MENTORING NURSE PRACTITIONERS IN A HOSPITAL SETTING

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ABSTARCT

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In 2009, the American Academy of Nurse Practitioners report identified more than 125, 000 Nurse Practitioners (NP) working in the United States. As the number of NPs increases and their role expands, questions about their work satisfaction and ability to learn and perform the role arise. Since NPs have to combine a nursing philosophy with a medical care model, it is often difficult to mediate the two approaches and fully understand the role. Mentoring has been successfully used to facilitate role transition and role understanding for nurses and physicians, but has been rarely studied in NPs. Although widely used in nursing and medicine, the concept of mentoring is poorly defined and often used interchangeably with coaching and precepting, thus making program design and evaluation difficult.

The purpose of this study was to develop a theory of mentoring for NPs in a hospital setting. A total of 18 participants (eight mentors and eight mentees) were interviewed to learn about their experience with mentoring. A three component mentoring process emerged from the data: forming the relationship, developing the relationship, and outcomes. While some of the themes identified in this study have been previously discussed, others like journey, career path, gain a friend, and defining self have never been associated with mentoring. Nurse practitioners participating in this study were continuously defining both personally and professionally in an effort to improve themselves. The journey to a successful mentoring relationship required hard work, commitment, and trust. When mentoring

participants took the time to know each other and were able to build trust, the relationship moved beyond the traditional framework of formal mentoring into informal mentoring and friendship.

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CHAPTER 1

INTRODUCTION

The number of nurse practitioners (NP) increases every year and their practice is expanding to various specialty areas (American Academy of Nurse Practitioners, [AANP], 2009). Despite numerous advances in NPs education and training, new NPs experience difficulties transitioning from the registered nurse (RN) role to the advanced practice role (Forbes & Jessup, 2010; Heitz, Steiner, & Burman, 2004; Spinks, 2008). Healthcare organizations are looking for solutions to alleviate some of these difficulties and to promote NP role understanding and integration. Orientation programs for new NPs are often used to facilitate role transition (Bahout & Esposito-Herr, 2009; Soeren & Micevski, 2001).

Mentoring has been found to improve role transition, job satisfaction, and retention while facilitating socialization, emotional well being, and the acquisition of skills and knowledge for nurses and nurse practitioner students (Barton, 2006; Barton, 2007; Cashin & Potter, 2006; Faron & Poeltler, 2007; Halfer, Graf, & Sullivan, 2008; Persaud, 2008). Mentoring is a main component of orientation and internship programs for NPs, but there is little empirical evidence that mentoring can effectively improve transition to the advanced practice role (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Sorce, Simone, & Madden, 2010). While anecdotal reports of mentoring programs for new NPs abound, there are no published reports of their structure or effectiveness.

1.1 Background and Significance

Nurse practitioners are an important group of midlevel healthcare providers who serve in both primary and acute care areas. In 2009, there were more than 125, 000 NPs in the United States (AANP, 2009). Of these, 39% have hospital privileges and 13% have long term care privileges. Although more

than half of the NPs work in primary care, about 31% practice in inpatient units, emergency, surgical or specialty departments in hospital settings (AANP, 2009).

Nurse practitioners are registered nurses with advanced academic and clinical expertise and pass a national certification exam (Curren, 2007). Nurse practitioners can receive education and specialization in various areas such as acute or primary care, family health, pediatric and child health, adult health, gerontology, psychiatry, women's health, and neonatology. Besides these specialties, NPs have the opportunity to practice in many sub-specialties. High levels of patient satisfaction with NP care reflect their ability to provide safe and effective services for their patients (Bevis et al., 2008; Budzi, Lurie, Singh, & Hooker, 2010; Kleinpell, Wesley, & Grabenkort, 2008; Sakr et al., 1999). Nurse practitioners provide a variety of services aimed at managing the overall care of patients. They can carry out diagnostic tests, execute procedures, diagnose and treat health conditions, prescribe medications and treatments, counsel, and educate patients (AANP, 2010). Despite their contribution to the healthcare system, NPs face various barriers to practice (Forgeron & Martin-Misener, 2005; Jones, 2005; Plager & Conger, 2007; Soeren & Micevski, 2001). Jones (2005) summarized these barriers as lack of role definition and understanding, lack of preparation, legislative issues, lack of confidence, poor support, and lack of resources and opportunities for professional development. The impact of these barriers on the NP practice can increase exponentially during the initial stages of NP practice.

Transition to the first NP job can be difficult and stressful (Kelly & Mathews, 2001). While registered nurses enrolled in advanced nursing education have a particular level of expertise in their specialty area their first position as a NP moves them from the expert level as an RN to the novice domain as an NP. Although they receive standard education and complete between 500 and 1000 hours of clinical rotations, many are inadequately prepared for the actual practice role. Changes in job characteristics, relationships, expectations, and required aptitude level can make new NPs feel inadequate and unable to fully perform in their new roles (Huffstutler & Varnell, 2006). These feelings of inadequacy have been described as the "impostor phenomenon" and considered a normal transitional emotional state (Huffstutler & Varnell, 2006). New NPs have to travel the novice to expert road again to reach adequate clinical competence.

Although challenging, the transition to the first NP job can be made easier with effective organizational and peer support. When new NPs are supported during the novice stage they become empowered and better equipped to develop as expert care providers (Bahout & Esposito-Herr, 2009; Faris, Douglas, Maples, Berg, & Thrailkill, 2010). As the number of NPs increase, healthcare organizations are looking for solutions towards reducing barriers to practice. Better role definition, orientation programs, and mentoring are options considered by healthcare organizations to promote NPs professional development and facilitate the transition from school to practice (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Kleinpell & Hravnak, 2005).

Mentoring has been found to improve retention, reduce stress, and facilitate the acquisition of skills and knowledge for nurses, NP students, and physicians (Buddenberg-Fischer & Herta, 2006; Castiglioni, Bellini, & Shea, 2004; Faron & Poeltler, 2007; Halfer, et al., 2008; Persaud, 2008; Tsai et al., 2006). Unfortunately this concept is poorly understood and inadequately studied in the advanced nursing practice context. A very limited number of studies about mentoring in advanced nursing practice are published.

Mentoring is part of NP orientation programs in many organizations, but its potential impact on NPs role transition and professional development may not be fully understood as a result of poor conceptual and operational definitions. It is imperative that this concept is clearly described and understood and it is also important to understand the process of mentoring, related concepts, and relationships between these concepts. Without a good understanding of the concept and the process, mentoring programs may not produce the expected outcomes and their evaluation and generalization may be difficult if not impossible.

Mentoring in nursing has been defined and characterized only through borrowed definitions and concepts from other disciplines not through research (Barker, 2006; Stewart & Krueger, 1996). There are no theoretical frameworks for mentoring in nursing or advanced nursing practice. As a result, many nursing mentoring programs are not based on theoretical foundations or conceptual definitions. Those using theoretical foundations do so based on the desired outcomes of the program. Variations in

mentoring outcomes, program design, evaluations, and theoretical framework further fuel the confusion about this concept. The use of a theoretical framework may aide the process of defining and understanding the concept and the process of mentoring for NPs.

1.1.1 Theoretical Framework

The focus of Humanistic Nursing Theory (HNT) (Paterson & Zderad, 2007) is the relationship and dialogue between the nurse and the patient. Initiated when the patient calls for help, this interaction promotes active presence and experience sharing. As a result, both the nurse and the patient can experience improvements in their well being. This growth takes place as a result of an authentic presence and dialogue in a clinical context populated and influenced by other human beings, physical environment, space, and time.

Some of the HNT concepts are well defined, while others are barely explained. Lived dialogue, comfort, being and doing, and clinical are major concepts. They are clearly described and defined in the theory, but operational definitions are not provided. Presence, relating, meeting, nurture, and call and response are derived concepts described in detail, while important concepts such as I/Thou and I/It are not explained at all. Concepts central to nursing phenomena are present, but their explanation varies. This theory brings a unique perspective on human interaction and allows for the individualization of each encounter. The nurse can make a difference in a patient's life by using this approach and can enhance her/his practice as well.

A main idea of the HNT is that the participants in a human interaction become aware of their uniqueness and opportunities, and are able to become more through an existential interactive experience (Paterson & Zderad, 2007). A similar interaction takes place between individuals involved in mentoring. Mentoring is initiated as the mentee identifies a need for help. This process is similar to the call for help placed by a patient and described by Paterson and Zderad (2007). Each participant in mentoring brings to the relationship unique experiences and values shared through presence and authentic dialogue. The authentic commitment of participants fosters development and empowerment as part of a nurturing interaction (Vance & Olson, 1998). It is however important for mentoring participants to explore their own

feelings, needs, and expectations before engaging in the relationship and to accept the other as an equal participant. Only an authentic exploration and acceptance of self and others as active participants in the relationship will support an open and sharing experience (Paterson & Zderad, 2007).

While the decision to participate in mentoring stems from different reasons, both the mentor and the mentee make the decision freely (Barker, 2006; Stewart & Krueger, 1996). Mentees are drawn into the relationship by expectations of personal and professional growth. Mentors' only reason for participating in mentoring seems to be altruism and the desire to help, but they may experience growth and development as well (Barker, 2006; Cuesta & Bloom, 1998; Dancer, 2003). Mentoring may not contain all the human potentials and limitations associated with nursing, but frustration, discouragement, loneliness, impatience, anxiety, as well as caring, courage, trust, and hope may be experienced by participants. New NPs report experiencing some or all of these human potentials and limitations (Brown & Olshansky, 1997; Huffstutler & Varnell, 2006). New NPs are in need of nurturing as they struggle to transition into the new role. Their call for help may not be always voiced, but it is always present. A mentoring relationship based on humanistic nursing allows new NPs to understand and transition into the new role through a dynamic exchange of ideas and knowledge that may minimize limitations and maximize potentials (Grossman, 2007).

Like nursing, mentoring contains a mode of being and an active part of doing things. The doing component refers to teaching, coaching, and learning. In a humanistic context teachers and learners share their experiences and unique perspectives for the purpose of gaining knowledge and becoming more than they are (Paterson & Zderad, 2007). While the being component is not directly measurable, it is essential for an authentic relationship. Presence, commitment, active listening, and meaningful exchange of ideas and experiences constitute the being component of mentoring.

Time and space are important components of HNT and of mentoring (Paterson & Zderad, 2007). For an authentic relationship to occur, mentors and mentees need to be able to share and exchange experiences and ideas. When these exchanges take place during face-to-face interactions, there seem to be increased benefits for both participants. It is however difficult for mentoring participants to always

find time for meetings. How often the mentor and mentee are able to meet and for how long may affect the relationship and the outcomes of mentoring. Other people in the environment, and the environment itself, may also affect mentoring in both positive and negative ways. Despite potential time and space barriers, mentoring needs to be a synchronous relationship. This synchronicity comes not from the physical presence together, but from the simultaneous experience of helping and being helped.

The outcome of a humanistic nursing interaction with a patient is well-being and more-being (Paterson & Zderad, 2007) and the outcomes of a humanistic mentoring relationship are similar. Mentoring outcomes include professional growth and clinical competency, increased job satisfaction, improved retention rates, as well as personal development and learning (Block, Claffey, Korow, & McCaffrey, 2005; Campbell, 2007; Halfer et al., 2008; Mills & Mullins, 2008; Persaud, 2008).

Using a grounded theory research methodology based on the HNT will provide conceptual information about the process of mentoring in the NP population. Besides developing a theoretical framework of mentoring for NPs, this approach will provide the opportunity to focus and define theoretical concepts such as interaction, dialogue, and information exchange and the relationships between them. Other emerging concepts will also be defined in this theoretical context.

1.2 Method and Philosophical Perspective

Human behavior and interaction are greatly influenced by personal experiences, social traditions, and context. Theories about human behavior and interaction need to reflect the reality as perceived and/or experienced by the participants. Only theories derived from data collected using qualitative methods can provide a deep understanding of human behavior and interactions in the social context (Chen & Boore, 2009; Corbin & Strauss, 2008; McCann & Clark, 2003a; Munhall, 2007).

1.2.1 Method

Grounded theory provides the method and tools which allows researchers to produce theories based on and generated by the data (Munhall, 2007). Corbin and Strauss's (2008) version of grounded

theory will be used to explore the meaning of mentoring and its implications for participating NPs in a hospital setting.

Pragmatism and symbolic interactionism are considered the philosophical keystones of grounded theory (Chen & Boore, 2009; Munhall, 2007; Walker & Myrick, 2006). Even when participating in the same event people's actions and their comportment vary. The same event can be interpreted differently by its participants. Actions and reactions are influenced by meanings and symbols and are shaped by each person's perception of reality (Chen & Boore, 2009).

Pragmatism allows a choice of philosophical perspectives without promoting any one as more important. Its central focus is on practicability and applicability and on the effects of actions (Creswell & Clark, 2007; Warms & Schroeder, 1999). For pragmatists, truth does not exist independent of people's perceptions and their mental interpretation of it. Truth can change as it is discovered by science and everyday realities. People create their own truths according to their values and beliefs and their practical applications or utilities of the truth (Kremer, 2007; Rorty, 1982). The question is not only what difference will the truth make, but also how it will be realized, and how will people experience truth versus falsehood. For pragmatists, truth is embodied in ideas or theories we can understand, verify, and confirm (James, 1907). As a worldview, pragmatism promotes interdependence. Every event is influenced by other events or things that may or may not be visible. This interdependence promotes continuous changes and variations of reality and the progress of science (Kremer, 2007).

Symbolic interactionism implies that people assign meanings and symbols to events according to their values, beliefs, and previous experiences. Social interaction provides the vehicle to create and change meanings (Cleveland, 2009). Every situation or interaction can be defined and perceived differently by each participant (Chen & Boore, 2009). Every aspect of an interaction, from clothing to gestures and voice inflections, has a particular meaning and an assigned symbol. These meanings and symbols enable participants to build their reality, view of the world, and shape their feelings and actions (Munhall, 2007). Researchers capable of capturing and understanding meanings and symbols may be able to predict human behavior and interaction (Morse, 2009).

In their version of grounded theory, Corbin and Strauss use a post-positivist paradigm and give more importance and voice to the research participants. Reality is seen as complex and not fully apprehensible. As a result, the theory is applicable only to the particular group studied, in that particular context, and influenced by social and cultural events (Corbin & Strauss, 2008; Ghezeljeh & Emami, 2009; Heath & Cowley, 2004). When using this approach the initial research question is broad, but as data is collected and analyzed, the question becomes more focused and concise. Corbin and Strauss recognize barriers to complete objectivity and promote completion of a preliminary literature review to enhance theoretical sensitivity and to inform the researcher about the topic of interest (Corbin & Strauss, 2008; Heath & Cowley, 2004; McCann & Clark, 2003b). The analysis pattern moves from open coding towards high levels of conceptualization and integration of codes, categories, concepts, and themes. Codes and categories are defined using both properties and dimensions. Theoretical sampling, reflexivity, and memos are also used in the process of data collection and analysis. The final product is a substantive theory (Corbin & Strauss, 2008). Unlike formal theories which can be generalized, substantive theories can only be applied to a particular population in a specific context (Morse, 2009). Corbin and Strauss use induction, but they also added deduction, abduction, and validation to their data analysis and theory generation process. In their data analysis codes and categories are generated from the data, but also deducted from the data. Deducted codes and categories are compared against the data and are also validated. The researcher role is more active and participatory in the process of theory generation (Corbin & Strauss, 2008; Heath & Cowley, 2004; Morse, 2009).

Grounded theory is an appropriate method to generate a theory of mentoring for NPs in a hospital setting. The concept of mentoring and related concepts will be defined and the relationships between them described to better understand the mentoring process. The tenets of HTN (Paterson & Zderad, 2007) will be utilized as the guiding framework for the semi-structured interviews.

1.3 Statement of Purpose

The purpose of this study is to develop a theory of mentoring for NPs in a hospital setting by exploring the meaning of mentoring for this population.

1.4 Assumptions

Assumptions related to the meaning of mentoring for NPs in a hospital setting are based on the investigator's experience with mentoring as a mentoring participant and as a program coordinator and on the review of literature regarding mentoring and the experience of new NPs. The assumptions for this study are as follows:

1. The mentoring relationship is influenced by NP's values and previous experiences.
2. NPs mentoring relationship is based on a call for help and a response to the call for help.
3. A bi-directional exchange of information and knowledge takes place in mentoring.
4. Time, space, and other individuals create a unique context for mentoring.
5. Context influences all aspects of the NPs mentoring experience.
6. Each mentoring participant experiences mentoring in a unique way, but with common characteristics shared by other NPs.
7. In-depth interviews can uncover NPs values and experiences with mentoring.
8. NP's, by virtue of their experiences, can provide abstract, conceptual ideas about what mentoring is like for them.
9. NPs conceptual ideas can be used to build a theory of mentoring grounded in reality.

1.5 Summary

Most of the literature on nursing mentoring discusses this process and its implications for registered nurses not for nurse practitioners. The current conceptual definition of mentoring in nursing is based on terms and definitions borrowed from related fields not on research results from nursing. As a result, many mentoring nursing programs are not based on theoretical foundations or conceptual definitions. Qualitative research is needed to understand the process of mentoring for NPs in a hospital setting and to develop a theory of mentoring for this population. Humanistic Nursing Theory (Paterson & Zderad, 2007) will be used as the theoretical foundation to examine the meaning of mentoring for NPs. The concepts on this theory support the meaning of mentoring as an interaction and exchange of knowledge and information between two unique individuals with specific needs and expectations.

CHAPTER 2

MENTORING IN ADVANCED PRACTICE NURSING: LITERATURE REVIEW

This chapter will discuss the review of literature regarding the role of nurse practitioners (NP) in hospital settings and the use of mentoring to aide transition to the advanced practice role. A brief history of the NP role development will be provided alongside details about the role of NPs working in hospital settings. Barriers to practice, difficulties during the transition period, and solutions to these problems will be identified. The role of mentoring during role transition will be explored as it applies to several groups of healthcare providers, including physicians, nurses, and nurse practitioners. Gaps in the literature regarding the use of mentoring to facilitate NPs role transitions will be identified and the need for future research will be outlined.

Nurse practitioners are an important group of healthcare providers that serve in both primary and acute care areas. It is estimated that nurse practitioners and physician assistants provide 23-25% of generalist care in rural and urban locations (Kaplan et al., 2009). In 2009, there were more than 125, 000 nurse practitioners in the United States (American Academy of Nurse Practitioners, [AANP], 2009). Of these, 39% have hospital privileges and 13% have long term care privileges. Although more than half of the nurse practitioners work in primary care, about 31% practice in inpatient units, emergency, surgical or specialty departments in hospital settings.

The number of NPs increases every year and their practice is expanding to more specialty areas (AANP, 2009). Despite numerous advances in NPs education and training, new NPs experience difficulties transitioning from the registered nurse (RN) role to the advanced practice role (Forbes & Jessup, 2010; Heitz, Steiner, & Burman, 2004; Spinks, 2008). Mentoring during the transition period is

believed to alleviate some of these difficulties and to promote role understanding and integration (Bahout & Esposito-Herr, 2009; van Soeren & Micevski, 2001). The role of NPs in hospital settings and the use of mentoring to aide transition to the advanced practice role will be explored.

2.1 Advanced Practice Nursing History

While the AANP defines Advanced Practice Nurses as Clinical Nurse Specialists, Certified Nurse-Midwives, Certified Registered Nurse Anesthetists, and Nurse Practitioners, some experts argue that the APN concept is poorly defined (AANP, 2009; Mantzoukas & Watkinson, 2006). There seems to be a lack of consensus regarding the characteristics and the role of an APN (Mantzoukas & Watkinson, 2006). Some authors consider RNs with higher degrees and specialization working as administrators as being APNs, while others argue that only RNs with higher degrees, practicing as clinicians, and certified at a national level should be considered APNs. It is, however, recognized that the role of an APN cannot be defined by one unified concept alone, but rather by a variety of roles and characteristics (Mantzoukas & Watkinson, 2006). The evolution of the APN role may explain some of these conceptual conflicts.

The first advanced practice role in nursing was a result of patient needs. The development and use of anesthetics in the late 1800's required designated healthcare personnel to administer them. This role was assigned to nursing. Although not an advanced role at its inception, nurse anesthetists were the first group of nurses who have practiced at a higher level (Savrin, 2009). Initially, anesthetics were administered by the surgeon, whose primary focus was on the surgery. Because of this, the anesthesia was not always administered appropriately. As nurses took on this role, they were able to focus on the administration of anesthetics and were able to provide better care for surgery patients. The role of nurse anesthetists further developed through training and education, becoming one of the most recognizable APN roles in nursing.

