

# **Mentoring Perceptions of Registered Nurses**

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## Abstract

Mentoring has been proposed as a human resource strategy to encourage recruitment and retention of nurses in Canada. However, very little research exists related to mentoring in nursing. The purpose of this study was to describe the mentoring perceptions of acute care, clinical registered nurses based on their years of nursing practice, age, gender, and education level. A descriptive correlational design was performed on an analysis of a subset of the pre-workshop data gathered as part of the research of Ferguson, Myrick, and Yonge (2006). The conceptual framework used to structure the research questions was Benner's Novice to Expert model (Benner, 1984; Benner, Tanner, & Chesla, 1996). The main research question related to the relationship between nursing experience level and mentoring perceptions. More specifically, what is the relationship between age, years of nursing practice, education level, gender, and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships? This research established that age, years of nursing practice on the current unit, and education level had some impact on mentoring perceptions. Older nurses believed that the mentor played a greater psychosocial function in the mentorship than did younger nurses. Nurses with fewer years of practice on their current unit perceived fewer "costs" to mentoring, were more satisfied with their mentor, and were more willing to mentor. Previous experience as a protégé positively impacted mentoring perceptions. Nurses with prior mentoring experience were more willing to mentor. There were no significant differences between nurses with diplomas or degrees as their basic or highest level of education in nursing and mentoring perceptions. Nurses with a baccalaureate degree in another discipline perceived more "benefits" to mentoring than their diploma-prepared colleagues. No significant differences were noted when comparing gender

with mentoring perceptions. The results of this study will provide healthcare organizations with a deeper understanding of mentoring perceptions and mentorships. From the knowledge acquired by this study, organizations can better encourage and endorse formal and informal mentoring in acute care environments. Retention and recruitment of registered nurses can be facilitated through support for mentoring.

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## CHAPTER 1

### Introduction

A nursing shortage exists in Canada (O'Brien-Pallas et al., 2003; Smadu, 2007). Creating a positive work environment by incorporating mentoring has been suggested to aid in recruitment and retention of nurses, and has been proposed to reduce this shortage. Literature in the area of mentoring in nursing has been primarily anecdotal and research is extremely limited. This thesis study has been completed to examine factors associated with mentoring for registered nurses in order to expand the nursing knowledge base related to mentoring. Mentoring has also been related to recruitment and retention of new nurses and may assist to address the nursing shortage.

#### *1.1 Statement of the Problem*

The Saskatchewan health care system is experiencing and will continue to experience a nursing shortage (Saskatchewan Registered Nurses' Association [SRNA], 2006). In 2006, the Saskatchewan Union of Nurses (SUN) identified 93 vacant registered nurse (RN) positions in the province. In addition, the average age of a Canadian RN is 44.7 years and the average age of a Saskatchewan RN is 45.6 years with 20% of RNs in Saskatchewan currently eligible to retire (Canadian Institute for Health Information [CIHI], 2007). Furthermore, five years after graduation, 23.5% of new graduate RNs have left Saskatchewan to work in other provinces or states (Nursing Education Program of Saskatchewan, 2007). Thus, health care organizations in the province of Saskatchewan need to concentrate their efforts on recruiting and retaining RNs in the healthcare system.

To encourage recruitment and retention, mentoring has been proposed by several authors (Butler & Felts, 2006; Casey, Fink, Krugman, & Propst, 2004; Greene & Puetzer, 2002). In

addition, Saskatchewan RNs have requested mentorship programs to encourage recruitment and retention of all nursing staff (Pederson, 2002; SUN, 2006). Mentorship is defined as a socialization process in which a mentor works closely with a protégé to teach, guide, support, and develop the protégé (Jowers Taylor, 2001). Mentorship is a mutually beneficial, long-term, voluntary relationship that can be informal or formal (Canadian Nurses Association [CNA], 2004). Few research studies have been conducted to investigate the nature of mentorship in nursing and more specifically, mentoring in acute care nursing practice.

### *1.2 Purpose of the Study*

The purpose of this research was to describe the mentoring perceptions, including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships of acute care, clinical registered nurses based on their years of nursing practice, age, gender, and education level. Since there has been limited knowledge development on mentoring in acute care nursing, this study will advance that knowledge. A study of this nature is extremely significant.

### *1.3 Relevance and Significance of the Study*

A priority of healthcare organizations is to find effective methods to recruit and retain nursing professionals. Mentoring in nursing clinical practice has been anecdotally proposed by authors to create a positive workplace and thus contribute to the recruitment and retention of acute care, clinical nurses (Barnard, 2002; Goran, 2001; Gordan, 2000; Greene & Puetzer, 2002). However, little research has been done in this area. This study is relevant and significant because it investigated acute care clinical nurses' mentoring perceptions based on their experience level as indicated by their years of nursing practice, age, gender, and education level. Once organizations obtain an understanding of the nature of mentorship in nursing practice and

mentoring perceptions of staff based on their experience level, they can identify methods that positively influence these perceptions and create an environment to encourage mentoring use. Increased mentoring may contribute to increased numbers of acute care clinical nurses, with a variety of experience levels, being retained and recruited.

## CHAPTER 2

### Literature Review and Background

For the literature review, the nursing database Cumulative Index to Nursing and Allied Health (CINAHL) and the commerce database Canadian Business and Current Affairs (CBCA Complete) were used. The limits placed on the searches included those articles that used the English language and those that were from the years 1990-2008. The rationale for this lengthy timeframe was based on the limited amount of nursing literature in this area and the long-standing interest in the area of mentoring by business and organizational behaviour researchers. The search terms used consisted of *mentorship* in combination with the terms *beliefs*, *perceptions*, *benefits*, *costs*, *barriers*, *age factors*, *sex factors*, *educational status*, and *nursing*. The process for determining the articles for use in the literature review consisted of examining articles that explored mentoring in relation to perceptions and beliefs, and discussed the variables that contributed to those beliefs. These articles were obtained mainly through the University of Saskatchewan online databases.

Both non-empirical and empirical literature was reviewed. There was a vast array of non-empirical literature on mentoring in nursing in general. However, empirical studies relating to mentoring perceptions in nursing were few. Therefore, the search was extended to business, applied psychology, and organizational behaviour literature.

Mentorship in the business environment is slightly different than mentorship in the nursing environment. For example, the mentoring relationship in business typically involves a high ranking member of the organization such as a vice president, manager, supervisor, or executive as the mentor and a lower level executive or employee as the protégé who may be from a different department (Allen, Poteet, Russell, & Dobbins, 1997; Ragins & Cotton, 1999;

Ragins & Scandura, 1999; Viator, 1999; Young & Perrewe, 2004). In nursing, the mentor and the protégé are more commonly equal status peers who work in the same environment such as acute care clinical nurses (DiVito-Thomas, 1998; Ronsten, Andersson, & Gustafsson, 2005). Furthermore, benefits of mentoring in the business context include more promotions, increases in salary, exposure to advantageous projects, and visibility for the protégé (Ragins & Cotton; Young & Perrewe). These findings may be evident in some nursing contexts, but they are not commonly found at the acute care clinical level. Therefore, more research on mentorship from a nursing context was needed to examine the nature of mentorship in nursing practice.

## *2.1 Non-empirical Literature*

### *2.1.1 Outcomes of Mentoring*

As mentioned previously, most of the literature on mentoring in nursing was anecdotal. Proposed benefits of mentoring for the protégé included increased confidence (Barnard, 2002; Goran, 2001), increased competence (Gordan, 2000), and less stress (Greene & Puetzer, 2002). Anecdotally, these benefits resulted in increased job satisfaction and retention of the mentor and protégé (Barnard; Goran; Gordan; Greene & Puetzer). Numerous nursing authors have proposed benefits to the mentor in the mentoring relationship, including personal growth and development (Barnard), advanced leadership skills (Goran; Gordan), and self-fulfillment (Greene & Puetzer).

### *2.1.2 Roles and Responsibilities*

From their experience, authors have proposed roles and responsibilities of a mentor. Roles of a mentor included being a role model, socializer, educator, supervisor, supporter, and challenger (Greene & Puetzer, 2002). As a role model, the mentor lead by example and demonstrated how a skilled nurse functioned. As a socializer, the mentor welcomed the protégé into his or her peer group, introducing the protégé to members and assisting in the integration of



the protégé into the social culture of the unit. The mentor acted as an educator as well as helping the protégé to establish goals, plan and implement learning experiences, and evaluate those experiences (Green & Puetzer). By observing the protégé's performance and giving constructive feedback, the mentor functioned as a supervisor. The mentor provided support to the protégé and challenged him or her when necessary (Green & Puetzer). It was the responsibility of the mentor to be willing to commit the time needed to develop the mentoring relationship and be knowledgeable in the area (Provident, 2005).

From anecdotal literature, authors have suggested that the protégé also had roles and responsibilities in the mentoring relationship. The protégé must identify visions or goals so that the mentor can work with the protégé to achieve those goals (Provident, 2005). The protégé must have a desire to learn, be motivated, demonstrate initiative, and be able to communicate effectively (Jowers Taylor, 2001; Provident). If the protégé was not motivated or did not demonstrate initiative then the process did not work. The protégé must be willing to ask questions and accept constructive feedback. Furthermore, he or she must seek and ask for advice or assistance when needed. Thus, mentoring was a reciprocal process (Jowers Taylor; Provident).

## *2.2 Empirical Literature*

### *2.2.1 Purpose*

There was a body of empirical literature from a business and organizational behaviour perspective that demonstrated that mentoring relationships had a positive impact on career development, job satisfaction, and personal growth for both the mentor and the protégé (Lankau & Scandura, 2002; Van Emmerik, 2004). Research on mentoring in the area of business has included exploration of the mentoring relationship by looking at perceptions of mentoring. Studies have examined individuals' perceptions of factors affecting mentoring relationships and

intentions to mentor. Some have considered relationship structure as it relates to perceptions of mentoring (Allen, Poteet, Russell, et al., 1997; Finkelstein, Allen, & Rhoton, 2003; Fagenson-Eland, Marks, & Amendola, 1997; Ragins & Cotton, 1993; Viator, 1999). In these instances, relationship structure meant formal or informal relationships (Fagenson-Eland et al., 1997; Viator), previous mentorship experience (Allen, Poteet, Russell, et al.), demographic differences in mentors and protégés (Finkelstein et al.), and gender differences (Ragins & Cotton). In addition, some investigators considered relationship expectations of mentoring support (Angelini, 1995; Fagenson-Eland, Baugh, & Lankau, 2005; Levesque, O'Neill, Nelson, & Dumas, 2005; Ragins & Scandura, 1999; Young & Perrewé, 2004). Relationship expectations included gender differences in expectations (Levesque et al.), expectations of career or developmental support (Angelini; Fagenson-Eland et al., 2005; Young & Perrewé), and perceived cost and barriers to mentoring (Ragins & Scandura).

### *2.2.2 Research Design and Data Collection*

Many design methods have been used when examining mentoring perceptions depending on the variables researched. A predictive correlational design has been used most commonly (Allen, Poteet, Russell, et al., 1997; Fagenson-Eland et al., 2005; Fagenson-Eland et al., 1997; Ragins & Cotton, 1993; Ragins & Scandura, 1999; Viator, 1999; Young & Perrewé, 2004). In two studies, a comparative descriptive design was described and used (Levesque et al., 2005; Raabe & Beehr, 2003). Finkelstein et al. (2003) used a mixed method design, incorporating a predictive correlational design and an unspecified qualitative methodology. The most frequent data collection tool for examining mentoring perceptions was a Likert scale questionnaire (Allen, Poteet, Russell, et al.; Fagenson-Eland et al., 2005; Fagenson-Eland et al., 1997; Finkelstein et al.; Raabe & Beehr, 2003; Ragins & Cotton; Ragins & Scandura; Viator; Young & Perrewé).

### *2.2.3 Sample and Setting*

Researchers have used a variety of techniques to stratify the sample. Some stratified the sample by gender (Allen, Poteet, Russell, et al., 1997; Ragins & Cotton, 1993; Levesque et al., 2005; Viator, 1999), whereas some stratified the sample by role, mentors or protégés (Fagenson-Eland et al., 2005; Fagenson-Eland et al., 1997; Young & Perrewe, 2004). In one study, both gender and mentor/protégé role were considered (Ragins & Scandura, 1999). Conversely, Finkelstein et al. (2003) and Angelini (1995) did not stratify the sample. In the majority of studies, convenience sampling was used (Angelini; Fagenson-Eland et al., 2005; Fagenson-Eland et al., 1997; Finkelstein et al.; Levesque et al.; Ragins & Cotton; Viator).

The majority of studies were based in the United States (Allen, Poteet, & Burroughs, 1997; Angelini, 1995; Finkelstein et al., 2003; Fagenson-Eland et al., 2005; Fagenson-Eland et al., 1997; Hurst & Kaplin-Baucum, 2003; Levesque et al., 2005; Nelson, Godfrey, & Purdy, 2004; Ragins & Cotton, 1993; Ragins & Scandura, 1999; Scott, 2005; Viator, 1999; Young & Perrewe, 2004). One study was based in the United Kingdom (Rosser, Rice, Campbell, & Jack, 2004). The writer was unable to find any Canadian articles pertaining to mentoring perceptions.

### *2.2.4 Key Findings*

Using a qualitative, grounded theory methodology, Angelini (1995) found that mentoring in clinical nursing was crucial and had a great influence on the career development of the nurse. The nurse participants stated the ideal mentors for them were their peers and nurse managers (Angelini). Furthermore, several mentoring programs in nursing environments have been implemented and evaluated to assess benefits to the mentors and protégés. In all studies, mutual benefits to mentors and protégés were found. For example, the mentors reported an increased sense of professionalism (Hurst & Kaplin-Baucum, 2003), increased leadership skills

(Scott, 2005), increased job satisfaction, and personal growth (Nelson et al., 2004). Protégés reported decreased stress levels and an increased sense of belonging and support (Hurst & Kaplin-Baucum; Scott), increased ease in transition into practice (Rosser et al., 2004), and increased assistance with socialization (Nelson et al.). The findings of these nursing studies on mentoring confirm and reinforce the claims made by the non-empirical articles.

Authors described the phases of the mentoring relationship differently; however, the categories were all very similar. What is important to remember is that the nature of the mentorship changes over time. Kopp and Hinkle (2006) and Kram (1983) described four phases of mentoring: initiation, cultivation, separation, and redefinition. In the initiation phase, trust was established and goals were set. The cultivation phase was the working phase. It involved the mentor assisting the protégé to reach the goals that were set out. When the protégé expressed or displayed an independence from the mentor, the separation phase had begun and the protégé became increasingly autonomous. Finally, a redefinition phase was reached where the relationship became a friendship and the protégé operated independently from the mentor (Kopp & Hinkle; Kram).

In the business context, Young and Perrewé (2004) demonstrated that individual expectations have an impact on perception of the mentorship. Fagenson-Eland et al. (1997) concluded that mentor and protégé perceptions cannot be generalized to each other and each require investigation. Intention to mentor was related to greater anticipated benefits and fewer anticipated costs (Ragins & Scandura, 1999). In addition, anticipated benefits to mentoring had a stronger relationship with intentions to mentor than anticipated costs (Ragins & Scandura). Allen, Poteet, Russell, et al. (1997) discovered that individuals with higher education levels reported greater intentions to mentor and perceived fewer barriers to mentor. In addition, Allen,

Poteet, Russell, et al. found that age was negatively related to intention to mentor. Furthermore, Ragins and Cotton (1993) identified that individuals with greater tenure in an organization reported decreased willingness to mentor. Fagenson-Eland et al. (2005) concluded that discrepancies in perceptions were found within the dyad if the mentor and protégé had a dissimilar tenure and age, as is usually the case in the business context. Fagenson-Eland et al. (2005) suggested that mentor and protégé tenure and age be taken into consideration. Finally, the age of the protégé influenced the perceived amount of career mentoring provided and perceptions of mutual learning (Finkelstein et al., 2003). The aforementioned studies examining mentoring perceptions related to age, years of experience, and education level were conducted in the business and organizational environment. These findings cannot be generalized to the nursing environment and further research was needed to either confirm or disprove these findings.

#### *2.2.5 Summary of the Literature*

In the business context, Fagenson-Eland et al. (2005) found that younger protégés perceived more developmental support and more frequent communication from their mentors. This was congruent with Finkelstein et al.'s (2003) findings, also in business, that older protégés reported less need for developmental support than younger protégés. As the age between the mentor and protégé increases, the greater the level of disagreement between their perceptions of the amount of developmental support provided (Fagenson-Eland et al.). Mentors and protégés with similar ages perceived more mutual identification and interpersonal communication (Finkelstein et al.). Therefore, age appears to play a role in the perception of the mentoring relationship. However, investigation related to age and mentoring perceptions in the nursing field was required as there was no research in this area.

