" (Skandia, p. 7).

Sveiby (1997) measured IC beginning with knowledge, which he described as "competence." Sveiby suggested that competence consists of five mutually dependent elements:

- *Explicit knowledge.* Explicit knowledge involves knowing facts. It is acquired mainly through information, often through formal education.

- *Skill.* This art of "knowing how" involves a practical proficiency—physical and mental—and is acquired mainly through training and practice. It includes knowledge of rules of procedure and communication skills.

- *Experience.* Experience is acquired mainly by reflecting on past mistakes and successes.

- *Value judgments.* Value judgments are perceptions of what the individual believes to be right. They act like conscious and unconditional filters for each person's process-of-knowing.

- *Social network.* The social network is made up of the individual's

   relationships with other human beings in an environment and a culture that is

   transferred through tradition. (p. 35)

In a mixed-method study of Department of Defense employees, McGill (2006)

examined the types of IC that employees were effectively transferring and the preferred

method of transferring the knowledge. Interviews of 23 individuals provided themes for

categories of IC that participants reported as present within the organization. Utilizing the

results from the qualitative portion of the study, 113 subjects participated in the

quantitative segment of the study. Participants were presented with four scenarios, each

representing one of four types of IC: subject matter expertise, analysis methodology,

customer protocols and relationships, and shared beliefs. With each scenario, participants

were asked to compare four methods for transferring knowledge: hands-on interaction,

documentation, observation, and mentoring. Participants revealed a desire to share

knowledge, and they identified IC as vital to the success of the organization. It was also

suggested that mentoring for the purpose of knowledge transfer was not occurring as

frequently as participants desired. Findings suggested that within the study organization,

the effectiveness of the method for exchanging knowledge (IC) between individuals was

dependent on the type of IC being transferred. Further, perceived effectiveness of

knowledge transfer was impacted by demographic and organizational factors.

Intellectual Capital in Nursing

Nursing literature addresses the value of IC within organizations. Organizations

benefit when the wisdom of the employees is translated into reusable and sustained

actions (Weston et al., 2007). However, health care organizations seldom take into

account knowledge and skill when evaluating their financial status (Hall, 2003). In a study that analyzed nursing productivity, Hall included the usual indicators—direct care hours, turnover, absenteeism, nursing errors, and patient satisfaction—but also included nursing knowledge indicators—educational preparation, experience, career development, autonomy, organizational trust and commitment, and employee satisfaction. Hall's theoretical approach for analyzing nursing productivity provides a representation of characteristics associated with nursing knowledge development, organizational support for knowledge development, and related expenses. Hall's theory also takes into account nursing errors related to patient safety and patient satisfaction with nursing care.

Davidson (2007) described an infrastructure that cultivates IC by providing access to knowledge, setting an expectation of knowledge transfer, and making successes visible to the entire organization. Weston et al. (2007) stated:

> Creating a culture to capture the wisdom of employees and embed it in the organization requires: (a) creating employee commitment through a professional practice environment, (b) establishing a culture of a learning organization, (c) generating social networks for sharing information, and (d) encouraging employee participation in decision making. (p. 7)

While nursing literature on intellectual capital was found to be limited, there was a sense of urgency for preserving IC either by retaining knowledgeable individuals (Falk, 2007) or by transferring knowledge from the experienced to the less experienced (Davidson, 2007; Scott, 2007). Facing a faculty shortage due to retirement eligibility, Falk suggested that educational institutions should develop strategies to retain and effectively utilize faculty who otherwise might leave their teaching positions. Scott

provided examples of how technology and teamwork can be supportive in preserving

knowledge in the health care environment. Technology has been developed that allows

for remote monitoring with visualization so that the care providers' knowledge can be

captured from afar.

Taking from the IC concepts of Leif Edvinsson and Thomas Stewart, Covell

(2008) developed a nursing theory for IC. Covell's theory provides health care

organizations with a model to view nurses' knowledge and skill as it relates to patient and

organizational outcomes. In the model, nursing human capital consists of nurse staffing

and employer support for continued professional development that directly impacts both

patient outcomes and organizational outcomes.

<p style="text-align:center">Succession Planning</p>

Literature specific to succession planning was primarily focused on health care or

general business (Blouin, McDonagh, Neistadt, & Helfand, 2006). Succession planning is

the process of identifying and preparing individuals to assume positions of key staff who

leave their positions for any reason (McConnell, 2006; Shirey, 2008). Prior to 2001, it

was not uncommon for the CEO or board of directors to identify a successor based on

"hunches, instincts, or intuition" (Greengard, 2001, p. 36). However, succession planning

is more than just filling a vacant position (Smeltzer, 2002). Successful succession

planning requires planned leadership development (McConnell). Smeltzer identified the

following steps for leaders to take to promote succession planning:

- Recognize what leadership qualities, skills, and knowledge are required for

  leadership in the current environment.

- Identify whether the same set of skills will be needed in the future or whether additional skills will be required.

- Take an inventory of current leadership's skills, potential for growth. And "wants and desires" for career advancement.

- Access a larger pool of individuals for development. Search for individuals who have demonstrated leadership but are not in traditional managerial roles.

- Communicate the intent to develop leaders.

- Provide the tools needed for development including education, coaching and assessment tools.

- Participate in the development by evaluating and monitoring progress.

- Continuously assess how candidates are functioning and the outcomes of their work. (p. 615)

The assessment and development of competencies is critical when planning for the future leadership needs of an organization (Redman, 2006). Factors to consider when assessing potential successors are as follows:

- The desires and aspirations of each candidate—what the individual wants to become, where he or she wants to go

- The opportunities that seem to present themselves most frequently within the organization, relative to the candidate's desires, aspirations, and basic skills

- The candidate's apparent capacity to learn, grow, and change as necessary

- The candidate's genuine level of interest in developing and growing into a broader, more responsible role

- The candidate's management skills and apparent developmental needs

    (McConnell, 2006, p. 96)

Succession Planning in Business

Preparing for a knowledge transfer to a new generation of leadership is a concern for many organizations (DeLong, 2004). However, some organizations have been caught unprepared. DeLong described two such companies. The Tennessee Valley Authority began downsizing in the 1980s in response to a need to control costs. Suddenly, in 1998, leadership realized that the median age of the remaining employees was 48. Plans to transfer critical knowledge would need to be a priority over the next few years. The National Aeronautics and Space Administration (NASA) is another example of lack of preparation for an aging workforce. In 2002, NASA realized that half of its workforce would be eligible for retirement just 4 years later. The group ready for retirement included the most experienced project managers.

Succession planning took on a new meaning in the business world following the events of September 11, 2001. Nothing could have prepared organizations for the loss of key executives on that tragic day in American history (Greengard, 2001). Jack Welch, former CEO of General Electric (GE), was recognized for his talent in managing people (Blouin et al., 2006). While at GE, Welch (2005) developed the "vitality curve," a system to differentiate employees. The vitality curve is a method of sorting employees into categories—A, B, or C—based on their performance. The As are identified as individuals with passion and drive, the ability to energize others and deliver on promises. The Bs are the heart of the organization and critical to its success. Companies put a lot of energy into

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developing the Bs. The Cs are procrastinators and can not deliver, therefore they need to be moved out (Welch).

Succession Planning in Nursing

Succession planning is vital for health care and, specifically, nursing due to the aging workforce (Buerhaus et al., 2000; Collins & Collins, 2006, 2007; Hart, 2007; Sherrod, 2006; Stein & Deese, 2004). In 1995, the Pew Health Professions Commission predicted a surplus of 200,000 to 300,000 nurses by the year 2000. In stark contrast, the United States Department of Labor, Bureau of Statistics' Employment Outlook 2006–2016 predicted a need for an additional 587,000 nurses by the year 2016 (Dohn & Shniper, 2007).

Changing demographics among nurses is cause for concern (Collins & Collins, 2007). While health care organizations have not maintained the same level of succession planning as other corporate organizations, successful programs have been reported in the literature (Blouin et al., 2006). Supported by a grant from the Robert Woods Johnson Foundation, one organization built a career development program for all levels of nurses (Cadmus, 2006). Specifics of the program included leadership and staff assessments, staff mentorship, visioning, and competency and career planning for staff and first-line managers.

The Veterans Health Administration Office of Nursing Services developed an electronic database to support succession planning and leadership readiness (Weiss & Drake, 2007). Information on potential candidates—including credentials, certifications, clinical or functional experience, training programs completed, and geographic

preference—is entered into the system. Veterans Affairs nurse executives access the database to identify individuals who meet the vacant position requirements.

The Portland Veterans Affairs Medical Center (PVAMC) developed programs to increase competencies and support individual development (Goudreau & Hardy, 2006). Individuals participating in one of three individual programs, specific to their rank and education, have shown promising increases in core competencies and skills necessary to grow with the organization. Commitment to succession planning through staff development programs has prepared the PVAMC for the future.

The University of Pittsburgh Medical Center introduced a Health Care Leadership Academy (Wolf, Bradle, & Greenhouse, 2006), which provided training for three levels of nurses:

> Level 1: Nurses transitioning into their first leadership roles; Level 2: Nurses experienced in managing others and who are counted on to drive change and impact staff performance; and Level 3: Vice-president level or aspiring executive level leaders. (p. 331)

Succession Planning Research

Two studies examined organizational plans for addressing the aging workforce (Kraus, 2007; Shipman, 2007). Kraus evaluated the aging population and turnover at a global corporate organization. The organization had only an informal succession plan in place. Recommendations resulting from the evaluation included developing a structured succession plan and coaching/mentoring of high-potential employees.

Shipman (2007) examined four randomly chosen health care organizations in Kentucky to gain knowledge about how health care was preparing for the exit of the

aging workforce. Specifically, the study wanted to find out if the organizations were identifying potential leaders, mentoring to address succession plans, and developing leaders. The four organizations in this study each had 150 licensed beds and represented 10% of hospitals in Kentucky with 150 beds or more. One representative (vice president) from each hospital participated in an interview process. Findings of interest included the fact that none of the organizations participating in the study had a formal succession plan, identified successors for key positions, or had a formal process for identifying high-potential employees—although each had leadership development programs for the purpose of developing internal leadership talent. While Shipman highlighted the lack of succession planning in the four organizations, a major limitation was the small number of hospitals evaluated.

In their research on what contributes to a leader's success or failure, Conger and Fulmer (2003) found that successful companies combine succession planning with leadership development. They identified five rules for creating a system that will deliver a "steady pipeline of leadership talent" (p. 78): focus on development (the process of providing educational opportunities to would-be leaders); identify linchpin positions (positions critical to organization's success), and begin developing leaders from all organizational levels; create transparency to provide employees with the information necessary to prepare for future positions; measure progress regularly to maintain an understanding of where individuals stand on their developmental needs; and maintain flexibility so that adjustments can be made as needed to the succession management program.

Recognizing the need for more strategic measures to manage the succession of leaders, managers, and workforce, the U.S. General Accounting Office set out to evaluate succession planning strategies in countries where effective programs were already in place (U.S. General Accounting Office [GAO], 2003). Practices utilized to manage succession in Australia, Canada, New Zealand, and the United Kingdom included the following:

- Receive active support of top leadership.

- Link to strategic planning.

- Identify talent from multiple organizational levels, early in careers, or with critical skills.

- Emphasize developmental assignments in addition to formal training.

- Address specific human capital challenges, such as diversity, leadership capacity, and retention.

- Facilitate broader transformation efforts.