The next APN role developed was the nurse midwife (Savrin, 2009). While midwives existed for centuries, the concept of a trained nurse for this role was new. This role started to develop and grow in the U.S. during the first part of the 20th century. Initially, midwives from England were used to fill the

need, but with time, local training and education was provided. The frontier Nursing Service was the first organization to provide training and education for nurse midwives in the United States (Savrin, 2009).

The clinical nurse specialist role was created next, but its development was concomitant with the NP role development. The clinical nurse specialist concept was first described by Peplau (1965) as a specialized nursing role in psychiatry. The role was narrow and specific to certain health problems (Dunn, 1997). With the expansion of the NP role into hospital settings, specifically into acute and critical care settings, the differences between the clinical nurse specialist and NP roles decreased. Some experts make the distinction between NPs and clinical nurse specialists by describing the NPs as nurses providing the care and clinical nurse specialists as nurses improving the care (Dunn, 1997).

The APN role of NP was last to develop in the United States. It was a result of patient needs and the evolution of medicine towards specialization. In the mid 1960's, the number of general medical practitioners was not sufficient to cover the population needs, especially in rural and underserved areas (Mantzoukas & Watkinson, 2006; Savrin, 2009). The NP role was developed at the University of Colorado by Loretta Ford and Henry Silver with the scope of preparing nurses as primary care providers for rural and underserved children.

As the NP role grew stronger in general practice, the hospital sector started looking into the possibility of also using NPs. Some of the first uses of NPs in hospital settings were in the neonatal intensive care and emergency room (Geier, 2000; Marsden, Dolan, & Holt, 2003). The neonatal nurse practitioner role emerged in the late 1970's as a result of limited resident availability in the NICU (Geier, 2000). The practice of NPs managing patients with minor injuries in the Accident and Emergency Department at Oldchurch Hospital in Romford was first presented in the British nursing press in 1988 (Marsden et al., 2003). NP practice initially focused on health promotion and prevention of illness, but as specialization occurred, the NP role expanded. Nurse practitioners provide healthcare services similar to those of a physician, with a unique approach that combines philosophical approaches from both nursing and medicine. The blended approach to patient care focuses on both cure and care (AANP, 2010; Barton, 2006; Geier, 2000; Spinks, 2009).

In today's healthcare environment nurses in these APN roles provide care for diverse patient populations in a variety of healthcare settings (AANP, 2009). They work collaboratively with physicians, nurses, and other healthcare professionals to provide the best possible care for their patients. The effectiveness of APNs in a practice setting seems similar to that of physicians, and is supported by the results of patient satisfaction with their services (Mundinger, et al., 2000; Rhee & Dermyer, 1995). The largest group of APNs is that of nurse practitioners. In 2008, there were a total of 250,527 APNs in the United States. Of those, 138, 600 were NPs (US Department of Health and Human Services, 2010). This literature review will continue to focus only on the NP group.

2.2 Nurse Practitioners

Nurse practitioners are registered nurses who have advanced academic and clinical expertise and pass a national certification exam (Curren, 2007). Nurse practitioners can receive education and specialization in various areas such as: acute and primary care, family health, pediatrics, gerontology, psychiatry, women's health, and neonatology. Besides these specialties, NPs have the opportunity to practice in many sub-specialties. NPs provide a variety of services aimed at managing the overall care of patients. They can carry out diagnostic tests, execute procedures, diagnose and treat health conditions, prescribe medications and treatments, counsel, and educate patients (AANP, 2010).

About 66% of NPs practice in primary care and 39% have hospital privileges to practice in a hospital environment (AANP, 2010). More than half (56%) of private physician groups and 40% of individually practicing physicians use NP services. Between 1997 and 2000, 6.8% of all outpatient visits were performed by NPs (Lin, Gebbie, Fullilove, & Arons, 2003).

Nurse practitioners function in a variety of hospital settings and spend most of their time (85% - 88%) in direct management of patient care (Bruce & Steinke, 2006; Kleinpell et al., 2008). Additional tasks performed by NPs include teaching, research, performance improvement, staff education, and participation in hospital-based committees (Kleinpell et al., 2008). They work collaboratively with medical staff while performing duties related to admissions, continuity of care, consultations, procedures, tests and medications orders, and the initiation and planning of patient discharges. Hospital NPs practice in

specialty-based and sub-specialty groups is specific to each hospital. NPs working in some sub-specialties such as trauma, emergency care, cardiology, and oncology may take additional training and/or certification by individual healthcare organizations. Specialized nurse practitioners perform roles similar to other NPs, but tailored to particular patient populations and/or services. The quality of care provided by NPs in a hospital setting, their effectiveness and issues related to their practice will be discussed as it relates to this study.

2.2.1 Quality of Care

The care provided by NPs for various patient populations seems to be equivalent to the quality of care provided by medical staff (Bevis et al., 2008; Budzi et al., 2010; Guzik et al., 2009; Kleinpell et al., 2008; Mundinger, et al., 2000; Pioro et al., 2001; Sakr et al., 1999). Nurse practitioners working in emergency departments provide care for a variety of patients and have to perform numerous procedures. The outcomes of thoracostomies performed by nurse practitioners were found to be similar to those performed by trauma surgeons (Bevis et al., 2008). A retrospective chart review of thoracostomies performed by nurse practitioners and trauma surgeons evaluated differences in patient outcomes. No significant differences in the need for additional intervention, length of stay, or morbidity were found. Complication rates were lower for nurse practitioner (8%) than for trauma surgeons (12%), suggesting that NPs were able to safely and effectively perform these procedures.

The care provided for patients with minor injuries by NPs in an emergency department was found to be similar to the care provided by junior doctors (Sakr et al., 1999). A total of 1453 patients with minor injuries were randomly assigned to receive care from a NP or a junior doctor. The number of errors made by both groups was comparable and not significant to the overall health outcomes. While the accuracy of assessments, adequacy of treatments, tests and follow up plans showed no significant differences between nurse practitioners and junior doctors, nurse practitioners were better at documenting medical histories. In addition, a smaller number of their patients had unplanned follow-up visits when compared to those seen by the junior doctors. These results suggest that well trained NPs can provide equal or better care for patients with minor injuries in an emergency department.

A retrospective review of medical records for 36 consecutive months revealed that the length of stay for pediatric patients requiring procedural sedation and anesthesia was significantly reduced in an emergency department when NPs managed their care (Wood et al., 2007). The wait time until sedation was also shorter for patients who were under NP care. Some of the difference in length of stay may be attributed to the different diagnoses and approaches to procedural sedation between NPs and physicians as well as the NPs ability to better collaborate with the emergency department nursing staff. These results suggest that NPs can safely conduct procedures traditionally performed by physicians.

Discharge outcomes and health status at six weeks after discharge were similar for adult patients from a general medical unit whether cared for by NPs or physicians (Pioro et al., 2001). A total of 381 patients participated in the study. Patients were randomly assigned to either the NP's (n=193) or physician's (n=188) care at admission to the unit. Patient groups had similar demographic, health status, and comorbidity characteristics. Length of stay, complication rate, 30-day mortality, and level of activities of daily living were similar for the two groups of patients, suggesting similar outcomes. However, it is important to note that 47% of the patients randomly assigned to NP care were later transferred to physician care at the attending physician's or nurse practitioner's request. Despite this limitation, NPs were able to provide quality care for their patients, resulting in similar outcomes.

A review of literature revealed that NPs and medical residents have similar contributions to patient care, education, and research activities in the ICU (Kleinpell et al., 2008). The quality of care provided and its effectiveness were also found to be comparable to those of medical residents. The use of NPs in emergency departments seems to be equally beneficial. The results of another systematic literature review suggest that the use of NPs in emergency departments can reduce wait time, improve patient satisfaction, and ensure a quality of care equivalent or better than the care provided by residents. NPs were equally accurate in interpreting radiological images and completed better documentation. Their use reduced wait time by about 20 minutes in some cases and patients were satisfied with their care (Carter & Chochinov, 2007).

It is evident from these studies that NPs can provide quality care for patients in hospital settings. Even procedures traditionally performed by physicians have comparable outcomes when performed by well trained NPs. Their approach to care management combines nursing and medical methodologies which proves to be safe, effective and well received by patients.

2.2.2 Patient Satisfaction

Patient satisfaction with NPs care seems to also be equivalent and, in some cases, superior compared to the patient satisfaction under the care of a physician. These results are found in many areas of NP practice including hospital-based emergency departments, inpatient, and primary care settings (Bevis et al., 2008; Budzi et al., 2010; Cooper, Lindsay, Kinn, & Swan, 2002; Guzik et al., 2009; Kleinpell et al., 2008; Lin et al., 2002; Mundinger et al., 2000; Sakr et al., 1999). While studies exploring patient satisfaction with NPs in primary care abound, there is a limited number of studies evaluating patient satisfaction in the hospital setting.

Levels of patient satisfaction with the care provided by NPs and physicians were similar in a survey of 129 patients visiting an occupational medicine clinic (Guzik et al., 2009). Besides the overall satisfaction with the provider, satisfaction regarding the time spent with patients, level of technical skills, and explanations given was also similar between the NPs and physicians.

Patients visiting emergency rooms (ER) for minor injuries report satisfaction with NP care (Byrne, Richardson, Brundson, & Patel, 2000; Jennings, Lee, Chao, & Keating, 2009; Organ, Chinnick, Stanhope, Hoskins, & Benger, 2005). A sample of 202 patients in the ER was surveyed regarding their satisfaction with care. Of those, 103 were seen by NPs and 99 by physicians (Jennings et al., 2009). Greater satisfaction was reported with the care provided by NPs in areas related to individualized approach, being thorough, and taking time to discuss concerns. Patient satisfaction was also found to be at least equal for care provided in ER by NPs compared to physicians in a study conducted in three ERs (Byrne et al., 2000). In a matched case-control study patients were asked about their satisfaction with the care received from NPs and physicians in an emergency department (Rhee & Dermyer, 1995). The overall satisfaction was high for both groups, without statistical significant differences between the NP and physician groups.

Patients seen by NPs were less worried about their health compared to those seen by a physician. Increased satisfaction with NP care was also identified for the quality and type of discharge health advice, including written discharge instructions. The authors attribute these findings to the holistic patient-centered approach adopted by NPs. Pediatric patients and their parents are also satisfied with the care provided by NPs in ERs (Organ et al., 2005). Survey results show that 98% of the patients and parents (n=123) were satisfied with all aspects of care provided by NPs.

NPs ability to provide safe and effective care is reflected in the levels of patient satisfaction. While in most cases patients are equally satisfied with the care received from NPs and physicians, in some cases NPs score higher. Higher patient satisfaction scores may be attributed to the NPs' unique approach, focused on both treatment and care.

2.2.3 Cost Effectiveness

Besides similarities in the quality of care provided and patient satisfaction, the use of NPs may also be a cost-saving approach. A reduction in the length of stay and savings up to $1591 per patient were found when nurse practitioners were added to the care team (n = 1200) for general medicine patients (Cowan, Shapiro, Hays, & Afifi, 2006). The length of stay was significantly shorter for patients cared for by the team with NPs, while there were no differences between the two teams in terms of re-admissions.

Based on the results from these studies, the use of NPs in hospital settings is a good alternative. Besides their ability to provide quality care for their patients, nurse practitioners are also focused on wellness promotion and illness prevention. As the role of NPs and their contribution to the overall healthcare of patients continues to develop, questions regarding their work environment, work satisfaction, and evolving role arise (Miller, Snyder, & Lindeke, 2005).

2.3 Barriers to Practice

While NPs contribution to the care of patients in hospital settings continues to grow, only a small number of articles discuss NPs work experience and work satisfaction. The paucity of studies evaluating

NPs satisfaction may be attributed in part to the novelty of this role and to the diversity of settings where NPs work. NPs empowerment to work independently and to provide high quality care depends on the quality of work environment and the support received to implement and understand the role (Bryant-Lukosis, DiCenso, Browne, & Pinelli, 2004; Campo, McNulty, Sabatini, & Fitzpatrick, 2008; Stewart, 2010).

Organizational structures supporting autonomy, professional development, collaboration, and reward systems may enhance NPs satisfaction, while also affecting their ability to provide effective, high quality care (Almost & Laschinger, 2002). A number of validated and non-validated tools are currently used to assess NPs satisfaction. Of these, the Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS) (Misener & Cox, 2001) and McCloskey Satisfaction Scale (MMSS) (Mueller & McCloskey, 1990) are used most often. With few exceptions, the level of NPs satisfaction is low (Dunaway & Running, 2009; Faris et al., 2010; Kacel, Miller & Norris, 2005; Miller, Apold, Bass, Berner, & Levine-Brill, 2005; Schiestel, 2007; Wild, Parsons, & Dietz, 2006). Lowest satisfaction scores were consistently found in areas such as opportunities for professional growth and development, opportunities to participate in research and committees, and the availability of support. These areas seem to represent barriers to the NP role development and implementation and may affect NP retention and recruitment as well as their ability to provide quality care (Faris et al., 2010).

Empowering work environments that promote collaboration, access to resources, information, support, and opportunities for professional growth are key factors in the development of effective and efficient NPs (Almost & Laschinger, 2002). Barriers to NP role fulfillment and satisfaction are a combination of legislative and practice setting issues.

In the practice settings, there may be conflicts between the nursing and medical components of the NP role (Plager & Conger, 2007). Combining care and cure approaches proves difficult in some settings where NPs are expected to be fully emerged in the medical model. The lack of knowledge about NP role is another barrier that leads to confusion, lack of recognition, and misuse of their services

(Forgeron & Martin-Misener, 2005). Inability to participate in education activities and lack of support are also perceived as barriers to role fulfillment and cause dissatisfaction.

Acute care nurse practitioner certification prepares NPs to care for acute and critically ill patients in the hospital setting. However, lack of mentorship, lack of guidance, and lack of support were identified as the leading barriers to their role implementation in some hospitals (van Soeren & Micevski, 2001). The level of preparation for the acute care role was also identified as a barrier alongside lack of support from physicians, nursing leadership, and hospital administration. Lack of mentorship was ranked as the most significant barrier by the participants (van Soeren & Micevski, 2001).

A summary of barriers and facilitators to NP practice is provided by Jones (2005) in a systematic review of literature. Lack of role definition and understanding, lack of preparation, legislative issues, lack of confidence, poor support, and lack of resources and opportunities for professional development were identified as barriers. The impact of these barriers on the NP practice can increase exponentially during the initial stages of NP practice.

Registered nurses enrolled in advanced nursing education have a particular level of expertise in their specialty area. Their first position as NP moves them from the expert level as an RN to the novice domain as an NP. Although they receive ample education and complete numerous hours of clinical rotations, many are inadequately prepared for the actual practice role. The transition to the first job as NP can be difficult and stressful for many (Kelly & Mathews, 2001). Changes in job characteristics, relationships, expectations and required aptitude level can make new NPs feel inadequate and unable to fully perform in their new roles (Huffstutler & Varnell, 2006). These feelings of inadequacy have been described as the “impostor phenomenon” and considered a normal transitional emotional state (Huffstutler & Varnell, 2006). New NPs have to travel the novice to expert road again to reach adequate clinical competence.

2.3.1 From Novice to Expert

As the new NPs find themselves at the novice level again, they need continued support and guidance to move up towards the expert level. In her novice to expert theory, Benner (1984) describes the road traveled by nurses from a novice to an expert stage. The knowledge and skills necessary to reach the expert level are developed mainly through practice, but also through theory and scientific investigation. As nurses move through this continuum, they are able to shift from analytical thinking and detachment, to involvement and engagement in clinical situations. As experts, nurses use intuition rather than a dictated set of rules to act in clinical situations. This development takes place over time and with the support of clinical experts willing to share their experiences. The main concepts found in Benner's (1984) theory are those defining the five stages of proficiency: novice, advanced beginner, competent, proficient, and expert. Each proficiency stage delineates a particular phase in the process of gaining expertise. These phases are not bound by time, but rather by the ability to practice at a certain level. New NPs leave their comfort zone of providing care and are challenged to become skillful at prescribing care (Forbes & Jessup, 2004). Although difficult, new NPs need to be able to recognize their novice status and practice accordingly. New NPs have to re-frame their practice and give themselves permission to be novices and learn their new role (Forbes & Jessup, 2004).

2.3.2 From Limbo to Legitimacy

Brown and Olshansky (1997) developed a theoretical model, "from limbo to legitimacy" for nurses transitioning into their first NP role. Although this model was mainly developed for primary care NPs, it applies to all areas of advanced nursing practice. The four stages of the model are: laying the foundation; launching; meeting the challenge; and broadening the perspective. These four stages of NP development vaguely imitate Benner's novice to expert model. New NPs move through the stages over time, but this is not necessarily a linear movement; at times, some stages may overlap.

Immediately after graduation, there is a relief felt by many NPs, but even though school is over, they still have to take the certification exams to become practicing NPs. Finding a job and completing the certification requirement can be difficult and emotional at the same time. During this time period the new

graduates ‘lay the foundation” for their future as NPs. Once they find a job, they are faced with another stressful reality. They are no longer RNs; they are now APNs. New NPs report feeling of insecurity, anxiety, and incompetence during this initial time (Brown & Olshansky, 1997). The “launching” stage was perceived by many NPs as a very difficult stage when they had to deal with lack of experience, new demands, lack of confidence, and time challenges. After the first couple of months and numerous opportunities to gain experience, new NPs feel more confident and competent. They also start feeling legitimate, as they sail through the “meeting the challenge” stage. Towards the end of the first year, many NPs feel capable to fully perform the role and have a much better understanding of the work environment and job requirements. While the increased competence does not mean that the new NPs have reached the expert level, it does mean that they moved away from being a novice towards gaining expertise. During the “broadening the perspective” phase, new NPs start challenging themselves and they become more efficient and confident.

This process of becoming and feeling legitimate is not linear. Throughout this period of adaptation, learning, and growth, progress may be hindered by periods of regression to previous stages. As suggested by the model’s authors, progression may be faster or slower, easier or harder depending on environmental factors such as role clarity, resource availability, and support (Brown & Olshansky, 1997).

Interviews with NPs about their experiences regarding transition from school to the first job, revealed similarities to the “limbo to legitimacy” model. Time challenges were identified as significant barriers to their development as NPs by a sample of 21 NP alumni during focus group discussions (Kelly & Mathews, 2001). Feelings of disconnection from both the nursing and medical community were common as the new NPs tried to define their role and find their place within the healthcare organization. These feelings of disconnection sometimes turned into feelings of isolation. They encountered relationship barriers with nurses who made them feel like they have betrayed the profession, and physicians, who did not always recognize the NPs as competent providers. Lack of role definition and organizational standards for NP practice left new NPs feeling ambiguous about their role.

During a series of telephone interviews with family NPs, two distinct phases of transition were identified: one during education and the second one immediately after entering the workforce as NPs (Heitz et al., 2004). The first transition starts when nurses begin their education to become NPs and involves learning and understanding the new role. Most NPs do not complete the transition into the new role until they start practicing. External and internal factors contribute to the role transition as both barriers and/or as positive experiences. The most significant external barriers to role transition were related to the preceptor's inability to train the new NPs, lack of mentorship, staff resistance, and environmental issues. Feelings of fear, insecurity, vulnerability, self-doubt, and isolation as well as role confusion were associated with intrinsic barriers. Another theme emerging from these interviews was "turbulence". Participants described the initial phase of their employment as new NPs as challenging and in sometimes chaotic (Heitz et al., 2004).

Spinks (2008) compared the transition from staff nurse to neonatal nurse practitioner to a marathon. It starts with excitement and enthusiasm, but also with apprehension due to the unknown. As the NP graduates, reaching a halfway point, new challenges are taken on with a sense of accomplishment. To finish the marathon and become a neonatal NP, barriers such as isolation, confusion, inadequacy, and anxiety must be overcome. New neonatal NPs feel in between the worlds of nursing and medicine, just like other new NPs. They feel expelled from nursing and not accepted into medicine, while in fact they belong to both worlds. Feelings of anxiety and struggle to understand the role were also identified as steps in the process of becoming an NP (Cusson & Viggiano, 2002; Nichols, Burr, & Powell, 2005). The change process experienced on both personal and professional levels was found to be challenging and sometimes frustrating. It was noted that in a supportive environment this process becomes easier.

Although not widely studied, many new NPs have a difficult time adjusting to their new role. The transitions from a bedside caregiver to a care provider role prove to be arduous for some (Brown & Olshansky, 1997; Huffstutler & Varnell, 2006; Kelly & Mathews, 2001; Kleinpell & Hravnak, 2005). Common barriers such as role confusion, lack of support, and feelings of isolation, insecurity, vulnerability, doubt, inadequacy, and anxiety are found across multiple studies (Barton, 2006; Brown &

Olshansky, 1997; Forbes & Jessup, 2004; Heitz et al., 2004; Nichols et al., 2005; van Soeren & Micevski, 2001). The process of becoming a competent NP involves a process of learning and practicing that is different for each individual. Called "from limbo to legitimacy" or "a rite of passage", transition to the NP role involves social, cultural, and professional changes and require negotiations within NPs own values and within their professional circles (Barton, 2006; Brown & Olshansky, 1997).