No significant gender differences in mentoring perceptions were observed in the business literature. Men and women were found to have similar perceptions of mentoring and mentoring expectations. For instance, there were only minor differences noted in men's and women's perceptions of mentoring functions (Levesque et al., 2005). The two mentoring functions found to be significantly more important to women than men were "championing" and "acceptance" (Levesque et al.). Several studies found no differences between gender and willingness to mentor and perceived barriers to mentoring (Allen, Poteet, Russell, et al., 1997; Levesque et al.; Ragins & Cotton, 1993; Ragins & Scandura, 1994). In addition, Viator (1999) identified that men and women were similar with regard to their perceptions of barriers to establishing a mentorship. Thus, it appeared that gender was not a significant factor when examining mentoring relationships and perceptions in the business context. Since there was no research examining the relationship between gender and mentoring perceptions in nursing, this association needed to be investigated.

Studies in the business context examined the impact of age on mentoring beliefs. Allen, Poteet, Russell, et al. (1997) found that perceived barriers to mentoring were not related to age and that intention to mentor was negatively related to age. The older the individual, the less likely that he or she was to mentor. Conversely, Ragins and Cotton (1993) concluded that willingness to mentor was not related to age. However, Ragins and Cotton found that participants with longer tenure within an organization reported a decreased willingness to mentor. Findings in the business context were equivocal, and therefore more investigation into age and mentoring perceptions was needed especially in the nursing environment.

### *2.2.6 Gaps in the Research*

An obvious gap in the literature was the lack of Canadian studies on mentoring. Furthermore, there was a serious lack of nursing specific research on mentoring in general and mentoring perceptions specifically. Based on the inconsistent and limited findings of the literature review, researchers must further examine the impact of age, gender, education level, and experience in relation to mentoring perceptions, especially from a nursing context. Researchers need to discover how to facilitate a mentoring environment in nursing.

### *2.3 Theoretical Framework*

Benner's (1984) Novice to Expert model provides a guide for directing future research in the area of mentoring. Benner adapted the Dreyfus model of skill acquisition to the nursing context. This model described five levels of skill acquisition and development: novice, advanced beginner, competent, proficient, and expert (Benner). It is important to note that nurses with certain characteristics had generally practiced for a specified number of years. However, merely practicing for a particular period of time does not guarantee achievement of specific stages. That achievement was based on different ways of thinking about practice issues due to experiential learning in practice.

A "novice" has no experience with nursing situations and was generally a nursing student. A "novice" focused on context-free rules to guide action (Benner, Tanner, & Chesla, 1996). Benner et al. described "advanced beginners" as having typical characteristics, including a marginally acceptable performance but limited prior experience to recognize important aspects of a situation. This level generally characterizes new nursing graduates. To "advanced beginners", situations and patients present as a set of tasks that must be completed. These tasks guided their actions, and generally their work was driven by a focus to organize, prioritize, and

complete tasks. “Taking good care of the patient” meant getting all the tasks done for that individual. “Advanced beginners” focused on the present hour or present shift and they were not able to think about future care as they were concerned about completing the tasks needed to be done at the present time. Due to this task focus, “advanced beginners” had minimal ability to see the patient as a person and other areas, like the patient’s status or family concerns, were maintained in the background. Guidelines for care were directed by unit procedures and physician and nurse orders. “Advanced beginners” were concerned about their own competence and this focus impeded their ability to cope with clinical situations. They may have recognized a change in a patient condition but they did not always know how to manage it. “Advanced beginners” were not able to understand how pieces of a situation fit together. Having discomfort with the nursing role was a common characteristic. They felt increased responsibility and were routinely asked to manage in situations that were above their skill level. Therefore, the “advanced beginner” had concerns for the challenging situation, how he or she would manage it, and how he or she would present himself or herself as a competent nurse in the situation. Also, they frequently delegated up to nurses who had more experience when they felt overwhelmed with a situation (Benner et al.).

A “competent” nurse was working for two to three years in the same environment. This stage materialized when the nurse guided his or her own actions by predicting, planning, and achieving goals for the patient (Benner, 1984). Benner et al. (1996) provided examples of characteristics of nurses at this level. They were more organized, had improved technical skills, and were better able to cope with complex situations than “advanced beginners”. To be organized in this stage meant to anticipate changes in patient status, have equipment and resources ready, and be able to act calmly and proficiently in times of crisis. Patient care became



individualized and flexible based on each patient's needs. The "competent" nurse's efforts concentrated on the clinical status and management of the patient. With familiar situations, the nurse understood and anticipated patient progress. Unlike the "advanced beginner", the "competent" nurse was able to plan for the present by anticipating what would be needed in the future. However, the nurse infrequently identified shifting importance in certain circumstances. This lack of identification was hindered by the necessity to gather data and achieve objectives. The patient and family were personalized. The nurse now saw the patient and family as people and not as a set of tasks. The "competent" stage was also a time of discouragement as the nurse began to see that other colleagues and healthcare providers did not always make the correct or best decisions for the situation. Furthermore, with increased experience and the increased ability to reflect upon practice, the "competent" nurse felt a sense of hyper-responsibility. The nurse was beginning to understand that not all situations were guided by rules and principles, creating internal conflict and anxiety. To counter these feelings, the nurse read clinical resources to help achieve a better understanding of patient conditions, typical progress, and interrelationships between disease states. In addition, this stage was a time of questioning of the nurse's own competence of what was expected of them and what the nurse expected of the nursing profession. Nurses second-guessed their abilities or effectiveness of schooling. Due to the work demands and feelings of hyper-responsibility, nurses at this stage, more than any other level, expressed an interest in moving to another position or leaving the profession altogether. In order to move beyond this stage of competence, the nurse must be open to experiential learning. This learning included testing the nurse's assumptions and expectations of a situation, having those assumptions be wrong, and changing the expectations. Of particular importance during this stage was the nurse's ability to utilize his or her clinical knowledge and judgment relating to a

patient's condition to present assessments and proposed interventions to the physician. The nurse began to problem solve the patient situation prior to calling the doctor (Benner et al.).

A nurse who worked three to five years with a similar patient population had usually reached the "proficient" level (Benner, 1984). The key characteristics of this stage were the abilities to analyze the situation, recognize what was most important at the time, and react accordingly (Benner et al., 1996). For example, the nurse learned from experience about typical events and particular patient groups' characteristics and planned actions in response to each situation. Through these experiences, the nurse was able to distinguish trends and had a strong sense of when something was not progressing normally. The nurse began to trust his or her emotional responses to a situation and used these feelings to guide his or her actions. A deeper relationship with the patient and family was established through an increased understanding of the patient condition and typical response. The "proficient" stage was reached when the nurse can perceive situations as whole. The nurse was attentive to and able to read the changing situation, and responded appropriately, based on the perception of the situation. The nurse used his or her finely tuned skills of perception and judgment to guide actions (Benner et al.).

An "expert" nurse did not rely on rules or guidelines, but relied on intuition, pattern recognition, and heuristics, based on experientially gained advanced clinical knowledge to attend to any situation (Benner, 1984). "Expert" nurses "know what to anticipate and how to prepare for possible issues and problems, expert practice requires remaining open to what the situation presents" (Benner et al., 1996, p. 143). There were common characteristics of nurses at this level (Benner et al.). For instance, the nurse's emotional interaction with the patient and family was dependent upon that which was required by the patient and family for the individual situation. The "expert" nurse reflected upon the past, present, and future course of events when caring for

patients. The nurse responded quickly and seamlessly to the patient needs and situations. The nurse acted based on identifying both recognizable and individual patterns of reactions. The “expert” nurse was able to see the “big picture” and was able to sense the requirements of other patients on the unit and the competence of the staff caring for them. This group of nurses felt responsible for supporting less experienced ones. When “experts” felt strongly that the type of care was inappropriate for the patient’s needs, they were compelled to challenge whoever they needed to to make the situation right for the patient (Benner et al.). Benner et al. suggested that it was best to assign a protégé to a “competent” or “proficient” nurse mentor than with an “expert” as the “expert” may not know how to explain procedures and processes thoroughly because an “expert” nurse acts on heuristics developed from years of experientially gained advanced clinical knowledge and practice.

In this study, nurses’ experience levels were operationalized using a demographic questionnaire. The researcher asked questions related to years of registered nurse employment on the current unit and in total, nursing education (diploma or baccalaureate), highest level of education (diploma, baccalaureate, masters), and nursing certification. Stated length of registered nurse employment on the current nursing unit and in total were taken into consideration when the researcher made generalizations regarding mentoring perceptions with novice to expert levels according to Benner (1984). It is acknowledged that years of nursing practice do not necessarily imply a specific level of expertise in practice. However, nurses with a specific number of years of practice are more likely to have achieved a certain level of practice expertise.

## 2.4 Research Variable Definitions

### 2.4.1 Experience Level

*Conceptual definition.* Having skill and knowledge in a particular area (Fitzgerald, Howell, & Pontisso, 2006).

*Operational definition.* Experience level was measured based on information provided in the demographic section of the questionnaire. Years of registered nurse employment on the current unit and in total, nursing education (diploma or baccalaureate), highest level of education (diploma, baccalaureate, masters), and nursing certification contributed to experience level. From the data available, it would be impossible to determine nurses' expertise levels, according to Benner (1984). However, using years of nursing practice was one way of estimating possible knowledge and skill level. Results from years of nursing practice on the current unit and in total influenced placement of nurses into Benner's "Novice to Expert" categories for discussion purposes only.

### 2.4.2 Years of Nursing Practice

*Conceptual definition.* The number of years as a practicing registered nurse on a nursing unit and years of registered nurse employment in total.

*Operational definition.* Participants were asked to report their length of employment on their unit. In addition, participants were asked to report their total years of registered nurse employment. They were also asked to list other nursing units they have previously worked on and for what duration of time.

### 2.4.3 Age

*Conceptual definition.* A measure of the number of years an individual has lived (Sanderson & Scherbov, 2007).

*Operational definition.* Participants were asked to write their year of birth on the demographic form.

#### 2.4.4 Gender

*Conceptual definition.* A person's sex (Fitzgerald, Howell, & Pontisso, 2006).

*Operational definition.* Participants were asked to specify their gender as either male or female on the demographic form.

#### 2.4.5 Education Level

*Conceptual definition.* The highest level of schooling an individual has completed (Statistics Canada, 2006).

*Operational definition.* Participants were asked to indicate their basic nurse education level, their highest level of completed education in nursing, and their highest level of completed education in another discipline. They were able to select from diploma, baccalaureate, or masters. They were asked if they had CNA national certification, the area of their certification, the length of time they had held their certification, and if they were currently working in the same area as their certification. These questions were "yes/no" questions with the exception of the length of time they have held their certification. They selected the corresponding length of time.

#### 2.4.6 Mentoring Perceptions

*Conceptual definition.* An individual's beliefs about mentoring or the mentoring relationship (Levesque et al., 2005).

*Operational definition.* Several scales were used to identify mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions, and satisfaction with current mentoring relationships. The Expected Costs and Benefits to Being

a Mentor Scale created by Ragins and Scandura (1999) assessed the perceived costs and benefits of mentoring in new nurses and experienced nurses. The Willingness to Mentor Scale created by Ragins and Cotton (1993) determined an individual's likeliness to mentor and was used in both the new nurse and experienced nurse questionnaires. To assess mentor functions in the new nurse questionnaire, the Mentor Role Instrument (Ragins & McFarlin, 1990) was used. Finally, to measure satisfaction with current mentoring relationships the Mentoring Functions Scale (Scandura & Ragins, 1993) and the Mentor Satisfaction Scale (Ragins & Cotton, 1999) were used in the new nurse questionnaire. The combined scale was a 49 item Likert scale questionnaire for the experienced nurses and a 97 item Likert scale questionnaire for the newer nurses.

### *2.5 Conceptual Framework*

A conceptual map was created to illustrate associative relationships between the variables "total years of nursing practice", "years of nursing practice on the current unit", "education level", "gender", "age", and mentoring perceptions including perceived costs and benefits to mentoring, intention to mentor, mentoring behaviours of coworkers, and satisfaction with current mentoring relationships (see Appendix A for the conceptual map diagram). As discussed in the literature review, there was specific evidence that a relationship existed between age, gender, years of nursing practice, and education level with mentoring perceptions. However, the findings in the literature were minimal or conflicting. Consequently, this study explored the relationships between these variables further within the nursing context.

The researcher was also querying the relationship between experience level [years of nursing practice on the current unit and in total as a proxy for Benner's (1984) Novice to Expert Model] and mentoring perceptions as indicated by the dotted lines on the conceptual map. It

must be noted that experience level and expertise level are not necessarily equivalent, using Benner's model of the development of clinical expertise. Experience level is a combination of years of nursing practice on the current unit and in total. Expertise level is categorized by the RNs way of thinking in the Novice to Expert model (Benner). Experience level may correlate with level of expertise, but the relationship is not confirmed and the researcher cannot confirm it with this study. Therefore, one cannot conclude that a nurse with 20 years of experience practices at the expert level. Expertise can exist with lower levels of experience as experience appears to be the necessary component, but experience alone does not guarantee expertise and experience can be present without expertise being developed. Thus, years of experience was used as a means of reflecting possible levels of practice expertise.

### *2.6 Research Questions*

The main research question related to the relationship between level of experience in nursing and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships.

1. More specifically, what is the relationship between age and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships?
2. What is the relationship between years of nursing practice and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships?

3. What is the relationship between education level and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships?
4. Finally, what is the relationship between gender and mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships?



## CHAPTER 3

### Methodology

#### *3.1 Introduction to the Primary Study*

A descriptive correlational design was completed for an analysis of a subset of the pre-workshop data collection in the prospective research of Ferguson et al. (2006). The main research question for the primary study was what is the nature of mentorship in professional nursing practice? The objectives included determining the nature of mentorship in professional nursing practice, identifying factors that promote and inhibit the development of mentoring relationships in professional nursing practice, examining the effects of preceptorship experiences in long-term mentoring relationships, determining the effect of specific organizational contexts on mentorship, and evaluating an educational workshop that supports mentoring (Ferguson et al.).

The study design was a mixed methods research design. The quantitative portion explored preceptor and mentor experiences, anticipated costs and benefits of mentoring, and assessment of the organizational context of practice. Grounded theory methodology will be used for the qualitative portion of the primary study to explore the process of mentoring or being mentored in professional nursing practice (Ferguson et al.). Findings will be utilized to create an educational video and a workshop focused on enhancing mentoring skills. Workshop effectiveness and subsequent mentoring will then be evaluated (Ferguson et al.). The current study utilized pre-workshop data collected in May 2007 to April 2008 as part of the primary study.

### *3.2 Research Design*

As previously mentioned, a descriptive correlational design was completed for an analysis of a subset of the pre-workshop data collection in the prospective research of Ferguson et al. (2006). A descriptive correlational design examines relationships between variables (Burns & Grove, 2005). In this type of study the variables are not manipulated (Burns & Grove). This type of research design aided the researcher to answer the proposed research questions and added to the meager literature on mentoring in nursing practice. In the primary study, data was collected from two groups, new and experienced nurses using a mixed method design. However, for the purposes of the analysis of this subset of the data, the researcher examined the data as a single group. The researcher examined subjects mentoring perceptions based on their age, education level, gender, and years of nursing practice, irrespective of whether the subject was classified as new or experienced.

### *3.3 Sample and Setting*

For the primary study, nurses were categorized as new nurses (with up to 3 years experience) and experienced nurses (more than 5 years experience). This categorizing was based on research from Benner et al. (1996) that theorized the amount of time needed to develop expertise in an area. Nurses with greater than 5 years of experience may have developed expertise in their area (Benner et al). These nurses were selected by convenience sampling. If they met the inclusion criteria of having up to 3 years of experience or greater than 5 years of experience on a participating nursing unit, they received questionnaires.

In the primary study, subjects were recruited from both urban and rural, acute care settings in two large health regions in Saskatchewan and Alberta. The Saskatoon Health Region, the largest health region in the province of Saskatchewan, serves 289,000 residents in 10

hospitals, 29 long term care facilities, and many primary health care centres and employs 11,500 registered nurses and other health care workers (Saskatoon Health Region, 2008). In comparison, the Capital Health Region in Alberta provides services to 1 million residents in the Edmonton area through 13 hospitals and two primary health care centres and employs 9,000 nurses, including registered nurses (Capital Health, 2008).

Lists of registered nurses who worked full time or part time with full time hours were obtained through nurse managers on nursing units within participating health regions.

Participants were selected via convenience sampling. It did not matter if the recruited subjects were involved in a mentoring relationship. The primary study examined mentoring perceptions regardless of whether or not the nurse was in a mentoring relationship. Since new nurses are commonly employed in hospital settings in areas such as medical, surgical, obstetric, paediatric, and psychiatric units, these units were utilized for the study (Bowles & Candela, 2005). In the rural settings, where smaller hospitals exist, the hospital itself was considered a single unit and a sample of all of the nurses was taken.