Conclusion

The nursing profession is facing challenges associated with the loss of knowledge and expertise as baby boomers begin to retire (Kaye & Cohen, 2008; Sherrod, 2006). Formal succession planning and mentoring have been reported as a means of creating a culture of sharing vital knowledge (Kraus, 2007; Shipman, 2007). Competencies required at all levels of the organization should be identified (Cadmus, 2006), and each individual in the organization should be considered as a candidate for leadership development (Beyers, 2006). Succession planning is an investment in both the organization and its human capital (Greengard, 2001). While organizations may agree that nurses have a

professional responsibility to mentor (Vance, 2002), mentoring is not without challenges (Ragins & Scandura, 1997; Vance).

This review of the literature addressed the topics of mentoring, intellectual capital, and succession planning from a broad perspective and specific to the nursing profession. No studies were found that clearly addressed the impact of mentoring relationships or succession planning on the cultivation of IC. More specifically, no studies were found that considered the mentor's perceived professional responsibility for mentoring his or her potential successor.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to examine nurse mentoring, succession planning, and perceived professional responsibility as a means of sustaining intellectual capital in a community hospital servicing Chicago's northwest suburbs. This section of the dissertation includes the following: research design, population, data collection procedures, analytical methods, and limitations. The researcher sought to answer the following questions:

1. To what extent was mentoring experienced by nursing personnel?

2. What impact does mentoring have on the cultivation of IC in the community hospital setting?

3. How do nurse personnel in the community hospital perceive their professional responsibility to mentor others as a means of succession planning?

Research Design

The current study used a mixed-method approach utilizing a descriptive two-phase research design. Mixed-method research uses procedures that are normally applied to both quantitative and qualitative studies to better understand the research problem (Gay, Mills, & Airasian, 2006). According to Polit and Beck (2006), "many areas of inquiry can be enriched and the evidence enhanced through the judicious blending of qualitative and quantitative data" (p. 245).

To answer research questions one and two, a quantitative approach was taken utilizing two questionnaires, the Alleman Mentoring Activities Questionnaire (AMAQ; Alleman & Clarke, 2000) and the Nursing Intellectual Capital Inventory (NICI; Reidinger, 2008). Questionnaires are structured, self-administered surveys (Fain, 2004). Leedy and Ormrod (2005) defined survey research as "acquiring information about one or more groups of people by asking them questions and tabulating their answers" (p. 183). The goal of survey research is to learn about a large population by surveying a sample of that population (Leedy & Ormrod).

Focus groups were conducted using a general interview guide to collect personal narrative related to mentoring experiences by the participants and to answer the third research question. Focus groups, for all intents and purposes, are interviews and not intended to be problem-solving sessions (Patton, 2002). The general interview guide involves outlining a set of issues to be explored with each respondent before interviewing begins (Patton). A conceptual model presenting assumptions on mentoring activities and their impact on succession planning is presented in Appendix A.

Population

The population for this study was registered nurses employed at one community hospital servicing the northwest suburbs of Chicago. According to 2008 data, the hospital employs 1,200 registered nurses. The average age of the nurse employees was 46.8 years. Twenty percent of the nurses were 56 or older, while 17% were 36 or younger (Northwest Community Hospital, 2008). All employed nurses were eligible to take part in the quantitative portion of the study.

The sample included nurses from each of the following categories: staff nurse, educator, APN, manager, and director. A total of 151 nurses responded to the survey for a 12.5% return rate. Of the 151 surveys returned, 14 were deleted due to missing data, so a total of 137 nurses were included in the study. Mentoring relationships were acknowledged by 122 (89%) of the respondents, leaving 15 (11%) of the respondents reporting no mentoring relationship. The mean age of respondents was 44, with a range from 22 to 65 years of age. The average length of employment within the organization was 11.74 years, with a range from 1 year to 42 years. Respondents' nursing roles were 54% staff nurse ($n = 74$), 9% educator ($n = 12$), 10% APN ($n = 14$), 11% manager ($n = 15$), 4% director ($n = 6$), and 12% other ($n = 16$). Education levels of nurse respondents were 9% diploma ($n = 12$), 18% associate degree ($n = 23$), 48% BS/BSN ($n = 61$), and 25% MS/MSN ($n = 32$).

Participation in the qualitative portion of the study was limited to 6 nurses for each focus group. Focus groups were organized to include only one job category per session: staff nurse, educator, APN, manager, or director. Two focus groups were conducted for each job category. A total of 32 nurses participated in a focus group. Focus group participants' nursing roles were 16% staff nurse ($n = 5$), 12% educator ($n = 4$), 28% APN ($n = 9$), 25% manager ($n = 8$), and 19% director ($n = 6$).

<center>Data Collection</center>

During the spring of 2009, two questionnaires, the AMAQ (Alleman & Clarke, 2000) and the NICI (Reidinger, 2008), were distributed and returned for this study. To examine the extent of mentoring experienced by nursing personnel, the AMAQ was chosen for its validity in measuring the amount and quality of mentoring activity.

"Content validity was based on the judgment of two panels of experts. Reliability of the AMAQ was determined by an internal consistency estimated at $r = .97$ using the SPSS program for Cronbach's Alpha" (Alleman & Clarke, 2002, p. 11). The AMAQ is a copyrighted tool with 72 Likert-scaled items that are intended to measure mentoring behaviors grouped into three categories: guiding activities, helping activities, and encouraging activities (see Appendix B). Each of the three categories of mentoring—guiding activities, helping activities, and encouraging activities—have three subscales that describe a total of nine mentoring activities. Figure 1 presents the subscales. Descriptions for each of the nine subscales are presented in Appendix B.

AMAQ Subscales		
Guiding Activities	Helping Activities	Encouraging Activities
Teach the Job	Career Help	Career Counseling
Provide Challenge	Protect	Friendship
Teach Politics	Sponsor	Trust

Figure 1. AMAQ subscales.

In an effort to explore the impact of mentoring on the cultivation of IC in the community hospital setting, nurses were asked to complete the NICI. The NICI was constructed by the researcher with the intent to gather demographic information and to quantify nurses' degrees of professional development activities and levels of organizational participation. Questions on the NICI were designed to seek information regarding the nurses' current states of professional development, their levels of involvement in organizational committees and leadership activities, and their predictions for future involvement (see Appendix C).

E-mail and unit-based flyers were used to introduce nurses to the study and to encourage them to complete the questionnaires. E-mail provided educators, APNs, managers, and directors with a link to an online version of the questionnaires. Paper copies of the questionnaires were made available to staff nurses who did not have access to the Internet. Surveys were collected over a four-week period with an e-mail prompt sent after two weeks.

Focus groups were conducted to collect personal narrative related to mentoring experiences by the participants and to examine how nurse personnel in the community hospital perceive their professional responsibility to mentor others as a means of succession planning. Nurses participating in the questionnaire segment of the study were invited to indicate interest in attending a focus group by providing their names and contact information to the study investigator on the bottom of the cover letter or by e-mail. However, when only 5 potential focus group participants were self-identified from the survey, e-mails were directed to specific nurse classifications within the organization to obtain additional focus group participants.

Focus groups were scheduled over a three-week period and conducted in meeting rooms at the organization to enhance both comfort and convenience for the participants. Each focus group was scheduled for 1 hour, beginning and ending as scheduled. Focus groups were tape-recorded after a signed consent was obtained from each participant. Ten focus groups were held with a total of 32 individuals participating. Definitions for three key topics that were addressed in the interview sessions—mentoring, intellectual capital, and succession planning—were provided for the focus group participants (see Appendix D).

Analytical Methods

The statistical program used for analyzing quantitative data collected during the current research study was the Statistical Package for the Social Sciences (SPSS). SPSS is a data entry software program that provided the researcher with the mechanism to run analytic calculations. Responses to the AMAQ and NICI were entered into SPSS.

Data from the AMAQ were also analyzed by the author of the tool. Data were sent in Excel format for group scoring of mentoring behaviors described as guiding activities, helping activities, or encouraging activities. The AMAQ is scored using a computer program to calculate the mean for each of the 72 mentor behavior items. The standardized scores were computed by converting individual mean scores to z scores using normed group mean and normed group standard deviation. The norm group mean represents the mean for the scales based on previous research with the instrument in reference to ideal mentoring relationships (Alleman & Clarke, 2002). The AMAQ scores can be used as a continuous measure or as a categorical measure with scores falling into the ranges of nonmentoring (0–29), limited mentoring (30–40), typical mentoring (40–60), and high levels of mentoring (above 60; Alleman & Clarke). Independent sample t-tests were run to compare mean total mentoring scores for each of the AMAQ subscales based on job role, highest level of education, and length of employment at organization.

The NICI focused on particulars of the respondents and included age, years of service, level of professional development, degree of organizational involvement, and intended year of retirement. Descriptive statistics were employed to look at demographic details specific to the current state of the study organization. Frequencies for age, years of service, educational preparation, and job classification were identified. Age, years of

service, degree of professional development activities, and level of organizational participation were key to quantify intellectual capital in each of the study groups—staff nurse, educator, APN, manager, and director. Survey respondents were given professional development and organizational participation scores based on the number of professional or organizational activities they reported. Figure 2 presents the activities included in the score for each category—professional development activities and organizational involvement activities. A total nursing involvement score was derived from combining the scores from both professional development activities and organizational involvement activities. Analysis of variance (ANOVA) was utilized to determine differences of professional development scores, organizational involvement scores, and total nursing involvement scores based on age, highest level of education, and length of employment.

ANOVA was also utilized to examine differences of AMAQ scores based on professional development scores, organizational involvement scores, and total nursing involvement scores.

Professional Development Activities	Organizational Involvement Activities
Certification	Unit Committee
Taking College Courses	Unit Committee Chair
Member Professional Organization	Hospital Council
Professional Organizational Committee	Hospital Council Chair
Seek New Role in Organization in 5 Years	Preceptor for New Staff

Figure 2. Professional development and organizational involvement activities.

Inductive and deductive analysis was utilized to organize and interpret qualitative data (Patton, 2002). Focus group recordings were transcribed by a transcription service. The transcription for the first focus group was verified by listening to a replay of the original recording while reading the transcription. This process was repeated for the final focus group. Analysis began with organizing responses to each of the interview questions. Data were then reviewed for common and recurrent themes. Deductive analysis was utilized to interpret the qualitative data related to mentoring experiences. Deductive analysis occurs when the data are analyzed according to an existing framework (Patton, 2002). Responses related to mentoring experiences were coded according to the nine mentoring behaviors described by Alleman and Clarke (2002). Inductive analysis was utilized to examine qualitative data collected in response to the question on succession planning. According to Patton, inductive analysis involves "discovering patterns, themes and categories in one's data" (p. 453).

Limitations

A primary limitation of the study was due to the fact that only nurses from a single organization were studied, making generalization of findings to other organizations difficult. Additionally, the organization is a community hospital with Magnet designation, further limiting generalization.

A second limitation was that gender was not addressed in the demographic portion of the surveys. The small number of male nurses employed at the hospital in this study would limit any statistical consideration.

A third limitation was level of participation in the quantitative phase of the data collection. The relatively small response rate (13%) for return of questionnaires created

some skepticism related to how representative the sample was to the larger population of nurses employed at the organization.

A fourth limitation was that focus groups as a qualitative research design may be limited due to the restricted time allowed for each session and the fact that some of the participants were acquaintances and therefore may have been guarded in their responses.

Several of these limitations arose because the goal of this study was to examine the state of mentoring in one organization. Findings will be restricted to the state of mentoring at the time of the study perceived by those who returned surveys or participated in focus groups.

CHAPTER IV

FINDINGS AND CONCLUSIONS

Introduction

This chapter presents the results obtained from the data collection segment of this study. The purpose of this study was to examine nurse mentoring, succession planning, and perceived professional responsibility to mentor as a means of sustaining intellectual capital (IC) in a community hospital. The researcher sought to answer the following questions:

1. To what extent was mentoring experienced by nursing personnel?

2. What impact does mentoring have on the cultivation of IC in the community hospital setting?

3. How do nurse personnel in the community hospital perceive their professional responsibility to mentor others as a means of succession planning?