2.4 Successful Role Transition

This challenging transition to the first NP job can be made easier with effective organizational and peer support. Support and assistance during the novice stage is empowering and plays a significant role in the development of new NPs as expert care providers (Bahout & Esposito-Herr, 2009; Faris et al., 2010). Almost and Laschinger (2002) found a negative correlation (r=-0.69) between workplace empowerment and job strain. Access to support and opportunities to improve skills and knowledge were identified as empowering components of the work environment. As the number of NPs increase, healthcare organizations are looking for solutions towards reducing barriers to practice. Better role definition, orientation programs, and mentoring are options considered by healthcare organizations to improve NP practice and facilitate the transition from school to practice (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Kleinpell & Hravnak, 2005).

Barriers and facilitating factors affecting the development and implementation of the NP role have been scantly studied. A systematic review (Jones, 2005) provides a summary of barriers and facilitators to NP practice. Clinical and role preparation, personal factors, supportive work environments and support from peers and other healthcare professionals were identified as facilitators to NP role implementation and development.

Availability of support, access to resources, and opportunities for growth and development are components of structural empowerment and are conducive to successful role development and implementation (Almost & Laschinger, 2002; Stewart et al., 2010). Successful collaborative relationships within organizations (Kleinpell & Hravnak, 2005) and low levels of job strain are important factors in the role transition process and can be enhanced when structural empowerment is present. A relationship

between structural empowerment and NPs ability to collaborate with physicians and administrators was found in a study evaluating structural empowerment, collaborative behavior, and job strain (Almost & Laschinger, 2002). NPs experienced higher levels of trust and respect from physicians and administrators, increased autonomy, greater participation in the decision-making process, and lower level of job strain when structural empowerment was present. A smaller sample (n-95) of NPs, participated in an on-line survey evaluating the relationship between structural and psychological empowerment (Stewart et al., 2010). Psychological empowerment definition in this study includes meaning, competence, self-determination, and impact and can facilitate role development and transition. Opportunity, information, support, resources, and power represent the components of empowering work environments. Overall scores for structural and psychological empowerment were significantly related, meaning that structural empowerment results in higher levels of psychological empowerment.

Structural empowerment is an important aspect related not only to NPs satisfaction, but to their ability to provide quality care and to further develop as mid-level providers. Orientation programs for new NPs combine activities related to role definition, education and training, opportunities for growth, and support (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Green, Gorrzka, & Kodish; Sorce et al., 2010). They are tailored to participants needs and provide support through the process of certification, credentialing and orientation specific for each healthcare organization (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Sorce et al., 2010). Mentoring is provided early to facilitate role adjustment and understanding of the scope of practice. It is also used to facilitate clinical training and access to resources. The specifics of core education and competency training vary based on the organizational and specialty requirements. Peer support and networking are facilitated by both mentors and as part of the orientation program. Throughout the orientation program mentoring is viewed as a very important component. Feelings of isolation and role confusion may be minimized by mentoring, while access to resources may be improved (Bahout & Esposito-Herr, 2009).

Mentoring has been found to improve retention, reduce stress, and facilitate the acquisition of skills and knowledge for nurses, NPs, and physicians (Buddenberg-Fischer & Herta, 2006; Castiglioni, Bellini, & Shea, 2004; Faron & Poeltler, 2007; Halfer, Graf, & Sullivan, 2008; Persaud, 2008; Tsai et al.,

2006). Unfortunately, this concept is poorly understood and inadequately studied in the advanced nursing practice context. A very limited number of studies about mentoring in advanced nursing practice are published.

2.5 Mentoring

Mentoring is often utilized in healthcare to guide students, residents, interns, young physicians and new nurses through career choices and role transition. Despite its widespread use in healthcare, mentoring is poorly defined and understood.

2.5.1 Definition

Traditionally mentoring takes place between a more senior, experienced person and a younger, less experienced one, but it also occurs between peers (Grossman, 2007). Knowledge usually flows from the mentor to the mentee, but there is a certain level of two-way knowledge and information exchange that benefits both the mentee and the mentor. Open, honest, and confidential communication and interaction are fundamental characteristics of mentoring in nursing (Grossman, 2007; Thorpe & Kalischuk, 2003). The overall goal of mentoring in nursing is to foster growth and development, satisfaction and competency, and to improve retention. Goals are achieved through supportive, encouraging, and non-judgmental relationships in which information and knowledge is shared (Beecroft, Santner, Lacy, Kuzman, & Dorey, 2006; Block et al., 2005; Cashin & Potter, 2006; Dancer, 2003; Dyer, 2008; Halfer, et al., 2008; Grossman, 2007; Latham, Hogan, & Ringl, 2008; Persaud, 2008). Mentors may fulfill the role of counselors, consultants, role models, tutors, coaches, guides, and sometimes friends to help mentees improve their clinical competency, provide emotional support, and guide their professional development (Castiglioni et al., 2004; Tsai et al., 2006).

Mentoring is used interchangeably with precepting and coaching to define programs aimed at supporting new staff during the initial stages of their employment. Although recognized as a complex and dynamic concept, there are few attempts to clearly define the concept of mentoring in healthcare and especially in advanced nursing practice.

2.5.2 Theoretical Frameworks

Theoretical frameworks and models have been used to design mentoring programs for nurses and NPs, although most mentoring programs are not rooted in theoretical frameworks. Some of the theories and models used are: role theory (Hayes, 1998), social learning theory (Masny, Ropka, Peterson, & Fetzer, 2008), social transition model (Barton, 2007), and theory of organizational empowerment (Wolak, McCann, Queen, Madigan, & Letvak, 2009).

2.5.2.1 Role Theory

Individuals fulfill particular social roles supported by specific behaviors and expectations. There is a specific status and set of attitudes associated with particular roles that are congruent with accepted societal norms. Both societal structure and the meaning of events and interactions define an individual's role ((Hayes, 1998; Jackson, 1998). In the mentoring relationship, both the mentor and the mentee fulfill specific roles and functions. Their particular status qualifies them to participate in the relationship (Hayes, 1998).

2.5.2.2 Social Learning Theory

Mentoring facilitates mentees transition from the novice status towards expertise. Becoming proficient to perform various nursing tasks involves more than knowledge acquisition. According to the social learning theory, observation of skills performed by experts, constructive feedback, practice, and confidence in own capabilities are also necessary to successfully learn. Mentoring can facilitate skill learning, knowledge acquisition, and professional development through the use of these concepts (Masny, Ropka, Peterson, & Fetzer, 2008).

2.5.2.3 Social Transition Model

As individuals or groups of individuals gain status, abilities, and/or skills, they change over time. As these changes occur the individual and/or group transition to a different societal status. These transitions can cause conflicts and may require negotiation of status. New nurse practitioners transition

from staff nurses to provider status. As conflicts may develop during their transition, mentoring can facilitate negotiations and adaptation. Mentors are viewed as the catalysts to gaining the knowledge and skills required to perform the new role within the new social and/or professional group (Barton, 2007; Holland, 1999).

2.5.2.4 Theory of Organizational Empowerment

Attitudes and behaviors supportive of professional growth are influenced by personal predispositions but also by aspects of the work environment (Wolak, McCann, Queen, Madigan, & Letvak, 2009). Individuals can be empowered to transition and fulfill their role when the work environment provides access to information, support, resources, and opportunities to learn and grow (Larkin, Cierpial, Stack, Morrison, & Griffith, 2008). Empowered employees perform better, are more accountable, and more committed to the organization. Mentoring can facilitate empowerment by facilitating access to information and resources and providing support. The availability of support may be particularly important for new nurses and NPs facing a multitude of challenges associated with the new role (Wolak, McCann, Queen, Madigan, & Letvak, 2009).

Theories and models are used to define mentoring as a relationship aimed at helping a novice nurse or APN learn new clinical skills and enhance professional development through sharing of knowledge, access to resources, and support (Lee & Fitzgerald, 2008; Masny, Ropka, Peterson, & Fetzer, 2008; Richmond, 2006; Wolak, McCann, Queen, Madigan, & Letvak, 2009). Others describe the goal of mentoring as to increase retention and satisfaction, promote clinical competence, improve communication, and patient satisfaction (Faron & Poeltler, 2007), while some add the goal of facilitating the transition to the clinical environment and socialization (Cusson & Viggiano, 2002; Halfer, et al., 2008; Hayes, 1998; Persaud, 2008). Variations in the definition and use of mentoring stem from the complexity of the mentoring concept.

2.5.2.5 Humanbecoming Mentoring Model

While most theoretical frameworks have been designed for other purposes and then adapted for mentoring, Parse (2008) developed a mentoring specific theoretical model. The humanbecoming mentoring model was built on the ontology of humanbecoming and offers a new perspective of the mentoring relationship. While this model moves mentoring from the traditional into higher open conceptual fields, it is not generated from mentoring participants' lived experiences. This is rather a high level analytical exercise that used existing theories and concepts to craft this new mentoring model. The assumptions, essences, and processes defined in this model are very abstract making it hard to grasp their meaning. The entire model is based on the informal mentoring process that assumes that mentoring participants freely choose each other.

The first assumption of this model is: incarnating meaning is co-constructing the now moment, as committing with enthusiasm arises with impelling gentle urging. The essence of this assumption is committing with enthusiasm which translates into a commitment of mentoring participants to work together guided by a specific agreement and plan. The process associated with the first assumption is impelling gentle urging, meaning that participants in the mentoring relationship use verbal and non-verbal communication modalities to make themselves available in a non-judgmental way. It also implies that the mentee has clear and well established goals in mind and will receive the appropriate help form the mentor to achieve these goals.

The second assumption presented by Parse (2008) is unfolding pattern is moving with cadent rhythms, as diligent loving presence arises with attentive respecting. This assumption reiterates the choice to engage in mentoring, but also suggests that the relationship follows a pattern of interaction. The essence of this assumption is diligent loving presence and exemplifies mentors' ability to foster guided independence for their mentees. The process of attentive respecting associated with this assumption is defined as mentees' ability to ask mentors for specific help associated with their clearly identified needs and suggests that mentors do not inquire beyond what the mentee asks.

The third and last assumption of Parse's (2008) model is discerning insight is shapeshifting possibles, as venturing with the new arises with affirming distinction. The essence of this assumption is venturing with the new, suggesting that mentoring participants leave their comfort zone to participate in the relationship. This is portrayed as a risky move that may leave participants vulnerable as they let themselves be known by the other. The process associated with this assumption is affirming distinction, meaning that mentoring participants recognize the other participant's merit as they engage in various projects that may have successful outcomes but are always somehow vague. When it occurs, success is acknowledged and celebrated by both participants.

Parse's model is a theoretically refined, abstract conceptualization of mentoring without a specifically targeted application. Its highly abstract definitions make it hard to understand and may discourage nurses to use it in practice. No studies using this model have been identified to date.

2.5.2.6 The Concept of Mentoring

Teaching and learning is present in mentoring, coaching, and precepting relationships. Preceptors focus on teaching new nurses and NPs the skills required for the job and orient them to the rules and regulations of the unit, coaches teaching is task or project oriented (Grossman, 2007), and mentors focus on nurturing new nurses' potential and help them grow (Faron & Poeltler, 2007; Persaud, 2008). While all types of relationships can be used to help new nurses and NPs transition to new roles, coaching and precepting lack the emotional involvement over a longer period of time, specific to mentoring (Grossman, 2007; Stewart & Krueger, 1996).

The last conceptual analysis of mentoring in nursing was published by Stewart and Krueger in 1996. They define mentoring as a teaching-learning relationship between an experienced nurse and a novice that takes place through sharing of personal experiences. Career progression, empowerment, and socialization are some of mentoring consequences identified by their analysis (Stewart & Krueger, 1996). Mentoring in nursing is also considered a developmental relationship between peers that results in increased potential and empowerment for both participants (Vance & Olson, 1998). The outcomes of this developmental relationship are success and satisfaction. In the advanced nursing practice,

mentoring is viewed as a complex and dynamic relationship aimed at improving competency and supporting growth and productivity while fostering confidence and self-efficacy (Barker, 2006).

2.5.3 Literature Review of APN Mentoring

The aim of mentoring in advanced practice is to help novice APNs develop professionally (Barker, 2006). While the specific timeline and outcomes of each mentoring program may vary, the overall goal is to establish a mentoring relationship based on openness and trust, where the mentee can freely discuss challenges and gain the confidence needed to practice. Much of the literature on mentoring focuses on nursing students and registered nurses, not on APNs. In the advanced practice, mentoring is mainly explored in the context of APN education and role transition. Several mentoring benefits themes have emerged from the APN mentoring literature.

2.5.3.1 Role Transition

Orientation programs for new NPs are offered by some healthcare organizations to facilitate role transition. These programs combine activities related to role definition, education and training, opportunities for growth, and support (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Green et al., 2005; Sorce et al., 2010). They are tailored to participants needs and provide support through the process of advanced practice certification, credentialing, and orientation specific for each healthcare organization (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Sorce, et al., 2010). Peer mentoring is provided early to facilitate role adjustment and understanding of the scope of practice. Throughout the orientation programs, mentoring is viewed as a very important component. Feelings of isolation and role confusion may be minimized by mentoring, while access to resources may be improved (Bahout & Esposito-Herr, 2009; Szanton, Muhaly, Alhusen, & Becker, 2010). Competing demands related to clinical competency, safety, and effectiveness while learning the new role may be alleviated when mentoring is available for new NPs (Cusson & Viggiano, 2002). Orientation programs with a mentoring component facilitate understanding of the advanced practice role and role integration, enabling new NPs to successfully transition, practice safely and effectively, and develop professionally (Bahout & Esposito-Herr, 2009).

A smooth transition into the advanced practice role is also the goal of mentoring programs for graduate nursing students. Support to learn the advanced practice role is even more important for minority students and those who work full time while in school (Mackin, Macera, & Jennings, 2006). Evolving mentoring programs that move from academic to clinical support as students advance through their education can provide the personal and professional assistance needed to successfully complete an academic program and facilitate transition into the clinical role (Mackin, et al., 2006). Clinical internships in collaboration with graduate nursing programs are also offered by some healthcare organizations. Mentoring is typically an important component of these programs (Lee & Fitzgerald, 2008). Mentoring during internship is aimed at helping new NPs understand the advanced practice role and facilitate transition. Role transition is a staged process that takes time and requires professional relationships re-negotiation and socialization into new professional groups (Barton, 2006; Barton, 2007).

2.5.3.2 Socialization

As RNs move through graduate education and become NPs, they move into a different social and professional group and have to re-negotiate social, cultural, and professional relationships (Barton, 2006; Barton, 2007). Mentoring validates their experiences and guides them through the process of integration. Besides the individual support, mentoring facilitates socialization through networking. Mentees can utilize their mentor's already established network to gain a broader perspective of the role and its social, cultural, and professional implications (Hayes, 1998; Szanton, et al., 2010) . Isolation and the feeling of disconnection experienced by new NPs may be alleviated by mentoring. New NPs may be introduced to the NP community by their mentor and may be more quickly recognized and accepted as mid level practitioners by both the nursing and physician groups when introduced by a mentor (Bahout & Esposito-Herr, 2009; Spinks, 2008). Socialization and role integration can be further enhanced for NPs practicing in a medical model when physicians fulfill mentoring roles (Barton, 2006). Transition to the NP role requires not only role understanding and socialization, but a different set of clinical skills as well.

2.5.3.3 Clinical Competence and Confidence

Although many new NPs were expert bedside nurses, they become novices again as they transition into the advanced practice roles. Accepting the novice state can be difficult for some new NPs (Forbes & Jessup, 2010). Guidance and assistance during the novice stage plays a significant role in the development of new nurse practitioners as expert care providers (Faris et al., 2010). Access to support and opportunities to improve skills and knowledge are empowering components of the work environment and can facilitate role transition (Almost & Laschinger, 2002). Mentoring can ease the transition to the NP role by facilitating the acquisition of clinical skills and helping new NPs build confidence in their practice (Barton, 2006; Cusson & Viggiano, 2002). Clinical decisions and time management can be enhanced when a mentor is available to guide the mentee, to answer their questions, and to provide access to resources (Lee & Fitzgerald, 2008). Mentoring can also improve NP students' self-efficacy and readiness for practice (Hayes, 1998). While readiness for practice and the acquisition of clinical skills are important steps in the transition to the NP role, being a NP involves more than clinical expertise.

2.5.3.4 Professional Growth

Mentees' professional development is not only a common finding, but an expected outcome of mentoring (Barker, 2006). Under the guidance of mentors, new NPs learn their role and re-negotiate their professional and social relationships to effectively fulfill the role. As their clinical skills, self-effectiveness, and confidence build, they start moving across the novice to expert continuum (Barton, 2007; Cusson & Viggiano, 2002; Lee & Fitzgerald, 2008). New NPs are expected to grow professionally and fulfill roles associated with education, leadership, consultancy, and research (Cussom & Viggiano, 2002; Doerksen, 2010). Through role modeling and networking, mentors can introduce these additional roles to the new NPs practice.

Although not widely studied and discussed, professional development may also occur for mentors. By participating in mentoring mentors can model best practices, find new ways to improve practice, keep up with new developments, and become more self-aware and responsible (Richmond, 2006). Mentors growth and development is part of the conceptual definition of mentoring in nursing, but

rather than being an expectation it is considered a potential benefit (Barker, 2006; Stewart & Krueger, 1996).

Support with role transition seems to be the core theme emerging from this review. Mentors play a vital role during new NPs transition and integration into the new role by providing professional, social, and emotional support. A successful role transition is associated with clinical competence, confidence, successful socialization, and professional development of the new NP (Brown & Olshansky, 1997; Cusson & Viggiano, 2002). While other benefits of mentoring such as those related to job satisfaction and retention are sparsely discussed or absent from the APN mentoring literature, they abound in the nursing mentoring literature (Beecroft, et al., 2006; Block, et al., 2005; Faron & Poeltler, 2007; Halfer et al., 2008; Latham, Hogan, & Ringl, 2008; Masny, Ropka, Peterson, Fetzer, & Daly, 2008; Persaud, 2008; Wolak, et al., 2009).

Although no correlation between mentoring and job satisfaction was found in advanced practice (Cuesta and Bloom, 1998), evidence that exists suggests that mentoring positively impacts job satisfaction for nurses. Mentored nurses feel more comfortable asking questions and dealing with job requirements. Their acceptance by peers can improve and they may feel encouraged to learn from previous mistakes. Overall, mentored nurses are more satisfied with their job than those who are not mentored (Faron & Poeltler, 2007; Halfer et al., 2008). Improved retention and lower turnover rates are also reported as a mentoring benefit in the nursing literature (Block, et al., 2005; Faron & Poeltler, 2007; Persaud, 2008). New nurses able to successfully transition into their clinical roles and socialize with their peers have a tendency to keep their current position. Without the support of mentors role transition may not occur, new nurses may experience isolation, frustration, and low confidence, and may want to leave the job (Block, et al., 2005; Faron & Poeltler, 2007; Latham, et al., 2008; Wolak, et al., 2009).

2.5.3.5 APN Mentoring Challenges

The design and implementation of a mentoring program for NPs takes time and resources. Support from organizational leadership and administration is essential to the success of a mentoring program (Doerksen, 2010). Once established, challenges associated with mentor selection and training

may hinder the success of mentoring. The role of mentors may vary depending on the program objectives, but they need to exhibit role modeling behaviors, support their mentees, and have the ability to give constructive feedback (Richmond, 2006). When these behaviors are not consistently exhibited, the outcome of mentoring may not be as expected. Excellent communication skills and the ability to listen rather that teach all the time is another challenge faced by mentors (Barker, 2006; Lee & Fitzgerald, 2008). Problems with communication and feedback may increase when the mentor and mentee are poorly matched. Although a variety of methods such as personality tests and profiles can be used to improve mentor-mentee compatibility, mismatching can still occur (Barker, 2006). While all of these challenges can be overcome with a good selection and training of mentors, the time challenge may be a real obstacle to successful mentoring (Lee & Fitzgerald, 2008; Richmond, 2006). Mentoring can be time consuming for both mentors and mentees. In today's healthcare environment plagued by high costs and limited budgets, NPs may not have the time to mentor and be mentored. Although face-to-face meetings between mentor and mentee are almost always recommended, many mentoring participants may not have the time to meet (Lee & Fitzgerald, 2008; Richmond, 2006). Using alternative ways to communicate may prove to be a viable alternative or addition to face-to-face meetings. Challenges associated with mentoring need to be thoroughly evaluated when mentoring programs are developed to minimize barriers and maximize benefits.