In the primary study, the sample size was estimated using a power analysis. Eighty-four participants were needed in each group, new nurses and experienced nurses, to provide a power of .8, moderate effect size of .3, and a two-tailed alpha of .05 (Cohen & Cohen, 1983). The questionnaire needed to be disseminated to at least 168 nurses from each group because a 50% response rate was expected (Dillman, 2000).

Inclusion criteria for the primary study included new and experienced nurses from urban and rural, acute care facilities in Saskatchewan and Alberta. Inclusion criteria for the descriptive correlational study included all participants who were included in the primary study.

### *3.4 Ethical Considerations*

An ethical exemption was obtained from the University of Saskatchewan Behavioural Research Ethics Board. The research proposal, including appendices, was submitted for ethical exemption. All data obtained from the descriptive correlational study will be stored by the thesis supervisor, Dr. Linda Ferguson, in a locked cupboard at the University of Saskatchewan for 5 years. The primary study received ethical approval from the University of Saskatchewan Behavioural Research Ethics Board (approval number Beh/BSC 06-174), the University of Alberta Human Research Ethics Board, and the participating health regions in Saskatchewan and Alberta.

### *3.5 Instruments*

The instrument used in the primary study was a combination of several mentoring and work-life scales. The format of the instrument was a Likert scale questionnaire. The combined scale was a 49 item Likert scale for experienced nurses and a 97 item Likert scale for the new nurses and each were a part of a larger questionnaire. The scales that were assessed in the analysis of a subset of the data are discussed here only.

In the primary study, two questionnaires were completed; one for experienced nurses and one for newer nurses (see Appendixes B and C, respectively. The shaded areas in the questionnaires were not analyzed in the analysis of a subset of the data). The questionnaire took 20 to 30 minutes to complete. The first section of each of the questionnaires was the demographic data section. Demographic data pertaining to the descriptive correlational study is discussed here only. Demographic data included the participant's age, educational level, gender, years of experience on the current nursing unit and previous units, and certification information.

One of the scales in the experienced nurse questionnaire included the Expected Costs and Benefits to Being a Mentor scale created by Ragins and Scandura (1999). This 41 item scale was used to assess the potential mentors' perceptions of the costs and benefits involved in becoming a mentoring. An alpha coefficient of .83 was noted for the "costs" scale and an alpha coefficient of .89 was noted for the "benefits" scale (Ragins & Scandura). A discussion of content validity through representatives from the business population and discriminant analysis was also included for this scale. The second scale was the modified Willingness to Mentor scale created by Ragins and Cotton (1993). This eight item scale was used to determine an individual's likeliness to mentor and included an "intention" to mentor and "drawbacks" to mentor section. The "intention" subscale assessed the individual's overall willingness to mentor and the "drawback" subscale assessed perceived drawbacks when undertaking a mentor role. An alpha coefficient of .81 and .83 respectively was noted for each section of the scale (Ragins & Cotton). A coefficient of .7 is considered acceptable for a newly developed tool and these instruments were above the requirements (Burns & Grove, 2005). The creators of this scale did not discuss validity of their instrument.

The scales included in the new nurse questionnaire comprised of five scales. The Mentor Functions scale by Scandura and Ragins (1993) incorporated 15 items that explored satisfaction with current self-defined mentoring relationships and measured protégé outcomes in three spheres: "career development", "psychosocial support", and "role modeling". The "career development" subscale assessed the perception of the coaching function of the mentor. The "psychosocial support" subscale measured the perceived friendship function of the mentorship. Assessment of the perceived protégé modeling of the mentor was measured in the "role modeling" subscale. Construct validity was addressed using factor analysis for the Mentor

Functions Scale. Alpha coefficients for the three spheres ranged from .70 to .81 (Scandura & Ragins).

The 33 item Mentor Role Instrument (Ragins & McFarlin, 1990) was used to assess mentor role functions including “career development”, “psychosocial”, “parent”, and “social” roles. The “career development” subscale assessed perceptions of the mentor’s role in the professional advancement of the protégé within the organization. Career development characteristics included sponsorship, coaching, protection, challenging assignments, and exposure. The “psychosocial” subscale assessed perceptions of the mentor’s role in advancing the interpersonal development of the protégé and included characteristics such as friendship, role modeling, counselling, and acceptance. The “parental” subscale assessed perceptions of the mentor’s role as a parental figure for the protégé and the “social” subscale measured perceptions of the mentor and the protégé socializing outside of the work environment. Construct validity was addressed by performing a factor analysis and coefficient alphas ranging from .63 to .91 were noted (Ragins & McFarlin).

The Mentor Satisfaction Scale (Ragins & Cotton, 1999) had four items and assessed the protégé’s satisfaction with the mentor and had a coefficient alpha of .83. There was no discussion of validity for this scale. As in the experienced nurse questionnaire, the Expected Costs and Benefits to Being a Mentor scale (Ragins & Scandura, 1994) was utilized to assess the perceptions of cost and benefits of mentoring. Four items from the modified Willingness to Mentor scale created by Ragins and Cotton (1999) were used as well to determine an individual’s likeliness to mentor considering “intention” to mentor and “drawbacks” to mentor.

To summarize, the coefficients for the scales used in the new nurse questionnaire ranged from .63 to .91 in the business literature. In some scales the coefficients dropped below the

acceptable value of .7. However, because each scale had a range of coefficient values including ones that crossed over into the acceptable range, these scales were still utilized. The researcher took the lower coefficient values into consideration when analyzing the data.

For the primary study, a pilot test of each questionnaire was completed by a small group of registered nurses. Modifications were made in terms of readability and comprehension of the questions and information letter. The pilot test was done because these questions had been developed and tested in business contexts and had been amalgamated into one questionnaire. In addition, the primary researchers were able to determine how long it took to complete the questionnaires.

### *3.6 Procedure*

Approximately 36 nursing units in two health regions, at least one urban and one rural, in each province was involved. Following ethics approval, the principal investigator, co-investigators, and research assistants in the primary study approached nurse managers on the nursing units to categorize registered nurses as new or experienced, according to the inclusion criteria. The questionnaires were delivered to the nursing unit and placed in the employee's mailbox by staff or researchers and the questionnaires were mailed to rural units and distributed by nursing managers. The participants read the information sheet provided, voluntarily completed the questionnaire, and mailed it back to the researchers in postage-paid, anonymous envelopes. To encourage a high response rate postage-paid envelopes and follow-up reminders were distributed to participating nursing units (Dillman, 2000).

### *3.7 Analytical Procedures*

Data were coded and entered into the Statistical Package for the Social Sciences-Version 15 (SPSS) software. Next, it was checked for errors using frequency runs. Any inconsistencies

were checked against the original questionnaire and resolved. Analysis of the data was completed using SPSS. An exploratory analysis of the data was performed (Burns & Grove, 2005). Descriptive analyses including mode for nominal variables, measures of central tendency (median and mean for continuous variables), and measures of dispersion (standard deviation, range, proportion) were calculated, as appropriate, for the data on age, educational level, gender, years of nursing practice on the current nursing unit, total length of nursing employment, certification information, and all scales. The stratified samples of the primary study were combined into one sample in the analysis for the descriptive correlational study. In addition, the relationships between various levels of nursing experience and mentoring perceptions were examined. Analyses included T-tests on gender, basic RN education, national certification, and whether subjects were currently being mentored or had mentored a newer nurse with all mentoring perception scales. A bivariate correlational analysis was completed using Pearson's correlation coefficient (two tailed), at an alpha of .05, examining age and all mentoring perception scales.

Analysis of variance (ANOVA) was performed on four variables with all mentoring perceptions scales: the highest level of completed education in nursing, the highest level of completed education in another discipline, years of nursing practice on the current unit, and years of nursing practice in total. If significant main effects were identified, post-hoc analyses were completed to determine where the groups differed significantly. Unequal sample sizes were present for all groups. For post hoc analysis of significant F values for ANOVAs, the Scheffe method was used if the differences in homogeneity of variances were non-significant. To determine homogeneity of variance, the Levene's test was performed prior to each post hoc analysis. Homogeneity of variance meant that the spread of scores among each group mean were



similar (Field, 2005). The Scheffe method is a very conservative post hoc test and is used quite frequently (Vincent, 2005). If the homogeneity of variances was significantly different, the Games-Howell procedure was used. This method offered the best performance when variances were different (Field; Games & Howell, 1976).

Newer nurses completed three scales that experienced nurses did not complete. When performing the ANOVAs on the scales specific to newer nurses, experienced nurses were filtered out of the sample and not considered in the analysis. Experienced nurses were filtered out for the variables for years of nursing practice on the current unit, years of nursing practice in total, highest level of completed education in nursing, and highest level of completed education in another discipline for the scales specific to newer nurses.

Furthermore, in some instances a main effect was noted for some of the scale variables in the ANOVA. However, when post hoc analysis was completed on these variables, no significant differences were noted. This could be due to a combination of dependent variables, a combination of groups, or a combination of both dependent variables and groups that lead to the significant F value. It possibly could have been a Type I error (L. McIntyre, personal communication, May 1, 2008).

## CHAPTER 4

### Results

#### *4.1 Introduction*

A descriptive correlational study was completed for an analysis of a subset of the pre-workshop data gathered from the research of Ferguson et al. (2006). The research questions included what is the relationship between age and mentoring perceptions, what is the relationship between years of nursing practice and mentoring perceptions, what is the relationship between education level and mentoring perceptions, and what is the relationship between gender and mentoring perceptions? Mentoring perceptions included perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships. Prior to conducting the analyses to examine the research questions, descriptive statistics were conducted in order to describe basic sample characteristics of the acute care clinical nurses. Also, all scales and responses were checked for normal distribution so that the appropriate parametric tests could be completed. All data were normally distributed.

#### *4.2 Response Rate*

A total of 424 questionnaires were sent out to experienced nurses and 353 questionnaires to newer nurses within the Capital Health Region and Saskatoon Health Region. In total, 124 experienced nurses and 80 newer nurses responded. The overall response rate for the experienced nurses was 29% and the response rate for the newer nurses was 23%.

#### *4.3 Demographics*

The Saskatoon Health Region had the most study participants (n=152, 74.5%) as compared with the Capital Health Region (n=52, 25.5%) (See Table 4.1). In this study, there

were 13 different employing institutions from the two health regions. The total individual nursing units involved in the study were 52.

**Table 4.1 Division of Participants by Employing Health Region**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Saskatoon Health Region	152	74.5	74.5	74.5
	Capital Health	52	25.5	25.5	100.0
	Total	204	100.0	100.0	

The greatest percentage of nurses were employed on their current unit for 5 to 10 years (n=34, 16.7%) and the greatest number of years of total employment was more than 25 years (n=42, 20.6%). See Tables 4.2 and 4.3 for a description of the ranges of years of nursing practice on the current unit and in total. Different categories for years of nursing practice were offered to new and experienced nurses in their respective questionnaires. Tables 4.2 and 4.3 reflect a combination of those time frames and thus the time periods differed in length.

**Table 4.2 Description of Years of Nursing Practice on Current Unit**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 to 6 months	27	13.2	13.3	13.3
	6 to 12 months	17	8.3	8.4	21.7
	1 to 2 years	22	10.8	10.8	32.5
	2 to 3 years	21	10.3	10.3	42.9
	3 to 5 years	18	8.8	8.9	51.7
	5 to 10 years	34	16.7	16.7	68.5
	10 to 15 years	17	8.3	8.4	76.8
	15 to 20 years	17	8.3	8.4	85.2
	20 to 25 years	14	6.9	6.9	92.1
	More than 25 years	16	7.8	7.9	100.0
	Total	203	99.5	100.0	
Missing	System	1	.5		
Total		204	100.0		

**Table 4.3 Description of Years of Nursing Practice in Total**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 1 year	28	13.7	13.7	13.7
	1 to 2 years	17	8.3	8.3	22.1
	2 to 3 years	13	6.4	6.4	28.4
	Less than 3 years*	1	.5	.5	28.9
	3 to 5 years	15	7.4	7.4	36.3
	5 to 10 years	24	11.8	11.8	48.0
	10 to 15 years	20	9.8	9.8	57.8
	15 to 20 years	21	10.3	10.3	68.1
	20 to 25 years	23	11.3	11.3	79.4
	More than 25 years	42	20.6	20.6	100.0
	Total	204	100.0	100.0	

\* Category offered only in experienced nurse questionnaire.

Basic RN education was nearly equal between diploma (n=105, 51.5%) and baccalaureate (n=99, 48.5%) education. Baccalaureate was slightly greater as the highest level of completed education (n=111, 54.5%) as compared with diploma (n=88, 43.1%) and master's (n=5, 2.5%). When asked if the nurses were currently enrolled in a nursing education program, 5.9% (n=12) were currently enrolled. When asked to further specify which education program they were in, 3.4% (n=7) stated they were enrolled in a post-registration bachelor of science in nursing program, 1.5% (n=3) stated they were enrolled in a master's in nursing program, .5% (n=1) stated he/she was registered in a primary care nurse practitioner course, and 94.1% (n=192) were not currently registered in a nursing program. When nurses were asked about the highest level of completed education in another discipline, 74.8% (n=151) did not have any other

completed education, 13.4% (n=27) stated diploma, 10.4% (n=2) stated baccalaureate, 1.5% (n=3) stated master's (n=2 missing). There was a small percentage of nurses who had national level certification (6.9%, n=14), while the remainder did not have certification (93.1%, n=190).

Table 4.4 describes the different areas of certification that the nurses obtained.

**Table 4.4 Description of Certification Area**

		Frequency	Percent
Valid	Not Certified in a Specialty Area	191	93.6
	Emergency Nursing	2	1.0
	Perioperative	1	.5
	NCC (American) Neonatal Nurse Practitioner	3	1.5
	CCRN (American Critical Care Nursing)	1	.5
	Critical Care	3	1.5
	Nephrology Nursing (CNeph-c)	2	1.0
	Neuroscience Nursing	1	.5
	Total	204	100.0

When asked if the nurses were currently working in their area of certification, 5.9% (n=12) stated “yes” and 1.5% (n=3) stated “no” (92.6%, n=189 stated “not applicable”). The nurses were asked how long they have held their certification; 4.4% (n=9) stated over 5 years, 2.0% (n=4) stated 1 to 3 years, .5% (n=1) stated 3 to 5 years (93.1%, n=190 stated not applicable).

All participants were asked if they had mentored a nurse during their career; 57.4% (n=117) stated “yes” and 42.6% (n=87) stated “no”. Table 4.5 describes the frequency and percentages of nurses having mentored a nurse previously. The participants with less than three years of experience were asked if they had been or were currently being mentored, 61.3% (n=49) stated “no” and 38.8% (n=31) stated “yes”. Table 4.6 describes the frequency of newer nurses being mentored.

**Table 4.5 Frequency of Having Mentored a New Nurse**

		Frequency	Percent
Valid	Yes	117	57.4
	No	87	42.6
	Total	204	100.0

**Table 4.6 Frequency of Newer Nurses Being Mentored**

		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	31	38.8	38.8
	No	49	61.3	100.0
	Total	80	100.0	

Nurses were asked to self disclose their gender, 92.5% (n=186) were female and 7.5% (n=15) were male (n=3 missing). For the participants that completed the newer nurse questionnaire, there were 6 males and 74 females. The experienced nurses comprised of 9 males and 112 females (n=3 missing). The participants were asked to write their birth year. The mean year of birth for new and experienced nurses together was 1969 and the mode was 1982. For the

individuals that completed the newer nurse questionnaires, the mean was 1978 and it was bimodal at 1982 and 1983. For the experienced nurses, the mean and the mode were 1963.

#### *4.4 Mentoring Perception Scales*

Section 3.5 provided a general description of all scales and subscales. Cronbach alpha reliability was performed on all scales. Reliability examines how consistently the measurement technique measures the concept of interest (Burns & Grove, 2005). Reliability for the Expected Costs and Benefits to Being a Mentor Scale (Ragins & Scandura, 1999) was divided into two portions. The “cost” section of the scale was established at .876 and the “benefits” section of the scale was .884. The Mentor Role Instrument (Ragins & McFarlin, 1990) was divided into the 11 specified sections for reliability testing and Cronbach alpha ranged from .539 to .903 with only three going below the accepted level of .700. The Willingness to Mentor Scale created by Ragins and Cotton (1993) was divided into “drawbacks” and “intentions”. Cronbach alpha for the “drawback” section was .365 and for the “intention” section was .946. The Mentoring Functions Scale by Scandura and Ragins (1993) was divided into three sections for the reliability analysis: psychosocial support, career development, role modeling. Psychosocial support had an alpha of .831, career development obtained .891, and role modeling was .771. Finally, the Mentor Satisfaction Scale (Ragins & Cotton, 1999) obtained a Cronbach alpha of .787.