In Chapter I, the author introduced statistics related to the aging nursing workforce, the potential for loss of intellectual capital, and the possibilities for succession planning. Chapter II presented a review of current literature on mentoring, intellectual capital, and succession planning. Earlier supporting literature was also included where relevant. While literature from the fields of social science, business, and education were included in the review, literature specific to nursing was given priority. In Chapter III, the author discussed the research design, population, data collection procedures, analytical methods, and limitations. Chapter IV presents results specific to each research question

with applicable tables and figures. This section of the dissertation includes the following: findings, conclusions, and implications and recommendations.

Findings

Research Question One

The first research question asked to what extent mentoring was experienced by nursing personnel in the organization. Quantitative measures from the AMAQ and qualitative findings from focus group recordings were included in the analysis. Table 1 presents descriptive statistics (minimum, maximum, mean, and standard deviation) for each of the nine mentoring subscales as reported for the mentored group ($n = 122$).

Table 1

Descriptive Statistics for AMAQ Subscales for Group

AMAQ Subscales	Minimum	Maximum	*M*	*SD*
Teach the Job	10.24	71.10	49.45	11.15
Challenge	35.26	81.33	62.96	7.74
Politics	16.18	63.58	42.94	9.06
Help	27.50	67.03	45.11	9.34
Protect	30.54	65.34	48.65	7.25
Sponsor	30.40	72.89	48.58	9.55
Counsel	26.71	66.59	50.13	8.56
Friendship	21.88	64.67	40.67	8.96
Trust	8.28	67.86	52.25	10.88

According to Alleman and Clarke (2002), AMAQ scores fell into four categories: nonmentoring (0–29), limited mentoring (30–40), typical mentoring (40–60), and high levels of mentoring (above 60). As can be seen from this table, mean mentoring scores for the group fell into the typical mentoring range (40–60) for eight of the nine subscales. Challenge was the only subscale that fell into the high level of mentoring category.

Figure 3 displays the mean scores for each of the nine subscales for each nursing role—staff nurse, educator, APN, manager, and director.
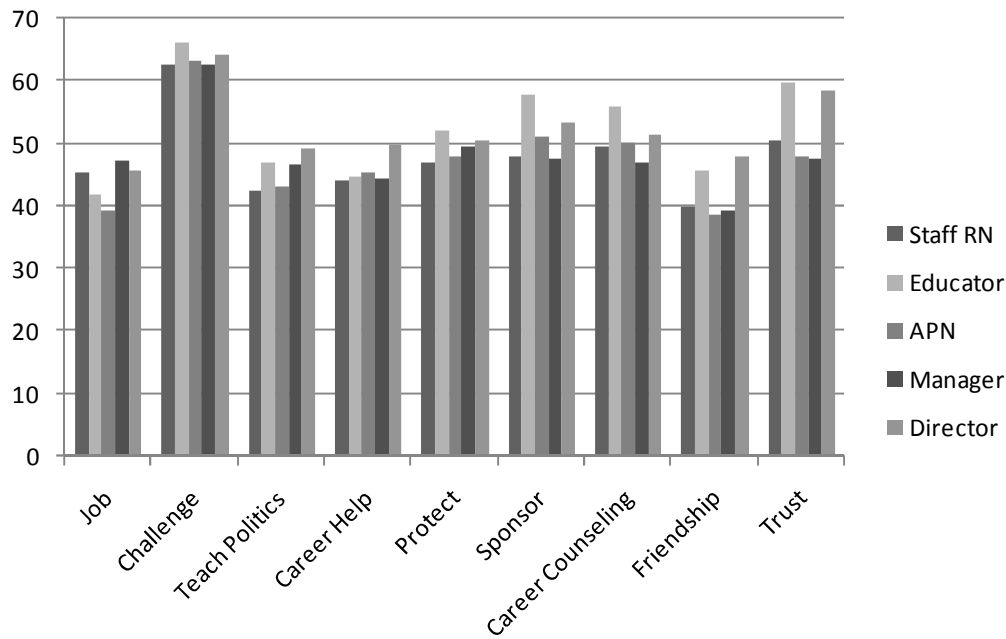
Figure 3. Mean mentoring scores for each subscale for each nursing role.

As the data in this graph shows, there was relative uniformity in the mean scores for each of the subscales across nursing roles. Most of the mean scores for each of the job roles fell within the typical mentoring range. Challenge was the only subscale that had a mean falling in the high mentoring range for all job roles. The mean score for the Friendship subscale fell into the limited mentoring range for the staff nurse, APN, and

manager groups. Independent sample *t* tests were run to compare mean total mentoring

scores for each of the AMAQ subscales based on job role, highest level of education, and

length of employment at organization. Table 2 presents a comparison of mentoring scores

for nurses in two groups—staff nurse (*n* = 66) and nonstaff nurse (educator, APN,

manager, and director; *n* = 56).

Table 2

Comparison of Mentoring Scores by Nursing Role

AMAQ Subscales	Staff Nurse		Nonstaff Nurse		
	M	*SD*	*M*	*SD*	*t*[a]
Teach the Job	51.83	10.70	46.65	11.10	2.62*
Challenge	62.57	7.89	63.41	7.60	-0.59
Politics	41.77	9.78	44.32	7.99	-1.56
Help	44.72	9.55	45.57	9.16	-0.50
Protect	47.94	7.50	49.48	6.91	-1.17
Sponsor	47.11	9.66	50.33	9.21	-1.88
Counsel	50.64	8.02	49.53	9.19	0.72
Friendship	40.68	8.27	40.65	9.79	0.02
Trust	52.52	9.67	51.94	12.25	0.30
Total	48.49	8.63	49.16	9.70	-0.40

[a]*df* = 112.

*p < .01.

As Table 2 shows, Teach the Job was the only subscale with a significant difference between the staff nurse and nonstaff nurse groups. Table 3 shows a comparison of mean total mentoring scores based on highest level of education. Respondents were classified into two groups, Diploma/AD (n = 32) and BSN/MSN (n = 82).

Table 3

Comparison of Mentoring Scores by Highest Level of Education

AMAQ Subscales	Diploma/AD		BSN/MSN		
	M	*SD*	*M*	*SD*	t^a
Teach the Job	50.1	11.64	49.71	10.82	0.17
Challenge	63.74	7.42	63.31	7.30	0.28
Politics	45.03	8.87	42.49	8.46	1.42
Help	46.01	9.26	44.86	9.54	0.58
Protect	49.95	7.41	48.40	7.13	1.03
Sponsor	48.70	10.13	48.26	9.41	0.22
Counsel	52.01	7.79	49.72	8.59	1.31
Friendship	39.70	10.14	41.36	8.35	-0.90
Trust	51.77	11.91	52.86	10.64	-0.48
Total	49.75	9.69	48.79	8.58	0.52

[a]df = 112.

There was no significant difference in mentoring scores based on level of education. Table 4 compares mean total mentoring scores based on length of employment at organization. Two groups were compared, 1 to 8 years of employment ($n = 59$) and 9 years or greater of employment ($n = 61$).

Table 4

Comparison of Mentoring Scores by Length of Employment

AMAQ Subscales	1–8 Years		9 Years or Greater		
	M	*SD*	*M*	*SD*	t^a
Teach the Job	49.89	11.22	49.37	10.90	0.26
Challenge	61.46	7.99	64.66	7.04	-2.33*
Politics	41.14	9.57	44.87	8.03	-2.32*
Help	44.46	9.77	45.89	8.93	-0.84
Protect	47.40	7.49	50.15	6.69	-2.13*
Sponsor	46.25	9.02	50.95	9.65	-2.75**
Counsel	48.99	7.72	51.64	8.85	-1.75
Friendship	39.81	8.42	41.72	9.34	-1.17
Trust	51.49	11.51	53.23	10.26	-0.88
Total	47.22	9.08	50.65	8.61	-2.13*

$^a df = 118.$

*$p < .05.$

**$p < .01.$

As seen in Table 4, nurses with nine years or greater of employment in the organization reported higher mean mentoring scores than the nurses with fewer than 9 years of employment on all nine mentoring subscales. In particular, the mean mentoring scores for three subscales—Challenge, Politics, and Protect—were significant ($p < .05$). Significance ($p < .01$) was also noted for the Sponsor subscale. Survey participants were asked to rate the mentor's influence on the protégé's career and personal development.

Tables 5 and 6 present descriptive statistics for each nursing group.

Table 5

Frequency of Responses of Mentor's Influence on Career by Job Role

Job Role	Not beneficial *n* (%)	Neutral *n* (%)	*Beneficial* *n* (%)
Staff Nurse	1 (1.5%)	27 (40.9%)	38 (57.6%)
Educator	0	8 (100%)	0
APN	1 (8.3%)	10 (83.3%)	1 (8.3%)
Manager	4 (27.7%)	10 (66.7%)	1 (6.7%)
Director	0	6 (100%)	0

Table 6

Frequency of Responses of Mentor's Influence on Personal Development by Job Role

Job Role	Not beneficial *n* (%)	Neutral *n* (%)	*Beneficial* *n* (%)
Staff Nurse	3 (4.6%)	29 (44.6%)	33 (50.5%)
Educator	0	8 (100%)	0
APN	2 (16.7%)	9 (75%)	1 (8.3%)
Manager	4 (27.7%)	9 (64.3%)	1 (7.1%)
Director	0	6 (100%)	0

As can be gleaned from these two tables, a vast majority of survey respondents perceived their mentor's influence on their career and personal development as neutral. Only staff nurse respondents reported a higher percentage of benefit than neutrality. Additional knowledge related to the extent of mentoring in the organization was gathered during taped focus group sessions. Focus groups were conducted for each of the nursing categories—staff nurse, educator, APN, manager, and director. Focus group participants were asked to describe their experiences of being mentored in the organization and to describe how they have mentored others in the organization. Deductive analysis was utilized to interpret the qualitative data collected. Deductive analysis occurs when the data are analyzed according to an existing framework (Patton, 2002). Transcriptions were reviewed and coded according to the nine mentoring activities as described by Alleman

and Clarke (2002; see Appendix B). Following are quotes from the focus group participants on the topic of mentoring in the organization.

Experiences Being Mentored

Teach the job.