2.5.4 Gaps and Limitations

While mentoring is widely utilized as a means to facilitate role transition, improve satisfaction, competence, and confidence, and facilitate professional development, the concept of mentoring in nursing is poorly understood and often used to define relationships that are not truly mentoring. Mentoring and related concepts such as role modeling, coaching, consulting, and precepting are interchangeably used causing confusion and perpetuating the lack of conceptual clarity (Barker, 2006; Stewart & Krueger, 1996). Mentoring in nursing has never been clearly defined and characterized through research, but rather through borrowed definitions and concepts from other disciplines. As a result, many nursing mentoring programs are not based on theoretical foundations or conceptual definitions. Those using theoretical foundations do so based on the desired outcomes of the program.

Variations in expected outcomes result in the use of various theoretical frameworks and may deepen the lack of concept clarity for mentoring in nursing.

Several articles discussing mentoring for APN seem to describe precepting or coaching relationships rather than mentoring (Barton, 2006; Barton, 2007; Mackin et al., 2006; Richmond, 2006). Although called mentoring, the relationships described in these studies lack the emotional involvement and focus mainly on skill acquisition. Even less specific to mentoring is the role of mentors as clinical supervisors and evaluators (Lee & Fitzgerald, 2008; Richmond, 2006). Adding to the confusion is the fact that some authors do not provide a clear description of the programs or compare programs with very different structures (Cuesta & Bloom, 1998). While true mentoring programs can be found in the nursing literature, many lack appropriate evaluation. Most programs only evaluate participants' satisfaction with mentoring rather than concrete benefits such as satisfaction, retention, and improved competence. A reason for not having appropriate evaluation tools may be lack of clear conceptual definition and especially the lack of an operational definition for the concept of mentoring. Without proper understanding of mentoring as an operational concept it is difficult to assess its benefits. Although some valid and reliable tools to evaluate mentoring exist (Caine, 1989; Freeman, 1989; Hayes, 1998) they are old and have been rarely used. The complexity and length of these tools may the reason for their limited use. Most studies develop their own evaluation tools based on the desired program outcomes. The lack of consistency in program evaluation makes it impossible to compare the benefits of these programs.

Mentoring has been found to improve role transition, job satisfaction, and retention while facilitating socialization, emotional well being, and the acquisition of skills and knowledge for both nurses and NPs (Barton, 2006; Barton, 2007; Cashin & Potter, 2006; Faron & Poeltler, 2007; Halfer et al., 2008; Persaud, 2008), but this concept is poorly understood and inadequately studied in the advanced nursing practice context. While anecdotal reports of mentoring programs for new nurse practitioners abound, there are no published reports of their structure or effectiveness. Mentoring is a main component of orientation and internship programs for NPs, but there is little empirical evidence that mentoring can effectively improve transition to the advanced practice role. There are only two studies exploring

mentoring in APNs, but their focus is on mentoring needs and mentors perceptions of their experiences rather than the exploration of meaning, relationships, and outcomes (Doerksen 2010; Richmond, 2006).

2.6 Summary

Reports of mentoring in nursing and advanced nursing practice show participants' satisfaction with mentoring and sometimes other benefits related to role transition, retention, socialization, work satisfaction, clinical competence, confidence, and professional development. Unfortunately many of these studies are poorly designed, have small samples, and use non-validated tools to evaluate mentoring. Additionally, there is a lack of consensus on mentoring definition and utilization. The term mentoring is used interchangeably with precepting and coaching denoting poor understanding of these terms. When discussing mentoring for nurse practitioners there is a significantly lower number of articles (9) published. While anecdotal reports of mentoring programs for new nurse practitioners abound, there are no published reports of their structure or effectiveness. Despite limitations, mentoring is a useful approach to facilitate new NPs transitions, role understanding, socialization, clinical expertise, confidence, and professional development.

Since more healthcare organizations use mentoring as part of their orientation programs for NPs it is imperative that this concept is clearly described and understood. It is also important to understand the process of mentoring, related concepts, and relationships between these concepts. Without a good understanding of the concept and proper program design, mentoring may not produce the expected outcomes. Furthermore, without a clear definition of the concept and the process involved it would be impossible to evaluate its benefits and generalize its use.

Qualitative research is needed to understand the experiences of hospital based NPs participating in mentoring. Findings can be used to define the concept, develop an operational definition of mentoring for NPs, and to develop a mentoring theory for this population. A theoretical framework of mentoring for hospital-based NPs and an operational definition could promote consistent development and evaluation of mentoring programs for this population and eventual generalization to other NP groups.

CHAPTER 3

METHODS AND PROCEDURE

This chapter will describe the design for conducting a grounded theory study about mentoring in the nurse practitioner population in a hospital setting. The design, sampling procedures, study setting, data collection methods, procedures, ethical considerations, data analysis, limitations, and delimitations of the study will be discussed.

Qualitative research provides a means for a researcher to understand multiple realities and perspectives. It allows the researcher to not only design and coordinate research, but to also actively participate in the study. Grounded theory is a unique qualitative research approach that moves beyond description or understanding to a higher level of theoretical representation of participant's experiences (Munhall, 2007). When using grounded theory, the researcher generates theory relevant for the participants through a systematic approach to data collection and analysis.

3.1 Grounded Theory

Throughout their lives human beings interact with each other and with the environment. Although people learn to assign meanings to events and situations based on accepted social rules, the impact of certain events may create a more profound and different meaning for each participant (Annells, 1996; Walker & Myrick, 2006). This new meaning can be quite different when compared with the generally accepted societal rules. Generalizations about accepted or expected social behavior occur as a response to social theories. Many of these theories have been developed by using deductive analysis methods (Parahoo, 2009). This type of analysis looks at events from the outside without taking into account participants' voice and perspective, thus failing to capture variations in interpretation and

meaning (Glaser & Strauss, 1967; Walker & Myrick, 2006). Human behavior is greatly influenced by personal experiences and context. Theories about human behavior not grounded in qualitative research may not be anchored in reality. Only theories derived from data collected using qualitative methods can provide a deep understanding of human behavior in the social context (Chen & Boore, 2009; Corbin & Strauss, 2008; McCann & Clark, 2003a; Munhall, 2007). Good human behavior and human interaction theories are generated from the data itself, they are not just verified by the data. Grounded theory provides the method and tools which allows researchers to develop theories based on and generated by the data (Munhall, 2007).

3.1.1 Philosophical Background

Pragmatism and symbolic interactionism are considered the philosophical keystones of grounded theory (Chen & Boore, 2009; Munhall, 2007; Walker & Myrick, 2006). People's actions and their comportment vary during similar experiences. The same event can be interpreted differently by its participants. Behaviors are generated from meanings and symbols and are shaped by each person's perception of reality (Chen & Boore, 2009). The person's understanding of interactions will differ based on his or her own experiences. These differences in opinions and understanding allow people to perceive reality in diverse ways. Understanding human behavior requires the acceptance of multiple realities as perceived by each participant in an interaction. Human behavior theories need to capture the meanings and symbols assigned to events by participants while acknowledging the uniqueness of each event and each participant (Chen & Boore, 2009).

Pragmatism allows a choice of philosophical perspectives without promoting any one as more important. Its central focus is on the practicability and applicability of a problem or idea to real-world situations and, most importantly, on the effects of actions (Creswell & Clark, 2007; Warms & Schroeder, 1999). For pragmatists, truth does not exist independent of people's perceptions and their mental interpretation of it. Truth is discovered by science and everyday realities, and can change over time. Without or outside the human mind there cannot be truth. People create their own truths according to their values and beliefs and their practical applications or utilities of the truth (Kremer, 2007; Rorty, 1982).

The question is not only what difference will the truth make, but also how it will be realized, and how will people experience truth versus falsehood. Truth is recognized by the pragmatists as ideas or theories we can understand, verify, and confirm (James, 1907). Truth and reality can be understood only when the complexity and the meaning of events and behaviors is captured from the participants' perspective (Chen & Boore, 2009; Corbin & Strauss, 2008; Munhall, 2007). These perspectives are influenced and shaped by the symbols assigned to them by participants. As a worldview, pragmatism promotes interdependence. A pragmatic approach to reality assumes that nothing in this world is or functions separately or independently. Every event is influenced by other events or things that we may or may not see. This interdependence promotes continuous changes and variations of reality and the progress of science (Kremer, 2007).

People make sense of their reality by assigning meanings to things and events. Symbolic interactionism implies that people assign meanings and symbols to events according to their values, beliefs, and previous experiences. Social interaction provides the vehicle to create meanings and to also change them (Cleveland, 2009). Every situation or interaction can be defined and perceived differently by each participant. There are multiple views and perspective of each event (Chen & Boore, 2009). Every aspect of an interaction, from clothing to gestures and voice inflections, has a particular meaning and an assigned symbol. These meanings and symbols enable participants to build their reality and view of the world. People's feelings and actions are influenced by the meanings assigned during social interactions (Munhall, 2007). Understanding these meanings and symbols allow researchers to understand and predict human behavior and interaction (Morse, 2009).

3.1.2 Origin

The development of theories from data did not start with grounded theory. This inductive method for developing theory has also been used in anthropology and ethnography (Parahoo, 2009). Although theories about human behavior were developed using observations in the field, there were no published procedures or methods to be used in this process. This lack of knowledge impeded the use of inductive methods for theory development outside ethnography and anthropology.

In the early 1960's two sociologists teaching at the University of California San Francisco School Of Nursing became interested in developing theories about the experience of dying. Glaser and Strauss studied the interactions of healthcare workers and dying patients in hospitals (Moore, 2009). Throughout the study Glaser and Strauss were interested in the meanings and symbols assigned to events by its participants. Their combined experience enabled them to examine the data from a symbolic interactionism perspective using constant comparison. Unlike other researchers, Glaser and Strauss used a rigorous and systematic method to analyze the data. When looking back at their methods, they realized this can be used by other researchers to generate theories on human behavior and interactions (Morse, 2009). This new method was called Grounded Theory. Details about the process used to generate theories from data were published by Glaser and Strauss (1967).

Although Glaser and Strauss are considered the creators of Grounded Theory, their work was built on elements of the Chicago School of Sociology (Morse, 2009, Munhall, 2007). The work of Mead and Blumer regarding the importance of social interactions on the self-actualization of individuals and people's ability to construct their social roles and reality is the foundation of symbolic interactionism (Cortese, 1995). Blumer was a symbolic interactionist who examined human behavior in a social context to identify meanings and symbols associated with particular behaviors. He was Strauss's advisor and introduced him to symbolic interactionism and Mead's work (Morse, 2009).

3.1.3 Rationale

While it is widely recommended to choose a research method based on the research question, it is also important for researchers to explore their capabilities and interests (Munhall, 2007). The lack of a clear conceptual definition of mentoring in advanced nursing practice is the main reason for conducting this study. The questions to be answered are about the meaning of mentoring and how it actually takes place. To answer these questions the concepts associated with mentoring and the relationships between them need to be identified and understood from the participants' perspective. Generating a theory of mentoring would allow a better understanding and evaluation of this process by providing the means to

operationally define this complex concept. As a result, grounded theory was chosen as the research methodology for this study.

Grounded theory was developed by Glaser and Strauss (1967) as a systematic method to conduct qualitative research by combining the logic and rigor specific to quantitative methods with the depth and richness of qualitative approaches (Glaser & Strauss, 1967). The purpose of grounded theory is to produce a theory that explains behaviors specific to particular events and participants. The focus is not on the events or interactions themselves, but rather on their meaning for participants. Although theories developed are specific to events and participants, they can sometimes be applied to other situations or groups of people (Morse, 2009; Munhall, 2007). In an effort to make qualitative research more approachable, especially when creating theories from data, Glaser and Strauss (1967) documented their process and developed a method to be followed.

3.2 Research Design

Grounded theory is a qualitative research process that combines the richness associated with qualitative methods with a rigorous and systematic approach. The research focus or question are not present at the start of the study, but take shape as the researcher moves on with data collection and analysis. While there are different versions of grounded theory, they all share some common elements.

Corbin and Strauss‘s (2008) version of grounded theory was be used for this study. They use a post-positivist paradigm and give more importance and voice to the research participants. They acknowledge that reality is complex and it cannot be fully apprehensible. As a result, the theory is applicable only to the particular group studied, in that particular context, and influenced by social and cultural events (Corbin & Strauss, 2008; Ghezeljeh & Emami, 2009; Heath & Cowley, 2004). When this approach is used, the initial research question is broad. As data is collected and analyzed a more focused and concise question emerges. Data collection is completed adhering to a single method. Corbin and Strauss recognize barriers to complete objectivity and promote completion of a preliminary literature review to enhance theoretical sensitivity and to inform the researcher about the topic of interest (Corbin & Strauss, 2008; Heath & Cowley, 2004; McCann & Clark, 2003b). Coding, theoretical sampling,

and memos are used in the process of data collection and analysis. The analysis pattern goes from open coding towards high levels of conceptualization and integration of codes, categories, concepts, and themes. Codes and categories are defined using both properties and dimensions, but Corbin and Strauss view coding simply as the process of analyzing the data. This approach links the theory to particular groups as well as to social and cultural contexts and generates substantive theories (Corbin & Strauss, 2008). Unlike formal theories which can be generalized, substantive theories can only be applied to a particular population in a specific context (Morse, 2009). Corbin and Strauss use induction, but they also added deduction, abduction, and validation to their data analysis and theory generation process. In their data analysis codes and categories are generated from the data, but also deducted from the data. The researcher interpretation of the data can be used to generate codes and categories. Deducted codes and categories are compared against the data and are also validated. Abduction is the process of interpreting unexpected data by considering a variety of theoretical ideas that could explain the unexpected finding, gathering more data, and choosing the most reasonable interpretation. The researcher role is more active and participatory in the process of theory generation (Corbin & Strauss, 2008; Heath & Cowley, 2004; Morse, 2009).

3.3 Methodology

The purpose of this study is to create a grounded theory of mentoring new nurse practitioners (NP) in a hospital setting.

3.3.1 Setting

The study was conducted at Children's Medical Center (CMC) in Dallas. Children's Medical Center is a large freestanding, pediatric, university-affiliated hospital. Nurse practitioners are part of the advanced practice services (APS) department at this hospital. They provide care for a variety of pediatric patients with acute, chronic, and critical illnesses in both inpatient and outpatient settings.

3.3.2 *Sample*

The targeted population for this study consisted of any new NPs working in a hospital setting and participating in a mentoring program regardless of their specialty, gender, age, and ethnicity, as well as experienced NPs acting as mentors. A convenience sample of new NPs and NP mentors was recruited from Children's Medical Center Dallas. New NPs and NP mentors who participated in the hospital's mentoring program for Advanced Practice Services (APS) in the past 18 months, and those currently participating in the program, were invited to participate. Nurse practitioners hired after graduation, newly hired NPs with previous experience as advanced practice nurses (APN) who have been in the mentoring program for at least three months, and experienced NPs acting as mentors for at least three months, qualified to participate in this study. Clinical nurse specialists (CNS), and physician assistants (PA) were excluded from the study. In addition to meeting the eligibility criteria, study participants had to complete a consent process and agree to participate in the interviews.

3.3.2.1 Sampling Rationale

Initially a purposive sampling method was used to ensure that prospective participants were chosen based on their relevancy to the research question. Individuals able to provide rich data to inform the research question were chosen first (Coyne, 1997; McCann & Clark, 2003a; Munhall, 2007). For this study relevancy refers to participants experience with mentoring as either a mentee, or as a mentor. NPs with rich mentoring experiences were initially chosen to describe their encounters and understanding of the mentoring process.

Further decisions about sampling were made based on the emerging concepts and theory. As the data collection and analysis continued, theoretical sampling was used. This type of sampling is derived from and responsive to the data (Corbin & Strauss, 2008). As new concepts and terms were discovered during data analysis, data was collected from people and events that allowed further development of the concepts as well as identification of relationships between them. New participants were invited and some existing participants who have already provided information were re-interviewed or

asked more questions. The use of theoretical sampling did require changes in data collection plans and exploration of literature sources (Corbin & Strauss, 2008; Munhall, 2007).

3.3.3 Definition of Terms.

1. Nurse practitioners are registered nurses who completed advanced education and training and are certified through a national certification organization.
2. Children's Medical Center is a pediatric hospital treating children ages 0 to 18 suffering for a variety of health problems. Care is provided in inpatient and outpatient settings for acute and chronic illnesses.
3. Inpatient units are hospital units where the patients are admitted for overnight stay.
4. Outpatient units are clinics, units, and doctor's offices providing care for pediatric patients who do not stay overnight.
5. New NPs are nurse practitioners taking their first job in advanced practice after completing their education and certification requirements.
6. NPs in a hospital setting are nurse practitioners working in inpatient and outpatient units in a hospital.
7. Experienced NPs are those with more than 5 years of experience in advanced practice.
8. Mentees are new NPs who have a mentor.
9. Mentors are experienced NPs who mentor a new NP. Although experience is a requirement for mentors, good communication skills and the ability to provide constructive feedback are also required.
10. Advanced Practice Services is a department at Children's Medical Center that manages and coordinates the practice of NPs, PAs, and CNSs.
11. APS Mentoring Program is a formal mentoring program lasting up to 12 months. NPs, PAs, and CNSs new to the hospital are eligible to participate. Once the required forms are completed, they are paired with a mentor by the program coordinator. Once pairing occurs, the program coordinator has no further oversight of the relationship, with the exception of final program evaluation and response to questions and/or issues.

3.3.3.1 Sample Size

The size of a sample is of little importance in qualitative research (Munhall, 2007). Unlike quantitative studies where the sample size can be pre-determined using mathematical formulas (Murphy, Myors, & Wolach, 2009), in qualitative studies data is collected until saturation occurs (Corbin & Strauss, 2009; Munhall, 2007). Saturation is reached when data collected reveals no new information relevant to the identified concepts and relationships between them. As a result, data collection was halted when all the dimensions and properties of the concepts were fully described, all the relationships between the concepts were defined, and newly gathered data became redundant. While the sample size is not an important issue in qualitative research, experts suggest a sample size between 10 and 40 participants for grounded theory studies. The size of the sample may vary depending on how broad or narrow the research question is (Munhall, 2007). The decision was made to include equal numbers of mentors and mentees, with a minimum of 8 in each group.

All interested individuals meeting the inclusion and exclusion criteria were invited to participate. Participants were enrolled as they responded to the request and based on their known experiences with mentoring. Participants with rich experiences were chosen first to ensure collection of data that was a good source for the development of codes, concepts, and to understand the relationships between them. For this study, saturation was reached after 16 participants were enrolled. Of those, eight were mentors and eight were mentees. Although there were some male mentors and mentees in the organization all 16 NPs who participated in this study were females. This outcome was not part of the study design since both male and female NPs participate in the mentoring program and may be one of this study's weaknesses. One reason for no male enrollment may the fact that the number of male NPs in the researcher's organization is very small, and the two male participants in this mentoring program were not available for interviews when the invitation was sent. Despite repeated attempts, the researcher was not able to schedule interviews with male participants in the mentoring program.

3.3.4 Data Collection Method and Procedures

3.3.4.1 Procedures

Face-to-face interviews were conducted with study participants. All participants took part in one interview. Although theoretical sampling was used, there was no need to re-interview any participants.

3.3.4.2 Recruitment

The APS mentoring program is available to all advanced practitioners newly hired at CMC. As the program coordinator, the researcher has access to all of the program participants. After the appropriate approvals from the University of Texas at Arlington and CMC were obtained, the study purpose and procedures were explained to the APS administrative team. Screening for potential participants was conducted by members of the APS administrative team. To avoid any form of coercion, the researcher did not make initial contact with potential participants. Prospective participants were invited to participate via e-mail by one of the APS administrative team members. Those who expressed interest via a return email were contacted by the researcher by telephone. Information about the study purpose and procedures was provided and ample time for questions was allotted.

3.3.4.3 Informed Consent

A verbal consent script was used (See Appendix A). The verbal consent process took place during a pre-scheduled meeting with prospective participants. This consent process included information about the study purpose, methods of collecting data, measures to ensure confidentiality, length of participation, and time for questions. Information about the risks and benefits of this study and the ability to withdraw from the study at any time were also discussed. Ample time was allotted to discuss the interview process and the methods employed to maintain participants' confidentiality. Prospective participants were given the option to participate in the study and emphasis was placed on the fact that non-participation will not negatively impact their employment status and performance evaluation.

A verbal consent procedure was chosen to minimize the risk for breach of confidentiality. Since a written signed consent would have been the only document linking participants to the study, a verbal consent was better suited to maintain participants' anonymity.

3.3.4.4 Interview Process

Interviews were scheduled for about 30 minutes to one hour long, based on participants' availability and at a location they preferred, but the actual interview time was between 20 and 40 minutes. To minimize interruptions and interference with job responsibilities, interviews were scheduled during non-clinical days, or after work and conducted in private rooms away from the clinical area. The interviews were audio-recorded, but no personal information was documented. To ensure anonymity, no names were used during the interview.