Both new and experienced nurses completed the Expected Costs and Benefits to Being a Mentor Scale (Ragins & Scandura, 1999) and the Willingness to Mentor Scale (Ragins & Cotton, 1993). Only the newer nurses completed the Mentor Role Instrument (Ragins & McFarlin, 1990), the Mentoring Functions Scale (Scandura & Ragins, 1993), and the Mentor Satisfaction Scale (Ragins & Cotton, 1999). The scales were organized so that the lower the score chosen, the



more the participant agreed and the higher the score chosen, the more the participant disagreed with the statement.

With regards to the Expected Costs and Benefits to Being a Mentor Scale (Ragins & Scandura), the scale was composed of a “costs” and “benefits” section. The minimum and maximum scores to be possibly obtained were 17 and 68 respectively for the “cost” section. The lower the score on the “cost” scale, meant the participant believed that there were greater costs to mentoring. For the “benefits” component, the minimum and maximum scores to be obtained were 24 and 96 respectively. The lower the score on the “benefits” scale meant the participant believed that there were greater benefits to mentoring. On average, the mean scores for the “cost” and “benefits” section were both 52. See Table 4.7 for a description of the scale scores.

**Table 4.7 Description of Costs and Benefits Scale Scores**

		Costs	Benefits
N	Valid	168	165
	Missing	36	39
Mean		52.47	52.58
Std. Deviation		7.11	8.53
Minimum		34.00	27.00
Maximum		68.00	79.00

For the Mentor Role Instrument (Ragins & McFarlin, 1990), there were 11 categories with three questions in each category giving a minimum score of three and a maximum score of 21 for each category. The most agreed upon perceptions of the roles of the mentor included a “friend”, a “challenger”, and one that “accepts the protégé”. On average, the categories that

participants disagreed with as the role of the mentor included a “parental” figure, a “social” figure, and a “protector”. See Table 4.8 for a description of the scale scores.

**Table 4.8 Description of Sub-Scale Scores for Mentor Role Instrument for Newer Nurses**

Mentor Role Instrument		sponsor	coach	protect	challenge	exposure	friend	social	parent	role model	counsel	accept
N	Valid	75	75	71	75	75	75	75	73	75	75	75
	Missing	5	5	9	5	5	5	5	7	5	5	5
	Mean	11.37	8.24	13.22	6.23	10.32	5.85	15.01	16.32	8.33	7.67	6.59
	SD	3.91	2.86	4.05	2.76	3.80	3.03	4.17	4.44	3.45	3.08	2.96
	Min	3	3	3	3	3	3	8	5	3	3	3
	Max	21	15	21	16	19	18	21	21	17	16	17

The Mentoring Functions Scale by Scandura and Ragins (1993) consisted of three categories. The minimum and maximum values for the “psychosocial support” function were 5 and 35 respectively. The mean value for “psychosocial support” was 20.1, indicating that participants’ were less likely to agree that psychosocial support was a priority function for the mentor in the relationship. Minimum and maximum values for the “career development” were 6 and 42. The mean value in this study was 17.2. This could indicate that this function of the mentor was somewhat important to the participants. Finally, 4 and 28 were the minimum and maximum values for the “role modeling” section of the scale. For this section of the questionnaire, the mean value was 8.7 possibly indicating that this was one of the more important functions of the mentor in the relationship. See Table 4.9 for a description of the scale scores.

**Table 4.9 Description of Sub-Scale Scores for Mentor Functions Scale for Newer Nurses**

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Mentor Function Scale		Psychosocial	Career	Role Model
N	Valid	76	74	76
	Missing	4	6	4
Mean		20.11	17.22	8.68
Std. Deviation		6.47	7.14	3.38
Minimum		7.00	6.00	4.00
Maximum		35.00	38.00	22.00

---

The minimum score for the Mentor Satisfaction Scale (Ragins & Cotton, 1999) was 4 and the maximum score was 28. The mean score was 8.9. This score may indicate that participants were generally satisfied with their mentor. See Table 4.10 for a description of the scale scores.

**Table 4.10 Description of Mentor Satisfaction Scale Scores for Newer Nurses**

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		Mentor Satisfaction
N	Valid	71
	Missing	9
Mean		8.92
Std. Deviation		4.03
Minimum		4.00
Maximum		22.00

---

The Willingness to Mentor Scale (Ragins & Cotton, 1993) had slightly different components for the new nurse questionnaire and the experienced nurse questionnaire. The experienced nurses completed eight questions on willingness to mentor whereas the newer nurses completed four questions on willingness to mentor. The minimum and maximum scores for the experienced nurses were 8 and 32 respectively. The newer nurses' values were 4 and 16. The mean score for experienced nurses was 15.7 and newer nurses was 6.7, indicating that both groups are willing to mentor with newer nurses more willing. See Table 4.11 for descriptive statistics for each of the scales.

**Table 4.11 Description of Willingness to Mentor Scale Scores**

		Experienced Nurses Willingness to Mentor	Newer Nurses Willingness to Mentor
N	Valid	112	77
	Missing	12	3
Mean		15.73	6.68
Std. Deviation		5.36	2.11
Minimum		8.00	4.00
Maximum		31.00	12.00

#### *4.5 Relationship Between Age and Mentoring Perceptions*

The relationship between age and mentoring perceptions was examined by Pearson's correlation coefficient using a two tailed probability. The Mentor Function Scale (Scandura & Ragins, 1993) yielded one significant result on the "psychosocial" perspective of the scale. As the age of the participants increased, the more they agreed that the mentor played a psychosocial

function in the relationship ( $r = -.233, p = .044$ ). See Table 4.12 for the significant correlation between age and mentoring perceptions.

**Table 4.12 Correlation: Age and Mentoring Perceptions**

		Year of Birth
<b>Mentor Functions Scale</b>		
Psychosocial Mentor Function	Pearson Correlation	-.233(*)
	Sig. (2-tailed)	.044
	N	75

\* Correlation is significant at the 0.05 level (2-tailed).

#### *4.6 Relationship Between Years of Nursing Practice and Mentoring Perceptions*

##### *4.6.1 Years of Nursing Practice on Current Unit*

An ANOVA was completed to examine the relationship between years of nursing practice on the current unit and mentoring perceptions. Table 4.13 describes the significant results of the ANOVA examining years of nursing practice on the current unit and mentoring perceptions. A main effect was noted for the “costs” section of the Costs and Benefits Scale (Ragins & Scandura, 1999) [ $F(9, 157) = 2.095, p = .033$ ]. However, when post hoc analysis was completed, there were no significant results noted. Subsequently, the group means were examined and provided details as to which particular group believed there were more “costs” to mentoring. Nurses working 10 to 15 years (mean = 48.500) and 20 to 25 years (mean = 48.200) believed there were most “costs” to mentoring as compared to the rest of the group. Conversely, nurses with three to five years of experience (mean = 56.100) and up to six months of experience (mean = 54.500) believed that there were less “costs” to mentoring than the rest of the group. See Table 4.14 for a list of group means on the “costs” scale.

A main effect was noted for the Mentor Satisfaction Scale (Ragins & Cotton, 1999) [ $F(3,67) = 2.893, p = .042$ ]. Significant results were not obtained when performing the post hoc analysis. Therefore, group means were examined. Nurses employed up to six months on their

unit were most satisfied with their mentor (mean = 7.333) and nurses with one to two years of experience were least satisfied with their mentor (mean = 10.632). See Table 4.15 for a list of group means on the Mentor Satisfaction Scale.

A main effect was noted for the Willingness to Mentor Scale (Ragins & Cotton, 1993) [ $F(7, 103) = 3.076, p = .006$ ]. However, when post hoc analyses were completed, there were no significant results noted. Thus, examination of group means was conducted. Nurses with three to five years of nursing practice on the current unit were most willing to mentor (mean = 12.889) and nurses with 20 to 25 years (mean = 20.000) and greater than 25 years (mean = 18.000) were least willing to mentor. See Table 4.16 for a list of group means on Willingness to Mentor Scale.

**Table 4.13 ANOVA: Years of Nursing Practice on Current Unit and Mentoring**

**Perceptions**

	F	df Between Groups	df Within Groups	Sig.
<b>Costs/Benefits Scale</b>				
“Costs” Scale	2.095	9	157	*.033
<b>Mentor Satisfaction Scale</b>				
Mentor Satisfaction	2.893	3	67	*.042
<b>Willingness to Mentor Scale</b>				
Experienced Nurse	3.076	7	103	*.006

\*Significance level  $p < .05$ .

**Table 4.14 Means: “Costs” Scale**

Length Employed as RN on Unit	Mean	N	Std. Deviation
0 to 6 months	54.500	22	6.759
6 to 12 months	53.933	15	5.861
1 to 2 years	53.765	17	7.085
2 to 3 years	50.412	17	5.896
3 to 5 years	56.118	17	7.582
5 to 10 years	52.741	27	8.041
10 to 15 years	48.500	14	7.573
15 to 20 years	52.333	15	7.158
20 to 25 years	48.200	10	4.541
More than 25 years	50.539	13	6.280
Total	52.455	167	7.124

**Table 4.15 Means: Mentor Satisfaction Scale**

Length Employed as RN on Unit	Mean	N	Std. Deviation
0 to 6 months	7.333	21	2.817
6 to 12 months	9.857	14	3.302
1 to 2 years	10.631	19	5.002
2 to 3 years	8.177	17	3.988
Total	8.916	71	4.028

**Table 4.16 Means: Experienced Nurse Willingness to Mentor Scale**

Length Employed as RN on Unit	Mean	N	Std. Deviation
3 to 5 years	12.889	18	4.057
5 to 10 years	15.931	29	4.743
10 to 15 years	14.563	16	4.442
15 to 20 years	16.188	16	5.588
20 to 25 years	20.000	11	6.899
More than 25 years	18.000	15	5.657
Total	16.262	105	5.383

*4.6.2 Years of Nursing Practice in Total and Mentoring Perceptions*

An ANOVA was completed comparing years of nursing practice in total with all mentoring perception scales. There were no significant results found. Therefore, years of nursing practice in total may not have an influence on mentoring perceptions.

*4.7 Relationship Between Previous Mentoring Experience and Mentoring Perceptions*

A T-test was completed to determine whether prior experience mentoring a new nurse impacted mentoring beliefs. Two significant results were found within the Mentor Role Scale (Ragins & McFarlin, 1990). Significant results were established within the “parental” role and the “counselling” role sub-scales. Nurses who had mentored disagreed more strongly that there was a “parental” role of the mentor [t(71) = 2.034, p = .046]. Nurses who had not mentored agreed more strongly that a role of the mentor was “counselling” [t(73) = 2.258, p = .027]. The “psychosocial” and “role model” functions were significant in the Mentor Functions Scale (Scandura & Ragins, 1993). Participants that had not mentored agreed more strongly that the mentor provided a “psychosocial” [t(74) = 3.243, p = .002] and “role model” [t(74) = 2.616, p =



.026] function in the mentorship. Significant results were found between previous mentoring experience and the Willingness to Mentor Scale (Ragins & Cotton, 1993). Participants that completed either the experienced nurse [ $t(110) = -3.282, p = .001$ ] or new nurse [ $t(75) = -3.005, p = .004$ ] Willingness to Mentor Scale and stated that they had mentored a new nurse were more willing to mentor. Table 4.17 describes all significant relationships between having previously mentored a new nurse and mentoring perceptions.

**Table 4.17 T-Test: Having Mentored a New Nurse and Mentoring Perceptions**

	Mentored a New Nurse During Career	Mean	Std. Deviation	t	Sig. (2 tailed)
<b>Mentor Role Scale</b>					
Parental Mentor Role	Yes	17.667	3.762	2.034	*.046
	No	15.521	4.656		
Counselling Mentor Role	Yes	8.679	3.507	2.258	*.027
	No	7.064	2.650		
<b>Mentor Functions Scale</b>					
Psychosocial Mentor Function	Yes	23.071	6.283	3.243	*.002
	No	18.375	5.977		
Role Model Mentor Function	Yes	9.964	4.203	2.616	*.011
	No	7.938	2.563		
<b>Willingness to Mentor Scale</b>					
Experienced nurse willingness to mentor	Yes	14.768	5.022	-3.282	*.001
	No	18.367	5.449		
Newer nurse willingness to mentor	Yes	5.793	1.656	-3.005	*.004
	No	7.208	2.183		

\*Significance level  $p < .05$

#### 4.8 Relationship Between Having Been Mentored and Mentoring Perceptions

T-tests were used to compare those subjects that had been or were currently being mentored with mentoring perceptions. A significant finding was found in the Willingness to Mentor Scale (Ragins & Cotton, 1993). Only newer nurses were asked about having been mentored or currently being mentored. Nurses that completed the newer nurse Willingness to Mentor Scale (Ragins & Cotton) and stated they had been mentored were more willing to mentor [ $t(75) = -2.685, p = .009$ ]. See Table 4.18 for the significant result between having been mentored and mentoring perceptions.

**Table 4.18 T-Test: Having Been Mentored and Mentoring Perceptions**

	Has Subject Been Mentored or Currently Being Mentored	Mean	Std. Deviation	t	Sig. (2 tailed)
<b>Willingness to Mentor Scale</b>					
Newer Nurse Willingness to Mentor Scale	Yes	5.90	1.668	-2.685	*.009
	No	7.17	2.220		

\*Significance level  $p < .05$ .

#### 4.9 Relationship Between Education Level and Mentoring Perceptions

##### 4.9.1 Basic RN Education and Mentoring Perceptions

A T-test was used to examine the relationship between basic RN education and mentoring perceptions. No significant results were identified. Therefore, there was no difference between diploma and degree-prepared nurses' perceptions of mentoring.

##### 4.9.2 Highest Level of Completed Education in Nursing and Mentoring Perceptions

An ANOVA was completed to examine the relationship between highest level of completed education in nursing with all mentoring perception scales. No significant results were

found. Therefore, there was no significant difference between a diploma, degree, or masters-prepared nurse's mentoring perceptions.

#### 4.9.3 Highest Level of Completed Education in Another Discipline and Mentoring Perceptions

An ANOVA was completed to compare mean differences between levels of completed education in another discipline (none, diploma, baccalaureate, masters) and mentoring perceptions. A main effect [ $F(3,160) = 3.331, p = .021$ ] and a significant post-hoc were found for the "benefits" section of the Cost and Benefits Scale (Ragins & Scandura, 1999). Nurses that had a baccalaureate degree in another discipline more strongly agreed that there were more benefits to mentoring as compared with their diploma counterparts. See Tables 4.19 and 4.20 to see the significant main effect and post-hoc results.

**Table 4.19 ANOVA: Highest Level of Completed Education in Another Discipline and Mentoring Perceptions**

	F	df Between Groups	df Within Groups	Sig.
<b>Cost/Benefits Scale</b>				
Benefits Sub Scale	3.331	3	160	.021*

\*Significance level  $p < .05$

**Table 4.20 Post Hoc: Highest Level of Completed Education in Another Discipline and Mentoring Perceptions**

Dependent Variable	(I) Highest Level of Complete Education in Another Discipline	(J) Highest Level of Complete Education in Another Discipline	Mean Difference (I-J)	Std. Error	Sig.
<b>Cost/Benefits Scale</b>					
Benefits Scale	Scheffe	Diploma	Baccalaureate	8.080(*)	2.767 .040

\* The mean difference is significant at the .05 level

#### *4.9.4 Certification and Mentoring Perceptions*

There was an inadequate sample size of newer nurses that had certification and who completed the questionnaire (n = 2). Of those two nurses, neither completed the whole questionnaire. Therefore, for the analysis of certification and mentoring perceptions, only two scales, the Costs and Benefits Scale (Ragins & Scandura, 1999) and the Willingness to Mentor Scale (Ragins & Cotton, 1993) could be used for the T-test. There were no significant results found between the two mentoring scales and certification.

#### *4.10 Relationship Between Gender and Mentoring Perceptions*

To examine the relationship between gender and mentoring perceptions, a T-test was completed. There were no significant findings. Therefore, gender does not have an impact on mentoring perceptions.

#### *4.11 Summary*

A descriptive correlational design was completed examining relationships between age, years of nursing practice, education level, and gender with mentoring perceptions. A discussion of scale reliability and demographic descriptions were given prior to the analysis. Several significant results were identified and will be discussed in greater detail in the discussion section.

## CHAPTER 5

### Discussion

#### *5.1 Introduction*

This descriptive correlational study examined specific demographic variables of registered nurses and their mentoring perceptions. Although the response rate was low, on average the demographic information approached national averages with the exception of percentages of baccalaureate-prepared nurses (CIHI, 2007). The research questions included what is the relationship between age, years of nursing practice, education level, and gender with mentoring perceptions including perceived costs and benefits to mentoring, willingness to mentor, mentoring functions of coworkers, and satisfaction with current mentoring relationships? Strengths and limitations of the study were noted. Recommendations for encouraging mentoring relationships and future research were suggested.