I have been mentored from the very beginning. I started as a care tech, was mentored working the night shifts by other nurses on the units showing me what to do. From there, I went to a different environment where I was mentored by other nurses, but also by physicians . . . then, in returning to the hospital, it's just accelerated because now I have all these contacts, and I feel like every idea that I have, if I bring it up to somebody, they're giving me feedback and support and telling me go ahead, do it. (staff nurse)

I came here to Northwest Community with 10 years of experience, so I joined a staff as someone with a lot of experience. There was one particular individual who kind of took me under her wing and showed me her leadership style. I watched her and developed my own style when I became in charge as a charge nurse. By observation, by being involved in different committees, by feedback, whether it be positive or negative, are ways that I developed as an individual as a nurse. (staff nurse)

When I was asked to take the educator role, I was mentored by our clinical nurse specialist and the other educator. It was extremely helpful, ease in talking, ease in

getting information from her, setting goals, and a lot of feedback, pertinent

feedback. (educator)

Recently, my position changed from a staff nurse to a clinical educator—and so,

in the true larger scope of mentoring, as I moved into my role, I'm working

directly with another educator for our department. And so that relationship has

really been a true direct mentoring relationship throughout the course of the last

year and a half, a very formal mentoring relationship. (educator)

I feel that it has been beneficial—not just to me personally, but to the

organization—to be able to move into my role and have another person in a

similar role who can mentor me. I think that my experience and my ability to

become immediately involved in activities on the unit—my confidence level, I

think—would have been less if there was not another person . . . that I had a

mentoring relationship with to be able to move forward. I certainly know that

happens in other organizations, and maybe here too, but I think it was really a

benefit to the unit and probably the institution in general because I have someone

I could speak to directly, get quick responses from, and had a comfortable

relationship with, so it really eased me into the role. (educator)

I had a mentor that started after I was in my position, but she was a clinical nurse

specialist. To me, that was probably the most mentoring I had in my position,

because when I started my position 8–9 years ago, it was a transition where

someone had left and I was an interim person for a while and I had really very little direction, training, or mentoring. I thought that was really difficult because I spent a lot of time learning things that someone probably could have explained to me in a lot shorter fashion. So when I had this new clinical nurse specialist come in, it was good to have someone to partner with . . . it was a benefit to me because she looked at things from a different perspective and I respected that, and that kind of pushed me to open my position and look at it a little differently, so it was a good mentoring experience. (educator)

For me, as I was still working at the bedside and going through my master's program, we were invited as students to be a part of the APN council. And to me, that was very valuable because we were kind of brought in and I got the chance to learn from a great bunch of people before I was even on my own. That was positive. . . . the mentorship. I had relationships already established with people that were APNs, so I knew many of them, but again it was an informal thing where I went out and was told to meet with so-and-so because everybody actualizes a little bit differently. And to this day, I can call on any one of my colleagues I know for any issues that I might have. (APN)

I have had a lot of mentoring . . .in my role as a clinical coordinator and now as a manager . . . my director teaches me things like budgeting . . . in the clinical coordinator role, I didn't get involved in the budgeting too much. As a manager,

now I have to do more of that, and I think my director has helped me with that a lot. (manager)

When I was a child, I thought I would be a nurse, and now I am, but I also have my MBA—go figure. It was really due to someone taking time and teaching me the "ins and outs," the "why we do things," and the impact of decisions that we make . . . I'm a problem solver, and if there's a problem, I want to fix things right away, and I learned the value of processing issues and really thinking it through. If you want to fix something and you think this is going to be the fix, and then you find out it didn't work and it's because you didn't really involve all the people that needed to be at the table. . . I just had a really good mentor. (director)

Provide challenge.

I had an idea for getting involved in medication reconciliation because I knew that it was a big part of what the Joint Commission was looking at. I went to an employee that is in charge of that and she said, "Great, this is what we should do and how we should do it." She pretty much gave me free reign to develop the concept. I would give her my ideas, and she would give me feedback, most of it positive. (staff nurse)

I had two mentoring relationships. One was when I was being mentored for the CRN role. My manager at the time helped me through the process of applying for the program, and she didn't tell me what to do, but she guided me through it by

saying, "Look at certain activities. Look at the things you've done in school." She

gave me a guide to look at myself to come up with the necessary requirements to

be accepted into the CRN role. The other mentoring relationship I've had was

through the research fellowship, learning about research, and once again the

information wasn't handed to me to read. I was guided through the process . . .

given the opportunity to make mistakes and then have the mistakes, or my work,

evaluated, and given feedback on how to improve my work. (staff nurse)

I had an excellent mentor in my director. I used to say she would give me the

ability to make decisions and do things with enough rope to hang myself doing

those decisions, but she was there to help pick me up and make me review what it

was that I did, what my choices could have been that would have been better. She

taught me that I should always have a reason for what I'm doing and be able to

explain that reason. I've used that in mentoring my own staff members. She

would ask me hard questions, and as long as I had that reason, it was OK. But if I

didn't, then I had to work through what I was doing and why I was doing it, so it

helped me clarify in my own mind when I made choices and when I made

decisions—what it was I was basing decisions on and why things became clear

and easier to do. (manager)

Teach politics.

In my current role, I've had a few different mentors, and it's kind of interesting

because when I think about it, none of them are nurses. One of them was my

director who has a marketing background. She was a very strong mentor, to help me grow professionally and help me with the ideas I came up with and how to implement them . . . One of the things I realized with the director mentor, even though she was quite a bit younger than me, it had nothing to do with age . . . mentoring really is not age . . . I had the clinical experience, and she had the marketing background . . . There was so much that she could teach me as far as how to deal with the position and what to say and what not to say. (APN)

When I came to the organization, I was a brand new APN, new to my role . . . so this was my first APN position and actually first APN to be working on the unit that I'm working in, so I was like a pioneer. The person who mentored me the most was my director who hired me . . . She mentored me in the ways of probably more organizational development and getting to meeting etiquette and how to present something to the physicians at meetings and have a good professional appearance and get your point across and come off as being authoritative and getting the doctors to notice you and respect you. So I felt that was very valuable. (APN)

I came here having experience as a director, so the mentoring that I received here was really in learning this hospital, learning this culture. And I was very fortunate to have also a mentor, someone that I could really go to and say, "I didn't really understand that" or "Is that how this person is?"—especially when you're trying to work with other people and you don't know them, to be able to have that

insight as to "That person really likes e-mail" or "That person really likes voice

mail." It's those little things that help us do our job. (director)

Protect.

I think what I appreciated the most was the freedom to make those decisions. And

if I got into trouble—yes, I knew she would back me up, and I knew I could

always count on her. She would never say anything to me corrective in front of

anyone else. We would talk about it later on the side, just the two of us. So

hopefully I'm doing more of that myself. And I found that extremely helpful, and

it helped me grow a lot. (manager)

Sponsor.

Coming here, there was not a formal orientation to become an APN. But working

with the nurse practitioner that I worked with, she helped me develop into the

APN that I am today. I came here with certifications, and I had my master's. With

a couple of other people, they helped me bring it all together so I was able to

become an APN. It was very positive. I've had so much support here, I can't

believe it. Even to go on and finish the next degree has been wonderful. And it's

both professionally and socially… (APN)

I had a very fulfilling relationship, once I came to my role as APN. I had a

director and a staff nurse who took me under their wing and really helped me see

what the potential of my role could be. And when I came up with ideas or things

that I thought may help the organization, we would sit down and talk about them

together, and they would either tell me that this was something that they felt

would better my work and my career here at Northwest Community, or they

would say, "Let's change this a few ways. Let's look at this." I felt really positive

about the organization and about what they were willing to support in my role,

and I came out of it really valuing what I could do for the hospital. (APN)

Career counseling.

The CNS for our medical unit is a wonderful mentor. [She] has encouraged me,

through my continued schooling, to get my bachelor's completion. So that's

probably a more formal, if you will, mentorship. But I think this organization in

general has mentors everywhere. (educator)

I feel as though I was always encouraged to continue with educational

opportunities, be it formal education or going to classes or seminars. Our previous

director always encouraged us to participate in going to seminars and such to

enrich our knowledge base. (manager)

Our manager is very supportive of getting out to the workshops and whatever is

going on that would help us to be better leaders. I've always been encouraged to

be involved in organizational activities at different levels—corporate levels, unit

level—to be involved and have a broader sense of the organization. I think it's

good for the entire organization, because not only the directors do that for us, but
it's like a trickle-down effect. (manager)

Friendship.

It's also the big things . . . to have a mentor who now I consider a friend who I
can have coffee with and be honest and say, "I really think I'm messing up," and
have them say, "Well, you could have done this differently, but you're doing a
good job." To get that encouragement, yet not be sheltered. I've developed
relationships with mentors to also get honesty—which, to me, is important, and I
hope that I provide that back to people as well. (director)

Demonstrated trust.

[The director] is very transformational in her approach to leadership. She did not
fear giving information to people below her. She felt that the more information
and the more strength you build in the people below you, the stronger the team is
and the more efficient the whole group is. So a lot of mentoring, a lot of
knowledge—never hold back on information. It just builds the team. (director)

Experiences Mentoring Others

Teach the job.

I feel that when I work with a younger individual, someone with less experience,
that they draw from my experience. They watch me. I feel that they learn that
way. They ask the questions, but I let them know that there is a way of getting to

solve a problem, different ways of doing it. They don't necessarily have to follow exactly what I'm doing, just so they get the principles straight. Just the emotional support of a new individual in a new institution taking on a new role, I feel like I've been there for them emotionally through their ups and downs, because as new nurses, we all have positive and negative part of our jobs. (staff nurse)

I enjoy mentoring students as they come through. They're so excited about everything they're doing, and they're excited and they're scared. I enjoy working with them and getting them to try to think critically. I tell them, "I'm going to ask you questions today. It's not to be mean. It's to get you thinking about what's going on with this patient." I love providing them with new opportunities, new ways to look at things. I also have another opportunity working as a CNC being kind of a mentor to the house, and helping people with problem solving on units. I enjoy that process. It gives me opportunity to teach and get feedback from the individual too, find out where they feel they're getting some support. (staff nurse)

You lead by example, and that is picked up by charge people when we're not on the floor . . . They're in the role of being the charge nurse, and they've seen how you've handled things. Then they step up and do the exact same thing, which is very good. (manager)

I believe role modeling is very important. I think you have to remember where you once were. And for me, I do go on the floor even today and give pain pills. I

help with patients, getting them up. I think that's the most important thing when

mentoring someone is to lead by example. (manager)

I have a mentoring relationship with a clinical unit leader or manager in the org

who sought me out to sort of validate whether her own thoughts or perceptions are

on target and actually asks me on a periodic basis to give her feedback on how she

can. (director)

I did learn to give honest feedback, because even if it's something constructive

that you don't want to say, it really does help improve performance, and people

do respond positively to it. (director)

Provide challenge.

In my role as a CNS, we have had quite a few nurses in our department become

clinical resource nurses. When I started here almost seven years ago, there were

only two. Now we have a group of 10, so I'm really proud of the nurses wanting

to achieve that and encouraging the nurses that I see that have potential to

definitely apply to be a clinical resource nurse . . . They come to me with their

projects and ideas, and it's been nice working with them and challenging them . . .

sometimes trying to organize them and keep them focused on different things . . .

I feel that, as a CNS, that that's part of my role is to help mentor the CRNs.

(APN)

Career help.

All of the new hires for our units look to you as one of the initial contacts when they come into the organization, and because they're new you're helping them through the orientation process—so in that respect, I think you're seen kind of as a mentor. I know I always like to make sure that they know that there are a lot of opportunities available as they climb the ladder here at Northwest. So that's probably, just by nature of the fact of being in the educator role, I'm seen as a mentor. People come to me with concerns, both professional and personal. (educator)

I have identified and offered support with particular staff that I think are going above and beyond and encouraging them to possibly, maybe, be a CRN or something else, and also identified, I think, a strength is identifying when an employee is struggling early on and trying to do regular meetings. (manager)

By encouraging staff to be involved, sometimes by starting at the unit-based level and then going into a corporate-level initiative. Also being a charge nurse, training them to do that role . . . encourage them, giving them positive feedback on how they've done. (manager)

Sponsor.

We have had two new CRNs since I've become an educator . . . and there's other people that we're identifying that we really want to move into that position, but

then just helping them with goal setting . . . Some come in with their own clearly defined goals, and then other staff really need assistance to determine what is a good goal, what can I do, what's a reasonable goal for me in my position? So that's been helpful to them, but helpful to me too, as a mentor. (educator)

One of the experiences I really remember was when my mentor from my first role came to me and asked me to help her with an abstract. To write an abstract and get it . . . that's interesting, because I never really thought about that I could mentor her as well. (APN)

I network, and the groups I'm part of—I'm part of a professional organization, I do it through that, as well as within our institution—we network in the APN team. And our colleagues— whether it's presentations, papers, the different other activities we are doing—I think we mentor through feedback with one another as well. (APN)

Career counseling.