3.3.4.5 Demographic Information

A demographic data collection form was completed by participants at the time of the interview (See Appendix B). This form contains information about participants' age, gender, ethnicity, years of experience in nursing, and work area.

3.3.4.6 Methods

Although many sources of data can be utilized for grounded theory research, face-to-face interviews were used for this study (Corbin & Strauss, 2008). Face-to-face interviews were chosen because they allow the researcher to hear participants' stories and their perspective on the mentoring experience, while bringing the researcher closer to their stories and experiences. Besides providing a context for open dialogue and interaction, interviews allowed the researchers to see emotions, postures, and facial expressions associated with various topics, which could not be captured through non face-to-face interviews. Interviews were audio-recorded and transcribed verbatim for the analysis.

3.3.4.7 Interview

Corbin and Strauss (2008) suggest the use of unstructured interviews as the best method to collect rich data, but it is difficult for inexperienced researchers to conduct this type of interviews. For this study, semi-structured interviews were used (See Appendix C). The interview started with an overview question and continued with follow-up and probing questions. A number of pre-determined core follow-up questions were used alongside some backup questions. Back up questions are very useful especially when participants had little to say (Corbin & Strauss, 2008). As the analysis started to reveal concepts and the emerging theory, follow-up questions were changed to corroborate findings and further develop the emerging theory (Munhall, 2007). A $15 gift card was given to study participants after the interview. All of the participants were interviewed one time. Second interviews were not conducted, but several participants were contacted after the interview to clarify statements or to further discuss some emerging themes. These follow-up contacts were made by telephone or email.

A non-judgmental approach was used for all interviews. The researcher's experience with mentoring as a mentee and as a participant in the design and implementation of the mentoring program for APS enhanced her sensitivity and her ability to understand participants' perspectives. Throughout the interviews close attention was paid to non-verbal clues and all participants were given the opportunity to express their feeling and opinions. A review of literature was also used to enhance sensitivity and as a possible source for interview questions.

3.3.4.8 Reflexivity and Journaling

Reflective notes and observations were also be documented by the researcher during or immediately after each interview. Reflexivity allowed the researcher to examine her position and perspective on mentoring and guide the analysis process. Reflective notes and memos promoted self-awareness of feelings and emotions and helped maintain integrity during data collection and analysis (Corbin & Strauss, 2008). Since the researcher is the main designer and the coordinator of the APS mentoring program, reflecting on own feelings and expectations of the mentoring program enhanced the

study integrity and minimized bias. A journal was also kept to document data collection and analysis alongside specific notes and observations.

3.3.4.9 Questions

The overview question is considered an opening statement that allows participants to share their stories and experiences (Munhall, 2007). For this study, the overview question asked participants "what does mentoring mean for you?". The interview continued with follow-up questions. The number of follow-up questions varied depending on participants' response to the overview question.

3.3.4.10 Follow-up Questions

Additional questions inquiring about the actual experiences during mentoring as well as the description of positive and negative events were asked. These questions were used to clarify participants' experiences and the meaning of mentoring. Questions about reasons for participating in mentoring, expected and perceived benefits, barriers, and any unexpected experiences were also used. The type and number of follow-up questions changed as the data was collected and analyzed and as the principles of theoretical sampling were applied (Corbin & Strauss, 2008; Munhall, 2007). Back-up questions were also used for participants who had a hard time answering broad follow-up questions.

3.3.5 Ethical Considerations

3.3.5.1 Approvals

Study procedure did not commence until Institutional Review Board (IRB) and hospital specific approvals were obtained. IRB approval ensures compliance with federal laws as well as protection of human subjects and their private information (Amdur, 2003). The study was first submitted to the IRB serving Children's Medical Center (CMC), the site for this data collection. The study was approved as exempt since data collected was anonymous and the study posed only minimal risks to the participants (Clinical Research Resources, 2008). Once the CMC IRB approval was obtained, the study was

submitted to the UT Arlington for approval since the principal investigator is a doctoral student at this university. (See Appendix F and G)

3.3.5.2 Human Subjects Protection

Data collected for this study was anonymous. Since a signature on a written consent would have been the only link to the participants in this study, only verbal consent was obtained (Clinical Research Resources, 2008). Although the interviews were recorded, no names identifying participants were used during the interviews. Demographic data collection forms were also anonymous and did not provide the exact age or years of experience. Participants were asked to choose between age and experience groups, to minimize the possibility of linking the data to participants' names and/or information. Paper data was kept in locked cabinets and electronic data was kept on a password protected computer.

3.3.5.3 Risks and Benefits

There was a very small risk for breach of confidentiality and for psychological distress as participants discussed their mentoring experiences. To minimize psychological distress, interviews were scheduled at times and locations convenient for each participant. It was planned to stop or re-schedule interviews if the researcher sensed increased tension and/or distress during the interview, but this type of incidents did not occur.

Individual participants did not benefit from this study, but the development of a mentoring theory for new NPs in a hospital setting may be instrumental in the design of future mentoring programs for this population. A clear understanding of the mentoring process and its concepts could facilitate the development of effective mentoring programs and evaluation tools.

3.4 Data Analysis

Data analysis was initiated after the second interview was completed. Initially one mentor and one mentee interview were completed, but later interviews were conducted with mentors until saturation occurred and then with the mentees following the same plan. Interviews were transcribed into written

documents using voice recognition software. Data from the interviews were organized and condensed in order to be classified and conceptualized (Walker & Myrick, 2006). Data analysis followed a well-defined process.

The three phases of data analysis suggested by Corbin and Strauss (2008) were followed: open, axial, and selective coding. While these are distinct phases, the analysis was not a linear process and overlaps occurred, as suggested by the authors. Data collection and analysis continued concomitantly until saturation occurred.

During the open coding phase, data were divided based on the natural breaks of the interviews. Concepts or codes representing blocks of data were developed and defined in terms of properties and dimensions. The concepts were then grouped into categories and relationships between them were identified. As the process of relating and linking categories continued data were put back together at a higher level of abstraction. Development and integration of categories was continued through the selective coding phase. During this last part of the analysis, a core category was selected and its relation to all of the other categories was described, defining and consolidating the emerging theory.

A variety of analytic tools were used to enhance understanding of the data throughout the entire analysis process. The use of questions was done throughout the analysis to probe the data, to better understand its meaning, and to facilitate researcher's immersion into the data. Constant and theoretical comparison was also used. Constant comparison was performed to classify data. When unable to classify data by constant comparison, theoretical comparison was used. Examples from literature or from the researcher's experience were used to theoretically compare concepts and categories hard to classify. Exploring various meanings and the "flip-flop" technique was also used to uncover various perspectives on words and/or phrases. Other available analytical tools were used as deemed appropriate throughout the analysis. Data were analyzed for process and context. Understanding and mapping the mentoring process for new NPs in the hospital setting was one of the main purposes of this study. The matrix and the paradigm questions were not used.

Memos and notes were written during all phases of data analysis and were used to achieve theoretical integration. Memos captured the researcher feeling, thoughts, and ideas, while the notes described steps and decisions during the analysis. Theoretical sampling methodology was used to further define concepts and categories. Concepts were briefly discussed with some study participants to verify the fit of the analysis and to further clarify the emerging theory. Data collection was concluded when saturation occurred. Saturation was reached as no new data was provided by new interviews and all categories were fully defined in terms of both properties and dimensions. This study resulted in the development of a mentoring theory for new NPs in a hospital setting. Categories and concepts pertinent to mentoring in this context were defined and relationships between concepts described. As a result, a process of mentoring for new NPs in a hospital setting emerged.

3.4.1 Assumptions

The assumptions for this study are as follows:

1. All participants voluntarily entered the mentoring relationship.
2. Mentoring participants enter mentoring expecting positive experiences.
3. All participants will honestly and openly share their experiences.
4. Mentoring participants expect benefits from participating in mentoring.

3.4.2 Software

Microsoft Word was used to manage and analyze data for this study and Dragon Naturally Speaking 11.5 software was used to transcribe the interviews.

3.4.3 Validity and Reliability

Qualitative research is often described as unsystematic, unsophisticated, and as having poor rigor (Glaser & Strauss, 1967). However, internal validity refers to the degree to which a study supports the conclusion drawn from the results (Waltz, Strickland, & Lenz, 2005). Therefore, this type of validity can be used in qualitative research to account for the conclusions of the study (Cohen & Crabtree, 2008).

Reliability refers to the consistency and quality of measurements used in a study (Waltz, Strickland, & Lenz, 2005). Although there are no measurement tools in qualitative research, consistent use of appropriate methods to collect and analyze data is important. Qualitative researchers are challenged when attempting to adhere to the rigors of validity and reliability because the nature of qualitative research is very subjective (McBrien, 2008).

A variety of methods to evaluate the rigor of qualitative research have been developed over the years. The evaluation of validity has been replaced by trustworthiness and credibility evaluation (McBrien, 2008; Ryan-Nicholls & Wild, 2009), but not all qualitative researchers agree. They continue to create new guidelines to evaluate the quality of research based on the method used.

Glaser and Strauss (1967) described several methods to improve the quality or credibility of grounded theory research. Credibility of this study was ensured by adhering to a theoretical framework and by describing the data and findings in a way that allows readers to almost live the events themselves. A data analysis methodology appropriate for this theoretical framework and type of study was used to further enhance credibility. Credibility guarantees that researcher's perspectives are congruent with those of the participants (McBrien, 2008). The fit of research findings with participants' experiences and perceptions is also called applicability or transferability and it is considered the equivalent of external validity (Ryan-Nicholls & Wild, 2009). To validate the emerging theory, emerging codes and concepts were verified with several participants as well as with the committee chair. A second experienced qualitative researcher coded two interviews and the emerging codes obtained by the novice researcher and the experienced researcher were compared. The researcher and committee chair worked together to obtain consensus on codes and categories. This verification process enhanced the credibility of this study and its findings.

A clear description of the methods used and a clear trail of explanations about category development can also enhance the quality and rigor of qualitative research. Data collection and analysis were performed in adherence to Corbin and Strauss's grounded theory methodology to ensure study reliability and credibility. Rigor was maintained by using purposeful and theoretical sampling, changing

the interview questions based on analysis and literature and by continuing data collection until saturation occurred. Clear explanation of the process of category development was also provided to support the credibility and trustworthiness of the study. An audit trail was created to provide a time line of the data collection and analysis process.

Since researchers may have preconceived notions and prejudices about the research topic, it is important to make them known to the readers. Reflexivity allows researchers to stay aware of their biases and provides honest explanations about the research process (Cohen & Crabtree, 2008; McBrien, 2008). To minimize researcher's bias, reflexivity was used through journal writing, memos, and notes. Disclosure of researcher's personal biases, values, and beliefs as they relate to the study and experience gained in the field of qualitative research also contributed to the quality of this study (Corbin & Strauss, 2008). Since the researcher had a positive experience with mentoring and was instrumental in the design and implementation of the APS mentoring program, she regularly explored her feelings and beliefs during data collection and analysis. These feelings and beliefs were made public during the analysis and result interpretation.

3.4.4 Delimitations

Delimitations for this study were as follows:

1. Only new NPs and those new to the organization who are mentored will participate in this study.
2. Of the APS participants in the mentoring program only NPs will be part of this study. PAs and CNSs will be excluded.
3. Only NPs working in a pediatric hospital setting will participate in this study.

3.5 Summary

This qualitative study used Corbin and Strauss's (2008) version of grounded theory to uncover the process of mentoring in new NPs in a hospital setting and to develop a substantive theory of mentoring for this population. Grounded theory was an appropriate method for this theory development

since it is used to explain human actions and interactions in a social context (Munhall, 2007). Mentoring implies an array of human behaviors taking place in a social context and therefore the use of grounded theory enabled the researcher to gain a theoretical perspective and clarify this complex concept.

The use of Corbin and Strauss (2008) version of grounded theory provided the researcher with a structured methodology for data collection and analysis. The study was conducted according to the Human Subjects Protection rules and regulations and all necessary approvals were obtained prior to data collection commencement. Measures to ensure validity and reliability of the study were implemented and followed throughout the data collection and analysis phases. Concepts and the emerging theory were verified and validated by a second, experienced researcher and by some study participants. The focus was placed on the meaning of the events and experiences for the participants rather than their description (Corbin & Strauss, 2008; Munhall, 2007).

Theoretical sampling and a variety of analytical tools were used to analyze the data and to enable the researcher to achieve higher levels of conceptualizations needed to develop a theory (Draucker et al., 2009; Walker & Myrick, 2006). Using this method to explore mentoring for NPs in a hospital setting resulted in the development of a NP mentoring theory and a better understating of the mentoring concept in this population. Furthermore, an operational definition of mentoring may be developed allowing researchers to design better mentoring programs and evaluation tools.

CHAPTER 4

FINDINGS

This chapter begins with the sample characteristics. It continues with a presentation of the model of mentoring for female NPs in hospital settings and definition and explanations of themes and concepts generated by the interviews. Mentoring stages, themes and concepts are presented with exemplar quotes.

4.1 Sample Characteristics

A total of 16 mentoring participants were interviewed. Eight of them were mentors and eight were mentees. All of the participants were female NPs working in the hospital setting. Sample characteristics in terms of age and experience in nursing, advanced practice as well as in the organization are presented in the table below. Since in this organization NPs are assigned to service lines, some provide care for patients in both the inpatient and outpatient settings. Five participants in the study practiced in both areas, eight practiced in the outpatient setting only, and three in the inpatient area only.

Table 4.1 Mentoring Participants Demographic Information

Participants	Age Group	Years of Nursing Experience	Years of NP experience	Years of Experience at Children's
Mentees	25-30 years 7 or 87.5%	< 5 years 1 or 12.5%	<1 year 1 or 12.5%	< 1 year 1 or 12.5%
	36-40 years 1 or 12.5%	5-10 years 6 or 75%	1-2 years 4 or 50%	1-2 years 3 or 37.5%
		11-20 years 1 or 12.5%	3-5 years 2 or 25%	3-5 Years 1 or 12.5%
			6-10 years 1 or 12.5%	6-10 years 3 or 37.5%
Mentors	41-45 years 1 or 12.5%	11-20 years 2 or 50%	3-5 years 1 or 12.5%	6-10 years 2 or 25%
	45-50 years 1 or 12.5%	21-30 years 2 or 25%	6-10 years 1 or 12.5%	11-20 years 3 or 37.5%
	51-55 years 2 or 25%	> 30 years 4 or 50%	11-20 years 3 or 37.5%	> 20 years 3 or 37.5%
	56-60 years 3 or 37.5%		> 20 years 3 or 37.5%	
	>60 years 1 or 12.5%			

4.2 Model of Mentoring

The basic social process of mentoring resulting from this analysis is *defining self.* Whether the new NP is transitioning from the university to practice, or from one institution to another, she/he goes through a fundamental process of defining her/his professional self and how that self interacts with other professionals and with patients. The model of mentoring that emerged from the data has three steps: forming the relationship, developing the relationship, and outcomes. All of the steps, categories, concepts and relationships between them will be discussed in this chapter in the context of mentoring for female NPs in a hospital setting. (See Appendix D)

Both mentors and mentees freely choose to participate in mentoring relationships. They bring their previous experiences on both personal and professional levels as the foundation for the relationship. As they go through the stages of mentoring they continuously define themselves as human beings and as NPs, as individuals and as professional group members. While forming the relationship, mentoring participants get to know each other and identify needs. Once the relationship is initiated, they work on developing the relationship. At this stage, the relationship becomes a mutual journey to define roles, find balance, create networks, and define career paths.

Relationship development is influenced by how the two get to know each other and by the needs identified. The first two stages may not be linear and participants may move back and forth between them as new needs are identified. Participants' perceptions of trust and fit influence their mentoring journey and ultimately mentoring outcomes.

Previous personal and professional experiences affect not only the initial stage of mentoring, but the overall experience as well. Needs and engagement may stem from participants' motivation for participation in mentoring as well as their knowledge and clinical expertise. Giving back and changing the image of nursing from a profession that eats its young to a nurturing profession seem to be important motivators for mentors, as reflected in the following quotes.

> I participated [in mentoring] because I have a passion for teaching and precepting and for guiding others. For so many years nursing ate its young and I am so opposed to that idea. I think that if we were to grow as a profession we need to support each other. It's easy to tear someone down, but it takes much more time and patience to help build them up and give them the confidence and security to believe in themselves.

> I wanted to participate [in mentoring] because of my experience of people who had mentored me in the past. I wanted to pay it forward… The one thing I thought about is, when I got into nursing there was an instructor who told me to be careful because nurses eat their young. And I am thinking that is a horrible thing, and I determined that I do not want to be one of those nurses who ate their young, and that we can change the general perception one at a time, one person at a

> time, and I wanted to be part of that change. Change the perception that nurses eat their young to the perception that nurses do not eat their young, but nurture their young because nursing is a nurturing profession. What a horrible thing, a horrible indictment coming from within our ranks! And that's one thing I thought about; looking for an opportunity to do for somebody what others have done for me.

4.2.1 Forming the Relationship

Forming the relationship is the first stage of mentoring. During this stage mentoring participants build the foundation of the relationship and initiate communication and contact. *Getting to know each other* and *identify needs* are the two themes of this stage.

4.2.1.1 Getting to Know Each Other

Initial communication is focused on *getting to know each other.* Participants meet at mutually convenient times, pre-established through email communication. Face-to-face meetings take place in various places like coffee shops, restaurants, or hospital eating areas, but never in their offices, and last between 30 and 90 minutes. The duration and frequency of face-to-face meetings varies and seems to be influenced by personal preferences. While some mentoring pairs get to know each other during one meeting, others need to meet two or three times. *Getting to know each other* involves exchange of information regarding personal things such as family, friends, likes and dislikes as well as professional information about job history and career choices. Learning about each other's personal life seems to be the first step as stated by one of the participants. "Up front to just getting to know each other and get close as people first. There was a little bit of personal stuff, and then to learn about her experience." This process is further illustrated by the following quotes.

> In our first meeting I wanted to know her as a person. We talked about what brought you to Texas, what family do you have here, and where is your family. I was also able to share with her some things that are going on in my life.

> We both talked about what we liked in our careers, we talked about family and also if family affected how I was working; she [mentor] also had some hard times with her family. She was also able to meet me on a day that it was not being related to work, not related to family and just to meet and see how I was doing and have another aspect of life.

> Once or twice we kind of just did lunch dates. And then we socialized a little bit more; where I have been and what I was doing, and why I came back here, and what I was up to; kind of my thoughts and goals not only at work, but we also talked about families and where I was and where I was going… And she [mentor] shared of course her life and where she is with her career and her kids and her family, and so that was helpful.

4.2.1.2 Identify Needs

Once participants gain some understanding of who they are, the relationship moves towards identifying mentees needs. Some mentees have clear ideas about what they need, others have to adjust needs to changing career paths, while some require mentor support to identify their needs. Questions about practice, relationships, and role transition help mentors identify needs and deficits not recognized by mentees. "We both identified their needs. From themselves; they [mentees] would tell me about problems and issues then from our discussions you kind of point things out and how it relates to some other issues." In most cases both participants take part in this process as it is illustrated by the following exerts.

> They [mentees] pretty much identified their needs… I found some of her weaknesses from my colleagues and I was able to kind of discuss those weaknesses with her. It was kind of questioning her about how she gets along with staff or who is giving her problems, and she would tell me and then I would try to help her problem solve.

> I think that we both worked together to figure that [needs] out. Then also, she [mentor] would just ask how things are going in the unit. What things are hard, where are you struggling or what are you struggling with.

> She [mentor] had some ideas as far as what I would need to do this year since I was kind of new to the environment of the nurse practitioner here and I also had some ideas and thoughts of what my needs were and I think we both cooperatively came up with those goals.

Although identifying needs seems to be part of most relationships, there are some who form a mentoring relationship without identifying needs. In this case the mentor is used more as a resource. "We haven't identified any need that they feel they have and I haven't been giving them any help other than being a resource." In some rare cases the relationship does not form at all. If mentoring participants are not interested to know each other or if contact is not made, the relationship does not get started. This occurrence may be the result of mentee's decision not to pursue the relationship or because there are no perceived needs. "The second one [mentee] I took never called me. Because I think she ultimately didn't feel like she needed a mentor."

4.2.2 Developing the Relationship

After mentoring participants get to know each other, and once some of the needs are identified, they continue to the next stage of developing the mentoring relationship. This part of mentoring is described by participants as a journey on both personal and professional levels. *Developing the relationship* is the longest stage of mentoring and in some cases goes beyond the formal mentoring time frame. The relationship becomes mutual and is dependent upon participants fit to each other's values and aspirations as well as their ability to build trust. The aim of this stage is to work towards addressing needs and strengthening the relationship. The following quotes from participants describe the *developing the relationship* stage of mentoring as well as its major themes: *career path, balance work and life, develop network, role definition,* and *mutual relationship.* The themes *journey, trust* and *fit* will also be discussed as they characterize and influence this stage of mentoring.