#### *5.2 Response Rate*

Initially, the number of newer nurse respondents was small (16%). The researchers re-recruited newer nurses from the Saskatoon Health Region by disseminating questionnaires again to all newer nurses to encourage a larger response rate. The number of newer nurse respondents increased to 80 and experienced nurse respondents was 124. The response rate for experienced nurses was 29% and the response rate for newer nurses was 23%. Questionnaire response rates are generally low particularly if the questionnaire is mailed out (Burns & Grove, 2005). A normal expected response rate is 50% (Dillman, 2000) and if mailed out, the response rate is 25% to 30% (Burns & Grove). Questionnaires were left in staff mailboxes or with the unit manager. Furthermore, questionnaires were sent via mail to the rural facilities. Methods were

utilized to encourage a high response rate including pre-addressed, postage paid questionnaires and reminder cards.

### *5.3 Demographics*

According to CIHI (2007), the percentage of male RNs in Canada was 5.6% and female RNs was 94.4%. This study had a higher percentage of male RNs than the national average. The average age of a Canadian RN working in a hospital setting was 43.4 years (CIHI) and the average age of a Saskatoon Health Region RN was 43.7 years (Saskatoon Health Region, 2006). The results of the current study showed a mean age of 39 years with a birth year of 1969. Therefore, the participants, on average, were a younger cohort than the national and health region averages. In Canada, basic RN preparation was diploma (82.4%) and baccalaureate (17.6%) (CIHI). More specifically, the percentages of nurses with initial education in nursing as baccalaureate were 28.7% for Alberta and 25.1% for Saskatchewan (CIHI). In this study, basic RN education was nearly equal between diploma (n=105, 51.5%) and baccalaureate (n=99, 48.5%) education. This large discrepancy could be based on the fact that Saskatchewan had moved to baccalaureate degree as the entry to practice in 2000 and in recent years, most of the nurses in Alberta have been educated at the baccalaureate level.

CIHI (2007) reported that 5.2% of RNs have CNA certification. In this study 6.9% of RNs had national level certification. The numbers for the current study were elevated because United States certification programs were included in the total. In addition, some nursing units are supporting nurses for CNA certification as a retention strategy.

The highest level of completed education in nursing in Canada was as follows: Diploma 64.8%, Baccalaureate 33.3%, Masters 2.5% (CIHI, 2007). This study found that 43.1% (n=88) of nurses obtained a diploma as the highest level of completed education in nursing. Baccalaureate

prepared nurses as the highest level of completed education in nursing consisted of 54.4% (n=111) of the sample. Finally, masters prepared nurses constituted 2.5% (n=5) of the sample. The increase in baccalaureate-prepared nurses in the sample may be due to the fact that the majority of Alberta and all of Saskatchewan have moved to a baccalaureate degree as entry to practice. Although the current study met the national average for masters prepared nurses, the comparison must be re-considered. The masters percentage, in the clinical nurse population, may have been different because nurses who have their masters commonly do not work at the bedside and the CIHI study included nurses from all backgrounds/workplaces whereas this study only examined acute care clinical nurses. Therefore, the national average for masters prepared acute care clinical nurses may be lower than 2.5 %.

#### *5.4 Relationship Between Age and Mentoring Perceptions*

There was a negative correlational relationship between age and the “psychosocial” function within the Mentor Functions Scale (Scandura & Ragins, 1993). The scales were reverse scored, therefore the correlation found was as the age of the participants increased, the more they agreed the mentor played a psychosocial function in the relationship. This scale was found in the newer nurse questionnaire. A psychosocial function in the mentorship was commonly described in the literature (Finkelstein et al., 2003; Kram, 1983; Milner & Bossers, 2004; Scandura & Ragins). Kram stated that psychosocial functions included role modeling, acceptance, counselling, and friendship. As the mentoring relationship progressed and the interpersonal bond intensified, the psychosocial functions of the relationship surfaced. Through this psychosocial support, the protégé gained competence and confidence and the mentor gained personal satisfaction for guiding the protégé (Kram).

According to Erikson (1963), middle-aged adults contributed to the next generation through work or creative activities or they felt a lack of purpose. This contribution allowed the individual to feel a sense of challenge or stimulation when sharing knowledge with the younger individual (Kram, 1983). Thus, older individuals in the current study may have felt that a psychosocial relationship was important because of the life stage they were in. When examining generational differences, the older participants would be classified in the “baby boomer” (born from 1946 to 1964) or “generation x” stages (born 1965 to 1980). “Baby boomers” have a strong work ethic and are lifelong learners who were focused on compensation for their work and commitment (Boychuk-Duchscher & Corwin, 2004; Stewart, 2006; Widger et al., 2007). Individuals from “generation x” were independent, outcome-focused, and considered work as a means to learn and grow (Boychuk-Duchscher & Corwin; Stewart; Widger et al.). Based on these aforementioned characteristics, participants in these categories may have felt that it was important to share their knowledge regarding the work environment and provide support to the protégé in order to allow the protégé to be able to function effectively in the workplace.

### *5.5 Relationship Between Years of Nursing Practice and Mentoring Perceptions*

#### *5.5.1 Years of Nursing Practice on Current Unit*

A main effect was noted for the “cost” section of the Costs and Benefits Scale (Ragins & Scandura, 1999). However, when post hoc analysis was completed, there were no significant results noted. Examining the means between groups provided a greater insight into perceived “costs” of mentoring. Nurses with greater years of practice on the current unit (10 to 15 years and 20 to 25 years) were more likely to perceive increased “costs” to mentoring. Examples of items from the “costs” scale were “mentoring is an energy drain”, “the major drawback to mentoring is the time commitment”, and “mentoring takes too much time away from one’s job”.



Nurses with greater years of practice on the current unit could have felt that “mentoring was an energy drain”. As the more years of experience an individual has, the older one would be. Older participants may be more physically tired by the long nursing hours. Furthermore, the additional mental challenge that mentoring entails could be considered as a source of fatigue. Older participants may feel that the mentor needs to be ready to answer questions, thus contributing to their energy drain. Furthermore, nurses with greater years of experience may be increasingly disengaged with the work environment as they start to think about retirement or moving to a different nursing unit (McNeese-Smith, 2000) and thus less likely to consider mentoring. Conversely, Kupperschmidt (2001) identified that participants with less years of practice were enthusiastic to learn in the workplace and had an optimistic energy about their work environment. “The major drawback to mentoring is the time commitment” item could have also had an influence in the increased perceived “costs” for nurses with greater years of practice. Significant time needs to be committed to fostering the mentorship (Bower, 2000; Schwiebert, Deck, & Bradshaw, 1999). Possibly, participants with greater years of nursing practice had experience with mentoring and appropriately understood the time commitment involved. Furthermore, participants with greater years of nursing practice may have agreed that “mentoring takes too much time away from one’s own job” particularly if they understood the time commitment involved in mentoring. There are numerous stressors involved with nursing in acute care environments. For example, nursing units are experiencing increased patient acuity and increased workloads with decreased staffing levels (McGowan, 2001; McVicar, 2003; Stordeur, D’Hoore, & Vandenberghe, 2001). Nurses with greater years of nursing practice may feel that there is limited time to perform their daily duties and therefore adding mentorship would further stretch their limited time and add increased stress.

As discussed earlier, nurses with greater years of experience may be classified in the “baby boomer” category. Nurses in this generation wanted to be valued and compensated for their contributions and commitment to the nursing unit (Boychuk-Duchscher & Corwin, 2004; Stewart, 2006; Widger et al., 2007). Nurses that have previously mentored and have not received any appreciation or reward for their involvement may have perceived increased costs to mentoring because there have been no benefits for them.

The Mentor Satisfaction Scale (Ragins & Cotton, 1999) produced a main effect, but post hoc analyses could not be completed. Therefore, group means were examined. Scale items included the mentor “is someone I am satisfied with”, “meets my needs”, “does not disappoint me”, and “is effective in his/her role”. Results showed that nurses with up to six months of employment were most satisfied with their mentor and nurses with one to two years of experience were least satisfied with their mentor. Nurses with up to six months of employment in a new area were classified as “advanced beginners” (Benner et al, 1996). A characteristic of this stage was to unquestioningly trust the knowledge of those more experienced. “Advanced beginners” do not have the confidence in their own judgements and actions, so they rely on the experience of others. Nurses with up to six months of employment had a strong reliance on other nurses to socialize them to the culture of the unit and the role of the nurse. These nurses lacked confidence in their own abilities and relied on the clinical knowledge of others on the current unit (Benner et al.). Therefore, the newer nurses may not be as likely to be disappointed by their mentor because they have a high reliance on them. Nurses with limited experience had many needs that must be met in order to function on that unit (Benner et al.). Furthermore, nurses would be more satisfied with their mentors if their mentors met the protégé’s needs and were effective in their role. Nurses with greater years of experience on the unit know the intricacies of

the unit and the role expected of them, so they may not need to rely on their mentor as much. Nurses with one to two years of nursing experience on the current unit, have developed confidence in their abilities and have become socialized to the unit culture. They may have had experiences of coworkers letting them down and thus might sometimes be disappointed by them or feel that the mentor does not meet their needs leading to dissatisfaction with the mentor.

A main effect was present for the Willingness to Mentor Scale (Ragins & Cotton, 1993). However, when post hoc analyses were completed, there were no significant results. Therefore, group means were examined. Nurses with three to five years of experience on the current unit were found to have a greater “willingness to mentor” a new nurse as compared with those who had 20 to 25 years and greater than 25 years of experience. This result supports Ragins and Cotton’s (1993) research in the business literature that found that newer employees expressed greater intentions to mentor than individuals who had longer employment with the organization. Newer nurses may have had experiences with being a protégé in a relationship and want to continue with mentoring others as was found in Ragins and Scandura (1999). Conversely, they may not have had a mentor and recognize that having a mentor in a new position would be beneficial. Nurses who have worked 20 to 25 years and greater than 25 years may be thinking about retirement and not want to take on the responsibility of being a mentor. Furthermore, nurses who have worked longer on the current unit tend to have more dissatisfaction, become disengaged, and are less committed to the institution (McNeese-Smith, 2000). Thus, this may result in nurses with more years of practice on the current unit not wanting to mentor.

Therefore, years of nursing practice on the current unit had an influence on mentoring perceptions. Nurses with greater years of practice perceived greater “costs” to mentoring, nurses with less years of practice were more satisfied with their mentor and were more willing to

mentor. Although these results did not reach statistical significance, they should still be considered when encouraging mentoring among nurses.

#### *5.5.2 Years of Nursing Practice in Total*

Significant results were not established when an ANOVA was completed on years of nursing practice in total and mentoring perception scales. Thus, years of nursing practice in total may not have an influence on mentoring perceptions. These findings were not consistent with Ragins and Cotton's (1993) results in the business literature that identified that individuals with greater tenure in an organization reported a decreased willingness to mentor.

#### *5.6 Relationship Between Previous Mentoring Experience and Mentoring Perceptions*

The Mentor Functions Scale (Scandura & Ragins, 1993) was utilized to assess satisfaction with current mentoring relationships and there were significant findings when examining mentor functions with previous mentoring experience. The "psychosocial" and "role model" functions were significant. Participants that had not mentored agreed more strongly that the mentor provided a "psychosocial" and "role model" function. These functions were the ones more commonly stated as the role of the mentor in the literature (Fagenson-Eland et al., 1997; Kram, 1983; Scandura, 1992; Scandura & Viator, 1994). Nurses who had mentored perhaps considered the mentoring relationship to be a more formal, professional relationship and focused less on the psychosocial aspect of it. Perhaps nurses that had not been a mentor had a more idealistic view of the mentorship. Furthermore, Kram (1983) stated that career functions emerged first in the mentorship and as the relationship progressed, psychosocial functions appeared as the interpersonal relationship became stronger. If there was great intimacy in the relationship, a friendship evolved over time (Kram). Psychosocial development was based on trust and the formation of an interpersonal relationship (Kram). Therefore, perhaps the study participants that

had mentored had not developed long term relationships that enabled the psychosocial aspects to materialize. Nurses with mentorship experiences could be more career-focused as opposed to psychosocial development-focused in the mentorship or perhaps they thought that the psychosocial aspect of the mentorship was less important.

Two significant results were found within the Mentor Role Scale (Ragins & McFarlin, 1990): “parental” role and “counselling” role. Nurses who had mentored more strongly disagreed that the mentor plays a “parental” role in the mentorship. The role of the mentor was to teach, guide, support, and develop the protégé (Greene & Puetzer, 2002). This role could be similar to a parental role; however, these participants did not see it as such. Nurses that had not mentored agreed more strongly that a role of the mentor was a “counselling” role in the mentorship. The “counselling” component was included in the psychosocial aspect of the mentoring role (Kram, 1983; Scandura & Ragins, 1993). Therefore, this result was congruent with the Mentor Functions Scale (Scandura & Ragins).

A significant finding was found within the Willingness to Mentor Scale (Ragins & Cotton, 1993). Participants that had experience being a mentor were significantly more willing to mentor in the future. These results concurred with Ragins and Cotton’s, Ragins and Scandura’s (1999), and Allen, Poteet, Russell, et al.’s (1997) findings that past mentoring experience was related to increased willingness to mentor others.

To conclude, psychosocial aspects of the mentorship were not considered a priority function or role with nurses who had previous mentoring experience. Past mentoring experiences encouraged new mentorships. In order to encourage mentoring for recruitment and retention, individuals that have not been in a mentoring relationship need to be encouraged to enter into one.

### *5.7 Relationship Between Having Been Mentored and Mentoring Perceptions*

A significant finding was found when examining the relationship between having been mentored and the Willingness to Mentor Scale (Ragins & Cotton, 1993). Willingness to mentor was expressed by participants that had previously been a protégé in a mentorship. These results concurred with Ragins and Cotton's (1993), Ragins and Scandura's (1999), and Allen, Poteet, Russell, et al.'s (1997) findings that past mentoring experience was related to increased willingness to mentor others.

Therefore, nurses that had been or were currently in a mentoring relationship as a protégé showed a greater intention to mentor than those that had not or were not in a mentoring relationship. Thus, past mentoring experiences encouraged new mentorships. In order to encourage mentoring for recruitment and retention, this finding suggests that individuals who have not been in a mentoring relationship need to be encouraged to enter into one.

### *5.8 Relationship Between Education Level and Mentoring Perceptions*

#### *5.8.1 Basic RN Education and Mentoring Perceptions*

No significant differences were noted when a T-test was performed to examine basic RN education with mentoring perceptions. Therefore, it can be proposed that there was no difference between diploma and degree-prepared registered nurses' mentoring perceptions. Both RNs with diploma and degree backgrounds need to be recruited to enter into a mentoring relationship.

#### *5.8.2 Highest Level of Completed Education in Nursing and Mentoring Perceptions*

Results from the ANOVA between highest level of completed education in nursing and mentoring perceptions were similar to the basic RN education results. No significant results were obtained to differentiate between diploma, degree, or masters-prepared nurses' mentoring perceptions. These results conflict with a finding from the business literature where individuals

with higher education levels reported greater intentions to mentor and perceived fewer barriers to mentor (Allen, Poteet, Russell, et al., 1997). Registered nurses with varied educational status in nursing must be encouraged to become a mentor or a protégé.

### *5.8.3 Highest Level of Completed Education in Another Discipline and Mentoring Perceptions*

Nurses that had a baccalaureate degree in another discipline more strongly agreed that there were more “benefits” to mentoring as compared to nurses with a diploma in another discipline. Examples of baccalaureate degrees in another discipline could be an arts, science, pharmacy, or physical education degree and examples of a diploma in another discipline could be licensed practical nursing or laboratory and/or x-ray technology. Examples of items in the “benefits” section of the Cost and Benefits Scale (Ragins & Scandura, 1999) included mentors “gained a sense of immortality”, “gained a sense of fulfillment by passing their wisdom on”, and “viewed protégé’s as younger versions of themselves”. Nurses with baccalaureate degrees may have felt more strongly that mentors “gained a sense of immortality” and “gained a sense of fulfillment by passing their wisdom on” as compared to nurses with diplomas in another discipline. Swindells and Willmott (2003) found that nurses with baccalaureate degrees focused on teamwork, networking, and collaboration. Nurses were allowed to pass on their knowledge and insight regarding the role of the nurse onto others, thus obtaining a sense of immortality, self-fulfillment, and validation (Barnard, 2002; Hollister, 2001). Nurses with a baccalaureate degree may have agreed more that mentors “viewed protégés as younger versions of themselves” than nurses with a diploma in another discipline. Those individuals may have felt that the mentor would view the protégé as a younger version because the mentor could guide the personal and professional development of the protégé to be similar to the mentor (Allen, Poteet, & Borroughs, 1997). Based on the significant findings, in order to encourage nurses with a variety of

educational backgrounds to engage in mentoring relationships, the mutual benefits of mentoring must be made explicit.