There was someone who I already knew who, from my past, who came to work here as a staff nurse, and I mentored her. She had already obtained her master's degree, and I encouraged her to consider a CNS position, which then, as she transitioned to an APN . . . So that was something I sought out to suggest to her. She has flourished as an example for many other people. The other thing I've

done for staff RN is to recommend them to consider certification in our specialty, or a CRN position. So I've tried to encourage people to do that as well. (APN)

I encourage students and the staff alike to become professionally involved. Subscribe to journals and read them, because that's important, and presenting themselves as professionals and always to keep that in mind about your professionalism. (APN)

I think part of learning where people are at is giving them the opportunity to speak to you. To be a good listener to the people you are mentoring so you're not always the one feeding information, you have to take the time to say, "OK, what's on your mind? What do you need from me?" And I try to do that at the end of our meetings, and I still do meet with my managers once a week because I think it's crucial, even if I have nothing on the agenda, if we can just sit down and talk about what's going on in the department, and what help do they need from me. That's huge. But at that meeting, I really try to remember to say, "What do you need from me?" and "What haven't I given you?" We're in a leadership role, and as you're mentoring, people will have a tendency to just nod and shake their head and move on. I think getting the response back from the person you're mentoring is huge. (director)

Sometimes the person you have mentored into a leadership role has taken on that role successfully, but the mentoring relationship carries on, and maybe does

transform into something different. But from time to time, those folks have still

called, and I think you still have a responsibility to be there for them. (director)

Demonstrated trust.

I feel very fortunate that the staff feels confident and open with me, that they

allow me to help them and mentor them about the things that they have a need to

understand and better know and that it helps them in their practice. (APN)

<center>*Research Question Two*</center>

The second research question focused on the impact of mentoring on the

cultivation of intellectual capital in the organization. Nurses were asked to complete a

survey with the purpose of quantifying nurses' degrees of participation in professional

development activities and levels of organizational participation.

Questions on the NICI were designed to seek information regarding the nurses'

current states of professional development, their levels of involvement in organizational

committees and leadership activities, and their predictions for future involvement. Nurse

participants were asked to identify, from a list, professional activities that describe their

activity. Participation in organizational committees was identified by 57% ($n = 77$) for

unit-based committees and 59% ($n = 81$) for hospital-wide councils. Current membership

in a professional organization was indicated by 56% ($n = 76$) of the nurses. Eighty-one

percent ($n = 107$) of the survey respondents indicated that they would likely be involved

with a unit-based committee within the next five years. Eighty-four percent ($n = 109$)

reported that they would likely be involved in a hospital-wide council within five years.

<center>74</center>

Additionally, questions on the survey sought to identify nurses' degrees of professional development by asking if they held a current specialty certification, were currently enrolled in college courses relevant to health care, or had intentions to do either in the next 5–10 years. Current certification in a clinical specialty was reported by 53% ($n = 70$) of the respondents. Sixty percent (n = 76) indicated that they would likely be certified in the next 5 years. Current enrollment in college courses was reported by 17% ($n = 22$) of the nurses, with 45% ($n = 61$) indicating likely plans to begin taking courses within the next five years. Survey respondents were given professional development and organizational participation scores based on the number of professional or organizational activities they reported. A total nursing involvement score was derived from combining the scores from both professional development activities and organizational involvement activities.

Analysis of variance (ANOVA) was utilized to determine differences of professional development scores, organizational involvement scores, and total nursing scores based on age, highest level of education, and length of employment. Table 7 shows a comparison of professional and organizational activity scores based on age. There was a significant difference between the three groups in all three categories, professional development scores, organizational involvement scores, and total nursing scores. A Tukey HSD test showed that nurses who were 40 or less years of age reported significantly less professional and organizational activities than the nurses in the other two age categories ($p < .01$).

Table 7

Comparison of Professional and Organizational Activity Scores Based on Age

	Age						
	≤ 40		41–51		52+		
Activities	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*[a]
Professional	1.09	0.99	1.88	1.25	1.68	0.88	6.83*
Organizational	1.46	1.43	2.24	1.22	2.37	1.16	6.58*
Total	2.54	2.08	4.12	1.98	4.05	1.38	10.25*

[a]*df* = 2, 125.

*p < .01.

Table 8 compares professional and organizational activity scores based on the highest level of education. As the data in Table 8 present, there were no significant differences in the professional or organizational activity scores based on education.

Table 8

Comparison of Professional and Organizational Activity Scores Based on Education

| | Level of Education | | | | | | |
| | Diploma/AD | | BSN | | MSN | | |
Activities	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*[a]
Professional	1.37	1.19	1.43	1.01	1.94	1.13	2.87
Organizational	1.66	1.26	2.07	1.30	2.19	1.36	1.61
Total	3.03	2.07	3.49	1.95	4.13	1.76	2.70

[a]*df* = 2, 125.

Table 9 compares professional and organizational activity scores based on years of employment. There was a significant difference between the three groups for professional development scores and organizational involvement scores. A Tukey HSD test showed that nurses with fewer than 5 years of employment reported significantly less professional and organizational activities than the nurses in the other two age categories ($p < .01$).

Table 9

Comparison of Professional and Organizational Activity Scores Based on Years of Employment

	Years of Employment						
	≤ 5		6–15		16+		
Activities	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*[a]
Professional	1.04	0.97	1.80	1.26	1.75	0.84	7.39*
Organizational	1.24	1.45	2.22	1.16	2.50	1.01	12.94*
Total	2.28	2.01	4.02	1.82	4.25	1.48	16.11*

[a]*df* = 2, 132.

*$p < .01$.

ANOVA was utilized to examine differences of AMAQ scores based professional development scores, organizational involvement scores, and total nursing involvement scores. Table 10 presents a comparison of mean mentoring scores and professional development scores. As the data in Table 10 show, the only significant finding was for the Challenge subscale. A Tukey HSD test showed nurses reporting one or no professional development activities had a significantly lower score than nurses reporting two professional development activities ($p < .05$).

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Table 10

Comparison of Mean Mentoring Scores and Professional Development Scores

AMAQ Subscales	Professional Development Scores						
	≤ 1		2		3+		
	M	*SD*	*M*	*SD*	*M*	*SD*	*F*[a]
Teach the Job	49.64	11.29	48.69	11.76	50.13	10.05	0.13
Challenge	61.43	8.03	65.81	6.83	63.02	7.18	3.83*
Teach Politics	41.24	9.46	44.73	8.15	45.33	8.43	2.65
Career Help	43.57	9.35	46.22	7.30	48.11	11.58	2.28
Protect	47.52	7.43	49.34	6.92	51.05	6.77	2.14
Sponsor	46.93	9.07	49.84	9.37	51.69	10.67	2.46
Counsel	48.81	8.51	51.50	7.88	51.98	9.45	1.74
Friendship	40.36	8.86	40.49	8.25	41.92	10.64	0.25
Trust	51.14	10.94	52.18	9.86	55.89	12.01	1.53
Total	47.21	9.02	50.10	7.85	51.59	10.62	2.40

[a]*df = 2, 119.*

p < .05.

Table 11 presents a comparison of mean mentoring scores and organizational involvement scores. Significant findings were found for the Challenge and Protect subscales. A Tukey HSD test showed nurses reporting involvement in two or more organizational activities had significantly higher mentoring scores on the Challenge

subscale than those who reported one or no activities ($p < .01$). Nurses active in two or three activities had significantly higher scores for the Protect subscale than nurses involved in fewer than two activities ($p < .05$).

Table 11

Comparison of Mean Mentoring Scores and Organizational Involvement Scores

| | Organizational Involvement Scores | | | | | | |
| | ≤ 1 | | 2–3 | | 4+ | | |
AMAQ Subscales	M	SD	M	SD	M	SD	F^a
Teach the Job	47.59	11.54	50.49	10.73	51.28	11.69	1.10
Challenge	59.90	8.51	64.53	6.46	66.70	7.16	6.99**
Teach Politics	41.32	11.02	43.97	7.78	43.96	5.83	1.24
Career Help	43.69	10.22	45.80	8.50	47.06	10.03	0.97
Protect	46.55	7.79	50.45	6.69	47.40	5.74	4.32*
Sponsor	46.48	10.40	49.81	8.69	50.39	9.71	1.90
Counsel	48.39	8.37	51.55	8.53	49.50	8.79	1.90
Friendship	40.12	9.28	41.42	8.60	38.86	9.95	0.55
Trust	49.81	11.37	53.70	10.63	54.21	9.09	1.97
Total	46.27	10.27	50.47	8.22	49.89	6.77	3.06

[a]$df = 2, 119$.

*$p < .05$.

**$p < .01$.

Table 12 presents a comparison of mean mentoring scores and total nursing scores. There were a significant findings for the Challenge, Sponsor and Total subscales. A Tukey HSD test showed that nurses reporting two or less total activities had significantly lower mentoring scores on the Challenge subscale than nurses reporting three or more activities ($< .05$), nurses reporting two or less total activities had significantly lower mentoring scores on the Sponsor subscale than nurses reporting six or more total activities ($< .05$), and nurses reporting two or less total activities had significantly lower total mentoring scores than nurses reporting six or more total activities ($< .05$),Sponsor subscales and the total mentoring score between nurses with a total score of 2 or less and those with a score of 6 or greater ($p < .05$).

Table 12

Comparison of Mean Mentoring Scores and Total Nursing Scores

	Total Nursing Scores						
	≤ 2		3–5		6+		
AMAQ Subscales	*M*	*SD*	*M*	*SD*	*M*	*SD*	F^a
Teach the Job	49.09	11.48	49.33	11.19	50.85	10.65	0.16
Challenge	60.21	8.39	64.26	7.39	65.39	5.06	4.76*
Teach Politics	40.88	10.66	43.84	7.78	45.07	8.25	1.94
Career Help	44.07	10.15	44.69	8.01	49.31	10.98	2.08
Protect	46.88	8.10	49.22	6.28	51.16	7.53	2.58
Sponsor	46.34	9.82	48.87	9.05	53.36	9.24	3.51*
Counsel	48.52	8.12	50.11	9.04	54.36	6.64	2.94
Friendship	40.61	9.00	40.33	8.81	42.00	9.82	0.23
Trust	50.36	11.08	52.45	10.83	56.43	9.87	1.96
Total	46.69	10.00	49.15	8.17	52.98	8.76	3.12*

[a]*df = 2, 119.*

p < .05.

Research Question Three

The third research question sought to examine the nurses' perceived responsibilities to mentor others for the purpose of succession planning. Focus group interviews were utilized to gain a perspective on this topic. First, each group was asked to describe succession planning behaviors or activities within the organization. Secondly, participants were asked if they felt a responsibility to mentor others, followed by why or why not. Lastly, the group was invited to share additional thoughts on the topics of mentoring or succession planning. Inductive analysis was utilized to examine the transcriptions from this portion of the focus group. According to Patton (2002), inductive analysis involves "discovering patterns, themes and categories in one's data" (p. 453).

Succession Planning Activities

Focus group participants were asked to describe succession planning activities that they were aware of on their unit or in the organization. The excerpts that follow have been categorized as either unit-based succession planning or organizational succession planning.

Unit-based succession planning.