4.2.2.1 Career Path

As the relationship continues to develop, *career path* emerges as a category specific mainly to the mentee group. As mentees get accustomed to the job and the environment and with mentors'

assistance, they become more aware of where they want to go as NPs. As one mentee stated, “She [mentor] really kind of helped me to put things in perspective and concentrate on the career path… She [mentor] helped me narrow down the career path.” Some mentees realize that the current specialty or team may not be a good match and under mentors guidance they explore other opportunities. Although supported, mentees are allowed to make their own decisions.

> It meant a lot to me when we celebrated my new position that she [mentor] told me that on the first encounter with me she knew that I needed to be elsewhere, but she allowed me to try everything to maneuver, to figure out on my own that this position was not going to work for me.

> So, I think when I was in general surgery I enjoyed it, although it’s sort of, I don’t want to say it was boring, but I just realized that I was doing the same thing over and over again and I do not really know if that particular place was job satisfying for me for the long term… So we talked. I talked with her [mentor] about that. And she is really big on needing to find what fits you. And so, I wanted a bigger challenge and I went back to ICU.

> We talked a lot about goals and professional development long-term, and I have been able to see what hers [mentor] looks like and where she is on her process. I think I came to my role wanting to professionally develop and realized that I needed to scale back a little bit more in the first six month and really focus on myself; what is it look like… and then discovering later how to possibly make that broader scope in the future. And so she [mentor] helps me see how people have done that, but I definitely realized that for me right now, at six months in, I need to focus more on where I am.

Although more predominant with the mentee group, *career path* is also identified as a theme within the mentor group. As a result of their participation in mentoring, some mentors solidified their career paths.

> It helped me grow in my role as a team leader in trying to mentor the rest of the group, being open and listening and making suggestions… I am starting to be more confident in helping and

> making suggestions. It's still hard sometimes because it's like: let me think about this and I will get back with you. I was definitely doing that more before or when I just started mentoring. I am doing it less now and I am able to help the other team members.

Even with mentors' help, sometimes mentees cannot find a career path that meets their needs and expectations. "So as the mentor-mentee relationship was ending she ended up leaving the organization." Or as another mentor explained, "And so she actually was ready to leave Children's because it was a total… she just wasn't satisfied. Just like many of us, you can't do it anymore and just say, 'OK, I'm done.'"

4.2.2.2 Balance Work and Life

Mentor's previous experiences, their advice, and guidance helps mentees find balance between the new job, new role, and personal life while they continue to grow as NPs. It is especially difficult for new NPs to balance life and work because as novices to the advanced practice role they have a lot to learn. To keep up with the new knowledge and job expectations some spend longer hours at work, thus putting a strain onto their personal and family life. Balance is achieved with mentors help and as they learn more about their role. Difficult situations are easier to deal with when the mentor is able to assist the mentee focus on the good things.

> She [mentor] really kind of nailed it down; it's not like the whole world is crushing down. To me it was like everything is just terrible, but really it was just the job, it wasn't everything, just the work. So, she mentor kind of helped me focus on that. It was very, very good. She also gave me a lot of very good suggestions on what to do outside work.

> I think it was a lot of figuring out how to balance work with outside of work things and it wasn't so much how to manage patients or how to navigate the system, but how when you work really hard and then you leave work you really leave work and do things… I think I had an idea that I always have a hard time balancing work and life and I tend to be work heavy. I knew that about myself

> and I needed her [mentor] help to figure out in a new place where I knew no one, how to do that. So, that was good.

> I think that she [mentor] has impacted me as a person because I do think it is a struggle at this point in my life to maintain home life and to maintain work, and then continuing to grow at work. I think that's a struggle.

It is oftentimes difficult for NPs new to the profession or even for those new to a specialty to maintain a balance between work and personal life. "I was usually working through lunch, so I did not get a break and worked nine hour shifts." The struggle to maintain this balance is sometimes alleviated with mentors' help, but other times, the mentee has to change careers or departments to achieve this balance. "I went back to the ICU and I got a bigger challenge… the hours in the ICU were just not working for me. I was like, there must be something else out there to be better."

4.2.2.3 Develop Network

In the second stage of mentoring, *develop network* emerges as a strong category for both mentors and mentees. Both groups work on expanding their existing networks, learn about new specialties, and connect with new colleagues. Making new connections helps them solve professional problems, complete projects, and grow as NPs.

> So, I put her [mentee] in contact with the nurses and nurse practitioners at different institutions who had these protocols in place because they have a guru or whatever in the specialty she was in, and she was able to contact them and get this information.

> For me it's [mentoring] a mean to connecting with the younger generation or the younger employees. I get to know those people. I think that's a real benefit… I like to create bridges. So, I saw it as an opportunity to create a bridge with the neonatal acute care program here, to get the scoop from them on what's happening over there. So, it's a communication street.

> She [mentor] did help me to network. So, since I have transitioned to the new department and she works in pulmonary and I am in the allergy-immunology clinic, we work side by side in a way. And so, she was really able to network me with her colleagues. She also does a journal club every month and so she was able to get me connected with that.

Failure to connect with new colleagues results in dissatisfaction, stress, and even a desire to leave the team. "She's [mentee] kind of an outsider in a smaller group and they didn't accept her very well." Occasionally, mentees are unable to develop collegial networks. "She [mentee] was up against very, very difficult people that are not warm and fuzzy but a little bit pushing and old and it was really, really hard for her." Whenever collegial networks do not develop, mentees may have to find another department or specialty where they can feel welcomed and able to connect with the team. "I said I want to transition to another department."

4.2.2.4 Role Definition

While *role definition* is a category specific to new NPs, some of the experienced NPs being mentored have to also work on learning the role as they are now working in different specialties or a different environment. Role definition includes building confidence, re-negotiating relationships, and independence in clinical practice. Although confidence comes with time and practice, the mentor can speed this process by validating mentee's feelings and by encouraging them to make decisions and become independent. Building specialty specific knowledge and training under the mentor guidance helps new NPs define their roles.

> So, I think she's [mentor] helped me to come full circle and kind of say; now you know this, you have learned this, please step forward now and try to be more independent and not so much seeking always a second approval from the physician you are with, but let's move forward and trust yourself and become more independent. We talked a lot about that this year.

> She [mentor] guided and supported me to build my confidence. Confidence was a big thing for me. I think I had a lack of knowledge of the plastics practice because I came from the emergency

room. So, it was hard for me in the beginning, but once I got the knowledge it was a lot easier to have the role once I surpassed that and I got the confidence.

I felt like I helped her [mentee] defining her role and goals because she was pretty much brand-new into being a PNP, but basically helped her with time lines. She felt a lot of anxiety about her new role and so I think I helped her with her confidence by just helping her breakdown her new job.

The one in the middle was really more of a boost to get her to have more self-confidence. She [mentee] was in a new department that she had never worked in and try to help her build her confidence was mainly what we talked about.

For some mentees it is very difficult to move from practicing as bedside nurses to being nurse practitioners. Re-negotiating relationships especially with staff nurses is hard and confusing for some new NPs. Mentors' experience and guidance helps them create new relationships, understand the difference between the two roles, and also learn the NP role.

I was having some issues, maybe not issues, but some problems understanding what my role is and the differences between a nurse and a nurse practitioner as related to my role. She [mentor] helped me kind of tune in and helped me understand what I needed to focus on and what I needed to let go and that was very helpful.

This one [mentee] seemed to have some role confusion issues realizing that she was now a nurse practitioner and no longer a nurse. She is still a nurse but then she is a nurse practitioner and she did not fully understand her place in that role.

I think the relationships with other staff nurses were challenging. Just to establish what her [mentee] role is versus what staff nurses role. And moving forward and achieving an advanced practice purpose to the role rather than just being a staff nurse type of tasks.

Learning new communication patterns, working with different professional groups, and having a lot more responsibilities are also part of the role definition process. Besides all the learning, being a novice again after years of expertise proves to be difficult for some new NPs. Mentors' support can significantly alleviate some of the role definition struggles, as described in the following exerts.

> When going from a bedside nurse to a provider role you have a different relationship with the physicians and at first it was just different because I would meet somebody different; I do not want to say harsh personalities, but rough people, and so, she [mentor] helped me.

> I was an experienced RN and I was an educator for my unit and I was a resource. So, transitioning into a new role was becoming a novice all over again. And that was a big thing for me. That was a hard transition for me going from what was deemed as an expert in this area, into a novice in this area and starting all over again.

> In some ways self-define or establish yourself as a nurse practitioner. It [mentoring] allows me to get someone's perspective outside my team in things that may be part of my role that maybe my team may or may not see as important. So it helps me define what a nurse practitioner is, more than rather just seeing only I guess the pigeon hole in which I think is tempting to place yourself in, because in your first real defined position whatever someone says that the position is, you accept it. But by seeing someone outside of that department, shows you that there are other ways you can bring it and so, it helps me define the broader scope of the nurse practitioner.

Communication with team members can be very difficult for some new NPs and can slow their transition into the new role. Physicians may have a hard time accepting the new NP as a care provider. "She really struggled in that position… because of the roadblocks that a particular physician put in her way." Oftentimes staff nurses show a lack of respect and distrust new NPs, making their role transition more difficult. "She [mentee] was dealing with some resentment because she was young … and the nurses have been there for years and so, here you have a new start person to come in and tell them what to do." Another mentee explains her struggle dealing with staff nurses simply as, "I did have some problems with staff nursing."

4.2.2.5 Mutual Relationship

Besides a mutual participation in developing the relationship, mentoring participants talk about a two-way exchange of information and knowledge, “So I got almost as much as I gave. It was a mutual relationship.” Mentees are the main recipients of mentoring benefits, but mentors gain from the relationship as well. One mentor describes the relationship as, “I think it’s been fun, but I do think it’s mutual. They [mentees] are a resource for me and I am a resource for them. So, it’s a two way street.”

> I think any time you spend time interacting with someone else on a personal and professional basis and they are on a different level then you are, I learned as much from my mentees as I shared with them.

> We were able to vent at each other and so we had similar things like: this is really hard for me and this is how I am dealing with this as someone who is new. Then how she [mentor] deals with it as an experienced person and has been here for a while… We had one of the worst stretches, but we discussed together how we deal with things… So I think that made the relationship really good because we were both able to do things and bounce off each other and help each other.

4.2.2.6 Journey

Mentoring is described by participants as a *journey* of learning about themselves and the others, and also a journey of trying to find time to meet and to deal with various issues and problems as they present themselves. As a journey, mentoring is a process needing planning and time investment. “It [mentoring] was a journey that we had to start. This is what we are doing to progress and is a process and it takes time.” It is also a journey where participants play different roles such as counselors, “And we truly had what looked like a counseling session plan.” problem solvers, “I didn’t anticipate us having to deal with so many different problems a lot of times.” listeners, “I voiced to her some of my frustration.” guides, and supporters, “she was very guiding” and “she gave me hope.” Mentoring can be difficult and takes time, but it is perceived as a beneficial and challenging experience.

> It was a good experience [mentoring] because it was a difficult situation. I appreciated that experience of having to sit back and think, you know. I mean you have to be very constructive and I had to really think about what I was saying to her. So it was sort of enriching for me to be able to come up or to have to have difficult situations to get through and to figure out how I needed to guide her and things like that.

> We didn't expect how hard we would have to work to get her to feel successful… I think that I expected it to just see that as she developed the role became more comfortable it and would grow, which she did, but I didn't anticipate us having to deal with so many different problems.

4.2.2.7 Trust

Trust emerged as an important catalyst in the process of relationship development. Trust allows mentoring participants to open to each other and share personal and professional experiences, opinions, and thoughts. "She [mentee] was pretty, she was forthcoming about everything and stuff she didn't need to be forthcoming in a way that somebody else may not have been."

Since some of the problems experienced by mentees are sensitive in nature, they would not be shared with mentors without trusting them to maintain confidentiality. "To me the mentor-mentee relationship is confidential. Being able to talk about the things which you are going through in your job…" Also, mentors would not be able to help mentees without knowing all the confidential details of their problems. "I think the two things I provide are: one, a safe place to verbalize her concerns, achievements, and accomplishments…"

> I made it very clear to her [mentee] that I knew her colleagues, but I reassured her that everything was confidential and even though I knew her colleagues and I was friends with some of them… I assured her that it was confidential and I was never going to repeat anything and she could trust me. And I didn't; I really didn't. I think she trusted me and I think it was also helpful for me to know their personalities.

> There was a particular level of trust I had to build. She was not sure if I would be biased because I knew one of the people she was working with. I assured her that although I know her as a professional, what we say here remains here. This is confidential.

> At one point in time her [mentee] supervisor really wanted to talk to me and I just skirted because I didn't think it was appropriate. It would have been a breach of confidentiality… Because if they [mentees] don't feel quite as free to tell me things that could inhibit things.

Although trust seems to be an important component of good mentoring relationships, it is not always present, or it may not fully develop.

> I learned that she was close with my director and then all of a sudden I kind of felt like I did not want to say everything that I felt it might go to him, even though I kind of trusted her, but you automatically, we don't really know each other, so I did not trust her as much.

4.2.2.8 Fit

Mentor and mentee perception of *fit* with each other in terms of interests, values, and goals seems to directly influence the relationship. "She was a lot like me. She had a lot of the same interests as me and she had a lot of the same goals and ambitions and reasons that she went into nursing." When the two are a good fit, the relationship seems to move beyond the formal time. "This was a very good fit. I actually although I kind of moved into a different direction I actually called her and go to lunch with her and still view her as my mentor." Fit also influences the deeper development of the relationship beyond professional boundaries. "I felt connected to her [mentee]; without a doubt. We saw each other in the hall the other day and she hugged me."

> I did feel connected to her [mentee]. And in fact after the last incident which was couple of months ago, part of the plan to go forward was to continue meeting with me. So, in fact, we had an additional meeting after our year was up and she said she wanted to continue meeting.

I can say that I feel connected to the first one for sure. As I said, I only met the second mentee one time. So, I didn't have the opportunity to see if it fits, but from just the first impression, this seems like that's a good fit as well. So they both seem to be a good fit.

I requested to be with someone that was on the palliative care team, because that is one of my interests. So, immediately I was excited to get to know her… And I think it's been a very good relationship…and personality wise is a really good fit.

I think it was helpful that I was able to pick someone who has an interest that appeals to me that's outside my department. It helps with our personality meshing and also our views on life; I could talk to someone like that.

4.2.3 Outcomes

The last section of the mentoring model for female NPs in a hospital setting depicts the *outcomes* of the relationship. Several categories were identified as main outcomes. Some of these categories are specific to either the mentee or the mentor group, while others are found across both groups.

4.2.3.1 Satisfaction

By helping others, mentors experience personal and professional satisfaction. "Oh gosh, it's an ego buster for sure…it keeps you young. I think that's all that sharing… It's more of a personal feeling of acceptance." As stated by one of the participants, mentors experience satisfaction steaming from feelings of accomplishment and being valued. "I became more aware that sometimes I know more than I realize and to be able to share with somebody else. That's a good feeling." They also feel needed, and useful as a result of mentoring. "It was satisfying because I did feel like it makes me go back and help. Help support these nurse practitioners so they continue to grow and they stay in the institution."

Just feel like I made an impact on her, a positive one. That I kind of guided her through those rough times… I got that personal satisfaction in having helped somebody that, you know, really

needed some help and guidance… So, there was some personal satisfaction and professional satisfaction.

It makes you feel that you are more of a value for the institution. You feel more connected and giving more back and feeling you have more to offer than just doing the tasks of your daily job.

Although all of the mentors experience some degree of satisfaction assisting new NPs, some question their ability to help and even their contribution to a successful role transition. "I'm not sure I'm giving them what they need; just not sure." Others become emotionally involved when the mentees have a hard time. "I feel bad about what they were experiencing" or struggle if unable to always help.

The bad thing as a mentor…what did I do wrong or what should I have done differently. But then, really for the most part is the failure; two of the mentees that I have had were really not in any shape or form my problem…it was probably a relationship that was not meant to be for them to be employees in their departments.

4.2.3.2 Role Transition

Some of the participants were still in the process of developing the relationship when interviewed, but for those who completed the mentoring process, *role transition* was identified as a mentoring outcome. The time required to transition from a RN role to a NP role seems to be shortened when new NPs are mentored. "She [mentor] allowed me to become a nurse practitioner faster… My five year plan was to become a trauma nurse practitioner. But that five year plan happened in one year. "A successful transition is reflected by the mentees ability to perform their job with confidence, to effectively communicate with other professional groups, as well as the capacity to tailor their role to bring in their unique personality and talents.

I think it [mentoring] allows me to look at how other people approached their job and there's not just one way and it allows me to recognize that it doesn't have to be strictly defined. It's a fluid definition of the nurse practitioner, and so, allowing me to see that other people function in different ways allows me to realize that I can bring in a different definition into my role and yet

also knowing that there are options out there, and options even within children's to function differently or to change my role.

Because as a nurse you have a role and responsibilities, but as a practitioner you really take on more responsibility and you do not want to make a mistake, you do not want to be wrong on whatever decision you make regarding diagnosis and plan. You want to make the right decision. Having a mentor really helps you to gain confidence and really gets you into your role as a nurse practitioner.

She [mentor] helped me a lot with communication from department to department and she helped me grow in my role as a nurse practitioner, and she helped me find and define new boundaries to establish myself as a nurse practitioner.

4.2.3.3 Growth

Growth has been identified as occurring on both personal and professional level for mentees as well as mentors. Mentoring participants experience knowledge growth in areas outside clinical expertise. "It [mentoring] challenged me to become more computer savvy." Growth in terms of professional development as well as on a personal level is also experienced by mentoring participants as they become more balanced, confident, and more aware of whom they are. "I think it [mentoring] impacts me more as a person just being able to accept myself." Another participant stated: "I just think it [mentoring] made me look at my own self and the way I practice and things; I wanted to make sure I was living the way I was telling them."

She [mentor] was able to help me figure out ways to take things I was interested in and apply them in our unit… So we started doing a monthly M&M with the nurses. I was interested in education and teaching nurses and so she was able to help me figure out how to do professional development kind of things.

> It's [mentoring] been a good experience. Just to broaden my perception and to broaden my knowledge base. I learned from them [mentees] all the time too. I learned to do things differently and different things, and challenging me to go back and learn about things.

4.2.3.4 Gain a Friend

Most mentoring relationships last beyond the formal time frame and develop as strong personal relationships. While professional exchange of ideas and benefits related to professional growth are significant, personal connections seem to last the test of time. Participants feel personally connected and learn from each other's experiences. They become friends over time. "I always thought that me and my mentor will be friends and we will have mentoring as a foundation for our relationship moving forward. And that is exactly what I got. It worked."

> I think we have both a professional relationship and a friendship. I can go ask her about a patient or a treatment, but at the same time we would send each other emails and say that we need to meet outside here and catch up or do other things that are not work related.

> She [mentor] is a friend of mine now outside of my daily work environment. We kind of share what has been a struggle, things that I may not want to share with my co-workers, but I can talk with her about it. I think that it has been a nice friendship.

Interestingly, relationships where trust is not fully developed may not result in friendship and remain on the professional level, at least for one of the participants.

> So she [mentor] at the end said that it was more like a friendship and I was kind of, oh wow, I did not think it was a friendship at all, it was more a colleague relationship where I can go and ask her for her advice.

4.2.4 Defining Self

Throughout each section of the mentoring relationship, mentors and mentees try to self-reflect on their past and present experiences in an effort to plan their future, find the best ways to relate to each

other, and define themselves as individuals and as NPs. This *defining self* process allows them to develop a unique identity as NPs and as mentoring participants as well as members of the advanced practice team.

Although some mentors go through a defining self process as it relates to their new role as mentors, the defining self process is more evident in the mentee group. As they experience the transition from RNs to NPs and undergo numerous professional and personal changes, mentees continuously try to define themselves through their practice and though their choices. As explained by one mentee, during this period new NPs have to, "Move forward and trust yourself, and become more independent."

The defining self process allows mentees to learn the role and define their own ways of performing the role. "To really help me in my role and understand that I am not just a nurse practitioner, but also an educator." Mentor's perspective as well as other NPs interpretation of the role is an essential element of social self-definition. The support needed and received from mentors is seen as, "In some ways self-define or establish yourself as it allows me to get someone's perspective outside my team in things that I saw as part of my role that maybe my team may or may not see as important." Learning from the mentor and networking with other NPs allows those new to the role to understand the broader scope and enables them to bring their own personality and talent into the role.

> And so it helps me define what a nurse practitioner is rather that just seeing the pigeon hole in which I think is tempting to place yourself because being in your first real NP position, whatever someone says that the position is you want to accept it.