#### *5.8.4 Certification and Mentoring Perceptions*

There were no significant results found between certification and mentoring perceptions. It appears that certification does not influence mentoring perceptions. One of the reasons certified nurses may have decided to become certified was for career advancement (Cary, 2001; Redd & Alexander, 1997). Certified nurses reported increased self esteem and self confidence in their abilities as compared with their non certified colleagues (Cary; Redd & Alexander). Because certified nurses have increased confidence in their abilities, strong leadership skills, and have demonstrated an interest in continuing education and self-development, they could make great mentors. Organizations should find ways to encourage certified nurses to become mentors because of their specialized knowledge base which can contribute to the development of the protégé.

#### *5.9 Relationship Between Gender and Mentoring Perceptions*

Gender did not have an influence on mentoring perceptions and these results were congruent with the business literature. Ragins and Scandura (1994) found that men and women were equally likely to be mentors, have similar intentions to mentor, and report comparable costs and benefits associated with mentorships. Men and women reported equivalent willingness to mentor in studies conducted by Allen, Poteet, Russell, et al. (1997) and Ragins and Cotton (1993). Therefore, both men and women need to be encouraged to enter into a mentoring relationship as either a mentor or a protégé.



### *5.10 Benner's Model and Mentoring Perceptions*

Without assessing nurses' expertise level, years of nursing practice on the current unit was used as a proxy for Benner's (1984) expertise levels of "advanced beginner", "competent", "proficient", and "expert". It is important to recognize that experience level and expertise level are not equivalent. Experience level may correlate with expertise level, but the relationship is not confirmed. Expertise may also exist with lower levels of experience, but experience does not guarantee expertise. This rationale must be considered when reading the following generalizations. The findings from years of nursing practice on the current unit and total years of nursing practice were going to be amalgamated for this discussion. However, since years of nursing practice on the current unit was the only variable that had significant results, it was the one utilized for this discussion. The greatest numbers of significant findings were between the "advanced beginners" and the "expert" nurses.

In general, nurses who were classified as "advanced beginners" using years of experience on the current unit had a more positive view of mentoring, especially those with up to six months of employment on the current unit. For example, they were more likely to perceive less "costs" to mentoring and were most satisfied with their mentor. However, there was one significant negative finding from the "advanced beginner" category. Nurses with one to two years of practice on the current unit perceived the greatest dissatisfaction with their mentor.

No significant results were noted with nurses who were classified using years of experience as "competent". Nurses who were classified as "proficient" had two significant results. They were more likely to perceive less "costs" to mentoring and were most willing to mentor.

Nurses who were classified as “expert” using years of experience on the current unit had the most significant negative mentoring perceptions, especially those with 20 to 25 years of nursing practice on the current unit. Nurses with 10 to 15 years and 20 to 25 years of experience perceived more “costs” to mentoring. Furthermore, nurses with 20 to 25 years and greater than 25 years were least willing to mentor.

“Advanced beginners” had several positive perspectives regarding mentoring. This finding is significant since these nurses are the ones that would benefit most from mentoring. Furthermore, “proficient” nurses had several positive perspectives regarding mentoring. Benner et al. (1996) suggested that nurses who were at the “proficient” stage may be the best nurses to mentor others. Study findings would suggest that the category least likely to mentor would be “experts” with 20 to 25 years of experience. Benner et al. suggested that “experts” may not be the best mentors due to their experientially gained advanced clinical knowledge. However, these nurses have a vast knowledge base that is invaluable and worth passing on. As the nursing shortage continues, methods must be established to encourage all nurses with a variety of years of experience to mentor.

### *5.11 Study Limitations and Strengths*

One of the limitations of performing an analysis on a subset of the data was that the researcher was restricted to the demographic questionnaire and instruments chosen for the primary study. It was noted on the questionnaire that some of the categories in the demographic section were not mutually exclusive. A further limitation of the study may be the manner in which participants were placed into Benner’s Novice to Expert Model (1984). Participant placement was based on years of registered nurse employment on the current unit. Benner stated that experience level should not be based on nursing years of practice alone. However, in an

analysis of a subset of the data, it was difficult to consistently and fairly place participants into the appropriate expertise level based on the limited information from the questionnaires. Even though mentoring and preceptoring were defined, the participants could have mixed up the definitions, which is a common occurrence (Andrews & Wallis, 1999; Watson, 2000; Yonge, Myrick, Billay, & Luhanga, 2007). It is impossible to determine if this happened.

In general, a low response rate was noted especially from the newer nurses with less than three years of experience. This could be due to several possibilities. According to Benner (1996), newer nurses were task oriented and the transition to practice within the first year is an extremely stressful time (Boychuk-Duchscher, 2001). Newer nurses may feel that they do not have time to complete a questionnaire. Another possibility for the low response rate was that if the newer nurses decided that they had not been mentored, they may have felt that they were not justified in contributing to the study. Also, some newer nurses that chose to complete the questionnaire left whole sections uncompleted (see part four and five of the newer nurse questionnaire Appendix C). This could have been due to the wording of the questionnaire. These sections were asking questions regarding the role of the protégé's mentor and the nurse's relationship with the mentor. It then continued on to say that if the respondent had not been mentored, to complete it based on what they would expect or desire in a mentor. Perhaps, the newer nurses who did not fill in these parts did not read the whole statement carefully. Some may have felt that these sections did not apply to them. The low response rate must be taken into consideration. The study results may not be representative of the general nursing population.

Another potential reason for the overall low response rate could be that the nursing work environment is very busy with nurses working short handed. The nurses could have felt that they just did not have time to complete a questionnaire. There could have also been questionnaire

fatigue. The researchers were careful not to target wards that were in the process of other studies. However, nurses receive many questionnaires in a year to fill out, so perhaps they just did not want to fill out an additional one. Another possibility for the low response rate was that it could have been related to the length of the questionnaire; it took about 30 minutes to complete. Because the response rate was so low, one must question the representativeness of the sample (Burns & Grove, 2005).

As a result of the low response rate, the power and effect size of the study were slightly lower than anticipated. In order to obtain a power of .8 and a moderate effect size of .3 for a two tailed test with an alpha of .05, the sample size for each group, new and experienced, needed to be 84 respondents each. Sample size for the newer nurses was 80 and 124 for experienced nurses. Therefore, the power for the study was slightly less than .8.

An extremely low Cronbach alpha coefficient (.365) was noted for the “drawback” section of Ragins and Cotton’s (1993) Willingness to Mentor scale. This scale, as all the other scales used in this study, was constructed in the business context and may not be applicable to the nursing environment. Also, participants came from a variety of nursing settings where each may have their own unique drawbacks specific to that unit. Cronbach alpha coefficient, a division of homogeneity testing, investigates the degree to which all items in the scale consistently measured drawbacks to mentoring in the nursing environment (Burns & Grove, 2005). The “drawback” section of the scale obviously was not reliable, in a nursing context, and must be taken into consideration when examining the results.

This study was an analysis of a subset of the pre-workshop data. A perceived strength was that this study examined variables that the primary study had not proposed. A notable strength was that this study was the first of this nature in the nursing environment. Therefore, it

was a noteworthy contribution to advancing the nursing knowledge base and the nursing profession. Furthermore, this research contributed to the empirical literature on mentoring from a Canadian perspective.

### *5.12 Recommendations*

Based on the study results, several recommendations are proposed.

- All ages should be encouraged to mentor.

Age and generational differences may need to be taken into consideration when forming formal or informal mentoring relationships within nursing organizations. From the results, it was clear that age had somewhat of an impact on mentoring perceptions. Older nurses believed that the psychosocial function of the mentor was integral in the mentoring relationship. Mentor functions need to be discussed in an introductory workshop for mentors and protégés. For example, it should be discussed that at the beginning of the relationship, the “career” function of the mentor will be at the forefront of the relationship as the protégé is learning to be socialized into the role of the nurse on that unit. As trust is established, the “psychosocial” function will begin to emerge (Kram, 1983).

It is also important to consider the non-significant findings related to age and the rest of the mentoring perception scales. Age was non-significant for the Costs and Benefits Scale (Ragins & Scandura, 1999), the Mentor Role Scale (Ragins & McFarlin, 1990), the Mentor Satisfaction Scale (Ragins & Cotton, 1999), and the Willingness to Mentor Scale (Ragins & Cotton, 1993). No age group in particular thought that the benefits outweighed the costs of mentoring. Mentoring workshop developers need to promote the benefits of mentoring in relation to the costs. This approach might engage more nurses to become involved in a mentoring relationship. Different age groups did not show significance related to mentor roles. Each

protégé will have differing goals and needs for the mentorship. Therefore, each may visualize a different role of the mentor. Mentor roles should be discussed at the mentoring workshop, so that protégés can see potential areas for self-development that can be nurtured and strengthened by this relationship. No specific age groups were significantly more satisfied with their mentor. It would be beneficial to the mentoring relationship to see all protégés satisfied with their mentor. Methods to facilitate satisfaction need to be integrated into the mentoring workshop. For example, how to begin the relationship, getting to know the mentor or protégé, establishing ground rules, how to maintain open communication, and how to resolve conflict that may arise. Age was irrelevant when considering willingness to mentor. All ages should be encouraged to mentor newer nurses, as they each bring their own generational perspective to the relationship.

- Encourage nurses with greater years of experience to mentor.

Years of nursing practice on the current unit had three significant results whereas years of nursing practice in total did not produce any. Therefore, years of nursing practice on the current unit needs to be considered. Although the post hoc analyses were not significant, they were still considered for this discussion. In general, those with greater years of nursing practice on the current unit perceived more “costs” to mentoring, were less satisfied with their mentor, and were less willing to mentor. Examples of perceived “costs” were given: “mentoring is an energy drain”, “the major drawback to mentoring is the time commitment”, and “mentoring takes too much time away from one’s job”. A possible method of recruitment of mentors with greater years of nursing practice would be to decrease the workload of the mentor. This strategy could be in the form of decreasing patient loads when mentoring. Because nurses with greater years of nursing practice may state that mentoring is an energy drain and the major drawback is the time commitment, if organizations can decrease the work assignment or the other strains in the work

environment, nurses with greater tenure may perceive less costs of mentoring and be more willing to mentor. Another possibility would be in the form of rewards for the mentor. An example would be to provide the mentor with additional pay for taking on the mentor role or days off to allow the mentor to attend conferences or inservices of their choice. Furthermore, if rewards for being involved in mentoring are introduced, the younger individuals may be more likely to form a mentorship and may be more inclined to continue on in subsequent mentoring relationships. It is important to start the mentoring process early in the career of newer nurses. Not only will the nurses benefit professionally from a relationship as protégé, but they will be more inclined to act as a mentor later on.

- Encourage nurses that have not been a protégé or a mentor to do so.

Past mentoring experiences encouraged new mentorships. Nurses who had mentored previously expressed greater willingness to mentor. Nurses need to be encouraged to enter into a mentoring relationship as a mentor in order to facilitate the cycle of mentorship. Initially, incentives and rewards need to be instituted to encourage mentoring as discussed earlier. Furthermore, this study found that psychosocial aspects of the mentorship were not considered a priority function or role with nurses who had previous mentoring experience. It is suggested to initiate a mentorship workshop to increase nurses knowledge about the mentorship process and explain that the main initial focus of the mentorship is on career functions (socializing the newer nurse to the unit and sharpening the nurse's skills) and as the relationship progresses, it may develop into a more interpersonal one with a psychosocial focus.

This study found that previous experience as a protégé positively impacted mentoring perceptions and nurses that had been a protégé were more willing to mentor. Thus, past mentoring experiences encouraged new mentorships. In order to encourage mentoring for

recruitment and retention, individuals that have not been in a mentoring relationship need to be encouraged to enter into one to facilitate the cycle of mentorship. Information sessions/workshops on mentoring could be integrated into new nurse orientation to increase knowledge about mentoring with details on how to form informal and formal mentoring relationships. If nurses' knowledge and awareness of mentoring increases, they may be more inclined to enter into a mentorship.

- Encourage nurses with a variety of education levels to enter into mentorships.

Past nursing education (basic RN education and highest level of completed education in nursing) did not produce any significant results with mentoring perceptions. Baccalaureate-prepared nurses were not significantly different in their mentoring perceptions as compared to diploma-prepared nurses. Both must be encouraged to act as a mentor or protégé in a mentoring relationship. Nurses that had a baccalaureate degree in another discipline believed that there were more “benefits” to mentoring than nurses with a diploma in another discipline. The benefits of mentoring need to be promoted to all nurses, as once nurses recognize the benefits they may be more inclined to act as a mentor or a protégé.

Research indicated that nurses with certification were not significantly different in their mentoring perceptions than non-certified nurses. Certified nurses have a highly specialized knowledge base and have demonstrated an interest in continuing education and self-development, which could make them superb mentors. Nurses with certification should be recruited to mentor because their expertise would positively contribute to the development of the protégé.



- Encourage both genders to enter into mentorships.

There were no differences noted when comparing gender and mentoring perceptions. Neither males nor females significantly perceived more costs or benefits to mentoring or focused on individual roles or functions of the mentor. One gender was not more or less willing to mentor or more or less satisfied with their mentor. Both males and females must be targeted to enter into a mentoring relationship as both have valuable knowledge to contribute as a mentor or protégé.

From the study findings, some final recommendations are proposed in order to recruit and retain nursing staff through mentoring. A workshop must be created to increase nursing staff's knowledge and awareness of the benefits of mentoring. This workshop should include information on, but not limited to, mentoring perceptions based on age and years of nursing practice, benefits of mentoring, mentor and protégé roles and functions, and how to establish and maintain a mentorship. This workshop should be accessible to all nursing staff. Also, incentives and rewards need to be available to individuals that enter into mentoring relationships. Some examples could include monetary incentives for individual nurses and for the ward, opportunities for professional development, and a decrease in workload for staff that are in mentorships.

### *5.13 Future Research*

Based on the results of this study, future research is recommended. Further empirical research in the area of mentoring in nursing is suggested. As this is the first study examining demographic variables relating to mentoring perceptions in nursing, a replication study is recommended. This study was descriptive in nature, further experimental and qualitative designs regarding mentoring would be beneficial. Now that some insight has been gained into mentoring perceptions of acute care clinical nurses, more in depth investigation into factors that promote and inhibit mentoring relationships, influences into mentoring perceptions, factors in creating a

mentoring culture on the ward, investigation into comparing mentor and protégé perceptions of the relationship are warranted, and development of a nursing mentorship workshop. Also, mentoring perception scales specific to the nursing environment must be created and tested to further advance mentoring in nursing.

#### *5.14 Conclusion*

Recruitment and retention of registered nurses is at the forefront of healthcare organizations' mandates. Mentoring of nursing staff has been proposed as a strategy to encourage recruitment and retention. The purpose of this descriptive correlational study was to describe mentoring perceptions of urban and rural, acute care, clinical nurses based on their level of experience as indicated by their years of nursing practice, age, gender, and education level. It was established that years of nursing practice, age, and education level have somewhat of an impact on mentoring perceptions. Gender did not have an impact on mentoring perceptions. With knowledge of registered nurse mentoring perceptions, organizations may be able to propose methods to foster a mentoring culture on nursing units and therefore encourage recruitment and retention of nursing staff.