I think, for my unit, it's rotating the charge role to encourage most everyone. There are some people that will never have that role, but the ones that are qualified, we rotate that role so each person gets a chance to develop and to get support from others who have done it. We don't just throw them in and let them sink or swim . . . so hopefully when any one of us steps out of that role, there's always another person who can step into it and be just as knowledgeable and just as great. (staff nurse)

Each department has their own education that teaches and encourages research, encourages development of new ideas. People want to go back to school, so yeah, I think there's a lot of programs in the institution that favor returning to school and education. (staff nurse)

A continual process of constantly identifying nurses that have leadership strength to make sure that they get the support and training that they need to possibly fill in as charge person, or to step up to the responsibilities or step up to their strength and be able to fill more challenging roles for themselves. (educator)

I think having staff members as co-chairs on committees is one thing . . . it teaches them leadership and allows them opportunities to demonstrate leadership, project management. (educator)

Our directors made it really clear that there are opportunities for advancement in the hospital, regardless within your job as a nurse, promoting that. But I think she's been really clear on education, that it's really important. (educator)

I think our CRN program gives us the opportunity for developing leadership in our CRNs . . . They want to step up. We already know they want to step up . . . Myself and other coordinators assigned roles to have people filling in and learning certain parts of our job that they could pick up and take over as needed . . . And I

tell them I'm 60 years old and I'm going to retire one of these days. I'll be gone, and we need people ready to step up, and it's really rewarding to see the growth that's going on. (manager)

Clearly there were the people who were sort of rising to the top. So we really began to work diligently with those separate teams, bringing them together as a team, doing some education, communication feedback, leadership succession, putting examples to them. For instance, "If Joanne weren't here, how would you have handled that? What would you have done? Would you have done it differently? How could it have been different? Would you have done it exactly the same?" Just challenging them in terms of "If I weren't here, what would you do? How would you handle that?"—it's amazing to see how they really can get there and how you have to prove to them that they can get there. (director)

When a team member approaches me and they ask me what they should do, I have learned not to answer their question, but instead engage them in a dialogue about what do you think you should do—because I think that helps to build confidence in their ability to make decisions. And if I disagree with them, I say, "Well, have you thought about doing something else and then weighing the alternatives?" Just in the short 18 months I've been here, there is someone who I tend to give a lot of responsibility to because I don't think the time to identify who's going to succeed you is when you're thinking about leaving, but really it begins from day one. I have given this person additional responsibility, and I've

even gotten to the point of saying, "If I'm not here, I want you to be the person who could internally come up and take my place." And of course I get back from this person: "Oh, I don't want to do that. I don't see myself there." And that's OK. I just want them to sort of think about what the possibilities would be. (director)

It also includes encouraging education. Because the people that I'm now working with, I'm telling them, "I really think you can do my job someday." And they look at me like, "Are you kidding me?" And I think I don't know how I got here. It wasn't really succession planning, so to speak, in the first job that I got. It was just "You look like you can do it. Do you want to?" I just say that you need your bachelor's degree so you can get your master's degree. You need to do that so you're ready when I'm ready to leave. Even if you don't want my job, you're ready for other things. (director)

Organization succession planning.

I think being on corporate strategic council—the fact that now, as leaders, our leaders are asking staff nurses from their units to come to the corporate strategic council to see what we do, to see what we talk about, because it's breaking down the barriers and opening up, so people can see exactly what's going on and that it's not a big secret. It's about trying to move forward and create leaders in everybody. (staff nurse)

You're starting to see master's nurses following other APNs around. I've personally been asked to go to leadership training classes by my boss. Has there been anything specific said for what direction she wants me to go? . . . It's obvious that there's preparation with the corporation expanding, that there's something out there in the future, and they want people in place to be able to step up. (staff nurse)

I do know we're really focusing on advanced education, so as those who are leaving who have—are—in positions that require more degrees and more education, they're asking that nurses do that, that they consider that. Staff nurse-wise, just asking them to have the goals to move forward, to become involved. (educator)

I know that right now there's some organizational restructuring going on. Instead of having two clinical coordinators, it's going to a one-manager role. The idea is that those one managers, over time, will probably become directors. Those people are being mentored to have more responsibility on the units, so the directors will be at a higher level, and as well those people who are becoming managers and leaving the clinical coordinator role are mentoring staff nurses to be charge nurses. (APN)

I see the nurse resident program as a form of succession planning. We've already seen the important part of that on the unit I work with, because as it turned out, a

few staff left—one will leave, one due to retirement, and a couple others due to

major life changes that were not planned. And by having what appeared to be an

overload of nurse residents for the year has been a godsend because they will now

be ready to take those roles over. (APN)

I think our educational opportunities, advanced completion programs which are

offered by the organization to subsidize pay and cost, and encouraging and

providing programs. I think just having that increased education. (manager)

Perceived Responsibility to Mentor

Nurses participating in the focus groups were asked to explain their perceptions

around the responsibility to mentor other nurses. Participants unanimously agreed that

they not only had a responsibility to mentor, but were indeed committed to mentoring

other nurses. "There is a responsibility. It's a commitment. If we are not willing to invest

in people, there's really no way of insuring that the organization is going to succeed"

(director). Themes emerging from the discussion around nurses' responsibilities to

mentor other nurses included role modeling, knowledge sharing, and encouragement.

Role modeling.

I think it's our responsibility as nurses to always be mentoring, and not just

somebody who may have less experience, but we mentor each other every day, in

our roles as we work together. I wouldn't be the nurse I am today had it not been

for mentors. I hope individuals that are coming up in the institution feel the same way about nurses their senior. (staff nurse)

In a role modeling sense, to uphold the visions of the organizations, to conduct myself in an ethical fashion—all those kind of things that fall into the RN role period, regardless of whether it's educator or mentor. I personally feel like I need to be responsible for that, to the profession, to the organization, to myself. (educator)

I think, by the nature of our profession, we need to uphold certain standards and make sure that those coming behind us, either new to our organization or new to the profession of nursing, are nurtured along in being professional and upholding those standards and furthering the cause and furthering our values that we hold here in our institution. (educator)

Personally, I think any nurse has that responsibility. But as a CNS/APN, part of my education included that as a focus, so I've been doing that since both of my graduations. In regards to further developing other nurses that work around you, as well as being a role model, which is how I do it. (APN)

I think, as a leader, when you walk on a unit, all eyes are on you. And so how you say things, how you conduct yourself, how you dress, your body language—all of that makes a difference in staff. (manager)

Just by being there for people, there's so many different ways to do it. Nursing is going to be there forever. We won't be there forever, and we would hope that we feel that we are in the heart of this organization, as well as profession, that we could help put people out there as we feel we are. (manager)

I do still think there has to be a connection with the staff nurse somewhere along the way. If you see people within the department that are at a staff nurse level, if you still have a connection, you can start mentoring those people. Even if it's teaching your middle managers how to mentor that front line to bring them up, there still has to be a connection all the way to the front line, I think, somewhere along the way. (director)

Sharing knowledge.

I think it's a nurse's responsibility to mentor other nurses, whether they're equal in education or have a different education or equal in experience. It's just, if someone needs help and one nurse knows, then the other one should help provide the information. (staff nurse)

We expect everybody to come to us and have the same knowledge base. We know that's not reality. That's not how they come. So in order for them to be an affective part of the team, to value them as our coworkers, we need to get them to where they need to be. I feel that's really our responsibility. (educator)

If we don't do it, then when we're gone, there's not going to be anyone to do our job. So yes, I do, because it's inherent in our job. We have the knowledge, the background, the expertise, so it's really a duty as well as a pleasure and reward. (APN)

As an APN, that's one of the areas that is really a large part of my role and that I can give back to the organization on a daily basis to help the staff, even the physicians, who have many questions. (APN)

I think it's part of my role. And to share—that's part of why they employ me, to share this knowledge and develop others as well. Because I had the opportunity . . . advanced master's degree . . . I can share that with somebody else to help . . . If I keep it all to myself in my head, I haven't done anybody any good, because I can't be there at everybody's bedside. (APN)

Encouragement.

Because I'm the elder person, I have more experience than most of them together. I was a diploma graduate. I worked for 10 years at my institution, then I worked offices . . . Now that I've come back—I've been here 17 years—I really gained a lot of expertise, and it's kind of all . . . together. I went back to school . . . the joy that you get from gaining new information. I would spread that and encourage the

people that I worked with to go back to school, to continue to learn, to do more, see more. I think as long as I could continue to do that, I'm an asset. (staff nurse)

I think the nursing has gotten harder and harder—just even from the whole emotional piece, the confidence piece—just to be able to build nurses up that are just starting out. I go back to my first 6 months, this is reality. It's not my books anymore and my teachers protecting me. Just kind of build up the self-confidence and let me feel that this is not uncommon. I love doing that with students too—helping them, things that I've learned that I can pass on. (staff nurse)

We've seen such a huge increase in nurses on our unit going back to school. They're finishing their BSNs. I've had several come up to me and talk to me about master's programs, because they know I'm in a master's program now, so they're looking for advice and it's a good—it's really exciting. I think they're comfortable with that too. (educator)

It's our responsibility, mine as an educator, to help the unit run more smoothly and using evidence-based practice. So by mentoring staff to work on their projects or their committee work, it facilitates my role, but it facilitates the unit function. (educator)

I feel like, when I see nurses that have the potential to go on and they're asking questions, you have to be there to answer them. I feel like it's part of our role as a

leader to educate them to go on. We won't have anybody here for us if we don't

keep teaching and encouraging. (APN)

I've been in organizations where there was no mentoring. You're just fumbling

around, and some people survived and some don't. What's sad is that even if I

survived, I saw peers fail, and that was so sad to me. So I think it's all of our

responsibility. This is a very difficult job, and we all know there are days when

each one of us feel like we're not doing our job, that we've let the ball drop that

we're juggling. So we have to be there for one another to say, "OK, so you've

dropped them all. I'll help you pick them all up." So I think it's really important.

(director)

Additional Thoughts on Mentoring and Succession Planning

Focus group participants were encouraged to share any additional thoughts they

had on mentoring or succession planning in the organization. Following are excerpts

from this discussion.

Mentoring.

I think we do a good job when we're training new employees, as to having

preceptors. But I'm always toying with the idea of having a mentor, especially for

new grads, or just for any new employee. It would be nice if we had a formal

mentoring program so that they could choose that. When we had some employees

do that on their own, where they even meet their former preceptor who turned into

their mentor for lunch, and that was a relationship that I thought was really important. Building them up, both professionally and being part of the unit. But we don't have a formal mentoring program. (educator)

Some negatives that I've found in mentoring . . . to have a true mentoring relationship, you have to have the right two people together. There's problems with personalities. Some people don't do well with specific mentors. Some mentors don't do well with specific people that they're mentoring. I think that's a struggle, finding the right two people to put together. (educator)

I just think that our organization here really furthers mentoring and believes in it right from the bedside all the way up to administration. I've worked other places where I have not felt that be the case, and I applaud a hospital for that. And I really think that keeps our nurses and our staff here and that says, speaks highly of our longevity, because people are happier at their job . . . We're here to work together. This is a team. And I think that the whole concept of mentoring is a team spirit role. (APN)

It's definitely friendly and definitely encouraging, and I believe that's why people are happy to work here too, because there are always opportunities available . . . If someone is considering a job change within the organization or has some ideas, he or she can have a discussion with your director. I don't think anyone would ever discourage people from looking at other opportunities within the organization. It's

encouraged. They want to see the growth and they know that it makes people happy, so I find that a really positive thing. I think, in general, people—not just nursing, but staff—are very enthusiastic about the opportunities to mentor, like when people come to me and ask me questions, it makes you feel honored in a way that they recognize that you have that knowledge and that they can ask you. (APN)

I'll just say that I've really been fortunate in my career. I would not be where I'm at had it not been for somebody taking the time to invest, and clearly mentoring takes two people. I think that in our busy lives, it's easy to say, "Gosh, let me just do this myself," and step back and say, "Instead of doing it myself, how can I help somebody do it so that they gain the experience?" And that takes time. And how do you make time for mentoring in a schedule that's already stretched way too thin. I have to pause and say it really can't be the last thing on your to-do list. It probably has to be the very first thing you put on your list. But that's a very different way of looking at it, and I struggle with that. (director)

What I appreciated here when I became a director . . . I was approached by many people that were like "Come and have coffee with me." I met with at least three directors that I never would have thought I would have even needed to, because I'm focused on one area and they're in-house. I learned so much that I didn't even realize at the time I . . . it was so kind and generous, and it was mentoring to me in the new role. So there was nothing formal, nothing planned—it was just there. So

there is something within this organization—that culture, whatever—that mentoring really does exist here. And boy, is it needed. (director)

I think it's tough at the manager's level. That's that new level. I think we have a void there. I certainly think we're mentoring our own, but I don't know that they're getting the affordability of helping each other. They don't know each other, because there's no formal place for them to be. I'm hoping in this next year we develop something for them, because mentoring from up above is great, but inter-role mentoring, I think, is extremely important. I really encourage my own people to. I say, "So-and-so's got that same problem. Why don't you go talk to her? I can tell you some things, but she just had that happen last month." Solving it isn't always the thing. It's talking it out. (director)

I think the one thing that is missing from this organization is interdepartment mentoring or support between directors or managers. I notice there is not an organized group of directors that gets together. I think mentoring is a very complex thing to do. I never took a course on mentoring. It just sort of—I just sort of have to do it. I try to model it behind how I felt as I was being mentored, so I try to bring that to the people that I now feel would benefit from mentoring. It would be wonderful to talk about that subject as well as other things with my peers. Having that group with the director level as well as with the upcoming managing level would be very important. (director)

Succession planning.