The most common and most appreciated type of support with the defining self process for mentees is the ability to discover their own ways of performing the job and the best environment to practice under the watchful eye of mentors. "She held off telling me what to do and let me discover what I needed to do." This process may take months for some and requires a lot of support and validation, but giving mentees the freedom to experience it can prove to be very rewarding for both participants. "She just held me and allowed me to figure out what to do." Or as another mentee explained: "She allowed me

to come to my own terms…those months to try everything to maneuver, to figure out on my own…it meant a lot to me when we celebrated my new position."

During the transitional period, issues often occur. While difficult to resolve, problems may in fact help both the mentor and the mentee to identify new ways to discover and define themselves and to improve their practice. Mentors play a very important role in supporting mentees during difficult times and helping them define themselves and their needs. "She helped me kind of tune in and understand what I needed to focus on and what I needed to let go." This process of focusing on needs, letting go of practices no longer needed, and defining self as a person and as NP is fostered by mentoring and allows new NPs to establish themselves as members of the advanced practice community. "She helped me find and define new boundaries to establish myself as a nurse practitioner." Although defining self refers more to the professional role, it seems almost impossible to separate personal and professional aspects of self-definition. As one mentee stated: "It's [mentoring] made me a better practitioner because I can balance my life now; when I leave work now, I leave work."

> In our jobs our professions often defines our personal selves as well; so there is this part where if I have conflict with my professional definition or conflict in my professional identity, then I have conflict in my own self-identity.

Strong encouragement for self definition on both personal and professional levels independent from others' perspective yet as part of the advanced practice group, is exemplified by the following quote.

> All you can do is change yourself. Only change yourself and so you would become stronger and you would develop confidence; whether people respond to it or not, is up to them. You don't let someone else define you. You have earned what you have; don't let anyone take that away from you.

Learning who they are as practitioners closes mentees transition cycle and allows them to gain independence and trust themselves. "She helped me come full circle." Finding a position that provides professional satisfaction while it continues to challenge and allows the new NP to bring in his/her unique

perspective into the role is the final result of the defining self process. The process of changing jobs and/or departments is made easier by mentors' support. As one mentee stated, "It validated the fact that I have to move on." Yet, another said, "She [mentor] definitely and informally helped me with what I needed to do and where I was supposed to go."

> My mentor was really good affirming that there were some things that I do need to change that I've identified already, but also affirming that it's OK to say that these things are important to me and I want them as part of my role; and determining whether it's possible to bring them into the current role that I am holding.

While it seems natural for mentees to go through the defining self process as they transition from RNs to NPs and try to establish themselves as advanced practitioners, mentors may also experience it.

> It helped me to look at myself and reflect on my past and also on how a certain issue or thing I was dealing with in my current career or my position it was helping me to think through some things on my own as well.

This self-reflection and self-definition of mentor practice helps them live up to the mentees expectations and enables them to provide appropriate help for mentees. "I wanted to be true not trying to provide something that I, myself was not doing. It makes you look at yourself; it did for me… look at my practice and myself personally." Some mentors gain a broader perspective of their own role and take on challenges in the process of defining selves while others define themselves as guides or counselors in addition to their NP role to be able to provide needed help in difficult or challenging situations. "Figure out how I needed to guide her." While not always explicit, the defining self process takes place continuously throughout the entire mentoring relationship.

4.3 Summary

Female NPs in hospital settings freely choose to participate in mentoring relationships. All of the relationships contain three stages: forming the relationship, developing the relationship, and outcomes. The length of each stage is influenced by the specific characteristics of individual participants and

relationships. Mentoring is perceived as a journey that brings both satisfaction and challenges for both participants as they become mutually involved and may eventually become friends. Trust and fit are important factors that influence mentoring relationships and their outcomes. Throughout the entire mentoring relationship participants define themselves as individuals, as NPs, and as members of the advanced practice group. Defining self is the basic social process of mentoring and allows both mentors and mentees to differentiate themselves from other individuals and NPs by unique characteristics and approaches. Besides this individual self-definition, mentees collectively define themselves as members of the NP group through role development, communication, and networking.

Although this model and theory reflects mentoring participants' experiences and perspectives, it has limited applicability due to the qualitative nature of this research as well as the fact that only female NPs participated in this study. However, future research studies can be conducted to test the theory and the model with other NP groups in various settings.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Much has been published about mentoring in recent years, but this may be the only study designed to generate a theory of mentoring. As many models and theories have been used to develop mentoring programs for nurses and nurse practitioners (NP), their evaluation and comparison of outcomes is difficult. While most studies find mentoring for nurses and NPs beneficial, without a consistent use of theoretical frameworks, these programs may not result in significant benefits. This chapter will cover a discussion of research findings, study limitations, and implications for future research. The discussion of research findings will include an evaluation and comparison of the newly developed theory with published literature and existing models and theories of mentoring as well as implications for practice.

5.1 Humanistic Nursing Theory

Humanistic Nursing Theory (HNT) was used as the theoretical framework for this study to develop the semi-structured interviews. Some of the HNT concepts and relationships between concepts are supported by the findings of this study (Paterson & Zderad, 2007). An existential interactive experience aimed at promoting human dialogue, reflection, and authentic commitment are supported by the type of relationship taking place during mentoring. Mentoring is initiated when the mentee identifies a need for help, similar to the HNT call for help concept. New NPs are in need of nurturing as they struggle to adapt to and fit in a new or different clinical environment or role.

The main idea of the HNT is that two participants in a human interaction are aware of their uniqueness and opportunities, and both choose to become more through an existential interactive experience (Paterson & Zderad, 2007). A similar interaction takes place between two NPs involved in mentoring. This principle of HNT is present and first experienced by NPs during the initial stage of mentoring. While *forming the relationship*, mentoring participants *get to know each other* and learn about their unique personal and professional backgrounds. This information is not only made available, but used as a foundation for future interactions and needs identification.

The mentor/mentee relationship is a dynamic exchange of ideas and knowledge resulting in growth and development for both participants (Grossman, 2007). Only an authentic exploration and acceptance of self and others as active participants will support an open and sharing experience in a mutual relationship. Mentoring may not contain all the human potentials and limitations associated with nursing, but discouragement, loneliness, anxiety, as well as caring, trust, and hope are experienced by participants, especially during the *developing the relationship* stage of mentoring. The experience of some of these human potentials is reported in the literature and was also lived by study participants (Brown & Olshansky, 1997; Huffstutler & Varnell, 2006). Some of the participants described their new teams as less than welcoming, yet with support from their mentors they were able to overcome negative human potentials such as loneliness and discouragement.

Like nursing, mentoring contains a mode of being and an active part of doing things. The doing part of mentoring involves teaching, coaching, guiding, and validating. These are visible and measurable physical acts performed by mentors to address the needs identified by mentees. Mentees actions to learn and fulfill goals are also part of the physical acts of doing. The being part of mentoring relates to participants ability to be present for each other, to listen, be open, and be authentically involved in the relationship. While not directly measurable, the being component of mentoring is essential. Authentic presence extends beyond physical proximity to another person into intentional and meaningful exchange of knowledge and experiences. In this mutual relationship, both mentors and mentees are active listeners, confidants, and supporters of each other.

The outcome of a humanistic nursing interaction with a patient is more-being (Paterson & Zderad, 2007) and the *outcomes* of mentoring relationships are similar. Study participants experienced successful *role transition, growth*, and *satisfaction* while *gaining a friend* in the process. While some of the HNT concepts can be supported by the results of this study, mentoring for NPs in a hospital setting theory has a different structure and contains a number of different concepts.

5.2 Theory of Mentoring for Nurse Practitioners in a Hospital Setting

Based on the study findings, a new theoretical model of mentoring for NPs in a hospital setting was developed. This model is divided into three sections: forming the relationship, developing the relationship, and outcomes. Formal mentoring programs also contain three or four stages, beginning with initiation or recognition and ending with termination and re-alignment or closure and separation (Simpson, 2005; Smith, McAllister, & Crawford, 2001). This model loosely follows the formal mentoring stages, but also contains characteristics of informal mentoring. The relationship described by study participants varies based on participant characteristics and needs. Variations include frequency and length of meetings, total length of the relationship, and the type of support provided by mentors. For participating NPs the mentoring relationship does not seem to end, but rather transforms into a personal and professional friendship. Based on these characteristics, mentoring relationships described by participants are more aligned with informal mentoring (Ryan, Goldberg, & Evans, 2010; Simpson, 2005; Tourigny & Pulich, 2005). In her 1998 study, Heyes found a significant difference in mentoring scores between students who were assigned mentors and those who chose the mentors themselves, suggesting that informal mentoring is more beneficial. Although not supported by previous research, it seems like a well organized process of matching mentors and mentees, as part of a formal mentoring relationship, can transform into an informal relationship as long as it is not bound by strict rules and oversight. This finding is in sharp contrast with Parse's (2008) second assumption from her humanbecoming mentoring model. Parse suggests that mentoring relationships follow a well defined pattern of interaction, while participants in this study clearly identified variations in the type and characteristics of each mentoring relationship. These variations were more evident when the same mentor used different approaches with different mentees, indicating interactions specific to each mentoring pair. Findings from this study demonstrate

that mentoring is a complex process that may not be easily explained and classified using existing models.

5.2.1 Forming the Relationship

Formal mentoring programs imply matching mentors and mentees based on personal and professional characteristics and interests (Simpson, 2005; Smith, McAllister, & Crawford, 2001; Vance & Olson, 1998). While program coordinators may use a variety of tools to match mentors and mentees, participants' willingness to learn about each other may be more important than the initial matching in ensuring a successful relationship. Briefly discussed in the literature, the process of *getting to know each other* during the initial stage of mentoring was identified as a major category in this study. The identification of similar values and interests was recognized as a pre-requisite to the development of mentoring relationships in a study exploring rural nurses' experience with mentoring (Mills, Francis, & Bonner, 2007). Similarities in interests and values are important, but this study uncovered deeper meanings of the "getting to know each other" experience. Mentoring participants spent at least one entire session learning about each other. Their interests in getting to know the other went beyond professional values and experiences into the personal and family fields. This broader knowledge allowed them to connect, identify common values and interests, and learn about their strengths and weaknesses. While previous studies found that between 63% and 95% of mentees connect with their mentors, all of the participants in this study were able to connect and felt that the matching was a good fit (Beecroft et al, 2006). These findings suggest once again, that while initial matching of mentors and mentees is important, their desire to learn about each other and to participate in a mentoring relationship is equally important and may play a significant role in the success of mentoring relationships. Commitment to the mentoring relationship is also found in Parse's humanbecoming model of mentoring (2008), but her interpretation of commitment is that mentoring participants dedicate their efforts to achieve the pre-establish goals. This assumption is not supported by the findings of this study where commitment refers to participants' efforts to shape the relationship into a fluid sequence of interactions changing and adapting to accommodate mentees needs. The investment of time and commitment in forming the

relationship may be one of the most important elements of successful mentoring relationships for NPs in a hospital setting.

While Parse (2008) suggests that mentoring relationships follow a pattern and mentees have a clear understanding of their needs and what the type of help needed to achieve their goals, findings from this study revealed that mentees may need a lot of support to identify their needs and oftentimes have no idea how to achieve their goals. Instead of just providing the requested help, NP mentors participating in this study had to further inquire about mentees practices and socialization to identify areas needing improvement and to enable them to provide assistance.

5.2.2 Developing the Relationship

Numerous studies and articles discuss the role of mentors and the goals of mentoring, but very few discuss the details of the actual mentoring relationship. Mentoring is often offered as part of orientation or internship programs for new nurses and NPs. The main goal of these programs is to facilitate a smooth transition from school into the new role (Bahout & Esposito-Herr, 2009; Cusson & Viggiano, 2002; Green et al., 2005; Mackin, et al., 2006; Sorce et al., 2010). While orientation and mentoring programs are popular, participants' involvement in particular activities associated with mentoring is rarely explored.

Research reports suggest that role transition can occur faster and with fewer struggles when new nurses and NPs participate in mentoring (Barton, 2006; Cusson & Viggiano, 2002; Lee & Fitzgerald, 2008; Mackin, et al., 2006; Wolak et al., 2009). Activities aimed at increasing mentees confidence, re-negotiating relationships, and gaining clinical independence have been identified by the NPs participating in this study as taking place during the *developing the relationship* stage of mentoring. Mentors help new NPs to assimilate new knowledge, learn new communication patterns, and allow themselves to be novices again. Activities related to the NP role development are considered important, but poorly described in mentoring literature. Wolak and colleagues (2009) discussed the themes of mentor availability and providing support and knowledge as two important findings of their study. Although superficially explored in their study, these themes are supported by the findings of this study. Most

discussions about *role definition* are found in literature discussing graduate nursing students transition to the first NP position (Brown & Olshansky, 1997; Heitz et al., 2004; Kelly & Mathews, 2001; Spinks, 2009). While the importance of mentoring in facilitating this transition is always mentioned, no specific activities are discussed (Bahout & Esposito-Herr, 2009). This study provides information about a number of activities taking place during mentoring and aimed at helping new NP better develop and define their roles.

Although not focused on NPs, the study conducted by Wolak et al. (2009), identified several mentoring activities. Developing a sense of community was a category defined as facilitating learning about the organization and unit culture (Wolak et al., 2009). Socialization into the nursing profession is another category found in a study conducted by Beecroft and colleagues, but only 5% of the study participants identified mentoring activities aimed at improving their socialization (2006). While these categories are somehow similar to the theme of *developing networks* experienced by the NPs, they lack the depth of the develop networks theme which encompasses not only learning about the culture and profession, but also connecting with other NPs and becoming part of their professional group.

While working to develop networks and to define their role, both mentors and mentees explore and may eventually find a new *career path*. This theme has never been discussed in other research studies. Changes in professional relationships and transition obstacles experienced by new NPs may create high levels of stress and anxiety and lead to dissatisfaction (Barton, 2007). Under mentors' guidance they can explore other career paths until a successful transition and satisfaction are achieved. In other instances, new NPs want to expand their career path towards education, research, and even community or political involvement. One important characteristic of this category is the guided independence in making career choices provided by mentors. This characteristic can be compared to a mother-child relationship, where the child is allowed to explore and even get hurt while being carefully watched and protected from harm. Guided independence is also part of Parse's humanbecoming mentoring model, illustrating mentors role in guiding their mentees without suggesting a particular path. Interestingly, mentors may also explore or enhance their career path towards leadership, communication, and education.

As they try to define their role, develop networks, and find a career path, new NPs often experience high levels of stress and anxiety. They work long hours and have a lot to learn during the initial months on the job. Balancing work and life may become problematic during this time and may add additional stressors to this already demanding time. Help to *balance work and life* was identified as one of the main activities during the developing the relationship stage of mentoring for NPs. This type of help involved story sharing and consultation on various clinical and organizational issues. This category is comparable to the looking after each other category described by Mills et al. (2008). Interestingly, this category exemplifies the *mutuality* of the mentoring relationship experienced by the NPs. While the mentors provided most of the support and helped mentees learn to balance work and life, sharing stories and feelings allowed the mentees to also help mentors deal with stressful and difficult situations. Besides helping each other balance work and life, mentoring participants learned from each other. The category of mutuality is often present in mentoring literature, although not always explicit (Block et al., 2005; Dyer, 2008; Parse, 2008; Stewart & Krueger, 1996). Mutuality is portrayed in Parse's model as the recognition mentoring participants give each other for their efforts and successes experienced throughout the relationship (Parse, 2008).

The development of a mentoring relationship was perceived by study participants as a *journey* requiring hard work but also resulting in satisfaction. They had to build the relationship, find common values and interests, build trust, develop new roles, and deal with situations not encountered before. The journey theme is also new and has never been associated with mentoring. A successful mentoring journey is built on a good fit and trust between participants and requires good knowledge of self. The concepts of fit and trust have been reported in the literature as significant contributors to successful mentoring relationships (Beecroft et al., 2006: Hayes, 1998).

5.2.3 Outcomes

Evaluation of mentoring success varies greatly from project to project. Evaluation criteria as well as evaluation indicators seem to be specific to each study or project without much consistency or standardization. Despite these variations, a number of benefits such as satisfaction, improved retention,

and growth, and development are explicitly or implicitly reported in mentoring literature. The *outcomes* of mentoring captured through interviews with NP mentors and mentees in this study support most of the known benefits of mentoring, but also bring a new perspective and a deeper understanding of these concepts.

Satisfaction with the mentorship relationship is reported in numerous articles (Beecroft et al., 2006; Block et al., 2005; Richmond, 2006). However, when job or employee satisfaction were evaluated, some studies found no relationship between mentoring and these outcomes (Cuesta & Bloom, 1998; Ecklund, 1998). Even in studies were a correlation between mentoring and improved job satisfaction was identified, it is hard to attribute these improvements to mentoring alone (Dyer, 2008; Halfer et al., 2008). While *satisfaction* was identified as an outcome category of mentoring for NPs in a hospital setting, it is described as a more personal experience in a professional context. Participating NP mentors explain the satisfaction of being needed, being able to help and share, and being valued. Mentees satisfaction was not always explicitly expressed, but suggested by their perception of growth and successful role transition as a result of mentoring.

Role transition was identified in this study as a major category under mentoring outcomes. Several published studies discuss the effect of mentoring on role transition, but only as it pertains to NP students (Barton, 2006; Barton, 2007; Hayes, 1998; Mackin, et al., 2006). Others discuss role transition in the context of orientation and internship programs for NPs (Bahout & Esposito-Herr, 2009; Lee & Fitzgerald, 2008). This is the only study to date, where successful role transition was identified as a mentoring outcome. Transitioning into the NP role is a staged process that may not be linear at all times. Mentoring seems to facilitate a more rapid and less stressful transition through a friendly and comforting relationship. Parse's (2008), humanbecoming mentoring model suggests that mentoring participants leave their comfort zone to engage in the relationship. This assumption is in sharp contrast to other mentoring literature and the findings of this study. Another important facet added by mentoring was the ability to transition into a role that best suited participants' personality, abilities, and talents. These experiences suggest that under mentors' guidance, mentees were able to design their own roles rather than trying to fit into an already existing one.

Besides experiencing satisfaction, growth, and a smoother transitioning to the new role, mentoring participants also *gained a friend.* The transformation of a mentoring relationship into friendship is discussed only in the context of informal mentoring (Ryan et al., 2010; Simpson, 2005; Tourigny & Pulich, 2005). However, findings from this study suggest that well designed formal mentoring relationships can result in friendship. Mentoring participants' willingness to open to and learn about each other, their freedom to adjust and tailor mentoring activities and priorities, and the reduction of rules and supervision seems to be the catalysts for the transformation of formal mentoring relationships into informal friendships.

As suggested by previous studies, mentoring participants experience *growth* in areas of knowledge, skills, and professional development (Barton, 2006; Cusson & Viggiano, 2002; Hayes, 1998; Lee & Fitzgerald, 2008; Wolak et al., 2009). While all of these growth areas were identified by the NPs participating in this study, they also experienced growth at a deeper more personal level. Their ability to self evaluate themselves on a personal and professional level as well as to identify new ways to define themselves as individuals and as NPs was perceived as growth and as an important outcome of mentoring.

5.2.4 Defining Self

The over-arching theme of this theory of mentoring for NPs in a hospital setting is *defining self.* Although implied in some articles discussing NPs role transition and orientation programs, this term has never been used in association with mentoring programs. Mainly a psychology term, self-definition is one of the concepts used to define an individual's ability to develop personality traits and to adapt to new situations (Shahar et al., 2003). Also called identify formation, self-definition refers to a person's ability to ascertain an awareness of self that is rational, unique, and positive. Individuals able to clearly define themselves have an increased ability to solve problems, make choices, and plan their future (Shahar et al., 2003; Whitney-Thomas & Moloney, 2001). Self-definition occurs at two different levels: individual and social (Gaertner, Sedikies, & Graetz, 1999; Gaertner et al., 2002). The two levels of *defining self* are present throughout the entire mentoring relationship. Participants try continuously to establish

themselves as NPs with unique characteristics and roles while also becoming part of the advanced practice group.

The individual level refers to a person's ability to self-identification as a unique individual, while the social level encompasses the ability to establish healthy relationships and group membership (Besser & Priel, 2005; Gaertner, Sedikies, & Graetz, 1999; Gaertner et al., 2002; Shahar et al., 2003; Wiseman, 1997). A number of background and environmental factors can influence the development of both levels of self-definition. Among these, peer groups and family seem to be the most influential. Supportive environments are associated with an increased ability of self-definition, while isolation and stressful settings decrease this ability. Peer mentors have been suggested as a means to improve individuals' ability to self-define themselves (Shahar et al., 2003; Whitney-Thomas & Moloney, 2001). Results from this study show that mentoring enables and fosters self definition through mutual interactions that are supportive, guiding, validating, and trustworthy. Throughout each section of the mentoring relationship, mentors and mentees try to self-reflect on their past and present experiences in an effort to plan their future and find the best way to relate to each other.