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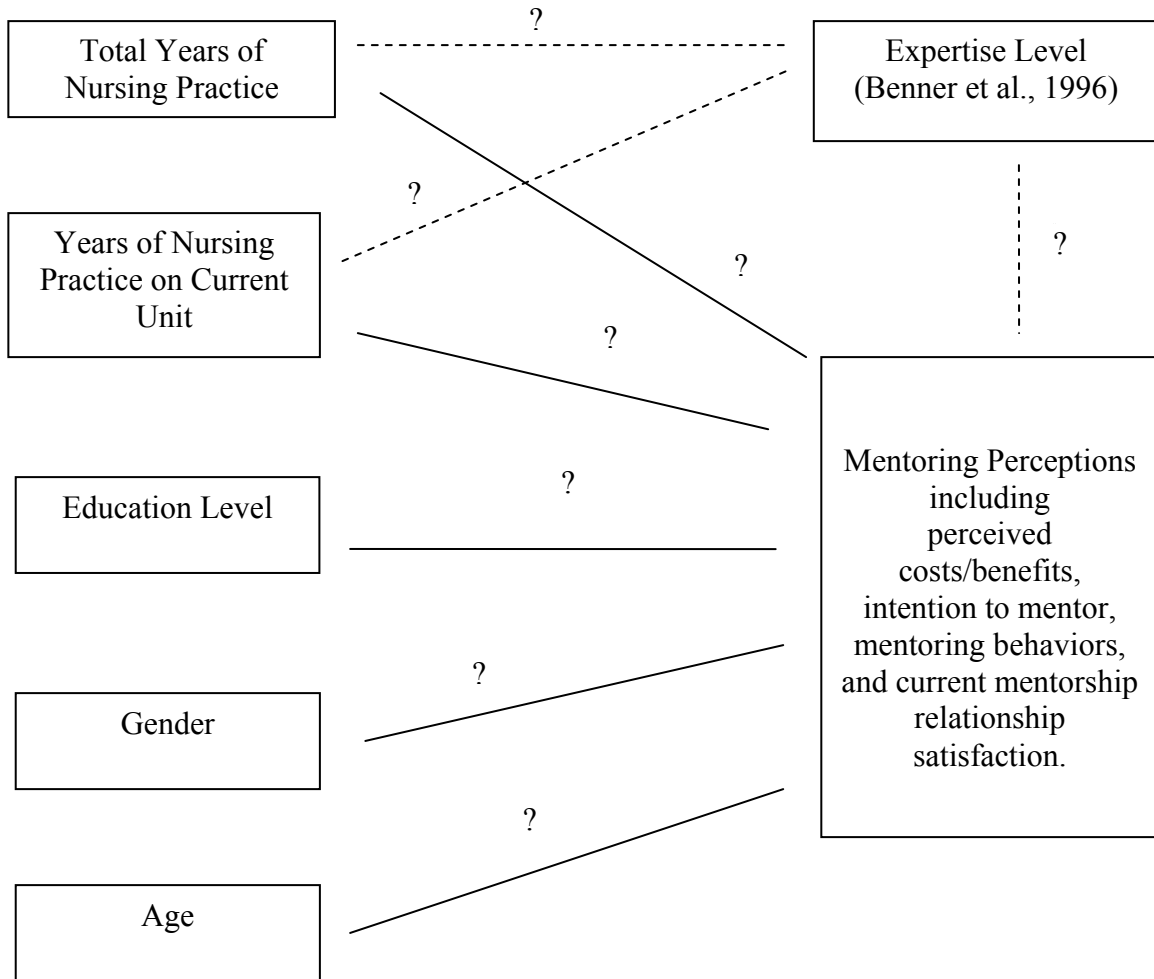


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Appendix A

Conceptual Map



# Questionnaire on Mentoring in Nursing Practice for Experienced Nurses

## Instructions

Please complete all questions on this form. You may refuse to answer any questions you wish. Please complete the questionnaire by referring to the nursing unit on which you received this questionnaire.

In this questionnaire, *preceptorship* is used to describe the formal practice relationship between an experienced nurse and a student or new nurse. This relationship is established formally by the authorities on the nursing unit, lasts for a specified time period, and is generally for the purpose of orientating the new employee or student. *Mentoring* is used to refer to informal relationships that develop over time between an experienced nurse and a less experienced nurse. In *Mentoring*, the relationship is an informal one that is focused on advancing the career of the newer nurse and develops over time. Occasionally, *mentoring* can refer to formal programs that are established with the intent of fostering a mentoring relationship between an experienced nurse and a newer nurse. In this instance, the questionnaire will make reference to a *formal mentoring program*. The term *mentor* refers to the more experienced nurse in the mentoring relationship and *protégé* or *mentee* refers to the new or less experienced nurse.

**In returning this questionnaire, you are consenting to participate in this study. The data you provide will be treated in confidence and only reported in summary statistics. You will not be identified in the final report.**

**When you have completed the questionnaire, please return it in the accompanying envelope via SHR inter-hospital mail or to:**

**Dr. Linda Ferguson,  
College of Nursing, University of Saskatchewan,  
107 Wiggins Road,  
Saskatoon, Saskatchewan, S7N 5E5**

## Questionnaire on Mentoring in Nursing Practice for Experienced Nurses

### Part 1: Background Information (Please circle or write in the appropriate response)

1. What is the name of your employing health region?
  - a. Saskatoon Health Region
  - b. Capital Health
  - c. Prince Albert Parkland Health Region
  - d. Regina Qu'Appelle Health Region
  
2. Within that health region, in what institution are you employed?  
\_\_\_\_\_
  
3. If you are employed on a specific nursing unit or within a specific department, please indicate the name of that unit. \_\_\_\_\_
  
4. How long have you been employed as an RN on that unit (in that department)?
  - a. 3 to 5 years
  - b. 5 to 10 years
  - c. 10 to 15 years
  - d. 15 to 20 years
  - e. 20 to 25 years
  - f. More than 25 years
  
5. How long have you been employed as an RN in nursing in total?
  - a. Less than 3 years
  - b. 3 to 5 years
  - c. 5 to 10 years
  - d. 10 to 15 years
  - e. 15 to 20 years
  - f. 20 to 25 years
  - g. More than 25 years

6. What was your basic RN nursing education?
- a. Diploma
  - b. Baccalaureate
7. What is your highest level of completed education in nursing?
- a. Diploma
  - b. Baccalaureate
  - c. Masters
8. Are you currently registered in a nursing education program?
- a. No
  - b. Yes
- If yes, please specify the program\_\_\_\_\_
9. What is your highest level of completed education in another discipline?
- a. Diploma
  - b. Baccalaureate
  - c. Masters
  - d. None
10. Do you have national level certification in a nursing specialty?
- a. Yes, Please Specify:\_\_\_\_\_
  - b. No
11. Are you currently working in the same area as your certification?
- a. Yes
  - b. No
12. How long have you been certified in this area?
- a. Less than 1 year
  - b. 1 to 3 years
  - c. 3 to 5 years
  - d. Over 5 years

13. How many times in the past five years have you precepted a nursing student for longer than 2 weeks?

- a. None
- b. 1-3 times
- c. 4-5 times
- d. More than five times

14. Have you attended a preceptor preparation workshop in the last 5 years?

- a. Yes
- b. No

15. During your nursing education, were you precepted for any of your clinical practice experiences?

- a. Yes
- b. No

16. How many times in the past five years have you acted as the primary preceptor for the orientation of a new staff member on your nursing unit?

- a. None
- b. 1-3 times
- c. 4-5 times
- d. 6-10 times
- e. More than 10 times

17. Have you mentored a new nurse during your nursing career?

- a. Yes
- b. No (If no, please go to question 17)

18. How many new nurses have you mentored in your practice setting?

- a. None
- b. One or two
- c. Three to five

- d. Six to ten
- e. More than eleven

19. If you have mentored a new nurse or nurses in practice, on average, how long did your mentoring relationships last?

- a. Not Applicable
- b. 1-6 months
- c. 6 months to one year
- d. One to three years
- e. Over three years

20. Have you participated as a mentor in a formal mentorship program organized by your employing agency?

- a. Yes
- b. No

21. Some nurses work in nursing workplaces that they describe as “mentoring environments.” Would you describe your nursing unit in this manner?

- a. Yes
- b. No

22. What is your gender?

- a. Female
- b. Male

23. What is your year of birth? \_\_\_\_\_

24. If you have worked on other nursing units other than the current unit (or department), please indicate your other areas of employment as an RN and the number of years in each setting (i.e. Obstetrics, 3 years, Medical Nursing, 5 years).



**Part 2: The following questions relate to your current nursing practice environment.**

<b>For each item in this section, please indicate the extent to which you agree that the following conditions are present in your current job. Indicate your agreement by circling the appropriate number.</b>				
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
1. Adequate support services allow me to spend time with my patients.	1	2	3	4
2. Physicians and nurses have good working relationships.	1	2	3	4
3. A good orientation program for newly employed nurses.	1	2	3	4
4. A supervisory staff that is supportive of nurses.	1	2	3	4
5. A satisfactory salary.	1	2	3	4
6. Nursing controls its own practice.	1	2	3	4
7. Active inservice/continuing education programs for nurses.	1	2	3	4
8. Career development/clinical ladder opportunities.	1	2	3	4
9. Opportunities for staff nurses to participate in policy decisions.	1	2	3	4
10. Support for new and innovative ideas about patient care.	1	2	3	4
11. Enough time and opportunity to discuss patient care problems with other nurses.	1	2	3	4
12. Enough registered nurses on staff to provide quality patient care.	1	2	3	4
13. A nurse manager who is a good manager and leader.	1	2	3	4
14. A chief nursing officer who is highly visible and accessible to staff.	1	2	3	4
15. Flexible or modified work schedules are available.	1	2	3	4
16. Enough staff to get the work done.	1	2	3	4
17. Freedom to make important patient care and work decisions.	1	2	3	4
18. Praise and recognition for a job well	1	2	3	4

done.				
19. Clinical nurse specialists who provide patient care consultations.	1	2	3	4
20. Team nursing as the nursing delivery system.	1	2	3	4
21. Total patient care as the nursing delivery system.	1	2	3	4
22. Primary nursing as the nursing delivery system.	1	2	3	4
23. Good relationships with other departments such as housekeeping and dietary.	1	2	3	4
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
24. Not being placed in a position of having to do things that are against my nursing judgement.	1	2	3	4
25. High standards of nursing care are expected by the administration.	1	2	3	4
26. A chief nursing executive who is equal in power and authority to other top-level hospital executives.	1	2	3	4
27. Much teamwork between nurses and doctors.	1	2	3	4
28. Physicians give high quality medical care.	1	2	3	4
29. Opportunities for advancement.	1	2	3	4
30. Nursing staff is supported in pursuing degrees in nursing.	1	2	3	4
31. A clear philosophy of nursing pervades the patient care environment.	1	2	3	4
32. Nurses actively participate in efforts to control costs.	1	2	3	4
33. I am working with nurses who are clinically competent.	1	2	3	4
34. The nursing staff participate in selecting new equipment.	1	2	3	4
35. A nurse manager backs up the nursing staff in decision making, even if in conflict	1	2	3	4

with a physician.				
36. An administration that listens and responds to employee concerns.	1	2	3	4
37. An active quality assurance program.	1	2	3	4
38. Staff nurses are involved in the internal governance of the hospital (e.g. practice & policy committees).	1	2	3	4
39. Collaboration (joint practice) between nurses and physicians.	1	2	3	4
40. A preceptor program for newly hired RNs.	1	2	3	4
41. Nursing care is based on a nursing model rather than a medical model.	1	2	3	4
42. Staff nurses have the opportunity to serve on hospital and nursing committees.	1	2	3	4
43. The contributions that nurses make to patient care are publicly acknowledged.	1	2	3	4
44. Nurse managers consult with staff on daily problems and procedures.	1	2	3	4
45. The work environment is pleasant, attractive, and comfortable.	1	2	3	4
46. Opportunity to work on a highly specialized unit.	1	2	3	4
47. Written, up-to-date nursing care plans for all patients.	1	2	3	4
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
48. Patient assignments foster continuity of care (the same nurse cares for the patient from one day to the next.	1	2	3	4
49. Regular, permanently assigned staff nurses never have to float to another unit.	1	2	3	4
50. Staff nurses actively participate in developing their work schedules (ie. what days they work, days off, etc.)	1	2	3	4
51. Standardized policies, procedures, and ways of doing things.	1	2	3	4
52. Use of nursing diagnoses.	1	2	3	4
53. Floating so that staffing is equalized among units.	1	2	3	4

54. Each nursing unit establishes its own policies and procedures.	1	2	3	4
55. Use of a problem-based medical record.	1	2	3	4
56. Working with experienced nurses who “know” the hospital.	1	2	3	4
57. Nursing care plans are verbally transmitted from nurse to nurse.	1	2	3	4

**Part 3: The following questions relate to your beliefs about mentoring.**

<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
1. Mentors get a sense of fulfillment by passing their wisdom on to others.	1	2	3	4
2. Serving as a mentor can be one of the most positive experiences of one’s career.	1	2	3	4
3. Being a mentor is more trouble than it’s worth.	1	2	3	4
4. Mentoring makes one feel better about oneself.	1	2	3	4
5. Mentoring takes more time than it’s worth.	1	2	3	4
6. There are more drawbacks to being a mentor than advantages.	1	2	3	4
7. A good protégé can enhance a mentor’s reputation.	1	2	3	4
8. The rewards that come from being a mentor more than compensate for the costs.	1	2	3	4
9. Mentoring takes too much time away from one’s own job.	1	2	3	4
10. Mentors gain a sense of satisfaction by passing their insights on to others.	1	2	3	4
11. The advantages of being a mentor far outweigh the drawbacks.	1	2	3	4
<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
12. The mentor-protégé relationship can become unhealthy.	1	2	3	4
13. One’s creativity increases when	1	2	3	4

mentoring others.				
14. Protégés can end up taking the mentor's job.	1	2	3	4
15. I plan to mentor a nurse in the future.	1	2	3	4
16. Mentors run the risk of being displaced by successful protégés.	1	2	3	4
17. Mentors can be backstabbed by opportunistic protégés.	1	2	3	4
18. The mentor-protégé relationship is often exploitive.	1	2	3	4
19. I would not want the risk of being put in a bad light by my protégé's failures.	1	2	3	4
20. Protégés are an important form of support for mentors.	1	2	3	4
21. One's job performance is likely to improve when one becomes a mentor.	1	2	3	4
22. Mentoring has a positive impact on the mentor's job.	1	2	3	4
23. I do not expect to mentor a nurse in my practice setting.	1	2	3	4
24. Members of the organization often view mentors as playing favourites with their protégés.	1	2	3	4
25. The mentor's job is usually rejuvenated by the relationship.	1	2	3	4
26. Mentors are often viewed by others as giving unfair advantages to their protégés.	1	2	3	4
27. Mentors run the risk of being viewed as developing a political cadre with their protégés.	1	2	3	4
28. Mentoring is a catalyst for innovation.	1	2	3	4
29. I do not have time to be a mentor.	1	2	3	4
30. I look forward to mentoring a nurse in my practice setting.	1	2	3	4
31. Mentoring has a positive impact on the mentor's job performance.	1	2	3	4
32. Choosing a poor protégé is a negative reflection on the mentor's judgement.	1	2	3	4
33. Protégés can be a positive reflection on the mentor's competency.	1	2	3	4
34. Mentors can count on their protégés to be loyal supporters.	1	2	3	4

35. Protégés are trusted allies for their mentors.	1	2	3	4
36. I do not seek to establish mentoring relationships with new nurses in my practice setting.	1	2	3	4
37. A poor protégé can ruin a mentor's reputation.	1	2	3	4
38. Mentors obtain positive recognition in their organization for assuming a mentoring role.	1	2	3	4
<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
39. Choosing a good protégé is a positive reflection on the mentor's judgement.	1	2	3	4
40. Protégés can be a negative reflection on the mentor's competency.	1	2	3	4
41. Mentors achieve recognition from their superiors for developing the talent of their protégés.	1	2	3	4
42. I have no desire to be a mentor.	1	2	3	4
43. Mentors gain status amongst their peers for their mentoring activities.	1	2	3	4
44. Mentors are able to relive their lives through their protégés.	1	2	3	4
45. The major drawback of being a mentor is the time commitment.	1	2	3	4
46. Mentoring is an energy drain.	1	2	3	4
47. By mentoring others, mentors gain a sense of immortality.	1	2	3	4
48. Mentors view protégés as a younger version of themselves.	1	2	3	4
49. I would like to be a mentor.	1	2	3	4

**Comments:**

**Thank you for taking the time to share your experiences and your opinions with us. We value your contributions to this research project.**

## Questionnaire on Mentoring in Nursing Practice for Newer Nurses

### Instructions

Please complete all questions on this form. You may refuse to answer any questions you wish. Please complete the questionnaire by referring to the nursing unit on which you received this questionnaire.

In this questionnaire, *preceptorship* is used to describe the formal practice relationship between an experienced nurse and a student or new nurse. This relationship is established formally by the authorities on the nursing unit, lasts for a specified time period, and is generally for the purpose of orientating the new employee or student. *Mentoring* is used to refer to informal relationships that develop over time between an experienced nurse and a less experienced nurse. In *Mentoring*, the relationship is an informal one that is focused on advancing the career of the newer nurse and develops over time. Occasionally, *mentoring* can refer to formal programs that are established with the intent of fostering a mentoring relationship between an experienced nurse and a newer nurse. In this instance, the questionnaire will make reference to a *formal mentoring program*. The term *mentor* refers to the more experienced nurse in the mentoring relationship and *protégé* or *mentee* refers to the new or less experienced nurse.