I'm concerned. I think about succession planning because, as I grow older, and I see the nurses my age, we're thinking about retirement in the near future, and who's going to take over for us? That's why I think it's so important that we do a good job mentoring those who are coming up behind us, so we can make them successful and have a drive. I just think about it. (educator)

Just getting people more involved for succession planning, getting them involved now so they have that desire to move forward, to gain more knowledge, making them excited about those opportunities. (educator)

It seems to me that it's been the buzzword. In the last year or two maybe, I've become more aware of it, but it seems like people are more concerned about what's going to happen down the line. Maybe it's just that I'm not going to be in this role forever. As the newer people come in, you see more of the varied rationales as to why we do what we do. You become more global in your brain, or maybe the world is changing that way. I don't know. (APN)

I think that as our roles continue to get broader and broader, we have to maintain the bottom line here on. Every day I come to work, I'm trying to figure out how to be organized, and I still haven't figured it out. I know now when I came here, I was extremely fortunate that there was somebody in a role with me and she took me on. It wasn't delegated—she just said, "Come here." There are some deficits

here, and I think it's because there isn't a lot of turnover here. When you work in an organization with a lot of turnover, there's generally more focus on orientation because you've got those new people coming in. Here, without a lot of new people, and we haven't had a new director in a long time. Do we have a formal thing that's written down and a checklist? No. In other organizations, for our role, there is. I think that's missing here. I think that we do have people that mentor us, but I think there are things missing, even in that, because people are mentoring us are doing their jobs as well. I worry about that, even as we go forward. If you look at the age here, there's probably going to be a year there's going to be a lot of people leaving. I wonder, are we getting ready for what that looks like? (director)

Conclusions

The purpose of this study was to examine nurse mentoring, succession planning, and perceived professional responsibility as a means of sustaining intellectual capital in a community hospital. The researcher sought to answer the following questions:

1. To what extent was mentoring experienced by nursing personnel?

2. What impact does mentoring have on the cultivation of IC in the community hospital setting?

3. How do nurse personnel in the community hospital perceive their professional responsibility to mentor others as a means of succession planning?

Nurse mentoring in the organization was examined through both quantitative and qualitative measures. The AMAQ was utilized to provide a quantitative picture of the quality and quantity of nurse mentoring in the organization. Mentoring scores in eight of the nine mentoring subscales fell in the typical mentoring range. Only scores representing

Challenge rose to a point described as a high level of mentoring. Scores for each of the nine subscales were relatively uniform across all nurse job roles: staff nurse, educator, APN, manager, and director. Mean mentoring scores for all of the AMAQ subscales were also compared between staff nurses and all other nurse job roles, between nurses with fewer than 8 years of employment and nurses with nine or more years of employment, and between nurses with a diploma or associate's degree and those with a bachelor's or master's degree. When a significant finding was discovered, it was never for more than one or two subscales. Nurses across all job roles predominantly perceived the mentor's influence on their personal development and career as neutral rather than beneficial. This finding falls in line with the typical level of mentoring that was revealed by the AMAQ scores. The mentoring scores provide only a snapshot into what is going on in the organization.

Focus groups were conducted to gather additional information on perceptions of mentoring in the organization. Participants willingly shared their experiences of being mentored and mentoring others. Narratives from the focus group transcriptions were organized according to the nine mentoring activities as described in the AMAQ.

Examples of informal mentoring were evident throughout the interviews. Teaching the Job was a common theme in the sessions: "One particular individual took me under her wing and showed me her leadership style." Educators and APNs shared examples of peer mentoring: "It was good to have someone to partner with." "Mentoring began while I was still in graduate school . . . APNs sharing their knowledge." When describing examples of mentoring others, it was evident that nurses are sharing their knowledge with peers, new staff, and student nurses: "I love providing them with new

opportunities, new ways to look at things." "You lead by example, and that is picked up when you are not there . . . someone with less experience draws from my experiences."

Mentoring scores for the Challenge subscale were the highest for all nurse job roles. This theme was also reflected in the focus groups. Nurses at every level are being challenged in a supportive way to grow professionally: "I used to say she would give me the ability to make decisions with just enough rope to hang myself, but she was always there to help pick me up." "She helped me through the process of applying for the program . . . encouraging, but challenging me at the same time." Educators and APNs are challenging staff nurses to get involved with professional activities and supporting their endeavors: "They come to me with their projects and ideas . . . sometimes it's just trying to organize them and keeping them focused."

Even though there were no significant findings related to career counseling in the mentoring scores, professional development counseling is happening. The APNs participating in the focus groups voiced a strong sense that they are making efforts to encourage staff nurses and students to become professionally involved. "Staff nurses are being encouraged to go back to school for their bachelor's degree if they don't have it," "always encouraged to continue with educational activities," "encouraged to be involved with committees—to be involved and gain a broader sense of the organization." Overall, the focus group discussions provided positive examples of mentoring going on in the organization. There was a sense that mentoring in the organization is mostly informal and often by chance.

In an attempt to examine the impact of mentoring on the cultivation of intellectual capital, nurses completed the NICI. Questions on the NICI were designed to seek

information regarding the nurses' current states of professional development, their levels of involvement in organizational committees and leadership activities, and their predictions for future involvement. Survey respondents were given professional development and organizational participation scores based on the number of professional or organizational activities they reported. A total nursing involvement score was derived from combining the scores from both professional development activities and organizational involvement activities.

When professional development and organizational participation scores were compared between groups based on age, years of employment, and highest level of education, the results were not unexpected. When nurses' scores were compared based on their highest level of education, scores were higher for the BSN and MSN nurses. When scores were compared based on years of employment, nurses who had been in the organization longer reported more organizational involvement and total involvement. However, nurses who had been in the organization for 16 years or more scored slightly lower on their professional development scores than nurses who had been here six to 15 years. Additionally, nurses over the age of 52 had lower professional development and total nursing scores than those nurses in the 41–51 age category. ANOVA was utilized to examine differences of AMAQ scores based on professional development scores, organizational involvement scores, and total nursing involvement scores. Nurses who reported a greater number of professional development or organizational involvement activities had a significantly higher mentoring score for the Challenge subscale. Lack of additional significant findings prevents a conclusion that mentoring is impacting professional development or organizational involvement activities.

The purpose of this study was to examine mentoring and its impact on cultivating intellectual capital for the purpose of succession planning. Data reviewed to this point has not supported the premise behind the conceptual model for this study. Quantitative data on mentoring indicated a typical level of mentoring. Participation in professional development and organizational activities did not show a significant impact from levels of mentoring. However, verbal data from the focus groups did provide evidence that mentoring is happening at all levels of nursing in the organization.

Focus group participants were asked to share examples of succession planning on their units or in the organization. Staff nurses and managers described unit activities that modeled mentoring. Nurses were getting opportunities to learn charge nurse responsibilities: "…rotating the charge role to encourage most everyone. There are some people that will never have that role, but the ones that are qualified, we rotate that role so each person gets a chance to develop and to get support from others who have done it". Other nurses were encouraging staff nurses to co-lead committee meetings: "we have a process of constantly identifying nurses that have leadership strength to make sure that they get the support and training that they need." APNs and directors are encourage nurses to go back to school, "Our directors made it really clear that there are opportunities for advancement in the hospital." "Clearly there were the people who were sort of rising to the top, so we really began to work diligently with those separate teams, bringing them together as a team, doing some education, communication feedback, and leadership succession."

Two programs were identified that support succession planning. The nurse resident program brings newly graduated professional nurses into the organization, even

though the vacancy rate is extremely low. The clinical resource nurse program provides

an opportunity for the staff nurse to get involved with hospital and unit-based initiatives.

The Corporate Strategic Nursing Team now includes staff nurses at the meetings.

Nurses participating in the focus groups were asked to explain their perceptions

around the responsibility to mentor other nurses. Participants unanimously agreed that

they not only had a responsibility to mentor, but were indeed committed to mentoring

other nurses. Themes emerging from the discussion around nurses' responsibilities to

mentor other nurses included role modeling, knowledge sharing, and encouragement:

> In a role modeling sense, to uphold the visions of the organizations, to conduct
> myself in an ethical fashion . . . I think, as a leader, when you walk on a unit, all
> eyes are on you. And so how you say things, how you conduct yourself, how you
> dress, your body language—all of that makes a difference to staff. (director)

> We have to share our knowledge. If we don't do it, then when we're gone, there's
> not going to be anyone to do our job. So yes, I do, because it's inherent in our job.
> We have the knowledge, the background, the expertise, so it's really a duty as
> well as a pleasure and reward. (APN)

> I think it's part of my role. And to share—that's part of why they employ me, to
> share this knowledge and develop others as well. I went back to school . . . the joy
> that you get from gaining new information. I would spread that and encourage the
> people that I worked with to go back to school, to continue to learn, to do more,
> see more. (educator)

I feel like, when I see nurses that have the potential to go on and they're asking questions, you have to be there to answer them. I feel like it's part of our role as a leader to educate them to go on. We won't have anybody here for us if we don't keep teaching and encouraging. (educator)

The qualitative portion of this study provided evidence of mentoring and succession planning activities occurring within this organization, even though the quantitative data does not provide significant evidence. Focus group participants were given an opportunity to share additional thoughts on mentoring or succession planning. The results of those discussions provided thoughtful insight into mentoring needs in the organization and will be presented with implications and recommendations.

Implications and Recommendations

This research study was entered into knowing that there was not a formal mentoring program in the organization. However, the organization is rich in potential for nurses at every level. Opportunities for education and advancement are available. There are low nurse vacancy rate and a high retention rate for nurses in the organization. That can be good, but also bad when you know that the average age of the nurses is steadily climbing.

The relatively low return rate for the mentoring surveys (13%) leaves open the possibility that the data received were not totally representative of mentoring going on in the organization. However, the consistency of the scores across the subscales and the fact that most survey respondents perceived their mentoring as neutral lends credence to the

results. Even though there were few significant findings between mentoring scores and professional activities, there is strong evidence that informal mentoring is alive and well in the organization.