5.3 Limitations

One of this study limitations is the fact that only female NPs were enrolled. Enrollment of female NPs only was not part of the inclusion/exclusion criteria. While there are male NPs, their number is low and they did not respond to the invitation to participate in this study. Another limitation may be the fact that although physician assistants (PA) and clinical nurse specialists (CNS) work at this organization and are part of the advanced practice mentoring program, they were not invited to participate. Future studies including male NPs as well as PAs and CNSs are needed to paint a more complete picture of mentoring for advanced practitioners in a hospital setting.

5.4 Implications for Practice

New NP graduates go through a transition process that involves re-negotiations of personal, professional, and social relationships as they get accustomed into the NP role. This transition can be

stressful and, without proper support, new NPs may not be able to fulfill their new role (Barton, 2006; Brown & Olshansky, 1997; Forbes & Jessup, 2004; Nichols et al., 2005). While mentoring is used to ease this transition, the lack of theoretical models and clear definition of mentoring for NPs generates wide variations in program design and evaluation.

While specific to NPs in a hospital setting, the theory generated by this study, provides a clear understanding of the mentoring process including activities conducted throughout mentoring stages as well as the perceived outcomes. This information can be used to design mentoring programs for NPs that include categories identified here as components of mentoring and as evaluation points. Since these categories emerged from the data collected from NP participants, they reflect participants lived experiences and can be used to generate operational definitions useful in developing evaluation tools. This theory can also be verified with other groups of NPs in other settings.

A significant finding with direct applicability in practice is the fact that participating NPs experienced mentoring on both personal and professional levels. This finding can be used to train and prepare NPs for mentoring roles. It is also important to mention that although the mentoring program studied used a formal structure, participants continued their relationships after the pre-set duration and in most cases transformed it into an informal mentoring relationship. It was suggested by participants that this occurred as a result of program flexibility and minimal supervision. By reducing the number of rules and allowing each mentoring pair to tailor the relationship, a deeper connection between participants was fostered, leading to a prolongation of the relationship and a change in character. This finding can be used to design mentoring programs that facilitate the initial matching, but are not bound by standardized agreements and regulations and rather provide guidelines that can be adjusted for each pair of participants. Participating NPs clearly identified numerous benefits of mentoring and many suggested that all new NPs should be assigned a mentor. The time needed to transition and barriers associated with it were minimized through mentoring and mentees became inspired to eventually become mentors themselves. Experienced NPs acting as mentors experienced satisfaction and renewed interest in their specialty. These findings suggest that mentoring programs should be used in association with or as part of orientation programs for new NPs.

5.5 Future Research

The theory of mentoring for NPs in a hospital setting generated by this study is specific to this particular population, but it is the first theory of mentoring for NPs. Future research focused on testing this theory with other NP populations can further refine its concepts and enable its generalization. Nurse practitioners populations such as those working in adult hospital settings and other pediatric or mixed population hospital could be used to test the theory. Since most of the concepts and processes identified in this theory are applicable to NP mentoring programs in outpatient and inpatient areas, the theory can also be tested with NPs who are working in outpatient settings. Variations in NPs characteristics may be attributed to the type of hospital setting such as university affiliated, not-for-profit, and for-profit. As a result, the theory can be tested with these populations as well.

The impact of mentoring programs for NPs using this theory can also be researched in terms of specific mentoring activities and outcomes. Since most mentoring activities identified by NPs participating in this study can be operationally defined and measured, quantitative or mixed methods studies could evaluate mentoring programs using the theory. Studies focused on specific activities such as those related to role development and socialization may be of particular interest since these areas are identified in the literature as significant to NPs successful transition into the new role. Studies focused on mentoring outcomes could also be developed.

Further examination of the details of relationship development and its transformation from a formal to an informal type may also provide much needed information useful in developing successful mentoring programs. Longitudinal studies over the course of mentoring relationships beyond 12 months would provide a clearer picture of mentoring stages and relationship progress. Future use of the theoretical model for theory validation and mentoring program evaluation may provide the much needed consistency for mentoring program development in the NP population.

APPENDIX A

VERBAL CONSENT

Verbal Consent

Dear Nurse Practitioner,

My name is Rodica Pop and I am a doctoral student at the University of Texas at Arlington. As part of my doctoral dissertation, I am studying formal mentoring in new NPs at Children's Medical Center, Dallas.

You are invited to participate in a research study aimed at developing a theory of mentoring for nurse practitioners in a hospital setting. I would like to learn about your experiences with mentoring and use them to guide the design of future mentoring programs. You are invited to participate in this study because you are or were involved in the Advance Practice Mentoring program as a mentor or as a mentee.

Participation in this study is voluntary. Non-participation will not have any impact on your employment status or your annual evaluation. If you choose to participate, you can refuse to answer any question you don't want to answer, and you can end the interview at any time you choose.

If you agree to participate, you will be asked to participate in a face-to-face interview. This type of data collection was chosen because it is considered one of the best sources of information for qualitative studies. A minimum of 8 mentors and 8 mentees will participate in this study, but we may interview up to 20 mentors and 20 mentees.

Interviews will last 30 minutes to one hour and will be scheduled based on your availability and location preference. The interview will be audio-recorded. No names will be used during the interview or on data collection forms. Before starting the interview you will be asked several demographic questions regarding your age, gender, and years of experience as a nurse and as a nurse practitioner. At the end of the interview you will receive a $15 gift card as a small compensation for your time.

Data from the interviews will be analyzed to identify common themes and/or concepts. These themes, concepts, and relationships between them will be used to develop a theory. You may be asked to review study findings with me or to participate in a second interview. Second interviews may be necessary to fully understand and define themes and concepts.

Your participation in the study will end after the first or the second interview, if there is a second interview.

Every precaution to protect your identity and private information will be taken. Names will not be used during the interview or on data collection forms. Your interview and demographic data will have a numeric code only. All the data will be kept on a password protected computer.

There may be no direct benefit for you as a result of participation in this study. However, the findings of this study could guide the development of a mentoring theory for nurse practitioners in a hospital setting and may be also used to design improved mentoring programs.

If you agree to participate we will schedule an interview. If you have any questions or concerns about this study you can contact me at 214 456-1296. If you still have unanswered questions or concerns you may also contact my research supervisor, Dr. Donelle Barnes, at 817-272-0108, or at donelle@uta.edu.

Thank you.

Rodica Pop, RN, MSN

214 456-1296

Rodica.pop@childrens.com

APPENDIX B

DEMOGRAPHIC INFORMATION

Demographic Information

1. Code _____

2. Mentor Mentee

3. Age:<25; 25-30; 31-35; 36-40; 41-45; 46-50; 51-55; 56-60; >60

4. Gender : M F

5. Years of experience as a nurse: <5; 5-10; 11-20; 21-30; >30

6. Experience as a NP: <6 months; 6-12 months; 1-2 years; 3-5 years; 6-10 years; 11-20 years; >20 years

7. Experience at Children's Medical Center: <6 months; 6-12 months; 1-2 years; 3-5 years; 6-10 years; 11-20 years; >20 years

8. Practice area: In patient Outpatient

APPENDIX C

SEMI-STRUCTURED INTERVIEW SAMPLE QUESTIONS: MENTEE

Semi-Structured Interview Sample Questions: Mentee

Mentee

Overview question: What does mentoring and the overall experience mean for you?

Core Follow-up Questions	Back-up Questions
1.Why did you decide to participate in mentoring?	1.a. How did you hear about the program?
	1.b. What were the benefits you were hoping to get from the program?
	1.c. What did you know about the program?
2.Describe your relationship with your mentor	2.a. Discuss your feelings about being matched with this particular mentor
	2.b. Discuss your connection with your mentor
	2.c. How did you communicate with your mentor?
	2.d. What kind of help did you receive from your mentor?
	2.e. How did you identify these needs?
	2.f. How did your mentor respond to your need for help?
	2.g. Describe some of the positive attributes of your mentor
	2.h. Discuss some of the negative attributes of your mentor
	2.i. What were some of the barriers to this relationship?
3. Describe your face-to-face meetings with your mentor.	3.a. Give examples of positive productive meetings
	3.b. Give examples of non-productive meetings
	3.c. Describe barriers to face-to-face meetings
4.What do you think is the best thing about mentoring?	Please give examples
5.What do you think is the worst thing about mentoring?	5.a. Please give examples
	5.b. What would you change to minimize these things?
6.How did mentoring impact you as a NP and as a person?	6.a. How did your practice change as a result of mentoring?
	6. How did you as a person changed as a result of mentoring?
7.What would you change about mentoring?	7.a. Why would you make changes to the program?
	7.b. How would you make these changes?
8.How did mentoring influence your job satisfaction?	8.a. Describe your job satisfaction before mentoring
	8.b. Describe some positive mentoring experiences

	related to job satisfaction
	8.c. Describe some negative mentoring experiences related to job satisfaction
	8.d. Describe your job satisfaction now
	8.e. What role did your mentor play in your job satisfaction?
9.How did mentoring influence your socialization into the organization?	9.a. Describe your socialization status before mentoring
	9.b. Describe positive socialization experiences during mentoring
	9.c. Describe negative socialization experiences during mentoring
	9.d. Describe your socialization status now
	9.e. What role did your mentor play in your socialization?
10.How did mentoring influence your professional development?	10.a. Describe mentoring experiences that helped your professional development
	10.b. Describe mentoring experiences that hurt or negatively impacted your professional dev.
	10.c. What role did your mentor play in your professional development?
11.How did mentoring influence your transition into the NP role?	11.a. Describe some of the transition difficulties
	11.b. Describe some of the positive transition influences of mentoring
	11.c. Describe some of the negative transition influences of mentoring
	11.d. What role did your mentor play in your transition?

APPENDIX D

SEMI-STRUCTURED INTERVIEW SAMPLE QUESTIONS: MENTOR

Semi-Structured Interview Sample Questions: Mentor

Mentor

Overview questions: What does mentoring and the overall experience mean for you?

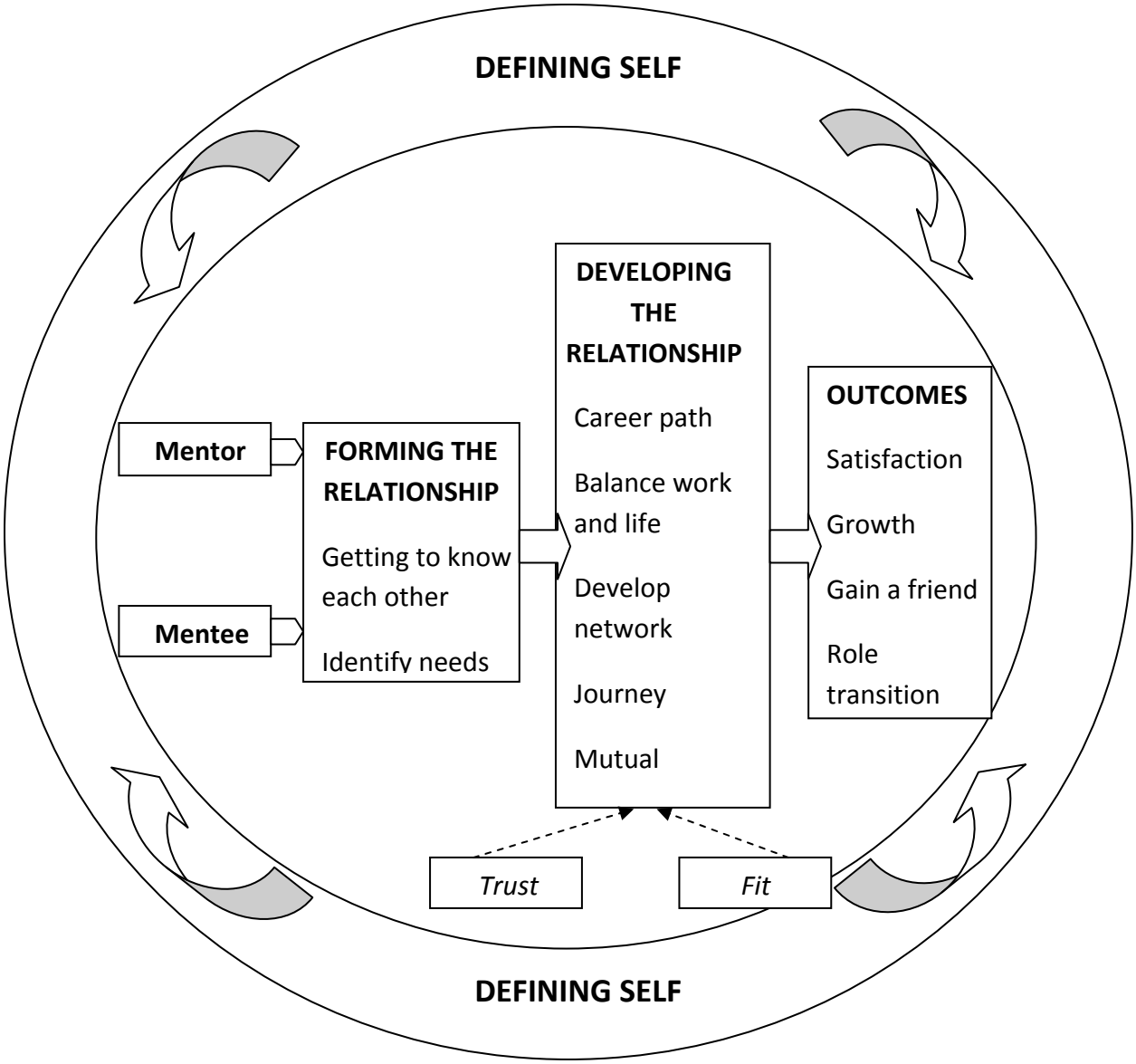
Core Follow-up Questions	Back-up Questions
1.Why did you decide to participate in mentoring?	1.a. How did you hear about the program?
	1.b. What were the benefits you were hoping to get from the program?
	1.c. What did you know about the program?
2.Describe your relationship with your mentee	2.a. Discuss your feelings about being matched with this particular mentee
	2.b. Discuss your connection with your mentee
	2.c. How did you communicate with your mentee?
	2.d. What kind of help did you provide?
	2.e. How did you identify these needs?
	2.f. How did you personal experience influence your ability to help?
	2.g. Describe some of the positive attributes of your mentee
	2.h. Discuss some of the negative attributes of your mentee
	2.i. What were some of the barriers to this relationship?
3. Describe your face-to-face meetings with your mentee.	3.a. Give examples of positive productive meetings
	3.b. Give examples of non-productive meetings
	3.c. Describe barriers to face-to-face meetings
4.What do you think is the best thing about mentoring?	Please give examples
5.What do you think is the worst thing about mentoring?	5.a. Please give examples
	5.b. What would you change to minimize these things?
6.How did mentoring impacted you as a NP and as a person?	6.a. How did your practice change as a result of mentoring?
	6.b. How did you as a person changed as a result of mentoring?
7.What would you change about mentoring?	7.a. Why would you make changes to the program?
	7.b. How would you make these changes?
8.How did mentoring influence your job satisfaction?	8.a. Describe your job satisfaction before mentoring
	8.b. Describe some positive mentoring experiences related to job satisfaction
	8.c. Describe some negative mentoring experiences related to job satisfaction
	8.d. Describe your job satisfaction now

9.How did mentoring influence your professional development?	9.a. Describe mentoring experiences that helped your professional development
	9.b. Describe mentoring experiences that hurt or negatively impacted your professional dev.
	9.c. What role did your mentee play in your professional development?
10.What do you perceive as the rewards for mentoring?	Please give examples

APPENDIX E

MENTORING NURSE PRACTITIONERS IN A HOSPITAL SETTING MODEL

Mentoring Nurse Practitioners In A Hospital Setting Model



APPENDIX F

UTSW IRB APPROVAL LETTER

UTSW IRB Approval Letter

UT SOUTHWESTERN MEDICAL CENTER eIRB System

From: George Buchanan, MD
Institutional Review Board Chairperson
IRB - 8843

To: Rodica Pop

Date: December 29, 2010

Re: Exempt

IRB Number: STU 112010-088

Title: Mentoring Nurse Practitioners in a Hospital Setting

Documents: Protocol and Study Related Documents

The UT Southwestern Institutional Review Board (IRB) determined on December 23, 2010 that this research is exempt in accordance with 45 CFR 46.101(b). Further review of this study by the IRB is not required unless the protocol changes in the use of human subjects. In that case, the study must be immediately resubmitted to the Board. Please inform the IRB when this research is completed.

If you have any questions related to this approval letter or about IRB policies and procedures, please telephone the IRB Office at 214-648-3060.

Thank You

Warning: This is a private message for authorized UT Southwestern employees only. If the reader of this message is not the intended recipient you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

University of Texas Southwestern Medical Center
Institutional Review Board

5323 Harry Hines Boulevard
Dallas, Texas 75390-8843
Room C1.206
phone: 214-648-3060
fax: 214-648-2171

APPENDIX G

UTA IRB APPROVAL LETTER

THE UNIVERSITY
OF TEXAS
AT ARLINGTON

Office of Research
Administration
Box 19188
202 E. Border St., Suite 214
Arlington, Texas
76019-0188

T 817.272.3723
F 817.272.1111

http://www.uta.edu/research
Expertise at UT Arlington
http://www.uta.edu/expertise

January 10, 2011

Rodica Simona Pop
Dr. Donelle Barnes
School of Nursing
The University of Texas at Arlington
Box 19407

Re: UT Arlington Institutional Review Board
Acknowledgement of Approved Research Activity

Project Title: *Mentoring Nurse Practitioners in a Hospital Setting*

UT Southwestern IRB Number: STU 112010-088

Principal Investigator: Rodica Simona Pop

UT Arlington IRB No.: 2011-0295

Dear Rodica Pop,

The UT Arlington Office of Research Administration and the UT Arlington Institutional Review Board are pleased to acknowledge your participation in the "*Mentoring Nurse Practitioners in a Hospital Setting*" protocol.

UT Southwestern is noted as the IRB of record for the project, last approved on 12/23/ 10. You will not be required to submit a protocol for UT Arlington IRB approval.

In agreement with the IRB of record, this project is approved as follows:

Review: Exempt

Having met the conditions set forth by UT Southwestern Institutional Review Board and in compliance with applicable regulations this acknowledgment is granted for a period not to exceed one year from the date of last review.

Please be advised that you will be responsible for forwarding to the Office of Research Administration, Regulatory Services, at minimum, a copy of the approval letter forwarded to you upon each continuation review period, modification approval or adverse event acknowledgment as documentation of assertion that the project remains in compliance with all applicable mandates, assurances and institution policies and procedures. In the conduct of cooperative research projects, each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with 45 CFR 46 and 46.114.

Be A Maverick

The UT Arlington Institutional Review Board and the Office of Regulatory Services appreciate your continuing commitment to the protection of human subjects engaged in research and wish you all the best in your research endeavors. Should you require further assistance, please contact Robin Dickey at 817-272-9329.

Sincerely,

Patricia Turpin

Digitally signed by Patricia Turpin
DN: o=The University of Texas System, ou=The University of Texas at Arlington CA, ou=www.verisign.com/repository/CPS Incorp. by Ref.,LIAB.LTD(c)99, cn=Patricia Turpin, email=pturpin@uta.edu
Date: 2011.01.15 14:59:00 -06'00'

Patricia Turpin, Ph.D., RN, NEA- BC
Clinical Associate Professor
UT Arlington IRB Chair

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BIOGRAPHICAL INFORMATION

Dr. Pop completed her basic nursing education in Romania where she practiced in a variety of settings, from community to critical care nursing. Dr. Pop earned her Bachelor of Science in Nursing from the University of Victoria and her dual Masters in Nursing Science and Healthcare Education from the University of Phoenix. Dr. Pop was inducted into the Sigma Theta Tau, the International Nursing Honor Society, in 2008 and Phi Kappa Phi in 2009. She was awarded the Ferne C.Newman Kyba Fellowship to complete her dissertation work in 2010. Dr. Pop's main research interest is mentoring. She designed and implemented a mentoring program for advanced practitioners at Children's Medical Center in Dallas and has conducted several research studies to assess and evaluate the program. Dr. Pop is also program director for the Orthopedic Mid-Level Provider Fellowship Program, a new fellowship designed to train mid-level providers for the pediatric orthopedic specialty. She was part of the design and development team for the fellowship program. Dr. Pop is adjunct faculty at Texas Women University and The University of Texas at Arlington. She is a mentor for nurses and allied health professionals interested in research and Evidence Based Practice. She also serves as an Institutional Board Review board member at The University of Texas Southwestern Medical Center. Other research interests also include validation of a peripheral intravenous infiltration assessment tool for pediatric patients, pain management for pediatric patients undergoing adenotonsillectomy, and extubation of pediatric patients by nurses in the Post Anesthesia Care Unit.