**In returning this questionnaire, you are consenting to participate in this study. The data you provide will be treated in confidence and only reported in summary statistics. You will not be identified in the final report.**

**When you have completed the questionnaire, please return it in the accompanying envelope via SHR inter-hospital mail or to:**

**Dr. Linda Ferguson,  
College of Nursing, University of Saskatchewan,  
107 Wiggins Road,  
Saskatoon, Saskatchewan, S7N 5E5**

## Questionnaire on Mentoring in Nursing Practice for Newer Nurses

### Part 1: Background Information (Please circle or write in the appropriate response)

1. What is the name of your employing health region?
  - a. Saskatoon Health Region
  - c. Capital Health
  - d. Prince Albert Parkland Health Region
  - e. Regina Qu'Appelle Health Region
  
2. Within that health region, in what institution are you employed?  
\_\_\_\_\_
  
3. If you are employed on a specific nursing unit or in a specific department, please indicate the name of that unit. \_\_\_\_\_
  
4. How long have you been employed as an RN on that unit (in that department)?
  - a. 0 to 6 months
  - b. 6 to 12 months
  - c. 1 to 2 years
  - d. 2 to 3 years
  
5. How long have you been employed as an RN in nursing in total?
  - a. Less than one year
  - b. 1 to 2 years
  - c. 2 to 3 years
  - d. 3 to 5 years
  - e. 5 to 10 years
  - f. 10 to 15 years
  - g. 15 to 20 years
  - h. 20 to 25 years
  - i. More than 25 years



6. What was your basic RN nursing education?
  - a. Diploma
  - b. Baccalaureate
  
7. What is your highest level of completed education in nursing?
  - a. Diploma
  - b. Baccalaureate
  - c. Masters
  
8. Are you currently registered in a nursing education program?
  - a. No
  - b. Yes  
If yes, please specify the program\_\_\_\_\_
  
9. What is your highest level of completed education in another discipline?
  - a. Diploma
  - b. Baccalaureate
  - c. Masters
  - d. None
  
10. Do you have national-level certification in a nursing specialty?
  - a. Yes, Please Specify:\_\_\_\_\_
  - b. No
  
11. Are you currently working in the same area as your certification?
  - a. Yes
  - b. No
  
12. How long have you held this certification?
  - a. Less than 1 year
  - b. 1 to 3 years
  - c. 3 to 5 years

13. How many times in the past three years have you precepted a nursing student for longer than 2 weeks?

- a. None
- b. 1-3 times
- c. 4-5 times
- d. More than five times

14. Have you attended a preceptor preparation workshop in the last 3 years?

- a. Yes
- b. No

15. During your nursing education, were you preceptored for any of your clinical practice experiences?

- a. Yes
- b. No

16. How many times in the past three years have you acted as the primary preceptor for the orientation of a new staff member on your nursing unit?

- a. None
- b. 1-3 times
- c. 4-5 times
- d. More than five times

17. Were you or are you currently being mentored in your nursing practice?

- a. Yes
- b. No

18. How many nurses on your nursing unit are currently mentoring you?

- a. One
- b. Two
- c. More than two
- d. None

19. How many nurses outside of your nursing unit are currently mentoring you?
- One
  - Two
  - More than two
  - None
20. How many protégés does your primary mentor on your nursing unit have?
- Not applicable
  - One
  - Two
  - More than two
21. Is your nursing manager also your mentor?
- Yes
  - No
22. Have you mentored a new nurse during your nursing career?
- Yes
  - No
23. How many new nurses have you mentored in your current practice setting?
- None
  - One
  - Two
  - Three or more
24. If you have mentored a new nurse or nurses in practice, on average, how long did your mentoring relationships last?
- Not Applicable
  - Less than one year
  - One to three years
  - Over three years

25. Have you participated as a protégé in a formal mentorship program organized by your employing agency?

- a. Yes
- b. No

26. How long did your formally arranged mentorship relationship extend?

- a. Less than 6 months
- b. 6-12 months
- c. 1-2 years
- d. 2-3 years

27. Did your formal mentoring relationship extend informally beyond the specified period for the formal mentoring program?

- a. Yes
- b. No

28. Some nurses work in nursing workplaces that they describe as “mentoring environments.” Would you describe your nursing unit in this manner?

- a. Yes
- b. No

29. What is your gender?

- a. Female
- b. Male

30. What is your year of birth? \_\_\_\_\_

31. If you have worked on other nursing units other than the current unit (or department), please indicate your other areas of employment as an RN and the number of years in each setting (i.e. Obstetrics, 3 years, Medical Nursing, 5 years).

**Part 2: The following questions relate to your practice environment.**

<b>For each item in this section, please indicate the extent to which you agree that the following conditions are present in your current job. Indicate your degree of agreement by circling the appropriate number.</b>				
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
1. Adequate support services allow me to spend time with my patients.	1	2	3	4
2. Physicians and nurses have good working relationships.	1	2	3	4
3. A good orientation program for newly employed nurses.	1	2	3	4
4. A supervisory staff that is supportive of nurses.	1	2	3	4
5. A satisfactory salary.	1	2	3	4
6. Nursing controls its own practice.	1	2	3	4
7. Active inservice/continuing education programs for nurses.	1	2	3	4
8. Career development/clinical ladder opportunities.	1	2	3	4
9. Opportunities for staff nurses to participate in policy decisions.	1	2	3	4
10. Support for new and innovative ideas about patient care.	1	2	3	4
11. Enough time and opportunity to discuss patient care problems with other nurses.	1	2	3	4
12. Enough registered nurses on staff to provide quality patient care.	1	2	3	4
13. A nurse manager who is a good manager and leader.	1	2	3	4
14. A chief nursing officer who is highly visible and accessible to staff.	1	2	3	4
15. Flexible or modified work schedules are available.	1	2	3	4
16. Enough staff to get the work done.	1	2	3	4
17. Freedom to make important patient care and work decisions.	1	2	3	4

18. Praise and recognition for a job well done.	1	2	3	4
19. Clinical nurse specialists who provide patient care consultations.	1	2	3	4
20. Team nursing as the nursing delivery system.	1	2	3	4
21. Total patient care as the nursing delivery system.	1	2	3	4
22. Primary nursing as the nursing delivery system.	1	2	3	4
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
23. Good relationships with other departments such as housekeeping and dietary.	1	2	3	4
24. Not being placed in a position of having to do things that are against my nursing judgement.	1	2	3	4
25. High standards of nursing care are expected by the administration.	1	2	3	4
26. A chief nursing executive who is equal in power and authority to other top-level hospital executives.	1	2	3	4
27. Much teamwork between nurses and doctors.	1	2	3	4
28. Physicians give high quality medical care.	1	2	3	4
29. Opportunities for advancement.	1	2	3	4
30. Nursing staff is supported in pursuing degrees in nursing.	1	2	3	4
31. A clear philosophy of nursing pervades the patient care environment.	1	2	3	4
32. Nurses actively participate in efforts to control costs.	1	2	3	4
33. I am working with nurses who are clinically competent.	1	2	3	4

34. The nursing staff participate in selecting new equipment.	1	2	3	4
35. A nurse manager backs up the nursing staff in decision making, even if in conflict with a physician.	1	2	3	4
36. An administration that listens and responds to employee concerns.	1	2	3	4
37. An active quality assurance program.	1	2	3	4
38. Staff nurses are involved in the internal governance of the hospital (e.g. practice & policy committees).	1	2	3	4
39. Collaboration (joint practice) between nurses and physicians.	1	2	3	4
40. A preceptor program for newly hired RNs.	1	2	3	4
41. Nursing care is based on a nursing model rather than a medical model.	1	2	3	4
42. Staff nurses have the opportunity to serve on hospital and nursing committees.	1	2	3	4
43. The contributions that nurses make to patient care are publicly acknowledged.	1	2	3	4
44. Nurse managers consult with staff on daily problems and procedures.	1	2	3	4
45. The work environment is pleasant, attractive, and comfortable.	1	2	3	4
<b>Present in current job</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
46. Opportunity to work on a highly specialized unit.	1	2	3	4
47. Written, up-to-date nursing care plans for all patients.	1	2	3	4
48. Patient assignments foster continuity of care (the same nurse cares for the patient from one day to the next).	1	2	3	4
49. Regular, permanently assigned staff nurses never have to float to another unit.	1	2	3	4
50. Staff nurses actively participate in developing their work schedules (ie. what days they work, days off, etc.)	1	2	3	4
51. Standardized policies, procedures, and ways of doing things.	1	2	3	4

52. Use of nursing diagnoses.	1	2	3	4
53. Floating so that staffing is equalized among units.	1	2	3	4
54. Each nursing unit establishes its own policies and procedures.	1	2	3	4
55. Use of a problem-based medical record.	1	2	3	4
56. Working with experienced nurses who “know” the hospital.	1	2	3	4
57. Nursing care plans are verbally transmitted from nurse to nurse.	1	2	3	4

**Part 3: The following questions relate to your beliefs about mentoring.**

<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
1. Mentors get a sense of fulfillment by passing their wisdom on to others.	1	2	3	4
2. Serving as a mentor can be one of the most positive experiences of one’s career.	1	2	3	4
3. Being a mentor is more trouble than it’s worth.	1	2	3	4
4. Mentoring makes one feel better about oneself.	1	2	3	4
5. Mentoring takes more time than it’s worth.	1	2	3	4
6. There are more drawbacks to being a mentor than advantages.	1	2	3	4
7. A good protégé can enhance a mentor’s reputation.	1	2	3	4
8. The rewards that come from being a mentor more than compensate for the costs.	1	2	3	4
<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
9. Mentoring takes too much time away from one’s own job.	1	2	3	4
10. Mentors gain a sense of satisfaction by	1	2	3	4



passing their insights on to others.				
11. The advantages of being a mentor far outweigh the drawbacks.	1	2	3	4
12. The mentor-protégé relationship can become unhealthy.	1	2	3	4
13. One's creativity increases when mentoring others.	1	2	3	4
14. Protégés can end up taking the mentor's job.	1	2	3	4
15. I plan to mentor a nurse in the future.	1	2	3	4
16. Mentors run the risk of being displaced by successful protégés.	1	2	3	4
17. Mentors can be backstabbed by opportunistic protégés.	1	2	3	4
18. The mentor-protégé relationship is often exploitive.	1	2	3	4
19. Protégés are an important form of support for mentors.	1	2	3	4
20. One's job performance is likely to improve when one becomes a mentor.	1	2	3	4
21. Mentoring has a positive impact on the mentor's job.	1	2	3	4
22. I do not expect to mentor a nurse in my practice setting.	1	2	3	4
23. Members of the organization often view mentors as playing favourites with their protégés.	1	2	3	4
24. The mentor's job is usually rejuvenated by the relationship.	1	2	3	4
25. Mentors are often viewed by others as giving unfair advantages to their protégés.	1	2	3	4
26. Mentors run the risk of being viewed as developing a political cadre with their protégés.	1	2	3	4
27. Mentoring is a catalyst for innovation.	1	2	3	4
28. I look forward to mentoring a nurse in my practice setting.	1	2	3	4
29. Mentoring has a positive impact on the mentor's job performance.	1	2	3	4
30. Choosing a poor protégé is a negative reflection on the mentor's judgement.	1	2	3	4
31. Protégés can be a positive reflection on	1	2	3	4

the mentor's competency.				
32. Mentors can count on their protégés to be loyal supporters.	1	2	3	4
33. Protégés are trusted allies for their mentors.	1	2	3	4
34. I do not seek to establish mentoring relationships with new nurses in my practice setting.	1	2	3	4
<b>Item</b>	<b>Strongly Agree</b>	<b>Somewhat Agree</b>	<b>Somewhat Disagree</b>	<b>Strongly Disagree</b>
35. A poor protégé can ruin a mentor's reputation.	1	2	3	4
36. Mentors obtain positive recognition in their organization for assuming a mentoring role.	1	2	3	4
37. Choosing a good protégé is a positive reflection on the mentor's judgement.	1	2	3	4
38. Protégés can be a negative reflection on the mentor's competency.	1	2	3	4
39. Mentors achieve recognition from their superiors for developing the talent of their protégés.	1	2	3	4
40. Mentors gain status amongst their peers for their mentoring activities.	1	2	3	4
41. Mentors are able to relive their lives through their protégés.	1	2	3	4
42. The major drawback of being a mentor is the time commitment.	1	2	3	4
43. Mentoring is an energy drain.	1	2	3	4
44. By mentoring others, mentors gain a sense of immortality.	1	2	3	4
45. Mentors view protégés as a younger version of themselves.	1	2	3	4

**Part 4: These questions explore your perceptions of the role of your primary mentor in your nursing practice setting. If you have not been mentored, please complete this section on the basis of what you would expect the role of a mentor to be.**

<b>The mentor:</b>	<b>Strongly Agree</b>			<b>Neutral</b>			<b>Strongly Disagree</b>
1. helps me attain desirable positions.	1	2	3	4	5	6	7
2. helps me learn about other parts of the organization.	1	2	3	4	5	6	7
3. protects me from those who may be out	1	2	3	4	5	6	7

to get me.							
4. gives me tasks that require me to learn new skills.	1	2	3	4	5	6	7
5. helps me to be more visible in the organization.	1	2	3	4	5	6	7
6. is someone I can confide in.	1	2	3	4	5	6	7
7. and I frequently get together informally after work by ourselves.	1	2	3	4	5	6	7
8. is like a father/mother to me.	1	2	3	4	5	6	7
9. serves as a role model for me.	1	2	3	4	5	6	7
10, serves as a sounding board for me to develop and understand myself.	1	2	3	4	5	6	7
11. accepts me as a competent professional.	1	2	3	4	5	6	7
<b>The mentor:</b>	<b>Strongly Agree</b>			<b>Neutral</b>			<b>Strongly Disagree</b>
12. uses his/her influence to support my advancement in the organization.	1	2	3	4	5	6	7
13. gives me advice on how to attain recognition in the organization.	1	2	3	4	5	6	7
14. “runs interference” for me in the organization.	1	2	3	4	5	6	7
15. provides me with challenging assignments.	1	2	3	4	5	6	7
16. creates opportunities for me to impress people in the organization.	1	2	3	4	5	6	7
17. provides support and encouragement.	1	2	3	4	5	6	7
18. and I frequently socialize one-on-one outside the work setting.	1	2	3	4	5	6	7
19. reminds me of one of my parents.	1	2	3	4	5	6	7
20. is someone I identify with.	1	2	3	4	5	6	7
21. guides my professional development.	1	2	3	4	5	6	7
22. sees me as being competent.	1	2	3	4	5	6	7

23. uses his/her influence in the organization for my benefit.	1	2	3	4	5	6	7
24. suggests specific strategies for achieving career aspirations.	1	2	3	4	5	6	7
25. shields me from damaging contact with important people in the organization.	1	2	3	4	5	6	7
26. assigns me tasks that push me into developing new skills.	1	2	3	4	5	6	7
27. brings my accomplishments to the attention of important people in the organization.	1	2	3	4	5	6	7
28. is someone I can trust.	1	2	3	4	5	6	7
29. and I frequently have one-on-one informal social interactions.	1	2	3	4	5	6	7
30. treats me like a son/daughter.	1	2	3	4	5	6	7
31. represents who I want to be.	1	2	3	4	5	6	7
32. guides my personal development.	1	2	3	4	5	6	7
33. thinks highly of me.	1	2	3	4	5	6	7
34. is someone I am satisfied with.	1	2	3	4	5	6	7
35. fails to meet my needs.	1	2	3	4	5	6	7
36. disappoints me.	1	2	3	4	5	6	7
37. has been effective in his/her role.	1	2	3	4	5	6	7

**Part 5: This section focuses on your relationship with your mentor in the practice setting. If you have not been mentored, please complete this section on the basis of what you desire in a relationship with a mentor.**

Item	Strongly Agree			Neutral			Strongly Disagree
1. I share personal problems with my mentor.	1	2	3	4	5	6	7
2. My mentor takes a personal interest in my career.	1	2	3	4	5	6	7
3. I try to model my behaviour after my mentor.	1	2	3	4	5	6	7

4. I socialize with my mentor after work.	1	2	3	4	5	6	7
5. My mentor has placed me in important assignments.	1	2	3	4	5	6	7
6. I admire my mentor's ability to motivate others.	1	2	3	4	5	6	7
7. I exchange confidences with my mentor.	1	2	3	4	5	6	7
8. My mentor gives me special coaching on the job.	1	2	3	4	5	6	7
9. I respect my mentor's knowledge of the profession.	1	2	3	4	5	6	7
10. I consider my mentor to be a friend.	1	2	3	4	5	6	7
11. My mentor advised me about promotional opportunities.	1	2	3	4	5	6	7
12. I respect my mentor's ability to teach others.	1	2	3	4	5	6	7
13. I often go to lunch with my mentor.	1	2	3	4	5	6	7
14. My mentor helps me to coordinate my professional goals.	1	2	3	4	5	6	7
15. My mentor has developed special time and consideration to my career.	1	2	3	4	5	6	7

### Comments

**Thank you for taking the time to share your experiences and your opinions with us. We value your contributions to this research project.**