Descriptive data collected in the survey do provide some insight into how nurses are predicting involvement in the future. Participation in organizational committees was identified by 57% ($n = 77$) for unit-based committees and 59% ($n = 81$) for hospital-wide councils. Eighty-one percent ($n = 107$) of the survey respondents indicated they would likely be involved with a unit-based committee within the next five years. Eighty-four percent ($n = 109$) reported that they would likely be involved in a hospital-wide council within five years. Current enrollment in college courses was reported by 17% ($n = 22$) of the nurses, with 45% ($n = 61$) indicating likely plans to begin taking courses within the next 5 years. Nurses declared intent to increase their professional development and organizational involvement activities in the future.

Focus group participants shared their thoughts on mentoring and succession planning in the organization. There was an overriding agreement that mentoring is happening, even if it is informal. Educators and APNs naturally mentor staff nurses as part of their roles. However, there is an opportunity to develop a mechanism for mentoring the manager role. The educators and APNs have formal networking groups in the organization, and staff nurses often relate to their peers or to the educator, but managers do not enjoy the same opportunity to network with their peers. Succession planning does seem to be active in the organization, at least at the staff nurse level. During the focus group for directors, a concern was raised about succession planning for leadership roles. Nurses are encouraged to seek higher education, and many are doing

just that. However, the organization is considered an ideal workplace, and retention is high. Nurses completing advanced degrees may not have positions to move into. Strategies to maintain highly educated nurses must be considered as part of succession planning activities.

Limitations

The study had the following limitations:

1. The researcher was a variable in the focus groups. Some of the participants were acquaintances and therefore may have been guarded in their responses.

2. Qualitative data obtained during focus groups were not validated by a second coder.

3. Nurses from only a single organization were included in the study.

4. Gender was not addressed in the demographic portion of the surveys.

5. The relatively small (13%) response rate for return of questionnaires created some skepticism related to how representative the sample was to the larger population of nurses employed at the organization.

6. The professional development and organizational involvement survey was not a validated tool.

7. Several surveys completed on the Internet were incomplete and had to be deleted.

8. Staff nurses had difficulty scheduling for focus groups.

9. Focus group participants were fewer than desired.

Recommendations for Further Research

    Further research is recommended in the following areas:

1. A comparative study between Magnet and non Magnet organizations related to the extent of nurse mentoring and its impact on professional development and organizational involvement.

2. Further exploration of the perceived neutral benefit of mentoring's influence on the nurses' career and professional development. How do nurses define mentoring? What are nurses' expectations for mentoring at different times in their career?

3. Further research is needed to examine the impact of a formal mentoring program on new nurse graduates' participation in professional development and organizational involvement activities.

This study has created the opportunity for dialogue around mentoring and succession planning activities. Findings from this study were restricted to the state of mentoring at the time of the study as perceived by those who returned surveys or participated in focus groups. Further research is needed to gain a better understanding of the needs and expectations for mentoring activities within the organization and for nurses in general as a means to support succession planning.

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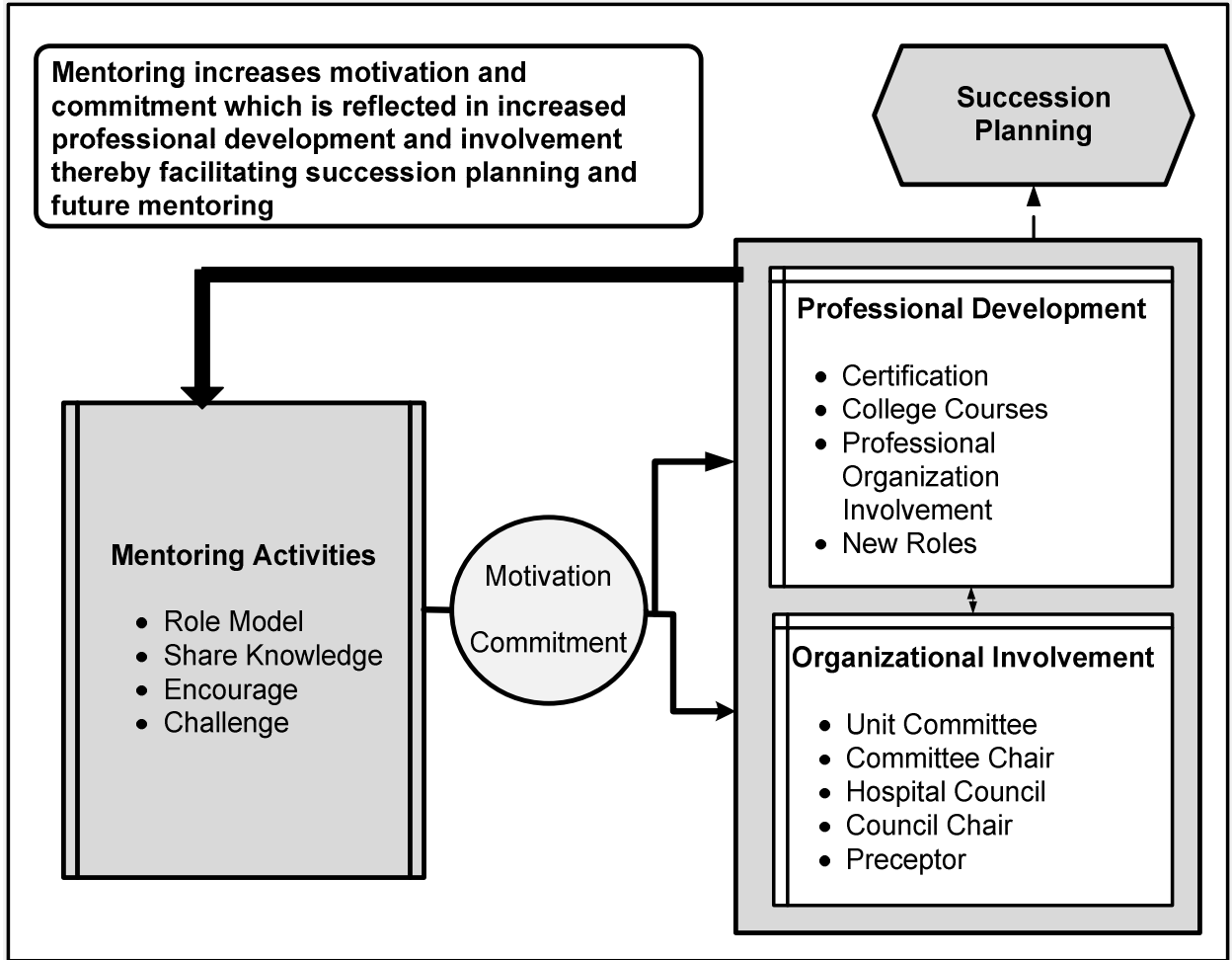
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APPENDIX A

Mentoring to Succession Planning Conceptual Model

Mentoring increases motivation and commitment which is reflected in increased professional development and involvement thereby facilitating succession planning and future mentoring

Succession Planning

Professional Development

- Certification
- College Courses
- Professional Organization Involvement
- New Roles

Mentoring Activities

- Role Model
- Share Knowledge
- Encourage
- Challenge

Motivation

Commitment

Organizational Involvement

- Unit Committee
- Committee Chair
- Hospital Council
- Council Chair
- Preceptor

Appendix B

The Alleman Mentoring Activities Scales Description

The Alleman Mentoring Activities Scales Description

Scales addressing Guiding Activities*:*

Teach the Job*.* Items in this scale reflect the amount and value of mentor behaviors that help a protégés learn how to perform job related tasks and accomplish work related goals. They teach by example, explanation and discussion, providing helpful information and giving feedback.

Provide Challenge. Items in this scale reflect the amount and value of mentor behaviors that delegate and give responsibility to protégés encourage protégés to take risks and assume initiative, and assign (or encourage protégés to take on) tasks that require the protégés to deal with other parts of the organization and other levels of the hierarchy.

Teach Politics. Items in this scale reflect the amount and value of mentor behaviors that help the protégés understand the behavior of others, how to avoid pitfalls, and how to use the informal system to accomplish goals. They do this by example, explanation, discussion and giving feedback.

Scales addressing Helping Activities:

Career Help. Items in this scale reflect the amount and value of mentor behaviors that showcase the protégés and help the protégés achieve career goals by providing visibility, introductions and recommendations.

Protect. Items in this scale reflect the amount and value of mentor behaviors that show the mentor is willing to provide a "safe place" for the protégés to try out new ideas without fear of penalty, is willing to bend the rules for the protégés, and is prepared to defend the protégés when necessary.

Sponsor. Items in this scale reflect the amount and value of mentor behaviors that support the protégé's initiatives and moves, show professional support for the protégés, and publicly give the protégés the mentor's backing

Scales addressing Encouraging Activities:

Career Counseling. Items in this scale reflect the amount and value of mentor behaviors that provide career counseling for the protégés, encourage the protégés to develop a career plan, contribute to the protégé's personal development, and act as a resource for the protégés when problems arise.

Friendship. Items in this scale reflect the amount and value of mentor behaviors that show liking for each other, association in nonwork situations, and concern for each other's personal welfare.

Demonstrated Trust. Items in this scale reflect verbal expressions of confidence in the protégés, seeking the protégés opinion, and acts such as revealing sensitive or confidential information to the protégé, and that help the protégés learn when to trust others.

Alleman and Clark (2002)

Appendix C

Nursing Intellectual Capital Inventory

Nursing Intellectual Capital Inventory

1. What is your age? (Round to the closest year)

[   ]

2. What is your current nursing role?

Staff Nurse

Educator

APN

Clinical Coordinator/Manager

Director

Other

3. How many years have you been a nurse? (Round to the closest year)

[   ]

4. How many years have you been employed at this hospital? (Round to the closest year)

[   ]

5. What is your original educational preparation?

Diploma

AD

BS/BSN

MS/MSN

6. What is your highest level of education?

Diploma

AD

BS/BSN

MS/MSN

7. Are you currently a Clinical Resource Nurse (CRN)?

Yes

No

8. Are you currently certified in a specialty related to your work? (Do not include verifications such as ACLS, PALS . . .)

Yes

No

9. Are you currently taking college courses relevant to healthcare?

Yes

No

10. What professional activities are you currently involved with? Please check ALL that apply.

Unit-based committee member

Unit based committee chair

Hospital-wide committee/council member

Hospital-wide committee/council chair

Professional nursing organization member

Professional nursing organization committee member

Preceptor for new staff

Preceptor for students

Adjunct faculty

11. In the next 5 years how likely are you to

	Very Unlikely	Unlikely	Somewhat Likely	Likely	Very Likely
Become involved in unit-based committees					
Become involved in hospital-wide councils/committees					
Take certification exam					
Return to school					
Seek another role within the organization					
Leave the organization to seek another role					
Retire					

12. In the next 6–10 years how likely are you to

	Very Unlikely	Unlikely	Somewhat Likely	Likely	Very Likely
Become involved in unit-based committees					
Become involved in hospital-wide councils/committees					
Take certification exam					

Return to school					
Seek another role within the organization					
Leave the organization to see another role					
Retire					

Thank you for participating in this study on mentoring.

If you would like to participate in a one-hour focus group on the topic of mentoring and succession planning, please contact Gloria Reidinger at 847-618-7970 or greiding@nch.org.
You may also receive an e-mail invitation with more details.

Appendix D

Definitions for Focus Group Topics

Definitions

MENTORING: A relationship between two people in which the person with greater rank, experience, and/or expertise councils, guides, and helps the other to develop both professionally and personally. You may have more than one individual involved in your professional and personal development.

SUCCESSION PLANNING: A business strategy that prepares for the exit of key employees by developing qualified individuals to take their places.

INTELLECTUAL CAPITAL: Knowledge assets that include "talent, skills, know-how, know-what, and relationships."